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Statement of Rep. Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
Hearing on “Medicare Contractors’ Efforts to Fight Fraud –
Moving Beyond ‘Pay and Chase’”
Subcommittee on Oversight and Investigations
June 8, 2012

Mr. Chairman, Medicare fraud wastes taxpayer dollars. It affects the quality of care provided to program enrollees, and it saps public confidence in Medicare. That's why I see fighting Medicare fraud as a critical need and an issue where we should be able to achieve bipartisan consensus.

The Obama Administration has an excellent record on preventing Medicare fraud, making it a priority from day one. Since 2009, the Administration has recovered almost \$8 billion in fraudulent payments. In fiscal year 2011, the Administration's Health Care Fraud Enforcement Team's efforts resulted in 132 indictments against defendants who collectively billed the Medicare program more than \$1 billion.

And since April 2010, the Administration has been busy implementing the new anti-fraud provisions in the landmark health care reform law. The law provides hundreds of millions of dollars in new funding to fight fraud. It imposes new penalties on fraudsters. And most important, it shifts the prevailing Medicare fraud prevention philosophy from pay and chase to inspect and prevent.

Thanks to the Affordable Care Act, Medicare fraud prevention now starts with the provider enrollment process. The health reform law added new screening requirements for Medicare providers, keeping bad actors out of Medicare before they can even attempt to commit fraud. CMS has now implemented these provisions, strengthening the enrollment process and verifying that providers are properly licensed and qualified to provide care before they are allowed into the Medicare program. This, Mr. Chairman, is the Affordable Care Act at work.

The health reform law also gave CMS enhanced authority to suspend Medicare payments to providers while they investigate an allegation of fraud – stopping fraudulent payments before they go out the door. Last year alone, CMS payment suspensions led to over \$27 million in recoveries against suspect providers.

The Affordable Care Act also provides hundreds of millions of dollars in new funding to help CMS, the Inspector General, and the Department of Justice fight Medicare fraud. Those funds are being put to good use. They help fund the Medicare Strike Force operations, which last month filed charges against 107 individuals who participated in Medicare fraud schemes. The funds help implement the new CMS Fraud Prevention System (FPS), which monitors 4.5 million claims each day and uses predictive analytics to identify and prevent fraud.

We're going to hear today from CMS, from GAO, and from the HHS Inspector General. I appreciate these witnesses coming, and I thank them for their hard work to protect taxpayer dollars and prevent Medicare fraud.

The Medicare Integrity Contractors that we will hear about at this hearing conduct critical work and are key fraud-fighting partners of CMS.

But the Inspector General has identified problems with the contractors and with CMS oversight of their activities. I hope to hear more from our witnesses today about the role that these contractors play and how we can improve this system to fight Medicare fraud.

Mr. Chairman, thank you for holding this hearing. I hope it results in a bipartisan approach to reducing Medicare fraud and abuse.