Recoveries From Combating Healthcare Fraud Exceed $4 Billion

Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius have released a new report showing that for every dollar spent on healthcare-related fraud and abuse investigations in the last three years, the government recovered $7.90. This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse (HCFAC) Program.

The government's healthcare fraud prevention and enforcement efforts recovered a record $4.2 billion in taxpayer dollars in Fiscal Year (FY) 2012, up from nearly $4.1 billion in FY 2011, from individuals and companies who attempted to defraud federal health programs serving seniors and taxpayers, or who sought payments to which they were not entitled. Over the last four years, the administration's enforcement efforts have recovered $14.9 billion, up from $6.7 billion over the prior four-year period. Since 1997, the HCFAC Program has returned more than $23 billion to the Medicare Trust Funds.

According ot officials, the success of this joint Department of Justice and HHS effort was made possible by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), "created in 2009 to prevent fraud, waste and abuse in the Medicare and Medicaid programs and to crack down on individuals and entities that are abusing the system". About $4.2 billion stolen or otherwise improperly obtained from federal healthcare programs was recovered and returned to the Medicare Trust Funds, the Treasury and others in FY 2012.

Since 2009, the Justice Department and HHS have improved their coordination through HEAT and increased the number of Medicare Fraud Strike Force teams to nine. These combined efforts coordinated under HEAT have expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud. In FY 2012, the two departments continued their series of regional fraud prevention summits, and the Justice Department hosted a training conference for federal prosecutors, FBI agents, HHS Office of Inspector General agents and others.

The strike force teams use advanced data analysis techniques to identify high-billing levels in healthcare fraud hot spots so that inter-agency teams can target emerging or migrating schemes as well as with chronic fraud by criminals masquerading as healthcare providers or suppliers. In July, Attorney General Holder and Secretary Sebelius announced the launch of a ground-breaking partnership among the federal government, state officials, leading private health insurance organizations and other health care anti-fraud groups to share information and best practices to improve detection of and prevent payments to scams that cut across public and private payers.

In FY 2012, the Justice Department opened 1,131 new criminal healthcare fraud investigations involving 2,148 potential defendants, and a total of 826 defendants were convicted of healthcare fraud-related crimes during the year. The department also opened 885 new civil investigations.

From May 2011 through the end of 2012, more than 400,000 providers were subject to the new screening requirements and nearly 150,000 lost the ability to bill the Medicare program due to the Affordable Care Act requirements and other proactive initiatives.

The HCFAC annual report is available at www.oig.hhs.gov/publications/hcfac.asp [1].

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