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Justice Department Recovers Over $3.5 Billion From False Claims Act Cases in Fiscal Year 2015

Recoveries Exceed $3.5 Billion for Fourth Consecutive Year

The Department of Justice obtained more than $3.5 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division, announced today. This is the fourth year in a row that the department has exceeded $3.5 billion in cases under the False Claims Act, and brings total recoveries from January 2009 to the end of the fiscal year to $26.4 billion.

"The False Claims Act has again proven to be the government's most effective civil tool to ferret out fraud and return billions to taxpayer-funded programs," said Mizer. "The recoveries announced today help preserve the integrity of vital government programs that provide health care to the elderly and low income families, ensure our national security and defense, and enable countless Americans to purchase homes."

Of the $3.5 billion recovered last year, $1.9 billion came from companies and individuals in the health care industry for allegedly providing unnecessary or inadequate care, paying kickbacks to health care providers to induce the use of certain goods and services, or overcharging for goods and services paid for by Medicare, Medicaid, and other federal health care programs. The $1.9 billion reflects federal losses only. In many of these cases, the department was instrumental in recovering additional millions of dollars for consumers and state Medicaid programs.

The next largest recoveries were made in connection with government contracts. The government depends on contractors to feed, clothe, and equip our troops for combat; for the military aircraft, ships, and weapons systems that keep our nation secure; as well as to provide everything that is needed to fund myriad programs at home. Settlements and judgments in cases alleging false claims for payment under government contracts totaled $1.1 billion in fiscal year 2015.

The False Claims Act is the government's primary civil remedy to redress false claims for government funds and property under government contracts, including national security and defense contracts, as well as under government programs as varied as Medicare, veterans' benefits, federally insured loans and mortgages, highway funds, research grants, agricultural supports, school lunches, and disaster assistance. In 1986, Congress strengthened the Act by amending it to increase incentives for whistleblowers to file lawsuits on behalf of the government.

Most false claims actions are filed under the Act's whistleblower, or *qui tam*, provisions that allow individuals to file lawsuits alleging false claims on behalf of the government. If the government prevails in the action, the whistleblower, also known as the relator, receives up to 30 percent of the recovery. Whistleblowers filed 638 *qui tam* suits in fiscal year 2015 and the department recovered $2.8 billion in these and earlier filed suits this past year. Whistleblower awards during the same period totaled $597 million.

Health Care Fraud

Including this past year's $1.9 billion, the department has recovered nearly $16.5 billion in health care fraud since January 2009 to the end of fiscal year 2015 – more than half the health care fraud dollars recovered since the 1986 amendments to the False Claims Act. These recoveries restore valuable assets to federally funded programs such as

Medicare, Medicaid, and TRICARE – the health care program for the military. But just as important, the department's vigorous pursuit of health care fraud prevents billions more in losses by deterring others who might otherwise try to cheat the system for their own gain. The department's success is a direct result of the high priority the Obama Administration has placed on fighting health care fraud. In 2009, the Attorney General and the Secretary of the Department of Health and Human Services, the department that administers Medicare and Medicaid, announced the creation of an interagency task force called the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to increase coordination and optimize criminal and civil enforcement. Additional information on the government's efforts in this area is available at StopMedicareFraud.gov, a webpage jointly established by the Departments of Justice and Health and Human Services.

Two of the largest health care recoveries this past year were from DaVita Healthcare Partners, Inc., the leading provider of dialysis services in the United States. DaVita paid $450 million to resolve allegations that it knowingly generated unnecessary waste in administering the drugs Zemplar and Venofer to dialysis patients, and then billed the government for costs that could have been avoided. DaVita paid an additional $350 million to resolve claims that it violated the False Claims Act by paying kickbacks to physicians to induce patient referrals to its clinics. DaVita is headquartered in Denver, Colorado, and has dialysis clinics in 46 states and the District of Columbia.

