BUDGET AND SPENDING CONCERNS AT HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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WITNESSES

SUBMITTED MATERIAL

BUDGET AND SPENDING CONCERNS AT HEALTH AND HUMAN SERVICES

WEDNESDAY, MAY 9, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:07 a.m., in room 2322 of the Rayburn House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Members present: Representatives Stearns, Terry, Burgess, Blackburn, Scalise, Barton, Schakowsky, Christensen, and Waxman (ex officio).

Staff present: Sean Bonyun, Deputy Communications Director; Mike Gruber, Senior Policy Advisor; Carly McWilliams, Legislative Clerk; Andrew Powaleny, Deputy Press Secretary; Krista Rosenthall, Counsel to Chairman Emeritus; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; John Stone, Counsel, Oversight; Roger Stoltz, Detailee-Oversight (GAO); Tim Torres, Deputy IT Director; Alex Yergin, Legislative Clerk; Alvin Banks, Democratic Investigator; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Advisor; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. STEARNS. Good morning, everybody.

We convene this hearing, the Subcommittee on Oversight and Investigations, on "Budget and Spending Concerns at Health and Human Services."

This is our fourth in our series of oversight hearings on the federal budget. This hearing aims to determine the results of the Department of Health and Human Services efforts to identify wasteful, duplicative or excessive spending and to assist in finding more spending cuts and savings, pursuant to the President's ordered line-by-line review.

HHS is the largest agency, by budget, under this committee's jurisdiction and is second only to the Department of Defense. The President's fiscal year 2013 budget requested $941 billion in outlays and $77 billion in discretionary budget authority for Health and Human Services, an increase of nearly 8 percent over last year's outlays and a slight increase over last year's discretionary budget. This increase is in addition to the $140 billion in Recovery Act funds provided to Health and Human Services programs.

HHS, as recently as 2009 fiscal year, was an agency of nearly 80,000 Federal employees. According to fiscal year 2010 Office of Personnel Management data, these include 91 of the federal government's top-100 highest-paid civil servants and 651 of the federal government's top-1000 highest-paid civil servants. And Health and Human Services continues to grow. Between fiscal year 2007 and 2013, the number of full-time equivalents rose from 64,000 to 76,000, an increase of about 20 percent.

At an agency as large as HHS, opportunities are ripe for wasteful and duplicative spending. It is clear that HHS has a long way to go to streamline its many, many multi-billion-dollar programs and restore trust in its management of our tax dollars. For example, HHS, just like DOE, failed to heed the President's April 2009 order to Cabinet secretaries to identify a combined $100 million in budget cuts by July 2009. And there is clearly waste.

The Centers for Disease Control's Communities Putting Prevention to Work program, for which the Recovery Act made hundreds of millions of dollars available, has paid for signage to promote recreational destinations, intergenerational urban gardening and community bike-sharing programs around the country. CDC's Web site even boasts that money under this program was provided to Kauai, Hawaii, "to develop remote school drop-off sites to encourage students and staff to walk farther distances to school entrances."

Perhaps HHS is telling Congress that we should eliminate mass transit as part of our war against obesity. Incredibly, this same program also funded free pet spaying and neutering. While a laudable goal, the Department of Health and Human Services should focus its limited resources on human health.

Now, my colleagues, just last month, GAO released a report on the Medicare Advantage Quality Bonus Payment Demonstration program, which it estimated will cost $8.35 billion over 10 years. Secretary Sebelius says that she intends to go forward with this project despite the fact that GAO concludes that it is unprecedented in size and scope and that its design "precludes a credible evaluation of its effectiveness." Obamacare stipulates cuts in Medicare Advantage funding. Therefore, the Wall Street Journal has suggested that the purpose of the demonstration project is to give a program that is popular with seniors a temporary reprieve past Election Day. And I think the Wall Street Journal is right.

When we are borrowing 40 cents of every dollar we spend, we need to ensure that the American taxpayer is getting the proper value for their tax dollars. In order to learn more about Health and Human Services' efforts, we will take testimony today from the Deputy Assistant Secretary for Budget at HHS, Norris Cochran, and Directors of Health Care at GAO, Carolyn Yocom and James Cosgrove, who will be providing joint testimony, and I welcome these witnesses this morning.

I would point out that the HHS Office of the Inspector General declined the Subcommittee's invitation to testify at this hearing, noting that due to statutory mandates and funding streams, it spends 80 percent of its limited resources on fighting fraud, waste and abuse in the Medicare and Medicaid programs. The IG also confirmed that it has not done any significant recent work looking

at duplicative programs within HHS, nor does it have plans to conduct such a review in the near future.

For this reason, only GAO will be present at the hearing to provide an independent, outside assessment of Health and Human Services' efforts to identify wasteful, duplicative and excessive spending within the agency. In the absence of the IG, this Subcommittee's role in providing much-needed oversight of HHS spending and operations becomes all the more crucial and important.

This Subcommittee, and the Committee as a whole, must remain deeply and regularly engaged with the agencies within its jurisdiction, including HHS as they define their priorities, identify their needs and set their goals for the years ahead.

[The prepared statement of Mr. Stearns follows:]

PREPARED STATEMENT OF HON. CLIFF STEARNS

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At an agency as large as HHS, opportunities are ripe for wasteful and duplicative spending. It is clear HHS has a long way to go to streamline its many multi-billion dollar programs and restore trust in its management of our tax dollars. For example, HHS, just like DOE, failed to heed the president's April 2009 order to cabinet secretaries to identify a combined $100 million in budget cuts by July 2009. And there is clearly waste.

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Mr. STEARNS. With that, I recognize Ms. Jan Schakowsky, the ranking member who is substituting, as I understand, for Ms. DeGette.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. It is my honor to be sitting in for Congresswoman Diana DeGette this morning as ranking member.

Led by my Republican colleagues, we are here to talk about spending priorities in the Health and Human Services' budget. Given the substantial short- and long-term deficit challenges we face, I understand the need to root out wasteful spending, and I am sure that every agency is being fiscally responsible. Because our test is to address those challenges while simultaneously constructing a strong foundation for a healthy and bright economic future for our country, I must point out what I see is the misplaced focus of my Republican colleagues. In March, the Republicans passed an irresponsible budget that will only make things worse for the middle class and those who aspire to it. The Republican budget makes it clear that their party puts the very richest Americans as the top priority and makes everyone else bear the burden.

The Republican budget would do nothing to address income inequality. Instead, it would make it worse by increasing defense spending while slashing investments important to job creation, seniors, children and the middle class. The Republican budget mandates additional cuts to discretionary programs like Medicaid, food stamps, the Social Services Block Grant and the Prevention and Public Health Fund to insulate the Department of Defense from spending cuts triggered by the failure of the Joint Select Committee on Deficit Reduction.

Our committee was directed to find at least $97 billion in cuts, nearly half of which came from public health programs. The committee has lost valuable time—time that we could have spent discussing ways to get needed health care to Americans who have lost their health insurance along with their jobs, who cannot afford costly insurance premiums. Instead, my Republican colleagues have repeatedly attacked Obamacare and once again they seek to repeal the law in their budget. We should be working to lower

health care costs by improving efficiency and providing access to prevention.

Instead, my Republican colleagues have railed against the Prevention and Public Health Fund and repeatedly used its funding to force choices we shouldn't and don't have to make, like the choice between the elimination of funding for the Prevention and Public Health Fund or relief for students who are saddled with student-loan debt.

If we want to build a healthier, economically strong America, we must maintain our investment in prevention. Understand what the fund is about: It is about preventing diabetes, heart disease, cancer, and it is about getting money to State and local governments and organizations so they in turn can put prevention programs in place that are designed to meet the needs of their communities. This is about keeping America healthy.

My colleagues on the other side of the aisle lose sight of this goal when they try to rile people up by labeling the Prevention and Public Health Fund as a slush fund. It isn't. Under the President's 2013 budget, the fund would support breast and cervical cancer screenings. Americans know that mammograms and pap smears are not slush. They are basic, routine and often lifesaving services for women. Cutting funding for prevention programs like breast and cervical cancer screening now will only lead to increased costs down the road.

I have to say, I am really disappointed that some of my colleagues continue to that the CDC funds or the Prevention funds are used to spay and neuter dogs. They are not. HHS has confirmed it. Yet the same talking point that was used in committee making this claim was used on the floor during the student loan debate.

The late Senator Moynihan said, "Sir, you are entitled to your opinion, not your own facts."

And Mr. Chairman, the priorities in the Republican budget are deeply flawed. They do not reflect the priorities of everyday Americans.

While I believe the focus of this hearing is misplaced, I still hope that we can have a serious discussion about reducing our deficit without hurting the programs that benefit low-income families, children, seniors and individuals with disabilities.

I yield back the balance of my time.

Mr. STEARNS. I thank the gentlelady.

I have here the recovery.gov Web site that confirms that the spay and neuter and wellness clinics for cats and dogs have been received in zip codes with higher rates of animal nuisance reports. And also, it was included in the Department of Health and Human Services as part of the Metro Public Health Department's Community Putting Prevention to Work campaign.

With that I look at the chairman emeritus of the full committee, the gentleman from Texas, Mr. Barton.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Mr. Chairman, for holding this hearing along with the ranking member, Ms. DeGette.

Department of Health and Human Services is an agency that spends over a trillion dollars. A trillion dollars is more than the entire federal budget spent the first year I was in Congress in 1985. A trillion dollars is more than the total GDP of almost every nation in the world. A trillion dollars is so much money that we can't even get our hands on it. It is obvious that HHS can't their hands on managing it either.

The Inspector General at HHS declined to testify, admitting to subcommittee staff that the Department was so big and their resources so constrained that they have to focus everything they are doing on two programs, obviously, the two biggest, Medicare and Medicaid. Obviously, HHS has a huge mission to protect the health of the American people. This is a daunting challenge. Having said that, it doesn't mean that we just throw up our hands and throw money at the problem. There are over 80,000 employees at HHS. There are about 40,000 cardiologists and neurologists in this country, so we have two HHS two bureaucrats for every cardiologist and neurologist that are actually trying to provide health services to the American public.

President Obama has talked a good game about trying to manage the agencies better but HHS is one of the agencies that when the President specifically directed that certain steps be taken to eliminate waste, fraud and abuse and to cut overhead, HHS didn't provide a program, didn't even attempt it.

So Mr. Chairman, here we have an agency that has a huge mission, admittedly, but their answer to ever problem is to create more bureaucracy that is more unmanageable and more uncontrollable. Hopefully this subcommittee on a bipartisan basis will first determine what the facts are and then perhaps we can get with the Health Subcommittee and start some sort of a reauthorization to put into statute some of the things that need to be done.

With that, I thank the chairman.

[The prepared statement of Mr. Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON

Thank you Mr. Chairman. The Department of Health and Human Services (HHS) has been growing, expanding, and spending its way to an annual budget of 941 billion dollars in entitlements and 76.7 billion dollars in discretionary spending, which is over a trillion dollars. And, the agency received over 140 billion dollars in Recovery Act funding.

The core mission of HHS is to protect the health of the American people. I understand that this is a challenging objective to meet, however, at a time when the federal government is borrowing over 40 cents of every dollar it spends, unemployment is over 8 percent, and medical and insurance costs are increasing, it is imperative that we maintain stringent oversight of these dollars to ensure that this money is working for the public to protect both their physical and economic health.

During my congressional service, I have remained a strong advocate for systematic reform within HHS and its operating divisions. Bureaucracy has exploded at HHS, especially since the passage of President Obama's health care law. This is evident on their organizational outline posted on their Web site. In the immediate Office of the Secretary alone there are six different chains of command.

After that, there are seven Assistant Secretaries to the Secretary and they each have an office and support staff, the Deputy Assistant Secretary of the Office of Budget is a witness today. In addition, there are another 9 different official Offices and Departments complete with their own staffs, like the Office for Civil Rights and the newly created Office of Consumer Information and Insurance Oversight. All of this is within the single Office of the Secretary, under her control, and so far with inadequate oversight.

On top of this HHS Secretary-level bureaucracy, there are eleven different Operating Divisions under HHS, the largest being the Centers for Medicare and Medicaid Services, and including the Food and Drug Administration, the Centers for Disease Control and Prevention and the National Institutes of Health. HHS employs nearly 80,000 people, many of whom fall under the Title 42 program enabling them to earn more than $200,000 a year. According to the American Medical Association, there are only about 16,000 Neurologists and around 23,000 Cardiologists practicing in the United States. So, there are five times as many HHS employees as there are Neurologists and three and a half times as many HHS employees than Cardiologists.

The Government Accountability Office and the HHS Inspector General's Office have commented on the perpetual financial managements problems that are endemic at this agency. Today, I hope we illustrate to HHS and this

Administration that we are serious about conducting meaningful oversight of federal agency budgets financed on the backs of hardworking American taxpayers.

Mr. STEARNS. I thank the gentleman.

The gentleman from Texas, Dr. Burgess, is recognized for 2 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition.

We are today focusing in the discretionary budget authorities within Health and Human Services, and recognize it represents almost a quarter of all federal outlays. President Obama has proposed $76 billion in discretionary spending for fiscal year 2013 in Health and Human Services.

Now, both as an agency working on public health and administering public health programs, it has got to be, it has to be the center of universe in government integrity efforts. If we cannot get it right at HHS, where can we get it right? And if we get it right at HHS, everything else looks easy by comparison.

On November 14, 2011, the Inspector General of Health and Human Services, Inspector General Levinson, notified Secretary Sebelius that an independent audit of Health and Human Services' fiscal year 2011 financial statements found that "weaknesses continue to exist in financial management systems." The Inspector General also confirmed that it has not done any significant recent work in looking at duplicative programs within Health and Human Services.

So I guess we have to ask ourselves, how much fraud is enough for the government to take notice? I will tell you the answer. The answer is zero, and it must be zero, and that must be the focus at Health and Human Services, but really, the lack of internal oversight, the lack of prosecutors with a background in health care law really compromises our abilities to actually get anything done.

So we are comfortable with the current situation? I can't believe that we would be, and if we are not, when are we going to correct it? And that applies to the committee, both sides of the dais, and it applies to the agency, everyone from the Secretary on down.

Health care expenditures are going to go nowhere but up, and Health and Human Services' work in public health is going to continue to rise. Developing new and innovative approaches must make sure that every dollar is spent where it belongs, and that is delivering services to the people.

I yield back.

Mr. STEARNS. The gentleman's time has expired, and our side is complete. Oh, Mrs. Blackburn. I am sorry. The gentlelady from Tennessee is recognized for 1 minute.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. I thank you for the hearing. Welcome to our witnesses. We are glad that you are here.

As you have heard, this is a necessary hearing. It is our fourth in a series to look at waste, fraud and abuse, and the reason we are doing this is because our constituents come to us and they let us know they are taxed too much, they are tired of it and they are frustrated with seeing the waste in our federal bureaucracies. HHS employs over 80,000 federal workers, and you do have a large portion of our budget that you are expending every day.

Mr. Cochran, specifically for you, I want to hear about the steps that HHS has taken to comply with the President's call for agencies to identify $100 million worth of administrative savings nearly 2 years ago, see where you are in that process. Additionally, let us quantify generated savings from the President's Executive Order 13589 from November 9, 2011, and I want to know what is actually savings and then where you have double counted or used funds to justify your cost increases or activities.

Finally, after our experience with the Department of Energy and Solyndra, I have very real concerns about similar financial mismanagement at HHS as brought to our attention by Ernst and Young, and we will explore that a bit today, and I yield back.

Mr. STEARNS. I thank the gentlelady and now recognize the ranking member of the minority, Mr. Waxman from California.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Mr. Chairman, wasteful federal spending should be eliminated. Fraud and abuse should be wiped out. I have long supported bipartisan efforts to cut spending and reduce waste and fraud. But we must recognize that HHS and the agencies contained in the department have a vital, lifesaving mission: providing health care to millions of Americans; investing in disease prevention and scientific research; keeping the food and drug supply safe. We must be smart about how we achieve savings or we put these important programs at risk.

Mr. Chairman, if you want to learn how to cut the budget in a sensible way, I would suggest you take a look at the work we did in the Affordable Care Act. A Democratic Congress, working with President Obama, passed into law provisions that cut waste and abuse from Medicare and Medicaid. We gave HHS important new authority and power to identify and prevent Medicare and Medicaid fraud. The net result is hundreds of billions of dollars in savings without the need to cut Medicare benefits or erode the core promises of the program.

Unfortunately, the cuts in the Republican budget passed by the House don't meet this standard. They take direct aim at our Na-

tion's commitment to provide health care to seniors and our most vulnerable citizens. The Republican budget would repeal the Affordable Care Act, end the basic Medicare guarantee by turning the program into a voucher system, directly cut seniors' benefits by increasing the Medicare eligibility age, and slash funding for Medicaid, breaking the social safety net. The Republican budget would also deny coverage to 33 million Americans and allow the worst abuses of the insurance industry, like denying coverage to those with preexisting conditions, to continue, and it would cut off benefits like coverage of young adult children and closing the Part D drug donut hole that millions of Americans are enjoying today.

The Republican budget's Medicare cuts would eliminate the program's basic guarantees. They would increase costs for seniors, according to CBO, by up to $2,200 per beneficiary starting in 2030. This is not holding down costs. This is simply shifting costs. And the Republican budget would increase the Medicare eligibility age from 65 to 67, meaning millions of older Americans would be stuck waiting for Medicare with no employer coverage or inadequate coverage.

The Republican budget also cuts Medicaid by a stunning amount—$1.7 trillion over the next decade—turning the program into a block grant and threatening access to health care for millions of low-income children, families, pregnant women, and seniors in nursing homes.

And Mr. Chairman, the Republican budget does more than devastate Medicare and Medicaid. FDA, NIH, CDC, and the Head Start program are all part of HHS. The Republican budget would hurt all of them. The Republican budget cuts non-security discretionary spending for all government agencies, including HHS, below levels agreed to under the Budget Control Act, by 5 percent in 2013 and by 19 percent in 2014 and beyond.

The Republican budget lacks specific details, but the implications are clear: cuts in the FDA budget for food safety and inspection, cuts in the NIH budget for basic science research, reduced capacity for CDC to respond to emerging diseases, fewer kids who are eligible for Head Start, less money to fight Medicare and Medicare fraud. These cuts in basic health programs would be a huge mistake. They would be pennywise and pound foolish, costing our Nation more money and more in terms of human suffering than they could possibly save.

Mr. Chairman, I hope we can find a way to work together to find bipartisan solutions to cutting waste, fraud and abuse at HHS and at other agencies in the federal government. But the Republican budget proposal is not the answer. It cuts Medicare and Medicaid, eliminates health care coverage for 30 million Americans under the Affordable Care Act, and includes devastating cuts to basic programs at FDA, NIH, CDC, and throughout HHS. I hope the Republicans will rethink that approach, and I yield back my time.

Mr. STEARNS. I thank the gentleman. I just remind him, we are looking at budget and spending——

Mr. WAXMAN. I am going to reclaim my time and say that I don't think it is appropriate for the chairman to comment on each Democratic statement. We have 5 minutes each side.

Mr. STEARNS. I know.

Mr. WAXMAN. If somebody on your side wants to yield you time——

Mr. STEARNS. Well, I appreciate what you are——

Mr. WAXMAN. But I do want to point out that I don't understand this business of neutering dogs. Is this an anti-abortion issue? Is it a family planning issue? Is this something where we have—is this waste, fraud, and abuse?

Mr. STEARNS. It certainly——

Mr. WAXMAN. I would like to yield to the chairman unlimited time, because I don't have the power to do that.

Mr. STEARNS. Well, I have given you the brochure just to corroborate my opening statement and also to point out we are talking about budget spending concerns at HHS.

With that, let me introduce our witnesses. Mr. Norris Cochran, Deputy Office Secretary, Office of Budget, the United States Department of Health and Human Services; Ms. Carolyn L. Yocom, Director, Health Care, U.S. Government Accountability Office; and Mr. James C. Cosgrove, Director, Health Care, U.S. Government Accountability Office. And I understand the two of you, there will be a joint statement from the two of you. Is that correct?

As you know, the testimony that you are about to give is subject to Title XVIII Section 1001 of the United States Code. When holding an investigative hearing such as this committee is doing, the Committee has a practice of taking testimony under oath. Do you have any objection to taking testimony under oath? The chair then advises you that under the rules of the House and the rules of the Committee, you are entitled to be advised by counsel. Do any of you wish to be advised by counsel? In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. STEARNS. We now welcome your 5-minute summary, and we will start with you, Mr. Cochran.

TESTIMONY OF NORRIS COCHRAN, DEPUTY ASSISTANT SECRETARY, OFFICE OF BUDGET, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JAMES C. COSGROVE, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

TESTIMONY OF NORRIS COCHRAN

Mr. COCHRAN. Thank you, Chairman Stearns, Representative Schakowsky, members of the subcommittee. Thank you for the opportunity to speak about the Department of Health and Human Services' stewardship of the resources provided by Congress.

In my role as the Budget Director at HHS, I oversee the formulation of our annual budget. I and my colleagues in the Department are committed to efficiently achieving the outcomes intended by Congress. I will keep my initial remarks brief and respectfully request that my written testimony be incorporated into the record.

Mr. STEARNS. So ordered.

Mr. COCHRAN. I will briefly summarize key aspects of the President's fiscal year 2013 budget request for HHS including the use

of unobligated balances and highlight efforts to improve program performance and integrity and to achieve savings.

The fiscal year 2013 budget for HHS totals $932 billion in budget authority and $941 billion in outlays. It is comprised of many types of funding including Medicare, Medicaid and other entitlements and other mandatory spending, discretionary budget authority, user fees, and funding made available through transfers from sources such as the Prevention and Public Health Fund, and the Public Health Service Evaluation set-aside.

As HHS develops the annual budget request, we conduct a thorough review of our ongoing activities and eliminate or reduce funding for outdated, duplicative and low-performing programs. The HHS discretionary budget request includes more than $2 billion in reductions and eliminations across HHS's many components. These reductions and terminations are informed by analysis of impact and performance data and the setting of priorities in a tight budget environment. These reductions are enabling HHS to propose a discretionary budget that is cut overall by $218 million while still making priority investments in key areas including biodefense to protect the safety of our Nation through the development of medical countermeasures, the Indian Health Service to address extreme health disparities experienced in Indian Country, and the Centers for Medicare and Medicaid Services to keep up with beneficiary growth and implement the Affordable Care Act.

In addition, HHS proposes net mandatory savings of $366 billion over 10 years. These savings include $303 billion in Medicare, $56 billion in Medicaid, program integrity savings, as well as mandatory investments to strengthen child support enforcement, child care and foster care, and to continue TANF-related activities.

In developing our annual budget, HHS with OMB also assesses whether the presence of unobligated balances enables the Department to request less funding from Congress than would otherwise be needed. For example, the budget request this year for bioterrorism and emergency preparedness assumes the use of more than $400 million in unobligated balances to achieve our preparedness goals.

As HHS components execute the budget, we continually work to eliminate unnecessary costs. For instance, HHS is currently in the process of reducing our spending in targeted categories such as travel and supplies by more than $800 million.

