STATEMENT OF SENATOR SUSAN COLLINS
SENATE SPECIAL COMMITTEE ON AGING HEARING
"PREVENTING MEDICARE FRAUD: HOW CAN WE BEST PROTECT SENIORS AND TAXPAYERS"
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Thank you, Mr. Chairman, for calling this hearing to highlight both the human and financial costs associated with fraud in the Medicare program and to examine ways that Medicare can work with private insurers and other stakeholders to improve fraud prevention.

The GAO has identified Medicare as being at high risk for improper payments and fraud for decades, since 1990. In 2012, Medicare reported that it had lost more than $44 billion in improper payments due to waste, fraud, abuse, and mismanagement. And that estimate may well be too low.

This is simply unacceptable. The loss of these funds not only compromises the financial integrity of the Medicare program, but it also undermines our ability to provide needed health care services to the more than 54 million older and disabled Americans who depend on this vital program.

In far too many cases, Medicare fraud schemes have directly affected the quality of care and put some of our most vulnerable patients at risk. Many patients are harmed as a result of unnecessary procedures or medical services provided as part of schemes to defraud Medicare. We will hear this afternoon about one Michigan physician who allegedly gave seniors cancer treatments they did not need simply so he could bill Medicare for his services.

In the late 1990s, when I was Chairman of the Permanent Subcommittee on Investigations, we held a series of hearings to examine fraud in the Medicare program. We identified the dangerous trend of an increasing number of bogus providers entering the system with the sole and explicit purpose of robbing it. One of our witnesses told us that he went into Medicare fraud because it was easier than dealing drugs. He could make a lot more money at far less risk.

In other cases investigated by the Subcommittee, more than $6 million in Medicare funds were sent to durable medical equipment companies that provided no goods or services whatsoever. One of these companies even listed an absurd fictitious address that, had it existed, would have been in the middle of the runway of the Miami International Airport.

We have made some progress in the battle against Medicare fraud since I chaired those hearings but the con artists have become increasingly clever in their schemes to rip off Medicare. We are devoting increased funding to Medicare program integrity activities to prevent improper payments and to detect fraud and prosecute offenders. Since it is estimated that we recover more than $8 for every dollar spent on anti-fraud activities, these are wise investments of federal funds.

In addition, Medicare contractors are now conducting on-site visits of durable medical equipment suppliers and other providers to make sure that they are legitimate businesses and meet

required standards before they enroll in Medicare. And, we are doing a better job of screening Medicare providers by using licensing and background checks to stop fraudsters from entering the program in the first place.

I do want to emphasize one important point. The vast majority of medical professionals are caring, dedicated providers whose top priority is the welfare of their patients. They, too, are appalled at the unscrupulous bandits who take advantage of weaknesses in Medicare to bleed billions of dollars from the program.

Unfortunately, there is no line item in the budget titled “Waste, Fraud, and Abuse” that we can simply strike to eliminate this problem. The task of ferreting out wasteful and fraudulent spending is made all the more difficult by the ingenuity of the scam artists. But it is clear that we must do more to shift from a “pay and chase” strategy to combat Medicare fraud to one that prevents the harm from ever occurring in the first place.

Again, Mr. Chairman, thank you for calling this hearing.