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Report to Congressional Requesters

September 2013

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

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

GAO-13-746

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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.

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Abbreviations

ACL	Administration for Community Living
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPA	Office of the Assistant Secretary for Public Affairs
CMS	Centers for Medicare & Medicaid Services
CHIP	Children's Health Insurance Program
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
DOJ	Department of Justice
EOUSA	Executive Office for United States Attorneys
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
HCFAC	Health Care Fraud and Abuse Control
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HIPAA	Health Insurance Portability and Accountability Act of 1996
JMD	Justice Management Division
OAS	Office of Audit Services
OCIG	Office of Counsel to the Inspector General
OEI	Office of Evaluation and Inspections
OGC	Office of General Counsel
OI	Office of Investigations
OMP	Office of Management and Policy
SMP	Senior Medicare Patrol
Strike Force	Medicare Fraud Strike Force
USAOs	U.S. Attorneys' Offices

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September 30, 2013

The Honorable Thomas R. Carper
Chairman
The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate

The Honorable Claire McCaskill
Chairman
Subcommittee on Financial and Contracting Oversight
Committee on Homeland Security and Governmental Affairs
United States Senate

GAO has designated Medicare and Medicaid as high-risk programs because their size, scope, and complexity make them particularly vulnerable to fraud and abuse.[1] According to the Department of Health and Human Services' Office of Inspector General (HHS-OIG), common health care fraud schemes include providers or suppliers billing for services or supplies not provided or not medically necessary, purposely billing for a higher level of service than that provided, and paying kickbacks to providers for referring beneficiaries for specific services or to certain entities. To help reduce fraud and abuse in health care programs, including Medicare and Medicaid, Congress established the Health Care

[1]GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Abuse represents actions inconsistent with acceptable business or medical practices.

Fraud and Abuse Control (HCFAC) program as a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[2] The departments of Health and Human Services (HHS) and Justice (DOJ) jointly administer the HCFAC program and, in fiscal year 2012, received over $486 million in HCFAC appropriations. Several components within HHS and DOJ receive appropriations to carry out HCFAC activities, including the Centers for Medicare & Medicaid Services (CMS)—the agency within HHS that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)[3]—the HHS-OIG, and DOJ's components—the Civil, Civil Rights, Criminal, and Justice Management divisions, the U.S. Attorneys' Offices (USAOs), and the Federal Bureau of Investigation (FBI).[4,5]

By statute, HHS and DOJ are required to issue a joint report annually to Congress on the amounts appropriated through the HCFAC program, and the amounts recovered as a result of HCFAC activities. In fiscal year 2012, HHS and DOJ reported having won or negotiated over $3 billion in health care judgments and settlements through the activities of the HCFAC program. The agencies also reported obtaining additional administrative penalties in health care fraud cases and proceedings as a result of these activities. In fiscal year 2012, about $4.2 billion was collected, a portion of which was deposited into the Medicare Trust Funds as a result of health care judgments and settlements and administrative penalties (including those that occurred before fiscal year 2012). We have previously reported that although there have been convictions involving multimillion dollar schemes that defrauded the Medicare program, there are no reliable estimates of the amount of fraud in the Medicare program

[2]Pub. L. No. 104-191, § 201, 110 Stat. 1936, 1992 (Aug. 21, 1996) (codified at 42 U.S.C. §§ 1320a-7c, 1395i(k)).

[3]Medicare is the federal health insurance program for persons aged 65 and over, certain disabled individuals, and individuals with end-stage renal disease. Medicaid and CHIP are joint federal-state programs that finance health insurance coverage for certain categories of low-income adults and children.

[4]In this report, we refer to the agencies, divisions, and offices within HHS and DOJ as components.

[5]In addition to HCFAC mandatory and discretionary funding appropriated to HHS, HHS-OIG, and DOJ, over $250 million in discretionary HCFAC funding was appropriated to CMS to support program integrity activities in Medicare and Medicaid for fiscal year 2012.

or for the health care industry as a whole.[6] Additionally, although HHS and DOJ work to reduce health care fraud and abuse through the HCFAC program, concerns have been raised about whether the HCFAC program has been effective in reducing health care fraud and abuse.

Given these concerns, you asked us to examine how HHS and DOJ have used their appropriations to achieve the goals of the HCFAC program, and to examine performance assessments and other metrics HHS and DOJ use to determine the HCFAC program's performance and 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.

For our review, we included agencies within HHS (including HHS-OIG) and DOJ that received mandatory and discretionary HCFAC funding in fiscal year 2012 whose activities are described in the annual HCFAC report,[7] and whose funding is included in the annual report's return-on-investment calculation (which compares the amount of monetary results to the federal government, such as funds returned to the Medicare Trust Funds as a result of HCFAC activities, with the funding appropriated to conduct those activities).[8,9] For CMS, we only included the HCFAC

[6]See GAO, *Medicare: Progress Made to Deter Fraud, but More Could Be Done,* GAO-12-801T (Washington, D.C.: June 8, 2012).

[7]Mandatory funding refers to budgetary resources controlled by laws other than appropriations acts. Discretionary funding refers to budgetary resources provided in annual appropriations acts, other than those that fund mandatory programs. HHS and DOJ receive mandatory funding as well as discretionary funding for the HCFAC program. The FBI receives mandatory funding to support HCFAC activities.

[8]HHS's components that received HCFAC funding in fiscal year 2012 were: Administration for Community Living (ACL), CMS, Food and Drug Administration (FDA), and Office of General Counsel (HHS-OGC). HHS-OIG's components that received HCFAC funding in fiscal year 2012 were: Office of Audit Services (OAS), Office of Counsel to the Inspector General (OCIG), Office of Evaluation and Inspections (OEI), Office of Investigations (OI), and Office of Management and Policy (OMP). DOJ's components that received HCFAC funding were: DOJ's Civil Division, Civil Rights Division, Criminal Division, Executive Office for United States Attorneys (EOUSA)—which provides administrative support for the 94 USAOs—the Justice Management Division (JMD), and the FBI.

[9]The Medicare Trust Funds refer to the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, which finance Medicare.

funding that was included in the HCFAC return-on-investment calculation.[10] We excluded all of the remaining HCFAC funding that CMS receives because it is not included in the HCFAC return-on-investment calculation and generally supports program integrity activities in Medicare Parts C and D, which are similar to the activities conducted under the Medicare Integrity Program.[11]

To describe how HHS and DOJ obligated funds for the HCFAC program, we obtained information about how the agencies obligated their HCFAC appropriations for fiscal year 2012, by expenditure category (such as personnel).[12,13] We received this information from the HHS, HHS-OIG, and DOJ components that received HCFAC funding.[14] Additionally, we obtained information on obligations of other appropriations that HHS,

[10]The HCFAC funding appropriated to CMS that we included in our review supports a Medicaid and CHIP financial management oversight project, a pilot project using data analytics to identify fraud in community mental health centers in 3 states, and some of CMS's contributions to the Medicare Strike Force teams, which provide additional investigative and prosecutorial resources in high fraud cities. The funding included in our review is a small portion of the HCFAC funding that CMS receives. In fiscal year 2012, CMS received over $250 million in discretionary HCFAC funding, and CMS officials told us that most of this funding was used to support program integrity activities in Medicare Parts C and D.

[11]In July 2011, we issued a report on how CMS used its Medicare Integrity Program (MIP) funding to support the program's activities in fiscal years 2006 through 2010, how CMS assessed the effectiveness of MIP, and the factors CMS considered when allocating MIP funding. See GAO, *Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*, GAO-11-592 (Washington, D.C.: July 29, 2011). CMS concurred with our recommendations that CMS update the return-on-investment calculation when program expenditure data are updated and implement data system changes that will permit CMS to capture accurate spending data.

[12]An obligation is a definite commitment that creates a legal liability of the government for payment of goods and services ordered or received. Obligations can be paid immediately or in the future.

[13]We requested that HHS, HHS-OIG, and DOJ report their information within five categories of expenses: (1) personnel compensation and benefits; (2) contractual services and supplies (including rent, transportation, printing, and supplies); (3) acquisition of assets; (4) grants; and (5) other expenses. In addition to fiscal year 2012, we obtained information for fiscal years 2008 through 2011, which is included in appendix II.

[14]Two HHS components, the Office of the Assistant Secretary for Public Affairs and the Office of the Assistant Secretary for Planning and Evaluation, had HCFAC obligations for fiscal year 2011 only.

HHS-OIG, and DOJ components used to support HCFAC activities.[15] Additionally, we interviewed officials at HHS and DOJ components, and reviewed agency documents to examine the process by which HHS and DOJ have obligated HCFAC funds. We reviewed the data for any errors and followed up with agency officials for clarification when necessary. On the basis of these activities, we determined that these data were sufficiently reliable for the purpose of our report.

To examine how HHS and DOJ assess HCFAC activities, and whether key program outputs have changed over time, we interviewed officials from HHS, HHS-OIG, and DOJ to obtain information on indicators reported by their agencies. We asked these officials about indicators listed in the HCFAC report, as well as other indicators that HHS, HHS-OIG, and DOJ components use to assess HCFAC activities. We also collected information from agency officials about how they use the indicators and other data analyses to determine how to target HCFAC resources and prioritize activities. We reviewed agency documents, including the fiscal year 2012 HCFAC report, agency annual and semi-annual reports, strategic plans, performance plans, congressional budget justifications, and other reports to obtain information on HCFAC activities that HHS, HHS-OIG, and DOJ components conducted. We reviewed the return-on-investment calculation outlined in the HCFAC report to determine what funding and amounts recovered are included, as well as the method used to calculate the return-on-investment.[16] To examine whether key program outputs have changed from fiscal year 2008 to 2012, we reviewed current and past HCFAC reports. We selected outputs from the annual HCFAC report to review, which the agencies consider to be key program outputs. For this analysis, we also took account of other funding (i.e., funds that agencies used to support HCFAC activities that were not specifically appropriated for the HCFAC program). We also interviewed agency officials regarding other factors that may have contributed to changes in program outputs in specific years.

[15]For the purposes of our report, we refer to HHS-OIG and its components separately from HHS and its agencies. Several HHS and DOJ components obligated funds not specifically appropriated for the HCFAC program in addition to HCFAC appropriations to carry out activities related to health care fraud and abuse. For example, DOJ's USAOs used other appropriations, including direct appropriations, to support HCFAC activities.

[16]The return-on-investment calculation compares the amount of funding returned as a result of HCFAC activities with the funding appropriated to conduct those activities.

To examine what is known about the effectiveness of the HCFAC program in reducing health care fraud and abuse, we conducted a review of relevant literature to identify measures used to assess the effectiveness of law enforcement programs, challenges associated with evaluating law enforcement programs, and the issues related to establishing a baseline estimate of the type and extent of fraud needed to measure progress over time. We included in our search both health care fraud enforcement programs specifically and law enforcement programs in general. We conducted literature searches in 44 online databases with health care and/or law enforcement content containing peer-reviewed publications and government reports to identify studies published from January 2003 through March 2013 using health care fraud, law enforcement, and performance measurement search terms. We conducted a preliminary review of abstracts for over 300 articles and selected 49 articles for closer review based on the following criteria: the article (1) identified performance indicators to assess the effectiveness of enforcement programs in general or health care fraud enforcement programs specifically; (2) discussed establishing a health care fraud baseline; or (3) identified challenges in evaluating law enforcement programs. Additionally, we interviewed HHS and DOJ officials to obtain information on the effectiveness of HCFAC activities and to determine the status of efforts by a CMS contractor to establish a health care fraud baseline. We also interviewed experts on health care fraud to discuss strengths and limitations of measuring the effectiveness of health care fraud enforcement programs, such as the HCFAC program.[17]

We conducted this performance audit from September 2012 to September 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[17]We selected these experts through our literature review.

Background

Health Care Fraud and Abuse Control Program

The HCFAC program was established under HIPAA to (1) coordinate federal, state, and local law enforcement efforts to control fraud and abuse associated with health plans; (2) conduct investigations, audits, evaluations, and inspections of delivery and payment for health care in the United States; (3) facilitate the enforcement of federal health care fraud and abuse laws; (4) provide guidance to the health care industry in the form of advisory opinions, safe harbor notices, and special fraud alerts; and (5) establish a national database of adverse actions against health care providers.[18]

HIPAA requires that HHS and DOJ issue a joint annual report to Congress that outlines the amounts returned to the Medicare Trust Funds for the previous fiscal year under various categories, such as amounts of criminal fines and civil monetary penalties—penalties for certain activities, such as knowingly presenting a Medicare claim that is not medically necessary. Additionally, HHS and DOJ are required to report the amounts deposited into and expended from the Medicare Trust Funds to conduct HCFAC activities during the previous fiscal year and the justification for those expenditures. In addition to the mandatory appropriations provided under HIPAA, which Congress increased in 2010, DOJ and HHS-OIG have received discretionary funding through annual appropriations for the HCFAC program since fiscal year 2009.[19]

The annual HCFAC report includes a summary of the key HCFAC activities that the agencies and their components carried out and provides information on the outputs or outcomes of those activities. For example, the report includes information on the amount of money returned to the

[18]Safe harbors identify payment or business practices that are protected from enforcement under federal laws that prohibit such payment or business practices.

[19]*See, e.g.,* Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, 123 Stat. 524, 773 (Mar. 11, 2009). In addition to appropriating discretionary HCFAC funds, this law and subsequent annual appropriations laws have required that the annual HCFAC report include measures of operational efficiency and impact on fraud, waste, and abuse in Medicare, Medicaid, and CHIP for the funds provided by these appropriations. Starting in fiscal year 2010, the annual HCFAC report has included a return-on-investment calculation. The calculation is estimated by dividing the monetary results (such as deposits and transfers to the Medicare Trust Funds) by the annual HCFAC appropriation in a given year.

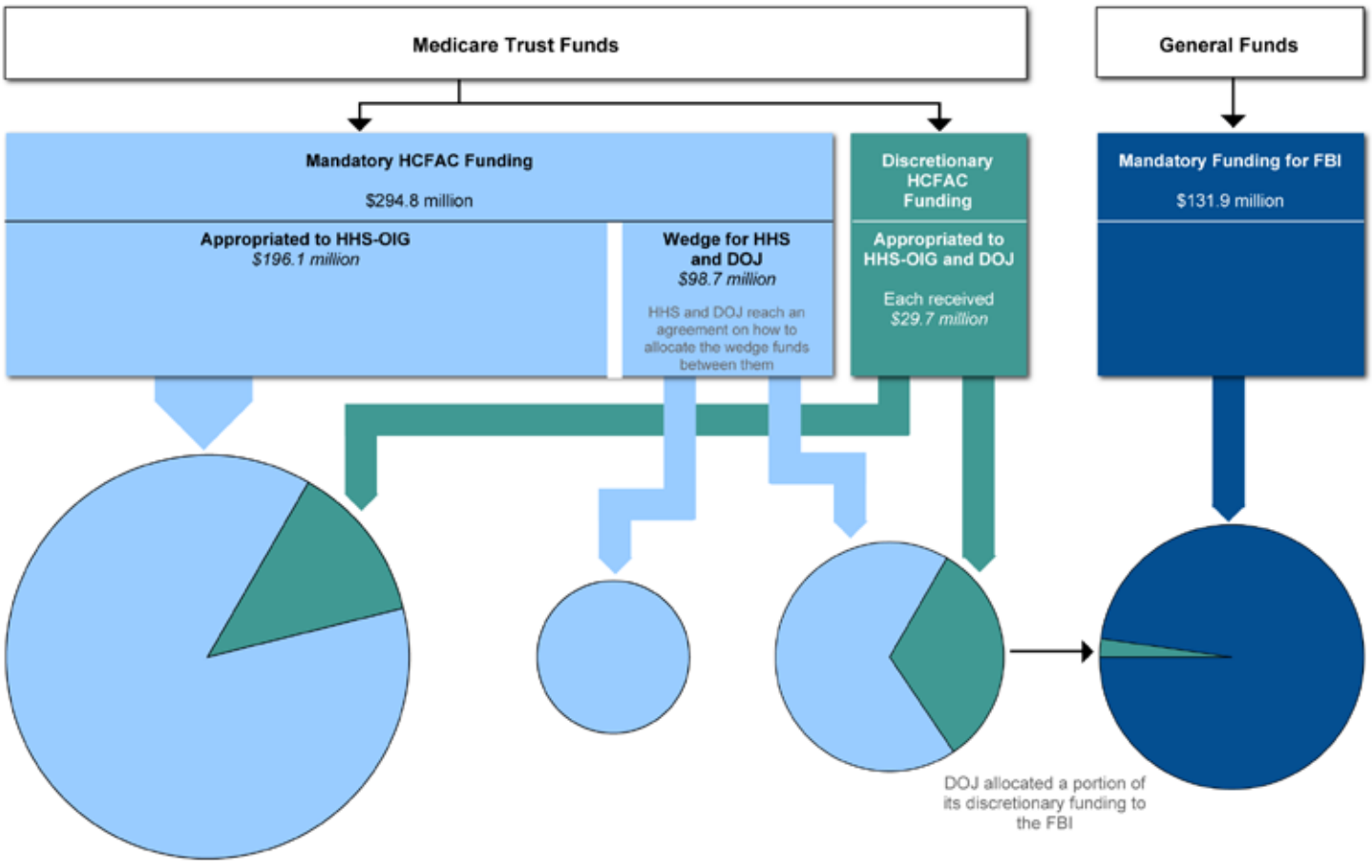
Medicare Trust Funds as a result of HCFAC activities. Additionally, the report includes sections that describe the activities each agency and component that received HCFAC funding conducted. These sections provide information on the outputs of each component's activities. For example, DOJ's USAO section highlights the number of new criminal investigations initiated and the number of civil matters pending.

