January 24, 2011

The Honorable Charles E. Grassley
United States Senate
Washington, D.C. 20510

Dear Senator Grassley:

Thank you for your letter, dated December 17, 2010, inquiring about the efforts by the Department of Justice (DOJ) and Department of Health and Human Services (HHS) to combat health care fraud.

As you noted, Congress has made significant investments in health care fraud enforcement, including, most recently, discretionary funding increases for health care fraud enforcement and prevention in Fiscal Years 2009 and 2010. DOJ and HHS are grateful for these funding increases and we continue to believe that we have put those funds to good use investigating and prosecuting health care fraud. Indeed, as the answers below to the questions posed in your letter demonstrate, far from there being a stagnation in health care fraud prosecutions, Fiscal Year 2010 was a record year in which 931 health care fraud defendants were charged, reflecting a 16% increase over the prior fiscal year.

Question 1. Provide a detailed breakdown of the following statistics for FY2010:

a. Number of criminal health care fraud investigations opened by DOJ	1,116
Number of criminal health care fraud investigations opened by HHS/OIG	1105
Number of criminal health care fraud investigations opened by FBI	883
b. Number of criminal health care fraud investigations originated by FBI (Note: Because HCF cases are typically developed through cooperative efforts, the FBI does not track the number of cases originated by the FBI. Although the FBI is DOJ's primary investigative agency involved in the fight against HCF, it leverages its resources through investigative partnerships with agencies such as the HHS/OIG, the FDA, the DEA, the Defense Criminal Investigative Service, the Office of Personnel Management, the IRS, and various state and local agencies.)	N/A
c. Number of criminal health care fraud investigations originated by HHS/OIG Because HCF cases are typically developed and investigated through cooperative efforts, the OIG and FBI do not track the number of	N/A

cases originated by either agency. Investigative partnerships are not only leveraged between OIG and the FBI, but also with agencies such as the FDA, the DEA, the Defense Criminal Investigative Service, the Office of Personnel Management, the IRS, and various State and local agencies	
d. Number of criminal cases filed by DOJ for health care fraud	488
e. Number of criminal defendants charged by DOJ for health care fraud violations	931
f. Number of criminal convictions for health care fraud prosecuted, or plea bargained, by DOJ	726
g. Number of criminal cases attributed to HEAT strike forces	140
h. Number of pending criminal investigations (as end of FY 2010) (Note: DOJ does not maintain HEAT-specific statistics as to pending criminal investigations)	1,787

Please note that the number of health care fraud investigations opened in Fiscal Year 2010 (1,116) is higher than in the previous Fiscal Year (1,014), with the number of DOJ investigations opened increasing by 10% versus Fiscal Year 2009 (and by nearly 17% versus Fiscal Year 2008); and the number of FBI investigations opened increasing by over 18% versus Fiscal Year 2009 (and by nearly 32% versus Fiscal Year 2008).

Question 2: Provide a detailed breakdown of the costs to fund each HEAT task force. Include all sources of funding for each individual HEAT team, both from DOJ and HHS, specifying the source of the funding-HCFAC, direct appropriation, 3% fund at DOJ...etc.

Answer: Please see the attached spreadsheet (Attachment 1) for the response. In addition, as to FY 2010, Strike Force expansions and additional personnel were funded with FY 2010 HCFAC funding. Due to the timing of the discretionary appropriation, HHS and DOJ did not receive funds until March of 2010, which delayed planned activities and resulted in HHS and DOJ not being able to obligate the entire funding appropriated in FY 2010. Consistent with the appropriated period of availability (i.e. 2 years), HHS and DOJ intend to appropriate these funds in FY 2011 in support of efforts to combat health care fraud.

Question 3: Provide a detailed breakdown of all criminal cases brought by each HEAT task force, including the number of defendants, and a detailed breakdown of all criminal convictions.

Answer: The Attorney General and Secretary Sebelius announced the HEAT Initiative on May 20, 2009 and the formation of an interagency DOJ-HHS HEAT Task Force, co-chaired by the Deputy Attorney General and HHS Deputy Secretary, to oversee implementation and operations of the Initiative. As of that date, the Medicare Fraud Strike Force operated in two cities: Miami and Los Angeles. During the 18 months following the commencement of the HEAT Initiative, the Medicare Fraud Strike Force was expanded to five additional cities, bringing the total to seven locations. One of the hallmarks of the Medicare Fraud Strike Force has been to bring health care fraud cases without delay – a goal that is being achieved as demonstrated by the data provided below regarding criminal cases, defendants and convictions (including guilty pleas and trial convictions) by city for Medicare Fraud Strike Force cases. The time period covered is FY

2007 through FY 2010. In addition, statistics are provided for performance from May 20, 2009 – the date of announcement of the HEAT Initiative – through FY 2010.

