

**THE MEDICARE PORTIONS OF THE  
PRESIDENT'S FISCAL YEAR 2009 BUDGET**

---

---

**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 14, 2008

**Serial No. 110-70**

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

58-275

WASHINGTON : 2011

---

For sale by the Superintendent of Documents, U.S. Government Printing Office,  
<http://bookstore.gpo.gov>. For more information, contact the GPO Customer Contact Center,  
U.S. Government Printing Office. Phone 202-512-1800, or 866-512-1800 (toll-free). E-mail, [gpo@custhelp.com](mailto:gpo@custhelp.com).

## COMMITTEE ON WAYS AND MEANS

CHARLES B. RANGEL, New York, *Chairman*

FORTNEY PETE STARK, California	JIM MCCRERY, Louisiana
SANDER M. LEVIN, Michigan	WALLY HERGER, California
JIM MCDERMOTT, Washington	DAVE CAMP, Michigan
JOHN LEWIS, Georgia	JIM RAMSTAD, Minnesota
RICHARD E. NEAL, Massachusetts	SAM JOHNSON, Texas
MICHAEL R. MCNULTY, New York	PHIL ENGLISH, Pennsylvania
JOHN S. TANNER, Tennessee	JERRY WELLER, Illinois
XAVIER BECERRA, California	KENNY HULSHOF, Missouri
LLOYD DOGGETT, Texas	RON LEWIS, Kentucky
EARL POMEROY, North Dakota	KEVIN BRADY, Texas
STEPHANIE TUBBS JONES, Ohio	THOMAS M. REYNOLDS, New York
MIKE THOMPSON, California	PAUL RYAN, Wisconsin
JOHN B. LARSON, Connecticut	ERIC CANTOR, Virginia
RAHM EMANUEL, Illinois	JOHN LINDER, Georgia
EARL BLUMENAUER, Oregon	DEVIN NUNES, California
RON KIND, Wisconsin	PAT TIBERI, Ohio
BILL PASCARELL JR., New Jersey	JON PORTER, Nevada
SHELLEY BERKLEY, Nevada	
JOSEPH CROWLEY, New York	
CHRIS VAN HOLLEN, Maryland	
KENDRICK MEEK, Florida	
ALLYSON Y. SCHWARTZ, Pennsylvania	
ARTUR DAVIS, Alabama	

Janice Mays, *Chief Counsel and Staff Director*

Brett Loper, *Minority Staff Director*

---

## SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

LLOYD DOGGETT, Texas	DAVE CAMP, Michigan
MIKE THOMPSON, California	SAM JOHNSON, Texas
RAHM EMANUEL, Illinois	JIM RAMSTAD, Minnesota
XAVIER BECERRA, California	PHIL ENGLISH, Pennsylvania
EARL POMEROY, North Dakota	KENNY HULSHOF, Missouri
STEPHANIE TUBBS JONES, Ohio	
RON KIND, Wisconsin	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

## CONTENTS

---

	Page
Advisory of February 12, 2008, announcing the hearing .....	2
WITNESS	
Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services .....	5
SUBMISSIONS FOR THE RECORD	
The Senior Citizens League, statement .....	15
American Federation of State, County and Municipal Employees (AFSCME), statement .....	16
Linda Schmidt, statement .....	18
Wim Kellett, statement .....	21



**THE MEDICARE PORTIONS OF THE  
PRESIDENT'S FISCAL YEAR 2009 BUDGET**

---

**THURSDAY, FEBRUARY 14, 2008**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:15 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee) presiding.  
[The advisory announcing the hearing follows:]

# ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

## SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE  
February 12, 2008  
HL-19

CONTACT: (202) 225-3943

### Hearing on the Medicare Portions of the President's Fiscal Year 2009 Budget with Acting CMS Administrator Weems

House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare portions of the President's fiscal year 2009 budget. **The hearing will take place at 1:00 p.m. on Thursday, February 14, 2008, in the main Committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

#### **BACKGROUND:**

On February 4, 2008, President George W. Bush submitted his Fiscal Year 2009 budget to Congress. Many of the spending and policy proposals related to the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services fall under the jurisdiction of the Ways and Means Committee.

The President's budget proposes spending cuts for Medicare over the next 10 years of \$556 billion in legislative changes and \$20 billion in regulatory changes. In total, the budget proposes \$576 billion in cuts to Medicare over 10 years. Program-level funding for the administrative activities at CMS for 2009 would receive a slight increase, while the number of full-time equivalent employees (FTEs) is projected to decrease slightly.

In announcing the hearing, Chairman Stark said, **"The proposed Medicare cuts exclusively target traditional fee-for-service Medicare providers, while protecting the overpayments to private insurance companies that drain Medicare solvency and raise beneficiary premiums. This budget again reveals the Administration's agenda to starve traditional Medicare and force beneficiaries and providers to rely on private plans. I look forward to hearing Acting Administrator Weems explain how these budget proposals are in the best interest of beneficiaries, providers and the overall strength of the program."**

#### **FOCUS OF THE HEARING:**

The hearing will focus on the Medicare portions of the President's fiscal year 2009 budget.

#### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please Note:** Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage,

<http://waysandmeans.house.gov>, select "110th Congress" from the menu entitled, "Committee Hearings" (<http://waysandmeans.house.gov/Hearings.asp?congress=18>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You MUST REPLY to the email and ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, February 28, 2008. Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

#### **FORMATTING REQUIREMENTS:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. We begin the hearing late. I apologize to Administrator Weems' staff and all of our guests who have been patiently waiting while we worked out a few problems on the floor, and I hope that we won't be disrupted a lot with votes and can proceed.

Many of our Members on both sides have been involved in these floor proceedings and hopefully will be finding their way here, but we'll start out. As I had suggested to Mr. Weems that I had a great opening statement that blames him for all the ills of the Medicare, but after keeping him waiting that long, I think that would just not be very hospitable.

I could just simply summarize where I think I was going and we'll talk later is that I have been concerned that while we have reduced resources for a variety of Medicare Programs, whether you call it slowing the growth or making cuts. It's indifferent to me.

We somehow overlooked doing anything with Medicare Advantage where there seemed to be some universal agreement among the experts that were overpaying, and I was concerned that we missed that opportunity with which we could have extended the trust fund a couple of years. The trigger would not have come into account had we reduced the payments. But, other than that, we can talk about a lot of issues. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman.

I also will forego a formal opening statement in light of the fact we've had somewhat of an unusual floor procedure, but I do want to say that we did hear about the long-term problems facing Medicare yesterday. I think that there are a number of challenges, we all agree.

I look forward to working with you in the time that we have left to develop some ideas that would improve the financial outlook for Medicare, while also preserving those important services that are offered to seniors through those programs. So, with that I would just ask unanimous consent to submit my statement for the record.

