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Health Care Fraud and Abuse Control (HCFAC) Act Discussion Draft

Background:
The Health Care Fraud and Abuse Control (HCFAC) Program was established by Congress in 1996 to detect, prevent, investigate, and prosecute health care fraud, waste and abuse. Congress included permanent mandatory funding streams across the Department of Health and Human Services (HHS) and Department of Justice (DOJ) to carry out the specific health care fraud, waste, and abuse purposes delineated in the statute.

In 2010, Congress temporarily increased mandatory HCFAC funding through annual increments that ended in FY 2021 and added a permanent inflation adjustment tied to the CPI-U. It also created a discretionary HCFAC account with annual appropriations and earmarks for CMS, HHS OIG, and DOJ. In FY 2023, about 63% of HCFAC funding was mandatory and 37% discretionary.

Problem:
Current HCFAC funding levels to combat fraud, waste, and abuse are helping to safeguard federal health care programs, but more needs to be done to ensure the government is keeping pace with the size, scope, and complexity of the healthcare industry and federal programs. Medicare prevention activities consistently return $8 for every $1 spent, returning over $10 billion to the Medicare trust funds annually. Law enforcement activities funded by HCFAC dollars consistently return $4 for every $1 spent, working with federal, state and local law enforcement officials to prosecute health care fraud cases and secure hundreds of convictions each year.

Absent additional resources CMS is only able to review one out of every 2,000 fee-for-service Medicare claims, HHS and DOJ are unable to respond to thousands of complaints received each year, and cannot act on hundreds of viable fraud cases each year. Absent additional funding, they will continue to be forced to forgo investigating serious instances of fraud, waste, and abuse. This challenge will become more acute as the American population ages, creating increased opportunities for fraud to take place within the Medicare program. Similarly, as enrollment in the Children's Health Insurance Program (CHIP) and Affordable Care Act (ACA) Marketplace grows, there are additional opportunities for fraud that HCFAC is not currently authorized by Congress to investigate and pursue.

Solution:
The HCFAC Act would address persistent funding shortfalls and ensure long-term stability of health care fraud, waste and abuse prevention efforts by increasing investment in mandatory HCFAC funding streams for HHS, CMS and DOJ by authorizing new, annual appropriations (specific amounts to be determined) for FY26-FY28. For each FY after FY28, funding would be determined annually with automatic increases tied to inflation (CPI-U).

The bill would also allow HCFAC funding to be used to investigate and prosecute fraud in CHIP and the ACA Marketplace and related private insurance programs such as the Advanced Premium Tax Credit program, closing long-standing gaps in enforcement authorities across CMS programs. Under current law, OIG can only use HCFAC funding for program integrity activities related to Medicare and Medicaid.

The investments and improvements in this legislation build off past Congressional efforts to rebase mandatory HCFAC funding streams in order to keep pace with program and beneficiary growth. This funding will allow HCFAC to keep pace with existing program and beneficiary growth, while providing HHS, CMS and DOJ with the type of long-term certainty and stability that allows for strategic planning and implementation of increasingly complex health care fraud and abuse interventions. Many fraud investigations and prosecutions are multi-year activities, and mandatory funding over time is essential to support those activities.