

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Friday, December 21, 2018

Justice Department Recovers Over \$2.8 Billion from False Claims Act Cases in Fiscal Year 2018

NOTE: The 2018 False Claims Act statistics can be found [here](#).

The Department of Justice obtained more than \$2.8 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2018, Principal Deputy Associate Attorney General Jesse Panuccio and Assistant Attorney General Jody Hunt of the Department of Justice's Civil Division announced today. Recoveries since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than \$59 billion.

"Every year, the submission of false claims to the government cheats the American taxpayer out of billions of dollars," said Principal Deputy Associate Attorney General Panuccio. "In some cases, unscrupulous actors undermine federal healthcare programs or circumvent safeguards meant to protect the public health. In other instances, deceitful contractors overcharge our military or sell faulty equipment to our law enforcement agencies. Such fraud will not be tolerated by the Department of Justice. The nearly three billion dollars recovered by the Civil Division represents the Department's continued commitment to fighting fraudsters and cheats on behalf of the American taxpayer."

"The False Claims Act was originally passed in response to rampant fraud perpetrated against the United States military during the Civil War. Back then, crooked contractors defrauded the Union Army by selling it sick mules, lame horses, sawdust instead of gunpowder, and rotted ships with fresh paint. Unfortunately, what we see today is just a modern version of the same thing — deceptive and fraudulent practices directed at the U.S. government and the American taxpayer," said Assistant Attorney General Jody Hunt. "The Department of Justice has placed a high priority on rooting out and pursuing those who cheat government programs for their own gain. The recoveries announced today are a message that fraud and dishonesty will not be tolerated."

Of the \$2.8 billion in settlements and judgments recovered by the Department of Justice this past fiscal year, \$2.5 billion involved the health care industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians. This is the ninth consecutive year that the Department's civil health care fraud settlements and judgments have exceeded \$2 billion. The recoveries included in the \$2.5 billion reflect only federal losses but, in many of these cases, the Department was instrumental in recovering additional millions of dollars for state Medicaid programs.

In addition to combatting health care fraud, the False Claims Act serves as the government's primary civil remedy to redress false claims for federal funds and property involving a multitude of government operations and contracts. These areas range from defense and national security to import tariffs and small business programs.

In 1986, Congress strengthened the Act by increasing incentives for whistleblowers to file lawsuits alleging false claims on behalf of the government. These whistleblower, or *qui tam*, actions comprise a significant percentage of the False Claims Act cases that are filed. If the government prevails in a *qui tam* action, the whistleblower, also known as the relator, receives up to 30 percent of the recovery. Whistleblowers filed 645 *qui tam* suits in fiscal year 2018, and this past year the Department recovered over \$2.1 billion in these and earlier filed suits.

Health Care Fraud

The Department investigates and resolves matters involving a wide array of health care providers, goods, and services. The Department's health care fraud enforcement efforts recover money for federal programs that fund health care for our nation's most vulnerable and deserving citizens, such as Medicare, Medicaid, and TRICARE. But just as important, the Department's vigorous pursuit of health care fraud prevents billions more in losses by deterring those who might otherwise try to cheat the system for their own gain.

The largest recoveries involving the health care industry this past year came from the drug and medical device industry. In one matter, AmerisourceBergen Corporation and certain of its subsidiaries paid \$625 million to resolve allegations that they sought to circumvent important safeguards intended to preserve the integrity of the nation's drug supply and profit from the repackaging of certain drugs supplied to cancer-stricken patients. Of that amount, \$581.8 million was paid to the federal government and \$43.2 million was paid to state Medicaid programs. <https://www.justice.gov/opa/pr/amerisourcebergen-corporation-agrees-pay-625-million-resolve-allegations-it-illegally>. In another matter, the medical device manufacturer Alere paid \$33.2 million to resolve allegations that it sold a materially unreliable testing device that was intended to aid clinicians in the diagnosis of drug overdoses, acute coronary syndrome and other serious conditions. Of the \$33.2 million paid by Alere, \$28.4 million was returned to the federal government and \$4.8 million was returned to state Medicaid programs. <https://www.justice.gov/opa/pr/alere-pay-us-332-million-settle-false-claims-act-allegations-relating-unreliable-diagnostic>.