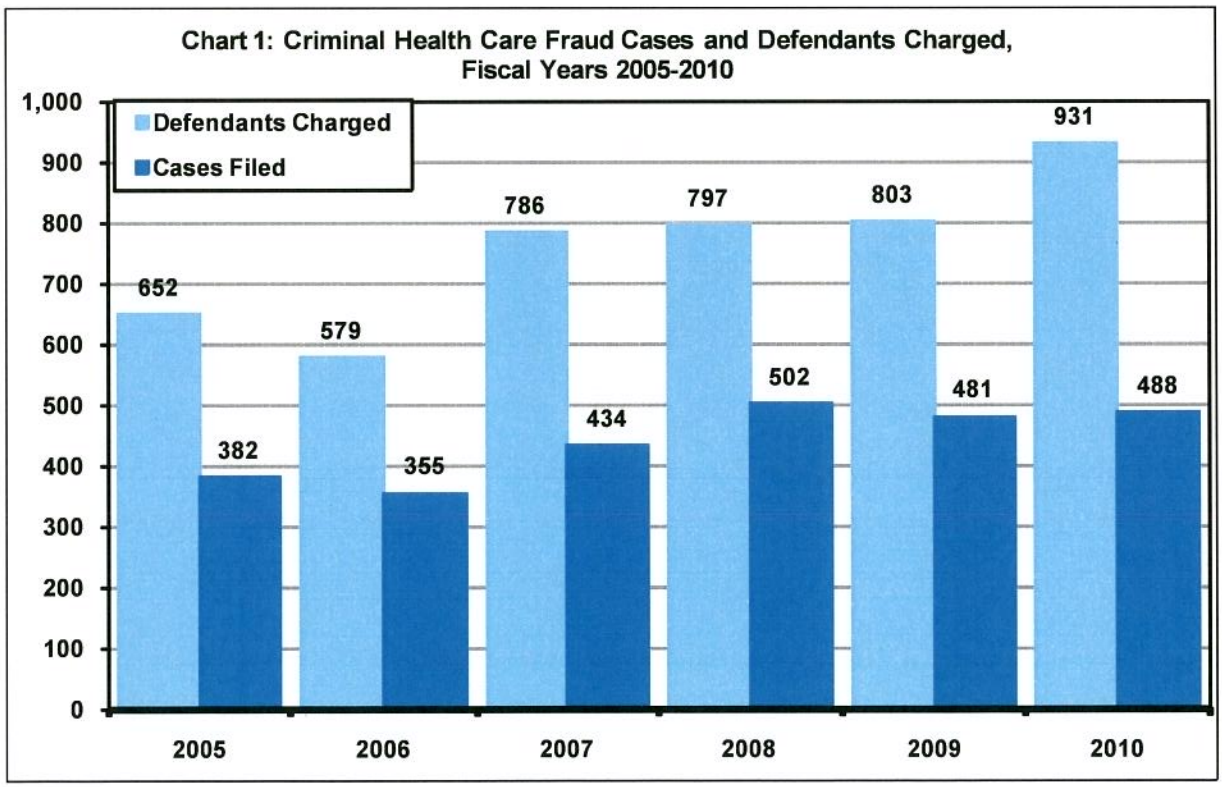
Medicare Fraud Strike Force (First Indictment/s Announced)	FY 2007	FY 2008	FY 2009	FY 2010	Total (FYs 2007-2010)	HEAT Stats: May 20, 2009-Sept. 30, 2010
Miami (Commenced in May 2007)						
Cases Filed	78	64	135	106	**383**	170
Defendants Charged	127	94	161	153	**535**	231
Guilty Pleas	43	89	101	124	**357**	161
Guilty Verdicts	4	7	10	5	**26**	8
Los Angeles (Commenced in May 2008)						
Cases Filed		20	13	3	**36**	11
Defendants Charged		34	31	8	**73**	32
Guilty Pleas		2	13	22	**37**	23
Guilty Verdicts		1	3	3	**7**	6
Detroit (Commenced in June 2009)						
Cases Filed			8	4	**12**	12
Defendants Charged			62	33	**95**	95
Guilty Pleas			16	39	**55**	55
Guilty Verdicts				8	**8**	8
Houston (Commenced in July 2009)						
Cases Filed			7	5	**12**	12
Defendants Charged			36	16	**52**	52
Guilty Pleas				23	**23**	23
Guilty Verdicts				7	**7**	7
Brooklyn (Commenced in December 2009)						
Cases Filed				9	**9**	9
Defendants Charged				33	**33**	33
Guilty Pleas				2	**2**	2
Guilty Verdicts						
Tampa (Commenced in January 2010)						
Cases Filed				6	**6**	6
Defendants Charged				10	**10**	10
Guilty Pleas				7	**7**	7
Guilty Verdicts						
Baton Rouge (Commenced in July 2010)						
Cases Filed				7	**7**	7
Defendants Charged				31	**31**	31
Guilty Pleas						
Guilty Verdicts						
(Note: These statistics do not include all criminal health care fraud cases filed and defendants charged; they only include the subset of Strike Force prosecution statistics for each district.)						

The following table provides total statistics for the Medicare Fraud Strike Force sites for the same time periods:

TOTAL Medicare Fraud Strike Force Prosecution Statistics	FY 2007	FY 2008	FY 2009	FY 2010	Total (FYs 2007-2010)	HEAT Stats: May 20, 2009-Sept. 30, 2010
Cases Filed	78	84	163	140	**465**	227
Defendants Charged	127	128	290	284	**829**	484
Guilty Pleas	43	91	130	217	**481**	271
Guilty Verdicts	4	8	13	23	**48**	29
(Note: These statistics do not include all criminal health care fraud cases filed and defendants charged; they only include the subset of Strike Force prosecution statistics for each district.)						

Notably, as these statistics demonstrate, about half of all Strike Force cases were filed -- and more than half of all defendants were charged and guilty pleas and guilty verdicts were received -- since the announcement of the HEAT Initiative on May 20, 2009, and since Congress authorized additional discretionary funding for health care fraud enforcement.

In addition, set forth below is a chart identifying the total number of health care fraud cases brought, and defendants charged, in Fiscal Years 2005 through Fiscal Years 2010.[1]



[1] The second table at the top of page 3 of your letter displayed statistics for criminal defendants, convictions, civil litigation, and HCFAC program financial recoveries and transfers. In Attachment 2 hereto, we update this table to include DOJ's prosecution statistics for FYs 2005-2010.

These increases coincide with the appropriation increases from Congress.[2] In FYs 2005 and 2006, DOJ civil and criminal litigation components received $49.4 million of $240.6 million in total HCFAC program funding (20.5%). Following enactment of the TRHCA in 2006, mandatory HCFAC funding provided to DOJ civil and criminal litigation components increased for inflation by an average of $2 million annually up to $55.3 million of $266.4 million in each of FYs 2009 and 2010. In 2009, Congress provided $198 million in new discretionary funding to HHS for health care fraud enforcement and prevention activities, of which $18.97 million (approximately 9.6%) was designated for DOJ. Therefore, DOJ received approximately $74 million in dedicated mandatory and discretionary appropriations for health care fraud enforcement in 2009. Last year, DOJ received $85 million in dedicated health care fraud enforcement funding from these same sources.

Question 4: In testimony before the Senate Committee on the Judiciary on October 28, 2009, Assistant Attorney General West stated that FBI-led investigations into health care fraud resulted in nearly 700 convictions in FY 2008. However, the FY 2008 annual report stated that there were only 588 HCF convictions that year.

a. Why is there a discrepancy between the two numbers? Do the 700 convictions include state convictions not calculated in the total health care fraud convictions outlined in the annual HCFAC reports?

