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More Than \$1 Billion Recovered by Justice Department in Fraud and False Claims in Fiscal Year 2008

More Than \$21 Billion Recovered Since 1986

WASHINGTON – The United States secured \$1.34 billion in settlements and judgments in the fiscal year ending Sept. 30, 2008, pursuing allegations of fraud against the federal government, the Justice Department announced today. This brings total recoveries since 1986, when Congress substantially strengthened the civil False Claims Act, to more than \$21 billion.

"Now, more than ever, it is crucial that taxpayer dollars aren't lost to fraud," said Gregory G. Katsas, Assistant Attorney General for the Department's Civil Division. "The billion dollars collected this year is only part of the story. By rooting out fraud and vigorously pursuing it, the Department, with the help of concerned citizens who report fraud in hotline calls and in *qui tam* complaints, undoubtedly saves the country many times that amount in aborted schemes and misconduct."

Assistant Attorney General Katsas also paid tribute to Senator Charles Grassley of Iowa and Representative Howard L. Berman of California who sponsored the 1986 amendments to the False Claims Act, the government's primary weapon to fight government fraud. "Without this important legislation strengthening the Act and, in particular, the *qui tam* provisions which encourage private citizens to uncover government fraud, such recoveries would not have been possible."

Almost 78 percent of this year's recoveries are associated with suits initiated by private citizens (known as "relators") under the False Claims Act's *qui tam* provisions. These provisions authorize relators to file suit on behalf of the United States against those who have falsely or fraudulently claimed federal funds. Such cases run the gamut of federally funded programs from Medicare and Medicaid to defense procurement contracts, disaster assistance loans and agricultural subsidies. Persons who knowingly make false claims for federal funds are liable for three times the government's loss plus a civil penalty of \$5,500 to \$11,000 for each claim.

Relators recover 15 to 25 percent of the proceeds of a successful suit if the United States intervenes in the *qui tam* action, and up to 30 percent if the government declines and the relator pursues the action alone. In fiscal year 2008, relators were awarded \$198 million. (This figure does not include relator shares awarded after Sept. 30, 2008.)

As in the last several years, health care accounted for the lion's share of fraud settlements and judgments—\$1.12 billion. This number includes both *qui tam* claims and those initiated by the United States. The Department of Health and Human Services reaped the biggest recoveries, largely attributable to its Medicare program and the federal/state Medicaid program which funds health care for the needy. Recoveries were also made by the Office of Personnel Management which

administers the Federal Employees Health Benefits Program, the Department of Defense for its TRICARE insurance program, the Department of Veterans Affairs and others.

The largest health care recoveries came from pharmaceutical companies and related entities. Settlements with Cephalon Inc., Merck & Co. and CVS Caremark Corp. accounted for more than \$640 million. In addition to federal recoveries, these pharmaceutical fraud cases returned \$430 million to state Medicaid programs.

The Civil Division's investigation of the pharmaceutical industry is part of a Department-wide effort. Typical allegations include "off-label" marketing, which is the illegal promotion of drugs or devices that are billed to Medicare and other federal health care programs, for uses that were neither found safe and effective by the Food and Drug Administration nor supported by the medical literature; paying kickbacks to physicians, wholesalers and pharmacies to induce drug or device purchases; establishing inflated drug prices knowing that federal health care programs use these prices to reimburse providers, then marketing the "spread" between the federal reimbursement and the provider's lower cost to induce drug purchases; and knowingly failing to report the company's true "best price" for a drug to reduce rebates owed to the Medicaid program.

The Department also collected \$133 million in defense procurement fraud. Defense contract recoveries included a \$53 million settlement with Pratt & Whitney, a division of United Technologies Corporation, and PCC Airfoils LLC, a subsidiary of Precision Castparts Corporation. The settlement resolved allegations that Pratt & Whitney and PCC Airfoils knowingly submitted false claims to the Air Force for defective turbine blades sold to the government to retrofit the F100-PW-220 engines in F-16 and F-15 aircraft. This case was pursued as part of a National Procurement Fraud initiative, launched in October 2006, to promote the early detection, identification, prevention and prosecution of procurement fraud.

