JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Tuesday, February 7, 2023

False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022

Second-Highest Number of Settlements in History

Settlements and judgments under the False Claims Act exceeded $2.2 billion in the fiscal year ending Sept. 30, 2022, Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division, announced today. The government and whistleblowers were party to 351 settlements and judgments, the second-highest number of settlements and judgments in a single year. Recoveries since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than $72 billion.

"Protecting taxpayer dollars by preventing fraud and abuse is a critical priority for the Department of Justice," said Principal Deputy Assistant Attorney General Boynton. "The large number of settlements and judgments this past year demonstrates that the False Claims Act remains one of the most important tools for ensuring that public funds are spent properly and advance the public interest."

The False Claims Act imposes treble damages and penalties on those who knowingly and falsely claim money from the United States or knowingly fail to pay money owed to the United States. The False Claims Act thus serves to safeguard government programs and operations that provide access to medical care, support our military and first responders, protect American businesses and workers, help build and repair infrastructure, offer disaster and other emergency relief, and provide many other critical services and benefits.

Of the more than $2.2 billion in False Claims Act settlements and judgments reported by the Department of Justice this past fiscal year, over $1.7 billion related to matters that involved the health care industry, including drug and medical device manufacturers, durable medical equipment, home health and managed care providers, hospitals, pharmacies, hospice organizations, and physicians. The amounts included in the $1.7 billion reflect recoveries arising only from federal losses, and, in many of these cases, the department was instrumental in recovering additional amounts for state Medicaid programs. The recoveries in fiscal year 2022 also reflected the department's focus on new enforcement priorities, including fraud in pandemic relief programs and alleged violations of cybersecurity requirements in government contracts and grants.

In 1986, Congress strengthened the False Claims 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. Qui tam cases may be pursued by the government or the whistleblower, and this past year significant recoveries were obtained by both. When a qui tam action is successful, the whistleblower, also known as the relator, typically receives a portion of the recovery ranging between 15% and 30%. Whistleblowers filed 652 qui tam suits in fiscal year 2022, and this past year the department reported settlements and judgments exceeding $1.9 billion in these and earlier-filed suits.

HEALTH CARE FRAUD

In fiscal year 2022, health care fraud remained a leading source of False Claims Act settlements and judgments. These recoveries 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, enforcement of the False Claims Act deters others who might try to cheat the system for their own gain, and in many cases, also protects patients from medically unnecessary or potentially harmful actions. As in years past, the act was used to pursue matters involving a wide array of health care providers, goods, and services.

Fraud and Abuse in the Medicaid Program

The Medicaid program affords health care coverage to millions of Americans, including some of the nation's most vulnerable populations, such as eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The program is funded jointly by states and the federal government.

Mallinckrodt ARD LLC, previously Questcor Pharmaceuticals Inc., paid $260 million to resolve separate allegations relating to its drug

H.P. Acthar Gel, which is approved to treat, among other things, acute exacerbations of multiple sclerosis and infantile spasms. The government alleged that the company knowingly underpaid rebates to the Medicaid program by improperly designating Acthar as a "new drug" as of 2013, as opposed to a preexisting drug for which Mallinckrodt had significantly raised the price in years prior. The government separately alleged that, from 2010 through 2014, Mallinckrodt knowingly used a foundation as a conduit to pay illegal kickbacks in the form of copay subsidies so that it could market Acthar as "free" to doctors and patients while increasing its price significantly.

Gold Coast Health Plan, a county-organized health system in California and three of its providers, **Ventura County, Dignity Health, and Clinicas Del Camino Real, Inc**., paid a combined total of $70.7 million to resolve claims that they knowingly submitted or caused the submission of false claims to California's Medicaid program in connection with the "Adult Expansion" population that was created by the Patient Protection and Affordable Care Act. The United States alleged that the payments were not for "allowed medical expenses" under Gold Coast's contract with the state, were pre-determined amounts that did not reflect fair market value, were duplicative of services already required to be rendered, and were unlawful gifts of public funds in violation of the state constitution.