Hospitals were involved in nearly $330 million in settlements and judgments this past year. A cardiac nurse and a health care reimbursement consultant filed a *qui tam* suit against hundreds of hospitals that were allegedly implanting cardiac devices in Medicare patients contrary to criteria established by the Centers for Medicare and Medicaid Services in consultation with cardiologists, professional cardiology societies, cardiac device manufacturers, and patient advocates. The department settled with nearly 500 of these hospitals for a total of $250 million, including $216 million recovered in the past fiscal year. For details, see 500 Hospitals.

Several settlements involved violations of the Stark Law. The Stark Statute prohibits certain financial relationships between hospitals and doctors that could improperly influence patient referrals. Services provided in violation of the Stark Statute are not reimbursable by Medicare or Medicaid. Hospitals settling false claims involving Stark violations include Adventist Health System for $115 million, an organization that operates hospitals and other health care facilities in 10 states; North Broward Hospital District for $69.5 million, a special taxing district of Florida that operates hospitals and other health care facilities in Broward County, Florida; and Georgia hospital system Columbus Regional Healthcare System and Dr. Andrew Pippas for $25 million plus contingent payments up to an additional $10 million. The Adventist settlement also involved allegations of miscoding claims to obtain higher reimbursements for services than allowed by Medicare and Medicaid.

Claims involving the pharmaceutical industry accounted for $96 million in settlements and judgments. Daiichi Sankyo Inc., a global pharmaceutical company with its U.S. headquarters in New Jersey, paid $39 million to resolve allegations of false claims against the United States and state Medicaid programs. Daiichi allegedly paid kickbacks to physicians to induce them to prescribe Daiichi drugs, including Azor, Benicar, Tribenzor and Welchol. Medicare and Medicaid prohibit reimbursement for drugs involved in kickback schemes. AstraZeneca LP and Cephalon Inc. paid the United States $26.7 million and $4.3 million, respectively, in separate settlements for allegedly underpaying rebates owed under the Medicaid Drug Rebate Program. As part of those settlements, the two drug manufacturers agreed to pay an additional $23 million to state Medicaid programs for their losses. And in another settlement, PharMerica Corp., the nation's second largest nursing home pharmacy, agreed to pay the United States $9.25 million to resolve allegations that it solicited and received kickbacks from pharmaceutical manufacturer Abbott Laboratories in exchange for promoting the drug Depakote for nursing home patients. PharMerica is headquartered in Louisville, Kentucky.

Skilled nursing homes and rehabilitation facilities have also been fertile ground for civil fraud and false claims actions. In the largest failure of care settlement with a skilled nursing home chain in the department's history, Extendicare Health Services Inc. and its subsidiary, Progressive Step Corporation, agreed to pay the United States $32.3 million to resolve allegations that Extendicare billed Medicare and Medicaid for deficient nursing services and billed Medicare for medically unreasonable and unnecessary rehabilitation therapy services. Extendicare and Pro-Step paid an additional $5.7 million to eight states for their Medicaid losses. The department has ongoing litigation against additional nursing home chains and rehabilitation centers based on similar allegations of false claims for medically unreasonable or unnecessary rehabilitation therapy. For example, see HCR ManorCare.

Housing and Mortgage Fraud

The department has recovered over $5 billion in housing and mortgage fraud from January 2009 to the end of fiscal year 2015, including this past year's recoveries of $365 million. Notable recoveries this past year include a $212.5 million settlement with First Tennessee Bank N.A. First Tennessee admitted that from 2006 to 2008, through its subsidiary, First Horizon Home Loans Corporation, it originated and endorsed mortgages for federal insurance by the Federal Housing Administration (FHA) that did not meet eligibility requirements. First Tennessee also admitted failing to report such deficiencies to the authorities as required under the program despite widespread knowledge by its senior managers by early 2008. In August 2008, First Tennessee sold First Horizon to MetLife Bank N.A., a wholly-owned subsidiary of MetLife Inc. Metlife admitted similar misconduct regarding the loans it originated and endorsed from September 2008 to March 2012. MetLife paid the United States $123.5 million to resolve liability under the False Claims Act arising from its misconduct in endorsing mortgagees for FHA insurance.