Answer: The 700 convictions include state convictions not calculated in the total HCF convictions in the annual HCFAC reports. The FY 2008 HCFAC report contains information relating to federal prosecutions and convictions. In FY 2008, however, the FBI included non-federal statistical accomplishments in tabulating total HCF indictments and convictions. The FBI's statistics for FY 2008 show 699 convictions, which was reflected in AAG West's testimony. Beginning in FY 2009, the FBI HCF program recorded and reported only federal indictments and convictions.

b. Are FBI health care fraud cases and convictions counted in the HCFAC program differently than other criminal cases and convictions?

Answer: As discussed above, prior to FY 2009, the FBI's HCF program included state and local statistical accomplishments in its reporting figures. Beginning in FY 2009, the FBI HCF program recorded and reported only federal indictments and convictions.

Question 5: The statistical breakdown derived from the HCFAC reports shows that over the last three fiscal years criminal conviction rates for health care fraud cases have fallen significantly from levels in FY2005 and FY2006. Why have the rates fallen from nearly 90% to 70%? How many of those cases where no conviction or plea is reached are re-filed? How many are closed? Does DOJ have a plan to deal with the decreasing conviction rate? If so, please provide a detailed summary of that plan.

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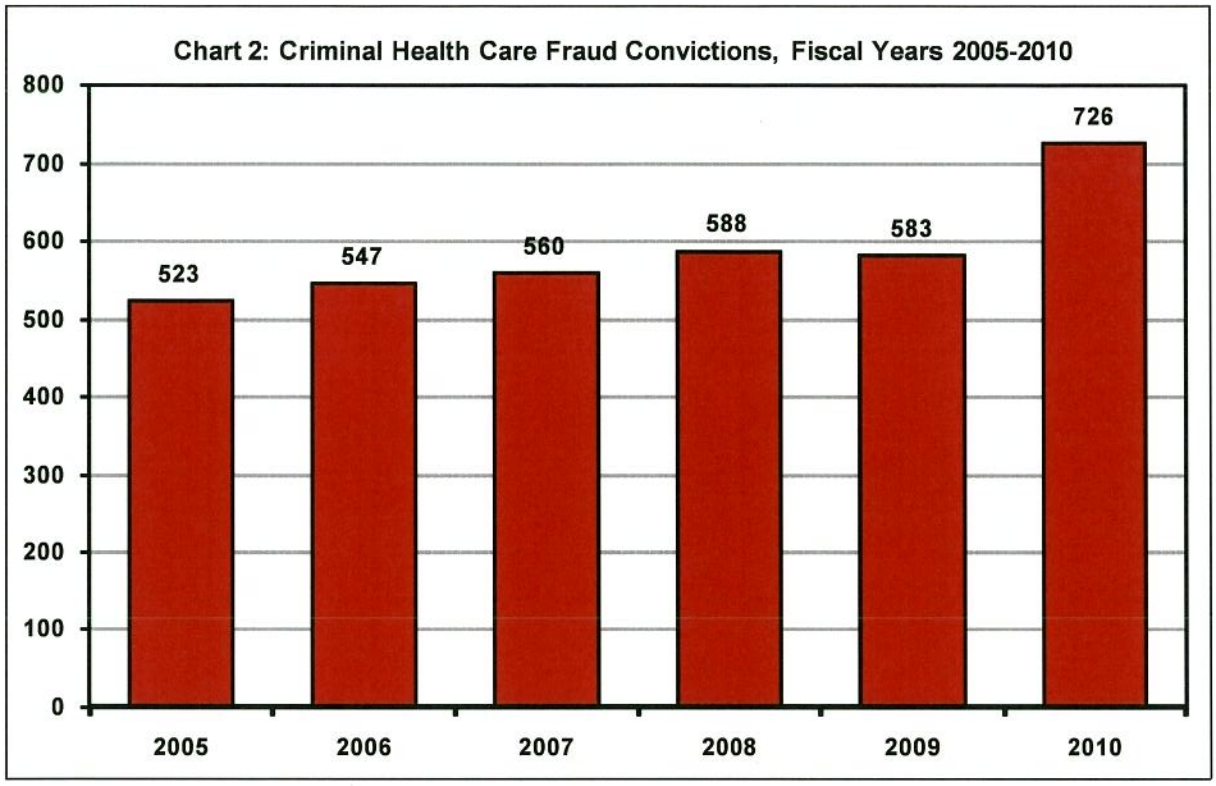
[2] The first table at the bottom of page 2 of your letter displayed the total HCFAC mandatory and discretionary appropriations for FYs 2005 through 2009. In Attachment 3 hereto, we update this table to provide the mandatory and discretionary amounts that DOJ received annually from these respective totals and updated other statistics, as necessary.

Answer: The Department's conviction rate in criminal health care fraud cases fluctuates from year to year, but has ranged from approximately 82% to 90% over each of the past five years. In FY 2010, 89.5% of criminal health care fraud defendants whose cases were closed pleaded guilty or were found guilty following trials. The conviction rate is calculated by looking at the court cases closed in a fiscal year, and dividing the number of defendants who were convicted by the total number of defendants in those closed cases. This is the best method for determining a conviction rate, and accounts for the fact that a defendant who is charged during one fiscal year often is not convicted by either plea or trial until a subsequent fiscal year given normal pre-trial proceedings including discovery and motions practice. The following table presents statistics for defendants in health care fraud cases that were closed during FYs 2005 through 2010 and the respective numbers and percentages of defendants who were convicted (a) by guilty plea or trial; (b) acquitted at trial; (c) dismissed prior to trial or guilty plea; (d) defendants who received other dispositions (for example, these may include transfers to other districts, deaths of defendants, change in status to fugitives, etc.)