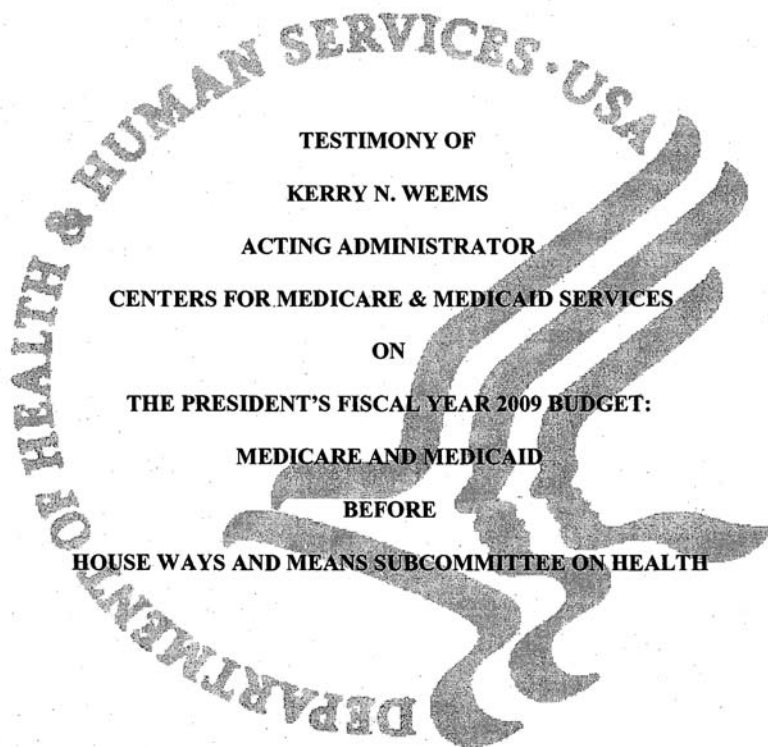
Chairman STARK. Without objection, the statement will appear in the record.

Administrator Weems, if you would like to add anything at this point to the record in addition to your statement that we will hear from you, we will make that part of the record. Why don't you proceed to enlighten us?

Mr. WEEMS. Thank you, Mr. Chairman and Congressman Camp. In keeping with the spirit of comity, I will forego my statement too, and wish you both happy Valentine's Day.

[The prepared statement of Kerry Weems follows:]





**TESTIMONY OF  
KERRY N. WEEMS  
ACTING ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
ON  
THE PRESIDENT'S FISCAL YEAR 2009 BUDGET:  
MEDICARE AND MEDICAID  
BEFORE  
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH**

**February 14, 2008**



**Testimony of Kerry Weems  
Acting Administrator, Centers for Medicare & Medicaid Services  
on  
The President's Fiscal Year CMS 2009 Budget Request  
Before the  
House Ways & Means Committee, Subcommittee on Health**

**February 14, 2008, 1:00 p.m.**

Good afternoon Chairman Stark, Representative Camp, and distinguished members of the Subcommittee. I am pleased to be here today to discuss proposals in the President's fiscal year (FY) 2009 budget request related to the programs administered by the Centers for Medicare & Medicaid Services (CMS): Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP).

For the past seven years, this Administration has worked to increase the effectiveness and efficiency of Medicare, Medicaid and SCHIP. Together with Congress, we have made great strides in modernizing and improving health care benefits, but there is more work to be done. The FY 2009 budget request for CMS builds on these past efforts by updating and strengthening our payment systems, beginning to incorporate value-based purchasing strategies, and improving quality and efficiency while restraining costs. The savings proposals identified in the FY 2009 CMS budget request also are integral to the President's goals of controlling entitlement spending and balancing the overall Federal budget by 2012.

While significant savings proposals have been identified in the President's FY 2009 budget request, particularly in the Medicare program, let me be clear about one thing: this budget is not a panacea for the funding problems looming on the horizon. Every member of this Committee knows that spending on Medicare is growing faster than we can afford. As the President noted in his recent *State of the Union* address, painful choices lie ahead for policymakers if entitlement growth is allowed to continue unchecked: massive tax increases, sudden and drastic cuts in benefits, or crippling deficits. Absent reform, these tough choices are coming soon. Indeed, based on the 2007 Trustees Report, in just eleven years from now the Hospital Insurance (HI) Trust Fund

that pays Medicare Part A benefits will no longer be able to pay full benefits. For those of you who think that eleven years is still far off, you should know that we already are on a path leading to exhaustion of the HI trust fund. In 2007, Part A expenditures exceeded dedicated tax revenues by \$4.7 billion. This year, expenditures are projected to exceed dedicated revenues by \$10.6 billion.

### **Medicare Proposals**

For 2008, a projected 44.6 million Americans will be enrolled in the Medicare program. In addition to the benefits of traditional Medicare, the Medicare prescription drug program (Part D) and Medicare Advantage are offering unprecedented choices, expanded benefits, and quality care through competition among private plans.

Current Medicare spending levels threaten benefits and access for current and future beneficiaries. Medicare spending is projected to be 3.3 percent of gross domestic product (GDP) in 2009. Under current law, the 2007 Trustees Report predicts that Medicare spending will grow to 7.3 percent of GDP by 2035, and to 11.3 percent of GDP by 2080. These trends are unsustainable. The FY 2008 budget included proposals to begin to address out-of-control costs, but Congress did not act to curb the spending in 2007. In fact, in some cases, Congress intervened to stop CMS from implementing administrative savings proposals.

It is in this environment that the FY 2009 budget request is presented to the Congress, including significant savings proposals to begin restraining exploding growth. I know these choices are tough and may not be popular; however, I hope we all can agree that major reform of the Medicare program is necessary to preserve its future. We may not agree on what those reforms should be – in fact, I would wager that we do not – but let us at least agree to acknowledge that in the absence of major change, the HI trust fund will no longer be solvent by the time any 54-year-old sitting in this room reaches Medicare eligibility. We need to find a way to come together and act now.

The President's budget request for CMS strives to move providers toward greater efficiency, with strong financial incentives for providers to slow cost growth through improvements in productivity and efficiency. In addition to encouraging appropriate, high-quality care for people with Medicare, the proposals would reduce the growth in premiums for most beneficiaries. Under the proposals in the FY 2009 Budget request, beneficiary premiums will be reduced by \$6.2 billion over five years.

The FY 2009 Budget request includes about \$486 billion in total gross mandatory spending for our Medicare program benefits. When combined with Medicare administrative proposals, the FY 2009 Medicare legislative proposals would produce net savings of \$12.8 billion in FY 2009 and \$182.7 billion over five years. Under this budget, Medicare's average annual growth rate would slow from 7.2 percent to 5 percent over five years. Make no mistake – this level of savings is not enough to shore up Medicare permanently. By extending near-term solvency, however, we do create an opportunity to devise and enact the vital, more permanent reforms that are required.

