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BUDGETING TO FIGHT WASTE, FRAUD AND ABUSE

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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BUDGETING TO FIGHT WASTE, FRAUD AND ABUSE

TUESDAY, JULY 17, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:02 a.m. In Room 210, Cannon House Office Building, Hon. John Spratt [chairman of the committee] Presiding.

Present: Representatives Cooper, Doggett, Scott, Etheridge, Moore of Kansas, Hooley, Bishop, Baird, McGovern, Boyd, Becerra, Ryan, Bonner, Simpson, Campbell, Alexander, Hensarling, Smith, Lungren, Tiberi, Porter and Garrett.

Chairman SPRATT. Good morning, and welcome to our hearing on Congressional Initiatives to Combat Waste, Fraud and Abuse in Federal programs. We have a panel of excellent witnesses before us today, and I want to welcome all of them, and especially say to Secretary Leavitt, who has testified before, touched on the subject then and sparked our interest in it, welcome back. And we look forward to your testimony initially. Wasteful and fraudulent spending and taxpayer evasion and noncompliance undermine our confidence in government, and they contribute to our fiscal imbalance, our deficit. Each time funds are diverted from their intended purposes, each time taxpayers fail to pay what they owe, legitimate beneficiaries and law-abiding taxpayers bear the burden. They pay the price. In the year 2006, according to information reported to OMB, Federal agencies made over $40 billion in improper payments. In the year 2001, the IRS and the Treasury Department undertook to determine how much was owed the Federal Government in taxes of various kinds as opposed to how much was actually paid. The tax gap they estimated that year is approaching $345 billion. If only a fraction of these costs can be recovered, we could make a significant reduction in the Federal deficit, and make room for needed and I think long-neglected investments across the board in our nation's future.

Earlier this year, just before testifying before the Budget Committee, Secretary Leavitt described to Congressman Ryan and me his experiences with a very far-reaching antifraud program in Florida in which he had participated. He told us that if the Congress agreed to provide additional funds dedicated to cracking down on Medicare and Medicaid fraud the money would be well spent and returned several times over. Mr. Secretary, we got the message and we responded with $200 million of additional compliance money for your agency. And we would like to hear you elaborate upon how

that could be used to good effect this year. Reflecting or acting upon our commitment to rooting out wasteful spending, we included in this year's budget resolution all together about a billion dollars in program integrity funds for four programs that account for a significant share of improper payments and unpaid taxes. These include $283 million for HHS, the Health Care Fraud and Abuse Program; continuing disability reviews and SSI redeterminations in the Social Security Administration, $203 million; IRS tax compliance, $406 million; unemployment insurance, $40 million to oversee and investigate improper payments beyond eligibility. This is the first time in years the Congress is taking a comprehensive approach, backed up by real money, to investigate program integrity issues and included, as I said, full funding for these critical initiatives.

The object of our hearing today is to help us understand better the source, the extent, the cause of improper payments, taxpayer evasion and noncompliance, how Federal agencies intend to use additional enforcement resources, a return on investment that we can reasonably anticipate from this initiative, and what additional changes Congress could consider to further cut down on wasteful spending.

We will begin our quest with Secretary Leavitt. Once again, you are more than welcome to be here. We very much appreciate you coming for a second round. We can make your statement, if you would like, part of the record, and you can summarize it as you see fit. But thank you for coming. The floor is yours. Oh, it is not. I beg your pardon. Mr. Ryan, my colleague, my able colleague, has asked—he just cut off my own. As usual, I defer to Mr. Ryan for an opening statement of his own.

Mr. Ryan.

[The prepared statement of Mr. Spratt follows:]

PREPARED STATEMENT OF HON. JOHN M. SPRATT, JR., CHAIRMAN, COMMITTEE ON THE BUDGET

Good morning and welcome to the House Budget Committee's hearing on combating waste, fraud and abuse in federal programs. We have an excellent panel of government witnesses before us including the Secretary of Health and Human Services, Mike Leavitt and I thank them for their participation in this hearing and hard work on this topic.

Ensuring the wise and effective use of taxpayer dollars is one of the Budget Committee's most important responsibilities. Wasteful and fraudulent spending and taxpayer noncompliance undermine confidence in the government, contribute to our long-term fiscal imbalance and jeopardize support for needed programs. Ultimately, this is about fairness. Each time funds are diverted from their intended purpose or taxpayers fail to pay what they owe, cynicism in government increases, legitimate beneficiaries are harmed and our shared sense of community is diminished.

In 2006, according to information reported to OMB, federal agencies made over $40 billion in improper payments. Similarly, the "tax gap" (that is the gap between taxes owed and those collected) is approaching $345 billion a year. If only a fraction of these costs could be recovered, we would make a significant dent in the federal deficit and begin to make room for needed and long neglected investments in our nation's future.

To this end, the 2008 budget resolution contains appropriation cap adjustments for four programs that account for a significant share of improper payments and unpaid taxes. These include: the Health Care Fraud and Abuse program, Continuing Disability Reviews and SSI Redeterminations, IRS Tax Compliance, and Unemployment Insurance improper payment reviews. This is the first Congress in years that has taken a comprehensive approach to program integrity issues and included full funding for these critical enforcement initiatives.

The objectives of our hearing today are to better understand the sources and extent of improper payments and tax noncompliance, how federal agencies intend to use their additional enforcement resources, the return on investment that can be anticipated from this initiative, and what additional changes Congress should consider to further cut down on wasted spending..

We will begin with Secretary Leavitt who has taken on this issue as a personal challenge. Earlier this year Secretary Leavitt shared with Congressman Ryan and me, some very interesting observations about an anti-fraud operation in Florida that he had participated in. I've asked him to discuss this as well as the broader efforts HHS has undertaken to tackle this critical issue.

Mr. RYAN. Thank you, Mr. Chairman. I appreciate the fact that you are holding this hearing, and I want to thank my good friend, Secretary Leavitt, for coming here and being with us today. You know, bipartisanship might seem often in short supply around here, but reducing the amount of waste in government programs is a goal that both of us can clearly agree on, because after all, we are spending someone else's money, and we have a moral obligation to do it as wisely and efficiently as possible.

But while we spend a lot of time talking about wasteful appropriations spending, and we have taken important steps to clean up the earmark process, we tend to spend precious little time talking about waste, fraud and abuse in the mass of entitlement spending programs. I want to commend Secretary Leavitt for his efforts on this front. And I also want to commend the chairman of the majority for including measures to fight abuse in their budget resolution. That was a great reform to see. I am very interested in hearing from the Secretary about the effectiveness of these measures. And I look forward to reviewing any data that examines whether these initiatives have achieved their potential in the past. Just as I noted, everyone can agree that Congress should and must work to reduce waste, fraud and abuse in government programs. But I think most would agree there is often room for much improvement in the way we go about doing this. The average taxpayer must find it a little ironic when Congress sets out to improve a program's efficiency by giving it even more tax dollars. The cap adjustments we are talking about today operate on just that premise. If we ask a government program to find out ways to reduce wasteful spending, we give them even more money than they already have to do it. It seems to me that this is something these programs should be doing as a matter of course.

It should be already a priority under their normal budget request, to ensure that their resources are being allocated to those who truly need it. This should be standard operating procedure for all government programs. So while these measures are certainly commendable and while they may provide an impetus for some improvement, they are not a long-term answer. As we have seen in the past, the best way to ensure a reduction in programs' waste, fraud and abuse is to mandate reform through the regular reconciliation process. Because when Congressional committees are actually required to reform programs and find savings, they tend to look a whole lot harder than if they were simply given the option. Now we were just reminded of this when Congress passed the Deficit Reduction Act, in which we not only managed to achieve necessary reforms, but we did so in the same Medicare program that we are talking about here today. And at the same time, we also saved taxpayers $40 billion in the process without spending an

extra dime. We need regular oversight. We need regular reform. And I believe the best way to ensure that this is achieved is through the regular budget reconciliation process. And we ought to do this every single year. And I look forward to today's discussion on how it might be combined with or replace other waste-reducing measures. These observations aside, I want to again commend the administration and the Secretary for all their efforts to improve government efficiency and effectiveness. While we may disagree on the best way to get there, we both certainly agree on the objectives we are trying to achieve. And I look forward to working together with the Chairman and the gentleman from South Carolina to make the Federal Government more accountable, more sustainable and more effective for the American taxpayer. And I thank you for your indulgence, Mr. Chairman, and I look forward to your testimony.

Chairman SPRATT. Thank you, Mr. Ryan. And before proceeding, I ask unanimous consent that all members have a right to file an opening statement within 5 days of this hearing. Now, Mr. Leavitt, you have the floor.

STATEMENT OF HON. MIKE O. LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Secretary LEAVITT. Thank you, Chairman Spratt and Congressman Ryan. I am very pleased to be here to talk about this. As you indicated, Medicare blesses the lives of millions of our citizens. Regrettably, however, $300-plus billion a year attracts people who would defraud and misuse and abuse for their own purposes those dollars. And it requires an aggressive and a vigorous response from us.

Regrettably, as I said, this exists everywhere, but today I want to talk a little about some areas that are particularly prone to this, the Miami and Los Angeles metropolitan areas. Over the last 2 years, the number of durable medical equipment suppliers, for example, claiming to operate out of southern Florida and southern California has doubled. As you might expect, the number of claims for Medicare reimbursement from those suppliers is disproportionately high. Additionally, the Miami-Dade area has the highest ratio of suppliers to beneficiaries of any place in the nation. Broward and Palm Beach Counties aren't far behind them. These three counties in Florida, according to the contractor data, account for approximately 5 percent of the entire number of DME payments on a national basis.

So it isn't a surprise, I suspect, that we began to focus on those areas. I have seen this firsthand. In December of last year, I went to southern Florida, and I went out with a group of agents from the Office of Inspector General. We had planned for that week to do an operation that would visit, on an unexpected basis, almost 1,600 DME suppliers. I just have to tell you what I saw was one of the most discouraging things I have observed in public life. We drove down the streets in this area, and you know, I suspect it is like this in other areas, but as they began to point out the number of these suppliers along the street, I was surprised. They suddenly appeared to be everywhere. We stopped at a small strip mall, and there were three of them in this small strip mall. Just as a matter

of background, when a person or an organization desires to be accorded a number for Medicare to be able to bill, they have to meet 21 different requirements. Those requirements include things such as having a physical facility. They have to be accessible during business hours. They have to have a visible sign. They have to post their hours of operation. They have to maintain a telephone number. In addition to that, they have to have a supply of durable medical equipment. There are a number of others among those 21 in order to get their license or their number, they have to go through all 21 of them, and there is a physical inspection.

Well, in this particular operation, they were going to look at just those five to see how they were doing. I walked up to all three in this little shopping mall. And yes, on the door there was a sign, and there was in fact a phone number. And if you peered through the window, you could see that on the shelf, there were three or four items of durable medical equipment. And there were a couple of chairs and a fax machine and—it was very clear that all of them had essentially the same thing. But there was no one there.

Now, this was right during the middle of the day. And so I would call, using my cell phone, the number. And I would get someone who would answer, someone would answer, but they didn't ever speak English, so we didn't have much of a conversation. I asked the members that I was with, the agents, if they had a record of how much those particular organizations had billed. And it was in every case in the hundreds of thousands and, in some cases, in the millions of dollars that they were billing Medicare. We then went to an office building not far from there. If I could describe this, it is probably 20,000, 30,000 square feet. It was on two levels. You walked into a small atrium, and on the side, there was a marquee. I would guess on the marquee, 50 businesses there. Probably 35 or 40 of them would have been medical equipment operators. If you can just envision walking down long halls, they were orange, and on each side almost like a dormitory, there were doors. And on each of the doors, there was a small marquee that listed the name of the company, the phone number and the office hours, checking off the boxes. You would try to open the door, there would be no one there. You would knock on the door, there would be no one there. This is in the middle of the day. Finally, you would get to a place where you would find someone, you could hear them in there, and you would knock on the door until they opened, and it would generally be a female who had small children who was there. And I later found out that they were hired to wait until someone could come in order to do the inspection of the 21 points. But in each one, you would see a couple of chairs. You would see some shelves, a small supply of durable medical equipment. It was very clear this was essentially a cookie-cutter operation. I found a couple of places that were quite busy. They were billing operations. And what I learned was that the billing operations were retained by these medical equipment operators, and they would do all of the billing or back shop for them. In essence, many of them would rent, if you will, lists of Medicare numbers that had been fraudulently obtained, and the billing organization would do the operation. It was all electronically conducted.

I found the office manager, the building manager, and we were doing some investigation, and I just stood by as the agent said, I am interested in renting some space here. I would like to go into the medical equipment business. Well, what is it you would like to be in? Well, you know, I don't know much about this. Well, he said, you need somewhere between 150, 170 square feet, depending on if you want to be in diabetics or—and he said, you don't seem to know much about this. And he opened the drawer and pulled out a card and said, call this consultant. She can help you get into this business. I called. And sure enough, for a fee, she would be willing to sit down and help me through how to get into this business. It was a discouraging and awful display.

I was told that there were three or four office buildings just like that in that one area. As I mentioned, during that week, in a combined operation between the Office of Inspector General and the U.S. Attorney there, Alex Acosta, who has been just terrific in all of this, they visited 1,581 suppliers. They found that 31 percent of them, or 491, didn't comply with even the first two requirements. In the calendar year of 2006, those 491 suppliers had billed nearly $390 million. They were allowed $111 million and paid almost $89 million. While I was there, the U.S. Attorney and the investigators showed me checks totalling $10 million in cash that they had recovered. Because the way this works, there are people behind this who then go out and find someone who can use their name to organize it who frankly know very little about this. They are told this is the American dream, and they will help set them up in business. When I went to the office manager to ask about renting space, he said, you know, you just need to make sure that we have the name of the person who is actually going to be on the articles of incorporation on the lease, and they need the first month's—I mean, there is a rhythm and a routine to this. And what they do is they will bill like crazy for 4 or 5 months, because they know the limits of the system. Then they will close down, stay out of it for a while, and then come back. And these just begin to—they have a life of about 4 or 5, 6 months, and then they start again.

You will be happy to know that we have closed a very high percentage of those numbers down, saving lots of money. I was going to say $10 million. So we go to—the investigators would go to the person who was the front and just say, we are here and we need to talk with you, and begin to ask questions. And it would become clear that they wouldn't know anything. And they would just ask them to go to the bank and clear out their bank account, and they would write out a check for the amount, and we would recover that money. Now, it was a discouraging—it has been a discouraging thing to find. And it is very clear to me, and I think to all of you, that we have got to aggressively work to assure that that does not continue. We have got several ongoing inspections like——

Chairman SPRATT. Mr. Secretary, could you expound a little on how they falsified the invoice and how they got the name of the patient and whose name that submitted the bill?

Secretary LEAVITT. Yes. Several ways in which this appears to happen. In some cases, they will go out and put people on a bus and pay them X amount of money to use their Medicare number, and then they will use their Medicare number to bill. In other

cases, they get fraudulently obtained physician—or Medicare numbers and physician numbers, and they will just flat make them up, and then they will submit them. And there has been quite a study of the system as to where the trigger points are. We are constantly working to get ahead of them on this with our Medicare contractors. And there are a number of different ways, but those tend to be the two primary. Others that you have on the panel during the course of the day will be able to be more explicit than what I have.

I will say that the kind of thing you see—I do want to say that, in Florida, we did 1,472 on-site inspections. The result was 634 suppliers having their Medicare billing privileges revoked.

Mr. SCOTT. How many again?

Secretary LEAVITT. In 2006, CMS and its partners conducted more than 1,472 onsite inspections in southern Florida. As a result, 634 suppliers had their Medicare billing privileges revoked, and the savings to the program is a projected $317 million. We are talking about motorized wheelchairs, nebulizers, artificial limbs, wound therapy treatments. Those are just a few of the medical devices that are billed at their normal rate. I will say that, last year, a similar initiative was conducted by CMS and its partners in the Los Angeles area, and it netted 770 violators. Several inspections of DME suppliers in Los Angeles have revealed, as I said, similar trends. Last August, CMS and its contractors began conducting unannounced site visits. As of April 2007, 95 visits—95, rather, of the 401 suppliers have had their privileges revoked. In February of 2006, in the State of California, in an operation that we have done jointly with the Food and Drug Branch of the State of California, site visits have been on 34. Within a month, the billing privileges of 12 of those have been revoked. And you get the picture here. And as the Chairman indicated, he and Mr. Ryan have been responsive to our suggestion. I will say to you that there is a big return on this. We believe that, based on our experience, that we will return 13 to 15 times the amount of investment we put into this kind of enforcement. And that doesn't even start to count the amount of prevention that we do, people who are engaged in this business, and many of them are legitimate, serving important needs, but those who aren't need to see that we are vigilantly and aggressively seeking this. We have begun a whole series of things to counteract it in addition to the kind of enforcement that I have talked about. We have, in southern Florida, the Office of Inspector General and its partners have taken a proactive role.

We have what we call Operation Whack-a-Mole. And the reason is obvious to you. They pop up, and you find them, and they pop up, and you—and we are leveraging the resources, all that we can. And one of the things that we are going to do is to begin inspecting them more often. And as it is now, they get a number, and there is no scheduled inspection for 3 years. They need to know we are going to go there more often and doing the kinds of things that we did.

The first phase is operation, we call it Operation Equity Exercise. It is working in cooperation with local Miami banks, for example, in identifying 200 bank accounts. I mentioned the exercise where we collected $10 million. The banks have been very helpful. We are also doing the second phase, which is Equity Exercise Two, which

represented the criminal investigations brought about by the work performed in the first exercise. In less than 3 months we had five indictments and one information plea. The indictments involved over $24 million in claims that were billed to Medicare.

In support of this, in March of 2007, the Department of Justice launched Medicare Fraud Strike Force. The strike force is staffed by four fraud section prosecutors. One of the things that we found that was discouraging to me is in the entire Miami area that we only had 13 prosecutors that could pursue these cases. And so one of the things that we are working is to enhance that. We are going to take additional action with a new demonstration project in the Miami and in the southern California area. Effective immediately, we are going to require submission of enrollment applications for everyone. In other words, we are going to say to everybody, if you are in business, we want you to reenroll. We want to go back and inspect everybody. And if you don't do it in the first 30 days, we are going to assume that there is something missing, and we are going to revoke your privilege.

We are going to—in addition to that, we are going to have enhanced reviews. In conclusion, there is a lot to be done here. And Mr. Chairman, you have been very responsive, and I want to thank you. I want to acknowledge the fact that this is a joint effort that we are making across the government, that includes the Department of Justice. It includes State and local law enforcement officials. And we are resolved to do this in an aggressive way, to be vigilant and to bring this under control.

[The prepared statement of Mike Leavitt follows:]

PREPARED STATEMENT OF HON. MIKE O. LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Good morning Chairman Spratt, Congressman Ryan and distinguished Members of the Committee. It is a pleasure to be here with you today to discuss the efforts underway to reduce overpayments, fraud and other abuses in Federal health care programs.

As part of that discussion, my testimony will largely focus on the Office of Inspector General's (OIG) and the Centers for Medicare & Medicaid Services' (CMS) recent work in three South Florida counties, where it was determined that 31 percent of suppliers did not meet one or more of five Medicare enrollment requirements we reviewed, and had their billing privileges revoked.

In enacting Health Insurance Portability and Accountability Act (HIPAA) in 1996, Congress directed the Secretary and the Attorney General to jointly promulgate a joint Health Care Fraud and Abuse Control Program and created a dedicated funding stream for health care fraud and abuse control activities funded through the Health Care Fraud and Abuse Control Account. The joint Health Care Fraud and Abuse Control Program and Guidelines approved by the Secretary and Attorney General became effective on January 1, 1997. Since that date, our Departments have actively partnered in our efforts against health care fraud. Our joint opportunities in South Florida are a prime example of this collaboration.

In criminal matters such as the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) problems found in South Florida and California, HHS works closely with the Department of Justice (DOJ) on investigations of HHS programs and personnel and interacts with State Licensing Boards, local law enforcement and other entities with regard to program exclusion, compliance and enforcement activities. These collaborative investigative efforts lead to criminal convictions, civil settlements, program exclusions, or civil monetary penalties and assessments, all of which help protect our beneficiaries and the Medicare trust funds.

This Administration maintains a strong commitment to ensuring that Americans have access to, and are receiving, high quality care from honest and dedicated providers. Consistent with the desire of the Administration and Congress to reduce the size of the Federal deficit, OIG, CMS and its partners continue to take an aggres-

sive approach to reducing Medicare and Medicaid fraud and abuse. Operational oversight of our Medicare and Medicaid programs and ensuring their fiscal integrity are core components of CMS management strategy and an integral part of the OIG's priorities. Detecting and preventing fraud, waste and abuse in those programs remain a high priority.

BUDGETING FOR THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

The Fiscal Year (FY) 2008 Budget Request includes resources and legislation to strengthen program oversight and reduce improper payments in the Medicare and Medicaid programs. A total of approximately $1.3 billion is proposed for the Health Care Fraud and Abuse Control (HCFAC) program—designed, under the joint direction of the DOJ and HHS to coordinate Federal, state and local law enforcement activities. Our collaborative efforts against healthcare fraud and abuse has been an unquestionable success. Under current law, mandatory spending for HCFAC will increase approximately $20 million from FY 2007 to FY 2008. To assist our expanded efforts in combating fraud and abuse in the new Part D prescription drug benefit and Medicare Advantage programs, and to strengthen oversight of the Medicaid program, we are seeking $183 million in discretionary spending for FY 2008. Of the approximately $1.3 billion combined total of mandatory and discretionary HCFAC funding for FY 2008, an estimated: $894 million is for the Medicare Integrity Program (MIP) which funds activities such as medical review, benefit integrity, provider and HMO audits, and provider education and training for all parts of Medicare. $187 million of FY 2008 HCFAC funding goes to the OIG for their continued effort in identifying fraudulent and abusive activities within the health care system through investigations, audits and evaluations. The FBI will receive $129 million for health care fraud enforcement activities. DOJ will receive $61million to help fund the prosecution of health care fraud cases. And $43 million will go to HHS to be used to control fraud and abuse, and limit payment errors within the Medicaid Program. I would also like to take this opportunity to thank the Chairman and other members of the Committee for your support of our request and your continued work to combat fraud and abuse on behalf of the American Public.

The OIG and the Government Accountability Office (GAO) have uncovered significant vulnerabilities in Medicare's oversight of suppliers of DMEPOS and in Medicare payments for certain types of these items. Over the past 12 years, OIG and the GAO have reported numerous times on weaknesses in Medicare's enrollment and payment standards for and oversight of such suppliers, and CMS has worked hard to address their recommendations for improving oversight and enforcement.

Earlier this month, CMS launched a two-year, multi-pronged campaign to better protect both people with Medicare and the program itself from fraudulent DMEPOS suppliers. It is built upon recent successes of addressing waste, fraud and abuse in South Florida. A Medicare Fraud Strike Force, directed by partners within HHS and the DOJ and manned by Federal, state and local investigators, is fighting fraud through the use of real-time analysis of Medicare billing data. We estimate that hundreds of millions of dollars in fraudulent activity can be saved as a result of this and concurrent efforts—and as momentum builds from successes in our initial target areas, we will examine the potential for applying these efforts on a national basis.

HIGH RISK REGIONS: SOUTH FLORIDA AND CALIFORNIA

The Miami and Los Angeles metropolitan areas have been identified as particularly "high-risk," with regard to fraudulent billing by DMEPOS suppliers. Over the last two years, the number of DMEPOS suppliers claiming to operate out of Southern Florida and Southern California has doubled. As expected, the number of claims for Medicare reimbursement from suppliers in these regions is disproportionately high.

Additionally, Miami-Dade has the highest ratio of DMEPOS suppliers to beneficiaries of any county in the nation—and Broward and Palm Beach counties aren't far behind. These three counties in Florida, according to contractor data, account for approximately five percent of total Medicare DMEPOS payments nationally. During the last two quarters of 2005, Florida led the nation in allegations of supplier noncompliance with Medicare standards.

I have seen this fraud first hand. In December of last year, I accompanied the OIG fraud investigation task force to Southern Florida to perform unannounced, out-of-cycle site visits and witnessed non-existent suppliers—where business names and hours were posted on locked doors during traditional hours of operation. In one two-story office building that supposedly housed more than 30 DMEPOS suppliers, we were hard-pressed to find a single legitimate proprietor. In these office buildings

were hallway after hallway and door and after door, each with a marquee listing business names, hours of operation and contact numbers. But when I knocked on the doors, no one was there. Repeated episodes made it clear that DMEPOS suppliers intent on defrauding Medicare could take advantage of the predictable site-visit cycle by establishing businesses that do not maintain compliance with program standards after the initial or re-enrollment site visit. I have no doubt that hundreds of thousands of dollars were being billed by these sham companies. When I asked one building manager about renting space for a diabetic supplies company, he actually gave me the name of a consultant who could help me set up a fake company. Since that time, some of the suppliers located in the building I visited have been indicted.

During these site visits, investigators zeroed-in on DMEPOS supplier standards that could be verified quickly through direct observation and were central to how easily a beneficiary could access the advertised services. Medicare participation requirements require suppliers to meet 21 standards; of these 21 standards, investigators chose to focus on 5. These are as follows: (1) maintain a physical facility, (2) be accessible during business hours, (3) have a visible sign, (4) post hours of operation, and (5) maintain listed telephone numbers.

As part of this OIG-led initiative, the OIG in collaboration with CMS, conducted unannounced site visits to 1,581 suppliers in Miami-Dade, Broward, and Palm Beach Counties in the fall of 2006. The visits found 31 percent of suppliers (491 of 1,581) did not comply with the first two requirements of maintaining a facility at the business addresses that they provided Medicare and being open and staffed during business hours. In calendar year 2006, these 491 suppliers billed almost $390 million, were allowed $111 million and we paid almost $89 million. An additional 14 percent of suppliers were open and staffed but did not meet at least one of the three additional requirements for the standards reviewed. These findings were reported to CMS and subsequent action taken to safeguard the Medicare program.