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Defendants in Cases Closed	**616**	**627**	**627**	**679**	**713**	**811**
A. Total Convictions	**523**	**547**	**560**	**588**	**583**	**726**
Conviction Rate	84.9%	87.2%	89.3%	86.6%	81.8%	89.5%
Guilty Pleas	***477***	***472***	***499***	***543***	***540***	***662***
% Total Convictions	*91.2%*	*86.3%*	*89.1%*	*92.3%*	*92.6%*	*91.2%*
Guilty Verdicts	***46***	***75***	***61***	***45***	***43***	***64***
% Total Convictions	*8.8%*	*13.7%*	*10.9%*	*7.7%*	*7.4%*	*8.8%*
B. Acquittals	**9**	**8**	**15**	**9**	**3**	**11**
Acquittal Rate	1.5%	1.3%	2.4%	1.3%	0.4%	1.4%
C. Dismissals	**61**	**59**	**34**	**69**	**70**	**53**
Dismissal Rate	9.9%	9.4%	5.4%	10.2%	9.8%	6.5%
D. Other Dispositions	**23**	**13**	**18**	**13**	**57**	**21**
Other Dispositions Rate	3.7%	2.1%	2.9%	1.9%	8.0%	2.6%

In addition, set forth below is a chart reflecting the total number of health care fraud convictions for Fiscal Years 2005 through Fiscal Year 2010:



Question 6: How many U.S. Attorneys or Assistant U.S. Attorneys specialize in health care fraud? How many U.S. Attorneys or Assistant U.S. Attorneys have received specialized training in prosecuting health care fraud cases? How many U.S. Attorneys, or Assistant U.S. Attorneys, have been found by the Office of Professional Responsibility to have violated any rule, regulation, procedure, or law while prosecuting health care fraud cases? If any, how many of those attorneys were disciplined?

(a)How many U.S. Attorneys or Assistant U.S. Attorneys specialize in health care fraud?

Answer: The U.S. Attorneys' offices track personnel time by recording the amount of hours worked on health care fraud matters and cases. In FY 2010, approximately 200 Assistant U.S. Attorney full-time equivalent (FTE) workyears were devoted to health care fraud enforcement.

(b) How many U.S. Attorneys or Assistant U.S. Attorneys have received specialized training in prosecuting health care fraud cases?

Answer: In 2009, approximately 242 Assistant U.S Attorneys attended 4 HCF training sessions. In addition, approximately 100 United States Attorney's Office support personnel received HCF training. In 2010, approximately 350 Assistant U.S Attorneys attended 5 HCF training sessions.

In addition, approximately 180 United States Attorney's Office support personnel received HCF training.

(c) How many U.S. Attorneys, or Assistant U.S. Attorneys, have been found by the Office of Professional Responsibility to have violated any rule, regulation, procedure, or law while prosecuting health care fraud cases?
(d) If any, how many of those attorneys were disciplined?

Answer: As you know, the Office of Professional Responsibility (OPR) investigates allegations of professional misconduct made against Department of Justice (DOJ) attorneys where the allegations relate to the exercise of the attorney's authority to investigate, litigate, or provide legal advice. OPR finds that an attorney engaged in professional misconduct if it concludes that the attorney violated a clear and unambiguous professional obligation or standard intentionally or in reckless disregard of that obligation. Each year, OPR prepares an Annual Report that sets out the number of investigations closed during that year in which it found that one or more DOJ attorneys engaged in professional misconduct. The report also provides summaries of selected closed investigations and indicates in the instances where misconduct was found, the discipline imposed, if available. OPR's Annual Reports are public and available on the OPR website. OPR does not track or report the subject matter of the underlying prosecutions – health care fraud or otherwise -- involved in these professional misconduct matters.

Question 7: According to the most recent HCFAC report, FY2009, HHS allocated over $390 million to its subordinate agencies for the purpose of combating health care fraud. The report detailed expenditures to the Office of Inspector General, Office of the General Counsel, Administration on Aging, and Centers for Medicare & Medicaid Services. However, it failed to detail how the funds were allocated within each subordinate entity. Provide a detailed breakdown of how HCFAC monies are allocated within each subordinate agency and what programs and activities those monies funded.

Answer: In FY 2009, the Secretary and Attorney General certified $266 million in mandatory funding to further the goals of the HCFAC program. Of this amount, $211 million were allocated within HHS to the Office of the Inspector General (OIG), Office of the General Counsel (OGC), Administration on Aging (AoA), and Centers for Medicare & Medicaid Services (CMS) for the purposes of combating health care fraud and abuse. Additionally, Congress appropriated $198 million in discretionary HCFAC funds in FY 2009, of which $179 million were appropriated to CMS and HHS/OIG. Additional detail on how these funds were allocated within each agency, including detail on the programs and activities these dollars funded, is provided by agency for your information:

<u>Administration on Aging (AoA)</u>

In FY 2009, AoA was allocated $3.2 million in HCFAC funding by HHS to support AoA's Senior Medicare Patrol (SMP) program. The SMP program fights health care fraud by recruiting and training senior volunteers to educate their peers on how to prevent, detect and report instances of potential Medicare, Medicaid and other health care fraud. In FY 2009, SMP projects received about $9.4 million under Title IV of the Older Americans Act. The additional

$3.2 million in HCFAC funds supported infrastructure, technical assistance, and other SMP program support and capacity-building activities designed to enhance program effectiveness.

HCFAC funds were used in FY 2009 in support of three major grant programs. SMP Integration Grants ($743,046) supported the development of innovative strategies for reaching isolated and hard-to-reach beneficiaries, particularly in rural and tribal areas. The National Hispanic SMP grant ($225,000) focused on creating culturally and linguistically appropriate interventions to reach Hispanic older adults. Finally, the SMP Resource Center ($646,773) provided professional expertise and technical support to maximize the effectiveness of the SMP projects and administer the SMART FACTS reporting system, which reports SMP performance data to the HHS OIG on a semi-annual basis. SMART FACTS also facilitates referrals of fraud complaints directly from SMP projects to the CMS fraud contractors.

Three contracts were also funded by HCFAC in FY 2009. Two of these contracts, totaling $190,551, provided logistical support for SMP grantee meetings and three regional SMP trainings. In addition, a contract ($19,004) was awarded at the end of FY 2009 to launch the National SMP Volunteer Program Management and Quality Improvement Project. Finally, $1.3 million was utilized to support seven FTEs in AoA headquarters and regional offices to carry out program oversight and provide on-site technical assistance to SMP projects.

Office of the Inspector General (OIG)

As described in the response to question two and documented in the 2005 GAO Report titled, "Health Care Fraud and Abuse Control Program: Results of Review of Annual Reports for Fiscal Years 2002 and 2003," OIG charges a percentage of its total payroll and non-payroll expenses to the HCFAC program. The percentage that is charged each year is based on the relative proportion of its annual HCFAC funding to its total funding.