Unnecessary Services and Substandard Care

The department also pursued and resolved matters in which providers billed federal health care programs for medically unnecessary services. The provision of unnecessary medical services not only wastes taxpayer funds but also can expose patients to harmful procedures and treatments or cause them to forego other potentially more effective treatments.

The department filed claims under the False Claims Act against **American Health Foundation** (AHF), its affiliate management corporation, and three affiliated nursing homes — **Cheltenham Nursing & Rehabilitation Center (Cheltenham), The Sanctuary at Wilmington Place (Wilmington Place),** and **Samaritan Care Center and Villa (Samaritan)** — for providing grossly substandard skilled nursing services between 2016 and 2018. In its complaint, the United States alleged the three AHF nursing homes provided grossly substandard services that failed to meet required standards of care in various ways, including by failing to follow appropriate infection control protocols and not maintaining adequate staffing levels.

Providence Health & Services Washington (Providence), a health care and hospital system operating in seven western U.S. states, paid $22.7 million to resolve allegations that it billed federal health care programs for medically unnecessary neurosurgeries. At one hospital in Washington state, neurosurgeons were paid based on a productivity metric that provided a financial incentive to perform more surgeries of greater complexity. As part of the settlement agreement, Providence admitted that its medical personnel expressed concerns that two neurosurgeons were endangering patient safety, creating an excessive level of complications and negative outcomes, performing surgery on candidates who were not appropriate for surgery, and failing to properly document their procedures and outcomes.

Eargo Inc., a company that sells and dispenses hearing aid devices directly to customers nationwide, paid $34.37 million to resolve False Claims Act and common law allegations that it submitted or caused to be submitted claims containing unsupported hearing loss-related diagnosis codes to the Federal Employees Health Benefits Program for the reimbursement of its hearing aid devices.

Carrefour Associates LLC and its related companies, which operate under the name Crossroads Hospice, paid $5.5 million to resolve allegations that Crossroads Hospice knowingly submitted false claims to Medicare for hospice services for patients who were not terminally ill.

Signature Home Health Services of Florida LLC and its related entities (collectively, SignatureHomeNow) paid $2.1 million to resolve allegations that SignatureHomeNow improperly admitted and provided services to Medicare beneficiaries who: (i) were not homebound; (ii) did not require certain skilled care; (iii) did not have valid or otherwise appropriate plans of care in place; and/or (iv) did not have appropriate face-to-face encounters needed to be appropriately certified to receive home health services.

Hayat Pharmacy paid $2.05 million to resolve allegations that it submitted false claims to Medicare and Medicaid for prescription medications that the pharmacy had switched from lower cost medications to higher cost medications without any medical need and/or a valid prescription.

The department also resolved several matters in which providers billed federal health care programs for unnecessary drug testing. **Physician Partners of America LLC** (PPOA), its founder, its former chief medical officer, and certain of its affiliated entities paid $24.5 million to resolve allegations that they billed federal health care programs for unnecessary urine drug, psychological, and genetic testing. The United States alleged that PPOA required its physician-employees to order multiple urine drug tests at the same time without determining whether any testing was reasonable and necessary, or even reviewing the results of initial testing to determine whether additional testing was warranted. Similarly, the United States alleged that PPOA instructed physicians to automatically order psychological and genetic testing that it did not use or intend to use, and that PPOA instructed physicians to schedule bi-weekly telehealth appointments for the sole purpose of increasing revenue during the pandemic. Finally, the United States alleged that, at the time PPOA was engaged in this conduct, it obtained a loan under the Paycheck Protection Program while certifying that it was not engaged in illicit activity. This settlement resolved allegations under the False Claims Act, the Physician Self-Referral Law (Stark Law), and the Financial Institutions Reform, Recovery, and Enforcement Act (FIRREA).

MD Spine Solutions LLC dba MD Labs Inc. and two of its owners agreed to pay up to $16 million to resolve allegations that MD Labs submitted claims for medically unnecessary urine drug tests.