HCFAC Appropriations

HHS and DOJ receive funding from several appropriations to conduct their HCFAC program activities. Figure 1 describes HCFAC appropriations to HHS, HHS-OIG, and DOJ. Mandatory funds are appropriated by HIPAA from the Medicare Trust Funds, and are available until expended, meaning that the funds can be spent in other years.[20] A large portion of these funds are appropriated to HHS-OIG; the law appropriates the remainder to both HHS and DOJ, which must determine together how to allocate the funds—referred to as the wedge—between the agencies.

[20]The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 provided additional mandatory appropriations from the Medicare Trust Funds for the HCFAC program for fiscal years 2011 through 2020. The additional fiscal year 2012 mandatory appropriation is reflected in figure 1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(i), 124 Stat. 119, 760 (Mar. 23, 2010); Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, § 1303(a), 124 Stat. 1029, 1057 (Mar. 30, 2010).

Figure 1: Appropriations for the Health Care Fraud and Abuse Control (HCFAC) Program for Fiscal Year 2012, By Agency



Source: GAO analysis of fiscal year 2012 annual HCFAC report and other agency documents.

Note: In fiscal year 2012, total appropriations to the Department of Health and Human Services (HHS), HHS's Office of Inspector General (HHS OIG), and the Department of Justice (DOJ) for HCFAC activities amounted to $486.1 million. This includes the $131.9 million in mandatory appropriations that the Federal Bureau of Investigation (FBI) received to conduct health care fraud and abuse activities and the portion of the DOJ discretionary funding that it allocated to the FBI ($3.4 million).

In each fiscal year, beginning with fiscal year 2009, Congress appropriated discretionary funding to DOJ and HHS-OIG to finance activities conducted under the HCFAC program. In addition, Congress also appropriated discretionary funds to CMS for program integrity activities it conducts in Medicare and Medicaid, which was outside the scope of our review.[21] Although the FBI is a component of DOJ and was allocated a portion of DOJ's discretionary HCFAC funding (about $3.4 million), the FBI also received mandatory funding under HIPAA to conduct health care fraud and abuse activities. This mandatory funding was appropriated from the general fund of the U.S. Treasury.

In addition to the HCFAC mandatory and discretionary funding that HHS, DOJ, and its components receive, the agencies use funding from other appropriations to support HCFAC activities. For example, HHS's Office of General Counsel (OGC) uses appropriations from HHS's General Departmental Management appropriation to support its HCFAC activities.

Activities Conducted Under the HCFAC Program

HHS and DOJ components conduct a variety of activities under the HCFAC program using mandatory and discretionary HCFAC funding. Among other activities, HHS components identify and investigate fraud through programs, including the Administration for Community Living's (ACL) Senior Medicare Patrol programs, which are designed to educate and train Medicare beneficiaries to identify fraud. HHS's OGC supports a variety of program integrity work, including assisting DOJ on False Claims Act cases.[22] HHS's Food and Drug Administration (FDA) conducts the Pharmaceutical Fraud Program, which is designed to detect pharmaceutical, biologics, and medical device fraud. CMS uses a portion of HHS's HCFAC funding to improve its financial oversight of the Medicaid program and CHIP, and for a pilot project related to fraud in

[21]In fiscal year 2012, CMS was appropriated over $250 million in discretionary HCFAC funding and CMS officials told us that most of this funding was used to support program integrity activities in Medicare Parts C and D. In addition to HCFAC funding, CMS also received about $863 million in funding for the Medicare Integrity Program in fiscal year 2012.

[22]The False Claims Act prohibits certain actions, including the knowing presentation of a false claim for payment by the federal government. Such claims may be brought by the United States or a private person—known as a relator or whistleblower—on behalf of him or herself and the United States, alleging the submission of false claims for payments by the federal government. DOJ may intervene in such an action, known as a "qui tam" action, and litigate the case along with the private party. 31 U.S.C. §§ 3729-3733.

community mental health centers. CMS also uses its portion of HCFAC funding to support its efforts related to the Medicare Fraud Strike Force (Strike Force) teams, which consist of investigators and prosecutors who use advanced data analysis techniques to identify, investigate, and prosecute potentially fraudulent billing patterns in geographic areas with high rates of health care fraud.

HHS-OIG conducts a variety of activities to identify and reduce fraud, waste, and abuse. For example, HHS-OIG assesses civil monetary penalties and imposes other administrative penalties—such as excluding individuals and entities from participating in federal health care programs—against individuals and entities for certain types of conduct. Each of HHS-OIG's components receives HCFAC funding for the work it conducts. Among other activities:

- The Office of Investigations (OI) coordinates and conducts investigations of allegations of fraud, waste, and abuse in Medicare and Medicaid.
- The Office of Evaluation and Inspections (OEI) conducts national evaluations on issues related to preventing fraud, waste, and abuse, and promoting economy, efficiency, and effectiveness of HHS programs.
- The Office of Audit Services (OAS) conducts independent audits of HHS programs, grantees, and contractors.
- The Office of Counsel to the Inspector General (OCIG) exercises the authority to impose civil and administrative penalties related to health care fraud, as well as issue advisory opinions.
- The Office of Management and Policy (OMP) provides management, guidance, and resources in support of the other HHS-OIG components.

DOJ's components have the primary role in enforcing U.S. laws related to health care fraud and abuse, including both criminal and civil matters. For example:

- The Criminal Division prosecutes criminal health care fraud and leads the Strike Force teams.

- The Civil Division represents the U.S. in civil fraud matters, such as False Claims Act cases and has the authority to bring criminal charges under the Federal Food, Drug, and Cosmetic Act.
- The USAOs litigate or prosecute civil and criminal health care fraud cases in their 94 districts throughout the country and are part of the Strike Force teams.
- The Civil Rights Division enforces several laws related to cases of abuse, substandard care, or needless institutionalization of certain individuals.
- The Justice Management Division (JMD) provides financial oversight of the DOJ components.
- The FBI serves as an investigative agency with jurisdiction in both federal and private health insurance programs, and participates in task forces and undercover operations to investigate health care fraud.

Although the agencies and components conduct certain activities without assistance from other agencies and components, HHS, CMS, HHS-OIG, and DOJ—including the FBI—frequently collaborate to investigate and prosecute fraud in federal health care programs. For example, HHS-OIG, FBI, and DOJ investigators and prosecutors comprise Strike Force teams. Table 2 in appendix I provides further detail on these activities.

Agencies Obligated $583.6 Million for HCFAC Activities in Fiscal Year 2012; Most Obligations Were for Personnel

In fiscal year 2012, HHS, HHS-OIG, and DOJ obligated approximately $583.6 million to fund HCFAC activities. About 78 percent of obligated funds were from mandatory HCFAC appropriations, 11 percent of obligated funds were from discretionary HCFAC appropriations, and 12 percent of obligated funds were from other appropriations.[23] Most of the obligations for HCFAC activities were for personnel costs; some agencies reported obligating funds for services under contract and supplies. Additionally, HHS-OIG and DOJ obligated over 8 percent of their HCFAC funds to support Strike Force teams located in 9 cities nationwide.

[23]Percentages do not add to 100 due to rounding.

HHS, HHS-OIG, and DOJ Obligated $583.6 Million in Fiscal Year 2012; 12 Percent of Obligated Funds Came From Other Appropriations

In fiscal year 2012, HHS, HHS-OIG, and DOJ reported $583.6 million in obligations for HCFAC activities.[24] This total includes obligations of mandatory (about 78 percent) and discretionary (about 11 percent) HCFAC appropriations and other appropriations not specific to the HCFAC program (about 12 percent).[25] HCFAC mandatory funds are available until expended, while discretionary HCFAC funds are available for 2 fiscal years. Other appropriations that agencies use for HCFAC activities vary in how long they are available. Because agencies reported in fiscal year 2012 obligating funds that were carried over from prior fiscal years, and because agencies obligated funds from other appropriations not specific to the HCFAC program, the obligations the agencies reported for HCFAC activities in fiscal year 2012—$583.6 million—exceed the HCFAC funds appropriated to the agencies for that year. For example, HHS, HHS-OIG, and DOJ were appropriated $486.1 million in HCFAC mandatory and discretionary funding for fiscal year 2012. However, for fiscal year 2012, these agencies reported HCFAC obligations of $583.6 million, including over $67 million in obligations of other appropriations, as well as obligations of funds appropriated in prior fiscal years.

In fiscal year 2012, DOJ incurred about 48 percent of the agencies' total HCFAC obligations (about $280.3 million),[26] while HHS-OIG incurred about 44 percent ($258.8 million), and HHS incurred the remaining 8 percent ($44.4 million). See figure 2 for the distribution of HCFAC obligations by appropriations type—HCFAC mandatory, HCFAC discretionary, and other appropriations—by HHS, HHS-OIG, and DOJ's

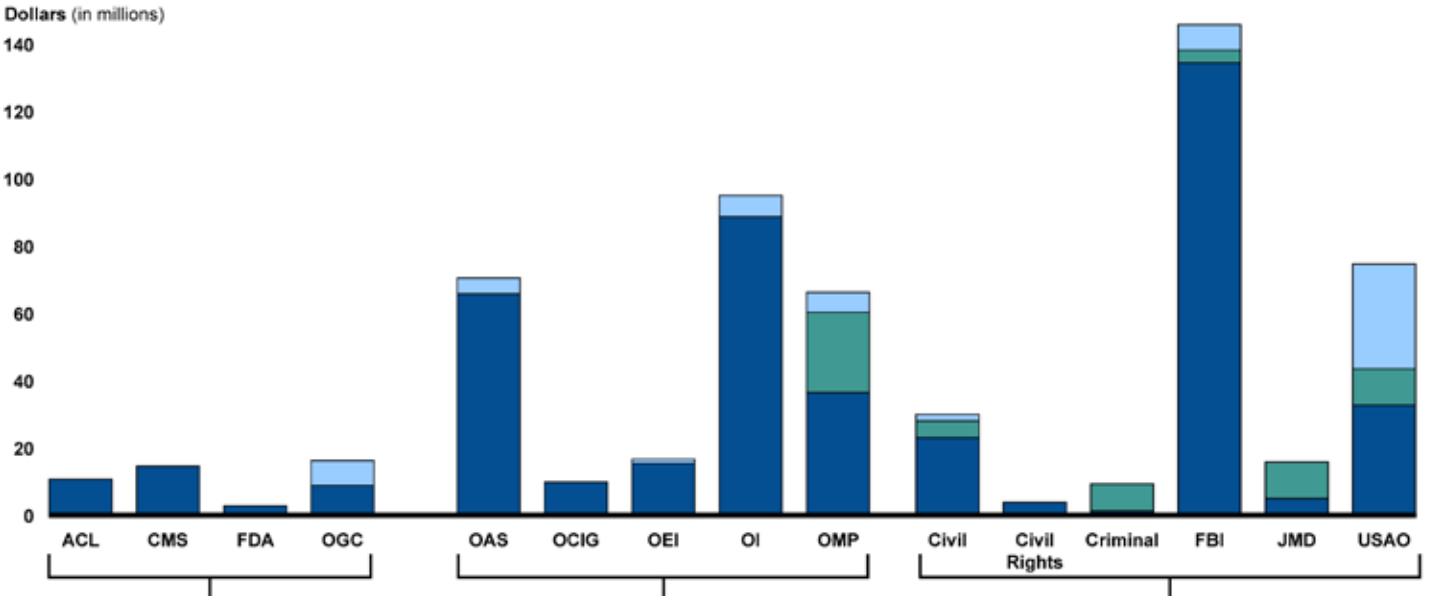
[24]An obligation is a definite commitment that creates a legal liability of the government for payment of goods and services ordered or received. Obligations can be paid immediately or in the future.

[25]In addition to mandatory and discretionary HCFAC funding, we requested that HHS, HHS-OIG, and DOJ components identify other appropriations used to support HCFAC activities. For the purposes of this report, we define "HCFAC obligations" to be obligations used to support HCFAC activities, which includes obligations of HCFAC mandatory and discretionary appropriations, obligations of FBI mandatory appropriations provided under HIPAA for health care fraud and abuse activities, and obligations of other appropriations not specific to the HCFAC program.

[26]As a component of DOJ, the FBI's obligations are included with DOJ HCFAC obligations, even though it receives its mandatory funding for health care fraud and abuse activities from the U.S. Treasury's general fund and not the Medicare Trust Funds. The FBI includes a description of its activities in an appendix to the annual HCFAC report and its funding is included in the HCFAC return-on-investment calculation.

components for fiscal year 2012. See table 3 in appendix II for the distribution of HCFAC obligations by appropriations type—HCFAC mandatory, HCFAC discretionary, and other appropriations—for HHS, HHS-OIG, and DOJ's components for fiscal years 2008 through 2012.

Figure 2: Fiscal Year 2012 Health Care Fraud and Abuse Control (HCFAC) Obligations (in Millions), by Agency Component and Type of Appropriations



	Department of Health and Human Services (HHS)[a]				HHS-Office of Inspector General (HHS-OIG)[a,d]					Department of Justice (DOJ)[a]					
	ACL	CMS[b]	FDA	OGC[c]	OAS	OCIG	OEI	OI	OMP	Civil	Civil Rights	Criminal[e]	FBI	JMD[f]	USAO
Total	10.6	14.9	2.8	16.2	70.5	10.5	16.6	95.0	66.2	29.9	5.2	9.3	145.7	15.8	74.6
Agency total		$44.4				$258.8						$280.3			

Obligations of other appropriations
Obligations of discretionary HCFAC appropriations
Obligations of mandatory HCFAC appropriations

Source: GAO analysis of HCFAC obligations that HHS, HHS-OIG, and DOJ reported for their components in fiscal year 2012.

Notes: Agency total HCFAC obligations may not equal the sum of HCFAC obligations for the agency's components due to rounding.

[a]The Department of Health and Human Services' (HHS) components that received HCFAC funding in fiscal year 2012 were: Administration for Community Living (ACL), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), and Office of General Counsel (OGC). HHS's Office of Inspector General's (HHS-OIG) components that received HCFAC funding in fiscal year 2012 were: Office of Audit Services (OAS), Office of Counsel to the Inspector General (OCIG), Office of Evaluation and Inspections (OEI), Office of Investigations (OI), and Office of Management and

Policy (OMP). The Department of Justice's (DOJ) components that received HCFAC funding were: DOJ's Civil Division, Civil Rights Division, Criminal Division, the 94 U.S. Attorneys' Offices (USAO), the Justice Management Division (JMD), and the Federal Bureau of Investigation (FBI).

[b]For fiscal year 2012, CMS reported amounts in HCFAC mandatory appropriations, about $1.6 million, that the agency reserved to fund HCFAC activities in future years. These funds were allocated to CMS in fiscal year 2012, but were not obligated.

[c]HHS's OGC reported estimated obligations of other appropriations, which included reimbursements for attorney services provided to OGC clients within HHS, that supported HCFAC activities.

[d]HHS-OIG's reported obligations also include any funding the agency received as reimbursement for the costs of conducting investigations and audits and other activities when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise authorized under 42 U.S.C. §1320a-7c(b).

[e]DOJ's Criminal Division stated that it uses some of its annual appropriation for health care fraud activities. However, Division officials indicated that the Division infrequently funds HCFAC activities with other appropriations and, as a result, the Division does not track its use of these appropriations for HCFAC activities.