CMS and its partners have also performed additional unannounced, out-of-cycle site visits. In January 2006, CMS and its contractors conducted ad-hoc site visits of 480 DMEPOS suppliers in Miami-Dade and Broward counties in a one-week period. When the dust had settled, 191 DMEPOS suppliers had their billing privileges revoked. These revocations are in addition to those that occurred as a result of the investigations in which I participated last December.

In FY 2006, CMS and its partners conducted more than 1,472 on-site inspections in Southern Florida. As a result, 634 suppliers had their Medicare billing privileges revoked, saving the program a projected $317 million. Motorized wheelchairs, nebulizers, artificial limbs and wound therapy treatments were but a few of the medical devices billed in excess of their normal rate. Last year, a similar initiative conducted by CMS and its partners in Los Angeles netted 770 violators.

Several ongoing inspections of DMEPOS suppliers in the Los Angeles metropolitan area have revealed similarly disturbing trends. Last August, CMS and its contractors began conducting unannounced site visits of DMEPOS suppliers suspected of non-compliance with Medicare regulations and/or billing fraud. As of April 2007, 95 of the 401 suppliers inspected have had their billing privileges revoked. In February 2006, CMS, its contractors, and the State of California Food and Drug Branch (CFDB) joined forces to conduct site visits of 34 DMEPOS suppliers. Within that month, the billing privileges of 12 were revoked. Finally, back in February and March 2005, CMS contractors, CFDB and MediCal (California Medicaid) conducted inspections of 138 DMEPOS suppliers. Of this total, 31 had their billing privileges revoked.

The types of fraud committed by the DMEPOS suppliers in South Florida and the Los Angeles metro area included billing for services not rendered, billing excessively for services rendered, and billing for services not "medically necessary." CMS and its contractors identified thousands of Medicare beneficiaries living in both metropolitan areas who are receiving medical equipment—like power wheelchairs, orthotics and equipment for testing their blood sugar—they do not require, based on their medical history. Thousands upon thousands of these devices are being billed for—and paid—in connection with the names of Medicare beneficiaries, despite the fact that the patients never received the equipment, nor had their physicians ever ordered them. Other concerns involve the co-pays beneficiaries paid for equipment their doctors didn't order and was not delivered, generating incorrect records suggesting these beneficiaries have DMEPOS items in their possession should future legitimate needs occur. Numerous physicians in both locales said they never saw the patients for which given medical devices or equipment had been ordered; nor, correspondingly, had they ordered the suspect DMEPOS.

Once a supplier has received an enrollment or reenrollment site visit, the supplier generally is not visited again outside the 3-year cycle. Though an unannounced, out-

of-cycle site visit may occur if NSC becomes aware that a supplier may be in violation of one or more Medicare standards, typically suppliers are only visited at the end of their 3-year reenrollment period. The successful efforts of the Department and its partners in the above efforts to combat fraud and abuse have shown, out-of-cycle, unannounced visits, very effective in detecting noncompliant suppliers.

OIG AND ITS PARTNER'S SOUTH FLORIDA INITIATIVE

To address the fraud committed by suppliers in South Florida, the OIG and its partners have taken a pro-active role in addressing the fraud. Below are some of the efforts underway in South Florida.

Operation Whack-a-Mole (WAM), which represented a multi-organization, multi-disciplinary project, intended to reduce health care fraud and abuse by providers in South Florida. WAM leveraged all of the OIG resources and those if its partners, including CMS and DOJ, to prevent, identify and prosecute health care fraud. The project incorporated a wide range of strategies to address systemic vulnerabilities in the Medicare program, as well as fraud schemes that appear to have permeated certain health care sectors in South Florida. The task force sought to develop the ability to identify and respond to similar problems in other parts of the country. The project has already had a significant impact on the integrity of the Medicare program. To date, the project has recovered over $11 million, and has resulted in 43 indictments, 1 information/plea, and in the revocation of supplier numbers of almost 500 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers for not meeting the minimal standards of participation. Some of these revocations have since been overturned on appeal. More results are expected in the future.

The OIG investigators, along with its partners, developed new and innovative methods to identify and prosecute fraud in a timely manner. The investigators developed a three-phase operation.

1. The first phase, Operation Equity Excise, working in cooperation with local Miami banks, identified over 200 bank accounts of health care entities for which the bank identified suspicious activities. For several months, the OIG, the U.S. Attorney's Office in Miami and the FBI worked collaboratively to perform preliminary investigations into corporate and claims history of these suspicious providers. Local banks placed administrative holds on these accounts while law enforcement investigated the providers associated with the accounts.

In the fall of 2006, OI agents and FBI agents attempted to locate the listed account holders for 103 of the largest accounts. The agents confronted account holders they were able to locate, obtained statements from them regarding their involvement with the schemes, and secured their agreement to voluntarily return the funds in the bank account to the Federal government. In less than 8 months, this initiative resulted in the recovery of over $11 million.

2. The second phase, Operative Equity Excise 2, represented the criminal investigative actions brought about by the work performed in Operation Equity Excise. In less than 3 months, there have been 5 indictments and 1 information/plea. The indictments involved over $24 million in claims that were billed to the Medicare program. Two of the indictments involved individuals with alleged businesses where I personally visited when I accompanied the OIG team performing the unannounced site visits.

3. In support of this multi-agency approach, in March 2007, the DOJ Criminal Division launched a Medicare Fraud Strike Force to prosecute individuals and companies that have schemed from inception to commit DME fraud rather than to provide any legitimate health care services. The Strike Force is staffed by four Fraud Section prosecutors (including a HHS-OIG attorney on detail), two Assistant U.S. Attorneys, one full-time nurse/auditor, and a part-time program analyst and paralegal, with investigative support from the FBI and the HHS-OIG. It supplements ongoing U.S. Attorney's Office (SD/FL) prosecution efforts. Strike Force accomplishments during its first four months include:

a. 43 defendants indicted since March for fraudulent billings to Medicare totaling $157 million with a minimum expected recovery through criminal fines and forfeitures totaling at least $23.2 million.

b. Estimated criminal forfeitures, fines, and restitution to date from indicted Strike Force cases represent a $14.66 return per $1 in annual HCFAC funding to the Criminal Division.

NEW CMS DEMONSTRATION PROJECT

Recognizing the significant vulnerabilities presented by DMEPOS providers in South Florida and Southern California, CMS has used its authority for conducting

demonstrations of effective controls to curb fraud and abuse within Medicare to launch a new demonstration project.

In a new, 2-year CMS demonstration project I announced on July 2, 2007, suppliers of DMEPOS in the greater Miami and Los Angeles areas must re-apply annually for participation in Medicare in order to maintain their billing privileges. The demonstration has three components:

1. Immediate submission of enrollment application. Letters will be sent to suppliers asking that they resubmit applications to be a qualified Medicare DMEPOS supplier. All DMEPOS suppliers in the demonstration locales must submit a Medicare enrollment application within 30 days of CMS notification.

2. Revocation of billing privileges. Medicare billing privileges will be revoked (and appropriate recoupment measures applied) if a DMEPOS supplier fails to reapply within 30 days of receipt of CMS' letter; fails to report a change in ownership or address; fails to report owners, partners, directors or managing employees who have committed a felony within the past 10 years; or fails to comply with DMEPOS supplier standards.

3. Enhanced review of suppliers. DMEPOS suppliers that successfully complete the enrollment process will be subject to enhanced review, including site visits driven by established risk factors.

Eliminating fraudulent suppliers protects people with Medicare and enhances their quality of care. Enhancing our review of DMEPOS suppliers will go a long way to ferret out those who are not meeting the needs of beneficiaries and upholding Medicare's promises.

CONCLUSION

The initiatives and examples that I have discussed today are a small fraction of the Department's efforts to protect the health, vitality, and integrity of Federal health programs as well as protect the resources allocated to pay for these services and programs. We are committed to investing in program integrity efforts in order to send a clear message that criminal fraud in our Federal health care programs will not be tolerated. We are committed to vigorously pursuing the goals of the Health Care Fraud and Abuse Control Program with the Department of Justice, our co-partner. We appreciate the support of our Budget Committee colleagues in providing the necessary resources to permit us to continue as well as expand these important program integrity and health care fraud and abuse control program endeavors.

By attacking fraud vigorously, wherever it exists, we all stand to benefit. Taxpayers will save hundreds of millions of dollars each year. Medicare trust fund resources will be protected and remain available for their intended purposes. Medicare dollars that have gone to fraudulent suppliers will instead be available for legitimate businesses whose purpose is to serve the needs of our program beneficiaries. And most importantly, we can ensure that seniors and disabled persons get the necessary supplies and care they need to stay healthy, so as to enjoy enhanced wellbeing and quality of life.

Thank you for the opportunity to discuss our work to protect the integrity of Federal health care programs. I would be happy to answer any questions the Committee may have.

Chairman SPRATT. Mr. Secretary, Mr. Ryan raises an entirely valid point, and that is, why do you need extra funds? Why can't you do this out of your ordinary resources, your regular appropriations?

Secretary LEAVITT. One of the things that has been inhibiting is that the moneys we recover go back into the trust fund. And so our enforcement comes in the discretionary money, and the money goes back into the trust funds. And so one of the changes we are asking to be made this year is that we have the ability to use those funds. We just need more—and we need more enforcement resources.

Chairman SPRATT. Based on what you have seen so far, do you think you can reliably, comfortably say that a dollar will bring back $10 or $12 in recoveries?

Secretary LEAVITT. I can. I believe with little question that we will recover 13 to 15 times the investment. Now there is a limit to that. I mean, you couldn't do that indefinitely. But I believe, based

on what I am seeing—I travel to every State in the country on a fairly regular basis, and I am often accompanied by members of our Office of Inspector General. And I ask them always, tell me the kinds of things you are seeing. Now, it is not all—not all communities are like what I have described. But there are pockets of this all over the country. And we are not getting to them yet, and we need to. And that is why we need the additional resources. And I feel not just optimistic, I feel certain that the return on investment will be extraordinarily high.

Chairman SPRATT. You mentioned the lack of prosecutors or the paucity of prosecutors. I think you said there were 13 in Dade County qualified to handle these cases. I guess they were Assistant U.S. Attorneys. Having handled a few of these cases as a lawyer, what I found was the shortage of forensic accountants, auditors skilled in this kind of adversarial audit work was even a greater problem, much greater problem than the lack of prosecuting attorneys. Have you run into the same shortage?

Secretary LEAVITT. Most of the money that we have requested will go into personnel. And those are precisely the type of individuals that the Office of Inspector General works to employ. Most of them have a financial background, typically accounting or some other kind of financial means that allow them to do the kind of forensic accounting that you have talked about.

Chairman SPRATT. One of the numbers given to us is that the error rate for Medicare, and we can get into this with further witnesses, but this falls under your purview, too, just in making out payments is $12 billion a year. Are you investigating that problem as well?

Secretary LEAVITT. Yes. Each year, after the publication of that fiscal year's error rate, and it is referred to as the comprehensive error rate testing, or CERT we refer to it, we develop a correctional action plan outlining the actions for the next year that we will be taking, using a very sophisticated and detailed data analysis. CERT, this effort, then begins to work with Medicare contractors to improve the edits and the systems. I will say that the combination of the efforts that I am describing to you over the course of the last 3 years has been making substantial—a substantial impact.

Chairman SPRATT. Have you been able to reduce that number demonstrably?

Secretary LEAVITT. Yes, we have had a 56 percent reduction in the Medicare error rate over the last 3 years, from 10.1 percent in 2004 to 4.4 percent in 2006. I have to acknowledge as well that a certain percentage of the error rate is caused by claims submitted by fraudulent providers. So the fraudulent providers fall within that 4.4 percent error rate. Still too high.

Chairman SPRATT. You mentioned hiring more personnel, and you just mentioned also contractor personnel. To what extent do you expect to go to independent contractors who work for CMS and HHS and outsource to them this investigatory work?

Secretary LEAVITT. Most of the claims processing, in fact all of the claims processing essentially for CMS is done by contractors——

Chairman SPRATT. Yeah.

Secretary LEAVITT [continuing]. Who are experienced in this area. We also hire contractors who are specialized in looking at the algorithmic patterns of the claims, and looking for ways—and most of the cases that we get come from, at least in my conversations with agents all over the country—from either a disgruntled employee who calls and tips them off, or one of these—one of our Medicare contractors, who begins to see a pattern in billing and refers it to an agent, and then, with investigation, we are able to get to the bottom of it.

Chairman SPRATT. Thank you very much. Others have questions as well. And I think we are all probably astounded by this testimony. Once again thank, you for coming.

And Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. Mr. Secretary, thank you for being here. It is quite a task that you have got. I am blown away. It is just incredible. First, kind of give me some feedback, how many claims does Medicare handle a year roughly? I mean, just kind of give me a magnitude, rough estimate.

Secretary LEAVITT. About a billion claims.

Mr. BARRETT. About a billion claims. And how many independent insurance agents or outside sources help you with the claims and stuff like that?

Secretary LEAVITT. As I indicated, there are Medicare contractors done on a regional basis, and I will look for some—there are 15.

Mr. BARRETT. Fifteen, okay. So a billion claims. As you described the situation, it doesn't sound like mom and pops are setting up and working onesie-twosies; this sounds to me like organized crime. Is that where you are leading? Is that what you are seeing? And of the 601 situations where you shut down, how many convictions do you have? How hard is it to find these convictions? Kind of go into that realm, Mr. Secretary.

Secretary LEAVITT. I am not able to respond to that. I don't have the information. Others on the panel may. I will tell you that, in certain areas, there is an aggressive effort to prosecute. In others—you know, one of the things that became evident to me is that this has attracted people because it is the—there is a risk assessment made by those who would perpetrate crime, and this one has been a relatively low risk. And it has found—and as a result, by comparison to the drug trade, for example, this is a relatively low risk. And it has attracted a lot of people.

But, frankly, there are direct patterns of similarity between this and the drug trade. There is always someone behind it, and I believe it is organized. And they are recruiting people to become essentially their fronts. They pay them a small amount of money. The money—then they use their name. They direct them. And so the money—the people who are the fronts only see a small amount. It is generally a fee for the use of their persona. And then those behind it, who are really doing it all, are never seen or heard.

Mr. BARRETT. Do you see correlations in different areas from, for example, from Florida to California, that the two might be associated?

Secretary LEAVITT. Again, others would be in a better position to answer those questions. I can tell you that the techniques are simi-

lar. And when we crack down, they tend to move to a different area. We have to continue to pursue them.

I will also say that there tend to be activities within certain ethnic and nationalities. A community finds out that they can do this. And without naming any particular one, they begin to operate within their ethnic network. And it is very clearly organized. How widespread and sophisticated that is, I think, is still something we are pursuing.

Mr. BARRETT. The integrity program that you are talking about, I know you were asking for permission to take some of the funds that were going back into the general fund for enforcement, I guess you could say. Do you see that as being self-sustaining in a very short time, Mr. Secretary, rather than us having to fund money for enforcement?

Secretary LEAVITT. Well, there is little question, if you are able to recover 10 to 15 times the amount that you expend, that it is self-sustaining. Now, again, I don't—hopefully, this is not an unlimited proposition. Hopefully, we can in fact begin to see a diminishing return on that investment. That would be victory.

Mr. BARRETT. Yes, sir. And I guess enough time for one last question. And I salute you. I think it is a lofty goal, and it is a much needed goal, but reform through the appropriations process rather than the integrity programs, doesn't that make more sense? Wouldn't that be better to simplify the systems to have people come in and say, this is how we need to change the overall system to make money rather than through integrity programs, Mr. Secretary?

Secretary LEAVITT. This would get us into a large conversation about all of the incentives around Medicare. We would be far better off with a competitive system where the marketplace became—where market forces became better—and we are beginning to do that. We are beginning to inject market in some with incentives with great success. So this isn't simply a matter of cracking down with enforcement. We have got to change the system in ways that allow market forces to both drive costs down and at the same time create incentives for integrity.

Mr. BARRETT. Fantastic. Thank you, Mr. Secretary. I appreciate it.

Chairman SPRATT. Thank you.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

Mr. Secretary, so you are asking for more money, or are you asking for any changes in the law, Mr. Secretary?

Secretary LEAVITT. We are asking for language that would allow some of the recoveries to be used in ongoing enforcement. Right now the discretionary side of the budget contains all of the money for enforcement.

Mr. COOPER. That is on the money side. I was wondering if you need any new enforcement tools to do the job. You mentioned you were going to reenroll some of the companies. That sounds like an administrative change.

Secretary LEAVITT. Yes. The authorities necessary exist in the law. We are using administrative authority to impose the changes I have discussed.

Mr. COOPER. Okay. As you mentioned, authority exists in the law. But I am worried that this hearing is only touching the very tip of the iceberg. In another set of hearings done by the Government Reform Committee, the Department of Justice testified, I think, in the last 5 or 10 years, some $10 billion has already been collected in health care fraud judgments from health care companies, which includes some of the leading name brands in America, some of which are repeat offenders, which has led some critics to even conclude that perhaps they are so likely to commit fraud that it becomes business plan fraud. When you are caught several times and you are a major national company, that leads some people to conclude this isn't done necessarily by fly-by-night enterprises but is a more systematic and organized effort than that.

You remind me a little bit of Claude Rains in that movie, "Casablanca," professing shock that there is gambling going on. The DME area has been known for decades to be rife with fraud. And certain areas of the country have been particularly likely to indulge in it, particularly the areas where Medicare offers the highest reimbursement. And the number one community in the country that does that is the Miami area.

So when Willie Sutton was asked why he robbed banks, he said, that's where the money is. You know, most U.S. Attorneys and their staffs have known for years, and prosecutors in the Philadelphia area, the Boston area and others have been known for their vigorous enforcement of these laws. I am not sure why the Miami prosecutor has not been known for his or her vigorous enforcement.

But to me, it is good that you went down and visited a building. It is good that you caught a few bad guys. But one group that you have left completely off the hook in your testimony are the Medicare intermediaries and carriers. These are the private sector insurance companies that work with your agency to interface with suppliers, vendors. What success have you had, for example, in getting Palmetto or other intermediaries to help the Federal Government identify fraudulent behavior so that we can crack down on it?

Secretary LEAVITT. Mr. Cooper, may I say that I think despite your being well acquainted with these, I think you would have been shocked, too, by what I saw. It wasn't the existence of it that surprised me; it was the scale of it that surprised me.

Mr. COOPER. Mr. Secretary, the largest health care company in my town was fined $2 billion by the Federal Government for fraudulent behavior. So that is a big fish. Today you are talking about small fish, minnows.

Secretary LEAVITT. That add up to billions of dollars.

Mr. COOPER. You have mentioned a few hundred million at most today. The Department of Justice today has 60 cases pending that they think will take 60 years to prosecute. And those are existing filed cases. And the Department of Justice is not pursuing those at a rate of more than three or four a year.

Secretary LEAVITT. The good news is, Mr. Cooper, we are on the same side here, and I agree.

Mr. COOPER. But you are asking for no legal changes to help speed prosecution? And can you help me understand what any intermediaries or carriers are doing to help pursue some of these cases? Because those are the private sector companies who are

charged today to process some of those billions of Medicare claims, and they are in the best position to identify suspicious behavior.

Secretary LEAVITT. Mr. Cooper, I have just received further light and knowledge on this subject. In Medicare, we are seeking legislation to establish a benefits clearinghouse at CMS that will coordinate benefits between private payers and the Federal Government and ensure that Medicare and Medicaid are the payer of last resort. We are also asking to phase out Medicare bad debt reimbursements over 4 years, thereby eliminating payments that should not be Medicare's responsibility. We are asking to eliminate a loophole that would allow providers to bypass Medicare's administrative appeals process and go directly to Federal courts, an abuse of the process that exposes the trust funds to additional liability.

In Medicaid, we are proposing legislation that would establish a demonstration in two States that would use health information technology to ensure individuals meet the financial asset test required for Medicaid eligibility, and we are enacting three third-party payer changes that will ensure that Medicaid is a payer of last resort, thereby avoiding improper payments in the first place. There are others, but I think your point is well made, and it is one I accept.

Mr. COOPER. You have given me a nice bureaucratic answer. My time is about to expire. Let me urge you to take a look at Malcolm Sparrow's book, it is about 10 years old, it is entitled, "Health Care Fraud." And he points out that IT systems, instead of being a solution, can often be part of the problem once suspicious companies figure out how to game the computer systems.

Secretary LEAVITT. I actual——

Mr. COOPER. So we need to be on alert——

Secretary LEAVITT. You will be happy to know I have read the book, and it is what stimulated my interest in this. And I concur with your conclusion.

Mr. COOPER. Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Simpson of Idaho.

Mr. SIMPSON. Thank you, Mr. Chairman.

Thank you, Governor, for being here today. When you were Governor of Utah, did you ever anticipate this problem? You were dealing with the same thing as Governor. Did you ever anticipate this problem as big as it is.

Secretary LEAVITT. Well, I saw it in Medicaid. Any time there is a pool of funds and any time you have got a system that is command and control, there are going to be people who advantage it. And again, I wasn't surprised that it existed. I was surprised by its scale and just how blatant it was.

Mr. SIMPSON. I guess the lesson here is that enough guppies can eat a treasury. Are any of these people going to jail?

Secretary LEAVITT. Oh, yes. I indicated in my testimony that there are indictments. But we do need to be more aggressive. And that is not something that we control. That is something that the Department of Justice has to make as a priority. In certain areas, it is a priority. In other areas, it is not, and for reasons that I understand; they have resource—they have resource limitations as well.

Mr. SIMPSON. Forgive my ignorance on this, but what happens to the money you recover, $10 million you recovered or anything else that you recover? What happens to the money that you recover?

Secretary LEAVITT. It goes back into the trust fund.

Mr. SIMPSON. Into the trust fund. Not the general fund, but into the trust fund.

Secretary LEAVITT. Into the trust fund. And that has been part of our dilemma, is that the money for enforcement is on the discretionary side of our budget, and the money we recover goes back into the trust fund. So we have a limited amount—and moneys we have requested have not been funded in the past. So one of the things we are asking is, A, more money, which this committee has recommended, and secondly, that we use some of it in the future for——

Mr. SIMPSON. When you say the resources for enforcement, are you talking about prosecutions or enforcement in general of going out and finding these guys and stuff?

Secretary LEAVITT. I am speaking of the HHS part of it, which is the enforcement. We have to depend, of course, on the Department of Justice for prosecution.

Mr. SIMPSON. Right. Is there any program in the Federal Government that has an incentive for either employees, employers, other people, to turn in these bad actors?

Secretary LEAVITT. Yes, there is. We have a TIPS line, and it is the—and we have a program to broadcast that among Medicare beneficiaries. And it is a very active source of leads.

Mr. SIMPSON. What is the benefit that someone gets? As an example, we started a program in Idaho that has been fairly successful. If you—in fact, it is in your Department, if you are an employee and you find a way of doing something better and saving money and so forth, you can actually get a money compensation for that. I think it is up to a certain level and so forth.

Secretary LEAVITT. I don't know the answer.

Mr. SIMPSON. And if there is——

Secretary LEAVITT. I am told there is a program—I am not acquainted with it—but where there would be incentives provided.

Mr. SIMPSON. It would seem to me that one of the best things that we would have out there in terms of enforcement is other people. And there had be to people in the Miami area who knew about these bad actors that would help turn them in. And of course, the financial compensation for them is always something worthwhile, saves us money, saves them money. And it ought to be within the Department, if an employee has a way of saving money or an idea of it, and they can actually do it, to reward him also.

Secretary LEAVITT. Good.

Mr. SIMPSON. I would be interested in knowing what the program is and how effective it has been.

The other thing that we haven't talked about is and what concerns me—and I can give you three, four examples from personal knowledge that I know about, and maybe I will turn them in if you get an incentive program for me. No, I am just kidding. These are the suppliers. We talked about the medical companies and the insurance companies and those other things. We also have a problem

with individuals. And any time you have a program where it is a benefit to people and doesn't come out of their pocket, there is never an incentive to be frugal with other people's tax dollars. And I can give you several examples of people very close to me who have helped senior citizens that go down to—one example was—well, I will say it, my mother, who took—who was helping an older lady who was on Medicare, took her down to the doctor all the time, took her for her appointments down to the community about 20 miles south of her. And you know, one day she wants to go down because the prescription glasses she got last week, she doesn't like the frame and they don't fit her face right, you know. So they go down, and all of a sudden, she has got a new pair of prescription glasses. Another time she sees an advertisement on television for a new drug. We don't know what it does, but we sure know that it makes you feel good afterwards after looking at the advertisement. So she goes down to the doctor and wants to have her prescription changed to this. She is on generics; it is working great, the doctor says. But the reason they change it is because if he doesn't do it, she will go down to the next doctor, and he will change it. And the amount of money we spend on that kind of stuff multiplied across the system must be amazing. And I am wondering what we do to try to stop that type of abuse of the system.

Secretary LEAVITT. I would argue that one of the things that encourages it is the basic structure, where people have a complete disconnection between their actions and what they have to pay.

Mr. SIMPSON. Exactly. Exactly. In fact, that is why I always supported copayment of some sort for a variety of things and a copayment you have to think about it if you are going to go get a new pair of glasses or something.

Secretary LEAVITT. I am in agreement with that. And in certain parts of Medicare, that exists, and in other parts, it does not. I think it is always a healthy thing. Obviously, you have those who can't afford the copayment, and society has to make the decision. But where it can be afforded, I think it is a positive thing. I also believe that for the same—I think this is at the root of much of the problem in health care costs is this disconnection between what people pay—or what things cost and what—and people's actions.

Mr. SIMPSON. I want to thank you for being here today. And thanks for the work you are doing on this problem. I know it is a huge problem. It is one we have got to address.

Thank you.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Mr. McGovern is not here.

Mr. Scott of Virginia.

Mr. SCOTT. Thank you.

Thank you, Mr. Secretary. Mr. Secretary, we have heard that the error rate in Medicare is 4 percent. What is the error rate in private insurances, Blue Cross Blue Shield and other private insurance.