Finally, **Radeas LLC** paid $11.6 million to resolve allegations that it billed Medicare for medically unnecessary urine drug testing by performing presumptive and confirmatory tests on the same urine sample at the same time.

Medicare Advantage Matters

The department pursued cases alleging that organizations participating in the Medicare Advantage (or Medicare Part C) program knowingly submitted or caused the submission of inaccurate information or knowingly failed to correct inaccurate information about the health status of beneficiaries enrolled in their plans to increase reimbursement. This past year, the department intervened in one case against **Cigna Corp** and continued to litigate a number of other cases, including actions against **UnitedHealth Group**, **Independent Health Corporation**, **Elevance Health** (formerly Anthem), and the **Kaiser Permanente consortium**.

Drug Pricing

The department filed suit to protect TRICARE, the federal health care program providing insurance for active-duty military personnel, military retirees, and military dependents. The department sued **Professional Compounding Centers of America Inc.** (PCCA), a company that sells active pharmaceutical ingredients and other products and services to compounding pharmacies. The complaint alleges that PCCA reported fraudulent and inflated Average Wholesale Prices for its ingredients that bore no relationship to the actual prices at which it sold those ingredients to its pharmacy customers, thereby causing those pharmacies to submit inflated compound prescription claims to TRICARE.

Unlawful Kickbacks

Kickbacks paid or received by health care providers undermine the integrity of federal health care programs by tainting medical decision-making, increasing health care costs, and adversely affecting competition. Federal law prohibits 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.

The department intervened and pursued claims under the False Claims Act in several qui tam actions alleging kickback violations. For example, the department filed a complaint against two laboratory CEOs, a hospital CEO, six physicians, and other individuals and entities, alleging False Claims Act violations based on patient referrals in violation of the Anti-Kickback Statute (AKS) and the Stark Law, as well as alleging that defendants caused claims to be improperly billed to federal health care programs for medically unnecessary laboratory testing.

The department also filed suit against a chiropractor, 15 office-based labs primarily owned by the chiropractor, and five affiliated companies owned by the chiropractor, alleging that the defendants offered physicians the opportunity to invest in the labs to induce them to refer their Medicare and TRICARE patients to the labs for the treatment of peripheral arterial disease.

Fiscal year 2022 also saw the resolution of numerous matters involving kickback violations. In a case pursued by a whistleblower, the pharmaceutical company **Biogen Inc.** paid $843.8 million to resolve allegations that the company offered and paid kickbacks, including in the form of speaker honoraria, speaker training fees, consulting fees, and meals, to physicians who spoke at or attended Biogen programs in connection with Biogen's multiple sclerosis drugs Avonex, Tysabri, and Tecfidera. The relator alleged that this conduct occurred between 2009 and 2014.

Durable medical equipment manufacturer **Philips RS North America, LLC, formerly Respironics, Inc.**, paid $24.75 million to resolve allegations that it knowingly provided unlawful kickbacks to DME suppliers to induce them to select Respironics' respiratory equipment. The inducements allegedly came in the form of physician prescribing data that Respironics provided free of charge yet knew was valuable in assisting DME suppliers' marketing efforts to physicians.

Flower Mound Hospital Partners LLC, a partially physician-owned hospital, paid $18.2 million to resolve allegations that it knowingly submitted claims to federal health care programs that arose from violations of the Stark Law and the AKS. The government alleged that the hospital repurchased shares from physician-owners aged 63 or older and then resold those shares to younger physicians, impermissibly taking into account the volume or value of physician referrals when selecting the physicians to whom the shares would be resold and determining the number of shares each physician would receive.

Kaléo Inc. paid the United States $12.7 million for alleged false claims for the drug Evzio, used to reverse opioid overdoses, for providing illegal remuneration to prescribing physicians and their office staff, and for directing physicians to send Evzio prescriptions to certain preferred pharmacies that, in turn, submitted false prior authorization requests to insurers. In addition, the United States obtained a $1.3 million settlement from pharmacy **Solera Specialty** for submitting false and misleading prior authorizations for the drug.