HHS program and policy leaders also monitor the outcomes of the programs we administer and make needed adjustments to improve program performance. This is exemplified by regular data-driven meetings chaired by our Deputy Secretary during which senior officials review progress and key next steps for achieving measurable priority goals. In the areas of program integrity and budget execution, HHS benefits from the expertise of the HHS Office of Inspector General and the Government Accountability Office. For instance, before we spent funding from the Recovery Act, we worked with our OIG colleagues to better prevent waste, fraud and abuse with those investments.

With respect to program integrity, we are particularly proud of a joint effort with CMS, the Office of Inspector General and the Department of Justice through which multi-agency teams of federal,

State and local investigators combat Medicare fraud. Just last week, charges were made against 107 individuals for their alleged participation in Medicare fraud schemes involving approximately $452 million in false billing, which represents the largest single takedown in the history of this effort.

In conclusion, Mr. Chairman, thank you again for inviting me to testify about HHS stewardship of taxpayer resources. I look forward to answering your questions.

[The prepared statement of Mr. Cochran follows:]

Statement of Norris Cochran
Deputy Assistant Secretary for Budget
U.S. Department of Health and Human Services
Before the
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

May 9, 2012

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to speak about the Department of Health and Human Services' (HHS) processes for developing budget requests and ensuring responsible stewardship of all resources appropriated by Congress. As the Deputy Assistant Secretary for Budget at HHS, one of my responsibilities is to oversee the formulation of the Department's budget, and I am a member of a team of senior officials that is committed to using taxpayer resources to achieve the outcomes intended by Congress in the most efficient manner possible.

Formulating Budget Requests

The release of the President's Budget for HHS each February represents the culmination of a year of comprehensive analysis and review by program offices, budget and evaluation experts, and policy officials. This process involves a review of each line of our budget, in the interest of identifying a mix of investments that will cost-effectively improve the health and wellbeing of our nation. As a result of this careful review, each year we propose eliminating or reducing funding for programs that are outdated, duplicative, or low-performing. For instance, in the fiscal year 2013 Budget HHS identified $2 billion in discretionary terminations and reductions. In addition, HHS included proposals to improve activities by consolidating separate grants that

support similar efforts, such as in the area of state substance abuse prevention. As we formulate our budget request we also seek opportunities to make investments today that will yield greater returns in the future, such as the Health Care Fraud and Abuse Control program that has returned over $20 billion to the Medicare trust funds since 1997 and has a three-year return-on-investment ratio of 7.2 to 1.

Using Unobligated Balances

In developing our annual budget proposal, we also assess whether the presence of unobligated balances enables us to request less funding from Congress than would otherwise be needed. As an example, for fiscal year 2013 our request for bioterrorism and emergency preparedness assumes the use of more than $400 million in unobligated balances to achieve preparedness goals. In many instances, the availability of unobligated balances is the intentional result of Congress appropriating funding for use over the course of multiple years. This approach is often taken for initiatives that involve preparing for events that are difficult to predict, such as preparedness for an influenza pandemic, and projects intended to be carried out over a long period of time, such as buildings and facilities construction. As HHS develops plans for utilizing such funding, we take into account both current and future needs to ensure the investments are well planned and the objectives are fulfilled.

Spending Efficiently

HHS continually seeks to identify and eliminate unnecessary costs, in the interest of ensuring that our resources are optimally deployed to promote health and wellbeing. For instance, as part of the Administration's broader efforts to promote efficient spending, HHS is undertaking new measures to further reduce our spending on items such as travel, printing, professional services,

supplies and materials, and employee information technology devices. Reducing spending in these categories will enable us to redirect resources to mission critical investments that more directly benefit our programs' targeted populations.

Evaluating Program Performance

At HHS we carefully monitor the outcomes of the programs we administer, and make adjustments to improve program performance. In addition to this ongoing expectation for all of our programs, on a quarterly basis senior policy officials review our progress toward achieving a number of high priority, measureable, and ambitious goals. As part of this process, our Deputy Secretary chairs data-driven meetings during which senior officials report on progress to date and discuss upcoming actions that will contribute to the achievement of each goal. One of our current goals is to further reduce the national rate of healthcare associated infections, in recognition that each year such infections contribute to thousands of deaths and billions of dollars in excess healthcare expenditures. Reviewing program performance is one of a number of ways that HHS drives toward achievement of the ambitious goals articulated in our Strategic Plan (see http://www.hhs.gov/secretary/about/stratplan_fy2010-15.pdf).

Stewardship of Recovery Act Resources

The American Recovery and Reinvestment Act (Recovery Act) provided $140 billion to HHS programs, of which $110 billion had been spent by grant and contract recipients by the end of the last fiscal year. Most of the remainder was made available by the Act for a longer period to serve as an incentive to hospitals and health care providers to adopt and meaningfully use health information technology. The vast majority of Recovery Act funds helped state and local communities cope with the effects of the economic recession, but HHS Recovery Act funds are

also making long-term investments in the health of the American people and the health care system itself. HHS has ensured transparency and accountability in the management of its Recovery Act funds. At its height, HHS received more than 23,000 status reports from grantees and contractors that received Recovery Act funding from HHS discretionary programs. Over the past three years, more than 99 percent of the required recipient reports have been submitted on time. These reports are available to the public online, and non-filers have been sanctioned. More importantly, HHS worked to identify risks for fraud, abuse, and waste and took steps to mitigate those risks.

Ensuring Program Integrity

Over the last few years, HHS has adopted a more proactive stance toward the identification and mitigation of risks associated with implementing large and complex public programs. During fiscal year 2010, HHS developed a more comprehensive approach to assessing the challenges facing our programs and addressing programmatic vulnerabilities. The vision for this effort has been embraced by HHS leaders including the head of each of the Department's major components, while day-to-day activities are coordinated by the Department's Office of Finance and directed by senior officials in each of these same components.

HHS also proactively leverages the expertise of the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO). For instance, before we spent our first dollar of Recovery Act funding, senior policy officials sat down with our IG to develop a plan for ensuring that our focus on stimulating the economy by implementing programs quickly was balanced with proper attention to sound oversight and the prevention of waste, fraud, and abuse.

In instances where the OIG or GAO identifies threats to program integrity, HHS seeks to effectively and efficiently address these threats.

A program integrity effort of which HHS is particularly proud is the Heath Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. This joint program between HHS and the Department of Justice is focused on preventing and deterring fraud, and enforcing anti-fraud laws around the country. A prominent aspect of this effort is the Medicare Fraud Strike Force, a multi-agency team of federal, state and local investigators that combats Medicare fraud by targeting enforcement to geographic hot spots identified through the use of technology. Since inception, Strike Force operations have charged more than 1,330 defendants who falsely billed Medicare for more than $4 billion. Just last week, charges were made against 107 individuals for their alleged participation in Medicare fraud schemes involving approximately $452 million in false billing, which represents the largest single takedown in the history of this effort.

Conclusion

Mr. Chairman, thank you again for inviting me to testify about the Department of Health and Human Services' (HHS) processes for developing budget requests and ensuring responsible stewardship of taxpayer resources. I look forward to answering your questions.

Mr. STEARNS. I thank the gentleman.
Mr. Cosgrove, your opening statement, please.

TESTIMONY OF JAMES C. COSGROVE

Mr. COSGROVE. Chairman Stearns, Ms. Schakowsky, members of the subcommittee, I am pleased to be here with my colleague, Carolyn Yocom, as you discuss budget considerations at HHS, which is responsible for both discretionary spending and mandatory spending. These funds support a variety of important activities. However, the overwhelming share goes to Medicare and Medicaid, and for that reason, our remarks today focus on HHS's responsibilities for those two programs, which are administered by the Department's Centers for Medicare and Medicaid Services.

Over the past several years, GAO has recommended that HHS and CMS take a variety of actions to enhance agency oversight of Medicare and Medicaid and foster more prudent spending. We are pleased that many of our recommendations have been implemented, saving money for taxpayers and beneficiaries. For example, CMS saved at least $3.4 billion over 5 years from implementing multiple recommendations on the oversight of Medicaid supplemental payments.

However, some of our recommendations remain unaddressed and so today we want to focus on those key recommendations made within the last 6 years where HHS has not taken action or only partially addressed the recommendation. Some of our still open recommendations would help reduce improper payments and enhance payment safeguards in traditional fee-for-service Medicare. For example, we recommended that CMS require its contractors to identify potentially improper claims when billing reaches atypical levels. CMS agreed, but has not implemented our recommendation. We recently noted that CMS could better screen providers to avoid enrolling those who are intent on committing fraud.

To enhance payment safeguards, in a 2008 report, we recommended that CMS adopt front-end approaches such as considering requiring prior authorization for certain diagnostic imaging services. Although not implemented, the President's 2013 budget does call for such an approach.

We also believe that HHS needs to address certain issues related to the Medicare Advantage program. Approximately one in four beneficiaries are enrolled in private health plans that participate in Medicare Advantage. These plans are popular because relative to traditional Medicare, they typically cover more services and cost beneficiaries less. However, Medicare's payments to these plans, specifically, the adjustments for beneficiaries' health status, could be improved and a billion or more dollars could be saved annually. We recommended specific steps that CMS could take to better ensure the accuracy of its required payment adjustment. CMS commented that our findings were informative but it did not indicate that it would implement our recommendation.

We also recommended that HHS cancel its Quality Bonus Payment Demonstration for MA plans. This demonstration, estimated to cost more than $8.3 billion, is poorly designed and unlikely to yield meaningful results. Although intended to encourage high-quality health care, most of the money will go towards plans of av-

erage quality. Moreover, because of design shortcomings, it will be nearly impossible to evaluate whether the $8.3 billion influenced the quality of care provided. We therefore recommended that HHS cancel the demonstration and implement instead the quality bonus payments provided for by PPACA, which pays bonuses only to plans that achieve above-average quality levels.

Our substantial work on the Medicaid program has also resulted in numerous recommendations to improve program management, several of which remain open. For example, gaps remain in the oversight of State supplemental payments to hospitals and other providers for uncompensated care. We recommended that CMS make such payment arrangements transparent and ensure that the agency has reviewed and approved these arrangements. CMS has acted on some of these recommendations. We believe additional action is warranted.

Several times we have reported that HHS had approved State Medicaid demonstrations that could increase federal costs despite a policy against such increases. HHS has since reported taking certain steps such as monitoring the budget neutrality of ongoing demonstrations. However, no changes are planned in the methods used to determine budget neutrality and ensure the federal government's financial liability is not increased.

CMS has been inconsistent in reviewing States' rate setting for compliance with Medicaid managed care actuarial soundness requirements. In 2010, we found that one State received billions of federal dollars that had not been certified by an actuary, and another State's rates hadn't been fully reviewed since the requirements went into effect. We recommended that CMS improve its oversight of State rate setting, and while HHS agreed with the recommendations and has taken steps to improve its oversight, it has not yet completed actions that would ensure the quality of the data or develop guidance for reviewing the rates.

In conclusion, given the size and scope of the programs for which it is responsible, HHS must be vigilant in seeking ways to reduce spending, prevent improper payments and improve the efficiency of operations. We look forward to working with this committee to help the Department further advance its performance and accountability. We are happy to answer any questions you might have.

[The prepared statement of Ms. Yocom and Mr. Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Opportunities for Financial Savings and Program Improvements in Medicare and Medicaid Remain

Statement of James Cosgrove
Director, Health Care

Carolyn L. Yocom
Director, Health Care

GAO-12-719T

May 9, 2012

GAO
Accountability * Integrity * Reliability
Highlights

Highlights of GAO-12-719T, before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Opportunities for Financial Savings and Program Improvements in Medicare and Medicaid Remain

Why GAO Did This Study

HHS manages hundreds of complex programs benefiting the health and well-being of Americans, accounting for a quarter of all federal outlays. For fiscal year 2012, HHS is responsible for approximately $76 billion in discretionary spending and for an estimated $788 billion in mandatory spending. The size and critical mission of the two largest HHS programs, Medicare and Medicaid, make it imperative that HHS is fiscally prudent yet vigilant in protecting the populations that depend on these programs. In recent years, GAO has identified shortcomings and recommended actions to enhance operations and correct inefficiencies in Medicare and Medicaid, and HHS has implemented many recommendations, resulting in billions of dollars in savings. Because agencies now must do more with less, recommendations not yet implemented are opportunities for further conserving HHS funds and strengthening oversight of programs serving the nation's most vulnerable populations.

GAO was asked to testify on issues related to HHS's budget. This statement draws from GAO's prior work, including work on these two high-risk programs, in which GAO made recommendations related to (1) the management of Medicare and (2) the need for additional oversight of Medicaid. To the extent information was available, GAO updated the status of these recommendations.

View GAO-12-719T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov or Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Over the past several years, GAO has made a number of recommendations to the Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—to increase savings in Medicare fee-for-service and Medicare Advantage (MA), which is a private plan alternative to the traditional Medicare fee-for-service program. Open recommendations that could yield billions of dollars in savings remain in many areas, such as the following:

- **Minimizing improper payments and fraud in Medicare.** GAO recommended that CMS require contractors to automate prepayment controls to identify potentially improper claims for medical equipment and supplies, expand current regulations to revoke billing privileges for home health agencies with improper billing practices, designate authorized personnel to evaluate and address vulnerabilities in payment systems, and enhance payment safeguards for physicians who use advanced imaging services.
- **Aligning coverage with clinical recommendations.** GAO recommended that CMS provide coverage for services recommended by clinical experts, as appropriate, given cost-effectiveness and other criteria.
- **Better aligning payments to MA plans.** To ensure that payments to MA plans reflect the health status of beneficiaries, GAO recommended that CMS more accurately adjust for differences between MA plans and traditional Medicare providers in reporting beneficiary diagnoses. GAO also recommended that CMS cancel the MA Quality Bonus Payment Demonstration because its design precludes it from yielding meaningful results.

GAO has made recommendations to CMS regarding Medicaid program oversight. Open recommendations remain in many areas, such as the following:

- **Improving oversight of Medicaid payments.** GAO recommended that CMS adopt transparency requirements and a strategy to ensure that supplemental payments to providers have been reviewed by CMS. These supplemental payments are separate from and in addition to those made at states' regular Medicaid rates.
- **Ensuring Medicaid demonstrations do not increase federal liability.** GAO recommended that CMS revise its approval process for demonstrations to ensure they are budget neutral, which GAO subsequently referred to Congress as a matter for consideration.

The size of Medicare and Medicaid requires CMS to focus continually on the appropriateness of the methodology for payments that these programs make and the pre- and postpayment checks that can help ensure that program spending is appropriate, overpayment recovery is expedient, and agency practices with regard to operations for these programs are efficient. Therefore, GAO urges HHS to ensure action is taken on open recommendations to advance its performance and accountability.

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee:

We are pleased to be here today to discuss budget considerations at the Department of Health and Human Services (HHS). As the federal government's principal agency for protecting the health of Americans and providing essential human services, especially for vulnerable populations, HHS manages over 300 highly complex programs, which account for almost a quarter of all federal outlays. For fiscal year 2012, HHS is responsible for approximately $76 billion in discretionary spending and approximately $788 billion in outlays of mandatory spending. With this funding, HHS provides health care insurance for one in four Americans through its two largest programs—Medicare and Medicaid—and administers more grant dollars than all other federal agencies combined. HHS also funds disease research and prevention, oversees the safety and effectiveness of medical products, and helps ensure that the nation is prepared to respond to public health emergencies, among other things. HHS's size, diverse programs, and critical mission render its finances particularly important as Congress and the administration seek to decrease the cost of government while improving its performance and accountability.

In recent years, we have examined a broad range of issues, identified program design and oversight shortcomings, and made numerous recommendations to enhance agency operations. In particular, many of these recommendations relate to the Medicare and Medicaid programs—which are the responsibility of the Centers for Medicare & Medicaid Services (CMS), an agency within HHS. HHS has implemented many of these recommendations, resulting in billions of dollars of savings. Other recommendations have led to program improvements that, while not always quantifiable, have nonetheless enhanced the efficiency of agency operations. For example, in 2004, we reported on CMS's management of its Medicare Secondary Payer debt, which occurs when Medicare pays for services that are subsequently determined to be the financial responsibility of another payer.[1] CMS's implementation of our recommendation that it reduce the number of contractors managing this workload resulted in savings of $86 million from 2006 through 2010. More

[1]GAO, *Medicare Secondary Payer: Improvements Needed to Enhance Debt Recovery Process*, GAO-04-783 (Washington, D.C.: Aug. 20, 2004).

recently, greater savings have been realized as a result of work on CMS's oversight of states' Medicaid supplemental payment arrangements.[2] In 2007, we reported on a CMS oversight initiative established in response to our work, which increased the agency's scrutiny of state Medicaid financing arrangements and resulted in savings of approximately $3.4 billion from fiscal year 2007 through 2012.[3]

While HHS has successfully implemented many of our recommendations, our remarks today will focus on spending for which HHS is responsible in the context of recommendations we have made that it has yet to implement and that we therefore consider open. Specifically, we will concentrate on our recommendations to improve the Medicare and Medicaid programs. We have designated both as high-risk programs, in part because of their size, complexity, susceptibility to improper payments, and the need to improve program management.[4] The recommendations that we will discuss include those that were recently made, those not yet fully implemented, and others for which no actions have been taken, although several years have elapsed since they were made. These recommendations—some of which could result in financial savings—include those that address (1) missed opportunities for savings in the management of Medicare and (2) the need for additional oversight of Medicaid.

Our testimony today draws on our prior products, issued from January 2007 through April 2012, including our work on overlap and duplication of federal programs that may result in inefficient use of taxpayer funds.[5] To the extent that information was available, we updated the status of HHS's

[2]Medicaid supplemental payments are payments separate from and in addition to those made at states' regular Medicaid rates.

[3]GAO, *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007).

[4]GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[5]GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, GAO-12-342SP (Washington, D.C.: Feb. 28, 2012); *Follow-up on 2011 Report: Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue*, GAO-12-453SP (Washington, D.C.: Feb. 28, 2012); and *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO-11-318SP (Washington, D.C.: Mar. 1, 2011).

implementation of these recommendations in May 2012. Detailed information on the scope and methodology for our prior work can be found in the reports that we have cited throughout this testimony. We conducted the underlying performance audits in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audits to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our statement today.

Missed Opportunities for Savings in Medicare

In the past several years, we have made a number of recommendations for CMS to address missed opportunities for savings in the Medicare program, which the agency has not fully implemented. These include recommendations related to the Medicare fee-for-service (FFS) and Medicare Advantage (MA) programs.

Medicare Fee-for-Service

Minimizing improper payments and fraud. We have a body of issued and ongoing work about improper payments in Medicare. In 2007, we reported on program integrity activities conducted by CMS contractors to minimize improper payments for medical equipment and supplies.[6] We recommended that CMS require its contractors to develop automated prepayment controls to identify potentially improper claims when billing reaches atypical levels. CMS agreed with the recommendation, but has not implemented it. The agency has added other prepayment controls to flag claims for services that were unlikely to be provided in the normal course of medical care. However, implementing our recommendation and adding additional prepayment controls could enhance identification of improper claims before they are paid to reduce reliance on "pay and chase" strategies.[7] In 2009, we reported that fraudulent and abusive practices in home health agencies, such as overstating the severity of a beneficiary's condition, contributed to Medicare home health spending and utilization.[8] To strengthen controls on improper payments in home

[6]GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007).

[7]We have ongoing work updating CMS's progress in implementing prepayment controls.

[8]GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009).

health agencies, we recommended that CMS amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. CMS told us that it has begun to explore its authority to expand the types of practices that are grounds for revocation of billing rights. We believe that CMS should do so expeditiously.

In 2010, we recommended that CMS designate responsible personnel with authority to evaluate and promptly address vulnerabilities identified to reduce improper payments.[9] CMS concurred with this recommendation and has begun to implement this process, but does not yet have written policies and procedures for a fully developed corrective action process that includes monitoring of actions taken.[10] Likewise, we recently testified before the Senate Committee on Finance regarding CMS efforts to combat Medicare fraud.[11] We reiterated our prior recommendation and noted that CMS could do more to strengthen provider enrollment screening to avoid enrolling those intent on committing fraud, improve pre- and postpayment claims review to identify and respond to patterns of suspicious billing activity more effectively, and identify and address vulnerabilities to reduce the ease with which fraudulent entities can obtain improper payments.

Enhancing payment safeguard mechanisms. In 2008, we reported on rapid spending growth for advanced imaging services.[12] We recommended that CMS examine the feasibility of adding front-end approaches, such as prior authorization, to improve payment safeguard mechanisms. CMS has not implemented our recommendation, but is currently engaged in a demonstration project to assess the appropriateness of physicians' use of advanced diagnostic imaging services furnished to Medicare beneficiaries.

[9]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: Mar. 31, 2010).

[10]We have ongoing work updating CMS's progress in implementing these recommendations.

[11]GAO, *Medicare: Important Steps Have Been Taken, but More Could Be Done to Deter Fraud*, GAO-12-671T (Washington, D.C.: Apr. 24, 2012).

[12]GAO, *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*, GAO-08-452 (Washington, D.C.: June 13, 2008).

Aligning coverage for services with clinical recommendations. We reported in early 2012 that Medicare beneficiaries' use of preventive services did not always align with the U.S. Preventive Services Task Force's recommendations.[13] We concluded that opportunities exist to improve the appropriate use of preventive services through means such as revising coverage and cost-sharing policies and educating beneficiaries and physicians. In the case of osteoporosis screening, for instance, Medicare coverage rules may preclude utilization of the recommended screening by all those for whom the service is recommended. Conversely, given that the Task Force recommended against prostate cancer screening for men aged 75 or older, the absence of cost sharing for that population may encourage inappropriate use of this service. To better align preventive service use with clinical recommendations, we recommended that CMS provide coverage for Task Force recommended services, as appropriate, given cost-effectiveness and other criteria. In response to our recommendation, the agency stated that it had recently used its authority to expand benefits to cover several new preventive services. This additional coverage, however, does not address the misalignment that remains between Medicare coverage for certain services and the corresponding Task Force recommendations. We also offered a matter for congressional consideration. We suggested that Congress consider requiring beneficiaries to share the cost of the services if they receive services the Task Force recommends against.

Medicare Advantage

Better reflecting beneficiary health status in payments to MA plans. In 2010, the federal government spent about $115 billion on the MA program, a private plan alternative to the Medicare FFS program. In January 2012, we reported that CMS could achieve billions of dollars in additional savings by more accurately adjusting for differences between MA plans and Medicare FFS providers in the reporting of beneficiary diagnoses.[14] CMS uses this diagnosis data and other information to construct a risk score for each beneficiary. Higher risk scores result in

[13]GAO, *Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations*, GAO-12-81 (Washington, D.C.: Jan. 18, 2012).

