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Justice Department’s False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021

Second Largest Amount Recorded, Largest Since 2014

The Justice Department obtained more than $5.6 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2021, Acting Assistant Attorney General Brian M. Boynton of the Justice Department’s Civil Division announced today. This is the second largest annual total in False Claims Act history, and the largest since 2014. Settlement and judgments since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than $70 billion.

“Ensuring that citizens’ tax dollars are protected from fraud and abuse is among the department’s top priorities,” said Acting Assistant Attorney General Boynton. “The False Claims Act is one of the most important tools available to the department both to deter and to hold accountable those who seek to misuse public funds.”

Of the more than $5.6 billion in settlements and judgments reported by the Department of Justice this past fiscal year, over $5 billion relates to matters that involved the health care industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories and physicians. The amounts included in the $5 billion reflect recoveries arising from only federal losses, and, in many of these cases, the department was instrumental in recovering additional amounts for state Medicaid programs.

In addition to being used to combat health care fraud, the False Claims Act serves as the government’s primary civil tool to redress false claims involving a multitude of other government operations and functions. The act helps to support our military and first responders by ensuring that government contractors provide equipment that is safe, effective and cost efficient; to safeguard American businesses and workers by promoting compliance with customs laws, trade agreements, visa requirements and small business protections; and to protect other critical government programs ranging from the provision of disaster relief funds to nutrition benefits for needy families.

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, typically receives a portion of the recovery ranging between 15% and 30%. Whistleblowers filed 598 *qui tam* suits in fiscal year 2021, and this past year the department reported settlements and judgments exceeding $1.6 billion in these and earlier-filed suits.

Health Care Fraud

Health care fraud was once again the leading source of the department's False Claims Act settlements and judgments this past year. The department's health care fraud enforcement efforts restore funds to federal programs such as Medicare, Medicaid and TRICARE, the health care program for service members and their families. But just as important, the department's vigorous pursuit of health care fraud prevents billions more in losses by deterring others who might try to cheat the system for their own gain. In many cases, the department's efforts also protect patients from medically unnecessary or potentially harmful actions. The department investigates and resolves matters involving a wide array of health care providers, goods and services.

Combatting the Opioid Epidemic

Opioid abuse remains a serious problem for our nation, with tens of thousands of Americans dying from opioid overdoses each year. Civil enforcement actions against the parties responsible for triggering and fueling the opioid epidemic are a critical part of the department's ongoing efforts to address this crisis.

Consistent with this focus, the largest False Claims Act settlements in the past year resulted from significant resolutions with prescription opioid manufacturers: Indivior Inc. and Indivior plc (Indivior), and Purdue Pharma (Purdue). As part of a $600 million global resolution of criminal and civil liability, the Indivior companies agreed to pay $209.3 million to the federal government to resolve civil allegations that the companies, among other things, promoted the opioid-addiction-treatment drug Suboxone to physicians who were writing prescriptions that were not for a medically accepted indication and were often diverted; and made false and misleading claims that Suboxone Film was less susceptible to diversion and abuse and to accidental pediatric exposure than other buprenorphine products.

As part of a global resolution of criminal and civil liability, in October 2020, Purdue agreed to an allowed, unsubordinated, general unsecured bankruptcy claim for $2.8 billion to resolve civil allegations that the company promoted its opioid drugs to health care providers it knew were prescribing opioids for uses that were unsafe, ineffective, and medically unnecessary, and that often led to abuse and diversion. The civil settlement also resolved allegations that Purdue paid kickbacks to doctors, certain specialty pharmacies and an electronic health records developer to increase prescriptions of Purdue's opioid products. Purdue incorporated the civil settlement into its plan of reorganization, but the district court subsequently reversed a bankruptcy court order confirming the plan and litigation over the plan continues. Separately, certain individual members of the Sackler family who were shareholders and board members of Purdue agreed to pay $225 million to resolve civil False Claims Act allegations that they approved a new marketing program that intensified marketing of OxyContin to extreme, high-volume prescribers, causing opioid prescriptions for uses that were unsafe, ineffective and medically unnecessary, and that often led to abuse and diversion.

Medicare Advantage Program (Medicare Part C)

Another important priority for the department has been investigating and litigating a growing number of matters related to the Medicare Advantage program, also known as Medicare Part C, which is Medicare's managed care program. Medicare Part C pays a capitated amount to private health insurance carriers for each patient enrolled in their plans, rather than a payment for each distinct patient admission or service. CMS adjusts the payments for various "risk" factors that affect expected healthcare expenditures to ensure that plans are paid more for enrollees who pose a greater risk. In 2021, more than 26 million Medicare beneficiaries were enrolled in Part C plans, and the Congressional Budget Office projected that CMS would pay more than $343 billion to private carriers who offered those plans.

