



Department of Justice

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LARGEST HEALTH CARE FRAUD CASE IN U.S. HISTORY SETTLED **HCA INVESTIGATION NETS RECORD TOTAL OF \$1.7 BILLION**

WASHINGTON, D.C. - HCA Inc. (formerly known as Columbia/HCA and HCA - The Healthcare Company) has agreed to pay the United States \$631 million in civil penalties and damages arising from false claims the government alleged it submitted to Medicare and other federal health programs, the Justice Department announced today.

This settlement marks the conclusion of the most comprehensive health care fraud investigation ever undertaken by the Justice Department, working with the Departments of Health and Human Services and Defense, the Office of Personnel Management and the states. The settlement announced today resolves HCA's civil liability for false claims resulting from a variety of allegedly unlawful practices, including cost report fraud and the payment of kickbacks to physicians.

Previously, on December 14, 2000, HCA subsidiaries pled guilty to substantial criminal conduct and paid more than \$840 million in criminal fines, civil restitution and penalties. Combined with today's separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), under which HCA will pay an additional \$250 million to resolve overpayment claims arising from certain of its cost reporting practices, the government will have recovered \$1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.

"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by the payment of kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgment, health care for all Americans suffers," Robert D. McCallum, Jr., Assistant Attorney General for the Civil Division said. "This settlement brings to a close the largest multi-agency investigation of a health care provider that the United States government has ever undertaken and demonstrates the Department of Justice's ongoing resolve and

commitment to pursue all types of fraud on American taxpayers, and health care program beneficiaries."

"Let this case be a continuing reminder to all that in the fight against health care fraud this office will not be deterred," said Acting Principal Deputy Inspector General Dara Corrigan. "Medicare dollars paid to provide ever more expensive health care services to the country's taxpayers should never be fraudulently diverted. This is our job and our trust and we take these duties very seriously," Corrigan concluded.

This latest settlement resolves fraud allegations against HCA and HCA hospitals in nine False Claims Act qui tam or whistleblower lawsuits pending in federal court in the District of Columbia. Under the federal False Claims Act, private individuals may file suit on behalf of the United States and, if the case is successful, may recover a share of the proceeds for their efforts. Under the settlement, the whistleblowers will receive a combined share of \$151,591,500, the highest combined qui tam award ever paid out by the government.

"We are grateful for the assistance given by the whistleblowers over the course of the past nine years of investigation and litigation," McCallum said. "And we are proud of the work of government personnel as well as counsel for the whistleblowers, who together pursued these matters through investigation and strenuous litigation. This result demonstrates the commitment of the Department to the qui tam statute and that the statute works as Congress intended."

Under the first of three agreements announced today, which becomes effective upon the court's dismissal of the lawsuits, HCA will pay nearly \$620 million to resolve eight whistleblower lawsuits in which the government had intervened alleging that HCA systematically defrauded Medicare, Medicaid and other federally funded health care programs through schemes dating back to the late 1980s. HCA will pay an additional \$11 million to resolve separate allegations of improper HCA billing practices.

The settlement requires HCA to pay:

- \$356 million to resolve whistleblower lawsuits alleging that HCA engaged in a series of schemes to defraud Medicare, Medicaid and TRICARE, the military's health care program, through hospital cost reports, the year end claims submitted by hospitals to the government to reconcile payments received throughout the year with amounts they claim are actually owed. In 2001, a subsidiary of Nashville-based HCA, Columbia Management Companies, Inc., pled guilty in the Middle District of Florida to related charges on eight counts of making false statements to the United States and paid \$22.6 million in criminal fines. An additional amount of \$20 million of the settlement is being paid toward a resolution of cost reporting fraud allegations pursued separately by James Alderson and John Schilling, the relators who filed the lawsuits. In total, the two relators are to receive a total of \$100 million as their statutory share of the settlement.

- \$225.5 million to resolve lawsuits alleging that HCA hospitals and home health agencies unlawfully billed Medicare, Medicaid and TRICARE for claims generated by the payment of kickbacks and other illegal remuneration to physicians in exchange for referral of patients. In 2001, Columbia Management Companies, Inc., pled guilty to one count of conspiracy to pay kickbacks and other monetary benefits to doctors in violation of the Medicare Antikickback Statute and paid a \$30 million criminal fine. Dr. James Thompson, a doctor who filed suit against the company in 1995, will receive \$41.5 million as his statutory share of the settlement. Gary King, a former HCA employee, will receive \$5 million and Ann Mroz, a former HCA nurse, will receive a share of \$837,500.
- \$17 million to resolve allegations that certain company-owned hospitals billed Medicare for unallowable costs incurred by a contractor that operated HCA wound care centers, and for a non-covered drug that the contractor manufactured and sold to hospital patients. The 2001 Columbia Management Companies' guilty plea concerning cost report fraud included a charge related to wound care center costs. HCA's wound care center management contractor, Curative Healthcare Services, Inc., previously paid \$16.5 million to resolve related allegations pending at one time in these same lawsuits. Joseph "Mickey" Parslow, a former HCA financial officer, will receive \$2,990,000 and Francesco Lanni, a former Reimbursement Manager at the Wound Care Center at New York Methodist Hospital in Brooklyn, New York, will receive a share of \$680,000.
- \$5 million to resolve allegations concerning the transfer of patients from HCA facilities to other facilities and the claiming of excessive costs for those transfers.
- \$5 million to resolve allegations that HCA's Lawnwood Regional Medical Center in Fort Pierce, Florida submitted false claims in Medicare cost reports by inflating its entitlement to funds to treat indigent patients and by shifting employee salary costs in order to increase its reimbursement from the federal health care program.
- \$950,000 to settle allegations made by Michael Marine that HCA improperly shifted its home office costs to hospitals. Marine will receive a share of \$116,500.

Today's settlement agreement incorporates the terms of a Corporate Integrity Agreement executed by HCA and the Office of the Inspector General, Department of Health and Human Services in December 2000 that obligated the company to engage in significant and comprehensive compliance efforts into 2009.

In a separate agreement, HCA agreed to pay \$1.5 million to resolve allegations that an Atlanta, Georgia hospital, West Paces Medical Center, paid kickbacks for the referral of diabetes patients. Those allegations had been pursued since 1996 by a whistleblower in a case in which the United States had declined to intervene, captioned U.S. ex rel. Pogue v. American Healthcorp, Inc. et al.. Pogue, a former employee of a co-defendant in the case, Diabetes Treatment Centers of America, will receive a share of \$405,000 from the HCA settlement. Pogue continues to litigate claims against his former employer and a group of Atlanta physicians.

Additionally, a state negotiating team appointed by the National Association of Medicaid Fraud Control Units has reached agreement with HCA to resolve related issues

with affected state Medicaid plans for \$17.5 million, representing direct state losses. The terms of that agreement are being finalized by the parties and are not part of today's settlement.

Today's administrative agreement between HCA and CMS will require HCA to pay CMS \$250 million in order to resolve claims they maintained against each other arising from HCA's hospital cost reports and home office cost statements for cost reporting periods ending July 31, 2001. These claims resulted from HCA cost reports that were not processed since 1997 as a result of the government's investigation.

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