[14]GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, GAO-12-51 (Washington, D.C.: Jan 12, 2012).

increased Medicare payments to plans, while lower risk scores result in reduced Medicare payments to plans. Risk scores should be the same among all beneficiaries with the same medical conditions and demographic characteristics, regardless of whether they are in MA or Medicare FFS. MA plans have an incentive to code diagnoses more comprehensively because doing so affects plan payments, which is not the case in Medicare FFS. CMS is required by law to make an adjustment to MA risk scores to bring them in line with those of Medicare FFS. In this report, we found that CMS's adjustment for diagnostic coding differences was too small. We estimated that MA beneficiary risk scores in 2010 were from 4.8 to 7.1 percent higher than they likely would have been if they had been enrolled in FFS, while CMS's adjustment for diagnostic coding differences was only 3.4 percent. Compared to CMS's analysis, our analysis incorporated more recent beneficiary data and accounted for additional beneficiary characteristics that affect risk scores, such as health status and sex. A revised methodology that incorporated this information could have saved Medicare between $1.2 billion and $3.1 billion in 2010 in addition to the $2.7 billion in savings from the adjustment CMS made. We expect that savings in 2011 and future years would be even greater. CMS has continued to use its 2010 adjustment method for 2011 and 2012, even though both we and CMS noted an upward trend in the impact of coding differences over time. To improve the accuracy of the adjustment made for differences in coding practices over time, we recommended that the Secretary of HHS direct the Administrator of CMS to incorporate the most recent data available in its estimates; identify and account for all years of diagnostic coding differences that could affect the payment year for which any adjustment is made; account for the upward trend of the annual impact of coding differences in its estimates; and to the extent possible, account for all relevant differences in beneficiary characteristics between the MA and Medicare FFS populations. CMS stated that it found our findings informative, but did not comment on our recommendations.

Canceling the MA Quality Bonus Payment Demonstration. We recently reported that CMS could achieve billions of dollars in savings by canceling the MA Quality Bonus Payment Demonstration—which CMS's Office of the Actuary has estimated will cost more than $8 billion over

10 years.[15] Rather than implement the quality bonus payments prescribed in the 2010 Patient Protection and Affordable Care Act (PPACA), as amended, CMS is conducting a nationwide demonstration to test whether a scaled bonus structure would lead to larger and faster annual quality improvement for MA plans at various performance levels. Compared with PPACA's quality bonus payment system, the demonstration extends the bonuses to average-performing plans, accelerates the phase-in of the bonuses for plans with above-average performance, and increases the size of the bonuses in 2012 and 2013. We found that the demonstration's estimated $8.35 billion cost offsets more than one-third of PPACA's MA payment reductions during its 3-year time frame and that most of the additional spending will go to average-performing plans rather than to high-performing plans. The MA Quality Bonus Payment Demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact. It is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and is greater than the combined budgetary impact of all those demonstrations. For a variety of reasons, the design of the demonstration precludes a credible evaluation of its effectiveness in achieving CMS's stated research goal. We therefore believe that it is unlikely that the demonstration will produce meaningful results. Accordingly, we recommended that the Secretary of HHS cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect. HHS did not concur with our recommendation, stating that it believed the demonstration supports a strategy to improve the delivery of health care services, patient health outcomes, and population health.

Need for Additional Oversight of Medicaid

We have conducted a substantial body of work on Medicaid program management. Our recommendations have involved a variety of topics and have included different aspects of payment arrangements with states.[16]

[15]GAO, *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, GAO-12-409R (Washington, D.C.: Mar. 21, 2012).

[16]We recently testified about CMS's oversight of Medicaid program integrity. See GAO, *Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement*, GAO-12-674T (Washington, D.C.: Apr. 25, 2012). We also have ongoing work in this area.

Improving oversight of supplemental payments. We have reported on varied financing arrangements involving supplemental payments—disproportionate share hospital (DSH) payments that states are required to make to certain hospitals and other non-DSH supplemental payments—that increase federal funding without a commensurate increase in state funding.[17] Our work has found that while a variety of federal legislative and CMS actions have helped curb inappropriate financing arrangements, gaps in oversight remain. For example, while there are federal requirements designed to improve transparency and accountability for state DSH payments, similar requirements are not in place for non-DSH supplemental payments, which may be increasing. From 2006 to 2010, state-reported non-DSH supplemental payments increased from
$6.3 billion to $14 billion; however, according to CMS officials, reporting was likely incomplete. We made numerous recommendations aimed at improving oversight of supplemental payments. We have recommended that CMS adopt transparency requirements for non-DSH supplemental payments and develop a strategy to ensure that all state supplemental payment arrangements have been reviewed by CMS. CMS has taken action to address some of these recommendations, but we continue to believe additional action is warranted. CMS has raised concern that congressional action may be necessary to fully address our recommendations.

Ensuring Medicaid demonstrations do not increase federal liability. HHS has authority to waive certain statutory provisions to allow states to implement Medicaid demonstrations that are likely to assist in achieving program objectives. By policy, these demonstrations should not increase federal costs. However, we reported in 2008 that HHS had approved two state Medicaid demonstrations that could increase the federal financial liability substantially.[18] This report followed earlier work that had identified similar concerns with HHS approvals of state Medicaid demonstrations that were not budget neutral. At the time of our work in 2007, HHS disagreed with our recommendation to improve the demonstration review

[17]GAO, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington D.C.: May 30, 2008) and GAO, *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted*, GAO-10-69 (Washington D.C.: Nov. 20, 2009).

[18]GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, GAO-08-87 (Washington, D.C.: Jan. 31, 2008).

process through steps such as clarifying the criteria for reviewing and approving states' proposed spending limits and ensuring that valid methods were used to demonstrate budget neutrality. Consequently, we referred this to Congress for consideration. HHS subsequently reported taking steps, such as monitoring the budget neutrality of ongoing demonstrations, to improve its oversight. However, no changes are planned in the methods used to determine budget neutrality of demonstrations to ensure that demonstrations do not increase the federal financial liability.

Improving rate-setting methodologies. In August 2010, we reported that CMS had not ensured that all states were complying with federal Medicaid requirements that managed care rates be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.[19] For example, we found significant gaps in CMS's oversight of 2 of the 26 states reviewed—CMS had not reviewed one state's rate setting in multiple years and had not completed a full review of another state's rate setting since the actuarial soundness requirements became effective in August 2002. Variation in practices across CMS regional offices contributed to these gaps and other inconsistencies in the agency's oversight of states' rate setting. This work also found that CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans—efforts that did not provide the agency with enough information to ensure the quality of the data used. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending. We made recommendations to improve CMS's oversight of states by implementing a mechanism to track state compliance with Medicaid managed care actuarial soundness requirements, clarifying guidance on rate-setting reviews, and making use of information on data quality in overseeing states' rate setting. HHS agreed with these recommendations, and as of May 2012, CMS officials indicated that they were reviewing and updating the agency's guidance and exploring the incorporation of information about data quality into its review and approval of Medicaid managed care rates.

[19]GAO, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*, GAO-10-810 (Washington, D.C.: Aug. 4, 2010).

Concluding Observations

Improved financial stewardship of federal programs is becoming increasingly important as the pressure to reduce spending mounts. In an agency as large as HHS, the need for vigilance in continuously seeking out cost savings cannot be overstated. In our work, we have examined many aspects of HHS operations and made recommendations to help HHS prevent unnecessary spending, save money, recover funds that should rightfully be returned, improve the efficiency of agency operations, and improve service for beneficiaries. HHS has implemented many of our recommendations that have proven to be financially beneficial while also enhancing program management. However, there are still recommendations we have made that remain open. While we recognize that some of the recommendations we have highlighted today are relatively new, others are several years old. HHS has made clear that it is committed to improving the nation's health and well-being while simultaneously contributing to deficit reduction. We therefore urge HHS to expedite action on our open recommendations to further advance its performance and accountability.

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, this completes our prepared statement. We would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact us at (202) 512-7114 or cosgrovej@gao.gov and yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are listed in appendix I.

Appendix I: GAO Contacts and Staff Acknowledgments

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Staff Acknowledgments	In addition to the contacts named above, Geri Redican-Bigott, Assistant Director; Kelly DeMots; Helen Desaulniers; David Grossman; Elizabeth T. Morrison; and Kate Nast made key contributions to this statement.

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Mr. STEARNS. Thank you.

And with that, I understand, Ms. Yocom, you are here to assist if we have any questions. You are sort of a detail expert?

Ms. YOCOM. That is correct.

Mr. STEARNS. Let me start by—Mr. Cochran, I think you just heard Mr. Cosgrove indicate in his opening statement many things he has recommended you have not done. Isn't it true that the President has committed to conducting an exhaustive line-by-line review in the spending budget to reduce unnecessary waste, fraud and abuse? Isn't that true? Yes or no.

Mr. COCHRAN. Yes. We go through an exhaustive review each year.

Mr. STEARNS. And the idea was to increase efficiency and to overall provide ways to do better with less. I think that was the idea, and in fact, that is what the GAO had indicated to you, that we want to do more with less. I think we have a hard realizing—the statistics I gave you this morning in my opening about the huge number of employee increase and the amount of money you have got, it doesn't appear that you are actually doing more with less. And when I hear Mr. Cosgrove talk, he noted that they have implemented some of the recommendations but not all the GAO recommendations to conserve HHS funds and strengthen the oversight of the program. So I guess the question is, why haven't you implemented many other detailed recommendations that he mentioned including one that caught my eye was dealing with bonuses that he brought to bear on your watch. So I guess the main question is, considering what we see here, for instance, canceling the MA Quality Bonus Payment Demonstration program. Why haven't you implemented all the other things that he suggested?

Mr. COCHRAN. Well, CMS has leadership for managing Medicare and Medicaid, and as we heard, has made progress on a number of the recommendations. We have also incorporated a number of recommendations and findings in our annual budget request such as in the area of medical devices. We are finding efficiencies through identifying discretionary programs——

Mr. STEARNS. No. The question is, why haven't you implemented the other recommendations? You have implemented some, is what Mr. Cosgrove said, but the ones he outlined, why haven't you done those?

Mr. COCHRAN. There are——

Mr. STEARNS. You don't have the money?

Mr. COCHRAN. Well, there are different reasons. Again, this is managed principally by CMS at the operating division level. In some cases, it could be an issue of whether or not they have existing authorities. In other cases CMS continues to work with and talk to GAO.

Mr. STEARNS. OK. So you are working on them? Is that what you are saying?

Mr. COCHRAN. In a number of areas.

Mr. STEARNS. Now, canceling the MA Quality Bonus Payment Demonstration, there is an estimate, it could save $8 billion over 10 years. Are you familiar with that recommendation?

Mr. COCHRAN. I am familiar with the——

Mr. STEARNS. Is there a reason why you didn't implement that recommendation from the GAO?

Mr. COCHRAN. The Secretary, as she has testified to the House, has indicated that HHS has made a policy decision to continue that demonstration.

Mr. STEARNS. Even though the GAO said it should be canceled, you have agreed to override their recommendation. Is that true?

Mr. COCHRAN. The position of the Department as articulated by the Secretary is to continue——

Mr. STEARNS. So you are going to override their recommendation? I understand. I just want to understand that if they make a recommendation you don't agree with, you are just not going to implement it.

I have a slide here that if possible I would like to bring out. The number of full-time equivalents, or FTEs, at HHS has been rising over the past several years. Is that true? Yes or no. I mean, you just confirmed to us that the budget continues to grow as does the number of full-time equivalent employees. In fact, the President's request of Congress for HHS funding from year to year continues to rise. Isn't that true?

Mr. COCHRAN. The areas where we have had FTE growth are principally in the Food and Drug Administration, which is funded both by budget authority provided by the Congress and by user fees from industry as well as the Indian Health Service, which provides direct medical care to Indian Country and those populations.

Mr. STEARNS. Mr. Cochran, the HHS was apparently absent from the list of the 15 agencies that were heeding the President's April 2009 order to Cabinet secretaries to identify a combined $100 million in budget cuts by July 2009. Wasn't that true that you were absent from that?

Mr. COCHRAN. HHS identified savings in two areas. That process is managed by OMB. You are correct that it was not carried in that memo. The two areas at HHS identified subsequent to the delivery of the memo are in data centers where we have consolidated data centers in CDC and FDA starting in fiscal year 2009, and the migration from paper to electronic filing principally in FDA but as well as CDC and ACF.

Mr. STEARNS. Well, I think you can realize from this standpoint, it just seems odd that given the President has instructions in April 2009 in his first major attempt to demonstrate a serious effort to cuts budgets and to streamline federal spending and at the same time HHS was apparently absent from the list of the 15 agencies that were heeding the President's April 2009 order to Cabinet secretaries. So we just find that a little puzzling.

And my time is expired. I recognize the ranking member, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I would like to ask the witnesses some questions about Medicare's fraud prevention efforts. Reducing fraud has been an Obama Administration priority, and we are seeing significant taxpayer savings as a result of these efforts. The Administration's antifraud efforts recovered a record $4.1 billion, taxpayer dollars, last year. It is the second year in a row for a new record. The Administration has recovered a total of $10.7 billion over the past 3 years. Prosecu-

tions are way up from 797 in fiscal year 2008 to 1,430 in fiscal year 2011, a more than 75 percent increase. So the Affordable Care Act gives HHS a broad range of new tools to reduce waste, fraud and abuse, a national screening program, and I heard Mr. Cosgrove talk about pre-screening for providers, enhanced screening for providers in high-risk areas like durable medical equipment and home health care, required disclosure of prior association with delinquent providers and suppliers, onsite visits as part of the enrollment process, new CMS powers to enact a moratorium on enrolling new providers, and new funding to fight fraud.

So Mr. Cochran, can you offer some perspective on these new tools and how will they help CMS cut fraud?

Mr. COCHRAN. Yes. As you know, this has been a major area of focus for the Administration. The number of recoveries has increased dramatically, as you note, in the last 3 years alone totaling $10.7 billion. Some of the authorities that CMS is now using that come specifically from the Affordable Care Act include efforts to create a risk-based screening process for new and enrolling providers. Also, importantly, CMS now has the express authority to suspend payments to a provider or supplier pending an investigation wherever there is a credible allegation of fraud. In addition, the Act, for example, requires face-to-face encounters between patients and practitioners prior to a physician certifying eligibility for Medicare's home health, and the Act also provides resources that are available to CMS and our Office of Inspector General where we partner with the Department of Justice in our health care fraud and abuse control areas.

Ms. SCHAKOWSKY. Mr. Cosgrove, would you agree that these new authorities under the Affordable Care Act will help HHS fight fraud?

Mr. COSGROVE. With your permission, I would like to see if Carolyn Yocom could address the question. Carolyn is an expert both on the Medicaid program and on the overall program integrity efforts.

Ms. YOCOM. Good morning. We would agree that there is more work for CMS to do and some elements of PPACA do help provide aspects of improvement. Our three areas where we would suggest that CMS continue to work have to do with the provider enrollment, making sure that those enrollments are strengthened and that there are core elements for provider compliance in place.

A second area would be looking at post-payment claims review and also pre-payment claims review, which prevents the money from even going out the door until it is certain that it should. We have ongoing work in those areas.

And then lastly, to look at weaknesses within identifying known vulnerable areas, and again, we have ongoing work in this area that we expect to be reporting on.

Ms. SCHAKOWSKY. Thank you.

The CBO has estimated these changes will save more than $7 billion over the next 10 years, so clearly, and I think that CMS agrees, more needs to be done, but would you say that what is happening right now is a step in the right direction?

Ms. YOCOM. Yes, it is a step in the right direction. We have not done work looking at the savings. That is CBO's jurisdiction.

Ms. SCHAKOWSKY. And Mr. Cochran, in your testimony, you noted something that many of us saw on the news just last week, 107 people were charged in a $450 million Medicare fraud scheme, the largest Medicare fraud ever. What can you tell us about the Administration's efforts that resulted in this bust?

Mr. COCHRAN. Well, one key aspect in this effort is a collaboration between HHS and the two components, principally being the Centers for Medicare and Medicaid Services and our Office of Inspector General, and the Department of Justice. Another key aspect is that it involves both taking intelligence from headquarters but also importantly, focusing with agents and experts on the ground in nine key areas, strike forces, they are called, in higher risk areas and that has enabled HHS and DOJ to really step up enforcement by having more direct involvement where we face the greatest amount of fraud.

Ms. SCHAKOWSKY. Mr. Chairman, I know my time is up, but I went out on a drive-around with the strike force and I would recommend that it is very worthwhile for members in those areas to do that. Thank you.

Mr. STEARNS. The gentlelady's time is expired.

Mr. Terry from Nebraska is recognized for 5 minutes.

Mr. TERRY. Thank you, Mr. Chairman.

Continuing with you, Mr. Cochran, so I better understand our efforts on waste, fraud and abuse, there is nothing that frustrates our constituents more than abuse of something so sacrosanct as our Medicare and Medicaid programs. Especially, seniors really feel cheated when somebody is stealing from the program. They feel like they have been stolen from. Of course, there are different levels. There is outright fraud, there is improper payments, which may not be fraud but still payments that shouldn't have been made.

So I want to break this up into a couple different areas. First of all, on page 2 of your statement, Mr. Cochran, when I was reading it, you mentioned that you seek opportunities or the agency seeks opportunities to make investments that will yield greater returns in the future such as the Health Care Fraud and Abuse Control program that has returned over $20 billion to the Medicare trust fund since 1997 and then has a return of investment of 7.2 to 1 but yet we are hearing today from statements that there has been hundreds of billions saved in the last 2 years and $42 billion saved over the last 2 years. So that begs the question of whether there are more health care fraud and abuse control programs that weren't referenced in your statement.

Mr. COCHRAN. The initial description of recoveries to the trust funds including the $10 billion over the last 3 years is in reference to the work that we are doing with DOJ in health care fraud and abuse. The larger numbers, if I understand your question, relate to not necessarily fraud and abuse. Some of the savings in the 2013 budget as well as the Affordable Care Act relate to fraud and abuse. Others are reductions in payments again often informed by GAO's analysis as well as efforts to improve quality.

Mr. TERRY. It is reduced payments. Is that an issue of correcting improper payments? Because reduction just means you are paying somebody less.

Mr. COCHRAN. Well, in the area of improper payments, there can be——

Mr. TERRY. No, I am just asking for further clarification when you said that those further savings came from reductions of payments. I want to know if those were improper payments that were pulled back or just simply a reduction like a doctor was paid $48 instead of $50.

Mr. COCHRAN. I see. Yes. My reference to reduced payments relates to areas where CMS, GAO, in some cases OIG, and we also work closely with the Office of Management and Budget in this area where we have found that reimbursements are sort of out of balance or exceed what should arguably be provided for the level of service. Through legislative changes and budget proposals, those reimbursements are——

Mr. TERRY. Well, let us follow up on that, Mr. Cosgrove. GAO has designated Medicare and Medicaid as high-risk programs due to their susceptibility for improper payments estimated to be about $65 billion in fiscal year 2011.

Mr. Cosgrove or Ms. Yocom, does HHS appear to be doing everything it can to address the enormity of the improper payments issue?

Ms. YOCOM. There is always more to do. Any improper payment rate that is as high as it is right now, there is more work to be done.

Mr. TERRY. Specifically then, can you outline what their efforts have been in the last 2 years?

Ms. YOCOM. I can give you a general sense of some places where CMS has moved forward. They have strengthened some elements of their provider enrollment. They have designated risks across the levels of providers so they have a sense of who to keep the best eye on.

Where they need to do more work has to do with fingerprinting those providers, making sure that there are final regulations to ensure disclosure, and then also some core elements for provider compliance programs. That would allow them to strengthen more. That is one example.

Mr. TERRY. I am just confused. If I could have another 5 seconds? Fingerprint our providers? Our doctors have to be fingerprinted to be reimbursed?

Ms. YOCOM. For criminal background checks.[The reference to fingerprinting was made in conjunction with the statement regarding the level of risk associated with different providers. In 2012, GAO reported on CMS's plans to subject high-risk providers and suppliers to fingerprint-based background checks.]

Mr. STEARNS. The gentleman from Texas, Mr. Barton, is recognized for 5 minutes.

Mr. BARTON. Thank you, Mr. Chairman.

We have all seen the reports in the last several months about some of these abuses of public funds, the GSA and their trips to Las Vegas, the Secret Service and their escapades in South America. We all hope that those are exceptions and not the rule, that not everybody in the government behaves that way.

But I look at HHS, and by the admission of the Inspector General, he doesn't phrase it quite this way but it is an agency that

is almost not controllable because it is so big. So this subcommittee hopefully on a bipartisan basis is going to begin a process to determine what, if anything, can be done if we need to change statutory authority to regain control. Staff has indicated to me that at HHS, this is just a small example but it is big enough to have significance, that not just the travel budget at HHS but that the international travel budget is between $56 and $67 million per year, and then it has gone up 15 percent between fiscal year 2009 and fiscal year 2011. Why in heaven's name, Mr. Cochran, would international travel be over $50 million a year and why would it be going up 5 to 10 percent a year? International. This is health domestically, Health and Human Services domestically.

Mr. COCHRAN. The travel in 2011, as you noted, is $65 million. It was $57 million in 2010, $67 million in 2009. So relative to 2009, it is down just a little bit. But more to your question, the areas within HHS where there is the greatest amount of international travel are the Centers for Disease Control and Prevention, which operates directly funded programs in HIV/AIDS as well as global immunization areas like polio as well as executes on behalf of the Department of State major portions of the President's emergency plan for AIDS relief.

The second primary areas for international travel include the National Institutes of Health that does scientific work globally as well and the Food and Drug Administration.

Mr. BARTON. Could we invite those people to the United States and have them pay their dime to come see us since we are the experts? Do we have to go overseas? I understand there needs to be some. I am not saying zero. But if the international travel budget is $50 million a year, it is good to know that it has gone down a little bit. Do you happen to know what the Secretary's travel budget is?

Mr. COCHRAN. I do not. We would be happy to get back to you on that. The Office of the Secretary overall has a smaller travel budget, and especially international travel budget. Within the Office of the Secretary, the main travel costs are the Office of Global Affairs, which again in partnership with CDC, NIH and FDA helps implement some of our Congressionally funded international missions, but I don't know off the top of my head what——

Ms. SCHAKOWSKY. Would the gentleman yield for one sentence?

Mr. BARTON. Sure.

Ms. SCHAKOWSKY. The CDC and the FDA have both made clear, their travel budgets are down compared to those of the second term of the Bush Administration, so the trajectory is correct.

Mr. BARTON. Well, that is good information. Let us keep it going that way. Let us keep the trend going. That is good to know.

I have got one minute left. This is a standard question that I ask every agency that comes before us. Mr. Cochran, can you tell me of the 80,000 employees at HHS, how many of them have a government credit card?

Mr. COCHRAN. I do not have that information with me or off the top of my head, but we would be happy to get back to you.

Mr. BARTON. Do you have a government credit card?

Mr. COCHRAN. Yes, I was issued a credit card. I myself don't travel, it is not in the nature of my work, so I haven't used it for quite some time.

Mr. BARTON. So you have one but you don't use it?

Mr. COCHRAN. I don't use it often. That is correct.

Mr. BARTON. Well, if you have it, you should be allowed to use it.

Mr. COCHRAN. I just——

Mr. BARTON. I want the record to show, I have a government credit card issued to me by the United States Congress for travel, and I use it to put gasoline in my leased vehicle and I use it, as he said, on occasion when I travel domestically outside my district for airfare or hotel. I am not saying it is illegal or immoral to have one but I am saying that we ought to have an accountability protocol, and most of the federal agencies tend to issue them fairly liberally and tend not to oversee them, if at all. That is a standard question.

My time is expired, Mr. Chairman. I yield back.

