COMMITTEE ON ENERGY & COMMERCE
DEMOCRATS
RANKING MEMBER FRANK PALLONE, JR.

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Statement of Ranking Member Frank Pallone, Jr., as prepared for delivery
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
Hearing on "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse"

"For decades, Medicaid has been a lifeline for tens of millions of hard working Americans across the country. That is why we must make sure that the resources we devote to this program are administered efficiently and effectively. Every dollar lost to misuse or fraud of our federal health programs is one less dollar available to fund essential, life-saving medical services for Americans. Cutting down on waste, fraud, and abuse is and must remain a priority for CMS, state Medicaid programs, and this Committee.

Some of my colleagues on the other side of the aisle have expressed concerns that expansion of Medicaid will put state budgets in an untenable position and increase fraud. This is simply not true. Beneficiary access and program integrity efforts are not competing goals. Smart, effective regulation reinforces both goals simultaneously.

In the short time since states have had the option to expand Medicaid, those states have already realized significant qualitative and economic benefits as uncompensated care rates drop and states are able to collect more revenue.

Expansion makes good economic sense, and good moral sense. For instance, my home state of New Jersey's projects a nearly $150 million decline in charity care in FY 2016, with savings from the Medicaid expansion totaling nearly $3 billion through 2020.

Let's also not forget that Medicaid coverage lowers financial barriers to access, increases use of preventative care, and improves health outcomes. Making the program available to more vulnerable Americans is a great achievement, one that I am very proud of having played a part in.
But, of course, it is now more important than ever that we act as good stewards of Medicaid dollars and ensure that the benefits of this program are available for generations to come.

That is why, when we passed the Affordable Care Act (ACA) in 2010, we included a number of measures to strengthen program integrity and reduce fraud in the Medicaid

program. In 2011, for example, CMS established procedures to screen providers and suppliers based on their risk levels so we can prevent fraud before it occurs. This has changed the traditional "pay and chase" model towards a preventive approach, by keeping fraudulent suppliers out of the program before they can commit fraud.

There are a number of other ACA anti-fraud measures that have impacted the Medicaid program positively over the past couple of years. These include new and enhanced penalties for fraudulent providers. These new authorities allow the Inspector General to exclude from Medicaid any provider that makes false statements on an application to enroll or participate in the program.

The ACA also requires state Medicaid agencies to withhold payments to a provider or supplier pending investigation of a credible allegation of fraud. The law also significantly increased funding to fight Medicare and Medicaid fraud.

I want to hear today about how all of these measures have worked and about how CMS is implementing regulations to better protect patients and legitimate providers.

Although the ACA made significant steps to reduce fraud and abuse in the Medicaid program, I know that there is always room for improvement. I'm glad that GAO is here today to share their findings and provide constructive advice about how we can make the Medicaid program even stronger.

But I want to caution against applying GAO's findings too broadly. First, the analysis focused on four states – Arizona, Florida, Michigan, and New Jersey – and its findings are not generalizable across the country. Second, the report looked at data from fiscal year 2011, before many of the ACA anti-fraud provisions went into effect. GAO acknowledges several times in the report that CMS has since made changes to address improper payment issues.

Third, I want to make the point that many of the potentially improper payments listed in this report are likely examples of provider fraud, not beneficiary fraud. The GAO report lists examples such as billing under deceased beneficiaries' identities, or billing on behalf of currently incarcerated beneficiaries. Given that these beneficiaries are hardly in a position to defraud the government, I think it is likely that many of these are examples of provider fraud.

Mr. Chairman, good program integrity helps to ensure that beneficiaries receive the care they need. So I look forward to hearing from CMS and GAO how these latest efforts are being implemented by the states.

Thank you and I yield back."

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