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Opening Statement of Rep. Diana DeGette
Ranking Member, Subcommittee on Oversight and Investigations
“Waste, Fraud, and Abuse: A Continuing Threat to Medicare and Medicaid”
Subcommittee on Oversight and Investigations
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Health care fraud costs Americans billions of dollars every year. Fraud affects health care providers at all levels, in Medicare and Medicaid, and in the private sector.

Today’s hearing will focus on a worthy target of oversight: waste, fraud, and abuse in the Medicare and Medicaid programs. Medicare and Medicaid provide millions of people with access to essential medical services, and the integrity of these programs is a vital concern of this Committee.

Fortunately, fighting waste, fraud, and abuse in Medicare and Medicaid is also a high priority for President Obama. Beginning in 2009, the Obama Administration made fighting fraud a priority. These efforts expanded even more after passage of the Affordable Care Act, which contained dozens of provisions designed to help fight Medicare and Medicaid fraud.

The Administration asked for and received additional funding to fight health care fraud in 2009 and 2010. They have reorganized within HHS and started several new collaborations with law enforcement authorities to uncover and prevent health care fraud.

In May of 2009, HHS and DOJ announced the creation of the Health Care Fraud Prevention and Enforcement Team (or “HEAT”), designed to coordinate Cabinet-level agency activities to reduce fraud. Under the HEAT program, HHS and DOJ have expanded the use of dedicated strike force teams, placing law enforcement personnel in locations that are identified as health care fraud hotspots. These teams carried out the largest health care fraud takedown in U.S. history last month, netting over 100 arrests in a single day. The work undertaken by strike force teams has led to criminal charges against 829 defendants for defrauding Medicare of almost \$2 billion.

The Administration’s efforts have been a huge success for taxpayers, with a return-on-investment that would make most hedge fund managers jealous. And thanks to the landmark health care reform law passed by Congress last year, HHS and law enforcement authorities now have a host of new tools and new funding to fight fraud.

The Affordable Care Act contains dozens of new provisions to fight Medicare and Medicaid fraud.

The most important changes allow CMS to apply a preventive model in its anti-fraud efforts. For years, CMS employed a “pay and chase” model of enforcement, simply paying fraudsters’ claims, then attempting to recoup its losses. Now, CMS has new authority to keep fraudsters out of Medicare and Medicaid in the first place.

The Affordable Care Act contains stiffer enrollment requirements for all providers, mandates enhanced background checks, adds new disclosure requirements, and calls for on-site visits to verify provider information. It requires that providers create internal compliance programs. And it contains several provisions aimed directly at fighting fraud in the high-risk durable medical equipment and home health programs.

The government’s ability to act once it has uncovered fraud or the possibility of fraud is also enhanced by the Affordable Care Act. The Secretary now has authority to enact moratoria on enrolling new providers if she believes that such enrollments will increase fraud risks, and she can suspend payments to providers where there is a substantiated allegation of fraud. Once fraud has been proven, the Affordable Care Act provides stiffer civil monetary penalties and expands the HHS Inspector General’s authority to exclude violators from the Medicare and Medicaid programs.

Data sharing and collection between CMS, states, and other federal health programs are modernized under the Affordable Care Act

And the Affordable Care Act provides an estimated \$500 million in increased funding over the next five years to fight fraud – money that will return billions of dollars to the taxpayer.

This expanded authority, combined with the coordinated and focused attention of the Obama Administration, has laid the groundwork for a new era in the federal government’s response to health care fraud.

The Government Accountability Office first designated Medicare a “high-risk” program in 1990, and Medicaid joined the “high-risk” list in 2003. For two decades, the programs have been on GAO’s high priority list. We will hear today from GAO about why this is the case, and what can be done. I am hopeful that the Obama Administration’s commitment to reducing fraud, and the substantial anti-fraud boost provided by the Affordable Care Act will ultimately produce the result that preceding Republican and Democratic Administrations have been unable to achieve: removal of Medicare and Medicaid from the GAO high-risk list.

Waste, fraud, and abuse in Medicare and Medicaid are bi-partisan problems, and I believe there is bi-partisan commitment to combating them. I hope there is also bi-partisan recognition of the commendable anti-fraud efforts undertaken by the Obama Administration and the vital anti-fraud authority granted by the Affordable Care Act.

I thank the witnesses for joining us here today and look forward to hearing their testimony on this important topic.