Towards this end, the budget would:

(1) Improve Quality and Efficiency: For example, the budget proposes to implement a value-based purchasing (VBP) program for Medicare inpatient hospital payments that ties a percentage (5 percent) of a hospital's base payment for each discharge to the hospital's actual performance on a number of measures. Hospitals would be provided an opportunity to achieve bonus payments for either improving performance on a set of measures or achieving a high level of absolute performance.

Another proposal would require hospitals to report any occurrences of "never events," which are unambiguous, usually preventable, serious medical errors. No Medicare payment would be made for services connected to never events. Any hospital failing to report their never events would receive a 2 percentage point annual update reduction.

The budget also includes a regulatory proposal that would look to expand current policies that eliminate higher payments for certain health conditions that were not present at the time of admission to the hospital, so-called hospital acquired conditions.

(2) Align Medicare Payments with Current Costs and Practices: The budget proposes to align payment rates for certain dialysis services in hospital-based and free-standing facilities and implement a new bundled prospective payment methodology for the end-stage renal disease (ESRD) program that would include both dialysis services that are currently paid using a bundled prospective payment and ESRD drug treatment and laboratory costs for which Medicare currently pays separately. An additional legislative proposal would move Medicare toward site-neutral payment systems by establishing a new post-hospital payment rate for five conditions that are commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities.

Another proposal would establish a 13-month rental period for power wheelchairs to ensure that Medicare and its beneficiaries no longer pay excessively for the rental of equipment that could have been purchased. In a similar vein, the rental period for most oxygen equipment would be reduced from 36 to 13 months. This provision will lower Medicare and beneficiary spending.

(3) Increase Responsibility for Health Care Choices: The budget proposes to extend the Part B income-related premium adjustment to the Part D program. This proposal would increase premium amounts for the Medicare drug benefit for high-income Medicare beneficiaries in a manner similar to what is currently applied in the Part B program.

#### **Medicaid and SCHIP Proposals**

Medicaid and SCHIP provide access to affordable health care for vulnerable populations including low-income seniors, individuals with disabilities, and uninsured children. The President's FY 2009 budget request makes a number of proposals to

preserve and strengthen the Medicaid program, building on past efforts to create service efficiencies and to assure its fiscal integrity.

The FY 2009 budget also includes a proposal to re-focus SCHIP on uninsured, targeted, low-income children and to reauthorize the program responsibly. The proposal would increase funding to states by \$19.7 billion through FY 2013, with \$450 million in outreach grants. With this SCHIP reauthorization proposal, we are re-affirming our commitment to covering low-income uninsured children and promoting a fiscally responsible SCHIP program that will be available for the children who need it the most.

#### **Conclusion**

The President's FY 2009 budget demonstrates a commitment to improving America's health care system by strengthening Medicare's financial outlook; reauthorizing and sustaining health care coverage for low-income and vulnerable populations; and taking steps to make health care more affordable and accessible for all. This is a critical time in the life of Medicare and Medicaid. Steps taken now – or not taken – to adopt rational, responsible, and sustainable policies will directly impact our ability to preserve the promise of health care coverage for America's seniors, people with disabilities, and low-income, vulnerable populations. We look forward to working with Congress in the coming year to reauthorize SCHIP, strengthen our existing programs, and improve access to affordable health insurance for all Americans.

Chairman STARK. Without objection, it will appear in the record. I would ask you to talk about the Medicare Advantage plans, some of the concerns that I have are, let me just run through a few, and maybe you could address those.

In spite of what Medicare Advantage Plans say they “offer” beneficiaries, there is very little record as to what they actually provide. To offer me a wall-climbing episode at the health club is a generous offer, but one that I would not be inclined to accept. We do find in the statements of some of the large private insurance companies where we can get the records that are publicly traded that their loss ratios have dropped.

So, they’ve been spending less of their premium income on benefits. Also we know that some of them charge more than Medicare for certain copays, so that a beneficiary in certain plans will have a higher copay or deductible in copay than they would under traditional Medicare. So, there are a lot of those glitches in addition to what seems to be OMB, the year actuaries, our actuaries, all suggesting in Med-Pac that we are in varying amounts “overpaying” or paying more than we would pay for those services under fee-for-service. So, I guess, do you see some changes that we could make that would do two things: Save us some money and give some, say, protection if you will or a fairer treatment to our beneficiaries?

Mr. WEEMS. Maybe we can talk about the premises.

Chairman STARK. Pardon?

Mr. WEEMS. Maybe we can talk about the premise from which you operate first.

Chairman STARK. Okay.

Mr. WEEMS. So, you know, what are the extra benefits that are offered to beneficiaries? We can see and track a good deal of them, because much of that is in reduced cost-sharing, buying down premiums, things like that. You know, we can tell you where that’s happening.

Now with respect to what you say about copayments, that has to do with choice. There are plans that offer a variety of copayments, a variety of cost-sharing schemes where you may choose lower cost-sharing in one place and higher in another.

Chairman STARK. That doesn’t wash. Are you sure they make low ball at me coming in with a bill premium or 25 bucks.

Mr. WEEMS. Right.

Chairman STARK. Okay, and I could bring out the litany of plans and suddenly I find that their hospital copay is 700 bucks a day. Where, under Medicare, it’s what—900 for the whole procedure—and so if you are in for 3 days, you get whacked with \$2,100.

Then if you combine that with the marketing problems where they haven’t been always as up front as we think they ought to be or as transparent, if I thought that the beneficiaries understood that and made that choice, but I don’t, so from that standpoint I think there are great sales people out there and they do a wonderful job marketing, but their job is to sell their plan. It’s just like, you know, Ford forgets to tell me there’s no spare tire. They’re not misleading me, they just forgot to tell me.

So, that’s my concern. I would agree with you. If we could make it more transparent and clearer, and more easily understood by the

beneficiaries, no quarrel. But then you get to the cost issue, and it is costing us money to do it. So, let's take that part of it.

Mr. WEEMS. Let me just say one thing, if I can, about the sales, and then let's go into cost.

I actually, as you may know, have set through several of the sales pitches anonymously just to see what's going on and to ask questions to get a better understanding. In several instances, I heard marketers sort of lay out plans, you know, for needs.

Look, do you expect to go in the hospital? Not that that's a 100 percent guess, but they would lay out the benefit for the hospital. You know, do you see a doctor. Well, if you see a doctor a lot, this plan might be better. There was, I would say, an education moment where a beneficiary was educated about what their choices might be, especially with respect to cost-sharing.