The department has pursued plans and healthcare providers that manipulated the risk adjustment process by submitting unsupported diagnosis codes to make their patients appear sicker than they actually were. This year, Sutter Health, a California-based health care services provider, paid $90 million to resolve allegations that it knowingly submitted unsupported diagnosis codes for certain patient encounters, resulting in inflated payments to be made to the Medicare Advantage Plans and Sutter Health. In addition, Kaiser Foundation Health Plan of Washington, formerly known as Group Health Cooperative (GHC), paid $6.3 million to resolve allegations that it submitted invalid diagnoses and received inflated payments as a result. In addition, the department intervened and filed complaints in separate lawsuits against Independent Health Corporation and members of the Kaiser Permanente consortium alleging that those Medicare Advantage organizations submitted or caused the submission of inaccurate information about the health status of beneficiaries enrolled in their plans to increase reimbursement from Medicare.

Unlawful Kickbacks

Kickbacks in the healthcare industry are pernicious because of their potential to subvert medical decision-making and to increase healthcare costs. In addition to pursuing improper payments by drug manufacturers, the department resolved other schemes involving the willful solicitation or payment of illegal remuneration to induce the purchase of a good or service paid for by a federal health care program.

For example, mail-order diabetic testing supply company Arriva Medical LLC and its parent, Alere Inc., agreed to pay $160 million to settle allegations that Arriva paid kickbacks to Medicare beneficiaries by providing them “free” or “no cost” diabetic testing glucometers and by routinely waiving or not making reasonable efforts to collect their copayments for glucometers and diabetic testing supplies. In another example, the department resolved its claims against pain management clinics and urine drug testing (UDT) laboratories owned and operated by Daniel McCollum for paying unlawful kickbacks to providers to induce their referrals of urine drug tests, obtaining default judgments against the clinics and laboratories totaling more than $140 million and a $9 million civil consent judgment against McCollum.

Electronic health records (EHR) technology vendor Athenahealth Inc. paid $18.25 million to resolve allegations that it invited customers and prospective customers to lavish all-expense-paid sporting, entertainment, and recreational events to generate sales of its EHR product. Generic pharmaceutical manufacturers Taro, Sandoz, and Apotex paid over $400 million to resolve allegations that they paid and received compensation prohibited by the Anti-Kickback Statute through arrangements on price, supply and allocation of customers with other pharmaceutical manufacturers as part of a conspiracy to fix the price of certain generic drugs.

Other matters relating to kickback violations involved psychiatric hospitals and a substance abuse treatment facility (Oglethorpe Inc.), home health care agencies (BAYADA), hospitals (Akron General Health System, Texas Heart Hospital of the Southwest LLP, and Prime Healthcare Services), pharmaceutical companies (Biogen Inc.), diagnostic testing (Alliance Family of Companies LLC) and medical devices (Merit Medical Systems Inc).

Unnecessary Medical Services

As in years past, the department also resolved a number of matters in which providers billed federal health care programs for medically unnecessary services or services not rendered as billed. For example, SavaSeniorCare LLC and related entities agreed to pay $11.2 million for alleged false claims for rehabilitation therapy services provided as a result of aggressive corporate targets without regard for its patients’ actual clinical needs, resulting in the provision of medically unreasonable, unnecessary or unskilled services to Medicare patients. The settlement also resolved allegations that Sava provided grossly and materially substandard and/or worthless skilled nursing services.

Alere Inc. and Alere San Diego Inc. (collectively, Alere) paid $38.75 million to resolve allegations that they billed, and caused others to bill, for defective rapid point-of-care testing devices used by Medicare beneficiaries to monitor blood coagulation when taking anticoagulant drugs. In another matter, Apria Healthcare LLC paid $40.5 million to resolve allegations that it submitted false claims for the rental of costly non-invasive ventilators to program beneficiaries who did not need the devices or were not using them. St. Jude Medical Inc. paid $27 million to settle allegations that it knowingly sold defective, implantable heart devices and failed to disclose serious adverse health events in connection with premature battery depletion in those devices. Regency Inc. and its owner agreed to a civil settlement up to $20.3 million to resolve allegations that they falsified documentation to enable the billing of federal healthcare programs for medically unnecessary durable medical equipment. In addition, the department continues to focus on inadequate care and other fraud in nursing facilities, which provide care to a particularly vulnerable population (as reflected by the resolutions this year with SavaSeniorCare LLC, discussed above, and Select Medical Rehabilitation Services Inc).

