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## U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

## SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

**HEARING: "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"**

**Opening Statement of Senator Tom Carper, Chairman**
*As prepared for delivery*

Today's hearing will focus on one of our nation's critical safety net programs, Medicaid, and the steps that must be taken to help further reduce waste and fraud and improve efficiency and effectiveness there.

A combination of federal and state funding pays for Medicaid, though states take the lead in administering the program. Over the last year, state governments paid approximately $404 billion to care for 70 million beneficiaries. These numbers are expected to grow in the coming years as the Affordable Care Act expands access to Medicaid for millions of Americans.

As everyone in this room knows, both the federal and state governments have struggled with record budget deficits in recent years. Today our national debt stands at about $15.7 trillion, well over double what it was just ten years ago. The last time our national debt was this high was at the end of World War II. That level of debt was not sustainable then, and it is not sustainable today.

In order to address the burden this debt places on our country, we need to look in every nook and cranny of federal spending – in programs large and small – and make certain that the resources we're investing are being spent efficiently and effectively. We need to demand results and focus the scarce resources taxpayers entrust us with on what works. And across the federal government, program managers need to sharpen their pencils and stop making the kind of expensive, avoidable mistakes that lead to improper payments.

With Medicaid, a significant amount of taxpayer dollars are unfortunately lost to waste and fraud. Those resources could, and should, instead be used to help states provide quality healthcare to some of our most vulnerable citizens.

According to the Government Accountability Office, Medicaid made an estimated $21.9 billion in improper payments in 2011. And Medicaid continues to be on the Government Accountability Office's (GAO) list of government programs at "high risk" for waste, fraud and abuse — as it has been for many years.

Now more than ever, it's urgent that we step up our efforts to eliminate the problems that lead to waste and fraud across government. Success in doing so will help us as we work to curb our federal debt and, in the case of Medicaid, it will help states as they grapple with their own budget problems. Ultimately all of us -- Congress, the Administration, and the states -- want to improve program integrity at Medicaid to ensure that the program has the resources necessary to provide critical services to those in need.

That's why I was encouraged to learn that, in 2011, we saw a decline in the level of improper payments in Medicaid compared to the more than $22 billion estimate we saw in 2010. The Centers for Medicare and Medicaid Services (CMS) and state governments are clearly beginning to make progress. However, more work remains in our efforts to curb improper payments and to reduce the amount of taxpayer dollars lost to errors, waste, and fraud. I want to encourage CMS to continue to partner closely with the states to take advantage of every opportunity to prevent, identify, and recover improper payments. We can't afford not to.

Fortunately, Congress and the Administration have made reducing Medicaid waste and fraud a high priority and taken important steps to improve its management of this critical program. The Affordable Care Act, which was enacted in 2010, includes a number of provisions aimed at enhancing our efforts to fight waste, fraud, and abuse in Medicare and Medicaid. These provisions aim to eliminate avoidable mistakes and crack down on criminals. They are critical to our broader efforts of achieving better healthcare results and improving access to affordable, quality healthcare.

We are also looking at additional steps that the federal government should take. Senator Coburn and I, along with dozens of our Senate and House colleagues, have put forward legislation to fight fraud, waste, and abuse in the Medicare and Medicaid programs— "The Medicare and Medicare Fighting Fraud and Abuse to Save Taxpayers Dollars Act", or the FAST Act as we call the bill. It takes some of what we already know works to decrease waste and fraud in the private sector, or that we have already seen is beginning to work elsewhere in government, and applies these ideas to Medicare and Medicaid.

Our bill includes a wide range of initiatives. Among other things, the legislation would increase anti-fraud coordination between the federal and state governments, increase criminal penalties for fraud, encourage seniors to report possible fraud and abuse in Medicare through the Senior Medicare Patrol, and deploy cutting-edge data analysis technologies. Our legislation addresses loopholes in fraud-prevention efforts that have been exploited to an alarming degree over the years. For example, there's the glaring problem of dead doctors who still manage to charge us for care they provide their patients, obviously a form of fraud. This is both disturbing and unacceptable. Our bill

would require that the federal government and law enforcement take steps to curb the theft of physician identities.

I often say that there is no silver bullet to fighting waste and fraud. But this bipartisan bill provides a lot of smaller, proven, common-sense solutions. It builds on recommendations by the Office of the Inspector General, GAO, and other experts to improve upon the current work of the program integrity office at CMS, which, as I've mentioned, has already made important progress in reducing waste and fraud in these programs.

Even as we look ahead to implementing additional tools to help improve efficiency and effectiveness in Medicare and Medicaid, we also need to evaluate the effectiveness of the current tools at our disposal and identify what's working and where we need to improve our efforts. Today, our witnesses from the GAO and the Office of Inspector General will help us in that effort by describing weaknesses in the two primary Medicaid anti-waste and fraud systems now utilized by the federal government.

According to GAO, one program that relies on Medicaid Integrity Contractors only identified about $19.9 million in overpayments since 2008, yet we spent $102 million to operate the program during the same period. We clearly need to identify ways to improve our return on investment here.

There are similar problems with the second federal anti-waste and fraud program, called the Medicare-Medicaid Data Match program, where Medicare and Medicaid data are compared with each other to spot duplication and other problems. Over a two year time period, the program received $60 million in funding, but only prevented or recouped $57.8 million in improper payments.

But there have also been successes. Earlier this year, the Administration announced another record breaking year in joint federal and state efforts to identify and prosecute health care fraud, with more than $4 billion in recoveries from Medicare, Medicaid and other federal health care programs.

In addition, strong new steps have been taken to screen physicians and other providers in order to avoid physician identity theft and other fraudulent activity that can lead to drug diversion and fraud. In fact, CMS announced last week that this new automated screening process has already purged the provider database of more than 20 thousand providers that were ineligible to participate in Medicare and Medicaid due to death, licensing and other problems. This is a very important step forward.

I look forward to hearing today from Dr. Budetti, the head of CMS's program integrity efforts in both Medicaid and Medicare, about how he intends to build on what has

worked so far and improve the performance of those initiatives that have not worked as well. I also look forward to hearing from the state agency representatives we have with us today about their experiences curbing Medicaid waste and fraud.

We are here today in large part because we have a moral imperative to ensure that both present and future Medicaid beneficiaries continue to have access to quality care. At the same time, we must also ensure that the scarce taxpayer resources we invest in the program are being spent as effectively as possible.

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