[f]For fiscal year 2012, DOJ reported allocations of HCFAC mandatory and discretionary appropriations that the department reserved for future use to fund HCFAC activities, about $4.7 million in mandatory HCFAC appropriations and about $10.8 million in discretionary HCFAC appropriations. These funds were allocated to JMD, but were not obligated. We have included these HCFAC allocations under the JMD, in addition to the $208,676 in mandatory HCFAC obligations JMD reported. However, in the return-on-investment included in the fiscal year 2012 annual HCFAC report, only a portion of these allocations (about $13.2 million) were included in the calculation. JMD may use these funds for unanticipated HCFAC costs.

Mandatory HCFAC Funding

A portion of the mandatory HCFAC appropriation that supports HHS and DOJ's HCFAC activities—or wedge funds—is allocated to each agency. According to a HHS official, in fiscal year 2010, the departments reached a standing agreement for the following allocations: approximately 38 percent for HHS and 62 percent for DOJ.[27] Prior to fiscal year 2010, HHS and DOJ negotiated each year how to divide the wedge funds between the two agencies, which a HHS official described as time-consuming.

HHS distributes its wedge funds to HHS components based on their annual funding requests that the Secretary approves. In fiscal year 2012, HHS distributed mandatory funding to ACL for the Senior Medicare Patrol programs, OGC to support program integrity work of its clients, FDA to support the Pharmaceutical Fraud Program, and CMS to support Medicaid and CHIP financial specialists and a pilot project related to fraud in community mental health center providers in Texas, Florida, and

[27]The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, which provide additional mandatory HCFAC appropriations for fiscal years 2011 through 2020, require that these additional appropriations be allocated in the same proportion as the wedge fund was allocated in fiscal year 2010. The agencies have applied this allocation to the entire wedge appropriation since fiscal year 2010.

Louisiana.[28] According to a DOJ official, DOJ distributes mandatory HCFAC funds—its portion of wedge funds—to its components to carry out their HCFAC activities, and the distribution of such funds has not varied much since the inception of the program. Separately, HHS-OIG receives a mandatory appropriation for its HCFAC activities. This appropriation is HHS-OIG's primary source of funding for Medicare and Medicaid fraud investigations, as well as for audits, evaluations, and inspections it conducts related to the Medicare and Medicaid programs.

Discretionary HCFAC Funding

In fiscal year 2012, DOJ and HHS-OIG obligated discretionary HCFAC appropriations. According to the information each agency reported to us, each DOJ component received a share of DOJ's discretionary HCFAC appropriation for their HCFAC activities. A DOJ official told us that DOJ components generally received the same amount of funding from the agency's discretionary HCFAC appropriation for their HCFAC activities in fiscal year 2012 as they had in prior fiscal years. Additionally, the official indicated that a large portion of DOJ's HCFAC discretionary appropriation supports the Strike Force teams because DOJ believes that these teams reduce fraud. One component in HHS-OIG—OMP—received discretionary HCFAC appropriations.[29] OMP officials told us that most obligations of these funds are for overhead expenses for the HHS-OIG components that are handled by OMP (such as rent and utilities).

Other Appropriations Supporting HCFAC Activities

HHS, HHS-OIG, and DOJ components obligated over $67 million in funds from other appropriations in addition to the mandatory and discretionary HCFAC appropriations they obligated for HCFAC activities in fiscal year 2012. Within HHS, one component—OGC—used other appropriations to supplement its HCFAC funding.[30] To carry out its HCFAC activities, OGC obligated funds from the annual HHS General Department Management appropriation, which accounted for almost half of its overall obligations for HCFAC activities in fiscal year 2012. ACL, CMS, and FDA did not use other appropriations to support their HCFAC activities.

[28]CMS's efforts related to the Strike Force teams were funded with HCFAC discretionary appropriations.

[29]OMP provides management, guidance, and resources in support of the other HHS-OIG components.

[30]HHS-OGC's reported estimated obligations of other appropriations, which also included reimbursements for attorney services provided to OGC clients within HHS that supported HCFAC activities.

Each of HHS-OIG's components obligated funds from other appropriations to support HCFAC activities in fiscal year 2012. From other appropriations, HHS-OIG obligated about $18.9 million of these appropriations for HCFAC activities in fiscal year 2012, which represented about 7 percent of its overall HCFAC obligations. HHS-OIG reported that the other appropriations used to support HCFAC activities included funds appropriated specifically to support HHS-OIG's Medicare and Medicaid program integrity work. For example, in fiscal year 2012, each HHS-OIG component reported obligating funds appropriated in section 6034 of the Deficit Reduction Act (which, among other things, established the Medicaid Integrity Program and provided HHS-OIG with increased funding for Medicaid fraud and abuse control activities) to conduct HCFAC activities.[31]

Most of DOJ's components also used funding from other appropriations to support HCFAC activities, specifically the USAOs, the FBI, the Civil Division, and the Civil Rights Division.[32] The USAOs obligated the most funding from other appropriations among all of the DOJ components, about $31.1 million in fiscal year 2012. This accounted for 42 percent of the USAOs' overall obligations for HCFAC activities in fiscal year 2012. Officials from the USAOs reported obligating funds from DOJ's annual appropriations and the DOJ's "Three Percent" funds to support HCFAC activities.[33] According to USAO officials, a portion of the USAOs' annual appropriation is used to fund attorneys, paralegals, auditors and investigators, and litigation support for resource intensive health care fraud cases. Officials from the Civil Division told us that they also used "Three Percent" funds to continue the division's health care fraud litigation

[31]Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6034(c), 120 Stat. 4, 77 (Feb. 8, 2006).

[32]Although some DOJ components reported obligating funds from other appropriations for HCFAC activities, they also reported carrying over some of their HCFAC funding into other fiscal years. A DOJ official told us that funds are often carried over to a new fiscal year, such as in the situation of a continuing resolution, which may shorten the number of months in which they are able to obligate the appropriated funds.

[33]Section 11013 of the 21st Century Department of Justice Appropriations Authorization Act authorized the Attorney General to credit, as an offsetting collection, to the Department of Justice Working Capital Fund—a revolving fund that is authorized by Congress, as a form of permanent appropriation, to maintain moneys from certain sources for specific purposes—up to 3 percent of all amounts collected pursuant to DOJ's civil debt collection litigation activities. DOJ refers to this appropriation as "Three Percent Funds." Pub. L. No. 107-273, § 11013, 116 Stat. 1758, 1823 (Nov. 2, 2002).

work, such as to investigate qui tam cases alleging false claims and to prepare cases for trial.[34] The Civil Rights Division reported using DOJ's Salaries and Expenses, General Legal Activities appropriation to fund the rent for office space used by personnel, and the FBI reported using its annual appropriation to cover personnel expenses for investigators working health care fraud cases beyond those covered by HCFAC funds.

Most HCFAC Obligations Were for Personnel in Fiscal Year 2012

HHS, HHS-OIG, and DOJ reported that most of their HCFAC obligations were for personnel costs in fiscal year 2012, with some exceptions based on the type of HCFAC activities each component performs (see table 3 of appendix II for HCFAC obligations for fiscal years 2008 through 2012 for HHS, HHS-OIG, and DOJ's components).[35] A large portion of most HHS components' HCFAC obligations were for personnel costs. The same was true for HHS-OIG and DOJ. Each agency relied on personnel to conduct HCFAC activities—HHS-OIG employed investigators to examine potential fraud cases and DOJ employed investigators, attorneys, and other support personnel to investigate and prosecute fraud cases. Additionally, HHS-OIG employed auditors and evaluators to study issues related to the Medicare and Medicaid programs, including issues related to fraud in these programs, as well as a variety of other issues.

HHS, HHS-OIG, and DOJ components also reported that their next largest amount of HCFAC obligations was for contractual services and supplies. Components reported using these contractual services and supplies for transportation, rent, supplies, or other contractual services—such as for litigation consultants (for example, medical experts) and litigation support (for example, paralegals to review case documentation), among other things. Obligations for personnel and contracted services and supplies generally accounted for almost all of a component's HCFAC obligations.

[34]A qui tam case is a civil action brought under the False Claims Act by an individual—known as a relator or whistleblower—on behalf of him or herself and the United States, alleging the submission of false claims for payment by the federal government. In these qui tam cases, the relator may be eligible to receive a portion of the proceeds of the action or settlement, and reasonable expenses and attorneys' fees and costs. 31 U.S.C. § 3730(b),(d).

[35]We requested that HHS, HHS-OIG, and DOJ report their HCFAC obligations within five categories of expenses. These categories were personnel compensation and benefits; contractual services and supplies (including rent, transportation, printing, supplies); acquisition of assets; grants; and other expenses.

Specifically, for HHS's components, obligations for personnel costs represented the largest portion of FDA's, CMS's, and OGC's obligations for HCFAC activities for fiscal year 2012. In contrast, most of ACL's obligations in fiscal year 2012 were for expanding grants to the Senior Medicare Patrol programs.

Each of HHS-OIG's components, with the exception of OMP, reported obligations for personnel costs as their largest HCFAC obligations for fiscal year 2012, devoting 87 percent or more of their obligations to personnel in fiscal year 2012. For OMP, over 70 percent of its obligations were devoted to rent, communication, utilities, equipment, printing, and other contractual services. OMP officials told us that certain overhead expenses incurred by the HHS-OIG components—for example, rent payments—are handled by OMP.

About half or more of DOJ components' obligations for HCFAC activities were for personnel costs. In fiscal year 2012, the USAOs, Civil Division, Criminal Division, Civil Rights Division, and FBI reported that obligations for personnel costs ranged from 47 percent (Civil Division) to 84 percent (USAOs) of their obligations. For example, for the Civil Division, obligations for contractual services and supplies represented 53 percent of its HCFAC obligations; and officials told us that they use contracted services for litigation consultants (such as medical experts to review medical records or to prepare exhibits to be used at trial) and for litigation support (such as paralegals to review case documentation).

Over $47 Million in Obligations in Fiscal Year 2012 Supported Strike Force Teams in Nine Cities

In fiscal year 2012, HHS-OIG and DOJ obligated over $47 million in HCFAC funds to support Strike Force teams. This represented about 8.1 percent of the $583.6 million in obligations for HCFAC activities. DOJ officials told us that Strike Force teams are an important and valuable tool for identifying potential health care fraud schemes. (See table 1 for the HCFAC obligations by Strike Force location for fiscal year 2012, and see appendix II, table 4 for information on HCFAC obligations devoted to Strike Force teams for fiscal years 2008-2012.)

Table 1: Total Health Care Fraud and Abuse Control (HCFAC) Obligations By Agency Component and Strike Force Location, Fiscal Year 2012

Strike Force Location & Fiscal Year Launched	Department of Health and Human Services' Office of Inspector General (HHS-OIG)[a]	Department of Justice's (DOJ) Criminal Division	U.S. Attorneys' Offices (USAOs)	Federal Bureau of Investigation (FBI)	Total, by city
Miami, FL Launched FY 2007	$6,276,735	$1,570,190	$1,404,500	$3,711,474	$12,962,899
Detroit, MI Launched FY 2009	$2,483,564	$913,940	$623,000	$1,078,020	$5,098,524
Dallas, TX Launched FY 2011	$3,013,496	$480,834	$458,000	$1,075,460	$5,027,790
Los Angeles, CA Launched FY 2008	$2,360,294	$431,460	$428,000	$1,596,209	$4,815,963
Brooklyn, NY Launched FY 2010	$2,005,588	$855,329	$553,000	$978,934	$4,392,851
Baton Rouge, LA Launched FY 2010	$1,612,787	$943,497	$386,000	$496,083	$3,438,367
Chicago, IL Launched FY 2011	$1,270,269	–	$715,000	$1,394,940	$3,380,209
Houston, TX Launched FY 2009	$783,021	$738,069	$424,000	$621,018	$2,566,108
Tampa, FL Launched FY 2010	$1,341,201	$94.901	$578,000	$535,100	$2,549,202
Headquarters Support of Strike Forces	$187,840	$2,055,643	$485,000	$323,330	$3,051,813
Total	**$21,334,795**	**$8,083,863**	**$6,054,500**	**$11,810,568**	**$47,283,726**

Source: GAO analysis of HCFAC obligations reported to GAO by HHS-OIG's Office of Investigations and DOJ's Criminal Division, USAOs, and FBI for fiscal year 2012.

Notes: CMS also obligated $350,656 of its discretionary HCFAC appropriations for headquarters' support of the Strike Force teams. However, these obligations were not associated with any one of the nine Strike Force cities and this amount is not reflected in the table above.

[a]HHS-OIG reported estimated HCFAC obligations to support the Strike Force teams including obligations of non-HCFAC appropriations. In fiscal year 2012, these other appropriations consisted of funds appropriated to HHS-OIG under section 6034 of the Deficit Reduction Act that remained available for obligation in fiscal year 2012. Deficit Reduction Act, Pub. L. No. 109-171, § 6034(c), 120 Stat. 4, 77 (Feb. 8, 2006).

In fiscal year 2012, DOJ and HHS-OIG obligated over $12.9 million for the Strike Force team in Miami, which represented over 27 percent of funding for all Strike Force teams. The first Strike Force team was officially launched in Miami in fiscal year 2007, based in part on an HHS-

OIG evaluation that found aberrant claims patterns for infusion therapy for Medicare beneficiaries with HIV/AIDs that differentiated South Florida Medicare providers and beneficiaries from the rest of the country.[36] Additionally, obligations for Miami's Strike Force team were more than twice as much as in Detroit, the team with the second highest obligations for fiscal year 2012 ($5.1 million).

Based on the obligations reported for fiscal year 2012, HHS-OIG's Office of Investigations accounted for 45 percent of the total obligations used for Strike Force teams. The FBI incurred 25 percent, DOJ's Criminal Division incurred 17 percent, and the USAOs incurred 13 percent of obligations for the Strike Force teams. HHS-OIG's Office of Investigations and the FBI's agents conduct investigations and gather evidence, such as through surveillance for Strike Force cases, while DOJ's Criminal Division and the USAOs' attorneys are the primary prosecutors of Strike Force cases. Additionally, although not reflected in the table above, CMS obligated approximately $350,656 in discretionary HCFAC appropriations to support Strike Force Teams. CMS's HCFAC obligations were not associated with any one individual Strike Force city.

Since fiscal year 2010, the USAOs have used some of their HCFAC discretionary appropriation for three Special Focus teams—in San Francisco, Boston, and Philadelphia. These Special Focus teams are similar to the Strike Force teams, but handle pharmaceutical civil cases rather than criminal cases. Approximately $2.8 million of the USAOs' HCFAC obligations in fiscal year 2012 were for these Special Focus teams. This amount was in addition to the HCFAC obligations they used for the Strike Force teams.

[36]HHS-OIG found that three South Florida counties (Miami-Dade, Broward, and Palm Beach) accounted for half of the submitted charges totaling $976 million, and 79 percent of the amount for drugs, billed nationally for Medicare beneficiaries with HIV/AIDs in the last half of 2006. In addition, HHS-OIG found that CMS and its contractors' efforts to control these inappropriate payments through multiple approaches—such as payment suspensions, provider revocations, and claims-processing edits—resulted in limited success in controlling the aberrant billing. See HHS-OIG, *Aberrant Billing in South Florida For Beneficiaries with HIV/AIDs*, OEI-09-07-0030 (Washington, D.C., Sept. 2007).

Agencies Use Several Indicators to Assess HCFAC Activities, and Some Key Outputs Changed Over Time

HHS, HHS-OIG, and DOJ use several indicators to assess HCFAC activities as well as to inform decision-makers about how to allocate resources. These indicators include those listed in the annual HCFAC report as well as others outlined in agency reports. For example, FDA assesses the work of its Pharmaceutical Fraud Program by tracking the number of criminal investigations opened and the outcomes of criminal convictions obtained, among other indicators. Additionally, many of the indicators that HHS, HHS-OIG, and DOJ use reflect the collective work of multiple agencies since they work many health care fraud cases jointly. Outputs from some of these key indicators have changed in recent fiscal years. For example, the return-on-investment 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.

HHS, HHS-OIG, and DOJ Use Several Indicators to Assess HCFAC Activities and Inform Decisions about Resource Allocation and Prioritization of Activities

HHS, HHS-OIG, and DOJ officials reported using several indicators to assess HCFAC activities and that those indicators serve multiple purposes. Several indicators are included in the annual HCFAC report, while other indicators are reported in agency documents or used internally. Additionally, some indicators are collective—in that they reflect the work of multiple agencies—and other indicators outline the activities conducted by a particular agency or component. Appendix III, tables 5 through 8, provides detailed information on indicators used to assess the activities conducted using HCFAC funding, including those outlined in the HCFAC report, as well as other indicators the agencies use, by agency and component.