FACT SHEET: SIGNIFICANT RECOVERIES IN FISCAL YEAR 2008

Among the Department's most significant settlements and judgments in fiscal year 2008 were:

- \$361.5 million from Merck & Company to resolve allegations that the pharmaceutical manufacturer knowingly failed to pay proper rebates to Medicaid and other government health care programs, and paid kickbacks to health care providers to induce them to prescribe the company's products. The settlement resulted from two lawsuits brought under the *qui tam* provisions of the False Claims Act. In the first, which accounted for \$221.9 million of the \$361.5 settlement, a former Merck employee alleged that the company violated the Medicaid Rebate Statute by providing deep discounts to hospitals that used its drugs Zocor and Vioxx in place of competitors' brands, without reporting those discounts and other cost information to reflect its "best price," as required by the statute to ensure that Medicaid obtains the benefit of the same price concessions other purchasers enjoy. This suit also alleged that Merck paid kickbacks to physicians, disguised as fees for training, consultation, and market research, to induce them to prescribe its drugs, also contrary to law. The United States paid the relator \$46.6 million as his share of the settlement under the False Claims Act's *qui tam* provisions. In addition to the federal recovery, Merck paid \$162 million to state Medicaid programs.

In the second lawsuit, which accounted for the remaining \$139.6 million of the settlement, a

physician alleged that Merck provided deep discounts to hospitals to induce them to administer its antacid, Pepcid, as a means to boost sales through continued use after the patient's discharge. The suit went on to allege, similar to the first suit, that Merck knowingly failed to report these discounts as required by the Medicaid Rebate Statute, which resulted in illegal and inflated claims to federal and state Medicaid programs. In addition to paying the United States \$139.5 million in federal claims, Merck paid \$114 million to settle state Medicaid claims. The relator received \$24 million as his federal share of the settlement and an additional sum for the state recoveries. Merck also entered into a Corporate Integrity Agreement with the Inspector General of the Department of Health and Human Services (HHS) to ensure compliance with federal health insurance programs in the future.

For the original press release, see:

http://www.usdoj.gov/opa/pr/2008/February/08_civ_094.html

<http://www.usdoj.gov/usao/pae/News/Pr/2008/feb/steinkrelease.pdf>

- \$258 million from Cephalon Inc. to resolve claims that the company marketed three drugs for uses not approved by the Food and Drug Administration (FDA). By promoting the drugs for so-called "off label" uses, Cephalon caused providers to charge federal health insurance programs such as Medicare, Medicaid, TRICARE and the Federal Employees Health Benefits Program for unapproved uses of the drugs not covered by the programs. The settlement resolved four lawsuits, three of which were brought by former Cephalon sales representatives under the *qui tam* provisions of the False Claims Act. Consistent with those provisions, the relators who filed the suits will share \$46.7 million as their part of the settlement. In addition to the \$258 million recovered for federal programs, the United States recovered \$116 million for the Medicaid programs in 14 states and the District of Columbia. Cephalon also pleaded guilty to related criminal charges, paid \$50 million in fines and forfeitures and entered into a five-year Corporate Integrity Agreement with the Inspector General of HHS to ensure strict compliance in the future.

For the original press release, see:

<http://www.usdoj.gov/opa/pr/2008/September/08-civ-860.html>

- \$225 million from Amerigroup Corporation to settle both federal and state allegations that Amerigroup, together with its Illinois subsidiary, systematically avoided enrolling pregnant women and other high-cost patients in the company's managed care program in Illinois. The program was funded by Medicaid, which required open enrollment to all eligible beneficiaries. By excluding pregnant women and other high-cost patients, Amerigroup increased its profits in conflict with the law. The United States and Illinois jointly brought suit under the federal False Claims Act and the Illinois Whistleblower Reward and Protection Act. In October 2006, following a lengthy trial, the court entered judgment for \$334 million. Amerigroup appealed and the parties entered negotiations leading to settlement. The relator received \$56.25 million as his share of the federal and state recoveries. In conjunction with the settlement, Amerigroup entered into a Corporate Integrity Agreement with the Inspector General of HHS to ensure future compliance.