Secretary LEAVITT. I don't know the answer to that, Mr. Scott.

Mr. SCOTT. You indicated that some of this fraud seems organized. Are you suggesting it is large-scale corruption, as what we believe to be organized crime, or whether it is some small time operators who just see an opportunity to steal some money?

Secretary LEAVITT. Others could be better qualified to answer that question who you will talk to, I suspect, later today. But let me just make my observation. I think this is very sophisticated and seems wide scale to me. And it is clear to me that this is not just small time operators.

Mr. SCOTT. Now, there is a difference between fraud and mistake. I mean, a doctor could put down a procedure code for an intermediate visit when it was really a brief visit. But there is no procedure code for a patient that doesn't even show up. There is a difference between fraud and mistake. Are you doing an ongoing random check to see if fraud is being committed?

Secretary LEAVITT. Yes. As I indicated, the contractors for Medicare, their job is to look for algorithmic patterns and to see evidence that a practitioner is acting in an abusive way. It is not unusual, I am told, that they find a physician's number who has been—that has been stolen. And in some cases, it does require more investigation, because it may or may not be the physician that is actually doing it. In most of the cases that I have been told about, and in my discussions with agents, there are patterns that quickly emerge. And in some cases, it requires investigation. Other times it is just very evident.

Mr. SCOTT. Sometimes the computer can give you information, a person whose appendix is being taken out for the second time, for example.

Secretary LEAVITT. That is the kind of thing the contractors clearly look for, and where a lot of the cases come from that the investigators follow.

Mr. SCOTT. Now, are you doing professional development with your providers to avoid mistakes? I know many of the problems occur when the forms aren't filled out right, the wrong procedure code is put in. And it is particularly disturbing because sometimes physicians who have a lot of Medicaid patients tend to be in low-income areas, and you just have a few doctors in that situation. If you are looking for the doctors with the highest Medicaid billing, it is going to be the minority doctors in the minority community by and large, because they have—those are the ones in the community. Are you doing anything to make sure that, by professional development, they are minimizing their mistakes?

Secretary LEAVITT. Mr. Scott, I am probably not the best one to ask these questions to, because they are handled at CMS. And I feel confident that those who oversee that area directly would have better answers. I am confident that they are. I know that they work with—but I can't give you a specific personal answer that I am confident of.

Mr. SCOTT. It is a little unfair to have people in a very complicated situation without the professional development opportunities to crack down on them. It is pretty easy I think, if you have got someone with a high volume of cases without the appropriate guidance, they are going to make some mistakes. And a lot of the minority doctors get caught up in that, and that is not fair.

Secretary LEAVITT. In my observation, and again, it is just coming from having spoken with Office of Inspector General agents in every State in the country and asking them in detail about their questions, the places we are prosecuting and the places we bring

the regulatory enforcement power of this Department, it is not in the area of mistake; it is in the area where there is a clear pattern of ongoing abuse. And there are enough of those that that is where we concentrate our effort.

Mr. SCOTT. If you totally eliminate waste, you might reduce your services. I know in emergencies, like hurricanes, we got very casual with food stamps. We have a choice: We can feed the people when they are hungry, or you can meticulously go step by step to go through the process. In emergencies, at least in Virginia, we elect to skip a few steps to make sure we go a little more on the honor system, because they don't have their documentation, and just take their word for it. This will inevitably increase fraud, but it is a necessary decision. Are you weighing those equities as to what to do in those circumstances?

Secretary LEAVITT. Yes.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman SPRATT. Thank you, Mr. Scott.

Mr. Campbell of California.

Mr. CAMPBELL. Thank you, Mr. Chairman, and thank you, Mr. Secretary. You know, if I don't lock the door to my house and somebody comes in and steals something, they have broken the law. But I helped them by leaving the door to my house unlocked. If I lock the door, maybe that person wouldn't have broken in, there might be fewer people. Somebody can still break the window and still commit the crime, and likely and perhaps somebody would, but certainly fewer people would. And it would be more difficult for them to do so. You have mentioned various elements of out and out fraud. Mr. Cooper mentioned a different level of fraud. Mr. Simpson has mentioned what is not fraud but what is probably just simply overuse due to the third-party payer system. You have touched on it a little bit, but what is your view of what we can do that locks the door, if you will, that makes this sort of fraud more difficult to commit? Is it completely reforming the system to go away from a third-party payer type system? Is that it, or is there something else that we can do with the system we have got, or what is your view on that?

Secretary LEAVITT. Mr. Campbell, I am only able to speak about this in a philosophic way because I am not involved in the enforcement of it day to day. My observations are, you know, you clearly make it hard to do. You clearly enforce, and you create the proper incentives for people to have a stake in it. There will be those that I suspect you will speak with today during your panel that will have more specifics than that, because they deal in a day-to-day basis with the enforcement.

Mr. CAMPBELL. So, well, but I am trying to talk about something that is more than enforcement. A lot of the problem here is, in all of these cases, the fact that the person getting the service is disconnected from the cost of that service.

Secretary LEAVITT. People don't know what it costs. They haven't got a lot of reason to care what it costs. And they—you are right, there is a structural problem that is, I think, well defined and would be a big part of being able to reduce the fraud and abuse.

Mr. CAMPBELL. Your thoughts on what that might be or could be?

Secretary LEAVITT. Well, transparency would be a very important first step. If people could understand what it costs, and I think at the same time having some people having some interest in it. Now, we have begun to see that occurring in many different ways. One is with copays. Others is with medical savings accounts, where people have an opportunity to share in the benefit. And one of the things we have begun to experiment with is, if people did have the cost and did know the quality and were prepared to go to high-quality, low-cost producers or providers, perhaps we ought to share the benefit with them. And that would get to the overuse. It would also begin to drive costs down and the quality up.

Mr. CAMPBELL. Is that the market forces type—you mentioned that you are experimenting with some in your earlier comments, with something that injects some market forces into this process.

Secretary LEAVITT. That is what I am referring to.

Mr. CAMPBELL. That is what you are referring to. Thank you. I will yield back, Mr. Chairman.

Chairman SPRATT. You yield back the balance of your time?

Mr. CAMPBELL. I do, sir.

Chairman SPRATT. Mr. Etheridge of North Carolina.

Mr. ETHERIDGE. Thank you, Mr. Chairman.

And let me thank you for holding this hearing. Mr. Secretary, thank you. Let me just say, thank you for your work in this area. It is important. But let me touch on something—Mr. Simpson is not here right now. I think Mr. Campbell touched on it. You may have alluded to it. I don't think you meant to. You were talking about overuse is fraud and abuse. Overuse is really overuse and maybe abuse, but maybe not fraud in the case of the someone wanting to get the extra glasses. I want to make sure we got that in the record. But I am shocked, as everyone else is I think, at the numbers in the areas.

So let me ask a question a little different way, and you may not be prepared to answer it, but I hope you will be prepared to follow up on it. Because if this is as pervasive as you have indicated, and it tends to be in pockets around the country, it is obviously, from your testimony, organized. It seems to me there ought to be a joint effort with the Department of Justice in this area, and it ought to be a unit dedicated to this purpose. Because it is not about a senior getting extra glasses or a senior doing certain things. It is about someone who has decided, as Mr. Cooper said, this is easier than robbing banks or selling drugs or anything else. It is just robbing the government through billions of dollars of services that could be going to citizens or coming out of taxpayers' pockets.

Secretary LEAVITT. I will say that and remind all of us that, in 1996, when Congress passed the Health Insurance Portability and Accountability Act, they did create between the Secretary of Health and Human Services and the Attorney General, required that we jointly promulgate the Health Care Fraud and Abuse Control Program. And that has worked, continues to operate. We work very closely with the Department of Justice.

Mr. ETHERIDGE. How well funded is it?

Secretary LEAVITT. Much of the dollars—many of the dollars that we have asked for would go into this joint funding. And we have obviously asked for more, and believe it can be used. And I can't

tell you the exact number, but it is that vehicle we are using to approach the problem we have talked about today.

Mr. ETHERIDGE. Seems to me, I know over the last several years, funding has been tight and hasn't been there, and that is unfortunate. And I am glad we are starting to have hearings to at least bring out the problems so that, in those instances where we have obviously shops set up with the designed intention to defraud the government, we are able to get to it. Because we are not talking about someone who is providing a service to a senior.

Secretary LEAVITT. No. And it does tend to be, it appears to me, regional. There are those who can respond with more exactness to this than I. But one benefit I have is that I have been in all 50 States many times in the last 3 years, and I speak with agents in each State. And it is clear to me there are patterns. There are certain States where we see a fair amount of fraud in transportation. And it is obvious fraud—it is ambulances that take people to the grocery store—and a pattern of it. That is fraud in my mind. In other areas, it will be other disposable medical equipment. In Florida and California, I described what I see there. There are pockets of it in virtually every large metropolitan area, but it is not as intense as what I have described in Florida and in California.

Mr. ETHERIDGE. Let me ask the question a little different way. It seems to me, if I am understanding you correctly, you are not saying it is a system that is throughout. You are saying there are pockets and places, and there are different types of situations depending upon those pockets.

Secretary LEAVITT. That is exactly what I am saying.

Mr. ETHERIDGE. It may be organized in hierarchy, but it tends to work where the pockets are available and the enforcement is not where it needs to be at that level at that time.

Secretary LEAVITT. And according to the investigators who I speak with, it tends to migrate. It will begin to happen in Florida, and then you will see it in Houston. And then you will see it in Los Angeles, and then you will see it in Seattle. For some reason—and frankly, it tends—there are groups of people who tend to be from the same ethnicity or region of the world who have migrated to the United States who begin to operate. And you know, if you get a group of beneficiaries, a corrupt doctor and a Medicare license, you have got a formula that will produce money.

And if we don't have enforcement, it will engender and spread.

Mr. ETHERIDGE. Thank you, Mr. Secretary. I yield back.

Chairman SPRATT. Thank you, Mr. Etheridge. Mr. Alexander has left, Mr. Hensarling is gone. Mr. Smith of Nebraska.

Mr. SMITH. Thank you, Mr. Chairman and members and certainly Secretary Leavitt for not only coming today but for your service. I admire your hard work, especially in tackling, I think, some very challenging issues. Being enlightened by some of the fraud and certainly you can appreciate the fact you don't want to go swatting flies with a sledgehammer, and yet flies that mount up can still be a problem. It is always interesting, talking to frontline health care workers who do not directly benefit financially from holes in the system. And it is interesting just hearing from them what their ideas are. And I am just wondering, I guess my first question would be, how often would folks such as the frontline

workers be consulted or encouraged to be involved in the process of preventing fraud, identifying fraud and otherwise.

Secretary LEAVITT. Mr. Smith, I wish I could give you a clear delineating answer on this. I don't know the answer to that. I can tell you that wherever I go, I am asking the line inspector, Office of Inspector General agent, what are you learning, what do you find when you get into the health care workers and how things are coded in the system, I feel confident that there are processes at CMS that seek that out. I don't see that directly. And so I can be responsive in a written way to you, or perhaps there are those that we could, in the future panel, respond to that. I am not able to very clearly.

Mr. SMITH. I understand. And certainly I would appreciate a further response as time would allow. And Mr. Scott had mentioned part of this, I guess. But in an example cited to me that a—in this case Medicaid, Medicaid patient was afforded some eye glasses, and apparently, they kept breaking, and, you know, the patient was certainly needy of eye glasses, the number of pair of eye glasses that were afforded to him by the end of the year it is my understanding was a bit excessive. And perhaps this is a rhetorical question as well. But do we have a system in place where there would be some discretionary authority by the provider to not just have to afford the new pairs of eye glasses multiple times and perhaps—and this is an extreme example I will admit. But can we work on a system to where they, you know, the needs are met initially, and after a time of repeated neglect I guess would be the right word, that service or benefit would expire.

Secretary LEAVITT. That makes a lot of sense to me. Again, I am not involved enough in the detail of that to know exactly what it would be. Any help? Maybe we could talk offline and I would be happy to respond. I know exactly what you are saying. I just don't know the answer.

Mr. SMITH. Sure. Well again, I thank you, and that will conclude my questioning. But I certainly admire anyone who wants to tackle the health care issues, especially as relates to the budget and the growth of expenditures. Thank you. I yield back.

Chairman SPRATT. Thank you. Mr. Moore of Kansas.

Mr. MOORE OF KANSAS. Thank you, Mr. Chairman and thank you, Mr. Secretary, for being here. Is it correct, Mr. Secretary, that your agency has estimated that $12 billion a year is lost due to erroneous payments paid by Medicare fee for service program?

Secretary LEAVITT. That is correct.

Mr. MOORE OF KANSAS. Can you estimate for us, please, the amount of savings that you believe we could realistically expect to capture, both for cracking down on errors on the fee for service program and fraud and other areas of the Medicaid and Medicare programs?

Secretary LEAVITT. I am not able today to give you an accurate estimate. I earlier indicated that in terms of the dollars we invest in enforcement, we expect that will return somewhere between 13 and 15 times when you look at the——

Mr. MOORE OF KANSAS. What would that number be, 13 to 15 times?

Secretary LEAVITT. Well, if you put $100 million extra dollars in then you expect $1.3 or $1.5 billion in fraud and abuse that would have been prevented or recovered. Part of that will be recovery, part of it will be prevention. We don't really know how much the—when you have effective enforcement, how much it prevents.

Mr. MOORE OF KANSAS. If, in fact, we are losing $12 billion a year due to erroneous payments, I would hope—I believe you would too that we could recover more than $1.2 or $1.5 billion a year.

Secretary LEAVITT. I was making reference to the money, the additional money. You have asked a legitimate question. I am just not able to answer it. If you would like, I would be happy to have CMS and the Office of Inspector General provide to you and to the committee an overview of the broader picture of our enforcement, and the kind of return that that provides.

Mr. MOORE OF KANSAS. I would very much appreciate that. I think all of us would agree that when you are talking about $12 billion a year, you are talking about real money.

Secretary LEAVITT. It is a lot of money.

Mr. MOORE OF KANSAS. Mr. Secretary, I would like to tell you too and ask you a question with the potential savings that could be achieved through the widespread use of health information technology. The ranking member of this committee, Mr. Ryan, Congressman Ryan and I have filed a legislation to help speed the adoption of the National Health Information Network, H.R. 2991. The Independent Health Record Trust Act would establish a market-driven approach to building a national health information network through the establishment of independent health record trusts. Health record trusts would be run by for profit or not for profit entities that would be Federally certified and act as fiduciaries on behalf of the consumers to ensure the security, confidentiality and privacy of the consumers' medical information.

Under our bill, individuals will have the option of setting up an account with the health record trust to manage their electronic medical records. We also placed incentives in the legislation for physicians, health care providers and other entities to furnish the system with information so there is formed a comprehensive electronic medical record that would result in a more accurate diagnosis and treatments. Mr. Secretary, would having complete patient information available to health care providers, in your opinion, from an independent health record trust or a similar entity be helpful in reducing Medicare fraud?

Secretary LEAVITT. There is no question it would.

Mr. MOORE OF KANSAS. Do you think that participation in the health record trust by Medicare beneficiaries would help reduce costs, for example, by reducing medical errors and avoiding duplicative services?

Secretary LEAVITT. Yes.

Mr. MOORE OF KANSAS. We will forward to you a copy of that bill and I would like for to you look at it and perhaps if you feel it is appropriate, you could make some comments to some of the people you work with and Members of Congress in support of this legislation because our intention is, and this is truly a bipartisan piece of legislation, is to reduce the amount of wasteful health care

spending in this country. Would you be willing to take a look at that?

Secretary LEAVITT. Yes, I would. I share your goal and spend a lot of time right now working to develop the necessary standards to empower some system, whether it is the one envisioned in your bill or another.

Mr. MOORE OF KANSAS. Thank you. And finally, if, in fact, we are misusing or just basically giving away more than $12 billion a year, we would like to hear back from you. If you have additional comments or thoughts about what can or should be done to have our justice system address that, as a former prosecutor, I just absolutely believe in strong enforcement, and I have heard you say the same thing. And I think that would be a wise investment of taxpayers' money to make sure that we cut down on waste, fraud and abuse.

Secretary LEAVITT. Thank you.

Mr. MOORE OF KANSAS. Thank you, sir.

Chairman SPRATT. Thank you, Mr. Moore. Mr. Tiberi from Ohio.

Mr. TIBERI. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for coming today. We all know about the future growth of Medicare and Medicaid and how it can't sustain itself for the long term. Dr. Orszag from CBO gave us some startling testimony last month about some of those numbers, $12 billion certainly isn't going to fix the problem. But I agree with Congressman Moore that it is a lot of money, even in Washington, D.C. The flip side of that is from what I hear from health care providers in central Ohio is the hoops and the difficulties they have to jump through increasingly to get payments from the government. And I actually experienced that with my mom and dad, both who, with their doctors, were providing additional information to CMS regarding some testing that ultimately got paid, but it took 2 years, and there seems to be another category that we are not talking about that is efficiency, government efficiency when it comes to paying providers that we haven't talked about today and how much gets—how much it costs taxpayers and the Federal Government for not being as efficient as we could be and how much that costs as well.

So you put all that together, Mr. Secretary, how do we move forward? Because certainly this issue isn't something new today. I remember as a congressional staffer the issue of waste, fraud and abuse being talked about with respect to Medicare and Medicaid, and here we are today many, many years later still talking about waste fraud abuse and efficiency, $12 billion. It is just a subject that doesn't go away. And to the last point, maybe Mr. Cooper mentioned it earlier, how come Justice can do a better job in some areas than other areas where we know there is a problem? Miami, this has been a problem for a long time, and yet we don't seem to be as aggressive there as we have in other cities.

Secretary LEAVITT. Let me just mention that Alex Acosta, who is the U.S. attorney in southern Florida, in my judgment, has done an extraordinary job in taking this on as a priority, and prioritizing the assets of his office to get there. Every U.S. attorney has limited financial and human assets and they have to prioritize them in the way that they will. Obviously, I would like them to be focused on health care issues but there are others who have other purposes.

$12 billion is an enormous amount of money. The good news is we are making progress here. If I would have been here 5 years ago, the proportionate number would have been higher. We haven't talk much today about contractor reform which CMS has been aggressively seeking in terms of the way we bid the work, the way we concentrate on error rates, the incentives we provide them, all of that is an important part of how we identify and manage this. I would hope for the day when this would be a very small problem. It isn't a small problem now. It is a bigger problem than we would like it to be, but it is not as big of a problem as it was a few years ago.

Mr. TIBERI. So to follow up, Mr. Secretary. In Ohio, we have a pretty active and strong durable medical goods industry, and they are just as much offended by the waste, fraud and abuse that happens because the good operators get thrown in the same pool with the bad operators. So they would like to see more aggressiveness in going after the bad actors as well. Has CMS, department thought about maybe, working with the association a little bit more aggressively in trying to weed out the bad actors?

Secretary LEAVITT. We actually have ongoing dialogues with several associations related to durable medical equipment. And you are right, we do tend to—I mean, there are a number of other things that I haven't spoken of today because we are still in the process of considering additional actions that have an impact on the legitimate operators. And I wish there were a way to eliminate that. Anytime you raise the bar, anytime you do inspections, any time you require them to relicense it affects everyone. It is unfair in one respect. But there is no alternative. And you are right, the legitimate operator, the business that is just working to serve the public and not to rip the system off is affected by this, and our job obviously has to be to minimize the number of times we do that and optimize the number of times in which we focus.

Mr. TIBERI. Thank you.

Chairman SPRATT. Mr. Baird.

Mr. BAIRD. Thank you very much, Mr. Chairman. Governor, thank you for being here. As a personal graduate of the University of Utah, thank you for your service as governor and go Utes. And we appreciate you being here. I want to follow up on something Mr. Simpson said earlier. He said that the person who—if they deny the pair of glasses they go to another doctor. In my State, you couldn't do that because you don't get doctors who will take Medicare patients. 47 percent of docs in our State won't take new Medicare patients. And the reason they do that is because the compensation rates in certain parts of this country for the same procedure are dramatically lower than other parts of the country. It is a bit tangential to today's topic, but it is my chance to talk with you about this and it is of prime importance to my constituents. Have you any insight to that issue, any thoughts about what you might do to correct that?

Secretary LEAVITT. I think anytime you have a government-run system, you are going to have a system of price setting and cost—and the market forces aren't there, and we end up subsidizing the wrong things and underpaying things we ought to be paying better

for. And most commerce, there is a supply and demand that tends to optimize matters, and that is not always true in Medicare.

Mr. BAIRD. Okay. I appreciate that. But you preside over that government-run system and you have authority therefore to in some way adjust to the differential compensation. I think you may actually find that I don't think it is totally tangential, I think there may be areas where comprehension rates are higher because historical abuse is getting rewarded frankly in areas where comprehension rates are lower because of historical conservative use of resources is actually being penalized now. You may actually find more fraud. Have you given any thought to how your agency might seek to adjust compensation rates, perhaps raising the level of the have-not States and lowering the level of excessively-have States or not even States, it is really on a county-by-county basis.

Secretary LEAVITT. Well, if I had more unilateral authority, I would change the whole system.

Mr. BAIRD. But you don't. So given the authority you have got.

Secretary LEAVITT. Therefore, we use the authority we have to come up with the best and fairest under those circumstances system as done periodically and it is an ongoing process. But I will tell you that if you look at my mail on a weekly basis, you would see piles of advocacy letters from Members of Congress and others who not only on a geographic basis, but on a product-by-product basis. They have a product that is produced in their district and they think it ought to be looked at with an individual line-item or code, and the people at CMS work hard to come up with a fair approach to it, but it is a cumbersome, difficult, I think ineffective system and it would be far better off if over time we could get to a place where the market set those prices as opposed to government.

Mr. BAIRD. I appreciate that. In the interim, I will just ask you in your role, in the current structure to try to do what you can to address this differential. Ms. Hooley had to leave but I know she shares this concern. As you talk about this fraud and abuse situation, it seems there are two categories where money is being spent. One would be where billing is made and actually no products delivered because there is no patient, a complete imaginary situation. And the second would be where you have people who are perhaps really not in urgent need of a device or a medication but they are persuaded that they do need it.

Can you tease out a little bit for us the differential there and how much of the abuse or excess cost is just the imaginary patient being billed completely speciously and the other one is the patient who is incentivized in some way to get something they don't necessarily need.

Secretary LEAVITT. Others can put them into numerical categories better than I. But I would say there is a third category, and that tends to be situations where patients are recruited and compensated. You will have people on the panel today that will be more able to delineate what percentage goes into each category. I am not able to.

Mr. BAIRD. I have seen ads on TV where basically, if you don't need it—you may not have woken up one day and said boy, I think I need this device but suddenly you can get it free.

Secretary LEAVITT. I find those offensive.

Mr. BAIRD. I do as well. And somewhere here I want to—somehow we have got to get people to understand that the amount they have paid into Medicare in many, many cases is vastly inferior to the amount they are getting back. I got my Social Security statement, and after umpteen years of work, I think I have paid $29,000 into Medicare, which you know, one or two days of ICU hospitalization sucks that right up. One last question, what are the penalties for people who engage in this stuff? I mean, how stiff is this?

You mentioned the cost-risk ratio. I like the Chinese approach. Someone starts defrauding the American people, I think a couple of those folks would get their attention. Not to cabinet officials, mind you.

Secretary LEAVITT. Just a reminder in terms of what we pay in, we are paying for those there today and it will be our children who ultimately have to pay for us. I think the worry is they won't either be able to or be willing. With respect to the penalties, and again, Office of Inspector General, people can speak more directly to this, but when you get into the large fraud like Mr. Cooper was talking about, the penalties are substantial, and they go into the hundreds of millions and sometimes into the billions.

Mr. BAIRD. I don't really care about the money. I want people to spend time in jail.

Secretary LEAVITT. We are aggressively prosecuting them and they go to jail. And I can't tell you the actual penalties that they exact, again others will need to respond to that.

Mr. BAIRD. Okay. I would urge you to be as vigorous, and if you need this body to act and make a very—you know, we slap heavy penalties on guys who smoke marijuana, for God's sakes, and then these guys who rip off the entire country for billions of dollars, I want them to spend some serious time.

Secretary LEAVITT. I will just tell you, from my observation, the penalties aren't proportionate. It is not unusual at all for me to bump into a person from the Office of Inspector General who said, yes, we were able to shut it down and it saved a lot of money. But we just shut them down, and there was—there was no prosecution. We don't prosecute every case, but it is because there is a limit of resources, and that happens to be a decision made in each jurisdiction by each U.S. attorney.

Mr. BAIRD. Well, if there is something we can do to help, let us know. Thanks for your testimony.

Chairman SPRATT. Mr. Lungren, chief prosecutor of California, do you want to comment on that policy?

Mr. LUNGREN. Yes. I was going to ask Mr. Baird whether he wants the off with the head or only the hand. But Mr. Secretary, you have given us some numbers here. Have you given us a total number of how much fraud of this type on an annual basis that we are seeing?

Secretary LEAVITT. I have not given it to you. I do not have that number. I suspect it is available but I don't have it.

Mr. LUNGREN. Could you provide that for the record, please?

Secretary LEAVITT. I would be happy to.

Mr. LUNGREN. The reason I ask that is I suspect that when you see the amount of money we are talking about, asking for utiliza-

tion of some of the funds that otherwise would return to the trust fund might make more sense. We need some proportion here, and I think that would help us see what we are talking about. Secondly, when I was attorney general of California, we had the Medicaid fraud unit, which is funded, in part, I think substantial part, by the Federal Government. It is run by the States, in our State, the attorney general handles it. We work hand in glove with the Feds on that. And even though that goes more towards Medicaid than it does Medicare, these providers are usually the same people. What, if anything, has your Department done in trying to make the response from the states more vigorous?

Secretary LEAVITT. Well, on the Medicaid side, of course we all have an incentive to do that, and we continue to both provide funds and create incentives for that to occur. On Medicare, on the other hand the States have no interest financially in it. But as you point out, there are direct corollaries between those providers, who do one, who do the other.