Mr. STEARNS. I thank the gentleman, and the gentlelady from Tennessee, Ms. Blackburn, is recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to thank our witnesses for being here. I think as you can hear from the questions that we are asking, it does appear that HHS is now too big to control, and listening to the GAO report certainly lends an understanding of that. You can go look after a couple of programs but you have got all this other spending that is going on that you can't seem to get your hands around, as Mr. Barton said, the travel budget, and you have to say why in this time when our constituents are saying the federal government takes too much out of our pockets and it wastes money that we don't have and it spends money on programs that we don't want. Certainly, there is a disconnect between what the citizens want and what you all thing you have the right for whatever reason you feel entitled to spend money, the taxpayers' money.

Ms. Yocom, I wanted to come to you. In reading the testimony that you and Mr. Cosgrove had for us today, and in looking at how you have gone into look at the payments, the fraudulent payments, etc., in working with the States, have you all looked at the TennCare payment structure for Tennessee as you have audited the different states?

Ms. YOCOM. We have looked at Tennessee with regard to the actuarial soundness requirements for Medicaid managed care but we haven't done an intensive look at the rate-setting methodology itself.

Mrs. BLACKBURN. OK. Thank you. I would be interested at some point when you all do that to know if you do look at that methodology, and since it is one of the early waiver programs and is kind of the test case for what is now Obamacare or managed care, I would be interested to see what you found. I know what my experience was as a Tennessee State senator and how the program failed to live up to what the promises were.

Going back to Mr. Terry's question, you mentioned some of the core elements that were needed for some fiscal soundness. Are you looking at implemented new technologies that will help with the

tracking and the payments and the disbursements and there is a way to put some more transparency into this process? Either of you.

Ms. YOCOM. I want to make sure I understand. In terms of the review of payments within CMS and HHS?

Mrs. BLACKBURN. Correct.

Ms. YOCOM. There is, I think it is called IDR, and then 1–PI, one program integrity, which is a set of electronic review systems that look at claims overall in an attempt to combine them. This is important with respect to Medicare and Medicaid to get those claims in one place so they can do reviews and look for indications that there could be improper payments.

Mrs. BLACKBURN. Patterns?

Ms. YOCOM. Yes, patterns.

Mrs. BLACKBURN. All right. And is that widely used?

Ms. YOCOM. It is being used on the Medicare side. Medicaid is not yet up and running. We do have recommendations aimed at CMS putting a plan in place to make this more broadly available.

Mrs. BLACKBURN. What kind of timeline is that installation moving forward on?

Ms. YOCOM. I think one of our—I am pretty sure that one of our recommendations has to do with CMS developing a timeline. I do not believe at this point they have one.

Mrs. BLACKBURN. OK. Thank you for that.

Mr. Cochran, I want to come to you on the co-op program that was established under PPACA. OMB says they expect that the taxpayers may lose $370 million in this program from unpaid loans to nonprofit insurers. The estimate is that as many as 50 percent of the loans issued under this program may not be repaid. Are you familiar with these estimates?

Mr. COCHRAN. I am not immediately familiar with the particular numbers you cite. We have them but I am familiar with the role and the process that OMB goes through for all loan programs to estimate a default rate that they use as a way of scoring the overall cost of the program. That then enables HHS to determine the number of loans that can be made within the appropriation that Congress provided.

Mrs. BLACKBURN. Well, how can you know that you have them but you are not familiar with them when you are talking about a program that is expected to lose money? How can you be so dismissive of that? I mean, does that not concern me?

Mr. COCHRAN. It was not my intention to be dismissive. I just don't want to misquote numbers that I don't have in my head, but I do know OMB plays a key role in setting those default estimates, which then informs HHS on the number of grants that can be made within the appropriation that is provided.

Mrs. BLACKBURN. OK. Then let me ask you the question this way. How does stewardship of the taxpayer dollar figure in to the decisions, the departmental decisions, on the loans that you are going to approve or disapprove through this co-op program?

Mr. COCHRAN. Well, we work with OMB on the establishment of that rate to determine what the default rate would be in order to——

Mrs. BLACKBURN. So you are accepting of the premise of default?

Mr. COCHRAN. In every program, there is some portion that for, you know, a variety of reasons——

Mrs. BLACKBURN. OK. I am out of time. Can I ask Mr. Cosgrove to follow up on this?

Do you all have any advice for best practices or due diligence that would help them? I find it a little bit perplexing that I have a department with a trillion-dollar budget. You are flying all over the world. OMB says your loan program is set up to lose $370 million, and you work with them to set a default rate and it seems like that that is kind of standard operating procedure. Are we missing something in this, Mr. Cosgrove? Do you have any guidance that you would provide to him for how they could go about not planning to fail? I want you to succeed when you are dealing with taxpayer money but let us not plan to fail.

Mr. COSGROVE. I am leery about providing any explicit guidance. This is something that we haven't looked at before. We would be happy, but we haven't looked at it, so——

Mr. STEARNS. The gentlelady's time has expired.

Ms. Christensen, are you ready, or do you want me to take one more on the right side?

OK. I recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Clearly this is one of the most important hearings we will have all year. All of this information is important. I will never get to all the questions I have. I am going to submit some in writing, and Mr. Cochran, I trust that we will get those answers in a timely fashion. It is extremely important that we do. We have got some big decisions to make.

In your testimony, you talked about unobligated balances, and I must tell you, I am concerned about that concept of money that was not spent for what it was intended and now we are using it just within the agency. And the reason it concerns me is, I don't know precisely what the discretionary appropriation was but for the past 3 years it has been about $60 billion to $70 billion a year, so we are looking at a figure around $200 billion. You received money in the American Recovery Act? Is that right? In the stimulus bill?

Mr. COCHRAN. HHS, yes, received——

Mr. BURGESS. How much?

Mr. COCHRAN [continuing]. Appropriations in the stimulus bill. The largest——

Mr. BURGESS. Well, the aggregate number. It was well over $100 million, was it not?

Mr. COCHRAN. Yes. Some of the major portions——

Mr. BURGESS. OK, $100 million, and in the Affordable Care Act, there was pre-program money coming to HHS for implementation, so is it fair to say another $100 million in the Affordable Care Act? We are looking at half a trillion dollars in discretionary appropriations to HHS in the last 3 years. That is to say nothing of the mandatory money that you get to administer—to pay for the programs at Medicare and Medicaid.

So this is an enormous amount of money that this agency has, and again, the concept of reprogramming money just bothers me. Either that should offset your next year's appropriation or it should

be paid back to the federal Treasury to pay down the year's deficit. Why doesn't that happen?

Mr. COCHRAN. That is what we are doing with the balances. My reference to using balances as a way to reduce the amount of new resources requested from Congress is specifically in areas where Congress provided them for a purpose and we are using those balances for that purpose.

Mr. BURGESS. Here is the problem that we have. It was pretty much in evidence on this travel question that came up. Look, I get the fact that if the CDC did not go over to Geneva and literally run the World Health Organization, an outbreak of a deadly disease could be a serious problem on American soil, so I get the fact that that is important. But we have no level of detail. When we ask for your travel, here is this volume of dollars that is given. We really need the breakdown. How much travel was for CDC, how much was for HRSA? HRSA has got no business going other places in the world, so if they have an international travel item, that may be a red flag that this committee would want to know. And I am not picking on you because this has been a historic problem in Health and Human Services and the EPA, trying to get the level of detail in a budget, a balance sheet, that any private corporation could provide us if we were to ask it of them. You guys can't do it, and I have this discussion with Mr. Larsen at CCIIO. We need a level of detail when we ask for budgetary information, so I am going to ask you, I don't expect you to have it today but I am going to ask you for the budgetary, the line item budgetary information on these reprogrammed or unobligated funds and whether they were stimulus monies, PPACA monies or just regular discretionary appropriation monies because, again, we can't know how to help you until we really understand where the problems are.

Now, Ms. Yocom, you made a statement about the improper payment rate as high as it is now. How many dollars are we talking about in this improper payment rate?

Ms. YOCOM. I am not sure I can give you a specific——

Mr. BURGESS. Well, get one for me because I would like to have it, because this improper payment rate makes a big difference. We are struggling with what to do with the Sustainable Growth Rate formula. We would like to be able to offset that. If there is a 10-year budgetary window that equals or surpasses the amount of money it would take to place the Sustainable Growth Rate, we could solve a huge problem in Medicare, a huge problem for HHS. Why can't we have that information so we can solve that?

Now, you referenced also the concept of, or I guess, Mr. Cosgrove, it was you when you talked about a red flag when billing reaches atypical levels. Did I hear you right when you said that?

Mr. COSGROVE. That is correct.

Mr. BURGESS. So in other words, when the money going out the door is just clearly a red flag or an outlier, CMS should be able, or HHS should be able to say, uh-oh, we have got a problem here. Is that correct?

Mr. COSGROVE. That is correct. We are recommending that they increase their ability to look for patterns so that——

Mr. BURGESS. OK. Here is a pattern for you. More money spent on cosmetic braces in the State of Texas in Medicaid dollars than

the rest of the country combined. How is that not a red flag? What are all these great metrics that have been put in place and you didn't catch this? This was 2 or 3 weeks ago. These guys are laughing at you. You have got to do a better job with this.

I know my time is expired, Mr. Chairman. I hope we will have an opportunity to go to a second round because this information is so critical, but I know Ms. Christensen just got here so I will yield back.

Mrs. BLACKBURN [presiding]. The gentleman yields back.

Ms. Christensen, you are recognized for 5 minutes.

Dr. CHRISTENSEN. Thank you, Madam Chair.

We all recognize that we are in fiscally challenging times and the responsibility to ensure that we are making financially sound decisions is shared by all of us. But when it comes to health and health care, making financially sound decisions is more complicated than just slashing budgetary line items based on a price tag without any consideration really given to the long- and even the short-term economic consequences of those decisions.

So Madam Chair, if we want to talk seriously about decreasing the long-term health care spending, we should talk about the cost controls in the Affordable Care Act and how we can build on them. So I would like to ask the witnesses some questions about just how we do that.

Mr. Cosgrove, with a system that truly rewards doctors, for example, for quality and which decreases financial incentives to deliver unnecessary care, would that decrease Medicare costs?

Mr. COSGROVE. That is definitely the direction that we need to be moving in. Right now, we have a system that pays for volume of services, and the more providers do and the more expensive the services they provide, the more they get paid, and that is the wrong incentive.

Dr. CHRISTENSEN. Right. Thank you. And the Affordable Care Act takes a big step in that direction with a number of delivery system reforms in order to make Medicare and in time the broader health care system pay for value. It develops accountable care organizations so Medicare will pay one provider to coordinate all of a senior's care rather than paying many providers, no matter what the cost. It experiments with bundled payments so that Medicare would pay a lump sum for quality care rather than separately for each treatment. Also, within the Affordable Care Act, it implements the Independence at Home Demonstration Project to bring home-based primary care to some of Medicare's sickest and most frail seniors who are unable to make it to a doctor's office.

Mr. Cochran, these delivery systems reforms in the Affordable Care Act, are they projected to reduce the growth of Medicare expenditures?

Mr. COCHRAN. Yes. The——

Dr. CHRISTENSEN. The accountable care and——

Mr. COCHRAN. Yes. There are a number of quality provisions in the Act, there are payment reforms in the Act, there are program integrity reforms in the Act. That on total I believe CBO extended the Medicare solvency from 2016 to 2024.

Dr. CHRISTENSEN. Right. In fact, the Congressional Budget Office has estimated the Affordable Care Act will reduce the federal def-

icit by $210 billion this decade and more than a trillion in the following 10 years, and these are significant cost savings. We should be talking about how we can build on them instead of repealing the Affordable Care Act as the House Republican budget does.

And Mr. Cochran, can you talk about what CMS is doing to make Medicare more efficient and save federal dollars?

Mr. COCHRAN. There are a number of things that CMS is working on in the area of quality, there is the national initiative known as Partnership for Patients that is designed to improve safety and reduce readmissions, which both improves the quality of health as well as saves costs. There is a value-based purchasing effort to reward quality and efficiency in hospitals as well as public transparency efforts to provide more information about quality for nursing homes and other providers as well as accountable care organizations that are just being launched to encourage coordination and preventive care and bring down costs and improve quality.

Dr. CHRISTENSEN. Thank you.

These are all important steps, Madam Chair. These reforms all have one thing in common. They save taxpayer money and improve the quality of care without shifting costs to seniors or eroding the core basic benefits of the Medicare program, and in this way they stand in sharp contrast to the Republican budget. There is always a right way and a wrong way to cut the federal budget and reduce health care costs, and the Republican budget is exactly the wrong way.

Mr. Cochran, I think I have a little more time. I wanted to ask you another question. The Joint Center for Political and Economic Studies released a report a couple years ago that found that eliminating racial and ethnic health disparities could save the Nation $1.24 trillion in direct and indirect medical costs over a 3-year period. In your testimony, you mentioned that one of your many responsibilities was to investigate a mix of investments that would improve the health and wellbeing of the Nation in a cost-effective manner. So given the extremely high costs to absorb every year that racial and ethnic health disparities are not eliminated, don't you think that the national strategy that the Department of Health and Human Services has developed and is implementing right now is another component that would help to achieve the larger objective to improve the health and wellbeing of the Nation in a cost-effective manner?

Mr. COCHRAN. Yes. The work that the Office of the Assistant Secretary for Health and some of our key operating divisions are doing both to develop and implement the strategy is important as is the investments that the President's budget proposes in key areas including the Indian Health Service that I mentioned earlier, the Ryan White HIV/AIDS program including for drug treatment as well as a number of programs across HRSA and CDC that target those populations that are most vulnerable.

Dr. CHRISTENSEN. Thank you.

Thank you, Madam Chair.

Mr. STEARNS. And I recognize for 5 minutes the gentleman from Louisiana, Mr. Scalise.

Mr. LOUISIANA. Thank you, Mr. Chairman. I appreciate you having this hearing as we have had a number of hearings on the budg-

ets of the various agencies and things we are trying to do to control spending in Washington, and unfortunately, we don't have enough people in Washington that are serious about controlling spending and that is why we have got over a trillion-dollar deficit again, and so I think it is important that we look at the budget and scrutinize it and ask some of the questions that our members have been asking.

Mr. Cochran, HHS has requested a billion dollars in additional funding to implement the President's health care law, and that is in addition to the billion that has already been appropriated for implementation when it was originally enacted in March of 2010. First of all, why the need for an additional billion dollars on top of the billion that was already in the original bill?

Mr. COCHRAN. The original bill does include a billion, and the Congressional Budget Office initially estimated that it would cost roughly $1 billion per year to implement the Act. We have to date obligated roughly half of that billion dollars. The 2013 budget projects using the remainder this fiscal year in 2012 and the investment in 2013, and the proposed increase within the Centers for Medicare and Medicaid Services is to continue that effort. A major component within that request is to launch the health insurance exchanges, and there is a need for investments in 2013 in order to launch the exchanges in 2014 after which time they largely become self-sustainable.

Mr. SCALISE. So where did you get this billion dollars from? Did you just redirect it from other parts of the HHS budget? You had a billion dollars that was literally just lying around to go and take and move to to put in the area of the funding for Obamacare that was under, I guess underanticipated?

Mr. COCHRAN. The original billion that was in the Affordable Care Act or the billion——

Mr. SCALISE. The additional billion, the additional billion dollars that has been requested.

Mr. COCHRAN. So in formulating the annual budget, we go through each operating division and we work closely with the Office of Management and Budget to identify savings both to reduce the deficit overall but also to fund priority areas. We have identified roughly $2 billion in savings across HHS in our discretionary budget, which enabled us to invest proposed investments in the Indian Health Service, biodefense preparedness as well as CMS.

Mr. SCALISE. Have you all ever thought about investing in reducing the deficit if you have got too much money in your budget and you have gone through and you have identified areas where you can savings? You know, because one of the things I am looking at, the President issued an Executive Order directing you all to establish a plan to reduce 20 percent below 2012 levels for costs associated with travel, employee information technology, printing, other things, and from what we are looking at here, the quote, unquote, savings that you identify here, it looks like you are using those to spend in other areas to absorb cost increases. So are you actually saving in terms of reducing the deficit or just moving money from one area of your budget to another area of your budget to keep spending at the same levels?

Mr. COCHRAN. The 2013 President's budget includes savings of over $300 billion on the mandatory side by slowing the rate of growth in——

Mr. SCALISE. So not just actual cuts, you are just slowing the rate of growth? You are not actually reducing from prior levels?

Mr. COCHRAN. It is reductions relative to the baseline that CBO establishes and then——

Mr. SCALISE. You know, in Washington, unfortunately, people use a different set of languages than American people use across the country. Our small business owners, families, when they sit at their kitchen table and they say we have to balance our budget, we have to cut because we have less money this year, they don't say well, instead of having a 10 percent increase, we will just spend 5 percent more and call that a cut. They don't call it a cut. A cut means if you were spending $50,000 one year and you got $45,000 the next year, that is a cut. You don't say well, we had $50,000 last year, we are going to get $55,000 next year and so that is a cut because we wanted 60. I know that is kind of chic to use that around here but, you know, people back home don't get it when they hear wait a minute, the agency actually has more money and they are talking about how they reduced spending and they had less money than the proposal from the President's request. It is still more money, and they want to see—again, we are borrowing a trillion dollars than what we are spending.

I want to ask a couple questions as I am running out of time. You know, I think some of the other members had asked some questions about travel and even fleet vehicles. If you can just get the committee the number of vehicles that you have that are assigned to employees that they are able to take home. Can you get the committee that number, how many vehicles HHS has throughout the agency that are allowed to be taken home by employees?

Mr. COCHRAN. I can tell you that across HHS, our Program Support Center carries these statistics and reports there are 4,900 vehicles across HHS. Those aren't all for the purpose of executive travel or vehicles that someone would take home necessarily. They are primarily in the areas for movements of providers in the Indian Health Service.

Mr. SCALISE. I am not asking you to give me the number. If you have the number here right now, that is great, but if you don't have the number, can you get the committee that number, the number of vehicles that are allowed to be taken home by employees?

Mr. COCHRAN. Yes. Well, I can tell you that we have——

Mr. SCALISE. It is a yes or no question. I am just asking if you can get me that number.

Mr. COCHRAN. I will certainly work—I guess my only hesitation is, I am not sure how we have the data in terms of whether it is coded as——

Mr. SCALISE. You are not sure how many people are taking home vehicles?

Mr. COCHRAN. No, we know that there are 4,900 vehicles. We will do our best to provide the information you are requesting.

Mr. SCALISE. And if you can do the same thing on—we have talked about travel a bit and looked at the numbers on inter-

national travel. Can you give me within the travel budget how much was spent on first-class travel? Because there have been some outside reports that have looked at tens of millions of dollars in cost savings we can achieve just by having government employees when they are flying on the taxpayer nickel to fly coach, not economy, not business class or first class. And so if you can give me the amount of money that is spent on either first-class or business-class travel? Is that something you can get to the committee?

Mr. COCHRAN. We will work toward that. Travel overall, we are reducing by 17 percent, and the vast majority of travel is coach now. I don't know that there is much first class or business class.

Mr. SCALISE. We have seen some outside agencies have looked at, some outside groups have looked at this and seen tens of millions of cost savings that they could achieve, and I am sure your agency is one like most agencies that have the ability to do that. I am just asking if you can get us that information.

Mr. STEARNS. The gentleman's time has expired.

Mr. SCALISE. Thank you, Mr. Chairman. I yield back.

Mr. STEARNS. If you could accommodate him, that would be helpful.

We are going to do a second round of questioning, and I will start out. Mr. Cochran, there is a Health and Human Services Executive order. It is 13589. It proposed just under $900 million in cuts to administrative expenses. Is that true? Does that ring a bell?

Mr. COCHRAN. Yes, sir.

Mr. STEARNS. OK.

Mr. COCHRAN. The HHS target is $876 million.

Mr. STEARNS. OK. And it is noted in the budget of fiscal year 2013 that "agencies are redirecting some savings to absorb other cost increases and fund priorities activities." Isn't that correct?

Mr. COCHRAN. In some areas, our budget requests have come down——

Mr. STEARNS. Yes or no to that statement. Is that correct, that you in fact in your opening statement said, "We are seeking opportunity to make investments today that will yield greater returns in the future such as the health care fraud and abuse control system has returned"—in other words, what I am saying is, that you have indicated that your agencies are redirecting some savings that you find here elsewhere. Isn't that true?

Mr. COCHRAN. In some cases, that is correct. In other cases, we have reduced agency budgets, and that was made possible by——

Mr. STEARNS. OK, but in some cases—you are—OK. So I guess what we are concerned about that are you taking this Executive Order 13589 where you have roughly $900 million in savings or cuts in administrative expenses, are you considering that savings that you are redirecting elsewhere into other government programs? Is that true? Is that what is happening?

Mr. COCHRAN. In some areas, take, for example——

Mr. STEARNS. So the answer is yes?

Mr. COCHRAN [continuing]. Where we are investing that——

Mr. STEARNS. So the answer would be yes? Some would be yes, in some cases you are taking the so-called cuts and you are funneling them into other areas and you are considering them savings that you can use elsewhere. I am just trying to show to the com-

mittee here that the impact of these cuts are going to obviously be significantly less if you take that $876 million that you are saving in administrative costs and you are funneling it into another program, there won't be any savings.

Let me move on to the next question. You are aware that Health and Human Services has the most highly paid civil servants anywhere in the federal government? Would that be yes? Would that be true?

Mr. COCHRAN. Health and Human Services is subject to the same general schedule rules——

Mr. STEARNS. Well, let me just say, the fact is, you have the most highly paid civil servants anywhere in the federal government. For example, over 90 of the 100 most highly paid civil servants anywhere in the federal government work for Health and Human Services and these 90 are capped at $375,000 a year. Isn't that true? The cap is $375,000 a year?

Mr. COCHRAN. That is in reference to a specific, what is called Title 42 authority.

Mr. STEARNS. The answer is yes, they have a $375,000 cap. That is true. That is correct, isn't it?

Mr. COCHRAN. Under one specific authority. Most agency employees are under the——

Mr. STEARNS. And over 650 of the federal government's 1,000 highest paid civil servants work at Health and Human Services and its component agencies. Isn't that true?

Mr. COCHRAN. The majority of Title 42 employees that are under a different authority for a different salary level are at the National Institutes of Health and they are scientific—they are primarily scientific positions in——

Mr. STEARNS. Well, we have them including—these high-paid salary people are CDC, FDA, the Indian Health Service and NIH. Isn't that true where most of these highly paid civil servants are? Isn't that true?

Mr. COCHRAN. Yes, the largest number are at NIH. You referenced the Indian Health Service. There are some providers, medical doctors——

Mr. STEARNS. And in 2009, more than 530 NIH employees appear to have earned salaries of over $200,000 and above, and that is more than the President's own Cabinet. Isn't that true?

Mr. COCHRAN. Under this particular authority. The vast majority of HHS employees are under the same system.

Mr. STEARNS. So I think the dichotomy here is that the Cabinet officials are getting less than 530 of NIH employees, and then if you look at the salaries of these 90 of the most highly paid, which have a cap of $375,000, you see that these people are getting well paid even compared to some of their colleagues here, not to mention how they are well paid compared to the private sector.

My last area of concern here is the—let us see. We have the Health Reform Implementation Fund. The President proposed an additional $1 billion in discretionary funding for the implementation of the PPACA through the Center for Consumer Information and Insurance Oversight at CMS. As of January 31st, we have some figures here that stop at January 31, 2012. I guess the ques-

tion is, can you update this graph to take us up further beyond January 31st?