So, you know, I present that to you from actual experience. With respect to cost the Congress made a decision that nationwide people should have access to these kinds of products. They are, now, and the way that the benchmark system works, that is the result that we have. But more beneficiaries have more access to more choice than they had before.

Chairman STARK. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman.

I know CMS has been working on a number of initiatives on price transparency and quality and we've heard a lot from witnesses and through other meetings that if we are going to have real health care reform those are two areas that we certainly need to have better information. I believe Secretary Levitt yesterday touched on those as well.

Also in connection with the August 2006 Presidential Executive Order to increase transparency in the health care system, can you just quickly outline some of the initiatives CMS is working on to facilitate informed choice regarding treatment?

Mr. WEEMS. Certainly. We have a number of initiatives under way, first of all with respect to quality, and this is something that the Congress has come back to us on a number of occasions, and that's the physician quality reporting initiative. It began in 2007 and, you know, this year we are working to implement the enhancements that we have.

If you look at many of the places where we have contact with beneficiaries—that's the physician's office—in ESRD we have a number of quality measures and quality initiatives. In the inpatient hospital arena, you know, our rule that goes into effect this next year has us no longer paying for certain types of infection, certain types of procedures.

Those are all quality based. Now, with respect to transparency we have made information available for the cost of some procedures. In this year's budget, and I would ask the Chairman to look especially closely at this, we are looking for a legislative means of making Medicare information available to the public in a transparent way. Right now we have conflicting court orders. We are seeking a resolution from the Congress so that we can make that information available so that people can use it.

Now, we would like to make it available in a way that Medicare can still be the health care financing agency that we are and not



just turn into a data production agency. So, we would like to be able to do it in a rational way. As people understand quality, as people understand price, this Committee might be able to consider very rational changes to a program where—you know, I think we could all agree that maybe if the beneficiary were willing to choose a high-quality, low-cost provider—maybe their cost-sharing changes, things like that that would drive the system toward quality and to reduced costs.

Mr. CAMP. All right. I just follow up on another issue. You know, yesterday I asked a question and the secretary, the average of out-of-pocket costs with traditional Medicare at the highest levels, there is certainly a big difference between that and what they spent in Medicare Advantage. I mentioned a scenario where it was about \$2,100 difference if they were in a coordinated care plan. So, their significant savings for the highest and sickest beneficiaries in the program, can you comment on that?

Mr. WEEMS. Certainly. In some programs we find that beneficiaries will do better in these programs, and, you know, as you said, certainly their cost-sharing is substantially lower in these plans, and it is because they are getting coordinated care and because it is a risk plan that has capitated payment.

Mr. CAMP. All right, and thank you, Mr. Chairman.

Chairman STARK. This is going to be the shortest hearing on record. We have been told that this vote will conclude in about 10 minutes and then there is going to be, I think, 7 more 5-minute votes. There seems to be no willingness of our colleagues on the floor to shorten those to 2-minute votes. So, I don't intend to ask you to stay.

I might suggest and if we can find the time after the recess, Mr. Camp, that if we could ask you to return for an informal session with our Subcommittee on briefings on a lot of these issues of things that I know many of my colleagues wanted to talk about, plans for competitive bidding, the Iraq problems. I mean, there is a host of those things that we are hearing about from our constituents.

The ESRD, the nursing home things, and we just unfortunately don't have time. I would love to get into that today, but I think, if you would be agreeable and we could find some time after the recess. I want to note the arrival of Mr. Pomeroy.

We are about to conclude, Earl, and I would be glad to let you enter into it, just suggesting that there are so many issues that we wanted to cover and won't have time that I am going to ask Mr. Weems if he would come back and at least meet with us informally so that we would have a chance to go over a host of the issues that I know colleagues on both sides of the aisle want to find out in terms of what is going to happen this year.

Mr. WEEMS. It would be my privilege.

Chairman STARK. Would you? That would be good.

Did you have any statement, make a statement part of the record, Earl, or if you had a question?

Mr. POMEROY. Mr. Chairman, thank you for giving me this brief opportunity. The Administrator came all the way to North Dakota to look at a problem that we have had. We have been working with him to fix the problem. I am glad that we are going to

have a more fulsome opportunity to visit with the Administrator. He is not a sound bite guy; he is a program guy, and he knows this program inside and out.

I believe that we could all learn from one another in a more generous time environment for the discussion. I really do appreciate the Administrator and his attention to the issues that we have had in North Dakota. Thank you.

Mr. WEEMS. I learned a lot on that trip. Thank you.

Chairman STARK. Could I just doublecheck this with you that we are in agreement on the Med-Pac and GAO recommendations to move to an ESRD bundling program without having to go through demonstrations?

Mr. WEEMS. Yes, sir. We are actually prepared and we can go through the rationale.

Chairman STARK. Yeah, fine. That's one of the things that I thought we could proceed with.

Mr. WEEMS. Yes, sir.

Chairman STARK. Do you have anything else you would like to add? You have been waiting here for a chance to inform us.

Mr. WEEMS. Just, I'm very grateful for the opportunity to appear. Just my own personal thought after 25 years as a career civil servant: It's remarkable for me to sit here before you in this room.

Chairman STARK. Well, I am afraid we have more to do than we are going to be able to accomplish. We aren't going to be able to find pay-fors under our whatever that is we saddled ourselves with. We have the 10 percent doc cut. We have the trigger. You've got the trigger mechanism set for us yet?

Mr. WEEMS. I expect that you will hear about that soon, sir.

Chairman STARK. When I am on recess? I don't have much time. Do you know when it is coming? Can you give me a hint?

Mr. WEEMS. I am not in a position to give you a hint, but shall we say soon?

Chairman STARK. We have that and then a host of other issues, some more complex. We must have had 50 or 60 hospital transition things, and I don't know yet how we are going to handle that, but I will look forward to seeing if we can package up those things that we could all, Mr. Camp and I and you, could agree to, maybe wrap those up either in a quick procedure, get some of that off the table. Then we can worry about some of the bigger, more political issues, as we go along. There isn't going to be much time.

Mr. WEEMS. Well, you'll find what for—

Chairman STARK. The conventions. After the 4th of July, I think we are done, quite frankly. That's sad, but we've got the S-chip thing, the doctors, and hopefully we can either get extensions or something to prevent any radical changes to either providers or beneficiaries. If we could get that done, I'd call it a good year.

Mr. WEEMS. Hopefully you'll find us an energetic and helpful partner.

Chairman STARK. Thank you very much, and I again apologize for our fractured schedule today.

If there are no concluding remarks, thank you. We'll see you soon. The hearing is adjourned.