The Department has investigated efforts by drug manufacturers to facilitate increases in drug prices by funding the co-payments of Medicare patients. Congress included co-pay requirements in the Medicare program, in part, to serve as a check on health care costs, including the prices that pharmaceutical manufacturers can demand for their drugs. This year, pharmaceutical company United Therapeutics Corporation, a seller of pulmonary arterial hypertension (PAH) drugs, paid \$210 million to resolve allegations that it used a foundation as an illegal conduit to pay the co-pay obligations of thousands of Medicare patients taking its PAH drugs. <https://www.justice.gov/usao-ma/pr/united-therapeutics-agrees-pay-210-million-resolve-allegations-it-paid-kickbacks-through>. In addition, the drug manufacturer Pfizer paid approximately \$23.85 million to resolve claims that it used a foundation as a conduit to pay the co-pays of Medicare patients taking Pfizer drugs. The government alleged that Pfizer raised the price of one of those drugs by 40 percent in just three months. <https://www.justice.gov/opa/pr/drug-maker-pfizer-agrees-pay-2385-million-resolve-false-claims-act-liability-paying-kickbacks>.

The Department also reported substantial recoveries from other health care providers. In a matter that came to light in part by a voluntary disclosure by the company to the Department, HealthCare Partners Holdings LLC (HCP), doing business as DaVita Medical Holdings LLC, paid \$270 million to resolve its liability for providing inaccurate information that caused Medicare Advantage Organizations (MAOs) to receive inflated Medicare payments. DaVita acquired HCP, a large California-based independent physician association, in 2012 and disclosed to the government various improper practices that were instituted by HCP. In addition, this settlement resolved whistleblower allegations that HCP engaged in "one-way" chart reviews in which it scoured its patients' medical records to find additional diagnoses that enabled managed care plans to obtain added revenue from the Medicare program. At the same time, however, it ignored inaccurate diagnosis codes revealed by its reviews that, if deleted, would have decreased Medicare reimbursement or required the plans to repay money to Medicare. <https://www.justice.gov/opa/pr/medicare-advantage-provider-pay-270-million-settle-false-claims-act-liabilities>. In 2017, the Department filed suit against UnitedHealth Group Inc. (UHG) alleging similar allegations that UHG knowingly obtained inflated risk adjustment payments based on untruthful and inaccurate information about the health status of beneficiaries enrolled in UHG's Medicare Advantage Plans throughout the United States. <https://www.justice.gov/opa/pr/united-states-intervenes-second-false-claims-act-lawsuit-alleging-unitedhealth-group-inc>. That litigation is ongoing.

In a matter that concluded in both a civil recovery and criminal plea, the former hospital chain Health Management Associates (HMA) paid over \$216 million to resolve civil allegations that it billed government health care programs for more-costly inpatient services that should have been billed as observation or out-patient services, paid illegal remuneration to physicians in return for patient referrals to HMA hospitals, and inflated claims for emergency department facility fees. In addition to these civil recoveries, HMA's subsidiary, Carlisle HMA Inc., pleaded guilty to one count of conspiracy to commit health care fraud arising from illegal conduct designed to aggressively increase admissions to the hospital and paid a \$35 million monetary penalty. <https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one>. In another matter, William Beaumont Hospital, a regional hospital system based in the Detroit, Michigan area, paid \$84.5 million to resolve allegations of improper

relationships with eight referring physicians intended to induce patient referrals. <https://www.justice.gov/opa/pr/detroit-area-hospital-system-pay-845-million-settle-false-claims-act-allegations-arising>.

As some of the matters described illustrate, the Department continued to place great importance on enforcing the safeguards contained within the Anti-Kickback Statute (AKS). This law was enacted to ensure that clinical decisions and medical services are provided to patients based on their medical needs and not on the improper financial considerations of providers. Congress has made clear that claims submitted to federal health care programs in violation of the AKS are “false” claims for purposes of the False Claims Act.