In 2009, OIG was appropriated $196 million in mandatory and discretionary HCFAC funding and obligated $193 million in support of 1,079 FTE, carrying $3 million into FY 2010 for continued support of OIG's CMS oversight efforts. In FY 2009 78% of OIG's total funding was for CMS oversight, of which the mandatory and discretionary HCFAC funding represented 85% (66% of the 78%). As such, approximately 66% of activities in each of OIG's offices were supported with HCFAC funding including the Office of Audit Services, the Office of Counsel to the Inspector General, the Office of Evaluation and Inspections, the Office of Investigations and the Office of Management and Policy.

Within each of these offices, OIG's oversight of the Medicare and Medicaid programs are guided by the following principles of program integrity.

- *Enrollment:* Scrutinize individuals and entities that seek to participate as providers and suppliers prior to their enrollment in health care programs.
- *Payment:* Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
- *Compliance:* Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

- *Oversight:* Vigilantly monitor programs for evidence of fraud, waste, and abuse.
- *Response:* Respond swiftly to detected fraud, impose appropriate punishment to deter others, and promptly remedy program vulnerabilities.
- *Quality:* Ensure that the beneficiaries of Federal health care programs receive quality health care. This challenge has many dimensions, including overseeing providers' compliance with quality-of-care standards, ensuring patient safety, and identifying opportunities for improvements in quality of care.

Office of the General Council (OGC)

In FY 2009, the Office of the General Counsel (OGC) was allocated $5.7 million in HCFAC funding by HHS. Of this amount, OGC re-allocated the funding amongst its organizations in the following manner:

Centers for Medicare and Medicaid Services (CMS) Division - $2,857,000
The Centers for Medicare and Medicaid Services (CMS) Division focused its efforts on improving the overall integrity of the CMS program. Divisional efforts primarily focused on review and assessment of CMS' programs and activities in order to strengthen them against potential fraud, waste, and abuse. In addition, the CMS Division continued to expand its litigation role, in both judicial and administrative forums, which directly assisted in the recovery of program funds. The CMS Division also continued to coordinate and support the Department of Justice in areas such as False Claims Act, Stark Law, and Anti-Kickback litigations and enforcement. Please note, CMS program integrity efforts helped recover over $1 billion in judgments, settlements, and/or other types of recoveries, savings, and/or receivables.

Regional Resources - $2,857,000

This funding was distributed to seven different regional offices: Boston, New York, Philadelphia, Atlanta, Chicago, San Francisco, and Seattle (based on workload needs). The regional offices focused their efforts on program review and improving the overall integrity of the CMS program. Their work included reviewing nursing home enforcement assessments and administrative/judicial litigation, protecting the department's interests in bankruptcy litigation, provider enrollment litigation, and Medicaid enforcement. The regional office nursing home enforcement efforts, in particular, often serve as a resource for Department of Justice investigations into potential nursing home civil fraud cases. In addition, the regions worked to support recoupment, overpayment, and suspension activities, as well as to provide assistance in the Medicare Secondary Payer collection arena. The regional offices continued to work to support numerous litigation efforts related to all aspects of the CMS program and enforcement for the Department.

Centers for Medicare & Medicaid Services (CMS)

In FY 2009, CMS was allocated $24.9 million in mandatory HCFAC funding by the Secretary and was appropriated $179.0 million in discretionary HCFAC funding, for a total of $390.1 million described in the FY 2009 HCFAC report. CMS divided this funding amongst various projects in order to address the emerging needs in combating health care fraud and abuse.

The following chart lists the CMS projects which were provided funding:

Project Area	Funding Level *(in millions)*
Part C & D Oversight	$36.62
Part B, D, Medi-Medi Integrated Data Repository (IDR)	$21.55
Part D Claims – Drug Data Processing System	$2.09
Part C & D IT Compliance System Support	$15.91
Medicare Drug Integrity Contractors (MEDIC)	$19.22
Fraud Response Initiatives (Edits, Rapid Response, Target Provider Oversight)	$34.77
Other Activities (Special Projects)	$8.23
Provider Verification Systems: Provider Enrollment & Chain Ownership System (PECOS)	$7.47
Provider Statistical Reimbursement Report (PS&R)	$0.60
Payment Error Rate Measurement (PERM)	$13.03
Medicaid Oversight	$24.98
Carry Over of Two-year Funding to FY 2010	$0.56
TOTAL	**$185.04**

Question 8: Provide a detailed breakdown of how mandatory HCFAC funding is allocated at the Federal Bureau of Investigation. This breakdown shall include a list of offices where funded agents and support personnel are allocated. It should also include a list of full and half time employees funded by HCFAC funding. Additionally, please provide a detailed breakdown of funds not used directly for personnel matters that are utilized for "operational support for major health care fraud investigations and national initiatives currently focusing on Internet Pharmacy fraud, Training and the DOJ Strike Force" as outlined in the latest HCFAC report. Finally, include a breakdown of HCFAC funds utilized for "individual investigative need such as the purchase of specialized equipment and expert witness testimony."

Answer: In FY 2010, the FBI was allocated $126,258,242 in HCFAC funds for health care fraud enforcement. This yearly appropriation is used to support 769 positions (460 Agent and 309 Support). The below table details these position types.

HCF Position Type	# of Positions
Case Agent	400
Supervisory Agent	60
Support	283
Intelligence Analyst (IA)	26
Total	**769**

There are HCFAC funded agents and support personnel in each FBI Field Office and at FBI Headquarters.

The below chart details actual expense data for FBI HCF activities.

Health Care Fraud Activities	**FY08**	**FY09**	**FY10**
Personnel Comp	$67,435,598	$72,330,682	$75,149,259
Personnel Benefits	$24,491,227	$26,753,152	$28,468,377
Total Personnel	**$91,926,825**	**$99,083,834**	**$103,617,636**
Travel and Transportation	$1,346,086	$1,713,456	$1,112,792
Space and Utilities	$9,083,003	$11,370,544	$10,561,555
Printing and Reproduction	$1,351	$318,000	$350,000
Case Funds	$1,173,291	$1,263,063	$790,178
Operational Support Services (includes experts)	$2,804,748	$8,953,982	$8,756,418
Supplies and Equipment	$1,391,925	$4,250,707	$3,982,655
Total Non-Personnel	**$15,800,404**	**$27,869,752**	**$25,553,598**
Total, Health Care Fraud	**$107,727,229**	**$126,953,586**	**$129,171,234**

Question 9: Provide the number of criminal cases and defendants that originated from leads developed from False Claims Act relators. Provide the number of False Claims Act cases that were settled including a criminal charge. Provide the number of False Claims Act cases that were filed based upon cases originally filed under a state false claims act by a *qui tam* relator. Additionally, provide the number of criminal health care fraud cases that resulted from leads developed in state false claims act cases.