Mr. LUNGREN. Has there been any discussion of having State prosecutors be made special assistant U.S. attorneys? That is done in other cases of other natures in this regard. Since this problem is so large, have you discussed that with the attorney general? Has there been any effort to try and—if you need more prosecutors, you have got a lot of State prosecutors out there who could be specially charged for several cases to do this.

Secretary LEAVITT. I have not had conversations with the attorney general on that. It is a subject worthy of pursuit.

Mr. LUNGREN. The other thing is, in terms of deterrence, what would it take to require that signs be displayed at every single one of these outlets that you talk about, both English and whatever language of the community, because you said in one area you did not get English speakers, but whatever language it is, notifying people of the illegality of some of these practices, and also notifying them of the potential jail time that they could receive. The reason I say that is you indicate that these folks, the bad actors are evidently taking advantage of people who through naivete or a lack of understanding of our system or the system of Medicaid don't necessarily realize they are doing something illegal. And maybe we have to have something that tells them that, number one, and how about a specific notice of the tip line at all of these particular sites. Couldn't that be part of your checklist?

Secretary LEAVITT. That is a logical conclusion.

Mr. LUNGREN. Well, I know it is a logical conclusion, but can we do that? I mean, the reason I say that is you are talking about all the money we saved. But you know deterrents are tougher to actually analyze. It is just like when you stop a crime, you deter a number of crimes. You can't take credit of it. It is tough to quantify. But we know that there is an impact on society out there. And that is what I found missing in all of your presentation. I am happy we are getting money back, but we are obviously missing a lot. It doesn't sound like too many people are going to prison or going to jail for it. But just the knowledge that that could be the case may stop some of these people who frankly don't understand this system and realize that they are participating in an illegal scheme.

Secretary LEAVITT. Let me acknowledge you have the right person here for responsibility. I have the responsibility for this. I have made it a priority. However, there are those in the Department who have specific responsibility who would be better at answering that question than me. So if I seem evasive, it is because they are the ones who ought to be answering it and not me.

Mr. LUNGREN. Do you think it is a good idea?

Secretary LEAVITT. I do. I told you I thought it was well reasoned.

Mr. LUNGREN. Well, I have been in court and have had well reasoned arguments go the other way. I understand. We just——

I mean, it is mind boggling what you talked about here today. And the problem is, this is a system—this is a program that is very worthy for those people who need it. And because it is very worthy for those people who need it, we make it an open system, which means that it is ripe for fraud an abuse. And unless you really hammer the people who are going to take advantage of it, frankly we are never going to recover anywhere close to what we need. And that is the only suggestion I have. We need a bigger hammer, people need to know about it. And if tip lines and a little bit of a financial incentive for people to get them to turn these folks in, then that is what we ought to do. And I thank you for your work and your testimony and those who work with you.

Chairman SPRATT. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman for holding this hearing. Secretary Leavitt, good to see you. Thank you for being here.

Secretary LEAVITT. Thank you.

Mr. BECERRA. I think most of us, the information we have points to the fact that the more money you put into investigators and to working jointly with the different Federal agencies, whether it is justice or otherwise, that if we conduct some of these sting operations and use our inspectors to the full degree that we can, that we uncover fraud, which ultimately saves all of us money. But as my colleague and friend from California, Mr. Lungren, said, that ultimately means more resources available for the people who desperately need some of these programs and their services. Is there any reason why we should not actually increase beyond the capacities that this budget resolution provides to the administration for moneys to go after fraud and abuse through the inspection services that you currently provide but can beef up should you have the resources?

So I know that we gave about $200 million more in this budget resolution than the administration had requested for some of these investigative activities, but is there anything that limits us from trying to go beyond that? Or is that $200 million something that really reaches the level at which we could expect the Federal agencies, or in your case, HHS, to really move aggressively to try to do more enforcement and uncover some of that fraud and abuse.

Secretary LEAVITT. Well, there will be a point of diminishing return. We don't know where it. I think the committee's judgment has been, let's try at this level, and see if that is it, and if it is, then you can make a judgment. If it isn't, then a future committee hearing can be the venue for that discussion.

Mr. BECERRA. But do you believe that you will be able to use all those additional resources efficiently that are being provided?

Secretary LEAVITT. I believe that the Federal Government will, in fact, see a substantial return on this investment.

Mr. BECERRA. Okay. And I suspect that much of the additional spending for new inspectors, greater enforcement capacity, new technologies and equipment will pay for itself, but you have to still have the money in the next year's budget to pay for that inspector the following year. And so are there some ways that we can make sure that as you try to attract the best when it comes to these investigative activities, that you can provide them with that job security that they will need in order to accept a position with HHS, or with Justice, that would allow them to be those inspectors that we will need into the future.

Secretary LEAVITT. I feel some optimism that the success—as successes generated here that this committee will continue to acknowledge this is an important investment. I want to thank the committee for their understanding of this need, and we will do the best we can. You will get a chance to see some of the very able colleagues that will actually be involved in supervising this effort. They are able to get to a far level of specificity than I can.

As the head of the Department, it became painfully evident to me that this is an area that required that emphasis, and hence, the request for additional resources. They will tactically deploy it, and I feel next budget cycle they will come back and make a report to me and to you, and we will make the judgment that is based on that outcome.

Mr. BECERRA. Yeah. Well, Mr. Secretary, I don't have much to add, Mr. Chairman. I am not really sure there is a lot that I could really add to this discussion other than to say that I wish we could all act more aggressively to take advantage of the fact that in every study I have seen, the more we do professional inspection and enforcement, the greater the return on taxpayer dollars, and I hope that Secretary Leavitt, that when we see each other in about a year and report back on what happened for this fiscal year, that we will see that there is every reason for us to want to boost your allocation of funds for further enforcement activities even further so we could continue to try to root out that fraud as we know it exists.

Secretary LEAVITT. Thank you. And very important, I will acknowledge that a very important part of this in my judgment is recognizing that by having the enforcement money on the discretionary side of our budget and the recoveries all going into the trust fund, it does limit us in ways that are unnecessary. We are hopeful that that can be changed.

Mr. BECERRA. And Mr. Secretary, I hope that we address that point. I want to yield to the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you. I just wanted to ask a really brief question. In working with minority doctors, do you have a relationship with them and providing professional development at their annual conferences? And who in your office could I follow up with on that?

Secretary LEAVITT. To the extent that occurs, I need to respond to you in writing. I don't know the answer to that. I will have CMS respond to you directly.

Mr. SCOTT. I think if we just engage in conversation, I think that will be sufficient. Thank you.

Mr. BECERRA. Yield back, Mr. Chairman.

Chairman SPRATT. Mr. Porter.

Mr. PORTER. Thank you very much, Mr. Chairman. Thank you, Mr. Secretary, for being here today. I go back in time about 2 years ago, when hundreds of thousands of dollars were being spent in political campaigns saying how seniors should be scared and frightened of the Medicare prescription drug program. Having received the benefit of thousands of phone calls to my office across Nevada from incited seniors that were afraid of what was going to happen, I must say today in Nevada, seniors are very happy, and I applaud you and the administration for your efforts and it is unsolicited. When I visit senior centers or seniors around the district, I hear about it consistently how much they appreciate. They were a little frustrated earlier in figuring out how to operate and how to do it, but they are very happy, so thank you.

Secretary LEAVITT. Mr. Porter, thank you. And I acknowledge the fact that seniors are happy, and I think they are happy for a good reason.

Mr. PORTER. Again, I think they are. And unsolicited, I hear about it every time in the district. I am concerned about medical advantage, but I will save that for another time because they are very happy, the seniors with Medicare advantage. My question I have has to do with insurance companies and I hear there may be a problem with some insurance carriers in that they may delay approving the benefits to an extended period of time or in the meantime, the doctor will apply to Medicaid or Medicare to be reimbursed because the insurance companies have refused to provide that data. Is that an ongoing problem where we may have to pay a claim when there are insurance carriers that are technically covering this individual because of delays in the operations onsite?

Secretary LEAVITT. So you have an individual who is on Medicare?

Mr. PORTER. Yes.

Secretary LEAVITT. And the physician is not being paid?

Mr. PORTER. Correct.

Secretary LEAVITT. Reimbursed, and you are saying that the——

Mr. PORTER. Some may also have additional insurance and insurance carriers may delay in accepting responsibility so it is turned over to Medicaid or Medicare.

Secretary LEAVITT. As you know, the law provides that Medicare is secondary to other insurance. And we have an active part of CMS's job and our contractors as to determine when other insurance is available and either to pursue recovery or to encourage the insurance company to be the first payer. I suspect there are times when one is too slow in making a claim and it requires that there is some kind of adjudication that ought not to have to be done. I don't know the extent to which——

Mr. PORTER. Being put in the first position when we might well—should be in the second position because of delay.

Secretary LEAVITT. As I mentioned earlier today, we are seeking some legislation to help eliminate a loophole that will allow providers to bypass some of our administrative appeals in that way.

Mr. PORTER. Again, and I thank you and appreciate all the good words I hear from our seniors in Nevada. Thank you.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Mr. Garrett.

Mr. GARRETT. Thank you, Mr. Chairman. Thank you for your testimony. Before I begin, I will just treat Mr. Baird's comment that he actually sat down and did the computation on that for the $29,000 that you paid out over time, I am going to use that number now some time.

Mr. BAIRD. You actually get it. Social Security every year sends you, in the report it says how much you paid into Social Security, how much you paid into Medicare, it is actually an astonishing low amount given the potential service.

Mr. GARRETT. It is, in light of the fact that you probably have the same thing I do, that in your communities when you meet with seniors and what have you, they will say, well, I have been paying this my whole life, and now I anticipate or expect to be able to use it. And now I have a number to say well, this is how much you actually paid and let me ask you how much you got in benefits this year.

Mr. Secretary, you made the comment in some of your answers to others with regard to the cumbersomeness, I think was one of your words, ineffectiveness was another word, as far as the overall system that—cards that you have been dealt with as far as to administer. I have been on this committee now for 4 years, and we have been having testimony after testimony at the beginning of each year with regard to mandatory spending. It is always experts from across the aisle or across the spectrum I should say, come and say that is our biggest problem.

In the past, as you know, this side of the aisle has put forth legislation to try for reconciliation and find some fundamental changes. That is what we have attempted to do. Usually however from the administration you get two different suggestions, one of what we are talking about here, waste, fraud and abuse, which both sides of the aisle are in agreement that we want to do away with waste, fraud and abuse.

The second suggestion we often get in one form or another is reduction in the payments to providers in one form or another, the reduction in the growth curve of it or just a change in the numbers, what have you. What we don't normally get from the administration is someone to go with you and would seem to suggest would be needed is to go and eliminate the cumbersomeness or ineffectiveness of the system. The testimony we have today is good. I was reading your testimony. I was outside before. You refer to the WAM program, Whack a Mole. In my mind, though when you do the whack a mole game, or what have you, you hit 'em over here—and maybe you made that reference in your testimony, I don't know, when you hit 'em over here, they pop up someplace else.

So I am encouraged by what you say, but I get the idea that even if we go forward, try to do everything that you are suggesting here, you will hit the whack a mole here in Florida. That is one of my side questions, why you think maybe Florida and those counties in particular are the problems. But you will hit it over here and maybe California or New Jersey or someplace else will become

where the moles start popping up. So that is a side question you can address easily perhaps to why those areas are the problem areas on it. But can't we look to some more fundamental recommendations from the administration other than these two broad areas of waste, fraud and abuse? And just cutting back on the providers, which, again, Congress from both sides of the aisle usually say no because of the political pressure we receive from the providers, may be in line with what some members are talking about with SCHIP and Medicaid and a fundamental change as far as how we provide services in those areas so that you get at the root cause of the problem of trying to eliminate some of the waste of a government-run system that doesn't have market forces and doesn't optimize the services that are provided.

Secretary LEAVITT. Let me clarify a couple things.

Mr. GARRETT. Sure.

Secretary LEAVITT. One, frankly CMS and the Medicare system have been very efficient in their ability to administer the payment of money. They can cut a check for a smaller portion of Medicare than many insurance companies can cut a check based on their premiums. It is a very efficient system, it is a big system, because we handle a billion claims a year. The pricing mechanism, however, in my mind, is inefficient because we—it is done through regulation as opposed to through market. So when I talk about the cumbersomeness, that is, I think, what I am referencing. I hope that you have noted that we are big proponents of Medicare advantage, which is a fundamental reform in Medicare, where we allow a person to obtain their Medicare benefits through a private insurer. We believe that that not only moves us toward a rate setting system that is not directly linked to government price setting and allows the market to work, but we are seeing that the result of it, is people get better coverages and they like it better and they are having less trouble finding a doctor. We think all of those things are positive things and fundamental reforms and shifts and changes that would, in the long run, serve the system well.

Chairman SPRATT. Mr. Secretary, at this hour of the day, we won't take up the argument of Medicare advantage and the premiums paid on top of the per capita payments that otherwise pay FSS. You have been an excellent witness. You have left us a lot of information to consider. Somewhere down the road when you get the funds available, we hope they make it through the budget process this year. We would like to sit down again with you and see what results we have achieved.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Thank you so much for your participation today.

Now we move to our second panel. Linda Stiff who is the deputy commissioner of operations support for the Internal Revenue Service. Stephen C. Goss who is the chief actuary for the Social Security Administration. Timothy Hill, chief financial officer of CMS, Centers for Medicare & Medicaid Services. And Ms. Patricia Smith, commissioner of the New York State Department of Labor.

STATEMENTS OF LINDA STIFF, DEPUTY COMMISSIONER OF OPERATIONS SUPPORT, INTERNAL REVENUE SERVICE; STEPHEN GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; TIMOTHY HILL, CHIEF FINANCIAL OFFICER, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND PATRICIA SMITH, COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF LABOR

Chairman SPRATT. If it is agreeable with you, the panel, we will start from left to right, my left to your right, my left to right in the order that I just read your names, beginning with Ms. Stiff.

STATEMENT OF LINDA STIFF

Ms. STIFF. Good morning, Chairman Spratt, Ranking Member Ryan and members of the Committee on the Budget. My name is Linda Stiff, and I am the Deputy Commissioner for Operations Support for the Internal Revenue Service. I appreciate the opportunity to be here this morning to discuss the critical role that the program integrity cap adjustment plays in supporting the IRS's enforcement programs. First, however, I want to thank you, Mr. Chairman and this committee for your support for the fiscal year 2008 proposed budget. This budget will allow us to continue to balance a strong taxpayer service program with an equally effective enforcement presence. This balance is important to an effective tax administration program.

In fiscal year 2006, we generated almost $49 billion in enforcement revenue. This is an increase of 43 percent over fiscal year 2001. Despite our success and increasing enforcement revenue, we still have a long way to go. In February 2006, we released updated estimates of the tax gap. The tax gap is the difference between the tax that is imposed by law and what is actually paid voluntarily and timely. That estimate revealed that the gross tax gap for tax year 2001 was $345 billion. This represents a voluntary compliance rate of 83.7 percent. After we factored in collections from our enforcement efforts and other late payments, our estimate of the net tax gap was $290 billion.

In an effort to close this tax gap, the Department of Treasury and the IRS have developed a specific strategy to increase the level of voluntary compliance. Treasury submitted that strategy to Congress last September. We expect to submit an update to that plan in the near future. A key element to any strategy of reducing the tax gap is fully funding and protecting IRS resources for enforcement activities. The program integrity cap does just that by establishing a budget framework for funding and ensuring IRS resources are dedicated to enforcement activities.

The fiscal year 2008 IRS budget proposed a program integrity cap adjustment of $406 million for enforcement. Of that total, $115 million supports a portion of the cost to maintain current base enforcement levels while the remaining $291 million supports IRS initiatives that focus on increasing voluntary compliance and reducing the tax gap. There are seven specific initiatives in the fiscal year 2008 budget that are aimed at improving compliance. They are discussed in detail in my written statement. We estimate that by fiscal year 2010 these initiatives would generate an estimated $699 million per year.

I realize that it is important to this committee as it is to us that these investments in additional enforcement resources demonstrate a justifiable return. Historically, the return on investment resulting from IRS enforcement programs has ranged from $3 to $14 for every additional $1 invested. The range is a function of the specific type of enforcement activity. For the new initiatives included in the fiscal year 2008 budget proposal, the return on investment is approximately four to one. This estimate does not include the impact that enhanced enforcement has on deterring noncompliance. Research suggests that this indirect effect is at least three times as large as the direct impact on revenue.

Mr. Chairman, let me conclude by saying that we will never audit our way out of a tax gap. But it is important that we have the enforcement resources to collect everything we can without fundamentally changing the manner in which we interact with taxpayers. The use of the program integrity cap adjustment helps us do that and provides certainty that the revenues appropriated for enforcement are used in enforcement. Thank you, and I will be happy to respond to any questions.

[The prepared statement of Linda Stiff follows]

PREPARED STATEMENT OF LINDA STIFF, DEPUTY COMMISSIONER FOR OPERATIONS SUPPORT, INTERNAL REVENUE SERVICE

Good afternoon Chairman Spratt, Ranking Member Ryan and Members of the Committee on the Budget. My name is Linda Stiff and I am the Deputy Commissioner for Operations Support. I oversee, among other things, the IRS offices of Chief Financial Officer, Modernization and Information Technology Services, and Human Capital. I am pleased to be here this morning to discuss the program integrity cap adjustment and the use of the funds provided under this adjustment by the IRS.

First, however, I want to thank you Mr. Chairman and this Committee for your support for the IRS FY 2008 proposed Budget. As I will discuss later, this budget will allow us to go forward with several initiatives that will assist us from both a service and enforcement perspective.

This morning I would like to outline some of the accomplishments we have had with our balanced approach to tax administration, the challenges associated with increasing the levels of voluntary compliance, the importance of the program integrity cap adjustment to the success of our enforcement program, and the return we get on our enforcement investment.

A BALANCED APPROACH TO SERVICES AND ENFORCEMENT

In FY 2006, we continued making improvements in both our service and enforcement programs. This claim is not just our assessment, but also that of the IRS Oversight Board in its most recent annual report. According to the Board, the IRS has made steady progress towards "transforming itself into a modern institution that provides efficient and effective tax administration services to America's taxpayers."

We continue to see improvement in various taxpayer service programs. A survey commissioned by the Board in 2006 revealed taxpayers increasingly recognize that the IRS provides quality service through a variety of channels, such as our Web site, toll-free telephone lines, and Taxpayer Assistance Centers (TACs). This finding is supported by the metrics that we use to determine the effectiveness of our taxpayer service efforts. In category after category, we continue to see improvement in the numbers for our customer service and usage levels in our telephone services, electronic filing, and IRS.gov access.

We have had similar success on the enforcement side. In assessing our work in FY 2006, the Oversight Board said, "As demonstrated by a variety of measures, the IRS' performance on enforcement has improved considerably, and real progress has been achieved over the past six years."

One of the most obvious measures of that progress is the increase in enforcement revenue, which has risen from $34 billion in FY 2002 to almost $49 billion in FY 2006, an increase of 43 percent.

In FY 2006, both the levels of individual returns examined and coverage rates have risen substantially. We conducted nearly 1.3 million examinations of individual tax returns, almost 75 percent more than were conducted in FY 2001, reflecting a steady and sustained increase since that time. Similarly, the audit coverage rate has risen from 0.58 percent in FY 2001 to more than 0.97 percent in FY 2006.

While the growth in examinations of individual returns is visible in all income categories, it is most evident in examinations of individuals with incomes over $1 million. The number of examinations in this category rose by approximately 78 percent compared to FY 2004, the first year the IRS began tracking audits of individuals with income over $1 million. The coverage rate has risen from 5 percent in FY 2004 to over 6 percent in FY 2006.

Growth in audit totals and coverage rates extends to other taxpayer categories. Preliminary estimates show that the IRS examined over 52,000 business returns in FY 2006, an increase of nearly 12,000 over FY 2001. The coverage rate over the same period rose from 0.55 percent to 0.60 percent. For corporations with assets over $10 million, examinations rose from 8,718 in FY 2001 to 10,578 in FY 2006, an increase in the coverage rate from 15.1 percent to 18.6 percent. For the largest corporations, those with assets over $250 million, examinations have increased by over 29 percent growing from 3,305 in FY 2001 to 4,276 in FY 2006.

We have also been active in the tax-exempt community. Overall, examination closures for tax exempt organizations have risen from 5,342 in FY 2001 to 7,079 in FY 2006. In addition, we have an innovative program utilizing correspondence contacts to leverage our activities in the enforcement area. We have used it successfully in the hospital and executive compensation areas, and will be using it elsewhere.

While examinations in the tax-exempt community generally do not provide the tax collection "return on investment" that audits in other areas might, it is important that we keep a "cop on the beat" in order to prevent abuses in the exempt sector and an erosion of the tax base. Maintaining a strong enforcement presence in the tax-exempt sector is particularly important given the role that a small number of these entities have played in the past in accommodating abusive transactions entered into by taxable parties. In appropriate cases, this results in the collection of income or excise taxes—and in the most egregious cases, revocation of exempt status.

Our ability to achieve these successes is dependent on having adequate resources to fund IRS service and enforcement functions. As I will discuss later in the testimony, the use of the program integrity cap adjustment is an important component in ensuring we have those resources, especially for enforcement.

THE TAX GAP

Despite our success in increasing enforcement revenue, we still have a long way to go. In February 2006, we released updated estimates of the tax gap—the difference between the tax that is imposed by law and what is paid voluntarily and timely. That estimate revealed that the gross tax gap for Tax Year 2001 was $345 billion. This amount represents a voluntary compliance rate of 83.7 percent across all types of taxes and all types of taxpayers. When enforcement collections and other late payments were factored in, our estimate of the net tax gap was $290 billion.

Despite certain limitations, the most recent study incorporating results from a National Research Program (NRP) reporting compliance study of approximately 46,000 individual taxpayers for Tax Year 2001 represents the latest and best estimate of the tax gap. But, beyond the actual numbers, the study revealed a significant amount of information that has enabled us to address significant areas of noncompliance.

For example, the study revealed that underreporting—the failure to report one's full tax liability on a timely filed return—constitutes 82 percent of the tax gap. As with previous compliance studies, we also found that reporting compliance is strongest in the presence of substantial information reporting and withholding. While the net misreporting percentage for wages and salaries, on which there is withholding and substantial information reporting, is only 1.2 percent, amounts not subject to withholding or third-party information reporting (e.g., sole proprietor income and the "other income" line on Form 1040) are the least visible with a net misreporting percentage of over 50 percent.

The NRP also provided the IRS with a baseline for compliance trends and allowed the IRS to update audit selection formulas, meaning that we can target enforcement resources to those areas where we are most likely to find noncompliance. This improved focus not only improves our return on investment but avoids examinations of compliant taxpayers.

In an effort to attack the tax gap, the Department of the Treasury developed a "A Comprehensive Strategy for Reducing the Tax Gap." This plan was submitted to Congress in September 2006. It outlined a seven-prong approach to reducing the tax gap, including a plan to:

- Reduce the opportunities for evasion;
- Make a multi-year commitment to research;
- Continue improvements in information technology;
- Improve compliance activities;
- Enhance taxpayer service;
- Reform and simplify the tax law; and
- Coordinate with partners and stakeholders.

The Department of Treasury and the IRS are currently updating and providing additional information in support of the plan. That update should be submitted to Congress shortly.

It is important to note that while this plan presents a comprehensive strategy for increasing the rate of voluntary compliance, there are limits to how much we can increase that percentage without fundamentally changing the manner in which we interact with taxpayers. Achieving dramatic increases in the voluntary compliance rate would call for draconian measures that would likely be unacceptable to policymakers and taxpayers.

PROGRAM INTEGRITY CAP FUNDING

Fully funding and protecting IRS resources for enforcement activities are key to improving voluntary compliance and, ultimately, reducing the tax gap. The program integrity cap establishes a budget framework for funding and ensuring IRS resources are dedicated to enforcement activities.

The President's FY 2006 Budget first applied a program integrity cap adjustment of $446 million for additional enforcement investments and inflationary costs necessary to maintain IRS's base enforcement levels. In the final Appropriations bill for that fiscal year, Congress included this program integrity adjustment and earmarked $6.447 billion of IRS base resources for tax enforcement and added an additional $446 million enforcement increase, for a total of $6.893 billion.

Much of the enforcement success in FY 2006 that I discussed earlier was the direct result of this increased funding provided by the program integrity cap adjustment.

The FY 2007 President's Budget again proposed a program integrity cap adjustment of $137 million for the inflationary costs to maintain IRS base enforcement programs funded in FY 2006. However, the FY 2007 Joint Resolution approved by Congress in February 2007 did not include the cap adjustment.

Once again in FY 2008 the President proposed a program integrity cap adjustment of $406 million for enforcement. Of that total, $115 million supports a portion of the cost to maintain current FY 2007 base enforcement levels (i.e. pay raise and other inflationary increases). The remaining $291 million supports IRS initiatives that focus on increasing voluntary compliance and reducing the tax gap.

FY 2008 INITIATIVES FUNDED BY THE PROGRAM INTEGRITY CAP ADJUSTMENT

The IRS's FY 2008 enforcement initiatives are aimed at improving voluntary compliance by:

- Increasing front-line enforcement resources;
- Implementing legislative and regulatory changes; and
- Expanding the research program.

The following seven specific initiatives proposed in the FY 2008 Budget are aimed at improving compliance. When the new hires reach full potential in FY 2010, they will generate an estimated $699 million per year (all revenue estimates are FY 2010 estimates when the new hires reach their full potential). These initiatives provide:

- $73.2 million to improve compliance among small business and self-employed taxpayers in the elements of reporting, filing, and payment compliance. This funding will be allocated for increasing audits of high-risk tax returns, collecting unpaid taxes from filed and unfiled tax returns, and investigating persons who have evaded taxes for possible criminal referral. It is estimated that this request will produce $144 million in additional annual enforcement revenue per year.
- $26.2 million for increasing compliance for large, multinational businesses.

