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Department of Justice

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Middle District of Tennessee

FOR IMMEDIATE RELEASE

Friday, May 21, 2021

SavaSeniorCare LLC Agrees To Pay \$11.2 Million To Resolve False Claims Act Allegations

Allegations Include Medically Unnecessary Rehabilitation Therapy Services and Grossly Substandard Skilled Nursing Services

WASHINGTON – SavaSeniorCare LLC and related entities (Sava), based in Georgia, have agreed to pay \$11.2 million, plus additional amounts if certain financial contingencies occur, to resolve allegations that Sava violated the False Claims Act by causing its skilled nursing facilities (SNFs) to bill the Medicare program for rehabilitation therapy services that were not reasonable, necessary or skilled, and to resolve allegations that Sava billed the Medicare and Medicaid programs for grossly substandard skilled nursing services. Sava currently owns and operates SNFs across the country.

“Nursing home operators will be held accountable when they engage in fraudulent schemes and put their own financial gain ahead of the needs of their vulnerable residents,” said Acting Assistant Attorney General Brian M. Boynton of the Justice Department’s Civil Division. “To ensure the integrity of our public health care programs, the department will pursue operators who bill Medicare and Medicaid for unnecessary or grossly substandard services and who fail to provide adequate care.”

In 2015, the government filed a consolidated False Claims Act complaint against Sava, alleging that between October 2008 and September 2012, Sava knowingly submitted false claims for rehabilitation therapy services as a result of a systematic effort to increase its Medicare billings. The United States’ complaint alleged that, through corporate-wide policies and practices, Sava exerted significant pressure on its SNFs to meet unrealistic financial goals, resulting in the provision of medically unreasonable, unnecessary, or unskilled services to Medicare patients. Sava allegedly set these aggressive, prospective corporate targets for the highest Medicare reimbursement rates without regard for its patients’ actual clinical needs and then pressured its staff to meet those targets. Sava also allegedly sought to increase its Medicare payments by delaying the discharge of patients from its facilities, even though the patients were medically ready to be discharged.

This settlement also resolves allegations that between October 2008 and September 2012, Sava knowingly submitted false claims to Medicaid for coinsurance amounts for rehabilitation therapy services for beneficiaries eligible for both Medicare and Medicaid and for whom Sava also allegedly submitted or caused the submission of false claims to Medicare for those services.

In addition, this settlement resolves allegations that between January 2008 and December 2018, Sava knowingly submitted false claims for payment to Medicare and Medicaid for grossly and materially substandard and/or worthless skilled nursing services. The government alleged that some of the nursing services provided by Sava failed to meet federal standards of care and federal statutory and regulatory requirements, including failing to have sufficient staffing in certain facilities to meet certain residents’ needs. The government also alleged that in certain skilled nursing facilities,

Sava failed to follow appropriate pressure ulcer protocols and appropriate falls protocols, and failed to appropriately administer medications to some of the residents.

“When corporate greed rises to the level of defrauding federal health care programs, while subjecting one of our most vulnerable populations to grossly substandard care and unnecessary medical services, we must hold the companies accountable,” said Acting U.S. Attorney Mary Jane Stewart for the Middle District of Tennessee. “Any fraud that undermines the care being provided to elderly nursing home residents cannot continue and will be exposed and rooted out. We are grateful to the courageous whistleblowers who reported this egregious conduct.”

“Nursing home residents should not be at the mercy of nursing home operators that put their own economic gain ahead of the needs of the residents, and we will continue to aggressively pursue those operators who bill Medicare and Medicaid for substandard care,” said Acting U.S. Attorney Jennifer Arbittier Williams for the Eastern District of Pennsylvania. “This settlement holds Sava accountable, and the resulting Corporate Integrity Agreement should ensure that Sava provides seniors with quality care and treats its residents with dignity and respect.”

“Too many unscrupulous nursing homes operators seek maximum profit by routinely inflating bills while providing grossly substandard care,” said Special Agent in Charge Derrick L. Jackson for the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). “Medicare and Medicaid patients deserve so much better. With our law enforcement partners, we will continue to investigate and hold accountable those who place profits over patients.”

Under the settlement with the United States, and separate settlements with participating states, Sava has agreed to pay a total of approximately \$11.2 million, plus additional amounts if certain financial contingencies occur. The settlement was based on the company’s ability to pay.

In connection with the settlement, Sava entered into a five-year chain-wide Corporate Integrity Agreement (CIA) with HHS-OIG that requires an independent review organization to annually review patient stays and associated paid claims by Medicare for those stays. In addition, Sava is required to engage an Independent Monitor to review the quality of resident care. CIAs promote compliance and protect vulnerable nursing home residents.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act against Sava by Relators Rita Hayward, Trammel Kukoyi, Terrence Scott, James Thornton, and Barbara Roberts. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* cases are captioned *United States ex rel. Hayward v. SavaSeniorCare, LLC, et al.*, No. 3:11-cv-0821 (M.D. Tenn.); *United States ex rel. Scott v. SavaSeniorCare Administrative Services, LLC*, 3:15-cv-0404 (M.D. Tenn.); *United States ex rel. Kukoyi v. Sava Senior Care, L.L.C., et al.*, No. 3:15-cv-1102 (M.D. Tenn.); and *United States, et al. ex rel. Thornton, et al. v. SavaSeniorCare, Inc., et al.*, Civil Action No. 16-CV-0840 (E.D. Pa.).

The resolutions obtained in these matters were the result of a coordinated effort between the Civil Division’s Commercial Litigation Branch, Fraud Section, and the U.S. Attorneys’ Offices for the Middle District of Tennessee and the Eastern District of Pennsylvania, with assistance from the U.S. Attorneys’ Offices for the Southern District of Texas and the Western District of Texas, as well as from HHS-OIG and the National Association of Medicaid Fraud Control Units. The quality of care investigation was supported by the Justice Department’s Elder Justice Initiative, which helps to coordinate the department’s law enforcement and programmatic efforts to combat elder abuse, neglect, and financial exploitation. Learn more about the Elder Justice Initiative and the department’s elder justice efforts at www.elderjustice.gov.

The investigation and resolution of these matters illustrates the government’s emphasis on combating healthcare fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement, can be reported to the U.S. Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

These matters were handled by Fraud Section attorneys Alison Rousseau, Susan Lynch, Seth Greene, Breanna Peterson, Christopher Terranova, and Laura Hill; Assistant U.S. Attorney and Civil Chief Mark Wildasin of the Middle District of Tennessee; and Assistant U.S. Attorneys Charlene Fullmer, David Degnan, and Gerald Sullivan of the Eastern District of Pennsylvania.

The claims resolved by the settlement are allegations only and there has been no determination of liability.

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Topic(s):

Elder Justice

Health Care Fraud

Component(s):

Civil Division

USAO - Tennessee, Middle

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