[Whereupon, at 2:37 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

### Statement of The Senior Citizens League

On behalf of the approximately 1.2 million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding the Medicare portions of the President's Fiscal Year (FY) 2009 Budget. TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

In 2003, legislation that overhauled Medicare included a provision that requires the President to propose changes to Medicare in the event that the entitlement was going to draw more than 45-percent of its funding from the government's general revenue instead of the Medicare trust fund. This finding occurred in 2006 and 2007, and in the President's proposed budget for Fiscal Year (FY) 2009, Medicare spending is reduced by \$12.2 billion in FY 2009 and by \$178 billion over five years. It is not clear at this time if there will be additional proposals.

While TSCL fully understands the need to address the looming Medicare Trust Fund exhaustion, we are concerned that it may come at the expense of Medicare beneficiaries, many of whom are already financially strapped due to high premiums and an inadequate cost of living adjustment (COLA) to their Social Security benefits. Since 2000, Social Security benefits have increased 22%, and Part B premiums have increased 111%.

The 2009 Budget includes several legislative proposals that the Administration believes could strengthen the longevity of the Medicare entitlement program, if signed into law. The proposals would: "encourage provider competition, efficiency, and high-quality care; rationalize payment policies; increase beneficiary responsibility for health care costs, improve Medicare's fiscal sustainability, and improve program integrity."<sup>1</sup>

#### Encourage Provider Competition, Efficiency, and High-Quality Care

TSCL agrees that reform is needed when it comes to provider reimbursement, especially in the case of physicians providing outstanding care to Medicare beneficiaries. In recent years, premiums have been announced prior to increases in physician reimbursements, meaning that actual program costs are higher than originally estimated. Although temporary fixes have been issued, TSCL is concerned that with the "trigger," proposals could eventually lead to a substantial jump in Part B premiums to offset the rising cost of quality health care.

Last year, the Medicare Trustees estimated that Medicare Part B and Part D premiums, deductibles, and coinsurance costs were taking one-third of the average Social Security benefit. Skyrocketing premiums, accompanied with a COLA that does not take adequately into account health care expenses are making it difficult for many seniors, especially those relying solely on their Social Security benefits, to get by. We should note, however, that TSCL and its members were pleasantly surprised with a Part B premium increase of \$2.90 per month in 2008 for the majority of seniors.

#### Increase Beneficiary Responsibility

Increasing beneficiary responsibility on the surface may sound like a good idea to some. TSCL is concerned about the proposal to eliminate the annual indexing of income thresholds for Medicare Part B premiums, especially if Part D becomes subject to the same income thresholds.

We fear that halting the annual index for income related premiums will lead to more and more middle income seniors paying higher rates. Although some advocates consider it to be fair for those with higher incomes, we fear that low and middle-income seniors will be the ones to suffer and eventually end up paying higher premiums as the threshold is lowered to make up for future funding shortcomings. Further, it seems unjust to have a group of beneficiaries paying more for the same care and coverage. As the snowball grows, more seniors could look outside of Medicare plans for quality health care insurance at a lower cost.

TSCL also questions how private entities will be able to implement income indexing accurately. With the involvement of private companies, the Internal Revenue Service, and the Social Security Administration, the automatic deduction of premiums from monthly benefits could become more costly and onerous. It seems that the only way means testing could work for Medicare Part D is to consider eliminating private insurance companies from the equation, leaving Medicare to coordinate Part D as it does Part B.

<sup>1</sup> [www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf](http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf), p. 53-54.

### Improve Program Integrity

Greater program oversight is always a welcomed proposal. As reported in the new 2009 Budget in Brief, the Health Care Fraud and Abuse Control (HCFAC) program is responsible for detecting and preventing health care fraud, waste, and abuse. This is accomplished through investigations, audits, educational activities and data analysis. From 1997 to 2007, HCFAC returned more than \$10 billion to the Medicare Trust Fund. While this is impressive, we can only imagine how much more money could be saved and/or returned with a more streamlined process among the involved agencies.

Equipping health care providers with knowledge about problems and ways to increase accuracy will undoubtedly save money. As reported for 2007, improper Medicare payments have dropped to a new low of 3.9 percent. TSCL supports strong enforcement and greater audits of claims, especially when considering the problems occurring with Part D plans.

Also, it has been widely reported that the Medicare payment system should take a closer look at excessive payments for certain items. The New York Times has reported that Medicare pays much higher amounts for durable medical equipment than are charged to individuals buying the same product.<sup>2</sup> According to the 2007 NYT article, “. . . Even for a simple walking cane, which can be purchased online for about \$11, the government pays \$20, according to government data.” Another example of overspending occurs when the government rents oxygen equipment for up to 36 months at a cost of more than \$8,000 per individual. The article reports that the same equipment could be purchased from a retailer for “as little as \$3,500.”

TSCL is not suggesting that oxygen equipment not be provided for those in need. What we do believe is that there are more fiscally responsible ways to provide the same care, which in the end could save Medicare billions of dollars annually.

### Conclusion

Although we are pleased that the Administration has put together suggestions for strengthening the Medicare Trust Fund, TSCL and its members are concerned about what the cost to the public will be. While we do not have a perfect solution, there are some simple actions that could be taken in the meantime.

For example, TSCL is encouraging all Members of Congress to support a recently introduced bill, H.R. 4338, introduced by Representative Timothy Walberg (MI-7). H.R. 4338, titled the Social Security and Medicare Lock-Box Act, would establish a procedure to safeguard the surpluses of the Social Security and Medicare hospital insurance trust funds. Thanks to Representative Stephanie Tubbs Jones (OH-11), an original cosponsor, this legislation had bipartisan support from the start. Additionally, similar legislation, S. 302, was introduced last year during the first session of the 110th Congress by Senator David Vitter (LA).

As the Administration suggests, tougher enforcement and increased transparency will save Medicare billions of dollars annually. **A significant portion of the expenditures comes from fraud and abuse that hurts the solvency of important entitlement programs like Medicare for current and even future retirees.**

Regardless of which solution Members of Congress believe is best, TSCL sincerely hopes that the Medicare and Social Security Trust Funds are protected and strengthened for future generations.

---

### Statement of American Federation of State, County and Municipal Employees (AFSCME)

The American Federation of State, County and Municipal Employees (AFSCME) represents 1.4 million employees who work for Federal, State, and local governments, health care institutions and nonprofit agencies, and an additional 230,000 retiree members. AFSCME and its members are proud of labor's historic role in the creation of Medicare and we remain strong defenders of the Medicare program from those who would undermine its foundations.

When President Johnson signed Medicare into law on July 30, 1965, he spoke of the profound promise of Medicare to our Nation and its citizens:

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they

<sup>2</sup>Duhigg, C., “Oxygen Suppliers Fight to Keep a Medicare Boom,” New York Times, Nov. 30, 2007.

have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.”