This enforcement initiative will increase examination coverage for large, complex business returns; foreign residents; and smaller corporations with significant international activity. It addresses risks arising from the rapid increase in globalization, and the related increase in foreign business activity and multi-national transactions where the potential for noncompliance is significant in the reporting of transactions

that occur across differing tax jurisdictions. With this funding, we estimate that coverage for large corporate and flow-through returns will increase from 7.9 to 8.2 percent in FY 2008, and produce an estimated $74 million in additional annual enforcement revenue.

• $28 million to expanded document matching at existing sites.

This enforcement initiative will increase coverage within the Automated Underreporter (AUR) program by minimizing revenue loss through increased document matching of individual taxpayer account information. The additional resources will increase in AUR closures from 2.05 million in FY 2007 to 2.64 million in FY 2010 and generate an estimated $208 million of enforcement revenue per year.

• $23.5 million to establish a new document matching program at the Kansas City campus. This enforcement initiative will fund a new AUR site within the existing IRS space in Kansas City to address the misreporting of income by individual taxpayers. Establishing this new AUR site is estimated to generate over $183 million in additional enforcement revenue per year.

• $6.5 million to increase individual filing compliance.

This enforcement initiative will help address voluntary compliance. The Automated Substitute for Return Refund Hold Program minimizes revenue loss by holding the current-year refunds of taxpayers who are delinquent in filing individual income tax returns and are expected to owe additional taxes. We estimate that this initiative will result in securing more than 90,000 delinquent returns in FY 2008 and is estimated to produce $82 million of additional enforcement revenue per year.

• $41 million for conducting research studies of compliance data for new segments of taxpayers needed to update existing estimates of reporting compliance. The data collected from these studies will enable the IRS to develop strategies to combat specific areas of noncompliance.

• $23 million for information technology improvements to implement legislative proposals needed to improve compliance. The FY 2008 President's Budget includes several legislative proposals that would provide the IRS with additional enforcement tools to improve compliance. It is estimated that these proposals could generate approximately $29 billion in revenue over the next ten years.

In addition, the budget includes two non-revenue raising enforcement initiatives, which are still important to a balanced enforcement program. These initiatives are:

• $15 million to increase tax-exempt entity compliance.

This enforcement initiative will deter abuse by entities under the purview of the Tax-Exempt and Governmental Entities Division (TEGE) and misuse of such entities by third parties for tax avoidance or other unintended purposes. The funding will aid in increasing the number of TEGE enforcement contacts by 1,700 (six percent) and employee plan/exempt organization determinations closures by over 9,000 (eight percent) by FY 2010.

• $10 million for increased criminal tax investigations.

This funding will help us aggressively attack abusive tax schemes, corporate fraud, nonfilers, and employment tax fraud. It will also address other tax and financial crimes identified through Bank Secrecy Act related examinations and case development efforts, which include an emphasis on the fraud referral program. Our robust pursuit of tax violators and the resulting publicity is aimed at fostering deterrence and enhancing voluntary compliance.

All nine of these initiatives support our strategic plan to reduce the tax gap.

RETURN ON INVESTMENT (ROI)

I realize that it is important to this Committee, as it is to us, that these investments in additional enforcement resources demonstrate a justifiable return. Historically, IRS enforcement activities have yielded significant revenue.

ROI resulting from IRS enforcement programs ranges from $3 to $14 for every additional $1 dollar invested, depending on the type of enforcement activity. For example, labor-intensive activities such as the Collection Field Function have lower ROIs, and automated activities such as Automated Underreported have high ROIs. Overall, the ROI for the new initiatives discussed above is about 4 to 1, and the full benefit of revenue-producing initiatives is realized approximately three years after implementation when staff reaches its full performance level.

These ROI estimates are understated in that they reflect only direct enforcement revenue collected and do not include revenue protected through programs that deny fraudulent refunds such as Criminal Investigations. Nor does it include the impact that enhanced enforcement has on deterring noncompliance that helps to insure the continued payment of more than $2 trillion in taxes paid voluntarily each year. The indirect effect of increased IRS enforcement on improving voluntary compliance is

not actually observed. However, research suggests it is at least three times as large as the direct impact on revenue.

SUMMARY

Mr. Chairman, I would like to thank you and this Committee again for your support for the IRS FY 2008 Budget and the program integrity cap adjustment in the Budget Resolution. As the result of your demonstrated support of the IRS enforcement efforts, the House Appropriations Committee funded our entire request, including the cap adjustment, and the full House has since passed that appropriations bill.

Earlier I spoke of a balanced program—specifically the balance between service and enforcement and the balance within enforcement of targeting all areas of noncompliance. In many ways, our budget represents a balance. We will never audit our way out of the tax gap, but it is important that we have the resources to enforce the existing laws in ways that do not fundamentally change the manner in which we interact with taxpayers. The use of the program integrity cap adjustment provides certainty that the revenues appropriated for enforcement are used in enforcement.

Thank you and I will be happy to respond to any questions.

Chairman SPRATT. Thank you very much. Mr. Goss.

STATEMENT OF STEPHEN GOSS

Mr. GOSS. Chairman Spratt, Ranking Member Ryan and members of the committee, thank you very much for the opportunity to come today to discuss with you the Social Security Administration's efforts to reduce and correct improper payments and the discretionary cap adjustment that you are considering for fiscal year 2008 budget that would increase funding for these efforts. Specifically, the adjustment that is before you would provide funding above the base level of funding that would allow the Social Security Administration to conduct more continuing disability reviews, oftentimes referred to just as CDRs, as well as more non-medical supplemental security income redeterminations.

These would avoid and correct improper payments to Social Security beneficiaries and supplemental security income recipients. The adjustment under consideration would provide SSA with an additional $213 million, allowing us to conduct 200,000 more CDRs, that would roughly double what we are expecting in fiscal year 2008 otherwise, and would also allow us to increase by 500,000 the number of SSI redeterminations for the year. We project that on the basis of this $213 million investment, we would get in future years about a $2 billion reduction in overall program costs, reduction and i.e., that much in savings from this cap adjustment.

Most of these savings would come in the next 10 years. Let me elaborate just a bit on the nature of what CDRs and redeterminations are. A CDR is a review of the current status of an individual who has been on the disability rolls for some time to determine whether that individual's disability has ended or has significantly improved. Funding for CDRs has varied widely over the past decade or two. And as a result of funding shortfalls, we had a 3 to 4 million case CDR backlog develop as of the mid 1990s. However, in fiscal years 1996 through 2002, SSA was given an appropriation of special funds above the discretionary spending caps to be used exclusively to conduct these CDRs.

At the end of the period, SSA successfully worked all these cases or had them in process so that all cases that were due, were at least in process. The program savings from this effort were consid-

erable. Since the end of the period, fiscal year 2002, however, requests for CDR dedicated funding totaling $1.75 billion from the administration have not been met. This has meant that we have fallen behind on our scheduled CDRs and currently have a significant backlog once again. For SSI beneficiaries, SSA also conducts redeterminations in addition to these CDRs which are periodic reviews of the SSI nonmedical eligibility factors, and we do this in order to assure that SSI payments are made in the correct amount, and only to eligible individuals. Experience has shown us that redeterminations are a very, very effective tool to detect and prevent improper payments in the SSI program. Of course, as with CDRs, administrative resource limitations and other workload requirements have a significant impact on the number of redeterminations that we can actually process. In fiscal years 2003 and 2004, we processed well over 2 million, almost 3 million redeterminations in each of those years.

By 2006, however, the number was reduced substantially and for 2007 we were down to only 1 million redeterminations being processed. The expected present value of future program savings, which is reported by SSA annually in reports to Congress has remained close to $10 in program savings for every $1 spent on continuing disability reviews. This return on investment reflects not only Social Security but also Medicare and Medicaid savings as well. So by doing these efforts, we actually tap into savings across a number of programs. The savings for cessations in a specific year are generally expected to result in savings—I am sorry—the expenditures that result in cessations of benefits in a given year from CDRs result in savings that occur over the next 10 and even 20 years and even beyond. We conduct a similar analysis for estimating the results of SSI redeterminations. We estimate the program savings from SSI redeterminations, we do this by adding the expected recovery of overpayments detected by the redeterminations to the expected future overpayments that are avoided as a result of doing these redeterminations. For redeterminations that will be processed with the additional funding from a cap adjustment for 2008, the expected return on investment is about $7 in program savings over future years for every $1 spent in conducting them.

Mr. Chairman, CDRs and redeterminations are among the most important program integrity and stewardship tools that SSA has, and our ability to do more of them will go a long way in helping us to reduce and correct improper payments from the programs that SSA administers. It is vital that the cap adjustment under consideration be approved. SSA appreciates the committee's support in helping us maintain the integrity of the Social Security and SSI disability programs. We look forward to working with you in the future, and I will, of course, as the other panelists, be very, very happy to answer any questions.

[The prepared statement of Stephen Goss follows]

PREPARED STATEMENT OF STEPHEN GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Chairman Spratt, Ranking Member Ryan, and Members of the Committee: Thank you for the opportunity to discuss the Social Security Administration's (SSA) efforts to reduce and correct improper payments and the FY 2008 Budget proposal for an

adjustment in the discretionary spending caps to help increase program integrity efforts. Specifically, the proposal would provide an adjustment above a base level of funding that would allow SSA to conduct more continuing disability reviews (CDRs) and non-medical redeterminations to avoid improper payments to Social Security beneficiaries and Supplemental Security Income (SSI) recipients when factors affecting their eligibility or payment level have changed.

The proposal would provide SSA with a $213 million cap adjustment that would allow us to conduct an additional 200,000 CDRs and 500,000 additional SSI redeterminations in FY 2008. With these efforts, we project that we would realize about $2 billion in future program savings, with most of the savings coming in the next ten years. The return on investment from the additional $213 million is expected to be approximately $10 to $1 in program savings for CDRs and $7 to $1 for redeterminations.

SSA uses well-founded methods for determining administrative costs and estimating future program savings for these important program integrity workloads. The projected returns on investment for these workloads are substantial and thus contribute to the solvency of the programs and help to keep benefits well targeted to those who most need them.

In the case of CDRs, we use data from our CDR tracking file and other sources to develop estimates of future program savings. When the Congress previously provided SSA with cap adjustment funding for CDRs in FY 1996 through 2002, you also required us to submit an annual report to Congress. Because we well understand the value and importance of program integrity efforts, we have been reporting this type of information for over 20 years.

SSA supports this program integrity cap adjustment proposal as a highly effective and efficient means to prevent improper payments. The balance of this testimony will describe these CDR and redetermination workloads to you in more detail.

CONTINUING DISABILITY REVIEWS

For an individual to be entitled to disability benefits under either the Social Security Disability Insurance or SSI program, a determination must be made that the person meets the definition of disability in the Social Security Act. Most of these determinations are made by State agencies known as Disability Determination Services, or DDSs. These determinations establish whether the individual is disabled and the date the disability began. After an individual has been on the program rolls for a period of time, the DDS is also involved in the determination of whether the individual's disability continues.

Since the beginning of the disability program, Congress has required, under sections 221(i) and 1614(a) of the Social Security Act that SSA periodically review the cases of beneficiaries who receive benefits, based on disability, to determine if disability continues. When disability is established, each case is scheduled for a periodic continuing disability review. The frequency of review depends on the likelihood of medical improvement. In addition, if we receive information that a beneficiary may no longer be disabled, a CDR may be conducted earlier than scheduled.

In the early 1990s, concern over the reduced number of CDRs that SSA was doing each year began to grow. Of particular relevance, the Contract with America Advancement Act of 1996, P.L. 104-121, included a provision authorizing the appropriation of special funds for fiscal years 1996 through 2002 to be used exclusively to conduct CDRs. At that time, SSA estimated at least $6 in program savings for every $1 spent in CDR administrative costs. Based on subsequent data, we believe that CDRs are even more cost effective, with estimated savings of about $10 to $1 during the ten fiscal years 1996 through 2005.

The additional funding provided by P.L. 104-121 allowed SSA to embark on a seven-year plan designed to eliminate the backlog of CDRs, which had grown to between three to four million cases at the end of FY 1997. With the support of Congress, this funding outside of discretionary spending caps for SSA's CDR program allowed SSA to initiate a CDR for all of the cases in which one was due by the end of FY 2002.

Since FY 2002, however, requests totaling $1.75 billion in dedicated funding for CDRs have not been met. This has meant that we have fallen behind in our scheduled CDRs and currently have a significant backlog.

SSA reports annually to Congress on the CDR workload. In the most recent report, SSA reported that it spent $493 million processing CDRs in FY 2005 for an estimated present value of lifetime program benefit savings of $5.4 billion, including Medicare and Medicaid savings, showing that CDRs continue to be a highly cost-effective program integrity tool. As I mentioned earlier, the return on investment for CDRs is about $10 to $1. The report for FY 2006 will be published later this

year, and we expect the return on investment numbers will be consistent with previous reports.

Our past experience has shown us that additional funding through cap adjustments is effective and will help us become current on CDR processing.

THE REDETERMINATION PROCESS

SSI is a means-tested program that provides cash assistance to aged, blind, and disabled individuals with limited income and resources. Once individuals are found eligible for benefits, changes in their living arrangements or in the amounts of their income or resources can have an effect on their benefit amount or eligibility status even if their medical condition has not changed. In order to assure that SSI payments are made in the correct amount and only to eligible individuals, SSA conducts redeterminations, which are periodic reviews of SSI non-medical eligibility factors. Redeterminations are a very effective tool to detect and prevent improper payments in the SSI program.

The purpose of a redetermination is to determine whether a recipient is still eligible for SSI and still receiving the correct payment amount. Redeterminations can be scheduled or unscheduled, and except for certain institutionalized individuals, all recipients are periodically scheduled for a review. The frequency and the intensity of these reviews depend on the probability that the case is being paid in error, which is based on a number of case characteristics, and on the level of funding available for these reviews. While SSA selects for review the cases most likely to have a payment error, even the cases unlikely to have payment error are scheduled for review at less frequent intervals. Unscheduled redeterminations are completed on an as needed basis when recipients report, or we discover, certain changes in circumstances that could affect the continuing SSI payment amount or eligibility.

The number of redeterminations we complete varies from year-to-year based on available resources and workload requirements. In fact, fewer redeterminations were selected for processing in FY 2005 and 2006. In FY 2004, we processed over 2.2 million redeterminations, but in FY 2005 we only completed 1.7 million. In FY 2006, we conducted just over 1 million redeterminations, and it is expected that we will process a similar amount in FY 2007.

ESTIMATING PROGRAM SAVINGS FOR CDRS AND REDETERMINATIONS

SSA has been reporting CDR data to Congress since 1983. Beginning with the CDR report to Congress for FY 1996, SSA has included information on the number of reviews, the disposition of such reviews, the amount spent on reviews, and the estimated future program savings for those found to be no longer eligible for benefits. The calculation of estimated future program savings for benefit cessations is critical in determining the return on investment for CDRs. This calculation reflects the duration of additional benefit receipt that would have occurred in the absence of the CDR. Estimated benefit savings reflect the likelihood of successfully appealing the CDR determination or of reapplying for benefits and becoming re-entitled. Through the years, the analysis has become more detailed and many parameters have been refined. But the expected present value of future program savings has remained about $10 for every $1 spent in doing CDRs. It is important to remember that this return on investment reflects Medicare and Medicaid savings as well as Old Age and Survivor and Disability Insurance savings. Also, the savings do not reflect only benefit savings in the year the CDR is completed. The actual savings for cessations in a specific year reflect expected future savings over the next 10 to 20 years in many cases.

We conduct similar analysis for estimating the results of SSI redeterminations. However, unlike CDR cessations, redeterminations can result in an individual no longer receiving benefits or continuing to receive benefits but at a different level. In some instances, an individual's benefit may decrease—e.g., due to an increase in income—while in others, the benefit may increase—e.g., due to a change in living arrangements. We estimate program savings from SSI redeterminations by adding the expected recovery of overpayments detected by the redetermination to the expected future overpayments that are avoided as a result of the redetermination. For redeterminations that will be processed with the additional funding from a cap adjustment for FY 2008, the expected return on investment is about $7 in program savings for every $1 spent in conducting them.

CONCLUSION

The Social Security Administration is responsible for providing benefits to all qualified individuals, but only for as long as and to the extent that the benefit is warranted under law. CDRs and redeterminations are among the most important

program integrity tools SSA has, and our ability to do more of them will go a long way in helping us reduce and correct improper payments for the programs SSA administers. Therefore, it is vital that the cap adjustment under consideration, that would give SSA funding to conduct additional CDRs and redeterminations, is approved. SSA appreciates this Committee's support in helping us maintain the integrity of the Social Security and SSI disability programs, and we look forward to working with you in the future.

I will be happy to answer any questions you might have.

Chairman SPRATT. Thank you very much. We will have questions, but let's complete the testimony from the panel.

Now, Mr. Hill.

STATEMENT OF TIMOTHY B. HILL

Mr. HILL. Good morning, Chairman Spratt, Congressman Ryan, distinguished members of the committee. I am pleased to be here today to discuss the Centers for Medicare and Medicaid Services' efforts to ensure the continued integrity of the Medicare program.

I have submitted my written statement for the record, and let me focus this morning on three issues: the funding issues that we are currently facing, talk a little bit about how we measure our success, and then discuss very briefly some of our preliminary thinking about where we would devote extra resources that will hopefully come to us through the appropriation after your support from the committee.

As you know, beginning in 1997, the Health Care Fraud and Abuse Control Program has provided CMS with a dedicated funding stream to protect Medicare. With this funding we enter into contracts with a variety of organizations to audit provider financial data, review medical records and other billing data, coordinate benefits with other health plans, educate providers, and work with law enforcement to pursue fraud cases.

Funding for these activities actually grew from 1997 to 2003. Unfortunately, since 2003, funding for these activities has been capped, and CMS has sustained approximately $90 million inflationary loss to our purchasing power for program integrity activities.

Additionally, our current appropriations are only available to support activities conducted by contractors, and can't be used to support Federal staff and their program integrity activities. Thus, to preserve our commitment to program integrity, the President's budget is requesting an additional $183 million in discretionary budget authority above our current mandatory appropriation.

To be sure, this request is for a set of programs with a proven record of accountability; and I would like to now turn to a discussion of how we measure our success and the effectiveness of these programs.

One method that we use for measuring our effectiveness, as has been discussed here and by Secretary Leavitt, is a return on investment ratio, an ROI. Our activities have varying rates of return. For example, medical review, where we actually review the medical documentation supporting a claim, has a rate of return of close to 23 to 1, whereas a financial cost report audit is closer to 2 to 1. Some of the initiatives that Secretary Leavitt talked about earlier, the on-the-ground fraud initiatives and on-site visits have ratios

closer to a 100to 1. From year to year the ratios vary, but the composite rate for all our activities approaches 15 to 1.

Another key method to assess our effectiveness is our ongoing error rate measurement programs. As you know, we are required under the IPIA to undertake risk assessments and conduct measurement of errors across all our programs. Last year, for Medicare our error rate was 4.2 percent, as has been discussed here. It is a significant decrease from our prior year of 5.2. And in fact over the last 3 years, we have reduced the rate by 56 percent, which is a cumulative savings to the taxpayers of over $11 billion.

We are beginning to calculate error rates and report them for Medicaid—we will be reporting the first set of rates this fall—as well as for Part D and Part C of the Medicare Advantage and prescription drug programs. We will begin reporting rates for those programs this fall as well.

Let me conclude here by discussing three areas I think will be greatly enhanced by enhanced funding if it is provided through this year's budget process. The first, over the past 3 years the efforts of our LA and Miami field offices and our partners have resulted in nearly $4 billion in identified savings for the Medicare program. Given the success of our existing field offices, CMS is evaluating the potential for additional locations. New York, Texas, the upper Midwest, all represent areas of high vulnerability that can benefit from an enhanced Federal presence and "our feet on the street" efforts in high vulnerability areas of the country.

Second, CMS created the Medicare Drug Integrity Contractors to help us safeguard the new prescription drug benefit, and they played a key role in early implementation of the new program. Early in the program we identified theft scams and were able to identify certain pharmacies, again in Miami, who were phantom billing prescription drug programs.

Now, all of these problems were found through our MDIC contractors. Unfortunately, funding for these contractors expires at the end of this fiscal year. Additional resources would allow us to continue these efforts, as well as expand into the Medicare Advantage, the Part C benefit, so we could be more vigilant in that area in identifying, preventing, and combating fraud and abuse.

Finally, and as you heard the Secretary testify to, we have found that conducting on-site visits as a more complete part of our provider enrollment efforts offers a significant payback. We think there is even more to be gained once we have additional resources to devote to this effort. For example, in our most recent error report, a considerable amount of the improper payments were caused by potentially fraudulent providers in Florida who billed Medicare, but were unreachable 1 month later when their claims were selected for review. An analysis of the data indicates that without these claims, the national error rate would have been closer to 3.9 percent, as opposed to the 4.2 percent we reported, a savings of over a billion dollars.

Additional resources will enable CMS to expand our on-site inspection capacity to ensure that these types of providers and other providers around the country in various vulnerability areas that present the greatest risk to the program are visited on a more regular and surprise basis.

CMS continues to make great strides in identifying and preventing fraud, reducing improper payments, and saving billions in Medicare dollars that would otherwise be lost to fraud and abuse. But we have only begun to scratch the surface, and more work needs to be done. Additional flexible funding, which allows us to use these funds over multiple years and then, if not targeted for specific areas, will allow us to deploy resources in fraudulent areas of the country as we deem necessary in working with our partners in law enforcement.

I thank the committee for their support in this area, and welcome any questions you might have.

Chairman SPRATT. Thank you very much.

[The statement of Mr. Hill follows:]

PREPARED STATEMENT OF TIMOTHY B. HILL, CHIEF FINANCIAL OFFICER, CENTERS FOR MEDICARE & MEDICAID SERVICES

Good morning Chairman Spratt, Ranking Member Ryan and distinguished Members of the Committee. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to combat fraud and abuse within Federal health care programs.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding CMS programs are greater than ever. Fraud, waste, and abuse schemes have become increasingly complex, and are quick to adapt and stump even the latest oversight strategies of Congress, CMS, and our law enforcement partners. With CMS' expansive network of health care activities comes a tremendous responsibility to protect our programs' integrity, promote efficiency in their operation, and ensure safe and quality health care for all Americans.

Responsible and efficient stewardship of taxpayer dollars is a critical goal of this Administration, as evidenced by a government-wide effort to improve financial management by way of the President's Management Agenda (PMA). Under the PMA, Federal agencies are mobilizing people, resources, and technology to identify improper payments in high-risk programs, establishing aggressive improvement targets, and implementing corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse, and to improve quality of care in the Medicare program.

My testimony today will briefly describe the Agency's commitment to fiscal integrity and our evolving methods to prevent fraud and abuse within CMS programs. In addition, I will talk specifically about the Agency's numerous program integrity initiatives, the additional resources the CMS Health Care Fraud and Abuse Control (HCFAC) proposal brings to bear, and the potential return on investment offered by program integrity efforts.

BACKGROUND ON CMS PROGRAMS

CMS is the largest purchaser of health care in the United States, serving over 92 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries this year. Roughly two-thirds of CMS net outlays are devoted to Medicare, with Medicaid and SCHIP accounting for approximately one-third of CMS net outlays.

Medicare is a Federal health insurance program that provides comprehensive health insurance to more than 43 million people. Nearly 36 million individuals are entitled to Medicare because they are over the age of 65 and 7 million beneficiaries under age 65 are entitled because of disability; those under age 65 generally become eligible for Medicare after they have been entitled to Social Security disability cash benefits for 24 months. Gross Medicare outlays have grown from $206 billion in Fiscal Year (FY) 1996 to nearly $382 billion in FY 2006.

CMS processes claims and makes payments for fee-for-service (FFS) Medicare benefits through contracts with private companies: carriers, fiscal intermediaries (FIs), durable medical equipment (DME) Medicare Administrative Contractors (MACs), and A/B MACs. During 2007, CMS estimates that Medicare contractors will process well over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers. Medicare contractors review claims submitted by providers to ensure payment is made only for Medicare-covered items and

services that are reasonable and necessary and furnished to eligible individuals. In addition, CMS contracts with Program Safeguard Contractors (PSCs) to detect and deter Medicare fraud and abuse. Quality Improvement Organizations are contractors that ensure that payment is made only for medically necessary services and investigate beneficiary complaints about quality of care.

IMPROPER PAYMENTS AND REDUCED ERROR RATES

Given the staggering size of Medicare program expenditures, even small payment errors can have a significant impact to the Federal Treasury and taxpayers. For this reason, CMS, as part of a sound financial management strategy, has a long history of using improper payment calculations as a tool to monitor the fiscal integrity of Medicare. CMS uses improper payment calculations to identify the amount of money that has been inappropriately paid, to identify and study the causes of the inappropriate payments, and to focus on strengthening internal controls to stop the improper payments from continuing.

In recent years, CMS has made great strides in significantly reducing the Medicare FFS error rate by educating providers about appropriate medical record documentation and methods to improve their accuracy and completeness. Paying claims right the first time ensures the proper expenditure of the Medicare trust funds and saves resources required to recover improper payments.

For example, in FY 2005, we strove for a Medicare FFS error rate of 7.9 percent and the actual error rate was 5.2 percent. For FY 2006, the goal was 5.1 percent and the actual error rate was 4.4 percent. The goal for FY 2007 is 4.3 percent and CMS in its 2007 Medicare FFS error rate mid-year report indicated that the error rate to date is 4.2 percent, making progress toward achieving the target error rate. The Agency has set a performance goal of further reducing the error rate to 4.2 percent by the end of FY 2008.

Coordinating Program Oversight Activities CMS follows four parallel strategies in carrying out our program oversight activities. They are prevention of incorrect payment, early detection, coordination, and enforcement.

• Prevention: CMS identifies problems before a claim is paid, through our payment systems, prepayment medical review activities, and education of providers and beneficiaries.

• Early detection: CMS finds problems quickly, using proactive data analysis, probe reviews of claims, audits and post payment claims reviews, data matches, and other sources to detect improper payments.

