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HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

Indicators Provide Information on Program Accomplishments, but Assessing Program Effectiveness is Difficult

GAO Highlights

Highlights of GAO-13-746, a report to congressional requesters

Why GAO Did This Study

GAO has designated Medicare and Medicaid as high-risk programs partly because their size, scope, and complexity make them vulnerable to fraud. Congress established the HCFAC program and provided funding to HHS and DOJ to help reduce fraud and abuse in Medicare and Medicaid.

GAO was asked to examine how HHS and DOJ are using funds to achieve the goals of the HCFAC program, and to examine performance assessments and other metrics that HHS and DOJ use to determine the program's effectiveness. This report (1) describes how HHS and DOJ obligated funds for the HCFAC program, (2) examines how HHS and DOJ assess HCFAC activities and whether key program outputs have changed over time, and (3) examines what is known about the effectiveness of the HCFAC program in reducing health care fraud and abuse.

To describe how HHS and DOJ obligated funds, GAO obtained financial information from HHS and DOJ for fiscal year 2012. To examine how HHS and DOJ assess HCFAC activities and whether key outputs have changed over time, GAO reviewed agency reports and documents, and interviewed agency officials. To examine what is known about the effectiveness of the HCFAC program, GAO conducted a literature review and interviewed experts.

In comments on a draft of this report, HHS noted examples of CMS's efforts to reduce health care fraud, though these examples were not included in the HCFAC return-on-investment calculation. Additionally, HHS and DOJ provided technical comments, which GAO incorporated as appropriate.

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What GAO Found

In fiscal year 2012, the Department of Health and Human Services (HHS), HHS Office of Inspector General (HHS-OIG), and the Department of Justice (DOJ) obligated approximately $583.6 million to fund Health Care Fraud and Abuse Control (HCFAC) program activities. About 78 percent of obligated funds were from mandatory HCFAC appropriations (budgetary resources provided in laws other than appropriation acts), 11 percent of obligated funds were from discretionary HCFAC appropriations (budgetary resources provided in appropriation acts), and 12 percent were obligated funds from other appropriations that HHS, HHS-OIG, and DOJ used to support HCFAC activities. HCFAC funds were obligated to support a variety of activities, including interagency Medicare Fraud Strike Force Teams—which provide additional investigative and prosecutorial resources in geographic areas with high rates of health care fraud—located in 9 cities nationwide.

HHS, HHS-OIG, and DOJ use several indicators to assess HCFAC activities, as well as to inform decision-makers about how to allocate resources and prioritize those activities. For example, in addition to other indicators, the United States Attorneys' Offices use indicators related to criminal prosecutions, including the number of defendants charged and the number of convictions. Additionally, many of the indicators that HHS, HHS-OIG, and DOJ use—such as the dollar amount recovered as a result of fraud cases—reflect the collective work of multiple agencies since these agencies work many health care fraud cases jointly. Outputs from some key indicators have changed in recent years. For example, according to the fiscal year 2012 HCFAC report, the return-on-investment—the amount of money returned to the government as a result of HCFAC activities compared with the funding appropriated to conduct those activities—has increased from $4.90 returned for every $1.00 invested for fiscal years 2006-2008 to $7.90 returned for every $1.00 invested for fiscal years 2010-2012.

Several factors contribute to a lack of information about the effectiveness of HCFAC activities in reducing health care fraud and abuse. The indicators agencies use to track HCFAC activities provide information on the outputs or accomplishments of HCFAC activities, not on the effectiveness of the activities in actually reducing fraud and abuse. For several reasons, assessing the impact of the program is challenging. For example, it is difficult to isolate the effect that HCFAC activities, as opposed to other efforts such as changes to the Medicare provider enrollment process, may have in reducing health care fraud and abuse. It is also difficult to estimate a health care fraud baseline—a measure of the extent of fraud—that is needed to be able to track whether the amount of fraud has changed over time as a result of HCFAC or other efforts. HHS has a project under way to establish a baseline of probable fraud in home health care, and will determine whether this approach to estimating a baseline of fraud should be expanded to other areas of health care. Results from this project and other studies could provide HHS and DOJ with additional information regarding which activities are the most effective in reducing health care fraud and abuse, and could potentially inform agency decisions about how best to allocate limited resources.