For today's 44 million Medicare beneficiaries and our Nation, the need for Medicare to remain a sanctuary against financial ruin caused by the vicissitudes of illness and disability rings as true in 2008 as it did more than four decades ago.

President Bush's fiscal year 2009 budget would undermine Medicare by making substantial program cuts while protecting insurance company profits at the expense of moderate-income beneficiaries, hospitals and other providers. Instead of improving the fiscal solvency of Medicare by reducing the extra subsidies provided to insurance companies for offering a private alternative to Medicare, the Administration's budget shields these privatized Medicare Advantage plans from direct cuts.

#### **Damaging Cuts to Medicare**

The President's budget chops Medicare by more than \$178 billion over the next 5 years, \$556 over 10 years, and more than \$10 trillion over the next 75 years. These extensive cuts are funded, in large part, by shifting roughly \$6 billion of extra premium costs to moderate-income beneficiaries, nearly \$21 billion in costs to hospitals that treat significant populations of indigent patients, and more than \$117 billion in reduced payments to hospitals, nursing homes, home care agencies and other providers. Cuts at this level will have significant short-term and long-term negative impact on traditional Medicare which, for most AFSCME retirees, is the foundation of their health care benefits. These cuts will negatively impact retirees' health outcomes and quality of life by limiting access to care and by undermining the strength of traditional Medicare.

#### **Shifting Costs Onto Beneficiaries and Cutting Payments to Health Care Providers**

AFSCME is concerned with the President's renewed legislative proposals to shift added Medicare premium costs onto limited and moderate-income beneficiaries. All beneficiaries are already paying higher Part B premiums, in part to subsidize overpayments to insurance companies offering Medicare Advantage plans. In addition, those with incomes above certain levels pay a surcharge on their Part B premiums. The President's budget would abolish indexing the income threshold for the additional Part B premiums to the Consumer Price Index. The President's budget would also put an un-indexed surcharge on Part D prescription drug premiums as well. Without indexing the income threshold to inflation, over time more moderate- and even lower-income beneficiaries will be affected, in the same way that, without indexing, the Alternative Minimum Tax has expanded to include more moderate-income taxpayers. When President Bush proposed the same un-indexed premium surcharge in his FY 2007 budget it was reported that in a few years the Part B premium surcharge would cover nearly one in ten beneficiaries.

While the Medicare Payment Advisory Commission (MedPAC), the independent nonpartisan group charged with making recommendations to Congress on the Medicare program, has recommended some ways to adjust payments to providers, the President's budget ignores the magnitude and scope of these recommendations in an arbitrary and unbalanced manner. For example, contrary to MedPAC recommendations, the President would cut Medicare payments targeted to hospitals that serve large numbers of low-income individuals by 30 percent over 2 years, forcing many public and safety net hospitals to absorb \$20.7 billion over 5 years. This cut, along with other proposed cuts to providers, will limit beneficiaries' access to care and jeopardize the health of significant numbers of people who are elderly, and may be frail, or have serious disabilities.

#### **Subsidies to Inefficient Privatized Medicare Advantage Plans, Which Threaten Medicare's Financial Solvency, Remain Untouched**

While the President proposes cuts to providers who serve beneficiaries, his budget shields inefficient and costly Medicare Advantage plans from any direct cuts to their windfall subsidies. MedPAC has recommended that Congress curb the billions of dollars in excessive payments made to private insurance companies that offer a private alternative to supplant—not supplement—Medicare.

When Congress opened up Medicare to private plans, it was based on the claim that the private health insurance industry would be more efficient, provide more co-

ordinated care for seniors and the disabled, and do so with less cost to the taxpayers and beneficiaries than the traditional Medicare program. The promises of efficiencies and lower costs have been illusory; Medicare now pays private Medicare Advantage plans *more* than it would cost to cover the same beneficiaries through the traditional Medicare program. Current estimates are that for every dollar spent for benefits under traditional Medicare it costs \$1.17 when a private fee-for-service plan provides the benefits. Not surprisingly, with that enhanced profit incentive, enrollment in Medicare Advantage private fee-for-service has grown at an alarmingly rapid rate over the past year.

Growth in enrollment further exacerbates the strain on Medicare's financial health by draining the Medicare Hospital Trust Fund and taxpayers' resources. Over the next 10 years, these overpayments to insurance companies will cost an additional \$150 billion. These overpayments shave two years off the financial solvency of the Hospital Trust Fund. The ballooning growth in overpayments to private plans will drive premiums even higher for beneficiaries, erode Medicare's financial solvency and ultimately force major changes in the Medicare program, including substantial cuts in benefits. If left unchecked, these overpayments will ultimately lead our Nation backwards to a time when seniors were one illness away from poverty and were denied reasonable and necessary medical care because they could not afford to pay doctors or hospitals.

AFSCME is concerned that these plans, as a substitute for traditional Medicare, also undermine the quality and integrity of the Medicare program. Medicare Advantage plans may offer additional benefits, such as gym memberships, or hearing aids and eyeglass coverage, but they modify their benefits to cut corners in more important areas, such as limiting hospital days or charging higher copays for rehabilitative care than Medicare. State officials who forced retirees into Medicare Advantage plans acknowledged that "we know that . . . retirees who use more medical care will be worse off under this plan." We are concerned that Medicare Advantage plans deny claims more frequently to hold down costs and the appeals process is more difficult under these plans than under traditional Medicare. Retirees must go through the company rather than Medicare's transparent appeals process and can be bounced between the Federal agency that administers Medicare and the insurance company when they seek redress. Medicare Advantage plans, unlike traditional Medicare, are not stable. These plans can and do pull out of markets, disrupting health care services and causing much anxiety among beneficiaries. There is a lack of access, quality and accountability for many of these private replacements for Medicare. The private fee-for-service plans are exempt from basic quality reporting and they limit access to care and choice because significant numbers of doctors and hospitals have refused to accept beneficiaries from these plans.

Given these problems, Congress must act to rein in the runaway overpayments to these private plans. Congress must reject the President's budget which does nothing to curb the escalating growth of these privatized Medicare plans, reduce the excessive subsidies to these plans or improve Medicare benefits for current and future beneficiaries.