Procurement Fraud

In the past year, the Department also pursued a variety of fraud matters involving the government’s purchase of goods and services. Toyobo Co. Ltd. of Japan and its American subsidiary, Toyobo U.S.A. Inc., f/k/a Toyobo America Inc. (collectively, Toyobo), paid \$66 million to resolve claims that they sold defective Zylon fiber used in bullet proof vests that the United States purchased for federal, state, local, and tribal law enforcement agencies. The United States further alleged that between at least 2001 and 2005, Toyobo, the sole manufacturer of Zylon fiber, knew that Zylon degraded quickly in normal heat and humidity and that this degradation rendered bullet proof vests containing Zylon unfit for use. The United States alleged that Toyobo nonetheless actively marketed Zylon fiber for bullet proof vests, published misleading data that understated the degradation problem and, when one body armor manufacturer recalled some of its Zylon-containing vests in late 2003, started a public relations campaign designed to influence other body armor manufacturers to keep selling Zylon-containing vests. Toyobo’s actions allegedly delayed by several years the government’s efforts to determine the true extent of Zylon degradation. Finally, in August 2005, the National Institute of Justice (NIJ) completed a study of Zylon-containing vests and found that more than 50 percent of used vests could not stop bullets that they had been certified to stop. Thereafter, all Zylon-containing vests were decertified for use. With this year’s Toyobo settlement, more than \$132 million has been recovered by the Department in False Claims Act matters involving the manufacture, distribution or sale of Zylon by body armor manufacturers, weavers, and international trading companies. <https://www.justice.gov/opa/pr/japanese-fiber-manufacturer-pay-66-million-alleged-false-claims-related-defective-bullet>.

United Kingdom marine services contractor, Inchcape Shipping Services Holdings Limited, and certain of its subsidiaries paid \$20 million to resolve allegations that they overbilled the U.S. Navy under contracts to provide services to Navy ships at ports in several regions throughout the world, including southwest Asia, Africa, Panama, North America, South America and Mexico. In its suit, the government alleged that Inchcape knowingly overbilled the Navy by submitting invoices that overstated the quantity of goods and services provided, billing at rates in excess of applicable contract rates, and double-billing for some goods and services. <https://www.justice.gov/opa/pr/united-states-settles-lawsuit-alleging-contractor-falsely-overcharged-us-navy-ship-husbanding>.

In another matter, TrellisWare Technologies Inc., a communications company located in San Diego, California, paid over \$12 million to settle allegations that it was ineligible for multiple Small Business Innovation and Research (SBIR) contracts it had entered into with the Navy, Army, and Air Force. The SBIR program is designed to stimulate technological innovation by funding small businesses to engage in federal research and development efforts. The United States alleged that TrellisWare was not eligible for SBIR awards because it was actually a majority-owned subsidiary of a large company at the time it was awarded and performed the SBIR contracts. <https://www.justice.gov/usao-sdca/pr/san-diego-communications-company-pays-more-12-million-settle-false-claim-act>.

In addition, 3M Company, headquartered in St. Paul, Minnesota, paid \$9.1 million to resolve allegations that it knowingly sold dual-ended Combat Arms Earplugs to the United States military without disclosing defects that hampered the effectiveness of the hearing protection device. <https://www.justice.gov/opa/pr/3m-company-agrees-pay-91-million-resolve-allegations-it-supplied-united-states-defective-dual>.

Other Fraud Recoveries

The number and variety of judgments and settlements announced during fiscal year 2018 illustrate the diversity of fraud cases pursued by the Department. For example, in February 2018, Deloitte & Touche LLP agreed to pay \$149.5 million to resolve potential False Claims Act liability arising from Deloitte’s role as the independent outside auditor of Taylor,

Bean & Whitaker Mortgage Corp. (TBW), a failed originator of mortgage loans insured by the Federal Housing Administration (FHA) in the Department of Housing and Urban Development (HUD). Deloitte served as TBW's independent outside auditor during the time TBW had been engaged in a long-running fraudulent scheme involving, among other things, the purported sale of fictitious or double-pledged mortgage loans. The United States alleged that Deloitte's audits knowingly deviated from applicable auditing standards and therefore failed to detect TBW's fraudulent conduct and materially false and misleading financial statements. <https://www.justice.gov/opa/pr/deloitte-touche-agrees-pay-1495-million-settle-claims-arising-its-audits-failed-mortgage>.