Mr. COCHRAN. Yes, sir.

Mr. STEARNS. OK. Mr. Cochran, how has CMS used its resources from the implementation fund since January? Can you tell us that? Although we don't have the data, can you just maybe bring us up to speed on how much of the fund remains?

Mr. COCHRAN. Of the billion, $471 million has been obligated as of February 29th. Some of that is for personnel. More of it is for contractual services and the expenditures have been for closing the Part D coverage gap, one of the key provisions in the Act, as well as developing the new value-based purchasing models for Medicare providers that we talked about earlier as well as helping plan and prepare for the establishment of the State and federal exchanges.

Mr. STEARNS. All right. My time is expired.

Ms. Schakowsky is recognized for 5 minutes.

Ms. SCHAKOWSKY. I wanted to just set the record straight on a couple of things.

Regarding the salaries under the Title 42 program, Dr. Harold Varmus, the Director of NIH under the Bush Administration, who now runs the Sloan-Kettering Cancer Center, said, "If we don't pay enough to keep the best, we condemn ourselves to mediocrity." So my understanding, Mr. Cochran, is, we are trying to at least keep competitive to hire scientists that are required to have doctoral degrees in order to receive those high salaries. Is that not true?

Mr. COCHRAN. Yes.

Ms. SCHAKOWSKY. I also wanted to put into the record, Mr. Chairman, this is an article from Healthwatch, the Hill's health care blog, "House Republicans who say taxpayer funds went to spay and neuter dogs in Nashville have the story wrong. There was a spay and neuter clinic but it was funded by a Touchmark charities grant to the Nashville Humane Association," said Alisa Haushalter, whose job includes directing a federally funded program in the city known as the CPPW. That is the one you were referring to here.

So maybe the entire program—it says, "As a partnering agency, we would have had staff members that were there greeting people at the event and so forth but the funding was not from us." So I would like to put that in the record.

Mr. STEARNS. By unanimous consent.

[The information appears at the conclusion of the hearing.]

Mr. STEARNS. We will also, if you have no objection, put in these two flyers that I have given you, the one on the temporary veterinarian clinic initiative as funded in part by the Department of Health and Human Services as part of the Metro Public Health Department's Community Putting Prevention to Work campaign, which shows and corroborates that, together with these two web pages, which also corroborate. We will put both of them in by unanimous consent.

Ms. SCHAKOWSKY. OK.

[The information appears at the conclusion of the hearing.]

Mr. STEARNS. So ordered.

Ms. SCHAKOWSKY. I wanted to talk about the Republican budget priorities and women. From Medicare and Medicaid to the Preven-

tion and Public Health Fund, HHS is responsible for programs that millions of women rely on for critical health care needs, and I want to talk about some of the drastic changes to these programs that my Republican colleagues have recently endorsed through the budget and appropriations process.

The House Republican budget would turn Medicaid into a block grant, repeal the important new benefits under the Affordable Care Act and cut federal funding for Medicaid by a staggering $1.7 trillion over the next decade.

Mr. Cochran, am I correct that Medicaid covers more than 40 percent of all births in the United States?

Mr. COCHRAN. I don't have that statistic with me but that sounds roughly correct.

Ms. SCHAKOWSKY. And so what Medicaid does is, it offers a solution for low-income pregnant women who can't afford private insurance by covering maternity and prenatal care. Dramatic cuts to the program truly would have a disastrous effect on women and their children.

The Medicare program also provides important benefits for women. Mr. Cochran, am I correct that 56 percent of all Medicaid beneficiaries are women?

Mr. COCHRAN. That sounds correct. Again, I am sorry, I do not have that data with me.

Ms. SCHAKOWSKY. Well, the House Republican budget ends the guarantees we have made to our seniors by turning Medicare beneficiaries over to private insurers. It shifts costs to seniors. In fact, CBO has said that by 2030, beneficiaries could pay up to $2,200 more because of these changes, disproportionately falling on women because they have longer life expectancies.

I am looking at you, Mr. Cosgrove. Did you want to say something in this regard?

Mr. COSGROVE. No, I am simply acknowledging the fact that women do tend to live longer and so especially on the Medicare program you do expect to see more women, more older women.

Ms. SCHAKOWSKY. Thank you.

Mr. Cochran, can you tell us the purpose of the Prevention and Public Health Fund?

Mr. COCHRAN. Yes. The Prevention and Public Health Fund, the primary purpose is to support programs, activities, interventions at the State and local levels to prevent chronic disease, to reduce the use of tobacco, prevent obesity, help communities target health issues in their area. It is also being used to support childhood immunizations as well as some activities in the infectious disease area like hepatitis C.

Ms. SCHAKOWSKY. And isn't it also true that $140 million of the fund goes toward breast and cervical cancer screening services?

Mr. COCHRAN. As proposed in the 2013 budget, the fund will support those activities, yes.

Ms. SCHAKOWSKY. Which would help pay for 326,000 women to get breast cancer screening and for 284,000 women to get cervical cancer screenings and Republicans are voting to take it away.

And Mr. Chairman, I would just say this is a sad example of how the Republican budget is dangerous for women, and I yield back.

Mr. STEARNS. The gentlelady yields back.

The gentlelady from Tennessee is recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And Mr. Cochran, I wanted to come back to you, if I could. In my opening statement, I mentioned that I wanted to hear from you regarding the steps that you all had taken to comply with the President's call for agencies to identify $100 million worth of savings. Are you able to articulate that list or do you have a list?

Mr. COCHRAN. Yes—at that time we identified savings in the area of data centers at CDC and FDA as well as the migration from paper to electronic filing primarily at FDA as well as at CDC and ACF. In addition, we have subsequently identified——

Mrs. BLACKBURN. Hold on just a moment there. So you have identified CDC, FDA and the paper to electronic filing. So what portion, how much money from each of those?

Mr. COCHRAN. Well, for the President's Executive order in these administrative areas, we are reducing spending by 21 percent.

Mrs. BLACKBURN. And the budget was increased how much prior to your making this reduction?

Mr. COCHRAN. The 2013 budget, it is a decrease of $218 million. It is roughly flat on the discretionary spending.

Mrs. BLACKBURN. Your 2010 budget and the stimulus funding was a good percentage. I will get that number for you so that you have it. I don't have that exact number in front of me. So if you could submit in writing the answers to those, that list, that would be very helpful for us. We want to be able to see what you all have done to actually make these spending reductions and to live that.

One other question for you along the same line. We are working through reconciliation looking at the sequestration and reconciliation, so what are you all at HHS doing to prepare for reconciliation and the reductions that are going to come?

Mr. COCHRAN. Well, prepare for reconciliation or for sequestration? For sequestration, the Administration's position is that the 2013 budget provides specific savings proposals that if enacted would enable us to achieve the reductions to the deficit without relying on sequestration.

Mrs. BLACKBURN. OK. So you feel like you are ahead of the game?

Mr. COCHRAN. Well, the President's proposals overall, including HHS and other departments would enable savings with specific reductions——

Mrs. BLACKBURN. Let us do this. Why don't you submit in writing what you all are doing to make preparations to meet the sequestration numbers and to meet the reductions that we are going to continue to bring forward? May I remind you, you are an agency that as we read your reports and as we hear from your Inspector General, who should be here with us today and is not, and as we listen to GAO, it is very evident to us that you all are too big to manage. You have gotten too unwieldy. You are into areas where you should not necessarily be. You are spending money in ways that you should not, ought not to be spending it, and it is our responsibility to come back and to exercise some oversight on that. That is what we are doing here today.

And I know that maybe you weren't provided all of the information that you needed to have to handle this hearing today but even

if you were not properly given the information, with all due respect to you, let us just be sure that we submit all of this writing because it is something that it is important to us. It is important to our constituents. It is important to the hospitals and to the providers that serve all of these individuals that walk through their doors every day wanting health care and we come up here and we talk to you all and we see a lot of the money that ought to be going out there to individuals, to enrollees, to the health care system is spun up, tied up, wadded up over here in HHS and it is something that we want to get our hands around and help you all be more efficient and do a better job for the taxpayers, and I yield back.

Mr. STEARNS. The gentlelady yields back.

Ms. Christensen, I am glad you are here. Thank you. You are recognized for 5 minutes.

Dr. CHRISTENSEN. Thank you, Mr. Chairman.

Before I ask my questions, Ms. Yocom and Mr. Cosgrove, I wanted to just highlight on page 5 part of your testimony on aligning coverage with recommendations of the U.S. Preventative Services Task Force. I am sure you are aware that there have been several recent recommendations coming from that task force that not only I but others consider questionable, and they don't take into account some of the outlying groups like racial and ethnic minorities. For example, in the breast cancer recommendations, black and Jewish women are at risk for breast cancer at early ages, it didn't seem to take that into account. And it didn't take into account the high prostate cancer incidence in African American men with their recent prostate screening recommendations. So at least think that to tie reimbursement too tightly to all of their recommendations can be harmful to some groups in our population and will deny them access to some needed care because they won't be able to afford it. So I don't know how you address it but I wanted to call your attention to that because some of their recommendations are very questionable and really don't take into account the entire population in the United States. Go ahead.

Mr. COSGROVE. I just wanted to say that CMS has the authority to consider the recommendations of the task force when they are making coverage decisions. We didn't independently—because of that authority, we didn't independently go on and have experts that would look behind the task force recommendations.

Dr. CHRISTENSEN. But you still recommended CMS provide coverage for task force recommendation services, you do say as appropriate.

Mr. COSGROVE. Correct.

Dr. CHRISTENSEN. OK. Thank you.

But, you know, I listen to my Republican colleagues, and HHS houses agencies that Americans rely on every day to protect their health and keep them safe like the FDA, National Institutes of Health, Centers for Disease Control. The House Republican budget would result in drastic cuts and undercut the essential functions of these agencies, and I want to explore some of those implications of those cuts.

So Mr. Cochran, my understanding is that the Republican budget would make across-the-board cuts in discretionary spending. Is that correct?

Mr. COCHRAN. There are across-the-board cuts associated with sequestration that CBO estimates roughly 8 percent——

Dr. CHRISTENSEN. But they are going beyond that.

Mr. COCHRAN. The House budget resolution does set spending levels not specific to HHS but government-wide that are below those established in the Budget Control Act for 2013 and 2014.

Dr. CHRISTENSEN. And I am correct that this discretionary spending is what provides a significant amount of budget to the agencies like the Food and Drug Administration, NIH and our new Institute of Minority and Health Disparities and CDC?

Mr. COCHRAN. Yes. The majority of resources for our discretionary agencies outside of the entitlements is regular budget authority. Almost all of NIH's budget is provided that way. FDA is supported by a combination of budget authority and user fees.

Dr. CHRISTENSEN. So to single out just one, can we talk about what FDA's essential functions are? Can you tell us about what their essential functions are?

Mr. COCHRAN. Yes. FDA's mission is to protect the public's health by ensuring the safety, the efficacy, the security of human as well as veterinary drugs. They work on biologics and devices. They also work to protect the U.S. food supply. They are having new responsibility over the regulation of tobacco products to reduce youth smoking. And they are working to accelerate the review and approval of medical countermeasures to protect the public against bioterrorism attacks.

Dr. CHRISTENSEN. Right, and these cuts would jeopardize the safety of our drugs, our vaccines and medical services. And then at NIH, the center of U.S. medical research, one of the greatest research institutions in the world, but that Republican budget would mean that NIH would have less money available for cutting-edge research into breast cancer, HIV, Alzheimer's and others and health disparities.

So how much funding does NIH currently receive to conduct scientific research?

Mr. COCHRAN. NIH's budget is $30.7 billion.

Dr. CHRISTENSEN. Thank you. And we know that that money is well spent. As a matter of fact, I believe it is level funded in 2013 and that does not allow them to really make the kinds of research investments that they need. Their studies have led to development of the MRI, how viruses cause cancer, the mapping of the human genome with all that is going to lead to, and they boost our economy through medical breakthroughs. According to one study, for every dollar of public funding for scientific research, the drug industry gets a $3 return. So deep cuts to NIH would be an irresponsible fiscal decision.

So I appreciate your helping to explain the impact of the Republican budget, not just on Medicare and Medicaid but on other important government programs. So thank you for your testimony and your answers.

Mr. STEARNS. I think to the gentlelady, I would say that we are trying to control the budget. We will have to do some cost cutting somewhere if we are going to do that.

The gentleman from Texas, Dr. Burgess, is recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

I do want to go on record as saying there has been no bigger critic of the Title 42 program than myself, but I understand the necessity of having a Title 42 program. If we have the best virologists on the face of the earth, we want to be able to pay him or her an amount commensurate with their ability. If we have the person who sequenced the human genome working at NIH, we want to be able to pay him or her to a degree commensurate with their ability. But we don't need to be paying entry-level biologists and chemists, and I won't say that HHS has been as guilty of that as EPA has been over the years but it just points out that this committee must have oversight. If we are willing to spend more money to have top researchers in their field, we must have oversight into how those dollars are spent.

Off the editorial statement now. Let me just ask a question, Mr. Cochran. Dr. Christensen is very critical of the budgetary process. It is OK within her purview to do that. You may have heard or read in the papers the Supreme Court heard oral arguments about the Affordable Care Act at the end of March. Did you read about that?

Mr. COCHRAN. Yes, I am aware.

Mr. BURGESS. And then there was a lot of chatter afterwards that maybe something might happen to the Affordable Care Act. Can't know, won't know for another 6 weeks. But are you doing anything within your agency to prepare for the Supreme Court voiding a portion or all of the Affordable Care Act?

Mr. COCHRAN. The HHS again principally the Centers for Medicare and Medicaid Services as well as other components are focused on implementing the Act, which is the law of the Congress.

Mr. BURGESS. Focused? They are going on light speed. I am sorry. Continue on.

Mr. COCHRAN. I mean, I will stop there. That is where we are putting our attention is to carry out——

Mr. BURGESS. So there are no contingency plans, what if this thing gets struck down by the highest court in the land?

Mr. COCHRAN. The focus is on implementing current law.

Mr. BURGESS. So the answer is no, there are no contingency plans? We are not paying attention to current events surrounding our agency, and if the world comes crashing down around our ears on June 30th, so be it. Is that the impression you wish to give the committee?

Mr. COCHRAN. I wouldn't phrase it that way. I would say that we are——

Mr. BURGESS. I am trying to help you.

Mr. COCHRAN. We are focused on implementing—CMS is focused on implementing the Act that is current law.

Mr. BURGESS. So by inference, there are no contingency plans, and if your world comes to an end, then so be it.

Well, let me just ask you this. We have heard all this great testimony about all the wonderful tools you have under the Affordable Care Act for combating fraud and waste. A lot of this just sound like good management practices, and I suspect a lot of those were going on and we could study GAO reports from previous years and find that many of those things have already been going on. But if

there are specific tools that you were granted under the Affordable Care Act, what happens July 1st if the Affordable Care Act is no more? Do you stop prosecuting fraud in the Department of Health and Human Services? Do you just give up?

Mr. COCHRAN. CMS, our Office of Inspector General, DOJ, they have—CMS, for example, has tools that have been enhanced through the Affordable Care Act but they have been working in this area for a long period and have funding and authorities that preceded the Act.

Mr. BURGESS. So you wouldn't just throw up your hands and say we give up, fraudsters win, we are going to just hand the money over to the crooks, right?

Mr. COCHRAN. This is one of the highest priorities of the Department and it is an area of great focus.

Mr. BURGESS. The loss of the Affordable Care Act would not inhibit your abilities to fight fraud. Is that correct? Is that a fair statement?

Mr. COCHRAN. The law provides CMS with additional authorities that have enabled them to—that are enabling them to do a better job.

Mr. BURGESS. If I may, you wouldn't grind to a halt on July 1st or 2nd if the Supreme Court so rules?

Mr. COCHRAN. There are authorities and funds that precede the Act, and it is a major area of focus, a major priority for the Department.

Mr. BURGESS. Again, suffice it to say, fraud enforcement is not going to go away if the Affordable Care Act is struck down by the Supreme Court. You and I don't know the answer to that at this point so it is obviously a point of some conjecture.

What is not a point of conjecture is the sequestration that is going to happen. I have to tell you, I was a little disturbed by your answer to Representative Blackburn's questions about sequestration. You are giving us the impression that the President's budget for 2013 actually included those sequestration cuts.

Mr. COCHRAN. I am sorry, no. The President's budget includes specific targeted reductions that would make sequestration unnecessary to achieve the same end. Sequestration is an approach of across-the-board reductions——

Mr. BURGESS. Sequestration, you can't just say it is not necessary. I mean, it is a law. The President signed it. Surely he remembers that.

Mr. COCHRAN. And the policy of the Office of Management and Budget and of the Administration is to work with the Congress to find specific reductions and avoid an across-the-board approach to finding savings.

Mr. BURGESS. Well, OK. Sequestration starts when? January 1st of 2013? And what are the efforts that are ongoing now in working with the Congress to identify? You have 8 percent of your discretionary budget, if I understand things right. Does that sound right, 8 percent, that you have to cut?

Mr. COCHRAN. CBO estimates, right, just roughly 8 percent would be not just—but across discretionary spending.

Mr. BURGESS. Well, that is a lot more than the reductions that are proposed in the President's budget for 2013, correct?

Mr. COCHRAN. That is correct. The President's budget proposes a mix of—and not just in HHS but government-wide a mix of discretionary reductions, mandatory reductions, and other——

Mr. BURGESS. Well, correct me if I am wrong, but the way the law reads, the law that the President signed is that sequestration comes from HHS, right?

Mr. COCHRAN. No, the law created a committee to find specific savings. Sequestration was a backstop to that. The Administration's position is to——

Mr. BURGESS. That was the Super Committee. They failed. We all got that. They fell to earth. So January 1st, you have to come up with 8 percent in cuts in your agency. How are you proposing to do that?

Mr. COCHRAN. The way sequestration is modeled is to have a strict across-the-board reduction as opposed to the targeted savings that the Administration's budget proposals would——

Mr. BURGESS. And are you preparing for those across-the-board reductions within your agency? You are the Budget Director, right, or the Assistant Budget Director?

Mr. COCHRAN. I am, and the focus is on working with Congress to identify specific reductions as opposed to relying on across-the-board reductions.

Mr. BURGESS. So what specifically have you done to work with Congress? You have got 6 months before this thing kicks in.

Mr. Chairman, I beg some indulgence. You have given other people extra time. This is of critical importance.

Mr. STEARNS. The gentleman asks for unanimous consent for another 30 seconds.

Mr. BURGESS. Would the gentleman please answer the question? What have you done to work with this committee, this Congress in order to avoid that 8 percent across-the-board reduction that you are going to see January 1st?

Mr. COCHRAN. Well, the President submitted a budget in February that has a number of proposals and seeks to work with the Congress to have those proposals be enacted.

Mr. BURGESS. With all due respect, that budget was pure fantasy. It did not garner a single vote in the House of Representatives on either the Republican or Democratic side. I think we are going to have to do better than that. Would you not agree with that?

Mr. COCHRAN. I would agree we have a long way to go and——

Mr. BURGESS. So what is your proposal to work with this committee and Congress to avoid the sequestration across-the-board cuts to identify those areas of savings and/or cuts that can occur?

Mr. STEARNS. The gentleman's time has expired. You are welcome to answer the question, and if you can't, perhaps you could come back and provide us written material.

Mr. COCHRAN. By the way, our jurisdiction is just within the Department of Health and Human Services. We have proposed over $300 billion in specific reductions on the mandatory side as well as specific discretionary reductions. We briefed the Appropriations Committee on the discretionary budget.

Mr. STEARNS. Would the gentleman from Texas like to go a third round? Because we could do that.

Mr. BURGESS. Yes, I would be happy to.

Mr. STEARNS. I am not sure we will all use it, but I think I will take a third round and perhaps the ranking member and then we will come back to the gentleman, and he may not need his full 5 minutes.

I think the point that the gentleman from Texas is making is pretty important here, and I think as the Subcommittee on Oversight, we should have an understanding of what is going to happen with sequestration. The Impoundment Control Act and the Anti-Deficiency Act are going to complicate the budgeting process for your department. I think we all agree. The Act includes two main prohibitions. One, agencies can't spend more money than they have or spend money before they have it, and two, agencies cannot accept voluntary services. On the other hand, the Impoundment Control Act requires that agencies obligate the amount that Congress has appropriated. So in anticipation of the sequestration, what is the Department's plan to prevent violating these two laws?

Mr. COCHRAN. For our discretionary budget, it has in pretty recent history often been the case that at the beginning of the fiscal year we are under a continuing resolution where we don't yet know what Congress will provide for that full year, and in those situations, we operate at a lower level with respect to not releasing all grant funds, and in particular in this case under a continuing resolution in the fall leading up to January would take the same approach.

Mr. STEARNS. Mr. Cosgrove, do you have any comments that you might have relative to the sequestration and what Mr. Cochran has said?

Mr. COSGROVE. I don't specifically. My understanding is that agencies would need instructions from OMB, and those have not been provided, but I am not an expert on the sequestration law.

Mr. STEARNS. Ms. Yocom, do you have anything you might add?

Ms. YOCOM. I don't.

Mr. STEARNS. OK. Mr. Cochran, what percentage reduction amounts of cuts would hit HHS discretionary budget authority, for example, on NIH? Do you have any feel for that?

Mr. COCHRAN. Under sequestration?

Mr. STEARNS. Yes.

Mr. COCHRAN. CBO estimates sequestration would be roughly 8 percent, 7.8 percent.

Mr. STEARNS. And that would be true on CDC too?

Mr. COCHRAN. For the majority of funds, yes.

Mr. STEARNS. FDA?

Mr. COCHRAN. For the majority of funds, yes.

Mr. STEARNS. OK. I think that is going to complete my comments.

Ms. Schakowsky?

Ms. SCHAKOWSKY. Thank you.

I wonder if the gentleman and all those so interested in what HHS is doing to prepare for sequestration are equally as committed to the requirements for the defense budget under sequestration, which have been protested from day one on the Republican side of the aisle and have looked at the Prevention Fund as a way to help avoid cuts on the military side.

All this focus, which I agree, we want to cut all waste, fraud and abuse, we want to be absolutely efficient, and that frankly is why we passed the Affordable Care Act, or as I fondly call it, Obamacare. Is it not true, Mr. Cosgrove or Ms. Yocom, that the projection in savings under the Affordable Care Act is $210 billion over the next 10 years and $1 trillion over the 10 years after that, that repealing it would in fact raise the deficit?

Mr. COSGROVE. CBO did estimate savings associated with passage of the Act. Yes, that is correct.

Ms. SCHAKOWSKY. And at the same time, the Republicans added a $400 billion drug benefit program, unpaid for and with a prohibition that Medicare could even negotiate with the pharmaceutical companies for lower prices and have consistently opposed efforts to reduce the Medicare Advantage overpayments to insurance companies. So I am more than willing to roll up my sleeves with you and with HHS to figure out the ways that we can achieve needed savings in our health care spending but I just really find offensive the selective criticisms. I want to repeat that the travel budget is down from the second year of the Bush Administration, that they see a 17 percent further cut. I don't object to asking for the details but the affect here that somehow there is a disregard for saving taxpayer dollars I think is really misspent. In fact, I think we can look at how the Republican budget would increase Medicare fraud, and I want to ask a couple of questions about that.

