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Hearing Statement of Senator Max Baucus (D-Mont.) On the Anatomy of a Fraud Bust: From Investigation to Conviction As prepared for delivery

Julius Caesar once said, "Experience is the teacher of all things."

This morning we are here to learn from the experience of federal officials who fight health care fraud.

Each year, the federal government loses \$60 billion to health care fraud. This crime adds to the deficit, it wastes taxpayer dollars and it forces seniors to spend more out of their tight budgets on Medicare premiums.

Fighting health care fraud involves agencies across the federal government. The Centers for Medicare and Medicaid Services, or CMS, puts tools into place to investigate and prevent fraud. The Department of Health and Human Services Inspector General conducts criminal and civil investigations, and the Department of Justice prosecutes the criminals who steal taxpayer dollars.

A problem this big requires teamwork. The agencies involved need to work together seamlessly. They must have the right tools for the job and the resources available to deploy those tools.

Today, we're here to learn from a success story where CMS, the HHS Inspector General, and the Justice Department were able to work as a team. We will hear how the investigators rooted out the criminals, how the agents led the investigation and whether the government recouped its losses.

This case was made public last September, and at the time, it was the largest Medicare fraud bust in history. This Miami news clip from last fall shows one of the schemes involved.

These schemes were spread across eight cities, involved 91 defendants and almost \$300 million in fraudulent billing.

From this case, we hope to learn valuable lessons to further protect Medicare from criminals. I want to know what challenges you faced during the investigation.

What lessons were learned? What barriers, if any, exist between the agencies? How can we help you work together better? I also want to hear how the Affordable Care Act is helping to prevent and fight fraud.

We gave law enforcement an unparalleled set of new tools in health reform to prevent fraud. Before the health care law, even suspicious claims were paid and then investigated later.

Health reform changed that. It gives law enforcement the authority to stop payment and investigate suspicious claims before taxpayer money goes out the door.

Health reform also improved screening to ensure criminals can't get in to Medicare or Medicaid. Prior to health reform, most information was entered by hand into an inadequate and out-of-date database. As a result, Medicare paid providers who should have been prevented from joining the program in the first place.

Yesterday, GAO released a report at my request detailing the implementation of the new provider screening tools that health reform created.

The report says that a new automated system should ensure the provider enrollment system is up-to-date and accurate. As a result, criminals attempting to enter Medicare won't slip through the cracks and be able to defraud the government.

As we build upon our achievements fighting fraud, we must remain vigilant. Medicare has been growing at a fast rate for a long time. We all have concerns over the program's effect on the budget deficit and the health of the Medicare Trust Fund.

However, we have made real progress. Our non-partisan scorekeeper, the Congressional Budget Office, says that per-beneficiary Medicare spending will grow one percent above inflation in the next ten years. This is a major reduction compared to the past two decades, when Medicare grew five percent above inflation.

Our fight against health care fraud is one key piece to this progress. Last year, the federal government recovered a record \$4.1 billion as a result of health care fraud prevention and enforcement efforts. This is a worthy accomplishment, but we must do more.

So let us heed Julius Caesar's advice and learn from this success story. Let us take the experience we gained achieving this success and use it as a valuable teacher.

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