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Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
“Cutting Waste, Fraud, and Abuse in Medicare and Medicaid”
Subcommittee on Health
September 22, 2010

I want to thank Chairman Pallone for convening today’s important hearing.

Anyone who has followed my career in Congress knows how deeply I care about the Medicare and Medicaid programs. I have spent almost 40 years building, protecting, and expanding Medicare and Medicaid because I believe that the health care they provide for the aged, the poor, and the disabled is a critical right of all citizens and a crucial government responsibility. These programs work well, and they provide quality health care to millions of Americans who would otherwise be uninsured.

Of course, the vast majority of Medicare and Medicaid providers are honest and compassionate. But criminals do exist. That’s why part of standing up for Medicare and Medicaid means supporting the constant work that must be done to cut waste, fraud, and abuse in these programs.

Having served as Chairman of both the House Oversight Committee and the House Energy and Commerce Committee, a vital part of our work on both Committees has been reducing health care fraud.

The individuals and institutions that commit fraud against Medicare and Medicaid are bilking taxpayers and undermining public health. Whether it is a street corner criminal illegally trafficking in pharmaceutical drugs or a large multinational corporation paying illegal kickbacks to health care providers, the bottom line is the same: billions of dollars are stolen from these taxpayer-funded programs that provide health care to seniors, children, and the disabled.

Health care fraud does more than cost money. It corrodes the quality of care, and weakens the Medicare and Medicaid programs.

That’s why I’m proud of the provisions to help reduce Medicare and Medicaid fraud in the health care reform law that Congress passed and President Obama signed in March.

This new law contains dozens of provisions that amount to the most important reforms to prevent Medicare and Medicaid fraud in a generation.

The health care reform law contains new tools to prevent fraudulent providers from enrolling in or taking advantage of Medicare and Medicaid.

It shifts the prevailing fraud prevention philosophy from “pay and chase” – where law enforcement authorities only identify fraud after it happens – to “inspect and prevent.”

The Affordable Care Act requires enhanced background checks, new disclosure requirements, and on-site visits to verify provider information.

It requires that health care providers create their own internal compliance programs.

And it allow the Centers for Medicare and Medicaid Services (CMS) to impose moratoria on enrolling new providers if the Secretary believes that such enrollments will increase fraud risks. In short, it lets the Department of Health and Human Services (HHS) Secretary close the barn door before the horses have left.

But the new law does more than that. It contains several new requirements specifically aimed at preventing fraud in the high-risk home health and Durable Medical Equipment areas.

It contains new and enhanced penalties for fraudulent providers.

It contains new data sharing and data-collection provisions, providing additional access to anti-fraud databases for the Department of Justice, the Inspector General, and states.

And it contains new funding – almost \$500 million extra – to fight Medicare and Medicaid fraud. The Congressional Budget Office tells us that these new fraud provisions will save billions of dollars for taxpayers.

Even before passage of the Affordable Care Act, the Obama Administration asked for and received extra money to fight fraud in 2009 and 2010, increasing fraud recoveries by \$600 million. They expanded use of interagency strike forces to attack Medicare and Medicaid fraud in hot spots like Miami, Detroit, and Brooklyn. And they reorganized CMS to better coordinate fraud-prevention and enforcement efforts.

Now, thanks to the health care reform law, the Administration will be able to do even more.

Just last week, CMS released a proposed rule to implement the most significant Affordable Care Act anti-fraud provisions.

I am pleased that Peter Budetti – who many years ago worked as staff on this Committee – will be here to tell us about fraud-fighting efforts at CMS.

I also appreciate the HHS Inspector General, Daniel Levinson, appearing before this Committee for the second time in a week. Mr. Levinson, we appreciate all the hard work your office is doing to fight fraud, and look forward to hearing your perspective on the Affordable Care Act’s new fraud-fighting tools.