The department also settled claims against Walter Investment Management Corp. for $29.63 million. The government alleged that the company, through subsidiaries Reverse Mortgage Solution Inc., REO Management Solutions LLC, and RMS Asset Management Solutions LLC, caused false claims for fees and other costs in servicing reverse mortgages under the Department of Housing and Urban Development's (HUD's) Home Equity Conversion Mortgages (HECM) program. Reverse mortgage loans allow elderly people to access the equity in their homes. The loans provide monthly payments that enable the elderly to meet their day-to-day living expenses while remaining in their homes. To encourage these loans, HUD insures banks and other institutions that service the mortgages against loss, providing the institution complies with requirements to ensure the quality of such loans. Walter Investment allegedly failed to comply with these requirements.

These recoveries are part of the broader enforcement efforts by President Obama's Financial Fraud Enforcement Task Force. President Obama established the interagency task force in 2009, to wage an aggressive, coordinated, and proactive effort to investigate and prosecute financial crimes. The task force includes representatives from a broad range of federal agencies, regulatory authorities, inspectors general, and state and local law enforcement who, working together, bring to bear a powerful array of criminal and civil enforcement resources. The task force is working to improve efforts across the federal executive branch, and with state and local partners, to investigate and prosecute significant financial crimes, ensure just and effective punishment for those who perpetrate financial crimes, combat discrimination in the lending and financial markets, and recover proceeds for victims of financial crimes. For more information about the task force, visit www.stopfraud.gov.

Government Contracts

Government contracts and federal procurement accounted for $1.1 billion in fraud settlements and judgments in fiscal year 2015, bringing procurement fraud totals to nearly $4 billion from January 2009 to the end of the fiscal year. Significant cases include a $146 million settlement with Supreme Group B.V. and several of its subsidiaries for alleged false claims to the Department of Defense (DoD) for food, water, fuel, and transportation of cargo for American soldiers in Afghanistan. Supreme Group is based in Dubai, United Arab Emirates (UAE). In addition, Supreme Group affiliates Supreme Foodservice GmbH, a privately held Swiss company, and Supreme Foodservice FZE, a privately-held UAE company, pleaded guilty to related criminal violations and paid more than $288 million in criminal fines.

In two other defense contract settlements, Lockheed Martin Integrated Systems, a subsidiary of aerospace giant Lockheed Martin Inc., paid $27.5 million and DRS Technical Services Inc. paid $13.7 million to resolve allegations that their employees lacked required job qualifications while the companies charged for the higher level, qualified employees required under contracts with U.S. Army Communication and Electronics Command (CECOM). The CECOM contracts were designed to give the Army rapid access to products and services for operations in Iraq and Afghanistan.

In a pair of cases involving contracts with the General Services Administration, VMware Inc. and Carahsoft Technology Corporation paid the United States $75.5 million and Iron Mountain Companies paid $44.5 million to settle their respective liability under the False Claims Act. The government alleged that California-based VMware and Virginia-based Carahsoft misrepresented their commercial sales practices, which resulted in overcharging government agencies for their software products and services sold through GSA's Multiple Award Schedule. Similarly, Iron Mountain, a records storage company headquartered in Massachusetts, misrepresented its commercial sales practices to GSA and failed to give certain discounts given to its commercial customers, as required to gain access to the vast federal marketplace available to contractors through the Multiple Award Schedule.

The department settled allegations that private contractor U.S. Investigations Services Inc. (USIS) violated the False Claims Act in performing a contract with the Office of Personnel Management (OPM) to perform background investigations of federal employees and those applying for federal service. The government alleged that USIS took shortcuts that compromised its contractually-required quality review and that, had the government known, it would not have paid for the services. USIS agreed to forego at least $30 million in payments legitimately owed to the company to settle the government's allegations.