The False Claims Act was also used this past year to redress avoidance of antidumping duties that are in place to protect against foreign companies "dumping" products on the U.S. market at prices below cost. The Department of Commerce assesses, and the Department of Homeland Security's Customs and Border Protection collects, these duties to protect U.S. businesses and level the playing field for domestic products. This year, the Virginia-based home furnishings company, Bassett Mirror Company, paid \$10.5 million to resolve allegations that it knowingly made false statements on customs declarations to avoid paying antidumping duties on wooden bedroom furniture imported from the People's Republic of China (PRC). The Department alleged that between January 2009 and February 2014, Bassett Mirror evaded these antidumping duties by knowingly misclassifying the furniture as non-bedroom furniture on its official import documents. At the time of the alleged conduct in this case, wooden bedroom furniture from the PRC was subject to a 216 percent antidumping duty; non-bedroom furniture was not subject to an antidumping duty. <https://www.justice.gov/opa/pr/bassett-mirror-company-agrees-pay-105-million-settle-false-claims-act-allegations-relating>. Similarly, textile importer American Dawn Inc. agreed to pay over \$2.3 million to resolve allegations that it intentionally misclassified goods imported into the United States, such as bath and shop towels as polishing cloths, in order to pay lower tariff rates. <https://www.justice.gov/usao-ndga/pr/textile-importer-resolves-false-claims-act-allegations-0>.

And in a matter illustrating the government's continuing efforts to hold accountable those who seek to take improper advantage of a program that allows companies to remove gas from federal lands upon payment of royalties to the federal government, Citation Oil & Gas Corp. and its affiliates, Citation 2002 Investment Limited Partnership and Citation 2004 Investment Limited Partnership, paid \$2.25 million to resolve allegations that they underpaid royalties owed on natural gas produced from federal lands in Wyoming. <https://www.justice.gov/opa/pr/citation-companies-agree-pay-225-million-settle-civil-false-claims-act-allegations>.

Holding Individuals Accountable

The Department continued its commitment to use the False Claims Act and other civil remedies to deter and redress fraud by individuals as well as corporations. For example, after a two-week jury trial, the Department obtained judgments totaling more than \$114 million against three individuals who were found to have paid physicians illegal remuneration disguised as "handling fees" of between \$10 and \$17 for each patient they referred to two blood testing laboratories: Health Diagnostic Laboratory of Richmond, Virginia (HDL), and Singulex Inc., of Alameda, California (Singulex). The government also introduced evidence at trial that this kickback scheme resulted in physicians referring patients to HDL and Singulex for medically unnecessary tests, which were then billed to federal health care programs. <https://www.justice.gov/opa/pr/united-states-obtains-114-million-judgment-against-three-individuals-paying-kickbacks>.

In another kickback case, based on the jury's verdict for the United States, the court awarded judgment of \$5.5 million against neurosurgeon Dr. Sonjay Fonn, his fiancé Ms. Deborah Seeger, and their professional corporations DS Medical and Midwest Neurosurgeons. The evidence showed that Dr. Fonn performed spinal fusion surgery using implants for which his fiancé received commissions, which were used to benefit Dr. Fonn in the form of lavish purchases such as a yacht and home improvements. <https://www.justice.gov/usao-edmo/pr/federal-judge-trebles-damages-and-imposes-civil-penalties-against-cape-girardeau>.

In addition, former professional cyclist Lance Armstrong paid \$5 million to resolve a lawsuit alleging that his admitted use of performance-enhancing drugs and methods (PEDs) resulted in the submission of millions of dollars in false claims for sponsorship payments to the U.S. Postal Service (USPS), which sponsored Armstrong's cycling team during six of the seven years Armstrong was deemed the winner of the Tour de France. The lawsuit alleged that Armstrong and his team regularly and systematically employed PEDs, that Armstrong made numerous false statements denying his PED use, and that Armstrong took active measures to conceal his PED use during the USPS sponsorship and even

after the sponsorship ended. <https://www.justice.gov/opa/pr/lance-armstrong-agrees-pay-5-million-settle-false-claims-allegations-arising-violation-anti>.