The Republican budget repealing the Affordable Care Act, which contains significant new tools for fraud detection and prevention, new resources to fight Medicare and Medicaid fraud, and so while Dr. Burgess was saying you are going to still fight fraud, but doesn't the Affordable Care Act give you new tools to do that, Mr. Cochran?

Mr. COCHRAN. It does.

Ms. SCHAKOWSKY. And what is the typical return on investment for every dollar spent on Medicare fraud?

Mr. COCHRAN. The return on investment for the last 3 years for our health care fraud and abuse account has been 7 to 1.

Ms. SCHAKOWSKY. And would these significant budget cuts and eliminating the new authorities given to HHS to prevent fraud before it happens impact your agency's ability to fight fraud?

Mr. COCHRAN. CMS is finding the new authorities to be helpful in moving away from what is sometimes called a pay and chase and toward being able to suspend payments before they are made whenever there is an investigation of a credible allegation of fraud. The resources that the Act provides are important for not only the work of CMS as well as our Office of Inspector General in our partnership with the Department of Justice.

Ms. SCHAKOWSKY. And the Republicans' budget impact on preventing fraud in the Medicare program would also be profound. The Republican proposal to turn Medicaid into a block grant would result in dramatically decreased federal contribution to State Medicaid programs, a cut of more than $810 billion over the next decade.

Mr. Cochran, wouldn't such a dramatic cut on the federal contribution mean that States' antifraud spending would be increasingly in competition with their spending on patient care?

Mr. COCHRAN. In the context of reduced resources, that tradeoff is—I think it would be logical to expect that sort of tradeoff. The emphasis of the Administration on Medicaid is to find specific reductions and to retain its core function as a specific benefit for low-income populations.

Ms. SCHAKOWSKY. Well, I think this is a powerful example of why the Republican budget is so misguided. It is pennywise and pound very foolish, making cuts that would result in increased Medicare and Medicaid fraud and cost taxpayers more in the long run, and I yield back.

Mr. STEARNS. The gentlelady yields back. She is one of the first Democrats to use "Obamacare" in a way that she is proud of, and I think that is something. I would say to her that the cost savings that she talks about obviously come from the reduction in Medicare by $500 billion.

So with that, Dr. Burgess is recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Cochran, a former Member of Congress, Charles Stenholm, Democrat from Texas, provided what I think is a very useful model, and I really do wish that Health and Human Services would look at this and follow this. He was trying to do with inappropriate transfers of funds within the crop insurance program because he was on the ag committee, and I think the senior Democrat on the ag committee at the time, and it occurred to him, even within his own district that there were crop insurance payouts that were far in excess of what would be expected in the area. So they developed a predictive modeling program with Dr. Bert Little at Carlton State University in Texas, a relatively small State university in Texas, and using this predictive modeling program were able to achieve significant savings in the crop insurance program, and what they found much to their surprise was, once they started looking, the problem diminished, that is, people were willing to perhaps make embellished reports as long as no one paid any attention to them. But when there was seen that in fact there was this increased scrutiny, the numbers dropped.

So I would just suggest that to you. We are all looking at ways to find additional dollars, and again, the gentleman's name is Dr. Bert Little down at Carlton State. The crop insurance program that Mr. Stenholm developed through an earmark when he was in Congress turned out to be enormously helpful and protective of the program.

Now, look, we have had a lot of discussion about a lot of different things. The Supreme Court is going to rule irrespective of the Republican budget. So forget for just a minute about any evil associated with the Republican budget. You have the Supreme Court going to rule. And you are telling me that you won't have the tools you need if the Supreme Court strikes down the entirety of the Affordable Care Act?

Mr. COCHRAN. No, sir. There are important tools that are included in the Affordable Care Act as well as resources for CMS and the Office of Inspector General. There are tools that precede the Act and resources that precede the Act as well.

Mr. BURGESS. Very well, and they will continue to be there and be utilized, and if you need additional authority because the Afford-

able Care Act has vaporized overnight, you will be able to come back to Congress and ask for that authority. Is that not correct?

Mr. COCHRAN. Well, the Administration's focus is on using the tools that are current law to carry that out.

Mr. BURGESS. I get it, but there is a court case out there. You admitted that you had read about it.

Well, what you must be aware of, the law of the land is the Budget Control Act of last August, dreadful piece of legislation, but nevertheless, it is there and it proposes an 8 percent across-the-board. You are developing your budget, your fiscal year 2014 budget now, are you not? You don't want until the last minute to develop that?

Mr. COCHRAN. That is correct. We are just now starting to——

Mr. BURGESS. Are you taking into account that that 8 percent across-the-board hammer is hanging over your head January 1st?

Mr. COCHRAN. We formulated our budgets each year under the guidance that comes from OMB. We typically would get that over the summer. What we are doing now is looking at our performance information, looking at priority areas, identifying where we can find additional savings, and with that, the effort for the 2014 budget formulation will become, you know, more fulsome once we get the guidance from OMB.

Mr. BURGESS. OK. Well, Ms. Schakowsky correctly pointed out how the Pentagon is actively engaged in what it will have to do to deal with sequestration and are there ways to avoid it. We don't hear much out of HHS, and you have got the same sword of Damocles hanging over your head as the Department of Defense.

Let me just ask you this. Going back to the Affordable Care Act, and I know you don't want to think about the Supreme Court, but you have a Medicaid payment rate. In fact, there was a story out today on Politico Probe about the Medicaid payment rate which was just finalized, and it is going to pay Medicaid at the higher rate as authorized by Medicare. Are you prepared if that goes away July 1st? Are you prepared to step up to the plate to do something as far as provider payments in Medicaid or is that just tough luck for the docs?

Mr. COCHRAN. For Medicaid, you mean with respect to the State-federal share?

Mr. BURGESS. No, I am talking about, there was an enhanced payment rate in Medicaid up to the level—in primary care up to the level of as reimbursed by Medicare currently so that there wasn't that discrepancy in the payment rates between Medicare and Medicaid. You guys are going to take are of the docs if this thing goes away?

Mr. COCHRAN. Well, the emphasis for CMS as well as for the Department is to implement what is now current law and to carry out the provisions of the Affordable Care Act.

Mr. BURGESS. You have told me that before. You know, your authority to pay providers under Medicare and Medicaid may evaporate July 1st, according to some AP reports that were out last week. You have got to be having some contingency plans on what do you do to keep the Nation's doctors seeing your Medicare patients after July 1st in the absence of the Affordable Care Act. You just have to.

Mr. COCHRAN. The emphasis of the Department and of CMS is carrying out current law.

Mr. BURGESS. This is the equivalent of taking the Fifth on this issue. You have to be preparing because, I mean, again, I didn't make up this AP report. It bothered me when I saw it as well. I think we should be doing some contingency planning at the committee level. We, after all, are the committee of jurisdiction over these programs but I cannot believe that your agency, that Secretary Sebelius and the Administrator at CMS are not sitting down and at least looking at some black and white numbers of what do we do to take care of our docs if they Affordable Care Act vanishes in the morning dew.

Mr. STEARNS. The gentleman's time has expired.

Mr. BURGESS. May the gentleman provide us a response? You have got to be doing some contingency planning.

Mr. COCHRAN. The focus is on implementing what is current law, and at CMS, analysis that we are doing related to the Act has to do with——

Mr. BURGESS. Mr. Chairman, I am not going to get an answer but what I would like to suggest is that this committee request respectfully from the agency information regarding this, because it is important. If every doctor doesn't get a paycheck July 1st, we are going to be in a hell of a shape. Perhaps we could request meeting notes, emails. There is bound to have been some discussions that have gone on at CMS about what happens the day after the Affordable Care Act is—if the Supreme Court says it is unconstitutional.

Mr. STEARNS. I think that the gentleman is correct. I think the committee can formally request from you what actions your agency intends to take in the event of deferral of budget money because of sequestration, the tools you are going to use. I think that is a reasonable request in the event this occurs. I think your agency should get back to us, as Dr. Burgess pointed out, with some chronology of things and tools you are going to do, because for you to continue to say we are just going to implement Obamacare, it is like he said, you are taking the Fifth, and I think there is a point where Congress oversight, our responsibility under the Constitution, we have a right to ask this and ask what you are going to do. That is what I am requesting formally.

We are going to wrap up this hearing. I have the opportunity to give some closing comments. You mentioned, Mr. Cochran, under Obamacare that Obamacare provides additional funding to fight waste, fraud and abuse in Medicare and Medicaid, I believe, but it is also true that there remains billions of dollars to be saved immediately only if Health and Human Services would simply implement all of the GAO's outstanding recommendations that were in Mr. Cosgrove's opening statement, that are in his written statement that he gave us. So I think before Health and Human Services goes around asking for more money in order to cut waste, fraud, and abuse, we should start with the savings that the GAO has presented here, clearly, abundantly as pointed out, and obviously, in our opinion, and I think it appears to be from the GAO, you have not implemented and responded to those recommendations and you in fact pointed out one of them that you are going to totally disregard in dealing with the bonus program.

So that is the closing statement, and I thank the witnesses for the hearing. We want to put in by unanimous consent this little graph that we put on the slide. Without objection?

Ms. SCHAKOWSKY. Without objection.

Mr. STEARNS. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. STEARNS. And in conclusion, I would like to thank the witnesses and members that participated in today's hearing. I remind members that they have 10 business days to submit questions for the record, and I ask that the witnesses all agree to respond promptly to these questions.

With that, the subcommittee is adjourned.

[Whereupon, at 12:20 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL

Mr. Chairman, thank you for holding this important hearing today. The Department of Health and Human Services is the agency that ensures the health and well being of our nation's citizens. If we do not have a healthy society as our base to build off of, nothing else really matters. If we have a sickly workforce, all the jobs bills in the world won't make a difference. This is why we have and will continue to fund this agency the best we can.

The Department of Health and Human Services is responsible for implementing the Affordable Care Act. An Act that, if taken away, will take away health insurance from 33 million Americans. I realize these are difficult times and difficult decisions have to be made, but the propositions my friends on the other side of the aisle are putting forth are far from solutions, they are not even options. Mr. Ryan's budget, for all intents and purposes, gets rid of Medicare and Medicaid as we know it. I fail to understand how cutting programs that provide health care for those who need it most will save us money in the long run. Foresight does not seem to be a gift that the Republicans who drafted this budget have.

HHS is clearly striving to streamline their budget and save taxpayer dollars. They are working hard to implement recommendations from GAO reports that will achieve savings and reduce Medicare fraud. And HHS is succeeding. Just last week the Medicare Fraud Strike Force took down over 100 individuals responsible for $452 million in false billing practices.

Protecting and improving the public's health are vital goals of HHS and I know they work hard to meet these goals while using taxpayer dollars wisely. It would not be wise for Congress to wantonly disregard their important mission by indiscriminately cutting funding.

THE HILL

Official: No taxpayer funds went to neuter Tenn. dogs

By Elise Viebeck -

House Republicans who say taxpayer funds went to spay and neuter dogs in Nashville have the story wrong, a local public health official involved with the effort told The Hill.

"There was a spay-and-neuter clinic, but it was funded by a PetSmart Charities grant to the Nashville Humane Association," said Alisa Haushalter, whose job includes directing a federally funded anti-obesity program in the city known as Communities Putting Prevention to Work (CPPW).

Republicans on the House Energy and Commerce Committee **targeted CPPW** in a statement Wednesday, saying that the program gave $7.5 million to Nashville, which used the grant to provide "free pet spaying and neutering."

Haushalter said this was not what happened.

"Nashville did receive a $7.5 million grant in March 2010 under the stimulus act, and stray dogs running at large are very much an issue in our city," she told The Hill.

"But the spay-neuter clinic was paid for with a private grant."

"As a partnering co-agency, we would have had staff members that were there greeting people at the event, and so forth. But the funding was not from us," she said.

The Energy and Commerce GOP pointed to **two documents** on recovery.gov, a site that tracks activities under the stimulus bill, that list the spay-neuter clinics in quarterly updates submitted by the Nashville CPPW.

The reports appear to give updates on local public health happenings in general — events Haushalter described as "of interest" to the CPPW's mission — as well as describing the group's activities.

Haushalter said it's understandable why those records could be "misconstrued" to view the spay-neuter clinics as taxpayer-funded.

She said that CPPW reports include all the group's work, "collaborative" and otherwise, and other activities of interest.

"Nashville has been selected for an HBO documentary about 'Obesity in America,'" one entry reads.

"Services ... occurred to provide free spay/neuter and wellness clinics for dogs and cats in order to curb animals running at large," the entry cited by Energy and Commerce Republicans states.

"The spay-neuter clinic was a project that we convened and supported, but that the Humane Association funded," Haushalter repeated.

"We can assure you no taxpayer funds were used."

A **video** by *The Tennessean* dated Feb. 9 appears to support this version of the story.

CPPW "is working on an educational campaign promoting responsible pet ownership, the importance of spay-neuter, proper pet confinement as well as the leash laws in Davidson County," a man identified as a Nashville public health worker told the camera.

"And the Nashville Humane Association, one of our partners, is working on a PetSmart Charities grant that provides free targeted spay-neuter to residents," he said.

Updated at 10:45 a.m. Friday.

Source:
http://thehill.com/blogs/healthwatch/health-reform-implementation/225367--official-no-taxpayer-funds-went-to-neuter-tenn-dogs

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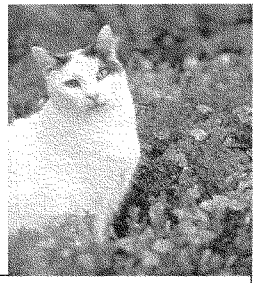

Space is limited and filling up FAST! To secure your appointment, call Nashville Humane Association @ 615-354-6343 today!
***Proof of residence & financial eligibility required**

The Temporary Veterinary Clinic initiative is funded in part by the U.S. Department of Health and Human Services, as part of Metro Public Health Department's Communities Putting Prevention to Work campaign.

GRANTS - AWARD SUMMARY

NASHVILLE & DAVIDSON COUNTY, METROPOLITAN GOVERNMENT OF

The Communities Putting Prevention to Work award is utilized for a community-wide initiative to reduce obesity. By increasing consumption of fruits and vegetables and decreasing intake of transfats, salt and sugary beverages, The Metro Public Health Department, Healthy Nashville Leadership Council, and partners have developed a community action plan that includes the establishment of an organizational infrastructure that is strategic and sustainable, the attainment of a web-based portal for data driven decision-making, and the implementation of multi-level MAPPS strategies designed affect policy, systems, and environmental change.The Metropolitan area continues to face a significant burden of chronic disease, obesity, unhealthy eating, and sedentary living. This award directly provides success for implementation of the plan, sustained engagement of a wide variety of partners, incorporation of health and well-being in decision making, decreases in existing safety barriers, and change in key measures of behavioral risk.
Clarification Of Codes

Choose a quarter and click "Go."
January 1 - March 31, 2012 Go

AWARD OVERVIEW

Award Number	1US8DP002447-01	Funding Agency	Department of Health and Human Services
Total Award Amount	$7,527,527	Project Location - City	Nashville
Award Date	03/19/2010	Project Location - State	TN
Project Status	More than 50% Completed	Project Location - Zip	37203-1511
Jobs Reported	34.28	Congressional District	05
Project Location - Country	US		

RECIPIENT INFORMATION (GRANTS)

Recipient Name	NASHVILLE & DAVIDSON COUNTY, METROPOLITAN GOVERNMENT OF
Recipient DUNS Number	078217668
Recipient Address	1 PUBLIC SQ
Recipient City	NASHVILLE
Recipient State	Tennessee
Recipient Zip	37201-5007
Recipient Congressional District	05
Recipient Country	USA
Required to Report Top 5 Highly	No

Compensated Officials	

PROJECTS AND JOBS INFORMATION

Project Title	Communities Putting Prevention to Work
Project Status	More than 50% Completed
Final Project Report Submitted	No
Project Activities Description	General population - General/Unspecified
Quarterly Activities/Project Description	Nashville's first annual NashVitality Week took place the week of January 15 - 21. Following a proclamation by Mayor Karl Dean declaring NashVitality Week, CPPW highlighted healthy, active and green activities in Nashville, including events: ? King Day of Service ? January 16: Teach-ins were conducted at five of community gardens located in underserved neighborhoods. One of the participating corner stores provided free water and fresh fruit to MLK Parade watchers. ? Health Impact Assessment Workshops - January 17, 20 and 25: Workshops introduced participants to the general concepts involved in HIA, provided in-depth instruction on the process of conducting HIA, and demonstrated the applicability of HIA through case-studies and discussion focusing on local examples. ? Healthy Eating/ Active Living (HEAL) Summit - January 18: The 3rd annual summit hosted local and national community health experts in a dialogue on how health impacts communities across the country, and how it directly affects our community in Nashville. ? Youth Serving Organization Workshop - January 19: Workshop assisted local organizations in acquiring the tools to adopt healthy eating/ active living policies. The share the road media campaign ? Moving in Harmony? was launched on March 15, in conjunction with the Music City Bikeway launch. The web site is www.nashvitality.org/movinginharmony Ten faith-based organizations signed the ?Pledge for a Healthier Place of Worship?. Five youth-serving organizations have adopted policy regarding healthy eating and active living. Four local birthing hospitals were awarded the ?Give Me Five? designation. Local campaign encourages hospitals to increase breastfeeding rates. Adjunct to this campaign, a Certified Lactation Consultant (CLC) course was held in Nashville to increase the number of CLC personnel in the community. A Garden to School Coalition was established in Nashville uniting efforts to address school gardens.
Jobs Created	34.28
Description of Jobs	Description of jobs- Project Director: Responsible for leadership and management of all aspects of CPPW. Finance Officer 2: Responsible for fiscal management of CPPW including monitoring of all contracts. Medical Admin Asst 1:Coordinates various activities within a departmental division. Responsible for administrative tasks such as operations control, budget analysis, gathering data to evaluate program effectiveness. Supervises personnel of lower classification. Assists in coordination of efforts within the department. Health Promotion Director/Med Admin Asst 2: Responsible for integrating current Health Promotion/HEAL initiatives with CPPW MAPPS strategies; liaison to CPPW groups and staff. Healthy Nashville Leadership Council Coordinator/Med Admin Asst 1: Responsible for coordination/liaison to the Healthy Nashville Leadership Council-CPPW Community Coalition. Media Director/Med Admin Asst 2: Responsible for oversight of media and marketing efforts. Program Evaluator/Med Admin Asst 3: Responsible for oversight and coordination of evaluation. Office Support Rep 3-Responsible for clerical support to all CPPW efforts. Animal Control Officers 2-Responsible for patrol and community outreach efforts to promote safety by reduction of dogs running at large. Promote policies to reduce dogs running at large. Campaign Director/ Med Admin 2 Mayor's Office-Responsible for serving as the Campaign leader at the Mayoral level. Responsible for coordination of PSE efforts among Metro government and community organizations. Facilitate integration and reduction of redundancy.
Description of	Project leader for school projects such as Green Bikes

Description of Jobs Created	Project leader for select projects such as Green Sinks initiative. Program Specialists 1:Participates in the development and promotion of service program(s). Assists in the development and design of program objectives and content. Assists in researching alternative methods of program management to identify possible alternative approaches or evaluate current techniques. Program Specialists 2:Participates in the development and promotion of service program(s). Assists in the development and design of program objectives and content. Researches and recommends alternative methods of program management to identify possible alternative approaches or evaluate current techniques. Program Specialists 3:Determines, develops and monitors service program(s). Community Food Advocates-Admin. Director, Community Garden Coordinator, Health Corner Store Coordinator, Food Policy Council Coordinator, Youth Outreach Coordinator, and Part-time Food Summit Coordinator. Belmont and Critical Learning Systems, Inc.: Principal Investigator Tennessee State University: Principal Investigator Data Coordinator Student Assistants Vanderbilt University: Principal Investigator LocoMotion Creative: Administrator and Creative Designer for CPPW Branding and Walk 100 Website. Informing Design: Area Analysts for Wayfinding Field Study Nashville Civic Design Center: Project Coordinators for Shaping Healthy Cities: Nashville book. Good Food for Good People: Accountant and Coordinators for SNAP EBT and BELL Learning Garden projects. Corinthian Baptist Church-Healthy Community Volunteers

PURCHASER INFORMATION (GRANTS)

Contracting Office ID	Not Reported
Contracting Office Name	Not Available
Contracting Office Region	Not Available
TAS Major Program	75-0942

AWARD INFORMATION

Award Date	03/19/2010
Award Number	1U58DP002447-01
Order Number	
Award Type	Grants
Funding Agency ID	75
Funding Agency Name	Department of Health and Human Services
Funding Office Name	Not Available
Awarding Agency ID	75
Awarding Agency Name	Department of Health and Human Services
Amount of Award	$7,527,527
Funds Invorced/Received	$4,762,089
Expenditure Amount	$5,476,055
Infrastructure Expenditure Amount	$0
Infrastructure Purpose and Rationale	Not Reported
Infrastructure Point of Contact	
Name	Alisa Haushalter
Infrastructure Point of Contact Email	Alisa.haushalter@nashville.gov
Infrastructure Point of Contact Phone	Not Reported
Infrastructure Point of Contact Address	311 23rd AVenue North
Infrastructure Point of Contact City	Nashville

Infrastructure Point of Contact State	TN
Infrastructure Point of Contact Zip	37203-1611

PRODUCT OR SERVICE INFORMATION (GRANTS)

Primary Activity Code	+A00
Activity Description	General population - General/Unspecified

SUB-AWARDS INFORMATION

Sub-awards to Organizations	14
Sub-award Amounts to Organizations	$1,480,285
Sub-Awards to Individuals	0
Sub-Award Amounts to Individuals	$0
Number of Sub-awards less than $25,000/award	3
Amount of Sub-awards less than $25,000/award	$52,000
Number of payments to vendors greater than $25,000	2
Total Amount of payments to vendors greater than $25,000/award	$187,500
Number of payments to vendors less than $25,000/award	434
Total Amount of payments to vendors less than $25,000/award	$532,115

SUB-AWARD TRANSACTIONS

Sub-Award 1U58DP002447-01-AACA-080111 - African America Cultural Alliance Ibe

Sub-Award Amount	$25,000
Sub-Award Date	08/01/2011
Sub-Awards Disbursed	25000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37208-2563
Project Location - Congressional District	05
Sub-Recipient DUNS Number	003772759
Sub-Recipient Address	1215 9th Ave N
Sub-Recipient City	Nashville
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37208-2560
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-BU080110 - BELMONT UNIVERSITY

Sub-Award Amount	$22,000
Sub-Award Date	08/01/2010
Sub-Awards Disbursed	22000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37212-3758
Project Location - Congressional District	05
Sub-Recipient DUNS Number	075383638
Sub-Recipient Address	1900 BELMONT BLVD
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37212-3757
Sub-Recipient Congressional District	05

Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-CFA080110 - COMMUNITY FOOD ADVOCATES

Sub-Award Amount	$640.156
Sub-Award Date	08/01/2010
Sub-Awards Disbursed	450372.94
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37201-2225
Project Location - Congressional District	05
Sub-Recipient DUNS Number	150678071
Sub-Recipient Address	415 4TH AVE S UNIT B
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37201-2225
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-CBC-418625 - Corinthian Baptist Church