Answer: The Civil Division does not track how False Claims Act cases originate, other than by *qui tam* complaint or through an investigation initiated by the Government. Nor does the Division track other matters that may have resulted from the filing of *qui tam* actions. Therefore, we cannot provide data on the number of criminal cases that originated from leads developed from FCA relators, the number of FCA cases that were based on cases originally filed under a state FCA statute, or the number of criminal health care fraud cases that were based on leads developed in state FCA cases.

DOJ, though, has a strong policy in favor of parallel proceedings and pursuing remedies both civilly and criminally when it is in the best interest of the United States. For example, in the area of pharmaceutical fraud alone, we note that since January 2009, the Civil Division, the United States Attorneys' offices, with assistance from the FBI and HHS/OIG, have recovered more than $3 billion in criminal fines, forfeitures, restitution, and disgorgement, and obtained 26 convictions, in matters relating to pharmaceutical products and medical devices. In this same time period, DOJ, along with the states, recovered more than $5 billion in civil settlements and judgments involving pharmaceutical products and medical devices. A significant portion of this amount was obtained as a result of global criminal and civil agreements. Global settlements are common in other areas as well.

Question 10: Provide the number of outstanding False Claims Act cases currently pending under seal with the Department of Justice.

Answer: As of January 4, 2011, there were 1,341 *qui tam* cases under investigation with no decision as yet on whether the allegations warrant intervention. Of these cases, 885 (66%) allege health care fraud. Although most of these cases are fully under seal, in some the seal has been partially lifted to facilitate discussions and possible settlement with the defendants. This process benefits the parties to these cases to the extent it fosters resolution without resort to often costly and lengthy litigation.

a. How many of these cases involve potential false claims to Medicare or Medicaid?

Answer: 867 (98%) of the 885 health care *qui tam* cases that are under investigation pending an election decision involve Medicare or Medicaid.

b. How many of these cases involve pharmaceutical pricing fraud?
c. How many of these cases involve off-label marketing of pharmaceutical fraud?

Answer: In response to (b) and (c), there are more than 180 *qui tam* cases under investigation pending an election decision that allege fraud in connection with the pricing and marketing of

pharmaceuticals. Many of these cases make allegations against multiple pharmaceutical manufacturers.

d. How many of these cases involve hospital up-coding Medicare and Medicaid payments?

Answer: The Civil Division does not maintain data on how many *qui tam* cases involve hospital up-coding; however, we have about 80 cases under investigation involving hospitals. The allegations in these cases are not necessarily confined to up-coding and may also include a variety of allegations arising from false claims submitted to the Government.

Question 11: How many False Claims Act cases have been resolved in the last five years?

Answer: As of January 4, 2011, based on data maintained by the Civil Division, the Civil Division, together with the United States Attorneys' offices, has obtained 716 settlements and judgments since fiscal year 2006 (541 in *qui tam* cases and 175 in other actions). These settlements and judgments total approximately $13.4 billion ($9.7 billion in *qui tam* cases and $3.7 billion in other actions). In some instances, the underlying cases remain open pending appeal or outstanding claims against other defendants. During the same period, an additional 1,244 *qui tam* cases were declined or dismissed before election, and numerous non-*qui tam* matters were completed as well. It should be noted that the Civil Division does not track, nor do these numbers include, non-*qui tam* matters that are delegated to United States Attorneys.

Since the beginning of fiscal year 2011 alone, the Civil Division and the United States Attorneys' offices obtained 19 settlements and judgments totaling more than $1.2 billion.

Question 12: What is the average length of time that an FCA case is filed under seal in Federal court while DOJ conducts a review of the cases to determine if intervention is necessary?

Answer: For *qui tam* cases filed since October 1, 2006 (i.e., fiscal year 2007 to the present), the average length of time a case remained under seal is 13 months. This number has remained fairly constant. As mentioned in response to question (10), in many of these cases the seal has been partially lifted to facilitate discussions and possible settlement with the defendants.

Question 13: What percentage of FCA cases has DOJ intervened on behalf of *qui tam* relators for the last five years? Please break this out for the total five year period and individual years.

Fiscal Year	All Elections	Intervened*	Percent Intervened
2011 To Date	29	7	24.10%
2010	224	53	23.70%
2009	311	77	24.80%
2008	324	64	19.80%
2007	359	79	22.00%
2006	397	85	21.40%
TOTAL	1644	365	22.20%

*** Includes partial intervention (i.e., intervening in some but not all allegations or against some but not all defendants).**

Question 14: Over the last five years, how many FCA cases has DOJ declined intervention initially, only to later intervene in the case for settlement purposes? How many of those cases also contained a state FCA claim?

Answer: The Civil Division does not maintain data from which we can determine how many cases the United States declines and later intervenes solely for settlement purposes, but based on experience there are very few, if any. In cases where courts have refused to extend the deadline for noticing intervention, it has been the United States' practice to nonetheless continue to investigate and remain active in those cases that the United States believes have potential merit, including negotiating with the defendants and working out the terms of settlement the same as if it had intervened. In these cases, it may appear that the United States "declined, only to later intervene … for settlement purposes," but in fact the Government remained actively involved throughout. It should also be noted that there are occasions when DOJ settles a case after we have initially declined to intervene and that we do not consistently intervene in those cases at the time of settlement. The Civil Division has no data on how many of these cases may have also contained a claim filed by a relator alleging a violation of a state false claims act.

Question 15: Provide an estimate of the total potential recovery of all the current FCA cases pending against the pharmaceutical industry (including both sealed and non-sealed cases).

Answer: See answer to question 16.

Question 16: Provide an estimate of the total potential recovery of all the current FCA cases pending against the hospitals (including both sealed and non-sealed cases).