HHS Indicators

Each HHS component conducts unique activities related to health care fraud and abuse. As a result of these different types of activities, the indicators that each HHS component uses to highlight the accomplishments of its HCFAC activities vary.

FDA uses indicators associated with its Pharmaceutical Fraud program—which focuses on detecting, prosecuting, and preventing pharmaceutical, biologic, and medical device fraud—including the number of criminal investigations opened during a fiscal year and the outcomes of criminal convictions obtained (such as amount of jail time, probation, or amount of restitution). FDA officials told us that the indicators they use are outlined in the annual HCFAC report. For example, FDA reported in the fiscal year 2012 HCFAC report that it had opened 42 criminal investigations since the inception of the Pharmaceutical Fraud Program, and 17 investigations during fiscal year 2012.

ACL primarily uses indicators that track information related to the Senior Medicare Patrol (SMP) programs—which train senior volunteers to inform fellow beneficiaries on how to detect and prevent fraud, waste, and abuse in the Medicare program—such as indicators related to beneficiary education and training, outreach activities, and events the SMP programs conduct, and cases that were referred for investigation. For instance, ACL tracks the number of group education sessions the SMPs conduct and the estimated number of beneficiaries who attended the sessions. Many of the indicators ACL uses are outlined in an annual HHS-OIG report on the SMP programs, as well as the annual HCFAC report.[37] According to ACL officials, ACL has hired a contractor to assess the adequacy of the current indicators used by ACL and to determine if the indicators are appropriate for evaluating the performance of the SMPs.

HHS's OGC uses several indicators to assess the HCFAC activities it conducts. These indicators include amounts of recoveries for matters on which OGC has assisted—such as False Claims Act matters and civil monetary penalties—and the number of physician self-referral disclosures in which OGC advised.[38] As with the other HHS agencies, OGC's indicators are outlined in the annual HCFAC report.

CMS officials told us that CMS uses a variety of indicators to assess the HCFAC activities included in our review. For the Medicaid and CHIP financial management project, CMS tracks information related to the amount of the federal share of Medicaid funds that were recovered as a result of the project's monitoring and financial management reviews of Medicaid expenditures. For the community mental health centers study, CMS officials told us that they do not have indicators since the project is relatively new. For CMS's efforts associated with the Strike Force teams,

[37]HHS-OIG's report on the Senior Medicare Patrol (SMP) programs presents performance data for each SMP program. HHS-OIG collects the data every 6 months, reports annually, and has done so since 1997.

[38]According to the fiscal year 2012 HCFAC report, OGC advised CMS on the new voluntary Self Referral Disclosure Protocol established by the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, § 6409(a), 124 Stat. at 772. Under this protocol, providers of services and supplies may self-disclose actual or potential violations of the physician self-referral law, commonly known as the Stark law. The Stark law prohibits physicians from making certain referrals for "designated health services" paid for by Medicare to entities with which the physician (or immediate family members) has a financial relationship, unless the arrangement complies with a specified exception, such as in-office ancillary services. 42 U.S.C. § 1395nn(a)(1), (b)(2).

officials told us that one indicator they use is the drop in number of claims for particular services, which they believe coincides with the efforts of the Strike Force teams to investigate and prosecute fraud. For example, according to information that CMS provided to us, payments for home health services dropped by nearly one-half from 2008 to 2011 in Miami-Dade County, which officials believe was, in part, due to the Strike Force team's efforts focused on reducing fraud in home health care.

HHS-OIG Indicators

HHS-OIG uses a variety of indicators to assess the work it conducts using HCFAC funds. Some of these indicators reflect the collective work of HHS-OIG's components and some are unique to the activities conducted by a particular component. For example, HHS-OIG tracks the health care savings attributable to HHS-OIG investigations, audits, and evaluations. This indicator includes work from nearly all HHS-OIG components, including the Office of Investigations, the Office of Audit Services, and the Office of Evaluation and Inspections. Among many other indicators, HHS-OIG's Office of Counsel to the Inspector General tracks the number of corporate integrity agreements monitored for compliance, which is specific to the work of that office.[39] HHS-OIG officials told us that the indicators they use to assess HCFAC activities are reported in the annual HCFAC report and in other HHS-OIG reports (such as its semi-annual reports to Congress).

DOJ Indicators

DOJ uses several indicators to assess the work it conducts with HCFAC funding. The indicators it uses relate to the activities that each DOJ component conducts to enforce health care fraud and abuse laws. For example, the USAOs use indicators related to criminal prosecutions, including the number of defendants charged and the number of convictions. In addition to those measures, the USAOs also track information related to civil matters, such as the number of pending civil investigations.

In addition to the indicators listed in the annual HCFAC report, officials from DOJ's components told us that they use other indicators to assess the work they conduct related to health care fraud and abuse. Officials

[39]Corporate integrity agreements outline conditions or requirements an entity agrees to as a part of a civil settlement. An entity agrees to the corporate integrity agreement's requirements in exchange for HHS-OIG's agreement that it will not seek to exclude the entity from participation in federal health care programs. HHS-OIG's Office of Counsel to the Inspector General monitors the compliance with these agreements.

told us that these indicators are tracked at the departmental level and aggregate the work of multiple DOJ components. For example, DOJ tracks the percentage of criminal and civil cases resolved favorably. These indicators include health care fraud cases, as well as other cases that DOJ components handle.

Indicators Inform Decisions about Resource Allocation and Prioritization of Activities

Officials from HHS, HHS-OIG, and DOJ told us that they use indicators to inform decision-makers about how to allocate resources. For example, officials from DOJ's Civil Rights Division told us that they use indicators to help determine what resources they need to handle their current caseload. The Civil Rights Division considers the number of cases the division is currently working along with the number of remedial agreements with facilities that the division needs to monitor in the upcoming year when developing requests for funding. Additionally, officials from FDA told us that they review the preceding year's number of investigations and the costs associated with those investigations, when requesting annual funding.

Additionally, HHS, HHS-OIG, and DOJ officials indicated that they use data to inform their decisions about which activities to prioritize, including what cases or studies to undertake, as well as where to locate specific resources. For example, officials from HHS-OIG told us that they use Medicare claims data to identify which service areas to target for investigations, audits, or evaluations, as well as which geographic regions to focus their efforts. Officials said that they continually review whether HHS-OIG staff are located in the most appropriate geographic areas and have relocated staff to areas to enhance the efficiency of HHS-OIG resources. HHS-OIG officials also told us that the agency uses several indicators for internal management purposes. Additionally, officials from DOJ's Criminal Division told us that one factor they consider when deciding how to prioritize cases is to review data analyses to focus on cases with large amounts of alleged fraudulent billing.

Some Key Outputs that Reflect Work of Multiple Agencies Have Changed in Recent Years

Since HHS-OIG and DOJ's components work many health care fraud cases jointly, many of the indicators included in the annual HCFAC report highlight the work of both HHS-OIG and DOJ, as well as various components within each agency. For example, the report includes information on the results of HCFAC activities, such as the dollar amount recovered as a result of fraud cases, which HHS-OIG and DOJ officials say reflects the investigative work done by HHS-OIG and FBI, as well as the work of DOJ's components in prosecuting the cases. Additionally, the report presents several indicators related to the work of the Strike Force

teams, such as the number of indictments and complaints involving charges that were filed, the outcomes of the cases, and the total amount of alleged billing to Medicare as a result of these Strike Force cases.

The return-on-investment is another indicator that reflects the work of multiple agencies and has changed in recent years. We have recognized that agencies can use a return-on-investment as a valuable tool for assessing a program's activities and for determining how best to target resources.[40] The return-on-investment is included in the annual HCFAC report and compares the amount of funds that were returned to the Medicare Trust Funds, such as restitution and compensatory damages awarded, with the amount of appropriations for HCFAC activities. Specifically:

- The total returns—the numerator—includes deposits to the Medicare Trust Funds. The calculation includes amounts that were deposited into the Medicare Trust Funds rather than amounts that were ordered or negotiated in health care fraud and abuse cases, but not yet transferred to the Medicare Trust Funds. Officials reported that although there may be large amounts of restitution ordered or agreed upon in health care fraud cases, the amounts actually returned to the Medicare Trust Funds may be lower.[41,42] By including only those funds that have been returned to the Medicare Trust Funds, the return-on-investment is not artificially inflated.

[40]GAO, *2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, GAO-13-279SP, (Washington, D.C.: April 2013); *Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*, GAO-11-592 (Washington, D.C.: July 2011); and *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO-11-318SP (Washington, D.C.: March 2011).

[41]For example, officials told us that although a defendant convicted of health care fraud may be ordered to pay restitution and penalties in a specific amount, the defendant may pay less than what is ordered as the ability to pay often affects how much is actually received.

[42]Many cases discussed in the annual HCFAC report include settlements reached with pharmaceutical and device manufacturers for criminal and civil liabilities. For example, the fiscal year 2012 HCFAC report describes many settlements reached with pharmaceutical and device manufacturers and the settlements ranged from about $200,000 to $3 billion.

- The total investment—the denominator—includes mandatory and discretionary HCFAC funds that were appropriated to HHS, HHS-OIG, and DOJ (including the FBI's mandatory funds devoted to health care fraud and abuse reduction activities) and does not include funding from other appropriations. DOJ officials told us that the HCFAC funding that CMS receives through HHS's wedge fund is included in the return-on-investment calculation, and a small portion of HCFAC discretionary funds that CMS uses to support the Strike Force teams.[43]

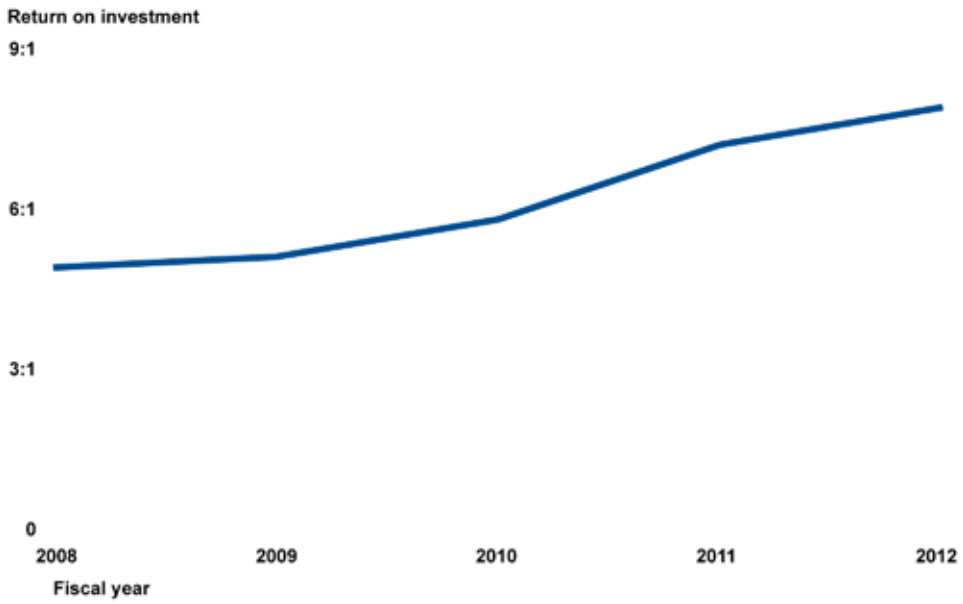
- Return-on-investment is calculated using a 3-year moving average. To account for differences in the amounts returned to the Medicare Trust Funds between years, the return-on-investment is calculated using a 3-year average. For example, a case may have been investigated in fiscal year 2010 but not settled until fiscal year 2012, and thus the funds received from that case would not be deposited until 2012. Similarly, although agencies may carry over HCFAC appropriations into future fiscal years, the amount of appropriations included in the calculation is also based on a 3-year average with carry over amounts included in the year in which they were appropriated.[44]

According to the annual HCFAC report, the return-on-investment for fiscal years 2010-2012 was $7.90 returned to the Medicare Trust Funds for every $1.00 of HCFAC funds appropriated for HCFAC activities. The return-on-investment increased steadily from fiscal year 2008 to 2012. In fiscal years 2006-2008, the return-on-investment was $4.90 to $1.00, and in fiscal years 2010-2012, the return-on-investment was the highest at $7.90 to $1.00. See figure 3 for additional information on the return-on-investment for fiscal years 2008-2012.

[43]The CMS activities for which funding is included are financial management oversight of the Medicaid program and CHIP; a pilot project related to payments for partial hospitalization programs made to community mental health centers (which is designed to use predictive modeling to prevent fraud in community mental health centers in Florida, Texas, and Louisiana); and for CMS support for the Medicare Strike Force teams. The return-on-investment calculation does not include the remaining HCFAC funding that CMS receives because it generally supports program integrity activities in Medicare Parts C and D.

[44]Mandatory HCFAC appropriations are available until expended. Discretionary HCFAC appropriations are available for two years.

Figure 3: Health Care Fraud and Abuse Control (HCFAC) Program Return-on-Investment, Fiscal Years 2008 through 2012

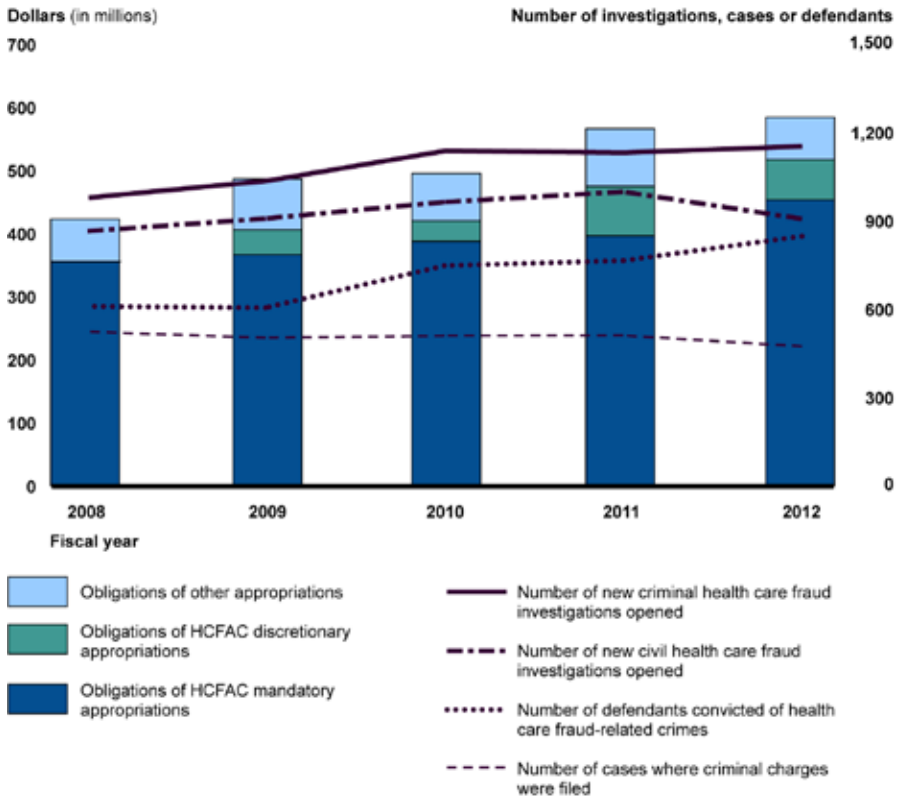


Source: GAO analysis of information provided by DOJ for fiscal years 2008-2012.

Note: The return-on-investment is based on amounts recovered from HCFAC activities and deposited into the Medicare Trust Funds and amounts appropriated to Department of Health and Human Services (HHS), HHS Office of Inspector General, and the Department of Justice (DOJ) to conduct HCFAC activities. The information about the return-on-investment was obtained from DOJ. The return-on-investment is calculated using a 3-year moving average and, as a result, the calculation for each fiscal year incorporates amounts that were deposited into the Medicare Trust Funds and appropriations from that fiscal year and the two prior fiscal years. For example, the return-on-investment for fiscal year 2008 is calculated using the amounts from fiscal years 2006, 2007, and 2008. Additionally, because many fraud cases can take years to investigate and prosecute, the amounts deposited into the Medicare Trust Funds may have been the result of prior year's HCFAC activities.