Sub-Award Amount	$24,275
Sub-Award Date	10/01/2011
Sub-Awards Disbursed	19996.95
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37209-2602
Project Location - Congressional District	05
Sub-Recipient DUNS Number	615623402
Sub-Recipient Address	819 33rd Ave N
Sub-Recipient City	Nashville
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37209-2602
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-CLS-832145 - CRITICAL LEARNING SYSTEMS INC

Sub-Award Amount	$24,000
Sub-Award Date	07/01/2011
Sub-Awards Disbursed	24000.00
Project Location - City	Cane Ridge
Project Location - State	TN
Project Location - Zip Code	37013-4882
Project Location - Congressional District	05
Sub-Recipient DUNS Number	076529598
Sub-Recipient Address	5548 CRAFTWOOD DR
Sub-Recipient City	CANE RIDGE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37013-4882
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-GFGPB-835966 - GOOD FOOD FOR GOOD PEOPLE

Sub-Award Amount	$6,000
Sub-Award Date	06/15/2011
Sub-Awards Disbursed	6000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37209-8277
Project Location - Congressional District	05
Sub-Recipient DUNS Number	065800494
Sub-Recipient Address	4611 ALABAMA AVE
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee

Sub-Recipient Zip Code	37209-3446
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-GFGPA-835966 - GOOD FOOD FOR GOOD PEOPLE

Sub-Award Amount	$25,000
Sub-Award Date	06/15/2011
Sub-Awards Disbursed	25000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37209-8277
Project Location - Congressional District	05
Sub-Recipient DUNS Number	065800494
Sub-Recipient Address	4611 ALABAMA AVE
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37209-3446
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-HCI060110 - Healthy Communities Institute Corporation

Sub-Award Amount	$80,000
Sub-Award Date	06/01/2010
Sub-Awards Disbursed	80000.00
Project Location - City	Sausalito
Project Location - State	CA
Project Location - Zip Code	94965-1757
Project Location - Congressional District	06
Sub-Recipient DUNS Number	962670670
Sub-Recipient Address	30 Liberty Ship Way, Ste 3200
Sub-Recipient City	Sausalito
Sub-Recipient State	CA
Sub-Recipient Zip Code	94965
Sub-Recipient Congressional District	06
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-ID-556119 - Informing Design Inc

Sub-Award Amount	$74,273
Sub-Award Date	04/22/2011
Sub-Awards Disbursed	74231.79
Project Location - City	Pittsburgh
Project Location - State	PA
Project Location - Zip Code	15222-2213
Project Location - Congressional District	14
Sub-Recipient DUNS Number	609927256
Sub-Recipient Address	4 Smithfield St FL 9
Sub-Recipient City	Pittsburgh
Sub-Recipient State	Pennsylvania
Sub-Recipient Zip Code	15222-2226
Sub-Recipient Congressional District	14
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-LC120110 - Locomotion Creative LLC

Sub-Award Amount	$270,842
Sub-Award Date	12/01/2010
Sub-Awards Disbursed	244072.14
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37204-2750
Project Location - Congressional District	05
Sub-Recipient DUNS Number	841299527

Sub-Recipient Address	124 12th Ave S Ste 400
Sub-Recipient City	Nashville
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37203-3170
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-NCDC-403774 - NASHVILLE CIVIC DESIGN CE

Sub-Award Amount	$150,000
Sub-Award Date	07/27/2011
Sub-Awards Disbursed	150000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37201-1981
Project Location - Congressional District	05
Sub-Recipient DUNS Number	195242479
Sub-Recipient Address	138 2ND AVE N STE 106
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37201-1981
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1 U58DP002447-01-NPT090110 - NASHVILLE PUBLIC TELEVISION, INCORPORATED

Sub-Award Amount	$35,000
Sub-Award Date	09/01/2010
Sub-Awards Disbursed	35000.00
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37203-5330
Project Location - Congressional District	05
Sub-Recipient DUNS Number	085838548
Sub-Recipient Address	161 RAINS AVE
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37203-5330
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-TSU080110 - TENNESSEE STATE UNIVERSITY

Sub-Award Amount	$57,134
Sub-Award Date	08/01/2010
Sub-Awards Disbursed	36246.35
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37209-1500
Project Location - Congressional District	05
Sub-Recipient DUNS Number	108814179
Sub-Recipient Address	3500 JOHN A MERRITT BLVD
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37209-1500
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

Sub-Award 1U58DP002447-01-VU-584804 - THE VANDERBILT UNIVERSITY

Sub-Award Amount	$46,605
Sub-Award Date	08/01/2010
Sub-Awards Disbursed	8551.66
Project Location - City	Nashville
Project Location - State	TN
Project Location - Zip Code	37203-6869

Project Location - Congressional District	05
Sub-Recipient DUNS Number	004413456
Sub-Recipient Address	3319 WEST END AVE STE 800
Sub-Recipient City	NASHVILLE
Sub-Recipient State	Tennessee
Sub-Recipient Zip Code	37203-6876
Sub-Recipient Congressional District	05
Required To Report Top 5 Highly Compensated Officials	No

VENDOR TRANSACTIONS

Lamar Advertising Of Nashville - Award Number 1U58DP002447-01 - Lamar Advertising Of Nashville

Award Number	1U58DP002447-01
Sub-Award Number	N/A
Vendor DUNS Number	Not reported
Vendor HQ Zip Code + 4	37207-4423
Vendor Name	Lamar Advertising of Nashville
Product and Service Description	Vendor provides outdoor advertising for the targeted audience reach of the CPPW Campaign.
Payment Amount	$50,000

NewsChannel 5 Network LLC - Award Number 1U58DP002447-01 - NewsChannel 5 Network LLC

Award Number	1U58DP002447-01
Sub-Award Number	N/A
Vendor DUNS Number	791310543
Vendor HQ Zip Code + 4	
Vendor Name	NewsChannel 5 Network LLC
Product and Service Description	Vendor provides advertising for targeted audience, reach of CPPW campaign.
Payment Amount	$137,500

PROJECT LOCATION DETAIL

Latitude, Longitude	36° 9' 8", -86° 48' 26"
Congressional District	05
Address 1	311 23rd Avenue
Address 2	
City	Nashville
County	Davidson
State	TN
Zip	37203-1511

What Does The Recovery Board Do?
What Is Recovery.Gov?
Inspectors General Reports

Job Information
Details About A Recipient
Funding By Program / Category

I AM...
An Interested Citizen
A Data User
A Member Of The Media
A Recipient

Recovery Data Explorer
Map Gallery

SITE INDEX

REPORT FRAUD, WASTE OR ABUSE

SUBSCRIBE TO MONTH-IN-REVIEW EMAIL

Find Details About A Recipient
Use Recovery Widgets
Get The Recovery iPhone Or iPad App

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Copyright Information
Freedom Of Information Act
No FEAR Act
Recovery Logos
Media Kit

Rising Budget Authority and Full-Time Equivalents at HHS: FY 2007-2013

Dollars in Billions							
	FY 2007 Actual	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Actual**	**FY 2012 Estimated**	**FY 2013 Estimated**
Authority	$657	$721	$779	$849	$883	$866	$932
FY 2007 %	100%	110%	119%	129%	134%	132%	142%
FTEs	63,748	64,509	67,875	71,047	73,704	74,948	76,341
FY 2007 %	100%	101%	106%	111%	116%	118%	120%

Source: HHS Fiscal Year 2009-2013 Budgets in Brief

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

May 25, 2012

Mr. Norris Cochran
Deputy Assistant Secretary, Financial Resources
Director of the Office of Budget
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Cochran:

Thank you for appearing before the Subcommittee on Oversight and Investigations on May 9, 2012, to testify at the hearing entitled "Budget and Spending Concerns at HHS."

At the hearing, you agreed to follow-up with Committee Members on several items addressed in your testimony, and which are attached. In addition, pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please e-mail your responses, in Word or PDF format, to Alex.Yergin@mail.house.gov by the close of business on Monday, June 11, 2012.

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

Sincerely,

Cliff Stearns
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member,
Subcommittee on Oversight and Investigations

Attachment

The Honorable Cliff Stearns

1. Please provide a detailed breakdown of the $876 million in administrative savings HHS claims it will be implementing pursuant to Executive Order 13589.

    a. How much of these savings will be redirected to absorb other cost increases and fund priority activities?

2. Since its inception, $140 billion has been provided under the Recovery Act to HHS. So far, $124.5 billion of this has been obligated by HHS through grants and contracts, Therefore, approximately $16 billion in Recovery Act funds remain unobligated. Does HHS have plans to deobligate or recertify any previously unobligated balances under the Recovery Act so that they can be put to another use?

3. What actions has HHS taken to resolve concerns over financial management, such as those raised by the Ernst & Young independent audit of HHS FY 2011 financial statements?

4. On July 14, 2011, HHS informed Congress of more than $1.4 billion in Antideficiency Act (ADA) violations in a variety of HHS accounts during FYs 2002-2012.

    a. What has HHS done to resolve the 47 violations of the ADA totaling over $1.4 billion it identified in its July 14, 2011 letter to GAO?

    b. Specifically, how has the Department corrected the reported over-obligation or overspending of budgetary authority?

5. What ADA violations have occurred subsequent to the July 14, 2011 letter?

6. What corrective actions has HHS taken to safeguard against future ADA violations?

7. At a March 6, 2012 appropriations hearing, the Subcommittee chairman asked the HHS Secretary to provide within 30 days a detailed 3-year corrective action initiative to rectify the HHS financial system and prevent ADA violations. Has this been done? Please provide a copy for the record.

8. HHS recently requested $1 billion in additional funding for implementation of PPACA – beyond the $1 billion already appropriated for implementation when the law was enacted in March 2010. Has HHS used funding from other parts of the HHS budget, such as programmatic funding for the administration of Medicare at CMS, to implement PPACA?

9. Section 1311 of PPACA requires the Secretary to award grants to states to establish health insurance exchanges. The law also provides the Secretary the authority to draw from the Treasury, as necessary.

    a. As you formulate the FY 2014 budget proposal – what is the anticipated spending amount for exchange grants? How is this amount determined? No grants may be awarded after January 1, 2015. Do you have some sense of what may be required in the first quarter of FY 2015?

b. How does the HHS budget office track these grants? Does HHS expect some of these grants to be recovered – unused? Are there progress reports submitted to HHS by the states?

10. Please detail what the Budget Office is doing to prepare for automatic spending cuts to non-defense discretionary appropriations of approximately 8% as of January 2, 2013.

11. If unobligated balances carried forward from previous fiscal years are exempt from sequestration, after January 2013, how much, if any, of HHS's carryover unobligated balances will be reallocated to fill funding gaps created by sequestration?

12. Please provide a list of HHS programs exempt from automatic spending cuts under sequestration.

13. Your authority to pay providers under Medicare and Medicaid may evaporate July 1st, according to some recent AP reports.[1] Please provide the contingency plans, including all documents and communications related to HHS's efforts to keep the Nation's doctors paid for their services after July 1st should the US Supreme Court strike down the Affordable Care Act, or any portion of it.

The Honorable Joe Barton

1. What is Secretary Sebelius's travel budget?

2. How many HHS employees have credit cards?

The Honorable Michael C. Burgess

1. The topic today before us is – how is HHS spending their budget and is this spending watched to ensure it is not duplicative, wasteful or fraudulent. I have two questions that point to the duplicative aspect:

   a. On March 29, 2012, CMS published an "announcement" in the Federal Register regarding CMS' intent to establish a Federally-funded research center. And while we can differ over policy matters, I think we would both agree that transparency and candor should be our minimum standard.

[1] Alonso-Zaldivar, Ricardo, "Medicare disruptions seen if health law is struck down," *Washington Times*, May 3, 2012, http://www.washingtontimes.com/news/2012/may/3/medicare-disruptions-seen-if-health-law-struck/?page=all

i. In that spirit, is the White House, HHS and or CMS creating a Federally-funded research center whose primary purpose is the implementation of the Affordable Care Act? And if so, can you please explain to all of us here today where those monies are coming from? Is Oak Ridge National Laboratory one of the entities – who the Administration itself says (according to the OFR citation) knows little about healthcare – that the Administration is relying upon to be at the center of this new cloaked research center?

b. In a similar vein, the CMS Innovations Center is spending half a billion dollars on Hospital Engagement Networks that appear to duplicate the work of the Medicare Quality Improvement Organizations, an effective program in my opinion. I hear this is creating confusion and frustration among the providers that are supposed to benefit. Can you explain to me the differences?

c. What is or should the Department of Health and Human Services be doing to prevent and identify such duplication of efforts?

2. The *Patient Protection and Affordable Care Act* predicts drastic cost savings from fraud prevention as well as allocating 10 million annually for fiscal years 2011 through 2020 to such efforts. The Health Care and Education Reconciliation Act provides an additional $250 million for the period FY2011 through FY2016 for the Health Care Fraud and Abuse program. In order to combat fraud and use the money in the most effective manner, do you believe it would be beneficial to hire more federal prosecutors with backgrounds in health care fraud to combat this current problem as opposed to hiring prosecutors with no previous health care experience?

3. As health care fraud schemes become more sophisticated, how do you plan to stay ahead of their activities and combat fraud?

4. I have asked this question in full committee and I would still like to know your plans. The House has passed a reconciliation bill, but the Senate has signaled they do not have plans to take it up. In order to prevent the sequestration cuts, what is your proposal to work with this committee and Congress to avoid the sequestration across-the-board cuts to identify those areas of savings and/or cuts that can occur?

The Honorable Steve Scalise

1. Please provide to the Committee the number of HHS vehicles that are allowed to be taken home by employees.

2. How much of the current fiscal year travel budget for HHS has been spent on first class or business class travel?

The Honorable Cliff Stearns

1. **Please provide a detailed breakdown of the $876 million in administrative savings HHS claims it will be implementing pursuant to Executive Order 13589.**

Answer: HHS has identified $876 million in cost savings in the following categories: Travel, Relocation, and Conferences ($66 million), Printing and Reproduction ($27 million), Employee IT Devices ($17 million), Executive Motor Fleet ($ .2 million), Management and Support Services ($225 million), and Supplies ($542 million).

a. **How much of these savings will be redirected to absorb other cost increases and fund priority activities?**

Answer: While some of the savings that will be achieved through this initiative are reflected as proposed reductions in the President's Budget, the majority of these savings are being reinvested to expand the reach of ongoing programs without a net increase in discretionary resources. An example of the savings includes FDA's data center consolidation and IT efficiencies, which results in a total savings of $19.7 million. Data savings were achieved by reducing the number of centers, eliminating redundant management teams, standardizing processes, consolidating operations support teams, and modernizing hardware and software infrastructure. In addition, FDA reduced the number of redundant IT devices as well as device and support costs. Further, in accordance with OMB Memorandum M-12-12, HHS will redirect savings from travel expenses to support transparency and accountability initiatives for the department and its agencies.

2. **Since its inception, $140 billion has been provided under the Recovery Act to HHS. So far, $124.5 billion of this has been obligated by HHS through grants and contracts, Therefore, approximately $16 billion in Recovery Act funds remain unobligated. Does HHS have plans to deobligate or recertify any previously unobligated balances under the Recovery Act so that they can be put to another use?**

Answer: As of May 4, 2012, HHS has obligated $124.9 billion to States, universities, local communities and other recipients; recipients have in turn spent nearly $116.2 billion, or 93% percent of total HHS Recovery Act funds.

Nearly all of the remaining Recovery Act funds available for obligation in FY 2012 and beyond are for the Centers for Medicare and Medicaid Services' Health Information Technology Incentive Programs which promote the meaningful use of Health IT. By statute, the incentive payments are not available to be put to another use. Furthermore, the statute specified that the Medicare and Medicaid Health Information Technology Incentive Programs could not begin to make incentive payments until FY 2011 and are to make payments over the following decade. In total over the life of the incentive programs, they are estimated to spend more than $25 billion to ensure that doctors and hospitals take advantage of health IT to benefit the Nation's health care system.

3. **What actions has HHS taken to resolve concerns over financial management, such as those raised by the Ernst & Young independent audit of HHS FY 2011 financial statements?**

Answer: Proper financial management and stewardship of public funds is a priority for the Department. HHS is committed to further strengthening internal control structure and financial systems that support our ability to effectively execute HHS's mission. HHS has a strong financial management system and controls, which the Department continues to strengthen each year. HHS has earned a "clean" opinion from our independent auditors on its financial statements for each of the past 12 years. In addition, the Department has reduced the material weaknesses identified by auditors from four in 2007 to one in 2011. This change represents a significant improvement in HHS financial management over time, and HHS continues efforts to strengthen financial statements and reporting processes and controls.

For example, HHS is working to eliminate the remaining material weakness this year. During FY 2012, HHS is continuing Department-wide collaborative efforts to improve financial systems and controls.

4. **On July 14, 2011, HHS informed Congress of more than $1.4 billion in Antideficiency Act (ADA) violations in a variety of HHS accounts during FYs 2002-2012.**
   - **a. What has HHS done to resolve the 47 violations of the ADA totaling over $1.4 billion it identified in its July 14, 2011 letter to GAO?**
   - **b. Specifically, how has the Department corrected the reported over-obligation or overspending of budgetary authority?**

Answer: The Secretary notified Congress last July of 47 contracts in violation of the Anti-Deficiency Act that that occurred over FY 2002-2010. As stated in the letter to Congress, the Secretary noted that there had been "a substantial lack of understanding throughout the Department of the legal limits on federal contracts; in particular, contracts that required effort or deliverables over a period of several years." The Department has made extensive and intensive efforts to correct misunderstandings and modify policies and procedures so that this long-standing problem could be solved. HHS has trained over 12,700 staff on appropriations law, updated the HHS Acquisition Regulation and internal HHS acquisition guidance, developed an appropriation law decision tree, and updated our Acquisition Plan template to ensure that program, contracting, and budget officials fund our acquisitions properly. Since HHS sent the letter to Congress, the President, and the Government Accountability Office (GAO) last July, the Department has updated its corrective action plan to include additional steps (see Enclosure 1).

5. **What ADA violations have occurred subsequent to the July 14, 2011 letter?**

Answer: HHS takes the Anti-Deficiency Act very seriously. HHS examines possible violations very intensely and carefully. These reviews are often lengthy and complex, but HHS remains committed to reporting any violations we find upon completion of such reviews. For reference,

GAO routinely posts all Anti-Deficiency Act letters, government-wide, at: http://www.gao.gov/ada/antideficiencyrpts.htm.

6. **What corrective actions has HHS taken to safeguard against future ADA violations?**

Answer: As noted previously, the Department has modified policies and procedures. HHS has trained over 12,700 staff on appropriations law, updated the HHS Acquisition Regulation and internal HHS acquisition guidance, developed an appropriation law decision tree, and updated our Acquisition Plan template to ensure that program, contracting, and budget officials fund our acquisitions properly. The Department's updated corrective action plan is enclosed.

7. **At a March 6, 2012 appropriations hearing, the Subcommittee chairman asked the HHS Secretary to provide within 30 days a detailed 3-year corrective action initiative to rectify the HHS financial system and prevent ADA violations. Has this been done? Please provide a copy for the record.**

Answer: The Secretary submitted HHS's Anti-Deficiency Act Corrective Action plan to the House Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee on March 22, 2012. A copy of the plan is enclosed (see Enclosure 1).

8. **HHS recently requested $1 billion in additional funding for implementation of PPACA – beyond the $1 billion already appropriated for implementation when the law was enacted in March 2010. Has HHS used funding from other parts of the HHS budget, such as programmatic funding for the administration of Medicare at CMS, to implement PPACA?**

Answer: In FY 2011, CMS obligated discretionary funds transferred from the Office of the Secretary to support ACA implementation. In addition, HHS has used, and plans to use CMS Program Management funding for some ACA activities in FY 2011 and FY 2012. Funds support a wide variety of activities that are integrated into daily CMS operations, including FTEs, Medicare and Medicaid provisions, and market reform activities.

9. **Section 1311 of PPACA requires the Secretary to award grants to states to establish health insurance exchanges. The law also provides the Secretary the authority to draw from the Treasury, as necessary.**

   a. **As you formulate the FY 2014 budget proposal – what is the anticipated spending amount for exchange grants? How is this amount determined? No grants may be awarded after January 1, 2015. Do you have some sense of what may be required in the first quarter of FY 2015?**

Answer: Our current baseline for Exchange Planning and Establishment Grants estimates that we will obligate approximately $2.5 billion from when the law was enacted until FY 2014 and

that we will outlay $2.0 billion during that timeframe. As Exchanges are established we will continue to refine our estimates.

b. How does the HHS budget office track these grants? Does HHS expect some of these grants to be recovered – unused? Are there progress reports submitted to HHS by the states?

Answer: HHS relies on the standard grants tracking process required of all grants and the review and monitoring conducted by the CMS State Exchange office. States are required to submit a work plan at the time of application as well as progress reports which include changes to their work plan, regular public reporting, the Federal Financial Report, and other standard grant reports. As with any grant, the projected need for funding during the project period of performance is an estimate and unused grant amounts will be recovered.

10. **Please detail what the Budget Office is doing to prepare for automatic spending cuts to non-defense discretionary appropriations of approximately 8% as of January 2, 2013.**

Answer: The Administration believes that Congress should prevent sequestration by enacting the balanced framework proposed in the President's Budget. In the event that Congress fails to pass bipartisan balanced deficit reduction legislation, the Congressional Budget Office estimates that automatic sequestration would reduce non-defense discretionary spending by 7.8 percent beginning in January 2013.

11. **If unobligated balances carried forward from previous fiscal years are exempt from sequestration, after January 2013, how much, if any, of HHS's carryover unobligated balances will be reallocated to fill funding gaps created by sequestration?**

Answer: Appropriations that provide HHS with funding that are available for obligation for multiple years, or available until expended, are usually targeted in law to very specific purposes and thus cannot be reprogrammed beyond the confines of the original appropriating language. As a result, those balances would generally not be available to provide additional funding to other programs.

12. **Please provide a list of HHS programs exempt from automatic spending cuts under sequestration.**

Answer: The Administration is reviewing the potential impact of sequestration including which programs would be exempt. The Administration believes that Congress should pass balanced deficit reduction legislation consistent with the President's Budget to avoid sequestration.

13. **Your authority to pay providers under Medicare and Medicaid may evaporate July 1st, according to some recent AP reports.[1] Please provide the contingency plans, including all documents and communications related to HHS's efforts to keep the Nation's doctors paid for their services after July 1st should the US Supreme Court strike down the Affordable Care Act, or any portion of it.**

The Administration is focused on implementing the law.

The Honorable Joe Barton

1. What is Secretary Sebelius's travel budget?

Answer: The Immediate Office of the Secretary budget supports travel by the Secretary of Health and Human Services (HHS) as an official representative of the United State Government and in support of the HHS mission. In fiscal year (FY) 2011 approximately $57,000 was spent on travel and total year-to-date support for travel in FY 2012 as of May 9 is just under $46,000.

2. How many HHS employees have credit cards?

Answer. The HHS Charge Card Program is organized into three distinct areas: travel, purchase and fleet. Each area has a designated Program Manager who is responsible for the overall management of the Program; as well as an Agency/Organization Program Coordinator assigned to each of the HHS Operating and Staff Divisions who is responsible for the implementation of the Program.

