Opening Statement of the Honorable Joe Pitts
Subcommittee on Health
Hearing on Examining Options to Combat Health Care Waste, Fraud and Abuse
November 28, 2012

(As Prepared for Delivery)

In May of this year, the Department of Justice brought charges against 107 individuals who bilked Medicare for over $452 million. Just seven individuals in Louisiana were responsible for over $225 million of this fraud. In a separate case in February, a single Dallas doctor was arrested for making $350 million in false claims. In February 2011, 114 individuals who had bilked over $240 million were arrested in another crackdown.

All told, that billion dollars in improper payments represents less than two percent of the estimated $60 billion annually lost to waste fraud and abuse.

As bad as that number is on its own, I want to put it into context.

The Medicare program is running out of money – the CMS Actuary predicts the program could be insolvent in just five years. As the Congressional Research Service wrote in a June 2011 report, "as long as the (Medicare) trust fund has a balance, the Treasury Department is authorized to make payments" on behalf of seniors.

However, the report continues, "there are no provisions in the Social Security Act that govern what would happen if [insolvency] were to occur." The report contends that when insolvency of the Medicare program happens, "…there would be insufficient funds to pay for all Part A reimbursements to providers."

If Congress and the president support the idea that seniors should depend on the Medicare program to pay their provider bills, reform of the program through legislative action will be needed. The Medicare Trustees, in their 2011 report to Congress, have already stated as much.

One area of reform that I hope we can tackle in a bipartisan way is the area of fraud and abuse in the Medicare program. The federal government has made strides recently to improve catching fraudulent providers and beneficiaries, and I commend them for their efforts. However, at the same time, they have largely failed to implement mechanisms that would prevent fraudulent payments from being made in the first place. Prosecuting offenders does not get back all the money they stole.

One such area is predictive analytics. CMS implemented the Fraud Prevention System in July 2011 to analyze Medicare claims data using models of fraudulent behavior after such a system was shown to work well in the private industry. However, while the current system can draw on a host of data sources in support of its efforts, the system has not yet been integrated with the agency's payment-processing system to allow for the prevention of payments until suspicious claims can be determined to be fraudulent.

Further, a recent GAO report stated that CMS has failed to define an approach for even measuring whether the current system is helping to prevent fraudulent billing. It is my firm belief that greater transparency from CMS with regards to current fraud programs is needed if we hope to build upon what is currently being done to make the program more secure.

Our nation's seniors are counting on us to ensure that Medicare fulfills its promises. We can do that in part by making sure their premium dollars are managed wisely and not lost to con artists.

Our hearing today will discuss the efforts Medicare has currently undertaken to prevent fraud in government programs. In addition, the panel has generously offered us their time and expertise to explore emerging technologies and mechanisms that might help improve those efforts.

I want to thank our witnesses for sharing their thoughts with us today, and I am confident that these ideas can help generate a bipartisan effort to improve the solvency of the Medicare program in the coming Congress.

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