A review of other key outputs listed in the annual HCFAC reports from 2008 through 2012 that reflect accomplishments or outputs of activities conducted by multiple agencies using HCFAC funding shows some key outputs have generally increased and some have remained stable. During the same time period, HCFAC obligations and funding from other appropriations used to support HCFAC activities increased about 38 percent. See figure 4 for data on selected key outputs for fiscal years 2008 to 2012, and see appendix IV, table 9 for additional detailed information on the key outputs for fiscal years 2008 to 2012.

Figure 4: Selected Key Program Outputs and Total Obligations for Health Care Fraud and Abuse Control (HCFAC) Program Activities, Fiscal Years 2008 through 2012



Source: GAO analysis of annual HCFAC reports for fiscal years 2008-2012 and obligations for HCFAC activities reported to GAO by HHS, HHS Office of Inspector General, and Department of Justice.

Note: Since many fraud cases can take years to investigate and prosecute, the number of investigations, cases, and defendants reported in the figure above may have been the result of a prior year's HCFAC activities. The obligations information included in the figure above reports obligations for HCFAC activities that Department of Justice, Department of Health and Human Services (HHS), and HHS Office of Inspector General reported to GAO for a single fiscal year.

One key output that has increased since fiscal year 2008 is the number of defendants convicted of health care fraud. For example, the number of defendants convicted of health care fraud generally increased from around 588 in fiscal year 2008 to 826 in fiscal year 2012 (a 40 percent increase).

Some key outputs did not change between fiscal years 2008 and 2012. While funding has increased since 2008, there has not been a consistent pattern of increasing outputs. For example, the number of new criminal health care fraud investigations opened increased from fiscal year 2008

(957 investigations) to fiscal year 2012 (1,131 investigations). Additionally, the number of new civil health care fraud investigations opened did not vary much between 2008 (843 cases) and 2012 (885 cases).

HHS-OIG and DOJ officials indicated that there are a number of factors that might contribute to these trends. DOJ officials told us that the complexity of fraud cases has increased in recent years and requires more substantial resources to investigate and prosecute than other, less-complex cases. Officials stated that this limits the amount of resources they are able to commit to other cases. HHS-OIG and DOJ officials also cited other factors, including external factors (such as an increase in the number of defendants opting to go to trial) and significant changes to federal health care programs (such as the implementation of the Medicare Part D prescription drug program), which might influence these trends.

Nonetheless, HHS-OIG and DOJ officials indicated that they consider the increase since 2008 in some of the key outputs to be significant. For example, HHS-OIG officials noted that there was an increase of 42 civil fraud investigations from 2008 to 2012, and they consider the increase to be of significance given the complexity of fraud schemes and the resources needed to handle these civil cases. Additionally, DOJ officials told us that they consider increases to the number of new criminal fraud investigations opened (an increase of 18 percent) to be significant. DOJ officials also indicated that several key outputs related to the Strike Force teams have increased since 2008. See appendix IV for detailed information on key outputs related to HCFAC activities, including the Strike Force teams.

Several Factors Contribute to Lack of Information about the Effectiveness of HCFAC Activities

The indicators used by agencies to track the outputs of HCFAC activities provide information on the accomplishments of HCFAC activities, not on the effectiveness of the activities in reducing health care fraud and abuse. HHS, HHS-OIG, and DOJ officials reported that they consider the indicators to be the outputs or accomplishments of the HCFAC activities they conduct and in that sense they provide a composite picture of the achievements of the HCFAC program. However, difficulty in establishing a causal link between HCFAC activities and output indicators, difficulty in determining the deterrent effect HCFAC activities may have on potential health care fraud and abuse, limited research on the effectiveness of health care fraud interventions, and the lack of a health care fraud

baseline hinder a broader understanding of the effectiveness of the HCFAC program in reducing health care fraud and abuse.

Indicators Agencies Use to Assess HCFAC Activities Provide Information on Accomplishments, but Not Effectiveness

The indicators that HHS, HHS-OIG, and DOJ use to track HCFAC activities offer insights on the accomplishments and outputs of HCFAC activities, but they do not measure the effectiveness of the HCFAC program in reducing health care fraud and abuse. HHS, HHS-OIG, and DOJ officials reported that they consider the indicators they use to be the accomplishments or outputs of the HCFAC activities they conduct. For example, the key program outputs discussed earlier in this report reflect accomplishments of activities agencies conduct using HCFAC funding. Officials from HHS, HHS-OIG, and DOJ told us that these indicators can be used to provide insights on program activities or the number of actions a component has been able to accomplish in a specific time frame (e.g., the number of defendants convicted in a fiscal year). However, several HHS and DOJ agency officials told us that they do not consider these indicators to be measures of the performance or the effectiveness of the HCFAC program in reducing health care fraud. The return-on-investment is an example of an indicator that describes program results but does not measure program effectiveness. We found that the return-on-investment provides information on the accomplishments of HCFAC activities in relationship to the amount of funds appropriated for these activities, but does not provide information on the extent to which the HCFAC program reduces health care fraud.

Additionally, most of the indicators used to track HCFAC activities do not have targets or goals associated with them. Although standard practices for internal controls indicate that ongoing performance monitoring should include comparison of performance indicator data against planned targets, our previous work has recognized that establishing measures and setting specific targets in the law enforcement area can be challenging.[45] Officials from HHS, HHS-OIG, and DOJ told us that they intentionally do not set performance targets for indicators such as the number of health care fraud investigations or prosecutions undertaken because such targets could cause the public to perceive law enforcement as engaging in “bounty hunting” or pursuing arbitrary targets merely to meet particular

[45]GAO, *Intellectual Property: Federal Enforcement Has Generally Increased, but Assessing Performance Could Strengthen Law Enforcement Efforts*, GAO-08-157 (Washington, D.C.: Mar. 11, 2008).

goals.[46] The officials believe that it is important that agencies carry out law enforcement actions that are based on merit and avoid the appearance that they strive to achieve certain numerical quotas.

Several Factors Make Assessing the Effectiveness of the HCFAC Program Challenging

HHS, HHS-OIG, and DOJ officials, as well as literature we reviewed, indicate that there are several factors that make assessing the effectiveness of the HCFAC program in reducing health care fraud and abuse challenging.

Establishing a Causal Link

It is difficult to establish if the HCFAC program has a direct relationship to changes in the amount of health care fraud and abuse. HHS, HHS-OIG, and DOJ officials told us that HCFAC activities—as well as other efforts by federal agencies and others, including non-government entities—may have helped reduce health care fraud; however, the effect that any of these actions may have had on health care fraud and abuse is difficult to isolate. For example, HHS-OIG officials stated that compliance training and guidance provided by the HHS-OIG to health care organization directors—an activity conducted with HCFAC funding—may have had an effect on health care fraud but that it is difficult to isolate how much of an effect the activity has had. However, according to HHS-OIG officials, a rise in the number of provider compliance programs established by hospital organizations in response to shareholder interest in improving compliance with federal and state health care program requirements may also contribute to reductions in health care fraud. Moreover, many efforts within CMS aim to reduce health care fraud and abuse, in addition to those identified as HCFAC activities, and it is difficult to know which CMS program or activity has had an effect on the incidence of fraud. For example, CMS has implemented a number of initiatives to prevent health care fraud and abuse that are not funded with HCFAC funds. One such effort is a change to the provider enrollment process, which is designed to better ensure that only legitimate providers and suppliers are allowed to

[46]According to one DOJ official, some of the department's indicators have targets that focus on the quality or efficiency of its work, rather than focusing on the number of cases opened or criminal charges filed. For example, DOJ has department-wide measures for the percentage of cases favorably resolved, that is, a judgment in favor of the U.S. government or a settlement. The target rate of cases favorably resolved is 90 percent for criminal cases and 80 percent for civil cases, which incorporate all of DOJ's cases (including health care fraud cases as well as other cases).

bill Medicare. However, it is difficult to isolate the effect that either HCFAC activities or broader CMS efforts may have had in reducing health care fraud and abuse.

Measuring Deterrence

Another factor that limits understanding of the effectiveness of the HCFAC program in reducing health care fraud and abuse is the difficulty in quantifying the HCFAC program's effect in deterring health care fraud and abuse. DOJ officials provided anecdotal evidence that HCFAC activities help to deter would-be offenders. For example, a Justice Management Division official asserted that DOJ prosecutions that result in doctors being sentenced to prison for health care fraud and abuse deter other doctors who are contemplating committing fraud. Other DOJ officials reported that cooperating witnesses in health care fraud investigations have told officials of instances where a provider committing potentially fraudulent acts had ceased operations because of the pressure brought on by Strike Force prosecutions. DOJ officials stated that they could recall about a dozen examples of specific individuals who have said they were deterred from committing fraud or ceased a fraudulent operation because they saw another individual get caught. However, these examples are anecdotal and DOJ and HHS-OIG officials stated that it is difficult to know how much health care fraud is deterred as a result of HCFAC activities.

Limited Research

Research on the effectiveness of health care fraud and abuse interventions, and on ways to measure the effectiveness of health care fraud and abuse interventions has been limited. We found that none of the 49 articles we selected to review for this study evaluated the effectiveness of the HCFAC program specifically, and few studies examined the effectiveness of health care fraud and abuse interventions in general. A recent review of literature conducted by experts in the field found similar results.[47]

[47]A. Rashidian, H. Joudaki, and T. Vian, "No Evidence of the Effect of the Interventions to Combat Health Care Fraud and Abuse: A Systematic Review of Literature," PLoS ONE, vol. 7, no. 8 (2012).

Establishing a Health Care Fraud Baseline

Another challenge that limits the ability to determine whether HCFAC activities are effective in reducing health care fraud and abuse is the lack of a baseline for the amount of health care fraud that exists at any point in time. Having such a baseline could provide information on the amount of health care fraud and how much it has changed in a given year or over time. We have previously reported that there currently is no reliable baseline estimate of the amount of health care fraud in the United States.[48] Several experts told us or have written about the importance of establishing a baseline in assessing the effectiveness of law enforcement programs. A baseline estimate could provide an understanding of the extent of fraud and, with additional information on program activities, could help to inform decision-making related to allocation of resources to combat health care fraud.

HHS and CMS have taken steps to try to establish a health care fraud baseline because, according to the fiscal year 2012 HCFAC report, they appreciate that a baseline would allow the agencies to evaluate the success of fraud prevention activities. HHS officials stated that the Assistant Secretary for Planning and Evaluation initiated work to establish a baseline measurement, and that work was subsequently transferred to CMS's Center for Program Integrity. According to the fiscal year 2012 HCFAC report, the project is designed to measure probable fraud in home health care agencies and will pilot test a measurement approach and calculate an estimate of probable fraud for specific home health care services. CMS and its contractor will collect information from home health care agencies, the referring physicians, and Medicare beneficiaries selected in a national random sample of home health care claims. The pilot will rely on the information collected along with a summary of the service history of the home health care agency, the referring provider, and the beneficiary to estimate the percentage of total payments that are associated with probable fraud, and the percentage of all claims that are associated with probable fraud for Medicare fee-for-service home health care. CMS reports that after completion of the pilot, it will determine whether the measurement approach should be expanded to other areas of health care. Officials from the Center for Program Integrity stated that as of May 2013, they were beginning the data collection phase of the fraud baseline measurement pilot, which they expect will last two years.

[48]See GAO, *Medicare: Progress Made to Deter Fraud, but More Could Be Done,* GAO-12-801T (Washington, D.C.: June 8, 2012).

Some HCFAC-funded agencies have attempted to determine the effect of HCFAC activities on specific types of fraud in certain locations. DOJ officials provided examples of reductions in billings for certain services in specific locations and told us that they believe these reductions are associated with the work of the Strike Force teams. For example, DOJ officials reported assessing the amount of home health care billings in certain Strike Force cities before the Strike Force began operations and then again after the Strike Force had begun operations.[49] Since the amount of home health care billing was measured before and after the Strike Force was implemented, HHS, HHS-OIG, and DOJ officials are able to estimate some effect that the Strike Force team had on the amount of billing in that area. For example, in a May 14, 2013 press conference, the Attorney General noted that after the Detroit Strike Force began investigating cases of potential group-psychotherapy fraud, claims for this type of treatment in Detroit dropped by more than 70 percent since January 2011.[50]

Concluding Observations

Making progress in preventing and reducing health care fraud and abuse is an essential yet challenging task. HHS and DOJ use a number of indicators to assess the activities they conduct to reduce health care fraud and abuse. However, the indicators do not provide information about the effectiveness of the program, and little is known about whether and how well the HCFAC program reduces health care fraud. While positive results on the program's return-on-investment can be seen as an indication of program success, the return-on-investment does not indicate the extent to which the program is reducing fraud. For example, the increasing returns from the fraud that is being investigated and prosecuted may indicate that HCFAC programming is effective in detecting or deterring potentially fraudulent schemes or indicate that there is simply an increase in potentially fraudulent activity. CMS's recent efforts to establish a home health care fraud baseline is a good first step to understanding the extent of the problem and, if implemented as planned, could provide policymakers with information on how much fraud

[49]For example, DOJ Criminal Division officials reported that home health billings in Florida dropped from $3.4 billion in 2009 to $2.3 billion in 2011.

[50]DOJ officials reported that they compared claims submitted to Medicare for group psychotherapy during the six-month period between January 1, 2011 and June 30, 2011 to claims submitted to Medicare for those same services during the six-month period between July 1, 2012 and December 31, 2012.

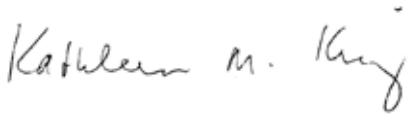
exists and in coming years, how potentially fraudulent activity has increased or decreased over time. However, CMS has not yet determined whether the methodology used to establish a baseline of probable fraud in home health care could be used to assess the amount of fraud in other health care services. Additionally, even with a baseline estimate of the total amount of probable fraud, there will likely be continuing challenges in understanding the effectiveness of the HCFAC program, such as isolating the program's ability to reduce or prevent fraud and abuse. Despite these inherent challenges, if a health care fraud baseline is established more broadly, it may become feasible to study how individual HCFAC activities, and possibly the program as a whole, affects changes in health care fraud. Results from these 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.

Agency Comments

GAO provided a draft of the report to HHS and DOJ. In its written comments reproduced in appendix V, HHS discussed its program integrity efforts to reduce fraud, waste, and abuse. HHS also provided examples of CMS's efforts to reduce fraud, waste, and abuse in Medicare. The examples provided were not included in our review because they were not included in the funding used to calculate the return-on-investment for the HCFAC program. While not commenting specifically on our report, DOJ sent us examples of reductions in Medicare billings for specific services (such as durable medical equipment, home health services, and community mental health center services) in certain Strike Force cities. In their comments, DOJ officials stated that based on their examples, the Strike Force efforts have had a lasting effect on savings to Medicare payments. In addition, HHS and DOJ provided technical comments, which we have incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS, the Attorney General, the Inspector General of HHS, and other interested parties. In addition, the report will be available at no charge on GAO's

website at http://www.gao.gov. If you or your staff have any questions about this report, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or Eileen R. Larence at (202) 512-8777 or larencee@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VI.



Kathleen M. King
Director, Health Care

Eileen R. Larence
Director, Homeland Security and Justice

Appendix I: Health Care Fraud and Abuse Control (HCFAC) Program Activities Conducted by Agencies in Fiscal Year 2012

The activities listed in table 2 below represent only activities that are supported with HCFAC funds (as reported in agency documents or interviews with agency officials). The table does not include other activities conducted by the agencies that are not related to health care fraud and abuse control.