---

#### Statement of Linda Schmidt

The mission of the Michigan Department of Human Services (MDHS) is to assist children, families and vulnerable adults to be safe, stable and self-supporting. While MDHS appreciates the State-Federal partnership that enables us to perform this mission, the strength of this partnership has eroded over the past several years, leaving an increasing share of the burden on our State in the midst of a severe economic challenge. As needs have risen in the area of income security and family support, the amount of Federal investment in real dollars toward meeting these needs continues to fall. The President's FY 2009 budget request falls \$15 billion below the amount needed just to keep pace with inflation nationally. Given Michigan's current economic outlook, a disproportionate amount of that imbalance will fall on the shoulders of Michigan's vulnerable children and families. In addition, the programs we manage in partnership with the Federal Government have undergone increasingly complex reforms that limit the department's ability to reallocate resources to meet growing demands. This testimony will highlight the areas that best represent my concerns with the proposed budget.

#### Temporary Assistance to Needy Families (TANF)

Michigan's TANF block grant has not increased since it was established 11 years ago. The 1996 welfare reforms were predicated on the belief that welfare participa-

tion would never rise above 1996 levels. Two interdependent assumptions of welfare reform are that workforce participation leads to self-sufficiency and that there are ample opportunities for families to work toward self-sufficiency if they are given appropriate temporary supports. In Michigan, we have found that traditional cash assistance caseloads have decreased, but that vulnerable families are finding it difficult to become entirely self-sufficient. Many continue to need some form of assistance, and workforce participation alone does not guarantee that a family will achieve self-sufficiency. Flexible funding to support programs that can address specific barriers to self-sufficiency is greatly needed.

The President's budget request includes a change in work participation requirements that is very welcome. This change eliminates the 90% work participation requirement for two-parent families that was established as part of the reauthorization of the TANF program in the Deficit Reduction Act of 2005. However, a number of very problematic rules related to TANF remain in effect. States need guidance on the application of TANF rules and work verification plans. MDHS suggests that Congress prohibits penalties to States that fail to meet work participation under the interim TANF rules if there was not an approved work verification plan in place over all or most of the period of review. Michigan was one of the first States in the country to receive approval of its Work Verification Plan, but that approval was not received until August 6, 2007—only 7 weeks before the end of the first fiscal year that the plan covered. MDHS has provided comments to HHS regarding the potential negative impact of Deficit Reduction Act implementation through the rule-making process. While some issues were resolved in the TANF Final Rules issued last month, MDHS still has three outstanding concerns in this area:

- English as a Second Language, high school completion, and General Equivalency Diploma courses do not count as core work activities. Clients without basic education and communication skills will find it extremely difficult to achieve and maintain self-sufficiency despite mandatory participation in work activities.
- Substance abuse treatment, mental health treatment, vocational rehabilitation services and other “barrier removal activities” do not count as core activities beyond 4 consecutive weeks, or 6 weeks total in a year. MDHS suggests the definition of qualified work activities found in the PRIDE bill, which includes substance abuse counseling, rehabilitation treatment, work-related education or training, job search or job readiness, adult literacy programs, post-secondary education and barrier removal activities, as defined by the State, and allowed all of them to count as core work activities for up to 4 months. This flexibility would allow States to develop case plans that properly prepare parents for success in the workplace.
- A work participation plan that includes reduced hours as a reasonable accommodation for a person with disabilities should count as full participation if the person is in compliance with that plan.

#### **Low-Income Home Energy Assistance (LIHEAP)**

Even with the help of Federal funding, the State of Michigan cannot ensure that vulnerable families can maintain heat and electricity in their homes. In FY 07, there were 10 weeks during which there were no State or Federal funds available for crisis assistance, regardless of the applicant's financial eligibility. As energy costs and economic pressures steadily increase across the country, the demand for crisis assistance funding will continue to rise. The budget proposal, however, significantly reduces this vital resource.

LIHEAP funding has also not been sufficient to fully fund the Home Heating Credit. In FY 07, Michigan had to prorate the Home Heating Credit paid to eligible households to 76%. In FY 08, the credit is prorated to 53%. Even though the State has been able to gain some funding through the Low Income Energy Efficiency fund established by the Michigan Public Service Commission, those funds have only decreased the overall amount of the shortage, not eliminated it. With the reductions in the Home Heating Credit and the total inability, at times, to provide crisis assistance, it is clear that Michigan cannot keep up with the dramatically increasing energy costs and demands for assistance. A significant increase in funding is needed to bridge this gap.

#### **Community Services Block Grant (CSBG) and Social Services Block Grant (SSBG)**

The President's budget request for Health and Human Services once again proposes to eliminate the CSBG, relying on the Program Assessment Rating Tool (PART). This program's purpose is to provide flexible funding to community-based organizations to promote innovative, community-generated actions to reduce the in-

cidence and severity of poverty. In Michigan, this results in extending the State-Federal partnership to reduce poverty to local communities through grants to Community Action Agencies, providing services to over 220,300 vulnerable families in FY 06. The reliance on the PART to evaluate the effectiveness of this program provides an incomplete picture of its actual impact. The PART report for CSBG acknowledges that the program is unique, meets a specific need, and is effectively targeted. However, we disagree with the PART in the area of performance measures. Since community-based solutions are a core principle of this poverty reduction program, the system in place among Community Action Agency (CAA) partners to identify and measure results aligns with this core mission more appropriately than a federally imposed set of performance criteria. This accountability system, called Results Oriented Management and Accountability (ROMA), initiated by HHS, was chosen as a semi-finalist for the Innovations in American Government Award at Harvard University. MDHS appreciates the strong bipartisan support to fund CSBG after repeated requests to zero out this program, and we look forward to the resolution of this issue around performance indicators so that this funding uncertainty is relieved.

Additionally, if the CSBG core funding is not there, then the weatherization program, having weatherized over 5,000 homes in the past year, would be in jeopardy as well as many other programs the CAAs operate. CAAs in Michigan leverage an additional \$62.5 million in local and private funds and \$12.9 million worth of volunteer support that benefit low-income families in their communities.

Similarly, the issue of performance indicators erodes support for the Social Services Block Grant (SSBG). This program is intentionally flexible. In Michigan, SSBG funds support Adult Foster Care, Adult Protective Services, guardianship services for adults and other programming. The FY 2009 reduction of 30% and the FY 2010 elimination of this program would add to our department's existing staffing pressures in these areas and seriously limit services available to vulnerable adults. In Michigan, as elsewhere around the country, we expect the population in need of these services to grow in accordance with demographic shifts. This growth in demand and elimination of support for services will create severe hardships.

#### **Child Support (Title IV-D)**

MDHS continues to support a repeal of the cuts to child support mandated by the Deficit Reduction Act of 2005 which prohibit States from using incentive funds to match Federal funds, even though these funds had been evaluated as effective and responsible by the Office of Management and Budget Program Assessment Rating Tool. These cuts result in \$50 million less Federal funding for child support programs in Michigan in FY 2008. Passage of H.R. 1386 and S.B. 803 would repeal these cuts.