Procurement Fraud

In the past year, the department also pursued a variety of fraud matters involving the government’s purchase of goods and services. In some cases, the department pursued allegations that government contractors falsified pricing data. For example, Navistar Defense LLC paid $50 million to resolve allegations that it fraudulently induced the U.S. Marine Corps to enter into a contract modification at inflated prices for a suspension system for armored vehicles known as Mine-Resistant Ambush Protected vehicles. In another case, Insitu Inc. paid $25 million to settle allegations that it knowingly submitted materially false cost and pricing data for contracts with the U.S. Special Operations Command and

the Department of the Navy to supply and operate Unmanned Aerial Vehicles. The department also recovered $7.1 million from furniture maker Workrite Ergonomics LLC to resolve allegations that the company did not provide the General Services Administration with accurate information about its commercial sales practices during contract negotiations for office furniture, and subsequently violated the terms of its contract by failing to extend lower prices to government customers.

In other cases, the department pursued allegations that government contractors provided goods or services that did not comply with contract requirements. For example, United Airlines Inc. paid $32.1 million to resolve allegations relating to its execution of contracts to deliver mail internationally on behalf of the U.S. Postal Service. In another case, Cognosante LLC paid $18.9 million to resolve allegations that it used unqualified labor and overcharged the government for health care and IT services provided to federal agencies under two General Services Administration contracts. The department also recovered $11 million from AAR Corp. and its subsidiary, AAR Airlift Group Inc., to resolve allegations that AAR Airlift knowingly failed to maintain nine helicopters in accordance with Department of Defense contract requirements and that the helicopters, which were billed under two U.S. Transportation Command contracts to transport cargo and personnel in support of missions in Afghanistan and Africa, were not airworthy and should not have been certified as fully mission capable.

The department also resolved matters involving allegations of kickbacks in government contracts. For example, Level 3 Communications LLC paid $12.7 million to resolve allegations that the owner of two subcontractors paid kickbacks to Level 3 senior managers in return for favorable treatment for those subcontractors on government contracts. The United States also alleged that Level 3 managers misstated compliance with woman-owned small business subcontracting requirements and knowingly obtained protected competitor bid information on the government contract to gain an advantage in bidding on task orders. In another example, Schneider Electric Buildings Americas Inc. paid more than $9 million to resolve allegations that one of its senior project managers solicited kickbacks from subcontractors and that the company fraudulently charged the government for design costs by disguising those costs and spreading them across unrelated pricing components.

COVID-Related Fraud

In response to the COVID-19 crisis, Congress authorized historic levels of emergency funding for federal agencies to provide direct financial assistance to individuals, businesses and state, local, and Tribal governments. Since the start of the COVID-19 pandemic, the department has worked closely with various Inspector Generals and other agency stakeholders to identify, monitor and investigate the misuse of critical pandemic relief monies.

The department's efforts in this area have included the pursuit of cases involving improper payments under the Paycheck Protection Program (PPP), which was enacted to provide loans guaranteed by the U.S. Small Business Administration (SBA) to eligible small businesses for payroll, rent, utility payments and other business-related costs. For example, the department has pursued small businesses that improperly received multiple PPP loans. Sandeep S. Walia and his medical practice paid a combined $70,000 to resolve allegations under the False Claims Act and the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA) that Dr. Walia, on behalf of his practice, falsely certified in an application for a second PPP loan that the medical practice had not previously received a PPP loan. The medical practice also agreed to repay the second PPP loan to the lender, relieving the SBA of liability for the federal guaranty of over $430,000 on the improper loan.

Sextant Marine Consulting LLC, a Florida-based duct cleaning company, paid $30,000 to settle allegations that it improperly obtained more than one PPP loan. Sextant also repaid the duplicative PPP funds in full to its lender, relieving the SBA of liability for the federal guaranty of approximately $170,000 on the improper loan. The department has also pursued cases against eligible borrowers who used PPP funds to pay for impermissible expenses. For example, Seth A. Bernstein, the owner of jet charter company All in Jets LLC dba JetReady, paid $287,055 to settle allegations that he diverted PPP funds to pay for personal, non-company related expenses.

Other Fraud Recoveries

The judgments and settlements announced during fiscal year 2021 reflect the diversity of fraud recoveries arising under the False Claims Act. For example, the United States leases federal lands for the production of natural gas in exchange for the payment of royalties on the value of the gas produced. The department recovered $6.15 million from oil and

natural gas exploration and production company Devon Energy Corp. to resolve allegations that it underpaid and underreported royalties for natural gas from federal lands in Wyoming and New Mexico.

Stargate Apparel Inc., Rivstar Apparel Inc., and the chief executive officer of both companies paid $6 million to resolve allegations that they engaged in two schemes to fraudulently underpay customs duties owed to the United States in connection with the garments that they brought into the country.

Concept Schools NFP, agreed to pay $4.5 million for allegedly engaging in non-competitive bidding practices in connection with the Federal Communications Commission's (FCC) E-Rate Program, which subsidizes eligible equipment and services to make internet access and internal networking more affordable for needy public schools and libraries. Concept Schools, a charter school management company, rigged the bidding for E-Rate contracts in favor of chosen technology vendors so that its network of charter schools could select those vendors without a meaningful, fair and open bidding process. Additionally, the government alleged that Concept Schools' chosen vendors provided equipment at higher prices than other vendors approved by the FCC for equipment with the same functionality, and that Concept Schools failed to maintain sufficient control over equipment reimbursed by the FCC.

