Prepared Statement of Senator Chuck Grassley of Iowa
U.S. Senate Committee on Finance
Hearing on "Preventing Health Care Fraud: New Tools and
Approaches to Combat Old Challenges"
March 2, 2011

Chairman Baucus, thank you for calling this hearing today to discuss ways we can prevent health care fraud. I think we can all agree that we need to cut down on health care fraud to ensure the sustainability of Medicare and Medicaid. Over the last nine years, the Finance Committee has held about 20 oversight hearings dealing with Medicare and Medicaid fraud. These hearings have highlighted flaws in how the federal government administers Medicare and Medicaid. They also emphasized the need to create disincentives for those who seek to defraud these vital programs. Every dollar lost to Medicare or Medicaid fraud is a dollar that's not available for beneficiaries.

In addition to my position on the Finance Committee, I now serve as the Ranking Member of the Senate Committee on the Judiciary. In January, the Judiciary Committee held a hearing to discuss with Department of Justice officials what is working, what isn't working, and what more can be done to combat fraud, including health care fraud. Today's hearing is another opportunity to continue that conversation with officials from the Department of Health and Human Services.

The federal government spent $502 billion on Medicare and $379 billion on Medicaid in fiscal year 2009. It is estimated between $40 billion and $70 billion was lost to fraud that year. Officials from the Department of Health and Human Services and the Department of Justice announced last month that their health care fraud prevention and enforcement efforts recovered $4 billion in fraud. That means we have a long way to go.

When it comes to public programs like Medicare and Medicaid, it is clear that the federal government needs to be more effective in combating fraud, waste and abuse. The federal government has simply made it too easy for bad actors to steal from these programs. It says a lot when you hear that organized crime groups have moved into health care fraud because it is profitable. Medicare and Medicaid are also attracting more criminals because the consequences of getting caught are significantly less onerous. And then there are those who don't get caught.

Taxpayer dollars should only go to bona fide providers and medical suppliers. But the reimbursement system is set up so that the federal government pays first and asks questions later; in other words, the program is founded on a "pay and chase" system.

Over the years, Congress has provided the executive branch with additional authorities to improve enforcement of fraud, waste and abuse laws. During health care reform, Chairman Baucus and I developed a bipartisan set of legislative proposals to combat fraud, waste and abuse. Many of these proposals are in the bill I introduced in the last Congress, S. 2964, the Strengthening Program Integrity and Accountability in Health Care Act, and were included in the Patient Protection and Affordable Care Act (PPACA). These provisions did not draw opposition from either side of the aisle. Tackling fraud, waste and abuse in health care is one of the areas where there is widespread agreement.

But our work does not end with reforms we passed last year. Congress needs to keep the pressure on federal officials to do everything possible to prevent and stop fraud. There is also more that Congress should pass in the way of reforms to enhance the government's ability to fight fraud. And there's a lot more the government should do to fully use the tools it has already.

We need to ensure that phantom doctors, pharmacies and durable medical equipment suppliers cannot simply bill Medicare millions of dollars in a few months and get out of town scot free. HHS, CMS and their contractors have to do more to detect potentially fraudulent claims and use the tools that are available to make sure the claims are legitimate before they are paid.

And even with all that, we must remain vigilant in our oversight efforts, because tomorrow's scammers will find ways to get around the laws and regulations we put in place today. That's why I will be introducing a bill today that contains provisions of S. 2964 that did not make it into PPACA.

The bill would create a national clearinghouse of information so we can better detect and prevent and thereby deter medical identity theft. This is about the federal government sharing information it already has in ways that protect the taxpayer and work against those defrauding the system and hopefully deter those who are thinking about stealing from the taxpayer.

It would change federal laws that require Medicare to pay providers quickly, regardless of the risk of fraud, waste, or abuse. Under current law, the government is required to make payment for a "clean" claim within 14 to 30 days before interest accrues on the claim. And that is not enough time for the limited number of Medicare auditors to determine if the claim is legitimate before the payment has to be made. The result is that this "prompt payment rule" requires that Medicare pay bad actors first, and ask questions later.

This requirement doesn't make any sense. So this bill would extend the time that payments must be made if the Secretary of Health and Human Services determines there's a likelihood of fraud, waste and abuse.

In addition, the bill would expand the HHS Inspector General's authority to exclude an individual from participating in federal health care programs if, for example, at the time an entity engaged in misconduct—such as health care fraud—the individual had ownership or control interests in that entity.

Last week, the *Los Angeles Times* reported that the Food and Drug Administration (FDA) is struggling to keep unapproved drugs off the market. It reported that "In many cases, the agency doesn't even know what the drugs are, or where they are." This is another example of flaws in the federal reimbursement system – how Medicaid pays for drugs creates an incentive for unapproved drug makers to sell their drugs without meeting FDA requirements. Medicaid pays until FDA identifies a drug or class of drugs as not approved for marketing and takes formal action. Under such circumstances, the federal government doesn't even have the option to chase

after these payments. My bill would stop such payments unless the state first verifies with FDA that the drug is being legally marketed.

The changes I'm proposing would go a long way to deter those who would defraud our health care programs. It also would provide greater protections to the taxpayer.

I look forward to hearing from the witnesses today on what more can be done to deter and detect health care fraud, waste and abuse. And I look forward to working with all my colleagues on the Committee to build on reforms to enhance the government's ability to fight fraud. Thank you.