GAO incorporated as appropriate.

provided technical comments, which
calculation. Additionally, HHS and DOJ
the HCFAC return-on-investment
these examples were not included in
reduce health care fraud, though
HHS noted examples of CMS’s efforts
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.

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
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HEALTH CARE FRAUD AND ABUSE CONTROL
PROGRAM

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

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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.

What GAO Found

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.

What GAO Found

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.

What GAO Found

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.

What GAO Found

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.

What GAO Found

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.