Educational services provider Innovative Educational Programs LLC paid $1.1 million to resolve allegations that it fraudulently obtained federal funds for tutoring services for underprivileged New York City students that it never provided. The New York City Department of Education had paid Innovative to tutor students using funds made available to New York State by the United States under the Elementary and Secondary Education Act of 1965, as amended by the No Child Left Behind Act of 2001.

Guild Mortgage Company paid $24.9 million to resolve allegations that it failed to maintain quality control programs to prevent and correct underwriting deficiencies and to self-report materially deficient loans insured by the Federal Housing Administration.

Cybersecurity Initiative

Malicious cyber activity threatens the health and safety of the American people, and the national and economic security of our country. On May 12, 2021, President Biden signed an Executive Order announcing that preventing, detecting, assessing and remediating cybersecurity incidents affecting federal government networks is a top priority, and set forth an expectation that all federal systems will meet the necessary thresholds for cybersecurity protections. On Oct. 6, 2021, the Deputy Attorney General announced the department's Civil Cyber-Fraud Initiative to use the False Claims Act to combat new and emerging cyber threats.

Civil enforcement plays an essential role in the department's cyber defense efforts. The department will pursue misrepresentations by companies in connection with the government's acquisition of information technology, software, cloud-based storage and related services designed to protect highly-sensitive government information from cybersecurity threats and compromises.

Information on how to report cyber fraud can be found here: https://www.justice.gov/civil/report-fraud.

Holding Individuals Accountable

The department continued its commitment to use the False Claims Act to deter and redress fraud by individuals as well as corporations. In addition to the settlements noted above with certain members of the Sackler family and with corporate entities that included payments by senior executives or owners, the following are additional examples of recoveries involving individuals.

Dr. Ashish Pal, a cardiologist based in Orlando, Florida, paid $6.75 million to resolve allegations that he performed medically unnecessary ablations and vein stent procedures. The government alleged that Dr. Pal performed the ablations and stent procedures on veins that did not qualify for treatment under accepted standards of medical practice and falsified patient medical records to justify the procedures. In addition, many of the ablations were allegedly performed either exclusively or primarily by one or more ultrasound technicians outside their scope of practice.

Two Texas physicians, Robert Wills and Brannon Frank, paid a total of $3.9 million to resolve allegations that they billed federal health care programs for medically unnecessary urine drug testing. The settlements resolved allegations that

the physicians, formerly co-owners of now-defunct Austin Pain Associates, knowingly ordered excessive and unnecessary urine drug testing for patients without any individualized assessment of clinical need.

Substance abuse treatment provider A.R.E.B.A.-Casriel Inc. dba Addiction Care Interventions Chemical Dependency Treatment Centers (ACI) and its primary owner and former CEO, Steven Yohay, agreed to pay a total of $6 million to resolve allegations that they provided kickbacks and engaged in fraudulent conduct in connection with the enrollment of Medicaid beneficiaries into ACI's inpatient treatment program. The United States alleged that ACI offered food and cash to homeless individuals to induce them to enroll in ACI's inpatient treatment program, offered sham employment to an individual to induce her to refer patients to ACI programs, and used medical admissions forms containing photocopied physician signatures to make it appear that new patients had been evaluated by a qualified health care professional. ACI agreed to pay $3 million, and Yohay agreed to pay an additional $3 million and divest himself of ownership and control of ACI.

Recoveries in Whistleblower Suits

Of the $5.6 billion in settlements and judgments reported by the government in fiscal year 2021, over $1.6 billion arose from lawsuits filed under the *qui tam* provisions of the False Claims Act. During the same period, the government paid out $237 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 598 *qui tam* suits filed this past year – an average of over 11 new cases every week.

"Industry insiders are uniquely positioned to expose fraud and false claims and often risk their careers to bring these schemes to light," said Acting Assistant Attorney General Boynton. "Our efforts to protect taxpayer funds benefit from the courageous actions of these whistleblowers, and they are justly rewarded under the False Claims Act."

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, further improvements were made to the False Claims Act and its whistleblower provisions.

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Acting Assistant Attorney General Boynton expressed appreciation for all the work over the past year by the many public servants who supported the department's efforts to protect the public: "We owe a debt of gratitude to the employees in the Civil Division, the U.S. Attorneys' Offices, the agency Offices of Inspector General and Offices of General Counsel and the many other federal and state agencies who have worked tirelessly to protect the public fisc from fraud."

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.

Attachment(s):
Download FCA FY2021 Statistics.pdf

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