• Coordination: CMS works through public and private partnerships to identify and fight fraud and abuse. CMS recognizes the importance of working with contractors, beneficiaries, law enforcement partners, and other Federal and State agencies to improve the fiscal integrity of the Medicare trust funds.

• Enforcement: CMS ensures that action is taken when fraud and abuse is found. CMS will continue to work with our partners, including the Department of Health & Human Services (HHS)/Office of Inspector General (OIG), Department of Justice (DOJ), State agencies for survey and certification, Medicaid Fraud Control Units (MFCUs), and State Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

For FY 2008, the Administration needs $1.3 billion to support the HCFAC program. This spending supplements routine program oversight activities and is an investment in future savings from programs that account for a significant share of improper and wasteful payments within CMS.

The FY 2008 HCFAC funding request is a critical foundation of support for our Agency initiatives to uncover fraud and abuse in CMS programs. CMS appreciates the Committee's recognition of the prudence of investment in these activities, demonstrated by an adjustment to the discretionary budget cap for increased HCFAC funding. The return on investment and savings to the Medicare trust funds more than compensate for every dollar that we invest in fraud and abuse activities. With the growing pressures on the Medicare trust funds due to the aging of our population, each investment CMS makes in fighting fraud and recovering improper payments will have an exponential impact on Medicare's long-term sustainability.

As noted above, the Administration is requesting a total funding level of $1.3 billion to carry out HCFAC functions, $202 million over the FY 2007 level. Section 1128(c) of the Social Security Act authorized the HCFAC program and Section 1817(k) of the Act specified the levels of funding for the activities in this account. These funds are permanently appropriated and are made available through the apportionment process. Of the $202 million, approximately $20 million is the result

of mandatory inflationary increases provided by the Tax Relief and Health Care Act of 2006 (P.L. 109-432) and the Deficit Reduction Act of 2005 (DRA) (P.L. 109-171). $183 million comes from the FY 2008 Budget discretionary funding request for HCFAC, which is sufficient to supplement the mandatory dollars. The $183 million in discretionary HCFAC funding will build upon programs with a proven record for maintaining the integrity of the Medicare trust funds and be used for prosecutions of Medicare Advantage and Part D health care matters, investigations, audits, inspections, evaluations, as well as for educating consumers and providers.

An investment in program integrity activities is needed to address new fraud concerns arising from the Part D drug benefit. As set forth in appropriations language, discretionary funds for HCFAC activities would be split among several government entities that collaborate to identify, prosecute, and fight fraud and abuse. In addition to $138 million for Medicare Integrity Program (MIP) activities, the remaining $45 million in HCFAC funding would be made available for work carried out by the HHS OIG, the Federal Bureau of Investigation (FBI), the DOJ, and other HHS agencies, including CMS.

RETURN ON INVESTMENT IN THE MEDICARE INTEGRITY PROGRAM

CMS tracks incorrect payments that were either avoided or recovered through initiatives funded by the MIP. The ratio of the amount spent on an activity compared to the measured savings is referred to as the return on investment (ROI). Activities have varying rates of return. For example, the ROI rate for all MIP activities is approximately 13 to 1; for the HCFAC account, the ROI is 4 to 1. From 1997 to 2005, HCFAC activities have returned approximately $8.85 billion to the trust funds.

MEDICARE-MEDICAID DATA MATCHING PROGRAM

Another important program integrity initiative is the Medicare-Medicaid (Medi-Medi) data matching program. Data mining health care claims for fraudulent activity has been commonplace for several years. However, by jointly mining Medicare and Medicaid claims, new patterns are being detected that were not evident when viewed separately. The knowledge gleaned from our Medi-Medi activities helps each program identify and address internal vulnerabilities. CMS has 10 Medi-Medi projects in place in key States and, as mandated by the DRA, will expand the program nationwide. To date, more than 50 Medi-Medi cases have been referred to law enforcement, $15 million in overpayments have been referred for collection, and $25 million in improper payments have been caught before erroneous payments were made. This project is a key contributor to overall reductions in payment errors.

PREVENTING FRAUD AND ABUSE WITH PROGRAM SAFEGUARD CONTRACTORS

As previously mentioned, CMS' actions to safeguard Federal funds are not merely limited to the error rate programs described in this testimony. Program and fiscal integrity oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud and abuse. To that end, CMS has made significant changes to its program integrity activities in recent years.

The PSCs are CMS' fraud, waste and abuse detection contractors. As of 2006, PSCs were established nationwide across all provider and supplier types in the Medicare FFS program. The PSCs perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners (e.g., law enforcement, affiliated contractors (i.e., intermediaries, carriers), and MACs).

To further supplement the PSCs' fraud identification efforts, CMS is making improvements to our own internal data analysis efforts. We are collecting vulnerability data from many of our partners, including Medicare contractors, and using a variety of data analysis tools to review Medicare claims data. Much of our work will focus on addressing vulnerabilities early in their lifecycle, and those that have high estimated dollar impact to the Medicare program. Our program integrity efforts will focus on the top 10 vulnerabilities identified through our data analysis and developing corrective actions to address these identified vulnerabilities.

PROGRAM INTEGRITY EFFORTS WITH RECOVERY AUDIT CONTRACTORS

Section 306 of the MMA gave CMS additional authority to pilot a new contracting authority designed to detect improper payments. This MMA provision directs the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, and collecting Medicare overpay-

ments. CMS implemented RACs in three States—Florida, New York and California—and in FY 2006, the RACs collected $68.6 million in overpayments and identified more than $300 million in improper payments.

The RAC program is consistent with the President's Management Agenda objective to prevent improper payments in Federal programs. CMS designed the demonstration to accomplish two specific goals—to demonstrate whether RACs can identify past improper payments in the Medicare FFS program and to determine whether the RACs can provide information to CMS that could help prevent future improper payments. In response to encouraging results under this demonstration effort to date, Congress mandated the expansion of the RAC effort nationally in the Tax Relief and Health Care Act of 2006, and the Agency is now in the process of developing its expansion and implementation plans.

PROGRAM INTEGRITY ENFORCEMENT VIA SATELLITE OFFICES

CMS has taken several specific actions to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. In particular, we have recently opened a new satellite office in New York City. This office, in conjunction with the existing Los Angeles satellite office, and an enhanced Miami office, will help curtail fraudulent spending in these high-risk regions of the country. CMS' three satellite offices will provide additional on-the-ground efforts to deter, detect, and report fraud, waste, and abuse in these high-vulnerability areas. The satellite offices enable CMS to be proactive in identifying potential fraud and abuse and promptly taking the appropriate corrective actions. Having an additional presence in these cities will allow CMS to better collaborate with our partners to design, develop, manage, and participate in special anti-fraud and abuse projects/programs.

Through the combined efforts of the Los Angeles satellite office, the PSC and the claims processing contractors operating in California, CMS has identified over $2.1 billion in improper payments in calendar years 2005 through 2006. This includes the prepayment denial of claims based upon fraud indicators and the post payment identification of overpayments for claims identified as potentially fraudulent or highly suspect. The Los Angeles office has also conducted a special project that addressed improper billing and potentially fraudulent claims submitted by Independent Diagnostic Testing Facilities (IDTFs) operating in California. This special project resulted in approximately $163 million in denied charges and the termination of Medicare billing privileges for 83 IDTF providers.

PROVIDER ENROLLMENT

CMS has seen a marked increase in fraud and abuse activities during the past few years that can be directly tied to provider enrollment issues. These activities are primarily focused in high vulnerability areas of the country such as Los Angeles, Miami, and Houston where a large number of beneficiaries and providers/suppliers are located. To fight fraud, CMS has sought to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and strengthen the provider revocation process.

CMS is also implementing new strategies to remove fraudulent providers from the Medicare program. Our Los Angeles satellite office has recently identified situations in which some physicians are submitting claims for services that have not been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary was not in the State or country when the services were furnished, or the equipment necessary for testing is not present where the testing is said to have occurred. We proposed through regulation that CMS have the authority to remove these fraudulent providers from the Medicare program.

Durable Medical Equipment Fraud As the Secretary noted in his earlier testimony, within the last 18 months, CMS and the OIG have identified and documented a significant amount of fraud being committed by DME suppliers in Miami and the Los Angeles metropolitan area. While both regions of the country have high numbers of Medicare beneficiaries, there has been a tremendous spike in the number of providers and utilization; the number of DME providers has almost doubled and billing from the providers remains disproportionately high.

During FY 2006, the National Supplier Clearinghouse (NSC), the national enrollment contractor for DME suppliers, conducted 1,472 inspections of Miami DME suppliers. As of October 2006, the billing numbers of 634 DME suppliers had been revoked, including 143 suppliers that had been enrolled within the previous 12 months. This effort, which is still ongoing, resulted in a projected savings to the Medicare program of $317 million. The NSC spent approximately $3 million on all enrollment efforts in Miami, resulting in a ROI of greater than 100:1 ($100 in sav-

ings for each dollar spent to conduct the project). A similar initiative was conducted in the Los Angeles area last year.

The types of fraud committed by the DME suppliers in Miami and the Los Angeles metropolitan areas included: (1) billing for services not rendered, which involved claims for power wheelchairs, scooters, nutritional products (e.g., Ensure), orthotics, prosthetics, hospital beds, etc., and (2) billing for services not medically necessary. CMS and its contractors have identified thousands of Medicare beneficiaries living in California and Florida who are receiving DME items that they did not require based upon their medical history and/or are receiving Medicare Explanation of Benefits (EOBs) for items that are not only unnecessary, but never ordered by their physician and never received by the beneficiary. CMS staff in Los Angeles and Miami have interviewed multiple physicians who have provided attestations that they never saw the patients for which DME was ordered and correspondingly never ordered by the suspect DME.

NEW APPROACHES TO FIGHT FRAUD

Under the initiative announced by Secretary Leavitt on July 2, 2007, CMS will implement a demonstration project requiring DME suppliers in Miami and Los Angeles to reapply for participation in Medicare in order to maintain their billing privileges. Letters will be sent out to suppliers in the demonstration locales asking that they resubmit an application to be a qualified Medicare DME supplier. Those who fail to reapply within 30 days of receiving a letter from CMS; fail to report a change in ownership or address; or fail to report having owners, partners, directors or managing employees who have committed a felony within the past 10 years will have their billing privileges revoked. DME suppliers who do not have their Medicare billing privileges revoked based on the information contained in their application will be subject to enhanced review and potential site visits.

As Secretary Leavitt relayed earlier today, CMS is launching an aggressive campaign to detect and prevent fraud and abuse activities, using a multi-prong approach. While the DME demonstration program is a first step, we also are carefully watching potential fraud trends in other industries, including home health and infusion therapies.

MEDICAID PROGRAM INTEGRITY

The HCFAC program, which is funded through Medicare's Hospital Insurance Trust Fund, has the Medicare program as its primary focus. In the Medicaid program, program integrity efforts have been funded through grants to the State MFCUs and, to a limited extent, from non-MIP activities in the HCFAC program.

The DRA was a major step in providing new resources for program integrity efforts in Medicaid. The DRA provided a dedicated and permanent funding stream for the Medi-Medi Data Match Program, which had received some start-up funds from the HCFAC account. It also established and provided permanent funding for the Medicaid Integrity

Program ($50 million this year) that will reach a total of $75 million annually by FY 2009 and each year thereafter.

CONCLUSION

When unscrupulous providers defraud Medicare, they are cheating us all—particularly more than 43 million people who rely on Medicare for their health care needs. Beneficiaries with stolen identities may lose eligibility for equipment in later years if a sham provider has already billed Medicare on their behalf. When suppliers provide empty promises to beneficiaries, they may simply be left without the equipment necessary to support their chronic conditions. And finally, illegal billing diverts funding from all beneficiaries in order to pay those engaged in fraudulent activity. For these and many other reasons, we take program integrity and other anti-fraud efforts very seriously at CMS.

Thank you for having me here to testify today. CMS appreciates your support of our efforts, and I would be happy to answer any questions.

Chairman SPRATT. Now our final witness, Mrs. Smith. We look forward to your testimony.

STATEMENT OF M. PATRICIA SMITH

Ms. SMITH. Thank you, Mr. Chairman, Ranking Member Ryan, and members of the committee for this opportunity to testify about New York's unemployment insurance system, our reemployment

programs, and particularly the success that we have achieved with our Reemployment Eligibility Assistance, or REA grant. I would also like to address concerns about the overall level of funding.

Adequate funding is essential to improve unemployment insurance services, reduce fraud and waste in the system, preserve the integrity of the trust fund, and maintain the quality and competitiveness of America's workforce. New York State is in its third year of a limited REA program, which is supported by the Federal Unemployment Tax Act, or FUTA, grant of only $647,000 a year. Its dual purpose is to reduce erroneous payments and to determine better which reemployment strategies will help reduce the length of time that people are on unemployment insurance and, more importantly, return to employment. This grant funds eight REA staff, who conduct in-person assessments in three one-stop centers in New York State.

The REA program in New York focuses on one-to-one services. Unemployment insurance claimants are scheduled early and often to make sure they are fully aware of their unemployment insurance benefits and their work search requirements. They are also called in to make sure that their job searches are effective, and that they understand and have access to the broad array of services which are provided under the Workforce Investment Act.

In New York State, the REA grant is limited to only one of our 33 local workforce investment areas, three small counties. We targeted this region because we believed that any strategies which could lead to successes in this economically depressed area of New York could be successfully replicated anywhere in the country.

I am pleased to report that the New York State grant results have exceeded our initial expectations of an average reduction of 1 week in unemployment insurance benefits. In fact, we have almost doubled that goal. That translates into unemployment insurance fund savings of approximately $1.67 million a year, a gross return of 250 percent on the investment.

New York State believes it would be a wise investment to expand the Federal allocation of only $20 million a year nationally for this program. The current grant serves only 1 percent of New York State unemployment insurance claimants. It would take an additional $7.2 million in New York State to expand this program to cover all areas of the State, although it would still only cover about 10 percent of the claimants. If we would achieve the gains we have seen to date, this would result in a net gain of $11 million in the trust fund in New York State.

What I would like to share with you are some of the key lessons we learned in administering this grant. The success of the REA grant is contingent upon there being sufficient reemployment services available and integrated into the local one-stop centers. The small Federal grant alone could not have achieved these results without significant State and local funding investments in reemployment services.

Keep in mind that REA funds can be used to review a claimant's work search activities, assess the need for reemployment services, and refer the individuals to needed services, but REA funds cannot be used to actually fund the delivery of needed reemployment services.

Fortunately, New York State already has a well-established statewide reemployment services program, which is funded by contributions from New York employers. In New York, up to $35 million a year is available for reemployment services.

The second lesson that we learned is that a strong linkage between the administration of unemployment insurance and the one-stop centers is critical to the delivery and to the success of the system. This linkage allows us to identify claimants early, to schedule them in for visits, and also allows the staff to stop unemployment insurance payments if the claimants do not report for their visits.

Third, many unemployment insurance claimants have no idea how their skills can translate into other occupations. So we found it necessary to hire additional employment counselors to help claimants navigate these important employment decisions.

As I mentioned earlier, I would like to share some concerns about the REA funding. REA has provided a small, but important tool in our portfolio of reemployment services. But to be effective in benefit payment control, it must be properly and directly linked to UI administrative systems. Continued success requires dedicated annualized funding, and Congress should consider moving from a REA grant approach to a permanent funding model if they wish to continue and secure long term results.

Moreover, the REA funds do not replace unemployment insurance administrative funds or Wagner/Peyser allocations, neither of which has been sufficient in recent years to effectively serve our customers. Funding is insufficient in the unemployment insurance program alone, which supports fraud and abuse prevention activities, such as employer tax fraud detection and benefit payment controls. These activities have suffered in New York State, as we have been forced to reduce our UI, or unemployment insurance, staff by 35 percent in the last 5 years.

Starting in fiscal year 2003, the United States Department of Labor implemented a revised funding methodology known as the Resource Justification Model. The intent behind this model was to provide States with the ability to request and justify an increase in unemployment insurance administered funding, but this has not occurred. Instead, the process has been used to allocate among the States an insufficient level of funding.

For example, in 2005, only 51 percent of the Federal Unemployment Tax Act taxes paid by employers were returned to the States in terms of administrative grants, yet in 2007, New York State demonstrated a base need in unemployment insurance administrative funding of approximately $210 million, but received only $159 million, a reduction of 24 percent.

At certain times in the past, Reed Act distributions were provided to the States in accordance with section 903 of the Social Security Act, and we would actively support current proposals for Reed Act distributions to the States.

We are proud of our success with the REA grant, but if you take one thing away from my testimony please take this. REA is not a separate program; it works when it is part of an integrated employment and training system, and we need Congress to fully support the continuation of these integrated services.

We would urge you today to consider the funding for the various components of the workforce system as part of a continuum and make sure that all parts are funded adequately, such that claimants can get the full mix of reemployment services that they need. We would also urge you to carefully consider the action taken by the House Appropriations Committee last week to rescind Workforce Investment Title 1 programs and those budgets. Our work in carrying out the congressional mandate for a one-stop system is undermined by actions that erode the economic support for the services that your constituents depend upon and need.

I thank you for this opportunity to testify and welcome any questions.

[The statement of Ms. Smith follows:]

PREPARED STATEMENT OF PATRICIA SMITH, COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF LABOR

My name is M. Patricia Smith, the Commissioner of the New York State Department of Labor. Thank you for the opportunity to testify today on the subject of New York State's unemployment insurance (UI) and re-employment programs, their funding levels and the critical services we are able to provide under these programs. In particular, I will describe the success we have achieved with our Re-employment Eligibility Assessment (REA) grant and address concerns about the overall levels of funding provided to states to provide these services. Adequate funding is essential if we are to improve services to our customers, reduce fraud and waste in the system, preserve the integrity of the Trust Fund, and maintain the quality and competitiveness of America's workforce.

As you know, funding for UI Administration, Wagner/Peyser (job service assistance) and Labor Market Information programs is provided from dedicated employer tax revenues collected under the Federal Unemployment Tax Act (FUTA). In addition to funding these core programs, national FUTA special grant funds currently support a limited REA Program in New York State. We are now in the third year of operating this competitively awarded REA grant program.

I'd like to thank Congress for providing this funding opportunity. This has allowed New York to better determine which re-employment services and strategies help to reduce the length of time individuals receive UI benefits and, most importantly, result in their re-employment. We are pleased with the program results and welcome the opportunity to share what we have learned from our experience.

New York was awarded an annual federal REA grant of $647,000 for the last two years, up from approximately $615,000 in the initial grant year. This grant funds approximately eight dedicated REA staff, who conduct in-person re-employment and eligibility assessments for over 3,000 UI customers annually in three full-service One-Stop Career Centers. This has permitted dedicated REA-funded staff to conduct approximately 10,000 individual REA assessment interviews annually. Our REA grant strategy focuses on scheduling the claimant early and often in his or her UI claim. This in-person service ensures that the individual is fully aware of and continues to meet the UI eligibility and work search requirements. It also ensures that he or she is actively engaged in effective job search activities and has access to the vast array of services available through the publicly-funded Workforce Investment Act (WIA) system.

In New York, the REA grant is limited to only one of 33 local workforce investment areas of the state. This local area includes the three small counties of Oneida, Herkimer and Madison. The region has sustained a serious and continued economic downturn from the shrinking of its traditional manufacturing economy. We targeted this region to pilot the REA model because we believe that any strategies which lead to successful re-employment in a challenged economic region of New York could be replicated anywhere in the country with similar outcomes.

I am pleased to report that New York's grant results have exceeded our initial expectations. The goal in the first year was to achieve a one-week average reduction in the duration of UI benefits. Actual results to date indicate we have achieved close to double that goal—a two-week reduction in the average duration of benefits, when compared to a control group. Based on an average of 3,000 annual participants, a two-week duration reduction at an average weekly benefit rate of $278 would result in New York UI Trust fund savings of approximately $1.67 million—a gross return on investment of over 250%!

This level of savings was consistent over the first two grant years and we believe the results can be replicated and expanded to other areas in New York State. However, they cannot be achieved without cost. The federal requirements for the REA program are staff-intensive. Our experience and analysis of the results indicate that providing a comprehensive, individual level of service and dedicated case management is the key to achieving success for the UI claimant and success for the UI Trust Fund. We believe it would be a wise investment to expand the $20 million available nationally for this grant program. New York has applied in each of the past two years for an increase in REA grant funds to expand our program statewide. However, the limited federal funds have not been available to do that.

Our 2007 REA application estimated that an additional $7.2 million over the current grant level would be needed to expand the REA model to all regions of New York State. The current grant annually serves only about 1% of the New York UI claimants that receive first payments and are not exempt from searching for work. The proposed grant expansion would allow us to increase to about 10% of that population, or approximately 35,000 additional participants. Assuming we achieve our previous rate of return, we would anticipate a net gain of over $11 million in Trust Fund savings.

Having touted the overall success of the REA model we piloted in New York, I would like to share with you the key lessons that we learned.

First of all, it is important to view the New York State REA results within the proper context. The minimal $647,000 federal REA grant alone could not have achieved these results. They were achieved only by combining the federal REA grant with significant state and local funding investments in UI Re-employment Services. Without the leveraging of other resources and the foundation of strong state and local partnerships in the delivery of re-employment services, we would not have been able to implement the REA model that works for New York.

Let me clarify:

1. The federal REA program is funded from UI administrative funds and comes with strict guidelines on what REA dollars can and cannot cover. REA funds can be used to provide general information about the labor market, review the claimant's work search activities against a work search plan, assess the need for re-employment services, and refer the individual to needed services. However, it is important to note that REA funds can not be used to fund the delivery of critical Re-employment Services, such as resume writing, interviewing workshops, skill development, job development, and job search, referral and placement activities. The success of REA is contingent upon there being sufficient Re-employment Services available through the local workforce system to serve the UI population. The REA program must be integrated into the local area workforce plan, and local One-Stop partners must buy in to the REA program goals.

The importance of these critical elements cannot be overstated. In New York, state policy and resource investment were important in providing this foundation:

• New York State law finances a Reemployment Services Program with contributions from employers (.075% of taxable payrolls) targeted to UI customers. Each year, up to $35 million dollars are made available to support local Department of Labor staff within the One-Stop system to provide re-employment services to UI claimants. As a result of this state-funded investment, New York already had a well-established statewide Re-employment Services program along with the tools and systems needed to support these targeted services to the UI population.

• New York has state policies that created true workforce system integration by mandating the alignment of service delivery for the WIA Title IB and Employment Service programs. Local workforce areas were required to submit plans that aligned their services according to function as opposed to funding streams. Plans were required to reflect such key concepts as a single customer flow, a shared customer pool, functional service units, functional leadership and supervision, common data management, increased service levels, service delivery designed from the customer perspective, and shared accountability.

As part of these efforts, regional Re-employment Service plans were required that demonstrated how the state-funded UI Re-employment Services program would be integrated within the One-Stop system. In addition, the policy required all UI claimants to be co-enrolled in both the Employment Service and WIA programs, thus making local workforce boards jointly accountable for our customers' success. This important policy change reflects the intent of Congress when it passed the Workforce Investment Act.

2. Another key component of the REA-funded pilot is the addition of UI benefit payment control to the service strategies available in the One-Stop system. REA staff can provide an individual assessment of a UI claimant's continuing eligibility for benefits. They can identify potential UI issues, while UI administrative-funded

staff must actually adjudicate issues and make eligibility determinations. This potential withholding of the UI benefit gets a claimant's immediate attention. The strong linkage between the administration of UI and the One-Stop service delivery system is critical to the success of any REA model. New York recognizes that unless UI and Re-employment Services are viewed as a set of services within a single system, and all segments of that employment and training system are aligned, we will not be able to make progress in our workforce employment and training efforts.

In New York State, the Division of Employment Service (DoES) has the lead responsibility for both the state-funded Re-employment Services program and the federally funded REA grant. New York continues to maintain the strong linkage between the public Employment Service and the administration of the Unemployment Insurance program. This historical Employment Service/UI linkage has been weakened in some areas of the country, as UI has moved to centralized call centers or the delivery of services over the Internet, and the Employment Service program has been absorbed within the broader, universal One-Stop system. In New York State, where the UI customer represents over 60% of the One-Stop system customer pool, the Employment Service program has maintained a strong focus on serving the UI customer as one of its core Wagner/Peyser roles. This has provided the strong bridge between the administration of UI and the One-Stop system that is needed for the success of the REA program.

Under the state-funded Re-employment Services program, the Department of Labor made significant investments in technology to share information among UI administrative systems, the One-Stop Center Case Management System, and a state-developed system specifically designed for scheduling and case management of UI customer re-employment services. This system integration identifies new claimants early in the claims cycle, provides the tools needed to efficiently schedule claimants for re-employment service appointments, and gives local staff the ability to suspend UI benefits if claimants fail to report for scheduled appointments. Without this integration, New York would not have been able to implement the REA grant as quickly and successfully.

3. People rely on the publicly-funded workforce system to help them navigate spells of unemployment. We learned that it was necessary to hire more employment counselors to help people navigate career choices and decisions. Assessing each worker's ability to perform in the global economy leads to better service strategies to help that individual make guided career and training choices. Many UI claimants had no idea how their skills could translate into other occupations. It took testing and counseling to help people decide the best path to their futures and guide them back into the workforce faster.

We also learned that many customers are unprepared for the realities of today's Internet job searching tools and many are totally unfamiliar with basic computer use. Many do not speak English as their first language. As an example, a staggering 48% of New York City's workforce is foreign born. To address these and other barriers, we need partners and all available community resources to help ensure our services reduce UI duration and provide tools to allow an individual to attain better employment options. The REA grant brought additional UI customers to the One-Stop system and having an array of services to assist them was essential to the program's overall success. We urge Congress to sufficiently appropriate funds for the public workforce system, which will allow us to continue serving the many New Yorkers, including UI customers, for whom these services are vital to economic self-sufficiency.

