Statement of Ranking Member Diane DeGette
Hearing on "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers."
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce

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Thank you, Mr. Chairman. Today's hearing is an important opportunity to discuss ways to strengthen two critically important government programs that serve over 100 million Americans: Medicare and Medicaid.

We will hear today about recent reports from the OIG and GAO on provider enrollment and screening in Medicare and Medicaid. These reports remind us that we must be vigilant in our efforts to fight fraud and abuse in these programs.

Many of us on the dais and at the witness table have been working to fight waste, fraud, and abuse in Medicare and Medicaid for decades. The idea that error rates or improper payments are associated with these programs is not new.

For example, a 2003 Committee report found that Medicaid fraud could exceed $17 billion each year. The report went on to say, [quote] "This year, the Committee will examine ways in which States could adopt more rigorous enrollment controls to keep unscrupulous providers out of their programs and improve their program integrity standards."

We all know that it has been very difficult to root out fraud, waste, and abuse in Medicare and Medicaid. Keeping fraudulent and unscrupulous providers out of the program has been a longstanding challenge. And we will hear again today that recent GAO and OIG reports find there is still progress to be made. But I am very encouraged

by the recent success of the program integrity measures implemented by the Affordable Care Act.

The ACA provided the Department of Health and Human Services and its Office of Inspector General with a wide range of new tools and authorities for fighting fraud. We are already seeing improvements through the use of these new tools, and I believe they will continue to make a big difference going forward. I am eager to hear more from CMS about their progress.

These new tools allow program administrators to better protect tax dollars and prevent bad providers from entering the program.

For example, the ACA provided nearly $350 million in new funds for fraud control efforts. It also provided new means for collecting and sharing data between states and the federal government to screen potential providers and suppliers. The ACA provided the HHS OIG with new authorities to impose stronger penalties on those who commit fraud and provided CMS with the ability to temporarily halt payments to suppliers suspected of fraud.

CMS is also now incorporating predictive analytics to screen payments to look for patterns of fraud that were previously much harder to detect. This new effort, called the Fraud Prevention System, uses computer-modeling tools similar to those used by credit card companies to look for fraud patterns and help the government prevent and recover fraudulent or improper payments. According to CMS, in just three years, this system has allowed the agency to identify or prevent nearly $820 million in fraudulent payments.

This is good news, Mr. Chairman, and we should applaud this progress. These tools and authorities should allow CMS and the OIG to move away from the "pay and chase" model and spend more time stopping bad actors from entering the program in the first place. These important new tools should greatly enhance program integrity in the

Medicaid and Medicare programs, and they will help us achieve some of the anti-fraud goals that have long been out of reach.

While these are positive developments, we will hear from the HHS OIG and from GAO on some areas where we can improve. A recent OIG report, for example, found that not all of the States are utilizing these tools as comprehensively as possible. I want to understand more about that report today, and hear from CMS about why this is the case and how we can work together to ensure all tools available are being implemented as broadly as possible.

Mr. Chairman, let me conclude by thanking all of the witnesses before us today for the work they do to help strengthen the Medicaid and Medicare programs and for working so closely with this Committee.

I look forward to hearing from the auditors about what additional measures they believe we can or should take to reduce fraud while maintaining the programs' flexibility in delivering critical health care services.

This Committee has consistently worked on a bipartisan basis to strengthen the fraud fighting efforts in both the Medicare and Medicaid programs. I hope today's hearing will be a continuation of that effort. These critical programs serve millions of hard working Americans, and it is our duty to make them run as efficiently and effectively as possible.

With that, Mr. Chairman, I yield back.