For the original press release, see:

<http://www.usdoj.gov/opa/pr/2008/August/08-civ-723.html>

- \$75 million to settle claims that Kyphon Inc., now Medtronic Spine LLC, violated the False Claims Act by knowingly causing the submission of false claims to Medicare for its kyphoplasty procedure—a minimally-invasive surgery used to treat compression fractures of the spine. The settlement resolved a lawsuit filed by two former Kyphon employees under the *qui tam* provisions of the False Claims Act. The suit alleged that Kyphon engaged in a seven-year marketing scheme that resulted in certain hospitals billing Medicare for kyphoplasties performed on an inpatient basis rather than for less costly and clinically appropriate outpatient kyphoplasty treatment. This conduct resulted in the Medicare program paying more for inpatient kyphoplasty procedures. The relators received a total of \$14.9 million as their share of the settlement. In conjunction with the settlement, Kyphon entered into a Corporate Integrity Agreement with the Inspector General of HHS to ensure future compliance.

For the original press release, see:

<http://www.usdoj.gov/opa/pr/2008/May/08-civ-455.html>

- \$74 million from Staten Island University Hospital (SIUH) to resolve two False Claims Act *qui tam* suits and two other matters. In the first action, a physician and former SIUH Director of Chemical Dependency Services, filed suit alleging that SIUH fraudulently billed Medicare and Medicaid for substance abuse and alcohol detoxification services provided to inpatients in unlicensed beds, in violation of state law, between 1994 and 2000. SIUH paid the United States \$11.8 million in settlement of this *qui tam* action, with the relator receiving \$2.3 million as his share of the government's recovery. In related allegations of inflated Medicaid billings asserted under New York State's false claims statute, SIUH paid New York \$14.88 million, with the relator receiving \$2.97 million as his share of the state's recovery. In the second action, the widow of an SIUH cancer patient filed suit alleging that between 1996 and 2004, SIUH submitted false claims to Medicare and TRICARE using incorrect codes for cancer treatments not covered by the programs. SIUH paid the United States \$25 million, including a relator share award of \$3.75 million. In the third matter, the United States alleged that SIUH deliberately inflated the number of residents it employed to fraudulently increase Medicare reimbursement between 1996 and 2003. SIUH paid the United States \$35.7 million in settlement of this matter. Lastly, SIUH paid the United States \$1.47 million to settle allegations that it billed Medicare and Medicaid for treating psychiatric patients in unlicensed beds from 2003-2005. In conjunction with the settlement, SIUH also entered into a Corporate Integrity Agreement with the Inspector General of HHS to ensure future compliance.

For the original press release, see:

<http://www.usdoj.gov/usao/nye/pr/2008/2008sep15.html>

- \$60 million from Lester E. Cox Medical Centers, a health care system headquartered in Springfield, Mo., to settle claims that it violated the False Claims Act, the Anti-Kickback Statute and the Stark Statute between 1996 and 2005. The United States alleged that Cox entered into illegal financial relationships with referring physicians at a local physician group and engaged in improper billing practices with respect to Medicare. Under the Stark Statute, providers such as Cox are prohibited from billing Medicare for referrals from doctors with whom the providers have a financial relationship, unless that relationship falls within certain exceptions. The United States contended that Cox and the referring physicians ran afoul of the Stark Statute, as well as the Anti-Kickback Statute, which prohibits offering inducements to providers in return for patient referrals. The settlement also resolves claims that Cox included non-reimbursable costs on its Medicare cost reports and improperly billed for dialysis services. In conjunction with the settlement, Cox entered into a Corporate Integrity Agreement with the Inspector General of HHS to ensure future compliance.