The Department of Health and Human Services (HHS) Charge Card Management Plan outlines the policies, procedures, and internal controls that are in place within HHS to manage its Charge Card Program. The Plan complies with Office of Management and Budget (OMB) Circular A-123, Appendix B; which consolidates and updates current government-wide charge card program requirements and guidance issued by OMB, the General Services Administration, and the Department of the Treasury.

Government Charge Cards Issued to HHS Employees include:

Travel Card	30,990
Purchase Card	4,818
Fleet Services Card[1]	11

[1]A limited number of Fleet Services cards are issued to HHS employees in the Office of the Assistant Secretary for Preparedness and Response and at the National Institutes of Health to support the maintenance of vehicles and equipment used in support of the agency mission.

[1] Alonso-Zaldivar, Ricardo, "Medicare disruptions seen if health law is struck down," *Washington Times*, May 3, 2012, http://www.washingtontimes.com/news/2012/may/3/medicare-disruptions-seen-if-health-law-struck/?page=all

The Honorable Michael C. Burgess

1. The topic today before us is – how is HHS spending their budget and is this spending watched to ensure it is not duplicative, wasteful or fraudulent. I have two questions that point to the duplicative aspect:

a. On March 29, 2012, CMS published an "announcement" in the Federal Register regarding CMS' intent to establish a Federally-funded research center. And while we can differ over policy matters, I think we would both agree that transparency and candor should be our minimum standard.

i. In that spirit, is the White House, HHS and or CMS creating a Federally-funded research center whose primary purpose is the implementation of the Affordable Care Act? And if so, can you please explain to all of us here today where those monies are coming from? Is Oak Ridge National Laboratory one of the entities – who the Administration itself says (according to the OFR citation) knows little about healthcare – that the Administration is relying upon to be at the center of this new cloaked research center?

Answer: The CMS Federally-funded Research Development Center (FFRDC) will support many different activities including ACA implementation, but the primary purpose is not ACA. CMS will use the FFRDC to perform strategic and tactical studies, analysis and prototyping of policy implications, business architecture, operations models and IT solutions.

CMS is in the process of a full and open competition to select the HHS FFRDC contractor. All eligible organizations, including Oak Ridge, are invited to submit proposals.

b. In a similar vein, the CMS Innovations Center is spending half a billion dollars on Hospital Engagement Networks that appear to duplicate the work of the Medicare Quality Improvement Organizations, an effective program in my opinion. I hear this is creating confusion and frustration among the providers that are supposed to benefit. Can you explain to me the differences?

Answer: Launched in April 2011, the Partnership for Patients is a nationwide public-private partnership that offers support to physicians, nurses and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other settings. The Hospital Engagement Networks are a part of the Partnership for Patients and are developing highly structured learning collaboratives to support hospitals nationwide in mastering the basics of patient safety and to adopt effective interventions. The networks were chosen for their expertise in the areas of hospital-acquired conditions and readmissions with the overarching goal of reducing preventable harm. This project will touch approximately 3,800 hospitals. The focus is on 10 explicit and targeted areas that are the cause of widespread patient

complications and deaths every year. These areas are: adverse drug events, central line associated blood stream infections, catheter-associated urinary tract infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, ventilator-associated pneumonia, and reduction of preventable readmissions. The Quality Improvement Organizations (QIOs) have also effectively worked on a variety of patient safety issues, including surgical safety, pressure ulcers, reduction of methicillin-resistant Staphylococcus aureus infections, and drug safety. The patient safety component, however, is only one area of many that the QIOs focus on. The QIO responsibilities are broad, and include numerous activities, such as general quality of care reviews, beneficiary complaint reviews, medical necessity reviews, discharge appeal reviews, improvement in prevention services, health information technology assistance, assistance in quality measurement programs, care transitions, and care interventions for chronic kidney disease. Furthermore, the focus of the QIOs is on many different provider types, not just hospitals.

Although the QIOs have made significant progress, their reach in the area of patient safety each year is limited by the required breadth of their responsibilities. In contrast, the premise of the Partnership for Patients is to test interventions quickly, and engage hospitals in the next three years to expeditiously achieve broad, widespread adoption of what are found to be the best patient safety techniques. As charged by the Secretary at the launching of the networks in December 2011, the QIOs and networks work in close synergy with each other, to reinforce and support their work to improve patient safety. In many cases, networks have formal relationships with their state QIOs. Each network contract was reviewed for potential overlapping responsibilities, and any areas of overlap have been addressed on a contract by contract basis.

c. What is or should the Department of Health and Human Services be doing to prevent and identify such duplication of efforts?

Answer. The Department is continuously reviewing all programs in order to identify potential duplication of effort and/or opportunities for improved efficiency. In the case mentioned above, while both network contractors and QIOs do important work to improve patient safety, they serve separate and well-defined functions.

2. The *Patient Protection and Affordable Care Act* predicts drastic cost savings from fraud prevention as well as allocating 10 million annually for fiscal years 2011 through 2020 to such efforts. The Health Care and Education Reconciliation Act provides an additional $250 million for the period FY2011 through FY2016 for the Health Care Fraud and Abuse program. In order to combat fraud and use the money in the most effective manner, do you believe it would be beneficial to hire more federal prosecutors with backgrounds in health care fraud to combat this current problem as opposed to hiring prosecutors with no previous health care experience?

Answer: Federal prosecutors work at the Department of Justice. HHS coordinates with DOJ and HHS does not employ a team of federal prosecutors outside of those employed DOJ. HHS

defers to the Justice Department's Criminal Division and the United States Attorneys' Offices around the country in making appropriate hiring decisions when it comes to federal prosecutors handling health care fraud cases. Based on the experience of HHS-OIG agents, who work hand-in-hand with federal prosecutors nationwide, the prosecutors assigned to the Medicare Fraud Strike Force and the Assistant United States Attorneys who handle health care fraud cases are extremely well qualified and have been achieving record results. For example, in fiscal year 2011, the Justice Department brought health care fraud charges against 1,430 defendants, more than in any previous year, and secured convictions against 743 defendants for health care fraud-related crimes, also a record.

3. As health care fraud schemes become more sophisticated, how do you plan to stay ahead of their activities and combat fraud?

Answer: Since passage of the Affordable Care Act, CMS has moved away from the old pay-and-chase approach to a new, more prevention-focused mission. The Administration has made fighting fraud a top priority and has been working with the private sector and experts in predictive analytics to bring CMS up to speed as quickly as possible. CMS is adapting the private sectors' best practices to the Medicare fee for service program. HHS has seen great progress in a short amount of time, and CMS is committed to using predictive analytics to prevent fraud and eliminate systemic vulnerabilities.

4. I have asked this question in full committee and I would still like to know your plans. The House has passed a reconciliation bill, but the Senate has signaled they do not have plans to take it up. In order to prevent the sequestration cuts, what is your proposal to work with this committee and Congress to avoid the sequestration across-the-board cuts to identify those areas of savings and/or cuts that can occur?

Answer: The Administration believes that Congress should enact meaningful reforms consistent with the FY 2013 President's Budget to avoid sequestration. The FY 2013 President's Budget proposes a balanced framework to achieve the savings needed to prevent sequestration, including a package of legislative proposals for Medicare and Medicaid that would save over $300 billion over 10 years.

The Honorable Steve Scalise

1. Please provide to the Committee the number of HHS vehicles that are allowed to be taken home by employees.

Answer: HHS has 685 vehicles participating in the Home to Work program. The positions that participate in the program meet the regulatory definition of field work. These field work positions include Criminal Investigators from the Office of Inspector General, Medical Officers from the Indian Health Service, Consumer Safety Inspectors from the Food and Drug Administration, and Police/Canine Handlers from the National Institutes of Health. The number of vehicles, broken down by agency, is below:

- Indian Health Service (IHS): 385
- Office of Inspector General (OIG): 196
- Food and Drug Administration (FDA): 74
- Centers for Disease Control and Prevention (CDC): 15
- National Institutes of Health (NIH): 14
- Centers for Medicare and Medicaid Services (CMS): 1

2. How much of the current fiscal year travel budget for HHS has been spent on first class or business class travel?

Answer: From October 2011 to the beginning of March 2012, HHS has spent approximately $2 million on premium class travel via commercial airfare. This represents less than four percent of HHS's estimated total travel expenses over that time period. Premium class travel is accommodations that are not coach, including first class and business class. HHS premium class travel is extremely limited and is consistent with Federal Travel Regulations (FTR). An agency may authorize business class accommodations where there is a medical disability or special needs, where there are exceptional security matters, where there is an urgent matter but coach accommodations are not available, or where flight time (including stopovers and change of planes) exceeds 14 hours and the origin/destination is from/to the continental United States.

ENCLOSURE 1

HHS ADA Corrective Actions – Past and Future

1. Corrective Actions HHS Has Already Taken

- Revised the HHS Acquisition Regulation (HHSAR) http://www.hhs.gov/policies/hhsar/subpart332.html#Subpart332.7--ContractFunding coverage in November 2009 and April 2010 on contract funding, based on consultation with OGC and the acquisition community, to make it consistent with applicable laws and regulations and easier to understand.

- Issued an Acquisition Policy Memorandum http://dhhs.gov/asfr/ogapa/acquisition/apm-2010-06.html on June 28, 2010 regarding funding of contracts exceeding one year of performance, which provided detailed guidance regarding pertinent HHSAR coverage. In doing so:

    - Improved the process for review and approval of appropriation-related acquisition regulations and guidance, including closer consultation with OGC and budget/finance officials.

    - Conducted continuous education and outreach sessions across the Department.

    - Identified, tailored and adopted best practices from other Federal agencies.

- Developed and implemented an appropriation law decision tree in June 2010 for use by the HHS budget, program, acquisition, and finance communities. A web-enable decision-tree with links to relevant resources will be available on-line for HHS personnel in the near future.

- Developed an on-line Appropriation Law course tailored to the HHS environment, which serves as the basis for future instructor-led training.

- Provided technical assistance to Heads of Contracting Activity and their staff on an as-needed basis.

- Shared pertinent legal advice with the acquisition community.

- Reorganized our management structure to more closely align acquisition and budget/finance management activities.

2. Additional OPDIV specific actions taken or under way

At the agency level, our Heads of Contracting Activity have mirrored the Department's cross-functional risk mitigation approach by:

- Issuing local procedural guidelines to implement our expanded acquisition guidance.

- Conducting or arranging for local appropriation law training.

- Working closely with their agency budget, program and finance communities to align business practices with appropriation laws and regulations.

Highlights of additional actions taken or to be taken by HHS' agencies include:

- The Program Support Center's (PSC) Strategic Acquisition Service (SAS), which provides contracting support to HHS' Office of Secretary, Administration for Children and Families, and Administration on Aging as well as other HHS agencies and non-HHS customers, uses its Division of Quality Assurance to review solicitations for new awards to ensure prospective contracts are properly structured. They also conduct town-halls to provide up to date training for its contracting staff and maintain a Contracting Officer Technical Representatives list to promulgate information to project and program officials responsible for acquisition planning and administration.

- As an initial step, the Centers for Disease Control and Prevention (CDC) developed an internal CDC guidance document to summarize how to properly fund both severable and non-severable service contracts. This was subsequently superseded by the HHS Acquisition Policy Memo APM-2010-1 (June 28, 2010). CDC's processes include: documentation of the severability determination for each contact or task order for services; the use of HHS' Acquisition Plan template for all acquisitions exceeding $150K, rather than $500K; a monthly QA/QC review of funding actions, accomplished with an independent random sampling of contract actions by three different offices (procurement, finance, and budget to ensure compliance; a secondary higher level review of all contract actions; and a review all funding actions that exceed $5 Million by the Acquisition Policy Office and the Head of Contracting Activity (HCA). An updated quality policy has been developed that also creates a contract review board for select high dollar, complex acquisitions. As an added control, the CDC's HCA is notified of all acquisitions and IAAs that exceed $1M, and any service contracts that add or retain contractor staff in CDC facilities.

  CDC also formed a multi-organization workgroup consisting of Contracting, Finance and program personnel and a sub-workgroup to review business processes and internal controls processes that have an impact on contract funding. This resulted in changes to CDC's contract writing system (ICE) and business processes to allow for a more complete fund certification process by certifying officers. This effort is ongoing. Training will be conducted to educate the acquisition community on the systems and business process changes.

  CDC also developed a classroom training course to educate acquisition personnel regarding the proper funding of severable and non-severable service contracts. The training was jointly presented by CDC Procurement and Finance senior staff. With approximately 1800 students being trained, the course was considered mandatory for procurement and finance personnel and strongly encouraged for program personnel. CDC has also converted the classroom severability training to an on-line training course.

- The Health Resources Services Administration (HRSA) had already implemented a requirement for appropriation law training of its acquisition-related staff beginning in 2006. HRSA has since also created a checklist to review prospective contracts for severability vs. non-severability and ensure that the planned funding source and amount is in compliance with the contract type. Additionally, HRSA will launch an initiative to improve its statements of work to more clearly indicate whether the requirements are severable or non-severable.

- The National Institutes of Health (NIH) has promoted the use of the *multi-year contracting* mechanism, codified at 41 U.S.C. 254c, which authorizes agencies to structure contracts using flexible funding methods and developed an instructor-led course on multi-year contracting tailored to the NIH environment to train and familiarize staff with how to award and administer a multi-year contract. NIH also established classroom-based training on appropriation law (based on HHS' on-line course) to enhance the available training. NIH will continue to deliver this class this fiscal year. NIH continuously shares successful appropriations-related business practices and its Office of Acquisition and Logistics Management provides technical assistance across NIH to ensure full compliance with appropriations law and HHS policy. Additionally, NIH conducts acquisition management and internal control reviews to validate full compliance with appropriations law and HHS policy.

- At the Agency for Health Research Quality (AHRQ), the Head of Contracting Activity has been proactively engaged by providing briefings on funding rules for contract actions presented to: AHRQ senior leadership, AHRQ contract staff, and each AHRQ Office/Center. She has also conducted numerous discussions/meeting with program staff/COTRs and contractors on appropriate contract funding, on an as needed basis to re-educate them on appropriate funding applications. Additionally, AHRQ has changed its processes to ensure that as contract modifications are processed, contracts are re-structured if necessary to ensure funding compliance from that point forward. Also, from the earliest possible point in the requirements development phase of the acquisition process (concept development), AHRQ's contracting, program, and budget professionals review the requirements to discuss the nature of the requirement (severable/non-severable) and identify appropriate funding strategy/budgeting. The requirement's severability/non-severability, and the rationale for which, is then addressed in written acquisition plans and included in contract file documentation. To date, AHRQ has also achieved near 100% compliance with appropriations law training.

- At the Food and Drug Administration, all contract actions are subject to a second level review to ensure compliance with FAR, HHSAR and acquisition guidance. FDA's Office of Acquisitions and Grants Services (OAGS) Policy and Procedure Memorandum (P&PM) requires that a review be conducted at a level above the Contracting Officer for actions (and decision-making documents) over $500K. Division Directors typically serve as the reviewing and approving authority at this level. Actions expected to exceed $1M undergo a formal Review Board process which may include Directors, Team Leaders, Contracting Officers and Contract Specialists. Actions valued at $10M or more are

reviewed in what is described as a "face to face" review process between the HCA and senior leadership.

- To prevent future problems, the Substance Abuse and Mental Health Services Administration (SAMHSA) SAMHSA will review the workflow for contract funding decisions, identify/clarify roles and responsibilities, determine what control gaps exist, and design controls to fill control gaps. SAMHSA also plans to review the Interagency Agreement processes, in coordination with OGC, especially as they relate to preparation of documents that commit SAMHSA to action to identify and will address any control gaps. Further, SAMHSA will ensure that both program and contracting officials are familiar with and held accountable for complying with appropriation law and the HHS funding guidelines. To ensure that contracting activities comply with the current HHSAR requirements, SAMHSA evaluated a sample of open contracts from all Offices and Centers as part of the fiscal year 2011 A-123 assessment.

3. Things that we are doing, going forward

The Department is doing everything it can to ensure that all new contracts awarded in FY 2011 (and beyond) are properly funded in compliance with laws and regulations. To safeguard against future violations, we are:

- Requiring all contracts, budget, finance, and program staff across HHS to take appropriations law training during the winter and spring of 2011. As of October, 2011, HHS' training completion by OPDIV is as follows:

OPDIV	Qty Complete
AHRQ	168
ACF	209
AoA	20
CDC	2656
CMS	1902
FDA	1656
HRSA	626
IHS	597
NIH	3899
SAMSHA	218
OS	836
Total	**12787**

  - Intent: Ensures that personnel who each have a role in ensuring compliance with appropriation law are all trained and knowledgeable on the proper funding of contracts so that, moving forward, there is an alignment between the budgets, spend plans, acquisition plans, resulting contracts, and financial controls.

- Sharing successful appropriation-related business practices, adopting quality assurance procedures, and providing technical assistance across the Department to ensure full compliance with appropriation law.

    - Intent: Provides for the cross-sharing of best practices and of challenges, which gives insight into what each OPDIV/contracting office is doing right, and how, and what challenges/problems they have overcome/resolved – enabling other OPDIVs/contracting offices to avoid or prevent similar issues.

- Requiring the use of HHS' new standard Acquisition Plan template for any contract expected to be $500K or over to: (a) ensure that program and contracting officials are actively considering appropriation issues as early as possible in the acquisition cycle; and (b) reinforce the need for proper, informed funds review and certification.

    - Intent: Provides a documented, internal-control measure and promotes accountability of those involved in the acquisition planning/contract structuring process.

- Conducting procurement management and internal control reviews of OPDIV acquisition operations to validate full compliance with appropriation laws and regulations.

    - Intent: In support of the A-123 Acquisition Assessment/Oversight process and to promote sound contracting practices and documentation – teams of contracting experts are formed quarterly (except Q4 of the FY) to review one contracting office per quarter to assess the operations, organization structure, workforce, and actual contracting practices of the individual contracting offices through a structured interviews and file/documentation review process. These Procurement Management Reviews (PMRs) identify an office's strengths and areas for improvement. One area assessed is compliance with appropriation laws. For each PMR, between 25 and 30 contract files – covering a variety of contract types – are reviewed. In FY11, PMRs were conducted at CMS, IHS, and CDC; the reviews found that contracts were being funded in compliance with appropriation law. PMRs will be conducted at ASPR, SAMHSA, and NIH in FY12.

- We now require - effective October 2012 - Department-level review of designated solicitations before issuance. These reviews, conducted by ASFR and OGC, are an additional safeguard to ensure the planned acquisitions for HHS' most challenging requirements – research and development, studies, and data collection with contract performance greater than 12 months – receive the necessary oversight to ensure compliance with appropriation laws and regulations.

    - Intent: Establishes a legal sufficiency and acquisition oversight review process for large R&D/Studies contracts and ensures that contracts will be properly funded at the outset of the acquisition process. For NIH, as an example, HHS conducts compliance reviews of all actions over $10 million and since October 2011 has reviewed six contract files; all were found to be compliant with appropriations law.

[redacted]

From: Barstow, Kevin [redacted]
Sent: Wednesday, September 19, 2012 2:47 PM
To: Spector, Sam
Cc: Abraham, Nick
Subject: RE: QFRs from 5/9/12 O&I Hearing
Attachments: IHS ADA letters to congress 9 12 2012.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Sam:

The ADA letter is attached. It states the amount of the violation and contains some other details. Please let me know if you have any additional questions.

Thanks.

Kevin

From: Spector, Sam [redacted]
Sent: Wednesday, September 19, 2012 12:44 PM
To: Barstow, Kevin [redacted]
Cc: Abraham, Nick
Subject: RE: QFRs from 5/9/12 O&I Hearing

. . .And any other relevant detail.

Thanks again,

Sam

From: Spector, Sam
Sent: Wednesday, September 19, 2012 11:46 AM
To: 'Barstow, Kevin [redacted]
Cc: Abraham, Nick
Subject: RE: QFRs from 5/9/12 O&I Hearing

Kevin –

Would it be possible to share with us the amount of the relevant violation?

Thanks,

Sam

Samuel J. Spector
Counsel, Majority Staff
Oversight and Investigations
Committee on Energy and Commerce

U.S. House of Representatives
[redacted]

From: Barstow, Kevin [redacted]
Sent: Wednesday, September 12, 2012 3:17 PM
To: Spector, Sam
Cc: Abraham, Nick
Subject: RE: QFRs from 5/9/12 O&I Hearing

Hi, Sam:

The Department has reported one ADA violation since July 2011. It was reported today, September 12, 2012. The violations occurred in account TAFS 75-10-0390 – Indian Health Service.

Please let me know if you have any additional questions. Thanks.

Kevin

From: Spector, Sam [redacted]
Sent: Monday, August 27, 2012 1:00 PM
To: Barstow, Kevin [redacted]
Cc: Abraham, Nick
Subject: RE: QFRs from 5/9/12 O&I Hearing

Good afternoon, Kevin –

Thanks again for passing this along last week.

With regard to the Department's response to Question 5, the GAO weblink provided http://www.gao.gov/ada/antideficiencyrpts.htm does not offer information about recent (post-FY 2010) ADA violations as I'm sure you can see. Therefore, would it be possible for you to check back in with your folks and see if you can provide us with the requested information – ADA violations by HHS, if any, since July 14, 2011?

Thanks,

Sam

Samuel J. Spector
Counsel, Majority Staff
Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
[redacted]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 12, 2012

The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

This letter is to report three violations of the Antideficiency Act, as required by section 1351 of Title 31, United States Code (U.S.C.).

Violations of section 1341 occurred in account TAFS 75-10-0390 – Indian Health Services (IHS) in the total amount of $10,668,285. The violations occurred in April 2010 when fiscal year 2010 obligations were made that exceeded the amount appropriated for Contract Support Costs (CSC) associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements. The violations exceeded the ceiling on new or expanded contracts. IHS did not exceed the ceiling on total CSC funding.

Mr. Ronald Demaray, GS-15, Acting Director of the Office of Direct Service and Contracting Tribes, was the officer found responsible for the violation. The individual responsible has separated from federal service, so no administrative discipline has been imposed. The primary reason the violation occurred is that the individual responsible for the allocation did not apply the Congressional limitation on appropriations for CSC funding associated with new or expanded contracts correctly. The Department of Health and Human Services review revealed no evidence that the violations were committed with willful or knowing intent on the part of the responsible party to violate the Antideficiency Act.

IHS's system of administrative control of funds has been approved by OMB and is available on the IHS website. The contracts have been reviewed in light of the Supreme Court's decision in *Salazar v. Ramah*, and that decision has no impact on this violation.

IHS has taken steps to strengthen internal controls for allocating CSC and prevent future violations from occurring. These steps included:

- Ensuring additional organizational components are involved in all aspects of reviewing, validating, and certifying CSC data, and reviewing all proposed CSC allocations, including allocations for new and expanded contracts or compacts;

- Requiring appropriations and contract training for all staff involved in the self-determination contracting process;
- Reviewing IHS's practices and procedures to proactively identify risks that could result in future violations and to strengthen the appropriate internal controls necessary to mitigate such risks; and,
- Evaluating the agency's policy for allocating CSC to ensure that application of the policy is consistent with appropriations acts.

Identical reports are being submitted to the President, the Speaker of the House of Representatives, and the Comptroller General.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

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