Prime Healthcare Services Inc., Prime Healthcare Foundation Inc., and Prime Healthcare Management Inc. (collectively “Prime”), and Prime’s Founder and Chief Executive Officer, Dr. Prem Reddy, paid \$65 million to settle allegations that 14 Prime hospitals in California knowingly submitted false claims to Medicare by admitting patients who required only less costly, outpatient care and by billing for more expensive patient diagnoses than the patients had. Dr. Reddy paid \$3.25 million of the overall settlement. <https://www.justice.gov/opa/pr/prime-healthcare-services-and-ceo-pay-65-million-settle-false-claims-act-allegations>. Dr. Arthur S. Portnow of Sarasota, Florida, the owner and operator of Arthur S. Portnow, P.A., d/b/a Apple Medical and Cardiovascular Group, d/b/a Apple Medical Group, agreed to pay \$1.95 million to resolve allegations that he and his practice violated the False Claims Act by knowingly seeking reimbursement for medically unnecessary ultrasound tests that were performed on Medicare beneficiaries. The government also alleged that Dr. Portnow falsified patient records in an effort to justify those unnecessary ultrasounds. <https://www.justice.gov/usao-mdfl/pr/sarasota-physician-agrees-pay-195-million-resolve-false-claims-act-allegations>. Dr. Michael Frey, M.D., a pain management specialist and one of the two principal owners of Advanced Pain Management Specialists P.A. in Fort Myers, Florida, agreed to pay \$2.8 million to resolve allegations that he violated the False Claims Act in a number of ways, including receiving illegal kickbacks and by ordering medically unnecessary laboratory tests. <https://www.justice.gov/usao-mdfl/pr/fort-myers-pain-management-physician-pleads-guilty-healthcare-offenses-and-agrees-28>.

Recoveries in Whistleblower Suits

Of the \$2.8 billion in settlements and judgments reported by the government in fiscal year 2018, over \$2.1 billion arose from lawsuits filed under the *qui tam* provisions of the False Claims Act. During the same period, the government paid out \$301 million to the individuals who exposed fraud and false claims by filing these actions.

The number of lawsuits filed under the *qui tam* provisions of the Act has grown significantly since 1986, with 645 *qui tam* suits filed this past year – an average of more than 12 new cases every week.

“Whistleblowers have played a vital role in unmasking fraudulent schemes that might otherwise evade detection,” said Assistant Attorney General Jody Hunt. “The taxpayers owe a debt of gratitude to those who often put much on the line to expose such schemes.”

In 1986, Senator Charles Grassley and Representative Howard Berman led the successful efforts in Congress to amend the False Claims Act to, among other things, encourage whistleblowers to come forward with allegations of fraud. In 2009 and 2010, additional improvements were made to the False Claims Act and its whistleblower provisions. Congress also included in the False Claims Act authority for the government to dismiss cases, and during the past year the government made increasing use of this tool to help prioritize the use of government resources.

Finally, Assistant Attorney General Hunt commended the many dedicated public servants throughout the Department’s Civil Division and the U.S. Attorneys’ Offices, as well as the agency Offices of Inspector General and the many other federal and state agencies that contributed to the Department’s False Claims Act recoveries this past fiscal year. “The accomplishments announced today would not have been possible but for the hard work of the men and women throughout the government who work tirelessly to protect the interests of taxpayers,” said Assistant Attorney General Jody Hunt. “I have served in the Civil Division for many years and it is now my great honor to lead this Division. I am grateful to work alongside so many passionate, dedicated, and talented employees who have committed their careers to serving the American people and defending the interests of our great nation.”

Except where indicated, the government’s claims in the matters described above are allegations only and there has been no determination of liability. The numbers contained in this press release may differ slightly from the original press releases due to accrued interest.

Topic(s):

False Claims Act

Component(s):

Civil Division

Office of the Associate Attorney General

Press Release Number:

18-1690

Updated December 21, 2018