Senate Committee on Finance

U.S. Senator Orrin Hatch (R-UT), Ranking Member

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HATCH STATEMENT AT FINANCE COMMITTEE HEARING EXAMINING MEDICARE FRAUD

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following opening statement at a committee hearing examining the anatomy of a Medicare fraud bust – from investigation to conviction:

American citizens are sick and tired of stories about government's failure to act as a faithful steward of taxpayer dollars. And there are few programs as rife with waste as Medicare. Estimates of the amount of fraud, waste, and abuse in the Medicare system vary widely, anywhere from $20 billion to as much as $100 billion. With numbers like those, it is no wonder that Americans, on average, believe the federal government wastes over half of what they pay in federal taxes each year.

Taxpayers have reason to be angry about the levels of waste, fraud, and abuse in Medicare and Medicaid. We have scheduled this hearing in part to address their concerns. As today's written testimony illustrates, progress is being made on this front, but much more needs to be done.

Two years ago, Congress significantly expanded the authorities and resources given to the Centers for Medicare & Medicaid Services to shore up CMS' historically underfunded program integrity efforts. CMS now has over $1 billion dollars available annually to use in its fight to ensure payments are made properly.

While CMS has begun to make some strides in its fight against fraud, its implementation of congressionally mandated program integrity efforts has been lackluster at best. The CMS report card is not one to be proud of.

CMS has not put in any temporary moratoriums to prevent new providers or suppliers from enrolling and billing the Medicare program, even in areas where more than enough already exist to furnish health care services.

CMS has not established a surety bond on home health agencies even though CMS considers new home health agencies a high risk.

CMS has not established mandatory compliance programs as a condition of participation for suppliers and providers despite HHS-OIG's continued finding that those programs help prevent fraud from recurring.

CMS has not implemented limits on how much high risk suppliers and providers can bill.

CMS has not established procedures to deny additional Medicare billing privileges to suppliers who have an existing overpayment or suspension.

Until this morning, CMS had not even finalized a rule to implement checks to make sure that physicians actually refer a Medicare beneficiary for a medical service before paying the claim.

And CMS has not implemented claims edits to verify that DMEPOS suppliers are accredited for each item or service for which they bill Medicare.

CMS does have new enhanced provider screening tools designed to ensure that only legitimate providers and suppliers are allowed into the Medicare program. Yet a recent search by our offices of convicted felons, who are also physicians, showed that many — including a physician convicted of conspiracy to commit murder — still appeared on Medicare's public ordering and referring file as active Medicare providers.

Historically, CMS has claimed that for every $1 invested in program integrity efforts the return is at least $14. If that is the case, taxpayers and Congress should expect to see proof of $14 billion in recoveries in the very near future. Yet, given the results provided to date and the ineffectiveness of many of the efforts highlighted by the OIG, I am not going to hold my breath.

Despite many public announcements about enhanced tools, flashy new systems, and high profile collaborations to combat waste, fraud, and abuse, CMS can show few tangible results from these investments. Recoveries by CMS' law enforcement partners are at their highest rate of return ever — $4.1 billion for the last reporting period, a 58 percent increase over the year before. But the administrative actions and recoveries which are under CMS' sole control are far less robust.

The failure to address fraud, waste, and abuse appropriately is a long-standing problem for CMS. Perhaps a fresh perspective is necessary. That is why later this week I, along with my colleague Dr. Coburn, will begin soliciting ideas from all interested stakeholders for combatting the billions in waste, fraud, and abuse in the Medicare and Medicaid programs. Together, we hope to identify innovative solutions that will provide taxpayers with a return on the investments being made to combat the waste in these programs.

I want to be absolutely clear. Waste and fraud in the Medicare system is not a minor issue. Government agencies can harm U.S. taxpayers by acting improperly, as appears to be the case with the GSA scandal. But they can also hurt taxpayers through inaction. The failure of CMS to

address waste, fraud, and abuse — in spite of billions in taxpayer dollars dedicated to doing so — is quickly becoming its own scandal. Waste in the programs that CMS supervises directly harms U.S. taxpayers. That is the way that CMS needs to think about this issue. This is not some victimless crime. Fraud and waste in these programs hurt the American taxpayer, no less than if someone lifted their wallets. It harms the integrity of a program that our seniors depend on. And it undermines citizens' confidence in the government's ability to perform its most basic functions.

Thank you again Mr. Chairman. I look forward to the testimony of our witnesses.

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