Table 2: Agencies, Components, and Health Care Fraud and Abuse Control (HCFAC) Program Activities

Agency	Components	HCFAC Activities
Department of Health and Human Services (HHS)	Office of General Counsel (OGC)	Supports program integrity work of its clients (such as the Centers for Medicare & Medicaid Services) through a variety of activities. Among other activities, OGC works to recover payments by Medicare that are the primary responsibility of other payers under the Medicare Secondary Payer provisions, which preclude Medicare payment for services and items that certain other health insurance or coverage is primarily responsible for paying; to protect Medicare funds when providers seek bankruptcy protections; and to defend CMS and its contractors in cases seeking damages for the alleged wrongful denial of claims and other actions. In addition, OGC assists CMS in implementing provisions of the Patient Protection and Affordable Care Act; and provides legal advice to CMS regarding the development and imposition of Civil Monetary Penalties and defends CMS in administrative appeals and judicial litigation resulting from these cases. OGC also participates in the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative; and assists the Department of Justice (DOJ) with cases filed under the False Claims Act.
	Administration for Community Living (ACL)	Provides infrastructure, technical assistance, and program support for the Senior Medicare Patrol (SMP) programs. Additionally, in fiscal year 2012, ACL used HCFAC funding to expand SMP programs and funded two technical assistance grantees.
	Centers for Medicare & Medicaid Services (CMS)	Supports, among many other program integrity activities, the Medicaid and Children's Health Insurance Program (CHIP) financial oversight project, which conducts a variety of financial oversight activities, including monitoring of Medicaid expenditures and financial management reviews of Medicaid. Project activities include reviews of proposed Medicaid state plan methodologies and associated financing sources, to ensure their compliance with federal requirements. Additionally, CMS conducts a pilot project designed to use predictive modeling and data analytics to detect fraud and abuse in community mental health centers in Florida, Texas, and Louisiana. The pilot is related to funding received by community mental health centers for partial hospitalization services, where CMS has seen high levels of fraud and abuse and will identify high risk providers, conduct targeted site visits, and apply appropriate corrective actions, such as revocations, suspensions, and referrals to law enforcement. Finally, CMS uses some of its HCFAC appropriations for its contributions to the Strike Force teams—which are comprised of staff from federal, state, and local investigation agencies, designed to combat Medicare fraud by using technology, such as data analysis techniques—located in nine cities nationwide.
	Food and Drug Administration (FDA)	Conducts Pharmaceutical Fraud Program to detect, investigate, prosecute, and prevent pharmaceutical, biologic, and medical device fraud.

Agency	Components	HCFAC Activities
Department of Health and Human Services' Office of Inspector General (HHS-OIG)	Office of Audit Services (OAS)	Conducts independent audits of HHS programs, grantees, and contractors. These audits review CMS operations and external entities that play a role in providing Medicare and Medicaid services, including Medicare contractors, state Medicaid agencies, and providers of healthcare services. These audits review program performance, identify opportunities for reducing costs, assess compliance with federal laws and HHS regulations, recommend recovery of improper payments, and identify vulnerabilities in systems controls and operations. OAS also responds to health care-related complaints received by the OIG Hotline; reviews proposed regulations and laws relating to Medicare and Medicaid; and responds to congressional requests.
	Office of Evaluation and Inspections (OEI)	Conducts national evaluations to provide HHS, Congress, and the public with information on issues related to preventing fraud, waste, and abuse; and promoting economy, efficiency, and effectiveness of HHS programs. OEI reports also include recommendations for improving HHS program operations. OEI issues referrals (both internally and externally) to identify specific entities—such as providers and suppliers—that merit further study or investigation.
	Office of Investigations (OI)	Coordinates and conducts investigations of allegations of fraud, waste, and abuse in HHS programs, including Medicare, Medicaid, and CHIP. OI is also responsible for excluding certain individuals and entities, such as physicians and pharmaceutical or device manufacturers, from participating in federal health care programs for certain types of conduct. OI investigators also play an active role in the Strike Force teams. OI also oversees the operations of the OIG Hotline, which receives complaints of fraud, waste, abuse, and mismanagement related to all HHS programs, and serves as the primary point of contact to report fraud.
	Office of Counsel to the Inspector General (OCIG)	Exercises the authority to impose civil and administrative penalties related to health care fraud, including civil monetary penalties. OCIG also litigates appeals of exclusions, and assists on civil False Claims Act cases and settlements. Additionally, OCIG operates the voluntary disclosure program for providers—a program whereby providers can voluntarily report their fraudulent conduct affecting Medicare, Medicaid, and other federal health care programs; monitors compliance with Corporate Integrity Agreements; and provides industry guidance, such as through advisory opinions, fraud alerts, and public outreach/training. According to OCIG officials, OCIG also provides legal support for HHS-OIG's evaluations and audits and legal clearance on issuance of all HHS-OIG subpoenas and uses of electronic surveillance by OI.
	Office of Management and Policy (OMP)	Provides management, guidance, and resources in support of HHS-OIG's other components, including budget formulation and execution, human capital planning, information technology solutions, and administrative services (such as space management, travel, and policies).
Department of Justice (DOJ)	Criminal Division	Initiates and coordinates health care fraud prosecutions and supports the United States Attorney's Offices (USAO) with legal and investigative guidance and training and attorneys to prosecute violations of criminal health care fraud. DOJ's Criminal Division plays an active role in the Strike Force teams, as well as provides legal guidance, such as through annual health care fraud training conferences and review of qui tam, or whistleblower, lawsuits under the False Claims Act to assess whether the defendants in such lawsuits have engaged in criminal activity. DOJ's Criminal Division also supports investigations and prosecutions of fraud and abuse targeting private sector health plans sponsored by employers and/or unions, as well as investigations and prosecutions of health care frauds perpetrated by domestic and international organized crime groups.

Agency	Components	HCFAC Activities
	Civil Division	Investigates and resolves matters against a wide array of health care providers and suppliers, often in response to qui tam, or whistleblower, lawsuits filed under the False Claims Act. For example, the Civil Division represents the U.S. government in civil matters, such as cases alleging that a pharmaceutical manufacturer has illegally marketed a prescription drug for an unapproved use and cases alleging that a provider improperly billed Medicare. The Elder Justice and Nursing Home Initiative, within the Civil Division, coordinates and supports law enforcement efforts to combat elder abuse, neglect, and financial exploitation, by hosting quarterly conference calls with DOJ attorneys to discuss issues or developments in connection with nursing home or failure of care cases. DOJ's Civil Division also has the authority to bring criminal charges against pharmaceutical and medical device manufacturers under the Federal Food, Drug, and Cosmetic Act.
	Civil Rights Division	Investigates cases of abuse and grossly substandard care in Medicare and Medicaid-funded long-term care facilities. The Civil Rights Division is the DOJ component responsible for enforcement of the Civil Rights of Institutionalized Persons Act, which authorizes investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiates civil actions to remedy practices in violation of an individual's rights. The Civil Rights Division also has primary enforcement authority for the Americans with Disabilities Act and investigates allegations of discrimination by public entities against individuals with disabilities, including discrimination in the form of needless institutionalization of persons who require health care services.
	U.S. Attorney's Offices	Prosecute both civil and criminal health care fraud cases in their districts—94 USAOs throughout the country—that involve a wide variety of health care fraud matters, including false billings by providers; kickbacks to induce referrals of Medicare or Medicaid patients; and failure of care allegations against nursing homes. The USAOs often partner with the Criminal and Civil divisions to prosecute health care fraud cases. The USAOs and support personnel in the nine cities where Strike Force teams are located participate in those teams.
	Federal Bureau of Investigation (FBI)	Serves as the primary investigative agency of health care fraud, with jurisdiction to investigate fraud under both federal health care programs and private health insurance plans. The FBI investigates health care fraud through coordinated initiatives with federal, state, and local agencies. Additionally, the FBI participates in task forces and undercover operations to pursue investigations for health care fraud and participates in the Strike Force teams. The FBI also provides training and guidance on health care investigative matters—such as innovative methods of employing advanced investigative techniques—to health care investigators and analysts.

Source: Information from fiscal year 2012 annual HCFAC report, in agency reports, on agency websites, and from interviews with agency officials.

Appendix II: Health Care Fraud and Abuse Control (HCFAC) Program Obligations for Fiscal Years 2008 through 2012

Table 3 summarizes the HCFAC obligations for the Department of Health and Human Services (HHS), including the HHS Office of Inspector General, and Department of Justice components for fiscal years 2008 through 2012 by type of appropriations. An obligation is a definite commitment that creates a legal liability of the government for payment of goods and services ordered or received. The table includes obligations of mandatory HCFAC appropriations, discretionary HCFAC appropriations, and other appropriations used to support HCFAC activities. Mandatory HCFAC appropriations refer to the HCFAC budgetary resources controlled by a law, principally the Health Insurance Portability and Accountability Act of 1996, rather than appropriations acts. Discretionary HCFAC appropriations refer to budgetary resources provided in annual appropriation acts, other than those that fund mandatory programs. Congress appropriated mandatory funding for HCFAC activities beginning in fiscal year 1997, and appropriated discretionary funding for HCFAC activities beginning in fiscal year 2009. Other appropriations include funding from other appropriations not specific to the HCFAC program that the agencies used, in addition to the HCFAC funds, to carry out activities related to health care fraud and abuse. In addition, the table shows the percentage of HCFAC obligations for personnel services and contracted services and supplies.

Table 3: Obligations For Health Care Fraud and Abuse Control (HCFAC) Program Activities, Fiscal Years 2008-2012, By Agency and Component and Type of Appropriations

	Fiscal Year 2008	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012
Department of Health and Human Services (HHS)[a]					
Administration for Community Living					
Obligations of Mandatory HCFAC Appropriations	$2,972,070	$3,180,221	$3,364,520	$3,702,737	$10,631,727
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$0	$0
Obligations of Other Appropriations	$0	$0	$0	$0	$0
Total HCFAC Obligations	$2,972,070	$3,180,221	$3,364,520	$3,702,737	$10,631,727
Percentage for Personnel	30%	29%	27%	24%	11%
Percentage for Contracted Services/Supplies	15%	22%	39%	27%	10%
Centers for Medicare & Medicaid Services					
Obligations of Mandatory HCFAC Appropriations	[b]	[b]	[b]	[b]	$14,530,000
Obligations of Discretionary HCFAC Appropriations	N/A	[b]	[b]	[b]	$350,656
Obligations of Other Appropriations	[b]	[b]	[b]	[b]	$0
Total HCFAC Obligations	[b]	[b]	[b]	[b]	$14,880,656
Percentage for Personnel	[b]	[b]	[b]	[b]	73%
Percentage for Contracted Services/Supplies	[b]	[b]	[b]	[b]	16%
Food and Drug Administration					
Obligations of Mandatory HCFAC Appropriations	$0	$0	$699,691	$1,988,451	$2,768,273
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$0	$0
Obligations of Other Appropriations	$0	$0	$0	$0	$0
Total HCFAC Obligations	$0	$0	$699,691	$1,988,451	$2,768,273
Percentage for Personnel	—	—	88%	100%	63%
Percentage for Contracted Services/Supplies	—	—	1%	0%	35%

	Fiscal Year 2008	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012
Office of General Counsel					
Obligations of Mandatory HCFAC Appropriations	$5,745,975	$5,712,705	$8,711,228	$8,873,169	$8,854,695
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$0	$0
Obligations of Other Appropriations[c]	$8,080,155	$9,113,745	$6,553,380	$6,680,831	$7,295,487
Total HCFAC Obligations	$13,826,130	$14,826,450	$15,264,608	$15,554,000	$16,150,182
Percentage for Personnel	74%	85%	86%	84%	84%
Percentage for Contracted Services/Supplies	26%	15%	14%	14%	16%
Department of Health and Human Services' Office of Inspector General (HHS-OIG)[d]					
Office of Audit Services					
Obligations of Mandatory HCFAC Appropriations	$53,638,586	$45,534,873	$55,134,402	$52,261,218	$65,804,004
Obligations of Discretionary HCFAC Appropriations	N/A	$14,314,348	$34,004	$0	$0
Obligations of Other Appropriations	$9,866,186	$6,904,396	$16,859,544	$24,863,597	$4,671,102
Total HCFAC Obligations	$63,504,772	$66,753,617	$72,027,950	$77,124,815	$70,475,106
Percentage for Personnel	91%	90%	91%	91%	92%
Percentage for Contracted Services/Supplies	9%	10%	9%	9%	8%
Office of Evaluation and Inspections					
Obligations of Mandatory HCFAC Appropriations	$11,373,838	$10,344,700	$14,919,144	$15,860,518	$15,410,246
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$0	$0
Obligations of Other Appropriations	$3,136,893	$5,365,036	$1,821,373	$1,297,694	$1,196,973
Total HCFAC Obligations	$14,510,732	$15,709,735	$16,740,517	$17,158,212	$16,607,219
Percentage for Personnel	88%	87%	90%	90%	92%
Percentage for Contracted Services/Supplies	11%	13%	10%	10%	8%
Office of Investigations					
Obligations of Mandatory HCFAC Appropriations	$59,181,222	$68,339,359	$71,854,447	$70,876,633	$88,675,409
Obligations of Discretionary HCFAC Appropriations	N/A	$4,600,019	$0	$19,103,354	$0
Obligations of Other Appropriations	$10,345,534	$5,038,277	$8,242,560	$6,961,168	$6,343,658
Total HCFAC Obligations	$69,526,755	$77,977,656	$80,097,007	$96,941,156	$95,019,067

	Fiscal Year 2008	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012
Percentage for Personnel	89%	87%	84%	82%	87%
Percentage for Contracted Services/Supplies	10%	10%	12%	14%	11%
Office of Counsel to the Inspector General					
Obligations of Mandatory HCFAC Appropriations	$7,363,903	$9,342,140	$8,699,671	$9,879,173	$9,822,896
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$0	$0
Obligations of Other Appropriations	$1,023,655	$511,664	$1,008,637	$741,009	$702,226
Total HCFAC Obligations	$8,387,557	$9,853,804	$9,708,308	$10,620,183	$10,525,122
Percentage for Personnel	96%	96%	95%	94%	97%
Percentage for Contracted Services/Supplies	4%	4%	5%	6%	3%
Office of Management and Policy					
Obligations of Mandatory HCFAC Appropriations	$44,335,892	$43,945,152	$37,639,506	$46,779,355	$36,421,764
Obligations of Discretionary HCFAC Appropriations	N/A	$29,927	$18,393,657	$17,113,762	$23,817,566
Obligations of Other Appropriations	$6,493,865	$13,754,488	$6,318,229	$4,782,107	$5,958,176
Total HCFAC Obligations	$50,829,757	$57,729,567	$62,351,393	$68,675,224	$66,197,506
Percentage for Personnel	21%	20%	20%	22%	25%
Percentage for Contracted Services/Supplies	71%	67%	60%	68%	70%
Department of Justice (DOJ)					
Civil Division					
Obligations of Mandatory HCFAC Appropriations	$15,396,015	$16,041,913	$19,874,046	$19,735,915	$22,977,000
Obligations of Discretionary HCFAC Appropriations	N/A	$8,236,767	$2,783,651	$6,405,988	$4,991,000
Obligations of Other Appropriations	$1,636,524	$4,059,000	$2,246,099	$10,211,184	$1,948,000
Total HCFAC Obligations	$17,032,539	$28,337,680	$24,903,796	$36,353,087	$29,916,000
Percentage for Personnel	56%	39%	47%	40%	47%
Percentage for Contracted Services/Supplies	44%	61%	52%	60%	53%

	Fiscal Year 2008	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012
Civil Rights Division					
Obligations of Mandatory HCFAC Appropriations	$2,375,999	$2,476,000	$2,376,000	$3,432,688	$3,823,868
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$1,769,255	$1,942,057	$892,606
Obligations of Other Appropriations	$629,995	$1,016,944	$373,283	$468,911	$453,209
Total HCFAC Obligations	$3,005,995	$3,492,944	$4,518,538	$5,843,656	$5,169,683
Percentage for Personnel	59%	70%	67%	67%	68%
Percentage for Contracted Services/Supplies	41%	30%	32%	32%	32%
Criminal Division					
Obligations of Mandatory HCFAC Appropriations	$3,080,000	$948,746	$1,541,998	$1,482,273	$1,212,507
Obligations of Discretionary HCFAC Appropriations	N/A	$2,881,619	$3,389,957	$5,286,118	$8,083,863
Obligations of Other Appropriations[e]	$0	$0	$0	$0	$0
Total HCFAC Obligations	$3,080,000	$3,830,365	$4,931,955	$6,768,390	$9,296,370
Percentage for Personnel	50%	47%	56%	65%	52%
Percentage for Contracted Services/Supplies	33%	28%	38%	35%	47%
Federal Bureau of Investigation					
Obligations of Mandatory HCFAC Appropriations	$118,085,122	$126,953,586	$129,171,234	$125,166,278	$134,381,774
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$5,902,130	$3,806,330
Obligations of Other Appropriations	$0	$0	$0	$3,570,676	$7,473,799
Total HCFAC Obligations	$118,085,122	$126,953,586	$129,171,234	$134,639,084	$145,661,903
Percentage for Personnel	78%	78%	80%	82%	81%
Percentage for Contracted Services/Supplies	22%	20%	18%	16%	17%
Justice Management Division[f]					
Obligations of Mandatory HCFAC Appropriations	$0	$0	$157,621	$5,416,098	$4,951,367
Obligations of Discretionary HCFAC Appropriations	N/A	$0	$0	$7,266,1530	$10,799,404
Obligations of Other Appropriations	$0	$0	$0	$0	$0
Total HCFAC Obligations	$0	$0	$157,621	$12,682,251	$15,750,771

	Fiscal Year 2008	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012
Percentage for Personnel	—	—	100%	3.3%	3.75%
Percentage for Contracted Services/Supplies	—	—	0%	0%	0.46%
U.S. Attorney's Offices					
Obligations of Mandatory HCFAC Appropriations	$31,421,769	$33,255,655	$32,893,926	$29,723,423	$32,659,037
Obligations of Discretionary HCFAC Appropriations	N/A	$9,023,000	$6,227,568	$15,338,747	$10,760,057
Obligations of Other Appropriations	$26,061,218	$35,035,966	$31,652,106	$31,896,207	$31,122,465
Total HCFAC Obligations	$57,482,987	$77,314,620	$70,773,600	$76,958,377	$74,541,560
Percentage for Personnel	84%	78%	83%	83%	84%
Percentage for Contracted Services/Supplies	15%	20%	16%	17%	16%

Legend: N/A=Not Applicable; $0 means no funds obligated in that fiscal year for the type of appropriation; and "—" means no percentage in that fiscal year for the type of appropriation.