For the original press release, see:

<http://www.usdoj.gov/opa/pr/2008/July/08-civ-638.html>

<http://www.usdoj.gov/usao/mow/news2008/cox.settlement.htm>

- \$53 million from Pratt & Whitney, a division of United Technologies Corporation, and PCC Airfoils LLC, a subsidiary of Precision Castparts Corporation, to resolve allegations that the companies knowingly submitted false claims for defective turbine blades purchased by the Air Force to retrofit the F100-PW-220 engines found in F-16 and F-15 aircraft. The settlement includes corrective action to replace defective blades and inspection of potentially serviceable blades to ensure their integrity. The case was pursued as part of a National Procurement Fraud Initiative launched in October 2006, to promote the early detection, identification, prevention and prosecution of procurement fraud.

For the original press release, see:

<http://www.usdoj.gov/opa/pr/2008/August/08-civ-675.html>

- \$26 million from St. Joseph's Hospital of Atlanta to resolve allegations that the hospital falsely claimed Medicare reimbursement for inpatient admissions that were, in fact, less costly outpatient visits. A registered nurse, formerly employed by the hospital, initiated suit under the False Claims Act's *qui tam* provisions. The complaint alleged that the hospital improperly billed for short inpatient admissions, usually of one day or less, when the service should have been billed as an outpatient "observation" or emergency room visit. Medicare reimburses hospitals a higher rate for inpatient admissions than it does for observation care or emergency room visits. The nurse who triggered the investigation received \$4.94 million as her share of the recovery. St. Joseph's entered into a Corporate Integrity Agreement with the Inspector General of HHS in conjunction with the settlement, to ensure future compliance.

For the original press release, see:

<http://www.usdoj.gov/usao/gan/press/2007/12-21-07.pdf>

- \$23.2 million from Bechtel Infrastructure Corp. and PB Americas Inc. to settle allegations of false claims for federal highway funds in connection with the firms' failure to provide adequate management and quality assurance services during the construction of the Central Artery Tunnel, known as the Big Dig, in Boston. The recovery, part of a \$458 million settlement of state and federal claims, resolved parts of a *qui tam* lawsuit, a related federal investigation and additional claims that Bechtel and PB Americas violated federal and state criminal and civil laws in connection with their services on the Big Dig. In addition to the federal recovery, the companies paid \$40 million in state claims and \$335 million into a state warranty fund for future repairs to the Big Dig. The private citizen who filed the suit received \$54,000 and \$96,000 as his share of the federal and state recoveries, respectively.

For the original press release, see:

http://www.usdoj.gov/opa/pr/2008/January/08_crt_048.html

<http://boston.fbi.gov/dojpressrel/pressrel08/govtclaimsettlement012308.htm>

- \$21.1 million from CVS Caremark Corp. to settle claims that from 2000-2006, the company illegally switched patients from the tablet version of the drug Ranitidine (generic Zantac) to a more expensive capsule version for the sole purpose of increasing Medicaid reimbursement. For example, CVS pharmacies in Illinois would charge Medicaid \$79.80 for 60 Ranitidine capsules, rather than \$17.10 for the tablets prescribed, increasing reimbursement by \$62.70 on a single prescription. CVS Caremark is headquartered in Rhode Island and operates more than 6,000 pharmacies nationwide. The settlement resolves *qui tam* claims under federal and state false claims statutes. In addition to the federal recovery, CVS Caremark paid \$15.6 million to 23 states and the District of Columbia. The *qui tam* plaintiff received \$4.3 million as his share of the federal and state settlements. CVS Caremark also entered into a Corporate Integrity Agreement with the Inspector General of HHS to ensure future compliance.

For the original press release, see:

http://www.usdoj.gov/opa/pr/2008/March/08_crt_214.html

Fraud Statistics 1986-2008

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