I would like to share our concerns about REA funding. For REA to be effective in benefit payment control—something I know is important to those of you who funded this pilot—it must be linked directly to other key components of the publicly funded workforce system, including the UI administrative system. REA's positive outcomes in New York were the result of a separate federal grant application process and not a systemic approach to properly fund activities that can meet the REA objectives. REA funds do not replace either UI administrative funds or Wagner/Peyser allocations, neither of which has been sufficient in recent years to effectively serve our customers.

Funding is insufficient in just the UI program alone, which, as you are aware, supports activities such as:

- Taking and processing of UI benefit claims;
- Employer tax processing, field audits and employer tax fraud detection;
- Integrity activities, including benefit payment controls; and
- UI federal funding dollars allocated to New York for administration of the program have decreased substantially in recent years while, at the same time, we experienced higher annual costs of doing business—this equates to a substantially reduced level of funded staff. In just the last five years, New York's number of sup-

ported UI staff has decreased 35% in the last five years. Although we have seen some reduction in the number of claims filed over this period, our staff reductions have greatly exceeded any reduced workloads.

As a result of under-funding the UI program:

1) Staff have been directed to front line claims-taking and eligibility determinations wherever possible;

2) Benefit payment controls have not always been sufficient. Nationally, the UI program ranks among the highest programs with improper payments;

3) Efforts to target employer tax fraud (including detection of misclassified workers) have not been given sufficient focus;

4) Efforts to integrate workforce programs system-wide are hurt. As indicated earlier, a strong linkage between the administration of UI and One-Stop service delivery systems is critical to getting UI claimants back to work and reducing waste in the system. Unless these are viewed as a single system and all segments are fully supported and aligned, none of these programs will be as successful as they must be. For example, efforts to profile those claimants most likely to exhaust benefits are not updated as quickly as needed, and re-employment programs for serving UI claimants require a sufficient level of staff to ensure success. In addition, as centralized call centers are implemented to take UI claims, a strong linkage with re-employment activities is more important than ever.

Like most or all other states, New York has undertaken many technological improvements and actions to improve efficiencies in our administration of the UI program. But, we are not able to keep pace with the needs of our customers with the reduced federal investment in UI. We implemented a virtual call center for taking UI claims and we were at the forefront of states implementing electronic benefit payments of weekly claims via direct payment cards. We have also recently implemented direct deposit as an option for claimants to receive their weekly benefits.

These technological improvements, which offer the opportunity for increased customer access and satisfaction, also come at a cost. Reduced funding levels impact our ability to provide quality service to our customers, maintain a sufficient level of integrity activities and also meet performance measures required by USDOL.

A proper amount of UI funds, both administrative and within the Trust Fund, will allow New York and other states to creatively make changes in multiple types of services provided to UI customers. Starting with Federal Fiscal Year 2003, a revised methodology was implemented by USDOL to allocate UI administrative funding to the states—the Resource Justification Model (RJM). This revised methodology was to provide states with an ability to request increased funding where needed and also provide an equitable and fair distribution of funds based on states' justification of their upcoming fiscal year needs.

RJM data was also to be used to justify an increase in the national appropriation to support all states' needs for UI administration. The goals of this methodology have yet to be realized by the states. As a result, the updated cost information provided through the RJM process has instead been used to allocate an insufficient level of national funding among the states.

For 2007, New York State demonstrated a need via the RJM for a base level of UI administrative funding of approximately $210 million. However, we received only approximately $159 million, a reduction of $51 million, or 24%. Similar deficiencies have occurred since the inception of RJM and are expected to continue in subsequent years. Nationwide in 2006, $2.8 billion was requested under RJM, while only $2.3 billion was allocated to states, a difference of $510 million.

Funding has not been sufficient nationally for a number of reasons. One I would like to address is the surplus employer FUTA tax collections that are retained each year on a national level and not provided back to states via UI, Wagner/Peyser and Labor Market Information program allocations. For example, in 2005 only 51% of the FUTA taxes paid by employers were returned to states in terms of administrative grants. At certain times in the past, when surpluses reached a given level, Reed Act distributions to states were provided in accordance with Section 903 of the Social Security Act. While it would only provide a temporary solution to funding these programs, New York supports the proposal from the National Association of State Workforce Agencies (NASWA) for a national Reed Act distribution to states of $800 million per year for the next three consecutive years.

Despite funding reductions in recent years New York takes seriously the need to maintain a high level of integrity in our UI program. I have already discussed how critical it is to call claimants in early within their claims for quality control purposes. We also continue to look to ways to improve the quality of our own UI program determinations, reduce the number of improper UI benefit claims and tax transactions whenever possible.

We are proud of our success with REA, but if you take away one thing from my testimony today, it is that the success of our REA model was totally due to the services provided through the One-Stop system, including the services provided through essential WIA Title 1 funding. We were able to reduce UI benefits duration by an average of two weeks per claimant, and save our Trust Fund millions of dollars because of the value-added services that were provided by dedicated staff through the One-Stop career system. REA is not a separate, isolated process in New York. It is part of an integrated employment and training system, and we need Congress to fully support the continuation of these integrated services.

Sufficient levels of national appropriations for the UI Program, Wagner/Peyser, Re-employment Assistance Programs and the One-Stop networks will help ensure that states will be able to maintain an emphasis on high quality services to customers in the workforce development system, including unemployed citizens looking to return to work as soon as possible. In addition, sufficient funding will allow states to implement cost-saving measures and the technology infrastructure upgrades they need to ensure effective solutions to assist the unemployed.

New York is committed to providing the full array of services envisioned by Congress with enactment of the Workforce Investment Act. Unemployment Insurance is a mandatory partner program in the One-Stop system, as are the Employment Service and the WIA Title 1 programs.

Actions to rescind funding such as those taken by the House Appropriations Committee last week undermine the very commitment of Congress to ensure that our country remains globally competitive. We understand the competing needs in crafting a budget. However, New York cannot provide Congress with an assurance that we can commit to a REA model without a fully-funded One-Stop Career Center system.

Finally, let me state that New York welcomes grant opportunities such as REA, but one-time grants merely allow us to pilot strategies on a very small scale. Continued success requires dedicated, annualized funding, and Congress should consider moving from a REA grant approach to a permanent funding model if they wish to secure long-term results. Congress has a right to hold states accountable for these investments, and New York would gladly implement our REA model statewide, if fully-funded, and accept REA funds on a performance outcome basis.

We would urge all of you today to view the funding for the various components of the workforce system as part of a continuum. The system can operate most effectively when all parts are sufficiently funded to provide the mix of services necessary to get individuals back to work. The integrity of the system is undermined when funding is rescinded mid-stream. Our work in carrying out the congressional vision and mandate for a One-Stop system continue to be undermined by efforts that erode the very basic support of the services your constituents depend upon and need access to. REA has provided a small, but important, tool in our portfolio of reemployment services and New York would urge continued and significantly increased investment by Congress in this program.

I thank you for providing me the opportunity to testify and I welcome your questions on these important issues.

Chairman SPRATT. In the interests of time, we have votes coming up, I am going to recognize the gentleman from Tennessee, Mr. Cooper, for 3 minutes, and then we will go to Mr. Scott, and then we will come back to Mr. Ryan.

Mr. COOPER. Thank you, Mr. Chairman. I would like to focus on Mr. Hill.

Secretary Leavitt mentioned that government programs regulation doesn't work nearly as well as in the private sector. Can you help me understand how intermediaries and carriers are selected by CMS? Aren't those contracts bid out to the private sector?

Mr. HILL. I think that there is—we need to take a point-in-time look at that. Prior to the MMA, the Medicare Modernization Act, intermediaries and carriers were sort of an historical artifact of the way Medicare was enacted. We basically contracted by statute with the Blue Cross-Blue Shield plans that were in each State, and had very little flexibility to choose or make distinctions among entities with whom we contracted. With the enactment of the MMA, we now have the authority to procure these services as anybody else,

any other Federal agency would under the FAR, and have begun to do so.

Our first set of contracts—I believe we now have four contracts in place—contracts to process DME claims, and a contract in the upper Midwest. So we have begun to go into a competitive process to afford the administrative services in the Medicare program.

Mr. COOPER. Can you tell me who the intermediary or carrier is for the Miami-Dade, Florida, area?

Mr. HILL. There is—for Miami Dade there are a couple. First Coast Services Options is a part of, I think, a corporate entity within Blue Cross Blue Shield of Florida, and processes Part A and Part B claims, I believe, in Florida.

DME is processed by Palmetto Government Services Options, which is——

Mr. COOPER. Out of South Carolina?

Mr. HILL. South Carolina, yes, sir.

Mr. COOPER. Don't these payment processors have some obligation to flag suspicious claims?

Mr. HILL. Absolutely. More than an obligation; it is their responsibility in fact. That is what they are paid for. And they are the first line of defense and our first line, with our partners in law enforcement, to help us identify where we have issues and where we should be investigating more.

Mr. COOPER. Are they doing their job?

Mr. HILL. I think they are doing their job within the limits that we have set for them, both statutorily and within the limits of the funding we have.

Part of the issue is, funding has gone down over the last 3 years for these activities, and that the contractors are funded with.

Mr. COOPER. You mentioned the limit we set for them statutorily. Secretary Leavitt asked for no new statutory authority.

Mr. HILL. We asked for $180 million.

Mr. COOPER. I know cash, but no legal tools to help find more bad guys. The Secretary doesn't have time to visit every office building in Dade County to ferret out DME fraud.

Mr. HILL. Right.

Mr. COOPER. What do we need to be doing to encourage First Coast or Palmetto to do a better job of catching these bad guys?

Mr. HILL. Quite frankly, we have to provide them the resources to do it.

Mr. COOPER. Money and no other tools? They have the tools under existing law?

Mr. HILL. Yes, sir.

Mr. COOPER. I see that my time has expired. Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. Just in the interests of time let me just state my questions, and if the witnesses could write them down and perhaps respond in writing.

Mr. Goss, on your CDRs, how many reviews do you do? How many reviews result in no change? How many result in a reduction in disability? And do any actually have an increase in disability upon review?

And, Mr. Hill, you mentioned 4.2 percent mistakes. You know what the mistake rate is in private insurance? And follow up what the gentleman from Tennessee, are prosecutorial resources the thing that you actually need? No new laws in dealing with identity theft?

And, Mr. Hill, with minority physicians we have heard some complaints that—I constantly get complaints that when you crack down on fraud, it turns into more of a witch hunt on minority physicians. What can we do to make sure that professional development is there to make sure that they aren't making honest mistakes and that you are actually going after fraud? They would be a necessary target because, generally speaking, they are in minority areas, high Medicaid; and they are individual doctors, not a great multiphysician operation that has a lot of staff.

So if you could just respond to those, Mr. Chairman. If you want to respond very quickly, since I apparently have a few seconds.

Mr. GOSS. Sure. Yeah, if I may, let me just share with you a couple items.

On the continuing disability reviews, the full medical continuing disability reviews we do, which is a rather comprehensive look at the individual, first of all, we select the cases that are most likely to have resulted in medical improvement. And of those, we find about 12 percent that actually have sufficiently medically improved that they are told that they are no longer disabled and they no longer receive benefits. I think you were also referring to the issue of a case where benefits might be increased. That is on the redetermination side, where we look at the SSI nonmedical situation. And that is the place where people can actually have their benefits increased if we find, in fact, that their income, for example, has been less than had been expected before.

And of the nonmedical SSI redeterminations we do, about 17 percent of those result in actually a small increase in their benefit level, 7 percent result in a cessation of benefits because they are no longer eligible, and 6 percent result in some reduction, but not complete. So we really run the gamut on these things, and really they are intended to correct the payments going forward, and do a very effective job.

Mr. SCOTT. Thank you. I think we are out of time.

Mr. RYAN. Let me just ask Ms. Stiff a quick question. What is your estimate that we will raise over the next 5 years out of the tax gap, without resorting to draconian reforms like requiring 1099s for all these personal transactions and things like that?

Ms. STIFF. I don't know that I have a number right off the top of my head for the next 5 years. I think we projected out that by the year 2010 we expect to approach a recovery of $20 billion.

Mr. RYAN. In 2010?

Ms. STIFF. Uh-huh.

Chairman SPRATT. Say it again. How much?

Ms. STIFF. Between now and the year 2010, based upon improved productivity, based upon a full funding of the fiscal year 2008 budget, the legislative proposals, the indirect impact.

Mr. RYAN. Thank you.

Chairman SPRATT. We have several votes on the floor, and I am not going to ask you to spend the rest of the morning waiting on us. You have been very patient and forbearing in the first place.

Thank you for your excellent testimony, provocative testimony. And down the road we may want to come back and revisit this subject with you to see if your best estimates have been attained.

Thank you very much indeed for coming and participating.

[The prepared statement of Daniel Fridman follows:]

PREPARED STATEMENT OF DANIEL S. FRIDMAN, SENIOR COUNSEL TO THE DEPUTY ATTORNEY GENERAL & SPECIAL COUNSEL FOR HEALTH CARE FRAUD

Mr. Chairman and distinguished members of the Committee. I appreciate the opportunity submit this Statement for the Record to discuss the critical role of the Department of Justice in fighting Medicare fraud and abuse. We are grateful for the leadership of your Committee on this important issue.

My statement will supplement the incisive testimony of Health and Human Services Secretary Michael O. Leavitt. The Secretary described the collaborative anti-fraud efforts of HHS and the Department of Justice in fulfilling our partnership role required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 (HIPAA), which directs the Secretary and the Attorney General to jointly promulgate and enforce the Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC program was jointly issued by the Attorney General and the Secretary on January 1, 1997 and provided the guidelines for our ongoing fraud and abuse enforcement and prevention efforts.

Since 1997, our annual joint reports to Congress demonstrate the significant accomplishments of our Departments in pursuing a coordinated fight against Medicare fraud and abuse. The Secretary's testimony provided details of HHS's Medicare program integrity and fraud and abuse efforts, and the important initiatives being undertaken by HHS. I will similarly highlight the role of the Department of Justice (DOJ) in the HCFAC program and provide more specific details of our successes in combating Medicare fraud and abuse. Last fiscal year alone, we "won or negotiated" a record $2.2 billion in health care fraud civil judgments and penalties, most of which involved fraud against the Medicare program. In addition, this year, we launched the highly effective first phase of our Medicare Fraud Strike Force in Miami which has indicted 53 defendants and obtained 23 convictions, including three by jury trials, in its first 5 months.

Presently, I advise the Deputy Attorney General on health care fraud enforcement policy. In that capacity, I am responsible for coordinating the efforts of all the components within the Department of Justice that are charged with investigating and enforcing the civil and criminal laws concerning health care fraud. I am also responsible for high-level, inter-agency coordination with my colleagues at the Department of Health and Human Services Office of the

Inspector General (HHS-OIG) and at the Centers for Medicare and Medicaid Services (CMS). Finally, I am an Assistant United States Attorney from the Southern District of Florida (SDFL), a district that is extremely engaged in investigating and prosecuting those who take advantage of seniors, endanger the health and lives of seniors, and defraud the Medicare program.

In this Statement for the Record, I will describe the role the Department of Justice plays in Medicare program integrity, including the role of the Criminal and Civil Divisions of the Department of Justice, the Federal Bureau of Investigation, and the 93 U.S. Attorney's Offices across the country. I will address our sources of funding, our cooperative relationship with HHS, and our accomplishments. I will review the unique appropriations mechanism by which the Department receives HCFAC program funding through the HHS appropriation process. I conclude by describing in more detail the strike force initiative we have launched in the SDFL to fight Medicare fraud.

OVER $11 BILLION IN RECOVERIES RETURNED TO THE MEDICARE AND MEDICAID PROGRAMS SINCE 1997

The Department of Justice is committed to rooting out and punishing individuals and corporations who commit health care fraud, including providers and practitioners, equipment suppliers, and corporate wrongdoers. The Department of Justice is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. We work closely with the Inspector General of the Department of Health and Human Services as well as our colleagues at the Centers for Medicare

and Medicaid Services (CMS). We also work closely with the Food and Drug Administration, including its Office of Criminal Investigations (FDAOCI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and with our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units.

Working with our colleagues, since the 1997 inception of the HCFAC program, the Department has obtained, according to our preliminary estimates, $11.87 billion in total recoveries, which include criminal fines and Federal and State civil settlements in health care fraud matters, predominantly involving losses to the Medicare program. Of this total, $10.4 billion has been transferred or deposited back into the Medicare Trust Fund and $604 million, representing the federal share of Medicaid fraud recoveries, has been transferred to CMS. (The balance of the money represents recoveries on behalf of private health insurers insofar as the HCFAC program also covers federal prosecution of health care fraud against the private sector.) The monetary recoveries we achieve go right back into the Medicare and Medicaid programs to help fund the health care costs of the Americans who are enrolled.

These recoveries were made possible by the dedicated funding stream provided by the "HCFAC account," which was established by HIPAA. This account, funded through appropriations to HHS, and expended in support of our joint-HCFAC program, provides the principal source of steady funding for Department of Justice efforts to combat Medicare fraud.

STATUTORY BACKGROUND AND HCFAC FUNDING

Social Security Act Section 1128C(a), as established by HIPAA, created the Health Care Fraud and Abuse Control Program, a comprehensive program to combat fraud and abuse in health care, including both public and private health plans. Under the joint direction of the Attorney General and the HHS Secretary, the HCFAC Program's goals are:

(1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;

(2) to conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;

(3) to facilitate enforcement of all applicable remedies for such fraud;

(4) to provide guidance to the health care industry regarding fraudulent practices; and

(5) to establish a national data bank to receive and report final adverse actions against health care providers, and suppliers.

The Act requires the Attorney General and the Secretary to submit a joint annual report to the Congress which identifies both:

(1) the amounts appropriated to the Trust Fund for the previous fiscal year under various categories and the source of such amounts; and

(2) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the Secretary and the justification for the expenditure of such amounts.

The Act requires that an amount equaling recoveries from health care investigations—including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and relators' shares—be deposited in the Medicare Trust Fund.[1] All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Medicare programs funded by the Trust Fund. The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act.

Congress established the dedicated HCFAC resources to supplement the direct appropriations that HHS and DOJ otherwise devoted to health care fraud investigation and prosecution. The Act specifies the total annual maximum amount collectively available to HHS (including the HHS Office of Inspector General (OIG)) and DOJ for their health care fraud enforcement work, assigns specific authorities to the HHS OIG, and, beginning with fiscal year 2007, specifies the minimum amount of funding OIG must receive each year.

The enactment of HIPAA, and establishment of the Account, authorized HHS and DOJ to appropriate from the Account up to $104 million collectively, and allowed the Departments to increase that appropriated amount by up to 15% annually until FY 2003. HIPAA separately provided $47 million in dedicated funding for the FBI's health care fraud investigations beginning in 1997 which also increased annually until 2003. From FY 2003 through FY 2006, the maximum available for HHS and

the Department of Justice (DOJ) collectively was fixed by statute at $240.558 million annually. Of this total, the OIG received the statutory maximum amount of $160 million annually. The DOJ litigating components and other (non-OIG) HHS components split the remaining $80.558 million, which we refer to as the "wedge." Thus, of the $240.558 million maximum amount, the DOJ litigating components have received $49.415 million annually from FY 2003 through FY 2006. Separately, HIPAA appropriated $114 million annually to the Federal Bureau of Investigation (FBI) over this same time period to support the Bureau's health care fraud investigative activities.

Section 303 of Division B of the "Tax Relief and Health Care Act of 2006," signed by President Bush last December, provides for annual inflation adjustments to the maximum amounts available from the HCFAC Account and for the FBI starting in FY 2007 for each year through FY 2010. In FY 2010, a fixed funding level or "cap" is reinstated at the 2010 level. The annual inflationary adjustments in the Tax Relief and Health Care Act of 2006 will help sustain the Department's current level of criminal and civil health care fraud enforcement activities during the period of 2007-2010. The President's FY 2008 budget includes an additional $183 million through a discretionary cap adjustment proposal for new program integrity work, predominantly for the Part D and Medicare Advantage programs, of which $17.5 million is designated for the important work of the Department of Justice.

HCFAC PROGRAM ACCOMPLISHMENTS IN FISCAL YEAR 2006

During Fiscal Year 2006, the Department "won or negotiated" approximately $2.2 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings.[2] The Medicare Trust Fund received transfers of nearly $1.55 billion during this period as a result of these efforts, as well as those of preceding years, in addition to $117.1 million representing the federal share of Medicaid money similarly transferred to CMS as a result of these efforts.[3]

In criminal enforcement actions during 2006, prosecutors for the Department and U.S. Attorneys' Offices:

- Opened 836 new criminal health care fraud investigations involving 1,448 potential defendants, and had 1,677 criminal health care fraud investigations involving 2,713 potential defendants pending at the end of the fiscal year; and
- Filed criminal charges in 355 health care fraud cases involving charges against 579 defendants and obtained 547 convictions for the year.

In civil enforcement actions during 2006, attorneys for the Department and U.S. Attorneys' Offices:

- Opened 698 new civil health care fraud investigations, and had 1,268 civil health care fraud investigations pending at the end of the fiscal year; and
- Filed complaints or intervened in 217 civil health care cases.

Since the inception of the HCFAC program in 1997, the Department's criminal and civil enforcement efforts funded through that program have returned nearly $11.87 billion total to the federal government, including more than $10.4 billion transferred to the Medicare Trust Fund and $604 million representing the federal share of Medicaid fraud recoveries transferred to CMS.

We have secured more than 4,500 criminal convictions for health care fraud related offenses, the vast majority involving Medicare fraud.

INTER-AGENCY DOJ-HHS COOPERATION

Because the Department of Health and Human Services administers the Medicare Program and maintains all the payment records and data submitted by providers, successful prosecution of criminal cases and litigation of civil cases requires close cooperation between our Departments both in litigation and in program coordination. Let me provide some examples of this close cooperation:

- Under auspices of HCFAC Program, DOJ and HHS hold senior staff-level meetings on a quarterly basis that include representatives from the Office of the Deputy Attorney General, Office of the Associate Attorney General, HHS Counsel to the Inspector General and Office of General Counsel, and CMS Program Integrity Director.
- Our agencies also hold quarterly CMS-law enforcement agency coordinating meetings among mid- and lower-level staff who work on specific collaborative initiatives, cases, and investigations.
- We hold monthly CMS-DOJ conference calls involving the staff of CMS Program Integrity, HHS Office of the Inspector General, among others, along with our USAO and FBI personnel nationwide.

• Interagency health care fraud task forces and working groups exist in a majority of federal judicial districts that consist of Assistant U.S. Attorneys, HHS and FBI investigative agents, CMS program agency personnel and Medicare Program Safeguard Contractors, Medicaid Fraud Control Units, state Attorney General staff, and some include private insurer investigators.

• The OIG shares summarized information about all Medicare contractor referrals for investigation with the FBI and DOJ, and the FBI exchanges copies of its health care fraud case opening memorandums with OIG.

• DOJ participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it conducted a nationwide closed circuit training session for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations.

• Last year DOJ attorneys and support staff trained CMS regional and central office staff hired to administer the Medicare prescription drug benefit and monitor the prescription drug plans on federal health care fraud statutes and possible fraud schemes which may occur in the Medicare Prescription Drug (Part D) program. Department attorneys and staff also conducted two national training seminars for CMS Medicare Drug Integrity Contractor staff hired to conduct program integrity and anti-fraud work for the Part D program.

DEPARTMENT COMPONENTS INVOLVED IN MEDICARE ANTI-FRAUD ENFORCEMENT

Health care fraud enforcement involves the work of several different components of the Department, each of which receives funding from the HCFAC Program. I will briefly summarize the roles that different parts of the Department play in pursuing health care fraud matters.

Civil Division of the Department of Justice

The Department's Civil Division attorneys pursue civil remedies in health care fraud matters, using the False Claims Act, 31 U.S.C. §§ 3729-3733, as the primary statutory tool. The False Claims Act (FCA) prohibits knowingly submitting false or fraudulent claims for payment from the government, and knowingly making false records or statements to conceal or decrease an obligation to pay money to the government. The penalties under the FCA can be quite large because the law provides for treble damages plus additional penalties for each false claim filed. In addition, lawsuits are often brought by private plaintiffs, known as "relators" or "whistleblowers," under the qui tam provisions of the FCA, and the government will intervene in appropriate cases to pursue the litigation and recovery against the provider or company. The Civil Division also pursues many of these cases as criminal violations of the Food, Drug, and Cosmetic Act.

In FY 2006, the Civil Division opened or filed a total of 239 health care fraud cases or matters. In addition to any new cases that are filed, however, there remain a significant number of matters that the Division continues to move toward resolution. At the end of FY 2005, there remained 680 open cases. Many of these health care fraud cases, typically those involving corporate or institutional providers, involve millions of documents and hundreds of witnesses, require experienced litigation support personnel to amass and organize the evidence, and need knowledgeable consultants to provide their expertise about the fraudulent schemes.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered $18.2 billion on behalf of the various victim federal agencies. Of that amount, $11.5 billion was the result of fraud against federal health care programs—primarily the Medicare program. Cases involving violations of the Food, Drug, and Cosmetic Act, or other types of fraud by pharmaceutical manufacturers in connection with federal health benefit programs, have resulted in total criminal and civil recoveries of over $5.2 billion since 1999.[4] The Civil Division's Office of Consumer Litigation works with many of the United States Attorney's Office on these prosecutions.

In addition to these accomplishments, the Department's Nursing Home and Elder Justice Initiative, coordinated by the Civil Division, supports enhanced prosecution and coordination at federal, state and local levels to fight abuse, neglect, and financial exploitation of the nation's senior and infirm population. Through this Initiative, the Department also makes grants to promote prevention, detection, intervention, investigation, and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field. The Department additionally is pursuing a number of cases under the FCA involving providers' egregious "failures of care."

United States Attorneys Offices

The 93 United States Attorneys Offices (USAOs) are the nation's principal prosecutors of federal crimes, including health care fraud. The USAOs pursue both civil and criminal cases and dedicate substantial resources to combating health care fraud. Each of the 93 districts has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator.

HCFAC funding supports about 100 attorney and 81 support positions, and many USAOs supplement the HCFAC program funding they receive by providing for additional attorneys, paralegals, auditors, and investigators, as well as funds for litigation expenses for these resource-intensive cases.