Source: GAO analysis of HCFAC obligations reported to GAO by HHS, HHS-OIG, and DOJ.

Notes:

[a]Two HHS components, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Office of the Assistant Secretary for Public Affairs (ASPA), had HCFAC obligations for fiscal year 2011 only—$45,000 for ASPE and $690,894 for ASPA. These amounts are not reflected in the table.

[b]We chose to report on the activities that CMS conducted in fiscal year 2012 because those activities were included in that year's HCFAC return-on-investment calculation. In total for fiscal year 2012, CMS reported about $14.9 million in HCFAC appropriations, about $1.6 million of which was allocated in fiscal year 2012 but not obligated, which CMS reserved to fund HCFAC activities in future years. We did not request fiscal years 2008 through 2011 HCFAC obligations from CMS because the agency conducted activities other than those that were funded with HHS's mandatory HCFAC appropriations in fiscal year 2012. For example, in fiscal year 2010, CMS used its HCFAC mandatory appropriations for the One Program Integrity database, a centralized web-based portal that enables users, such as law enforcement, to access claims, provider, and beneficiary data from a centralized source.

[c]HHS's OGC reported estimated obligations of other appropriations, which included reimbursements for attorney services provided to OGC clients within HHS, that supported HCFAC activities.

[d]HHS-OIG's reported obligations also include any obligations of funds the agency received as reimbursement for the costs of conducting investigations and audits and other activities when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise authorized under 42 U.S.C. §1320a-7c(b).

[e]DOJ's Criminal Division stated that it uses some other appropriations for health care fraud activities. However, officials indicated that the division infrequently funds HCFAC activities with other appropriations and, as a result, the division does not track the amount of other appropriations used specifically for the HCFAC program.

[f]For fiscal years 2011 and 2012, DOJ reported amounts in HCFAC mandatory and discretionary appropriations that the department reserved for future use to fund HCFAC activities. In fiscal year 2011, DOJ reported about $5.2 million in mandatory HCFAC appropriations and about $7.3 million in discretionary HCFAC appropriations; in fiscal year 2012, DOJ reported about $4.7 million in mandatory HCFAC appropriations and about $10.8 million in discretionary appropriations. These funds were allocated to the Justice Management Division, but were not obligated. We have included these HCFAC funds under the Justice Management Division, in addition to the $180,494 (in fiscal year 2011) and $208,676 (in fiscal year 2012) in mandatory HCFAC obligations the division reported.

Table 4 summarizes HCFAC obligations for Strike Force teams for fiscal years 2008 through 2012 by the geographic location of the Strike Force teams. Strike Force teams consist of investigators and prosecutors who use data analysis techniques to identify, investigate, and prosecute potentially fraudulent activities in geographic areas with high rates of fraud.

Table 4: Total Health Care Fraud and Abuse Control (HCFAC) Program Obligations by Strike Force Location and Fiscal Year, 2008 through 2012

	Fiscal Year				
Strike Force Location & Fiscal Year Launched	**2008**	**2009**	**2010**	**2011**	**2012**
Miami, FL Launched FY 2007	$5,335,321	$7,504,704	$8,344,504	$10,020,003	$12,962,899
Detroit, MI Launched FY 2009	$524,578[a]	$2,687,385	$3,963,202	$4,930,594	$5,098,524
Dallas, TX Launched FY 2011	$6,838[a]	$28,247[a]	$40,070[a]	$3,696,685	$5,027,790
Los Angeles, CA Launched FY 2008	$4,197,914	$4,488,269	$4,861,523	$6,487,639	$4,815,963
Brooklyn, NY Launched FY 2010	$43,782[a]	$308,666[a]	$4,785,975	$4,915,032	$4,392,851
Baton Rouge, LA Launched FY 2010	$71,757[a]	$253,915[a]	$1,806,066	$3,422,416	$3,438,367
Chicago, IL Launched in FY 2011	$39,334[a]	$145,841[a]	$434,390[a]	$2,954,041	$3,380,209
Houston, TX Launched in FY 2009	—	$2,611,054	$2,801,064	$3,038,569	$2,566,108
Tampa, FL Launched FY 2010	$251,702[a]	$566,604[a]	$1,450,824	$2,613,618	$2,549,202
Headquarters Support of Strike Forces	—	—	$1,618,348	$5,985,725	$3,051,813
Total HCFAC Obligations	**$10,471,226**	**$18,594,685**	**$30,105,966**	**$48,064,322**	**$47,283,726**

Source: GAO analysis of HCFAC obligations reported to GAO by the Department of Health and Human Services' Office of Inspector General's (HHS-OIG) Office of Investigations and the Department of Justice's Criminal Division, the U.S. Attorneys' Offices, and the Federal Bureau of Investigation for fiscal years 2008 through 2012.

Notes: CMS also obligated $350,656 of its discretionary HCFAC appropriations for headquarters' support of the Strike Force teams. However, these obligations were not associated with any one of the nine Strike Force cities and the this amount is not reflected in the table above.

[a]HHS-OIG reported obligations for the Strike Forces in these cities prior to their official launch, because HHS-OIG investigators worked to gather evidence on cases in those cities.

Appendix III: Indicators Used by Agencies to Assess Health Care Fraud and Abuse Control (HCFAC) Program Activities

Table 5: Collective Indicators Reported in the Annual Health Care Fraud and Abuse Control (HCFAC) Program Report, and Outcomes/Outputs for Associated Indicator, for Fiscal Year 2012

	Indicators reported in HCFAC report by agencies to assess activities	Outcomes/outputs of indicators for Fiscal Year 2012
Collective indicators, in which multiple agencies contribute (including Department of Health and Human Services' Office of Inspector General (HHS-OIG) and Department of Justice (DOJ))	Amount won or negotiated through health care fraud judgments and settlements	Over $3.0 billion in judgments and settlements
	Amount deposited with the Department of Treasury and the Center for Medicare &Medicaid Services, transferred to other Federal agencies, or paid to private persons (result of fiscal year's HCFAC efforts as well as efforts from previous fiscal years)	Approximately $4.2 billion deposited
	Number of new criminal health care fraud investigations opened	1,131 new criminal investigations involving 2,148 potential defendants
	Number of cases where criminal charges were filed	452 cases involving 892 defendants
	Number of defendants convicted of health care fraud-related crimes	826 defendants convicted
	Number of new civil health care fraud investigations opened	885 new civil investigations opened
	Number of individuals and entities excluded from participation in federal health care programs by HHS-OIG	3,131 individuals and entities excluded
	Return-on-investment	$7.90 returned for every $1.00 expended for fiscal years 2010-2012
Indicators related to the Strike Force Teams located in 9 cities nationwide	Number of indictments, informations (an accusation of a criminal offense made by a public officer rather than a grand jury), and complaints involving charges filed against number of defendants	117 indictments, informations, and complaints filed against 278 defendants
	Amount of alleged billing to Medicare from defendants	Over $1.5 billion in alleged collective billings to Medicare
	Number of defendants that pled guilty	251 guilty pleas negotiated
	Number of defendants convicted in jury trials	Guilty verdicts obtained for 29 defendants in 13 jury trials
	Number of individuals that were sentenced to imprisonment and amount of average term	201 defendants sentenced with average prison term of 48 months

Source: Fiscal year 2012 annual HCFAC report and interviews with HHS-OIG and DOJ officials.

Table 6: Indicators That Are Used by the HHS Components to Assess Health Care Fraud and Abuse Control Program Activities, Source of Indicators, and Outcomes/Outputs for Associated Indicator, for Fiscal Year 2012

HHS Component	Indicators used by agencies to assess activities	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicator for Fiscal Year 2012[a]
Administration for Community Living (ACL) – Senior Medicare Patrol programs[b]	Total number of active volunteers, number of volunteer training hours, and number of volunteer work hours	ü	n	5,137 active volunteers, 39,257 training hours, and 120,953 work hours in calendar year 2012
	Number of media airings	ü	n	188,199 media airings in calendar year 2012
	Number of community outreach education events conducted and estimated number of people reached by events	ü	n	10,032 education events in which 996,040 people were reached in calendar year 2012
	Number of group education sessions for beneficiaries and number of beneficiaries who attended	ü	n	14,748 sessions attended by 449,509 beneficiaries in calendar year 2012
	Number of one-on-one counseling sessions held with or on behalf of a beneficiary	ü	n	113,457 sessions in calendar year 2012
	Total number of simple inquiries received and number of simple inquiries resolved		n	84,061 inquiries received and 83,856 inquiries resolved in calendar year 2012
	Number of inquiries involving complex issues received and number of complex issue inquiries referred for further action	ü	n	2,270 inquiries received and 908 inquiries referred for further action in calendar year 2012
	Total dollar amount referred for further action	ü	n	$27,529,968 in calendar year 2012
	Number of complex issues resolved and number of complex issues pending further action	ü	n	1,748 issues resolved and 2,585 issues pending in calendar year 2012
	Cost avoidance on behalf of Medicare, Medicaid, beneficiaries, or others Additionally, expected recoveries or savings, including: · Expected Medicare funds recovered attributable to the projects, · Expected Medicaid funds recovered attributable to the projects, · Savings to beneficiaries attributable to the projects, · Other savings attributable to the projects (e.g., Supplemental Insurance), and · Total savings attributable to the projects (which is the sum of expected Medicare funds, expected Medicaid funds, savings to beneficiaries, and other savings attributable to the projects)	ü[c]	n	In calendar year 2012: · $113,692 in cost avoidance Additionally: · $5,957,910 in expected Medicare funds · $102,000 in expected Medicaid funds · $130,796 in savings to beneficiaries · $3,175 in other savings · $6,193,881 in total savings

HHS Component	Indicators used by agencies to assess activities	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicator for Fiscal Year 2012[a]
Centers for Medicare & Medicaid Services (CMS)	Estimated amount of the federal share of Medicaid funds that were removed as a result of CMS's financial oversight of Medicaid and Children's Health Insurance Program (CHIP), including approximate amount recovered and approximate amount resolved	ü		Estimated $895 million removed, including $451 million recovered and $444 million resolved
	Estimated amount of the federal share of Medicaid funds (in questionable reimbursement) that were averted due to preventive work with states from Medicaid and CHIP financial management project	ü		Estimated $128 million averted
	For the community mental health centers project, which uses data analytics to identify fraud in community mental health centers in 3 states			CMS officials indicated that because the project has recently started, CMS does not yet have indicators to assess it. CMS officials reported that they may consider using indicators similar to those used to assess the Fraud Prevention System, such as cost avoided as a result of the project.
Food and Drug Administration (FDA) – Pharmaceutical Fraud Program	Number of criminal investigations opened since the inception of the Pharmaceutical Fraud Program	ü		42 criminal investigations
	Number of criminal investigations opened during fiscal year, including a description of the types of cases opened	ü		17 criminal investigations
	Type of judicial actions related to the investigations (such as number of individuals convicted from investigations) and outcomes (including amount of jail time, probation, or amount of restitution)	ü		1 investigation resulted in conviction of 2 individuals, who received 12 months probation and were ordered to pay $36,040 in restitution
Office of General Counsel (OGC)	Amount of recoveries for the government from: · False Claims Act and related matters in which OGC participated, · Civil Monetary Penalties that OGC established the right to recover, and · Money that OGC petitioned law enforcement agencies to seize as a result of criminal and civil litigation matters.	ü		· Over $2.6 billion in recoveries under False Claims Act and related matters; · Over $4.5 million in Civil Monetary Penalties; · About $5.4 million in seizures
	Number of physician self-referral disclosures in which OGC advised CMS on how to resolve	ü		Over 100 disclosures

HHS Component	Indicators used by agencies to assess activities	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicator for Fiscal Year 2012[a]
	Amount of money that OGC established the right to recover under the Medicare Secondary Payer provisions and amount involving bankrupt providers that OGC established the right to collect	ü		Over $17 million recovered under Medicare Secondary Payer provisions and over $4.9 million collected from bankrupt providers

Legend:

ü indicates that measure is included in Fiscal Year 2012 annual HCFAC report

n indicates that measure is included in Department of Health and Human Services' Office of Inspector General (HHS-OIG) July 2013 report on Senior Medicare Patrol programs.

Source: Agency reports, including fiscal year 2012 annual HCFAC report, and interviews with HHS officials.

[a]Unless otherwise noted, the information on outcomes/output for each measure is for fiscal year 2012.

[b]For the outcomes and outputs for indicators associated with ACL's Senior Medicare Patrol program, we used the most currently available data, which was calendar year 2012 data obtained from the July 2013 HHS-OIG report on the Senior Medicare Patrol program. The outcomes and output for these indicators is also included in the fiscal year 2012 HCFAC report; however, the outcomes and output is calendar year 2011 data.

[c]In HHS-OIG's July 2013 report on Senior Medicare Patrol program, this indicator for Medicare and Medicaid funds recovered attributable to the programs was expanded to account for both expected and actual funds recovered. However, in the fiscal year 2012 report, the indicator included only actual funds recovered.