#### **Child Care Development Block Grant and Head Start**

The Child Care Development Block Grant (CCDBG) remains level funded in the FY 2009 budget request. This results in an actual reduction in the amount and quality of child care MDHS can provide working families. Because of the ongoing trend of reduced support for child care, it would take an \$874 million increase in funding to restore the program to 2002 levels. Continued flat funding of child care will cause 200,000 children to lose access to child care nationwide.

Similarly, Head Start funding is not adequate to meet even current participation levels, which is acknowledged in the budget request itself. The increase in funding proposed in the budget request will not cover the costs of mandated quality improvements contained in the recent reauthorization of this program. Head Start providers should not be required to meet higher educational standards without more funding. Finally, MDHS supports the current Federal-local partnership and the Policy Council/shared governance structure for local Head Start providers that ensure parents and other stakeholders a voice in improving Head Start programs.

#### **Foster Care Funding Option**

Capping the amount of Federal support for foster care will force untenable choices on States. If Michigan can not rely on Federal support for children in care, other options will have to be considered including reducing payments to foster care parents, decreasing funds to private foster care providers or shifting funds from child protection to foster care, which might well result in more children in care or at risk. While theoretically advantageous, access to TANF contingency funds as proposed would not address the gaps in service capacity. Further, linking foster care and the needs of children in crisis to an additional process for drawing down Federal funds from another source contingent upon meeting definitions of "severe foster care crisis" is not a reasonable approach to ensuring that our most vulnerable children have timely access to basic services to ensure safety.



**Title IV-B, Subparts 1 and 2**

The President's budget request for HHS proposed level funding for child welfare services (Part 1) and Promoting Safe and Stable Families (Part 2), continuing a trend of level funding. As with other programs administered by MDHS, this results in an actual decrease in our capacity to meet the needs of vulnerable children.

**Children and Family Services Discretionary Programs**

MDHS is concerned that cuts to Child Abuse Prevention and Treatment Act funds would decrease our ability to meet the training and service needs that are essential to maintaining our child welfare system. The incentive program for States that meet requirements for timely interstate placement of foster children would benefit Michigan if it were reinserted in the FY 2009 budget.

**Title IV-E**

The President's request proposes a \$118 million decrease in funding for foster care based on HHS projections of decreasing foster care caseloads. MDHS finds this argument for reducing funding incomplete. Even if caseloads decline as predicted, increases in the costs of service provision are not fully accounted for, and would likely more than offset any savings due to caseload reductions. Service participation numbers and actual costs are both relevant to predicting funding needs. Without considering both factors, foster care remains in danger of funding levels that are severely out of alignment with the actual cost of service provision, leaving States to reduce services or try to bridge the gap by shifting funds from other programs that prevent foster care placement. Considerable reform in the area of foster care financing is necessary to ensure that States can meet the demand for the most basic supports for vulnerable children, and work toward creating stronger systems of care to shorten and prevent out-of-home placements while ensuring child safety. MDHS cautions that these needed reforms must not be seen as potential savings of Federal funds. Child welfare is severely underfunded and cannot be a source of budgetary savings even with significant Federal financing reforms.

---

**Statement of Wim Kellett, Wando, SC**

I respectfully would like to comment on CMS and Congress' continuing efforts to reduce reimbursement to the Home Medical equipment industry. Furthermore, while staying on the path of reducing reimbursement fees, Congress is not addressing CMS's lack of accountability with fraudulent providers. It is unfortunate that there are people who fraudulently bill the Medicare system, there is bad and good in all sectors of industry and policymaking. CMS and Congress repeatedly comment on the growing expenses in Wheelchairs, Home Oxygen, Hospital Beds and other items we provide. The simple fact is the population of the "Baby Boomer" era is coming of Medicare coverage age. In addition, the correlation between the need for this type of service and the economic impact of Chronic Disease is very relevant. It is an unrealistic expectation to "REDUCE" Medicare expenditure when there are so many people becoming eligible.

Medicare is the only payor source that does NOT require a "Prior Authorization" for Power Mobility products. This is a simple step that would allow CMS more time to review claims, thus reducing the chances of a fraudulent claim. One of the largest manufacturers has severed its relationship with The Scooter Store. Read the writing on the wall. Do you see any other manufacturers ending business ties with multi-million dollar clients? There are some indicators pointing to the companies abusing the system. Do something to protect the system and those of us who are trying our hardest to do it right. Cutting our reimbursement is not the solution.

Our total company has 945 patients being serviced with Home Oxygen. We employ 13 service technicians (average income of \$30,000/year) and 5 Respiratory Therapists (average income \$63,000/year) to help maintain these patients in their homes. We employ 12 Customer Service Representatives (average income of \$34,000/year) that answer the phone and help process new orders and service tickets. These employees are critical in helping patients stay compliant according to written prescriptions. When patients stay compliant, there is a lower rate of time in which they have to go to the hospital. Simple facts; compare the number of people we employ and the costs associated with that of the hospital. The government has access to what the diagnosis of COPD costs the hospital per day. Compare that to the \$6.04 it cost with Home Oxygen with new technology portability. Where is the logic in this?

In addition to these employees we have five more in our billing department. They deal with Filing claims and working denials; which is an entirely different accountability problem that CMS has. Simply put, the comparison to Cost Effective Health Care is astounding. Even more frustrating is the Administration continuing efforts to reduce the most affordable Health Care model available.

There are some questions regarding references regarding Oxygen Concentrators. First, illustrative Internet Pricing. Is CMS insinuating that a beneficiary purchase an Oxygen Concentrator, which produces a "LEGEND DRUG" over the Internet? The Oxygen Concentrator produces oxygen which is considered a drug and requires a prescription. The FDA and SC Board of Pharmacy regulate the distribution of oxygen and it would appear that CMS is suggesting the patients go on the Internet to purchase; there is significant flaw in this process. Second, the cost of the commodity is a small percentage of the dollars that go into keeping the patient happy and in their home. The labor involved in keeping the maintenance on the machines, assisting the patients with cleaning of filters and changing the disposable portions is very large. In a perfect world we would all agree that patients need to be responsible for their health care, including maintenance to some degree. This is not a perfect world and we are very involved. If our reimbursement rates are continually cut, then the government is impeding our ability to help the Medicare population. We need not have unreasonable expectations at the costs of the system. This patient population needs assistance and it is more cost effective to do this in their home. There are many of us that are trying to offer solutions. Congress and CMS make it very difficult for us to manage our businesses and fight off the frequent legislation issues that keep coming at us.

Our industry is eager to meet and discuss the hurdles before us. Please act in accordance with the position you were elected to perform, and consult the people that will be impacted. The DME industry is not a large recipient of the overall Medicare expenditure, yet we are the most efficient at keeping people in the home.