In FY 2006, USAOs received 836 new criminal matters involving 1,448 defendants, and had 1,677 health care fraud criminal matters pending,[5] involving 2,713 defendants. USAOs filed criminal charges in 355 cases involving 579 defendants, and obtained 547 federal health care related convictions. During the last fiscal year, USAOs also opened 698 new civil health care fraud matters and had 1,268 civil health care fraud matters and cases pending.

USAOs receive referrals of health care fraud cases from a wide variety of sources, including the FBI, the HHS/OIG, state Medicaid Fraud Control Units, other federal, state, and local law enforcement agencies, and private insurers of medical services. The health care fraud coordinators often work with these partners in fighting health care fraud in local and regional task forces and working groups, and these also can be the basis of case referrals. Cases are also obtained by USAOs by means of qui tam complaints. Under the False Claims Act, a qui tam plaintiff (a "relator") must file his or her complaint under seal in a United States District Court, and serve a copy of the complaint upon the USAO for that judicial district, as well as the Attorney General. The USAO must then decide whether the case warrants an intervention by the government to litigate the complaint.

The Executive Office for the United States Attorneys' (EOUSA) through the Office of Legal Education (OLE) provides training for AUSAs and other Department attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud.

For instance, in FY 2006, EOUSA and the Civil Division participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it joined with both the Civil and Criminal Divisions to conduct a nationwide closed circuit training for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations. EOUSA and the Office of Legal Education also sponsored the Health Care Fraud Coordinator's Conference for Civil and Criminal AUSAs, and Health Care Fraud for new AUSAs and Affirmative Civil Enforcement for Auditors, Investigators and Paralegals at the National Advocacy Center, and, most recently, it sponsored a Health Care Fraud Trial Practice Seminar for over 120 Department lawyers.

Criminal Division of the Department of Justice

The Criminal Division's Fraud Section develops and implements white collar crime policy, and supports the federal white collar crime enforcement community through litigation, coordination, policy, and legislative work. The Fraud Section is responsible for handling and coordinating complex health care fraud litigation nationwide. The Fraud Section also supports the USAOs with legal and investigative guidance, training, and, in certain instances, provides trial attorneys to prosecute criminal health care fraud cases.

In FY 2006, the Fraud Section provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil, and administrative tools to combat health care fraud, and worked at an interagency level through the following activities:

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding patient medical records, including HIPAA health information privacy requirements, compliance with the Substance Abuse Patient Medical Records Privacy Act and regulations, and coordinating referrals from the HHS Office for Civil Rights of possible criminal violations of HIPAA privacy provisions providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;
- providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;

• monitoring and coordinating Departmental responses to legislative proposals, major regulatory initiatives, and enforcement policy matters related to prevention, deterrence and punishment of health care fraud and abuse;

• reviewing and commenting on health care provider requests to the HHS/OIG for advisory opinions, and consulting with HHS/OIG on draft advisory opinions per HIPAA requirements;

• working with USAOs and CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work;

• preparing and distributing to all USAOs and FBI field offices periodic summaries of recent and significant health care fraud cases; and

• organizing, overseeing and participating in interagency working groups formed to address specific cases and initiatives, often in conjunction with the Civil Division and Executive Office for United States Attorneys.

In FY 2006, Fraud Section attorneys and the USAO from the Eastern District of Louisiana filed a superseding indictment of four corporate executives in a case involving the collapse of Louisiana's third largest health maintenance organization and its subsequent takeover and liquidation by the state Department of Insurance. The USAO for the Southern District of Florida and Fraud Section attorneys also indicted five defendants who were involved in a scheme to defraud Medicare by submitting prescriptions for groups of Medicare beneficiaries who were paid kickbacks by certain pharmacies to allow the fraudulent billing of aerosol medicines. These cases are scheduled to go to trial in 2007. Along with the USAO for the Southern District of Mississippi, Fraud Section attorneys also prosecuted seven individuals who participated in a scheme to create bogus prescription histories and file fraudulent claims against a $400 million settlement fund established by the manufacturer of the diet drugs Redux and Pondimin, commonly known as "Fen-Phen," for medical injuries caused by the inappropriate prescription of these products. As of September 30, 2006, a total of 25 defendants were convicted in this multi-year ongoing joint investigation.

Civil Rights Division of the Department of Justice

The Civil Rights Division vigorously pursues the Department's goals of eliminating abuse and grossly substandard care in publicly-run Medicare (and Medicaid) funded nursing homes and other long-term care facilities. The Division undertakes this work pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes investigations of conditions of confinement at publicly operated nursing homes and other residential institutions and authorizes the initiation of civil action for injunctive relief from violations of federal rights. In performing this work, the Division often collaborates with United States Attorneys around the country and with the Department of Health and Human Services.

Division staff conducted preliminary reviews of conditions and services at 29 health care facilities in 12 states during Fiscal Year 2006. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The Division reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs. Separately, in Fiscal Year 2006, the Division opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 45 health care facilities in 23 states, the District of Columbia, and the Commonwealth of Puerto Rico.

For example, in Fiscal Year 2006, the Division: (1) opened an investigation of a nursing home in South Carolina; (2) made findings that conditions and practices at another nursing home, Fort Bayard Medical Center, in Fort Bayard, New Mexico, violate its residents' federal constitutional and statutory rights; (3) entered a settlement agreement to remedy unlawful conditions at one of the largest public nursing homes in the country, A. Holly Patterson Extended Care Facility, in Uniondale, New York; and (4) monitored the implementation of remedial agreements for four nursing homes: Banks-Jackson-Commerce Medical Center and Nursing Home, in Commerce, Georgia; Nim Henson Geriatric Center, in Jackson, Kentucky; Reginald P. White Nursing Facility, in Meridian, Mississippi; and Mercer County Geriatric Center, in Trenton, New Jersey. More recently, in response to allegations of shocking mistreatment and neglect of elderly veterans, including an apparent homicide, the Division last month opened investigations of two State veterans' homes in Tennessee.

The Division's recent findings regarding one nursing home are unfortunately illustrative.

The investigation revealed a wide range of dangerously deficient medical and nursing care practices that not only failed to comply with federal regulations or meet professional standards, but were in fact aiding and contributing to the need-

less suffering and untimely deaths of residents. The Division found numerous situations where residents' last days of life were spent in misery, as they died from the effects of what appeared to be reckless and almost willful disregard to their health and safety. In fact, in virtually every record reviewed of deceased or current residents, the Division discovered life-threatening breakdowns of treatment that were substantial departures from the generally accepted standards in nursing home care. The Division has entered into a settlement agreement to remedy these deficiencies.

Federal Bureau of Investigation

The FBI is the Department's primary investigative agency involved in the fight against health care fraud. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the HHS/OIG, the FDA/OCI, the Drug Enforcement Administration (DEA), the Defense Criminal Investigative Service, the Office of Personnel Management, the Internal Revenue Service, and various state and local agencies. In FY 2006, the FBI was allocated $114 million in HCFAC funds for health care fraud enforcement. This yearly appropriation was used to support 775 positions (455 Agent, 320 Support) in FY 2006. The number of pending investigations has shown steady increase from 591 cases in 1992 to 2,423 cases through 2006. FBI-led investigations resulted in 535 criminal health care fraud convictions and 588 indictments and informations being filed in FY 2006.

The FBI initiates health care fraud cases from various sources of information. This information can come from such sources as Medicare contractors, private insurance company Special Investigations Units, the National Health Care Anti-Fraud Association, employees of businesses providing medical services (hospitals, doctor's offices, clinics, medical equipment suppliers, nursing homes, etc.), confidential sources or cooperating witnesses with access to information and complaints from public citizens which are often beneficiaries of the health care services.

FRAUD SCHEMES

To give you a sense of the types of fraud schemes the Department has seen and the enforcement results the Department has achieved, I will outline below some of the significant Medicare fraud cases the Department pursued over the last year. This list is not meant to be exhaustive; it is meant to illustrate some of the fraud schemes we are seeing.

Hospital Matters

• Tenet Healthcare Corporation, the nation's second largest hospital chain, agreed to pay $920 million to settle allegations of fraud against Medicare and other federally insured health care programs. The settlement included $788 million to resolve claims that Tenet billed Medicare for excessive "outlier" payments. Federal health insurance programs, including Medicare, typically reimburse hospitals a fixed amount for treating a patient with a specific condition or illness, but will reimburse extraordinary "outlier" costs when they are reasonably incurred. Congress enacted the supplemental outlier payment system to ensure that hospitals possess the incentive to treat inpatients whose care requires unusually high costs. The United States alleged that Tenet artificially inflated its charges to make it appear that many of its patients received extraordinary care when, in fact, the treatment that was given was fairly standard and far less costly. The settlement also included $49 million to resolve claims that Tenet paid kickbacks to physicians for patient referrals, $48 million to resolve claims that Tenet billed the government at a higher rate than was justified by the services performed, and $20 million in pre-settlement interest. Government-initiated claims accounted for nearly $770 million of the settlement, with the remaining $150 million attributable to six qui tam suits. The relators who filed those suits will share $12 million of the settlement amount.

• St. Barnabas Health Care System, the largest health care system in New Jersey, paid $265 million to resolve allegations that nine of its hospitals fraudulently increased charges to elderly patients to obtain enhanced Medicare reimbursement for outlier claims. The United States alleged that between October 1995 and August 2003, Saint Barnabas and nine of its hospitals purposefully inflated charges for inpatient and outpatient care to make these cases appear more costly than they actually were, and thereby obtained outlier payments from Medicare that they were not entitled to receive. Saint Barnabas entered into a Corporate Integrity Agreement with the HHS-OIG. The Corporate Integrity Agreement contains measures to ensure compliance with Medicare regulations and policies in the future.

• Following a three-week trial, the former owner and chief executive officer of the now defunct Edgewater Hospital in Chicago was found liable under the False Claims Act for engaging in an illegal kickback scheme at Edgewater. The court

found that the defendant paid physicians for Medicare and Medicaid patient referrals in violation of federal law. The court held that the hospital's cost reports and individual patient claims for patients referred in connection with the scheme were false claims and awarded treble damages and penalties on just over 1,800 claims.

• Two owners of a former San Diego psychiatric hospital were found liable after trial for more than $15.7 million in damages and penalties for having included false claims in the hospital's cost report submitted to the Medicare program. Those cost reports sought reimbursement from the Medicare program for a variety of false costs, such as amounts for a fictitious lease, reimbursement for unused hospital space, and millions of dollars in costs that were actually attributable to the defendants' business enterprises unrelated to that hospital. The court awarded the United States $15,688,585 for treble damages and $31,000 in civil penalties.

Pharmaceutical Matters

• Purdue Pharma, its top lawyer and former president and former chief medical officer pleaded guilty in May for claiming that OxyContin was less addictive and less subject to abuse than other pain medications. Purdue Frederick Co., maker of powerful painkiller OxyContin admitted it understated the drug's potential for abuse. The company agreed to pay $600 million in penalties to resolve criminal and civil liability, while two current executives and one former executive agreed to pay a total of $34.5 million to the Virginia Medicaid Fraud Unit. The judge also ordered the executives to perform 400 hours each of community service related to prescription drug abuse and prevention.

• Schering-Plough Corporation, together with its subsidiary, Schering Sales Corporation, agreed to pay a total of $435 million to resolve criminal charges and civil liabilities in connection with illegal sales and marketing programs for its drugs Temodar, used in the treatment of brain tumors and metastasis, and Intron A, used in the treatment of superficial bladder cancer and hepatitis C. The resolution also pertained to Medicaid fraud involving Schering's drugs Claritin RediTabs, a nonsedating antihistamine, and KDur, used in the treatment of stomach conditions. Schering Sales Corporation agreed to plead guilty to charges that it conspired with others to make false statements to the FDA in response to the FDA's inquiry concerning certain illegal promotional activities by the company's sales representatives at a national conference for oncologists. Schering Sales also agreed to plead guilty to charges that it conspired with others to give free Claritin Redi-Tabs to a major health maintenance organization (HMO) to disguise a new lower price being offered to the HMO to obtain its business.

• Eli Lilly and Company agreed to plead guilty and to pay $36 million in connection with its illegal promotion of its pharmaceutical drug Evista. In pleading guilty to a criminal count of violating the Food, Drug, and Cosmetic Act by misbranding its drug Evista, the Indianapolis-based company agreed to pay a $6 million criminal fine and forfeit to the United States an additional sum of $6 million. In addition to the criminal plea, Lilly agreed to settle civil Food, Drug, and Cosmetic Act liabilities by entering into a consent decree of permanent injunction and paying the United States $24 million in equitable disgorgement. Evista is approved by the FDA for the prevention and treatment of osteoporosis in postmenopausal women. The government alleged that the first year's sales of Evista in the U.S. were disappointing compared to Lilly's original forecast; the company reduced the forecast of Evista's first year's sales in the U.S. from $401 million to $120 million. In order to expand sales of the drug, it was alleged, Lilly sought to broaden the market for Evista by promoting it for off-label uses, such as for the prevention and reduction in risk of breast cancer, and the reduction in the risk of cardiovascular disease. Lilly promoted Evista as effective for reducing the risk of breast cancer, even after Lilly's proposed labeling for this use was specifically rejected by the FDA.

• Serono, one of the world's largest biotech manufacturers, paid $704 million to resolve criminal charges and civil liabilities in connection with several illegal schemes to promote and sell its drug, Serostim, that resulted in the submission of false claims to Medicaid and Medicare. The FDA had granted accelerated approval for Serostim in 1996 to treat AIDS wasting, a condition involving profound involuntary weight loss in AIDS patients, then a leading cause of death in AIDS patients. Following the advent of protease inhibitor drugs, the incidence of AIDS wasting markedly declined, and Serono launched a campaign to redefine AIDS wasting to create a market for Serostim. Serono pled guilty to conspiring with RJL Sciences, a medical device manufacturer, to introduce on the market bioelectrical impedance analysis (BIA) computer software packages for use in measuring body cell mass and diagnosing AIDS wasting. The BIA software devices were adulterated medical devices in that FDA had not approved the devices for these uses. RJL and its owner also pled guilty to their roles in the conspiracy. In addition, Serono pled guilty to

conspiring to offer doctors kickbacks in the form of free trips to Cannes, France, to induce them to prescribe Serostim.

Physicians

• An Ohio physician was convicted by a jury of 56 counts of mail, wire, and health care fraud, as well as illegal drug distribution and sentenced to life for operating "pain management" clinics in which he treated all patients with weekly injections and Schedule II and III narcotic drug prescriptions during visits that lasted no more than a few minutes, and then claimed thousands of dollars in insurance reimbursements per visit. He saw upward of 100 patients per day and submitted $60 million in fraudulent bills to the victim health care benefit programs. The physician was also convicted of health care fraud resulting in death in this case.

• A Tennessee oncologist was sentenced to over 15 years' imprisonment for defrauding Medicare, TennCare, and BlueCross BlueShield at the expense of cancer patients. The defendant mixed diluted versions of chemotherapy medications that were then given to patients, and instructed her nurses to draw up partial doses of one of the medications to administer to patients.

• From 1996 through 2003, a physician employed an individual to work at the physician's medical practice in Connecticut. Although the individual was not licensed to practice medicine, he nonetheless treated patients in the physician's medical practice. During this time, he was referred to as "Doctor" by the physician and he wrote prescriptions. The physician then billed insurance companies for services that were rendered by the individual, representing them as services rendered by a physician. They both pled guilty to conspiracy to commit health care fraud. The physician also entered into a civil settlement with the government and paid $160,000.

Hospice Care

• Odyssey Healthcare, Inc., a Dallas, Texas-based hospice provider, agreed to pay the United States $12.9 million to settle allegations that the company billed the Medicare program for services provided to hospice patients who were not terminally ill and hence were ineligible for the Medicare hospice benefit. Odyssey Healthcare has also entered into a Corporate Integrity Agreement with the HHS-OIG. The Corporate Integrity Agreement addresses the company's practices regarding compliance with applicable Medicare regulations.

• Faith Hospice, Inc., settled allegations that it submitted fraudulent claims to Medicare and Medicaid for ineligible hospice. The investigation was initiated when a review of a sample of its medical records showed that more than half of Faith Hospice's patients were ineligible for hospice care. Under the agreement, the owner and Faith Hospice forfeited $599,165.29 to the United States, one half of the funds seized pursuant to the civil forfeiture action. The case occurred in Alabama.

Skilled Nursing Facilities

• USA Healthcare, Inc., (USAH) the owner of several skilled nursing facilities based in Cullman, Alabama, settled allegations of mischarging the Medicare Program by agreeing to pay the United States $1,217,808.00. The investigation arose out of an audit of cost reports filed by several of USAH's skilled nursing facilities which revealed that the company violated Medicare rules by failing to disclose that certain vendors were related to USAH by common ownership or control and therefore should have been reimbursed by Medicare at a lower rate based on actual costs and without inclusion of profit.

Medical Devices

• The owner and operator of V&A Services, a medical equipment supply company located in Stone Mountain, Georgia, was convicted by a federal jury of 11 counts of Medicare fraud in a motorized wheelchair fraud scheme. He was sentenced to 2 years and 3 months in federal prison to be followed by 3 years' supervised release. He was ordered to pay restitution of $164,590 in connection with the scheme. The judge entered an order of forfeiture at sentencing by which the defendant forfeited $36,416 from a seized bank account and durable medical equipment having a value of approximately $11,000.

• The owner of a power wheelchair store was sentenced to 63 months in prison and ordered to pay over $4 million in restitution to the Medicare and Medicaid programs after he was convicted by a jury of paying recruiters to take beneficiaries to a medical clinic where a physician would perform medically unnecessary procedures and then sign false Certificates of Medical Necessity (CMN) forms authorizing the beneficiaries to receive motorized wheelchairs. The physician also was sentenced to 11 years and three months in prison for his participation in the scheme for receiving payment for signing the CMNs, and for submitting claims for services that either were not performed properly, or were not performed at all.

• The owner of a power wheelchair store pled guilty in Lynchburg, Virginia to conspiracy to commit health care fraud for his involvement in an intricate scheme involving power wheelchairs and "power chair scooters." Among the allegations were that items not needed and not ordered by the physician, were simply added after the physician signed the Certificate of Medical Necessity.

• In the Southern District of Texas, the owner of a Houston-based DME company was sentenced to 63 months in prison for his role in a motorized wheelchair scam. His company fraudulently billed Medicare and Medicaid for almost $5 million and defrauded these health care programs of at least $1.6 million.

SOUTH FLORIDA INITIATIVES

The Secretary described special HHS demonstration projects undertaken to combat Medicare DME fraud in South Florida and Miami. I will discuss some of the parallel initiatives being taken by the U.S. Attorney's Office in SDFL in conjunction with the Criminal Fraud Section and the OIG. In late 2005, through the leadership of U.S. Attorney Alex Acosta, SDFL formed the South Florida Health Care Fraud Initiative to bring together the health care fraud prosecution resources of SDFL prosecutors, HHS-OIG and the FBI agents and Florida Attorney General's Office attorneys, cross-designated as Special Assistant United States Attorneys. Although still in its early phase, our Health Care Fraud Initiative has begun to pay dividends. Last fiscal year, we filed criminal charges against 111 defendants in 68 health care fraud cases, a 30% increase over the previous year. Our conviction rate was 97%. These cases typically involve at least one, and often several, million dollars in fraud.

Our prosecutors in South Florida are doing more than merely coordinating resources; they are developing and testing new law enforcement methods to add to our health care fraud litigation arsenal. I would like to describe two of these methods. The first concerns the use of civil complaints to freeze or seize money obtained through health care fraud as soon as our evidence will satisfy a civil standard.

"Operation Equity Excise" is an example. Working with HHS-OIG and the FBI, Operation Equity Excise identified clinics and DME companies that engaged in health care fraud. Often, these companies closed abruptly to avoid detection from law enforcement, and in that process abandoning their bank accounts, leaving behind substantial balances. Through this Operation, federal agents attempted to locate the signatories on the bank accounts. Many of the signatories, who were also typically listed as the president of the company, denied knowledge of the operation of the company and denied having any claim or right to the funds in the accounts. Thirty-four individuals were located; they voluntarily surrendered the funds, resulting in approximately $10.5 million returned to the United States Treasury. The signatories on twenty three accounts, with a total balance of over $30 million, have not been located. SDFL has filed civil health care fraud complaints against those individuals. We intend to provide notice through publication, proceed through default judgment, and return those funds to the Treasury as well. Importantly, our civil actions do not preclude a subsequent criminal prosecution. Where supported by facts, we continue to pursue criminal investigations of these companies. For now, at the very least, by seizing the bank accounts, we can recover some of the fraudulently paid moneys.

A second method is being refined through a recently-implemented short-term, proactive, surge operation that we are undertaking jointly with the Criminal Division, the FBI, HHS-OIG, and local law enforcement in Miami-Dade County. The Medicare Fraud Strike Force uses proactive law enforcement methods adapted from experience fighting illicit drug trafficking along with real-time data review often used to fight credit card fraud. A typical health care fraud prosecution relies heavily on billing records and other historical evidence. In this operation, however, HHSOIG agents have identified patterns that, standing alone, reveal medically impossible claims. Our agents are visiting the offices and interviewing providers as the fraud is taking place. Such "caught-in-the-act" cases are often easier to prosecute than ones based solely on historical evidence.

Finally, to augment the cooperation between the prosecutors and agents, we have co-located the prosecutors and investigative agents in a "fusion center." Modeled after similar arrangements more traditionally used in drug and organized crime prosecutions, we hope that the proximity of the investigators and prosecutors, working closely together, helps foster strong working relationships and a more proactive investigative technique.

In order for the Committee to better understand some of the fraud schemes we are seeing in Miami, let me present the facts of a typical case involving kickbacks and durable medical equipment. On March 22, 2007, Ricardo R. Aguera, a/k/a Pichi, the owner of three Miami durable medical equipment companies, was found guilty

on all counts, following a weeklong jury trial, of defrauding the Medicare Program of millions of dollars. He was charged with one count of conspiracy and four counts of soliciting and receiving kickbacks. Aguera was sentenced on June 12th to 121 months imprisonment, 3 years supervised release, and approximately $1.7 million in restitution for defrauding the Medicare Program of $17,373,000. Four other defendants, Ivan Aguera, Robert Berenguer, Aristides Berenguer, and Carlos Berenguer, entered guilty pleas to all counts in the indictment without plea agreements prior to trial. All five defendants are related and run health care companies that were involved in the fraud scheme.

Previously convicted co-conspirator pharmacy owners, Henry Gonzalez and Alfonso Rodriguez, billed the Medicare program for over $20 million and reached agreements with DME owners, including the defendants, to kickback half of the money paid by Medicare in exchange for the DME owners bringing patients to the pharmacies. Testimony at trial revealed that the DME owners paid the patients to get access to their Medicare information so that the owners could buy phony prescriptions from corrupt doctors to provide to the pharmacies. The heart of the conspiracy centered around three Miami pharmacies, Lily's Pharmacy, Unimed Pharmacy and Prestige Pharmacy, that illegally manufactured aerosol medications including albuterol, metaproterenol, and ipatropium bromide. These aerosol drugs are introduced into the lung through a piece of durable medical equipment known as a nebulizer. Medicare pays for such aerosol medication through the Part B program as it is taken through a nebulizer. Knowing this Medicare system rule, the pharmacy owners exploited the program by manufacturing the unnecessary, non-FDA approved medicine through a process known as "compounding."

Evidence at trial established that at Lily's pharmacy, one of the men making the medicine was trained to repair air conditioners and was not a licensed pharmacist. The fraud scheme further relied on (1) paid patients who provided their Medicare cards and signed delivery receipts for medicine which the patients did not need and which they ultimately discarded, (2) doctors who signed fraudulent prescriptions which listed non-commercially-available medications, and (3) DME company owners that recruited and paid the patients to take the false prescriptions to the pharmacy owners.

Additional evidence at trial established that patients were paid $100 to $150 per month for the use of their Medicare cards. Pharmacy owners testified that the scheme of using "compounding" was designed from the beginning to defraud Medicare. Unwilling to buy FDA-approved medication to fill those prescriptions, pharmacies "compounded" the aerosol medications by the gallons and then billed Medicare. Patients testified that they did not want the boxes of medicine and the only reason the patients visited the doctor with the DME owner was to receive cash kickbacks.

CONCLUSION

I hope my statement has given you a comprehensive view of the Department's essential role in prosecuting and deterring fraud on the Medicare program, restoring funds illegally stolen from the Medicare program, and protecting our citizens from those health care fraud schemes which have caused physical harm and loss of life. The Department is committed to the ongoing success of the HCFAC program and will continue to marshal its resources, including those provided by the HCFAC program and its own discretionary funds, to prosecute fraud and abuse in the Medicare program and restore the recovered proceeds of fraud to the Medicare trust funds.

We welcome continuation of our close collaboration with the Department of Health and Human Services as we co-direct the HCFAC program, which generates savings that more than compensate for the investment, and helps ensure the safety and availability of medical services to all beneficiaries. We urge the Committee to fully fund the President's FY08 Budget request for an additional $183 million through a discretionary cap adjustment proposal for new program integrity work, predominantly for the Part D and Medicare Advantage programs, of which $17.5 million is designated for the integral health care fraud work of the Department of Justice.

Thank you for the opportunity to provide you with this information concerning the ongoing efforts of the Department of Justice to combat healthcare and Medicare fraud.

ENDNOTES

[1] Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund

[2] Actual collections, transfers, and deposits that ultimately result from health care fraud judgments and settlements may not equal the total "won or negotiated" during FY 2006.

[3] Note that some of the judgments, settlements, and administrative actions that occurred in FY 2005 will result in transfers in future years, just as some of the transfers in FY 2005 are attributable to actions from prior years.

[4] A portion of this $5.3 billion is included in the reported False Claims Act recoveries for this same period.

[5] When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a matter until an indictment or information is filed or it is declined for prosecution.

[Whereupon, at 12:19 p.m., the committee was adjourned.]