Table 7: Indicators That Are Used by the Department of Health and Human Services Office of Inspector General (HHS-OIG) to Assess Health Care Fraud and Abuse Control (HCFAC) Program Activities, Source of Indicators, Associated Target (if any), and Outcomes/Outputs for Associated Indicator, for Fiscal Year 2012

HHS-OIG Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator		Outcomes/outputs of indicators for Fiscal Year 2012
		FY 2012 HCFAC report	Other	
Collective indicators in which more than one HHS-OIG component contributes	Number of prosecutions or settlements that resulted from investigations or other inquiries conducted by HHS-OIG	ü		1,145 prosecutions or settlements of which 1,047 were health care cases
	Amount of health care savings attributable to statutory changes enacted and administrative actions taken in response to HHS-OIG investigations, audits, and evaluations, including: amount of savings to Medicare and Medicaid	ü	v	$8.5 billion in total; $8 billion in Medicare savings and $525 million in savings to the federal share of Medicaid
	Examples of audits and evaluations by topic area	ü		Audits and evaluations covering a number of topics, including Medicaid drugs, Medicaid managed care, Medicare physician services, community mental health centers, and Medicare Advantage organizations
	Amount of HHS-OIG Audit Disallowances recovered in Medicare and Medicaid	ü		$89,667,376 in Medicare and $275,559,307 in Medicaid recovered audit disallowances
	Amount of expected recoveries, including audit receivables and investigative receivables and non-HHS investigative receivables resulting from work in areas such as states' shares of Medicaid restitution		v	$6.9 billion consisting of $923.8 million in audit receivables and $6 billion in investigative receivables (which includes $1.7 billion in non-HHS investigative receivables resulting from work in areas such as the states' shares of Medicaid restitution)
	Ratio of expected return on investment measuring the efficiency of HHS-OIG's health care oversight efforts (Target: $12.0)		°	$17.9
	Number of quality and management improvement recommendations that HHS program managers accepted		°	190 recommendations
	Number of audit reports with funds to be put to better use		v	19 reports
	Examples of recently completed cases and settlements by specific types		v	Examples cover many types, including medical equipment and supplies, pharmaceutical companies, laboratories, hospitals, and hospice care

HHS-OIG Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for Fiscal Year 2012
	Number of sanctions administered in the form of program exclusions or administrative actions		v	1,911 sanctions administered in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to federal health care programs and their beneficiaries
	Amount of civil monetary penalties and assessments from cases in which OIG was involved		v	$6.7 million
	Amount of HHS receivables from self-disclosure cases in which HHS-OIG was involved		v	$53.3 million in HHS receivables
Office of Audit Services (OAS)	Number of audit starts by program area		°	472 reports started, 337 of which were health care-related
	Number of final reports issued by program area		°	438 reports issued, 303 of which were health care-related
	Questioned cost recommendations (dollar value)		v	$860.6 million
	Funds put to better use recommendations		v	$1,659.2 billion
	Timeliness of draft reports (or final reports if issued without a draft) (Target: 63 percent)		°	72 percent
	Single Audits (A-133 audits) reviewed and transmitted to agencies for resolution		v	3,280 audits, which included 8,276 recommendations
	Audit receivables (disallowed questioned cost recommendations)		v °	$923.8 million
	Accepted management and quality improvement recommendations		°	83 recommendations, 18 of which were implemented
Office of Counsel to the Inspector General (OCIG)	Number of compliance roundtable meetings held and number of companies represented	ü		2 roundtables held with officials representing 55 companies
	Indicators involving Civil Monetary Penalties (CMP), including dollar value of penalties and assessments for CMPs		°	$20,980,462.53
	Indicators related to Corporate Integrity Agreements (CIA) or other similar agreements, including:			
	Number of Corporate Integrity Agreements, Integrity Agreements, or other similar agreements monitored for compliance in fiscal year	ü	°	214 agreements monitored
	Number of Corporate Integrity Agreements entered		°	35 agreements

HHS-OIG Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for Fiscal Year 2012
	Indicators related to advisory opinions, including: Number of advisory opinions issued and number modified, including the number issued since inception of HCFAC program	ü	°	19 advisory opinions issued and 2 modifications of advisory opinions in fiscal year 2012; 276 opinions have been issued since inception of HCFAC program
	Advisory opinion requests received		°	61 opinions received
Office of Evaluation and Inspections (OEI)	Number of evaluations started (Target: 57 evaluations)		°	83 evaluations
	Number of reports issued		°	59 reports
	Percentage of final reports completed within a year (Target: 55 percent)		°	51 percent
Office of Investigations (OI)	Number of individuals and entities excluded from participation in federal health care programs, including by the top reasons for exclusion	ü	v	3,131 individuals and entities excluded
	Complaints received (Target: 6,290 complaints)		°	4,827 complaints received
	Cases opened		°	2,369 cases
	Cases closed		°	2,105 cases

Legend:

ü indicates that the indicator is included in Fiscal Year 2012 annual HCFAC report.

v indicates that the indicator is included in at least one of the two HHS-OIG's Semiannual Report to Congress for fiscal year 2012.

° indicates that the indicator is included in HHS-OIG's Fiscal Year 2014 Justification of Estimates for Appropriations Committees, which includes outcomes/output of indicators for fiscal year 2012.

Source: Agency reports, including fiscal year 2012 annual HCFAC report, and information from HHS-OIG officials.

Notes: In addition to the indicators listed in the annual HCFAC reports and other HHS-OIG reports, officials indicated that they use additional indicators internally to manage and assess the work they conduct related to identifying and reducing health care fraud and abuse.

Table 8: Indicators That Are Used by the Department of Justice (DOJ) Components to Assess Health Care Fraud and Abuse Control (HCFAC) Program Activities, Source of Indicators, Associated Targets (if any), and Outcomes/Outputs for Associated Indicator, for Fiscal Year 2012

DOJ Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for fiscal year 2012[a]
Civil Division	Amount obtained through settlements and judgments	ü		Over $3 billion in settlements and judgments
	Number of new civil health care fraud investigations opened	ü		885 new civil investigations[b]
	Number of civil health care fraud matters pending at the end of the fiscal year	ü		1,023 civil investigations pending[b]
	Number of investigations completed per Department of Justice attorney working on financial fraud and health care fraud cases[c] (Target: 11.92 investigations per attorney)		t	10.28 investigations per attorney for fiscal year 2012
	Percentage of civil cases favorably resolved for litigating divisions[c] (Target: 80 percent of civil cases favorably resolved)		t	81 percent of civil cases favorably resolved
Civil Rights Division	Number of health care facilities reviewed (regarding conditions and services), including: · Number of health care facilities for persons with intellectual and developmental disabilities and/or mental illness found to violate residents' statutory rights · Number of investigations continued for residential facilities for persons with intellectual and developmental disabilities · Number of investigations continued for residential facilities for persons with mental illness · Number of investigations continued for nursing facilities	ü		· Conditions and practices at 12 state facilities for persons with intellectual and developmental disabilities and/or mental illness were found to violate residents' rights · Investigations of 10 residential facilities for persons with intellectual and developmental disabilities that were continued · Investigations of 3 facilities for persons with mental illness that were continued · Investigations of 2 nursing facilities that were continued
	Number of states where reviewed health care facilities are located	ü		Reviewed conditions and services at 19 health care facilities in 16 states
	Number of formal investigations opened or continued and remedial agreements entered or monitored at facilities	ü		62 health care facilities in 19 states, the District of Columbia, and the Commonwealth of Puerto Rico

DOJ Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for fiscal year 2012[a]
	Number of existing remedial agreements monitored, including: · Number of remedial agreements monitored for facilities for persons with intellectual and developmental disabilities · Number of remedial agreements monitored for state-operated residential facilities for persons with mental illness · Number of remedial agreements monitored for nursing facilities	ü		Remedial agreements for 17 facilities for persons with intellectual and developmental disabilities monitored Remedial agreements regarding 18 state-operated residential facilities for persons with mental illness monitored Remedial agreements at 2 nursing facilities monitored
	Number of actions involving unjustified institutionalization of a disabled individual in which the Civil Rights Division intervened	ü		2 actions involving unjustified institutionalization of a disabled individual where the division moved to intervene
	Number of statements of interest or *amicus* briefs in litigation filed	ü		10 statements of interest or *amicus* briefs filed
	Number of cases favorably resolved for litigating components[c] (Target: 80 percent of civil cases favorably resolved)		t	81 percent of civil cases favorably resolved
Criminal Division	Number of new health care fraud cases	ü		136 health care fraud cases
	Number of defendants charged and amount that was collectively billed to Medicare and Medicaid	ü		110 defendants charged who collectively billed Medicare and Medicaid for more than $1.3 billion
	Number of guilty pleas obtained	ü		99 guilty pleas
	Number of jury trials litigated	ü		10 jury trials litigated
	Number of guilty verdicts obtained against number of defendants	ü		Guilty verdicts for 21 defendants
	Average number of months of prison sentences in health care fraud cases	ü		56 months
	Amount secured through court-ordered restitution, forfeiture, and fines	ü		$373 million
	Number of investigations completed per Department of Justice attorney working on financial fraud and health care fraud cases[c] (Target: 11.92 investigations per attorney)		t	10.28 investigations per attorney for fiscal year 2012
	Percentage of criminal cases favorably resolved for litigating divisions[c] (Target: 90 percent of criminal cases favorably resolved)		t	92 percent of criminal cases favorably resolved

DOJ Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for fiscal year 2012[a]
Federal Bureau of Investigation (FBI)	Number of operational disruptions of criminal fraud organizations	ü		329 criminal enterprises disrupted
	Number of dismantlements of criminal hierarchy of health care fraud enterprises	ü		More than 83 criminal enterprises dismantled
	Number of new health care fraud investigations initiated by the FBI (Targets vary by field office)	ü		817 new investigations
	Number of pending health care fraud investigations (Targets vary by field office)	ü		2,835 pending investigations
	Number of criminal health care fraud convictions	ü		1,096 criminal convictions
	Number of indictments and informations filed	ü		909 indictments and informations filed
	Number of FBI health care fraud investigators and analysts that received training (Targets vary by field office)	ü		More than 400 FBI health care fraud investigators and analysts received training
	Number of dismantled criminal enterprises engaging in white-collar crime (Target: 360 criminal enterprises)		t	409 criminal enterprises
	Amounts received for restitutions, fines, seizures, civil restitution, and civil settlements		¤	In fiscal year 2011: $1.2 billion in restitutions; $1 billion in fines; $96 million in seizures; $320 million in civil restitution; and over $1 billion in civil settlements.
United States Attorneys' Offices (USAOs)	Number of new criminal matters received and defendants involved with those new matters	ü		1,131 new criminal matters involving 2,148 defendants
	Number of health care fraud criminal matters pending and defendants involved	ü		2,032 criminal matters pending involving 3,410 defendants
	Number of criminal charges filed and defendants involved	ü		Charges filed in 452 cases involving 892 defendants
	Number of Federal health care fraud related convictions	ü		826 convictions
	Number of new civil health care fraud investigations opened	ü		885 new civil investigations[b]
	Number of civil health care fraud investigations pending	ü		1,023 civil investigations pending[b]
	Number of investigations completed per Department of Justice attorney working on financial fraud and health care fraud cases[c] (Target: 11.92 investigations per attorney)		t	10.28 investigations per attorney

DOJ Component	Indicators used by agencies to assess activities (Associated target, if applicable)	Source of indicator: FY 2012 HCFAC report	Source of indicator: Other	Outcomes/outputs of indicators for fiscal year 2012[a]
	Percentage of criminal cases favorably resolved for litigating divisions[c] (Target: 90 percent of criminal cases favorably resolved; 80 percent of civil cases favorably resolved)		t	92 percent of criminal cases favorably resolved; 81 percent of civil cases favorably resolved
	Percent of white collar crimes cases concerning mortgage fraud, health care fraud, and official corruption favorably resolved[c] (Target: 90 percent of white collar cases favorably resolved)		¡	92.2 percent of white collar crime cases favorably resolved in fiscal year 2010

Legend:

ü indicates that measure is included in Fiscal Year 2012 annual HCFAC report

t indicates that measure is in DOJ's Performance and Accountability report

¡ indicates that the measure is in DOJ's Performance Plan for Fiscal Year 2012

¤ indicates that the measure is in FBI's Financial Crimes Report to the Public for Fiscal Years 2010 – 2011.

Source: Agency reports, including fiscal year 2012 annual HCFAC report, and interviews with DOJ officials.

[a]Unless otherwise noted, the information on outcomes/output for each measure is for fiscal year 2012.

[b]The outputs for these indicators are included in the summary of the HCFAC report and in the section regarding USAO activities. We report the outputs in the Civil Division section and USAO section of this table because the outputs include civil matters handled by the USAOs and/or Civil Division.

[c]These measures are reported at the departmental level for DOJ, in which several DOJ components contribute, and include health care fraud cases in addition to other cases.

Appendix IV: Key Outcomes and Outputs of Health Care Fraud and Abuse Control (HCFAC) Program Activities

Table 9: Key Program Outcomes/Outputs of Health Care Fraud and Abuse Control (HCFAC) Program Activities, Fiscal Years 2008 through 2012

HCFAC Key Program Outcomes/Outputs in Selected Years					
Program outcome/output	**Fiscal year 2008**	**Fiscal year 2009**	**Fiscal year 2010**	**Fiscal year 2011**	**Fiscal year 2012**
Approximate amount won or negotiated through health care fraud judgments and settlements	$1 billion	$1.63 billion	$2.5 billion	$2.4 billion	$3 billion
Approximate amount deposited with the Department of Treasury and Centers for Medicare & Medicaid Services, transferred to other federal agencies or paid to private persons (result of fiscal year efforts as well as efforts from previous fiscal years)	$2.14 billion	$2.576 billion	$4.02 billion	$4.1billion	$4.2 billion
Estimated amount in health care savings attributed to legislative or administrative actions to make funds available for better use (taken in response to HHS-OIG investigations, audits, and evaluations)	$16.7 billion	$16.47 billion	$21.0 billion	$19.8 billion	$8.5 billion
Number of new criminal health care fraud investigations opened	957	1,014	1,116	1,110	1,131
Number of cases where criminal charges were filed	502	481	488	489	452
Number of defendants in cases where criminal charges were filed	797	803	931	1,430	892
Number of defendants convicted of health care fraud-related crimes	588	583	726	743	826
Number of new civil health care fraud investigations opened	843	886	942	977	885
Outcomes/outputs associated with Strike Force teams[a]					
Number of defendants charged	65	209	284	323	278
Number of defendants convicted	75	104	240	198	280
Number of defendants sentenced to prison	71	77	146	175	201
Estimated total amount billed to Medicare in alleged Strike Force cases	$140 million	$253 million	$590 million	$1 billion	$1.5 billion
Number of individuals and entities excluded by HHS-OIG	3,129	2,556	3,340	2,662	3,131
Return-on-investment (3-year moving average)	$4.9:1	$5.1:1	$6.8:1	$7.2:1	$7.9:1
HCFAC mandatory obligations	$354,970,390	$366,075,050	$387,037,433	$395,868,822	$452,924,566
HCFAC discretionary obligations	—	$39,085,681	$32,598,092	$78,403,309	$63,501,482

HCFAC Key Program Outcomes/Outputs in Selected Years

Program outcome/output	Fiscal year 2008	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011	Fiscal year 2012
Obligations of other appropriations	$67,274,025	$80,799,515	$75,075,212	$91,473,384	$67,165,097
Total obligations	**$422,244,416**	**$485,960,246**	**$494,710,737**	**$565,745,516**	**$583,591,144**

Source: GAO analysis of annual HCFAC reports for fiscal years 2008 through 2012, return-on-investment data for fiscal years 2008-2012 reported to GAO by the Department of Justice, and HCFAC obligations reported to GAO by Department of Justice, Department of Health and Human Services (HHS), and HHS Office of Inspector General (HHS-OIG) for fiscal years 2008 through 2012.

[a]Some of the outcomes/outputs associated with the Strike Force teams are subsets of outcomes/outputs reported for the HCFAC program as a whole. For example, the number of defendants charged in Strike Force cases is a subset of the total number of defendants in health care fraud-related cases where criminal charges were filed. As a result, the outcomes/outputs reported in this table may be duplicative.

Appendix V: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

SEP 13 2013

Kathleen King, Director
Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: Indicators Provide Information on Program Accomplishments, but Assessing Program Effectiveness is Difficult" (GAO-13-746).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: INDICATORS PROVIDE INFORMATION ON PROGRAM ACCOMPLISHMENTS, BUT ASSESSING PROGRAM EFFECTIVENESS IS DIFFICULT" (GAO-13-746)

The Department appreciates the opportunity to review and comment on this draft report.

HHS uses a comprehensive program integrity strategy to reduce fraud, waste, and abuse, and our activities are designed to be coordinated throughout the Department, as well as with the Office of Inspector General and DOJ. We believe that the comprehensive approach permits us to be more effective in the allocation of our resources, even though it may be difficult to assess the impact of each activity in isolation. For example, CMS is currently revalidating the enrollment information of all currently enrolled Medicare providers. CMS used information from the Automated Provider Screening system to identify providers and suppliers as top priorities for revalidation. As a result, CMS was able to revoke or deactivate the billing privileges of tens of thousands of providers that do not meet Medicare requirements. While we are unable to quantify the savings that may result from these actions at this time, we know that improper payments, including potential fraud, have been prevented due to the removal of these providers and suppliers.

HHS is committed to reducing fraud, waste, and abuse in federal health care programs. Through a collaborative effort with DOJ, HHS works to fulfill the HCFAC Program's goals and support efforts related to the Medicare Strike Force teams. In conjunction with national takedowns, CMS, in particular, is using its expanded authority to suspend payments pending the investigation of a credible allegation of fraud for those providers involved. This immediately stops improper payments to potentially fraudulent providers and helps to shift our program integrity strategy beyond "pay and chase." In addition, CMS recently announced its first temporary provider enrollment moratoria using the authority provided by Section 6401(a) of the Affordable Care Act. The moratoria prevents the enrollment of new home health provider and ambulance suppliers in Medicare, Medicaid and the Children's Health Insurance Program (CHIP) in three Medicare strike force cities. The goal of the temporary moratoria is to fight fraud and safeguard taxpayer dollars, while ensuring patient access to care.

Under the moratoria, existing providers and suppliers can continue to deliver and bill for services, but no new provider and supplier applications will be approved in these areas for all three programs. The temporary enrollment moratoria apply to newly-enrolling home health agencies in the Miami and Chicago metropolitan areas; and newly-enrolling ground ambulance suppliers in the Houston metropolitan area.

1

Appendix VI: GAO Contacts and Staff Acknowledgements

GAO Contacts

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Staff Acknowledgements

In addition to the contacts named above, Martin T. Gahart, Assistant Director; Tom Jessor, Assistant Director; Christie Enders; Sandra George; Drew Long; Lisa Rogers; and Meghan Squires made significant contributions to the work.