Other Fraud Recoveries and Actions

Although health care, mortgage, and government contract fraud dominated fiscal year 2015 recoveries, the department has aggressively pursued fraud wherever it is found in federal programs. For example, the department recovered $44 million from Fireman's Fund Insurance Company for alleged fraud under the U.S. Department of Agriculture's federal crop insurance program. The United States alleged that Fireman's Fund knowingly issued federally reinsured crop insurance policies that were ineligible for federal reinsurance. Specifically, Fireman's Fund allegedly backdated policies, forged farmers' signatures, accepted late and altered documents, whited-out dates and signatures, and signed documents after relevant deadlines. The policies were issued by Fireman's Fund offices in California, Kansas, Mississippi, North Dakota, Texas, and Washington.

The department also recovered $13 million from Education Affiliates, a for-profit education company based in White Marsh, Maryland, for alleged false claims to the Department of Education for student aid for students whose qualifications for admission were falsified to get them enrolled so they could receive aid which would be paid to the school. Education Affiliates operates 50 campuses throughout the United States under various trade names.

In other actions, the department filed lawsuits to recover funds disbursed under the Troubled Asset Relief Program (TARP) and payments made under contracts awarded to benefit disadvantaged populations identified under the Small Business Administration's set-aside programs. In one action, the department sued the estate and trusts of the late Layton P. Stuart, former owner and president of One Financial Corporation, and its operating subsidiary, One Bank & Trust N.A., both based in Arkansas, alleging that Stuart made misrepresentations to induce the Department of the Treasury to invest TARP funds in One Financial as part of Treasury's Capital Purchase Program. The department recently settled with the Stuart estate and trusts for $4 million, but claims remain pending against One Financial Corporation.

In a second action, the department filed suit against Florida-based Air Ideal Inc. and its owner, Kim Amkraut. The government alleged that Air Ideal and Amkraut falsely certified that the company qualified for preferences given to small businesses located in a Historically Underutilized Business Zone (HUBZone) when Air Ideal's HUBZone location was no more than a virtual office and its principal place of business was in a non-HUBZone location. The government further alleged that Air Ideal used its fraudulently-procured HUBZone certification to obtain contracts from the Coast Guard, Army, Army Corps of Engineers, and Department of the Interior that were worth millions of dollars. The department settled with Air Ideal and Amkraut for $250,000 plus five percent of Air Ideal's gross revenues for five years.

These suits and settlements illustrate the diversity of cases pursued by the department and the department's quest to root out fraud and false claims against the government wherever it may be found.

Holding Individuals Accountable

On Sept. 9, Deputy Attorney General Sally Quillian Yates issued a memorandum on individual accountability for corporate wrongdoing. This memorandum reinforced the department's commitment to use the False Claims Act and other civil enforcement tools to deter and redress fraud by individuals as well as corporations.

In addition to those suits involving individuals described above, the department settled or filed suit against individuals in an array of cases. For example, Two Florida couples agreed to pay the United States $1.137 million collectively, to resolve allegations that they accepted kickbacks in exchange for home health care referrals to A Plus Home Health Care Inc. The United States previously settled with A Plus, its owner Tracy Nemerofsky, and five other couples that allegedly accepted payments from A Plus. Dr. Charles Denham, of Laguna Beach, California, paid the United States $1 million to settle allegations that he solicited and accepted kickbacks from CareFusion in return for promoting a CareFusion product and influencing recommendations by the National Quality Forum. Denham was a patient safety consultant who co-chaired a National Quality Forum Committee. After settling with two cardiovascular testing

laboratories for $48.5 million - Health Diagnostics Laboratory Inc. (HDL) and Singulex Inc., the department intervened in three *qui tam* suits against another laboratory, Berkeley HeartLab Inc., a marketing company, BlueWave Healthcare Consultants Inc. and three individuals – BlueWave's owners, Floyd Calhoun Dent III and Robert Bradley Johnson and HDL's co-founder and former chief executive officer, LaTonya Mallory. The department also intervened in two *qui tam* suits against Florida cardiologist Dr. Asad Qamar and his practice, the Institute for Cardiovascular Excellence PLLC, alleging that Qamar and his practice billed Medicare for medically unnecessary peripheral artery procedures and interventions and paid kickbacks to patients by waiving Medicare copayments irrespective of financial hardship. The department also filed a complaint against H. Ted Cain, Julie Cain, Corporate Management Inc. and Stone County Hospital Inc. for false claims for Medicare reimbursement. The government alleged that Ted and Julie Cain, the hospital and hospital management company owned and controlled by Ted Cain, claimed reimbursement for the hospital's costs at inflated rates and for ineligible expenses. These matters are ongoing.