Answer: In response to questions (15) and (16), it is impossible to give a meaningful estimate of the Government's potential recovery in any category of pending cases, including those against the pharmaceutical industry and hospitals. The Government's damages and potential recoveries under the FCA, other fraud statutes, and the common law must necessarily be done on a case-by-

case basis and evolve throughout investigation, discovery, and negotiation of these matters, as new facts are learned and as defenses are either corroborated or dismissed and cannot be determined until the investigation, negotiation, or litigation are complete. We note, however, that since January 2009, the Civil Division and the United States Attorneys' offices have recovered more than $5 billion in settlements and judgments for federal health care programs as well as $1.3 billion for state Medicaid programs. Of this $6.3 billion total, over $5 billion represents recoveries in cases involving pharmaceutical and device manufacturers.

Although the above information highlights only some of the accomplishments of the Department of Justice's and the Department of Health and Human Services' efforts to combat fraud, waste and abuse against federal health care programs, we believe these accomplishments demonstrate that Congress' investments yield significant returns, both financial and in patient protection. Senator Grassley, we appreciate your longstanding support of federal laws targeting health care fraud. We look forward to working together and to continuing our efforts to detect, investigate, prosecute and prevent such fraud and abuse.

Thank you for your attention and consideration.

Sincerely,

Jim Esquea
Assistant Secretary
U.S. Department of Health and Human Services

Ronald Weich
Assistant Attorney General
U.S. Department of Justice

Enclosures

cc: The Honorable Patrick J. Leahy
Chairman

Attachment 1

U.S. Department of Justice & U.S. Department of Health and Human Services
FY 2010 HEAT Strike Force Spending[1]

	FY 2010																	
	DOJ Direct Resources		DOJ Mandatory HCFAC		DOJ Discretionary HCFAC		DOJ 3% Fund		DOJ Mandatory HIPAA		OIG HCFAC[2]		CMS Mandatory HCFAC[3]		CMS Discretionary HCFAC[4]		Total	
	FTE	Total	FTE	Total	FTE	Total	FTE	Total	FTE	Total	FTE	Total	FTE	Total	FTE	Total	FTE	Total
Medicare Fraud Strike Forces																		
Miami, FL Medicare Fraud Strike Force	8	690,000	0	0	6	1,136,319	1	147,000	20	3,312,360	10	2,201,618	*		*	*	45	7,487,297
Los Angeles, CA Medicare Fraud Strike Force	1	173,000	0	0	3	728,996	0	0	8	1,324,944	8	1,825,926	*		*	*	20	4,052,866
Detroit, MI Medicare Fraud Strike Force	0	0	0	0	3	854,999	0	0	5	828,090	7	1,645,697	*		*	*	15	3,328,786
Houston, TX Medicare Fraud Strike Force	0	0	0	0	4	835,574	0	0	3	496,854	5	1,076,037	*		*	*	12	2,408,465
Baton Rouge, LA Medicare Fraud Strike Force	0	0	0	0	1	159,498	0	0	3	496,854	4	839,073	*		*	*	8	1,495,425
Tampa, FL Medicare Fraud Strike Force	0	0	0	0	2	343,498	0	0	2	331,236	3	633,629	*		*	*	7	1,308,363
Brooklyn, NY Medicare Fraud Strike Force	0	0	0	0	4	967,072	0	0	5	828,090	10	2,216,691	*		*	*	19	4,011,853
Medicare Fraud Strike Force HQ Support	0	0	0	0	5	1,618,348	0	0	0	0	1	274,828	*		*	*	6	1,893,176
Total, Medicare Fraud Strike Forces	**9**	**863,000**	**0**	**0**	**28**	**6,644,304**	**1**	**147,000**	**46**	**7,618,428**	**48**	**10,713,499**	*	**1,477,620**	*	*	**132**	**25,986,231**
U.S. Attorneys Special Focus Teams																		
Special Focus Team - San Francisco	0	0	0	0	0	126,900	0	0	0	0	0	0	0	0	0	0	0	126,900
Special Focus Team - Boston	0	0	0	0	4	635,400	0	0	0	0	0	0	0	0	0	0	4	635,400
Special Focus Team - Philadelphia	0	0	0	0	5	742,900	0	0	0	0	0	0	0	0	0	0	5	742,900
Total, Special Focus Teams	**0**	**0**	**0**	**0**	**9**	**1,505,200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**1,505,200**
South Florida Home Health Initiative																		
South Florida Home Health Initaitive	0	0	0	0	3	564,000	0	0	0	0	0	0	0	0	0	0	3	564,000
Total, HEAT Task Forces Spending - FY 2010	**9**	**863,000**	**0**	**0**	**40**	**8,713,504**	**1**	**147,000**	**46**	**7,618,428**	**48**	**10,713,499**	*	**1,477,620**	*	*	**144**	**28,055,431**

1/ Additional funds were allocated for HEAT Strike Forces in FY 2010, however due to the timing of the annual appropriation and the lengthy hiring process, all funding was not obligated in FY 2010. The remaining funds were carried-over into FY 2011 and will be obligated in the current fiscal year.

2/ This table includes OIG investigative and support costs for Strike Force activities. OIG supports its HEAT Strike Force efforts with its resources available for CMS oversight, of which HCFAC represents the largest share. As documented in the 2005 GAO Report titled, "Health Care Fraud and Abuse Control Program: Results of Review of Annual Reports for Fiscal Years 2002 and 2003," OIG charges a percentage of its total payroll and non-payroll expenses to the HCFAC program. The percentage that is charged each year is based on the relative proportion of its annual HCFAC funding to its total funding. As such, for the purposes of this analysis we are unable to disaggregate HCFAC discretionary and mandatory funded efforts. Accordingly, OIG tracks its Strike Force efforts, not by funding stream, but by level of effort.

3/ There are numerous CMS FTEs who support the HEAT Task Force through database development , data analysis and training, and various forms of technical assistance on administrative actions such as payment suspensions. The project breakout of the $1,477,620 is: $126,000 for STARs System Training, $87,000 for providing access to the STARs system to 176 law enforcement staff, $944,620 cost for software licenses to the National Data Base, $200,000 for the OIG hotline, and $120,000 for ONE PI training.