Outside the health care arena, EDF Resource Capital Inc. agreed to transfer assets worth $5.8 million to the United States, and its chief executive officer, Frank Dinsmore, agreed to pay $200,000 to the United States, to settle allegations that they violated the False Claims Act in failing to remit payments to the Small Business Administration under the 504 loan program. The 504 loan program provides growing businesses with long-term, fixed-rate financing for major fixed assets, such as land and buildings. The program operates through local lenders like EDF, who reap benefits from the program in return for shouldering certain financial obligations which Dinsmore and EDF allegedly ignored. The department also entered settlements with two individuals for evasion of Customs duties owed on imports of aluminum extrusions from the People's Republic of China (PRC). Robert Wingfield, the U.S. sales representative of a Chinese manufacturer, and Bill Ma, owner of an ostensible importer, allegedly misrepresented the country of origin of goods to avoid steep antidumping and countervailing duties imposed by the Department of Commerce and collected by U.S. Customs and Border Protection on imports of aluminum extrusions from the PRC to protect domestic manufacturers from unfair foreign pricing practices. The government previously settled related allegations with four importers, bringing total settlements in the case to $4.6 million, including the $435,000 from Wingfield and Ma.

Recoveries in Whistleblower Suits

Of the $3.5 billion the government recovered in fiscal year 2015, more than $2.8 billion related to lawsuits filed under the *qui tam* provisions of the False Claims Act. During the same period, the government paid out $597 million to the individuals who exposed fraud and false claims by filing a *qui tam* complaint, often at great risk to their careers.

The number of lawsuits filed under the *qui tam* provisions of the Act has grown significantly since 1986, with 638 qui tam suits filed this past year. The growing number of *qui tam* lawsuits, particularly since 2009, has led to increased recoveries. From January 2009 to the end of fiscal year 2015, the government recovered $19.4 billion in settlements and judgments related to *qui tam* suits and paid whistleblower awards of $3 billion during the same period.

"Many of the recoveries obtained under the False Claims Act result from courageous men and women who come forward to blow the whistle on fraud they are often uniquely positioned to expose," said Principal Deputy Assistant Attorney General Mizer.

In 1986, Senator Charles Grassley and Representative Howard Berman led 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, Senator Patrick J. Leahy, along with Senator Grassley and Representative Berman, championed the Fraud Enforcement and Recovery Act of 2009, which made additional improvements to the False Claims Act and other fraud statutes. And in 2010, the passage of the Affordable Care Act provided additional inducements and protections for whistleblowers and strengthened the provisions of the federal health care Anti-Kickback Statute.

Principal Deputy Assistant Attorney General Mizer also expressed his deep appreciation for the many dedicated public servants who investigated and pursued these cases – the attorneys, investigators, auditors and other agency personnel throughout the Department of Justice's Civil Division and the U.S. Attorneys' Offices, as well as the agency Offices of Inspector General and the many federal and state agencies that contributed to the department's recoveries this past fiscal year.

"The department's lawyers and staff, together with our law enforcement partners in federal and state governments, work tirelessly and often overcome daunting challenges to achieve these successes on behalf of the taxpayers," said

Principal Deputy Assistant Attorney General Mizer.

The government's claims in the matters described above are allegations only; except where indicated, there has been no determination of liability.

Attachment(s):
Download FY 2015 Fraud Statistics

Topic(s):
False Claims Act

Component(s):
Civil Division

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