4/ There is one FTE fully devoted to HEAT who provides daily assistance to law enforcement's requests for information. In addition, there are numerous CMS FTEs who support the HEAT Task Force through database development , data analysis and training, and various forms of technical assistance on administrative actions such as payment suspensions. There are CMS Strike Force liaisons for all seven of the HEAT Strike Force cities.

ATTACHMENT 2

Table 2 from December 17, 2010 letter to DOJ and HHS (top of p. 3 of 5)

Fiscal Year	Total Criminal Defendants (Cases Filed)	Criminal Convictions	HCFAC New Civil Cases	HCFAC Pending Civil Fraud Cases	Total HCFAC Judgments and Settlements	Total HCFAC Transfers to Treasury, CMS, or others *
2009	803	583	886	1155	$1,630,000,000	$2,576,122,000
2008	797	588	843	1311	$1,000,000,000	$2,140,880,114
2007	786	560	776	743	$1,800,000,000	$1,100,000,000
2006	579	547	915	2016	$1,780,000,000	$1,784,563,987
2005	652	523	778	1334	$1,470,000,000	$1,708,945,056

Table 2: Updated with Preliminary FY 2010 Statistics and Clarifications for Strike Force, HEAT and Civil Statistics

Fiscal Year	Total Criminal Defendants (Cases Filed)	Criminal Convictions	*Convictions from Strike Force Cases\1*	*SF Convictions Since HEAT\2\ (May 20, 2009)*	HCFAC New Civil *Matters\3*	HCFAC Pending Civil *Matters\4*	Total HCFAC Judgments and Settlements	**Total HCFAC Transfers to Treasury, CMS, or others ***
2010	*931*	*726*	*240*	*240*	*942*	*1130*	$2,500,000,000	**$4,021,727,786**
2009	803	583	*143*	*60*	886	1155	$1,630,000,000	**$2,545,679,894**
2008	797	588	*99*	-	843	1311	$1,000,000,000	**$2,140,880,114**
2007	786	560	*47*	-	776	1284	$1,800,000,000	**$1,070,214,656**
2006	579	547	-	-	698	1268	$2,200,000,000	**$1,784,563,987**
2005	652	523	-	-	778	1334	$1,470,000,000	**$1,708,945,056**

Notes:

1. The Department announced the formation of the Medicare Fraud Strike Force in Miami in May 2007.
2. DOJ and HHS announced HEAT and the expansion of the Medicare Fraud Strike Force from two sites (Miami and L.A.) on May 20, 2009.
3. The figures in the December 17, 2010 letter to DOJ and HHS reflect the number of new civil matters received during each fiscal year.
4. The figures in the December 17, 2010 letter to DOJ and HHS reflect the number of civil matters pending at the end of each fiscal year.

Figures include judgments and settlements negotiated in the fiscal year for which the report was issued as well as previous fiscal years that were transferred to the recipients during the fiscal year for which the report was issued. The total figure for FY 2009 includes the correction referenced in the HCFAC Report to Congress for FY 2010 on page 83.

ATTACHMENT 3

Table 1 from December 17, 2010 letter to DOJ and HHS (bottom of p. 2 of 5)

Fiscal Year	HCFAC Mandatory $	HCFAC Discretionary $	FBI Mandatory $	Criminal HCFAC Investigations Opened	HCFAC Criminal Cases Filed	HEAT Criminal Investigations	HCFAC Pending Criminal Investigations
2010	$266,425,182	$311,000,000	$126,258,242	*See below*	*See below*	*See below*	*See below*
2009	$266,425,206	$198,000,000	$126,300,000	1014	481	82	1600
2008	$255,196,557	$0	$120,900,000	957	502	30	1612
2007	$249,459,000	$0	$118,200,000	878	434	74	1677
2006	$240,558,000	$0	$114,000,000	836	355	N/A	1689
2005	$240,558,000	$0	$114,000,000	935	382	N/A	1626

Table 1 Updated with FY 2010 Figures for the Department of Justice Only and Clarifications for Strike Force and HEAT Statistics

Fiscal Year	HCFAC-DOJ Mandatory $ \1\	HCFAC-DOJ Discretionary $ \2\	HIPAA-FBI Mandatory $	Criminal HCFAC Investigations Opened	HCFAC Criminal Cases Filed	*Strike Force* Criminal Cases Filed \3\	*Strike Force Cases Filed Since HEAT 5/20/2009* \4\	HCFAC Pending Criminal Invstgtns	*HCFAC Pending Criminal Cases*
2010	$55,328,139	$29,790,000	$126,258,242	1,116	488	140	140	1,787	*855*
2009	$55,328,139	$18,967,000	$126,300,000	1,014	481	163	87	1,621	*798*
2008	$53,621,589	$0	$120,900,000	957	502	84	-	1,600	*773*
2007	$51,793,000	$0	$118,200,000	878	434	78	-	1,612	*677*
2006	$49,415,000	$0	$114,000,000	836	355	0	-	1,677	*607*
2005	$49,415,000	$0	$114,000,000	935	382	0	-	1,689	*645*

Explantory Notes:

1. The HCFAC mandatory allocation to DOJ from the HHS budget represented 21% of the annual total amount stated in the December 17, 2010 letter.
2. The HCFAC discretionary allocation to DOJ from the HHS budget represented less than 10% of the annual total amount in the December 17, 2010 letter.
3. DOJ and HHS announced the formation of the Medicare Fraud Strike Force in Miami in May 2007. Figures for MFSF cases in annual HCFAC reports to Congress for fiscal years 2007 and 2008 included cases handled with DOJ Criminal Division atttorneys only. The report to Congress for 2009 included statistics as of the report publication date for MFSF cases litigated by the DOJ Criminal Division and USAOs, but did not include all USAO Strike Force cases because reporting procedures were not fully implemented at that time. Statistics for fiscal years 2009 and 2010 included in this table represent all reported MFSF cases prosecuted by the USAOs and DOJ Criminal Division that were reported through the end of fiscal year 2010.
4. Since May 20, 2009, when DOJ and HHS announced HEAT, the agencies have expanded the Medicare Fraud Strike Force from two sites (Miami and L.A. at that time) to seven sites currently. (Detroit and Houston, Brooklyn, Baton Rouge and Tampa are new since May 20, 2009.) Figures in this column include Strike Force cases from all sites for each fiscal year since HEAT's announcement on May 20, 2009.