The United States obtained settlements from 32 Texas doctors totaling more than $5 million to resolve allegations that these doctors

violated the AKS and the Stark Law in a scheme to receive improper remuneration from management service organizations (MSOs) in exchange for ordering laboratory tests from designated entities, including a $582,522 settlement with **Dr. Mitchell Finnie**. The remuneration was allegedly disguised as investment returns but in fact was based on, and offered in exchange for, the doctors' referrals. The United States also obtained settlements with two health care executives in connection with the scheme.

Other recoveries relating to kickback violations involved clinical laboratories (**Metric Lab Services, LLC**), medical device companies (**Arthrex, Inc.**), and physician practice groups (**Ambulatory Anesthesia of Atlanta, LLC** and **Northside Anesthesiology Consultants LLC**).

PROTECTING SERVICEMEMBERS AND FIRST-RESPONDERS

The government continued its pursuit of fraud matters involving the purchase of goods and services in connection with military and similar programs. Fraud in these programs not only squanders government funds, but also potentially puts servicemembers and first responders at risk.

As part of a global resolution of criminal and civil liability, **Balfour Beatty Communities (BBC)** entered into a $35.2 million civil settlement with the United States in December 2021. BBC operates dozens of privatized military housing communities at military installations across the country and earned fees for management and maintenance of the communities. The settlement resolved allegations that BBC fraudulently induced each of the service branches to pay performance incentive fees for military housing management and maintenance that it did not earn. The government alleged that BBC obscured its performance failures by altering or manipulating data in its property management software and destroying or falsifying resident comments cards. The government further alleged that BBC's conduct resulted in lengthy and unnecessary delays in resolving maintenance issues — to the detriment of servicemembers and their families — and that the service branches were provided an inaccurate assessment of the condition of BBC-operated miliary housing communities and were thereby unable to assess, and potentially correct, BBC's performance.

Kellogg Brown & Root Services, Inc. paid $13.67 million to resolve allegations relating to its provision of logistics support to U.S. Army forces in Operation Iraqi Freedom under the Logistics Civil Augmentation Program III contract. The United States alleged that certain KBR employees responsible for awarding subcontracts rigged the bidding process in favor of certain local companies, and that those KBR employees received kickbacks from local companies in exchange for award of the subcontracts. The government also alleged that these subcontract prices were inflated, and that KBR sought reimbursement of these inflated subcontracts through vouchers submitted to the Army. This resolution came on the eve of trial and after the United States litigated this matter for many years.

Honeywell International, Inc., paid $3.35 million to resolve allegations that it sold defective material for bullet proof vests used by law enforcement officers. This settlement concluded the department's investigation and litigation of the body armor industry's use of defective Zylon, which yielded total recoveries of over $136 million from 17 different entities and individuals.

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.

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. The department has pursued borrowers that improperly received duplicate or inflated PPP loans or were otherwise not eligible to receive any PPP loan. Over the last year, the department has resolved 35 False Claims Act matters, recovering over $6.8 million and avoiding more than $1.5 million in losses for SBA tied to federal guarantees on improper loans.

The department also pursues lenders who improperly disburse PPP funds. This year, the department obtained its first-ever False Claims Act settlement with a bank that allegedly made a PPP loan to a customer it knew was ineligible because its sole owner was facing criminal charges at the time of the loan. **Prosperity Bank**, a regional bank in Texas and Oklahoma, paid $18,673 to resolve these allegations.

The department also pursued those who sought to misuse other pandemic-related resources. **MorseLife Health System Inc.** (MorseLife), a Florida-entity that oversees a nursing home and an assisted living facility, paid the United States $1.75 million to resolve allegations that it facilitated COVID-19 vaccinations for hundreds of individuals ineligible to participate in the Centers for Disease Control and Prevention's Pharmacy Partnership for Long-Term Care Program (LTC PPP). Although that program was specifically designed to vaccinate long term care residents when doses of the COVID-19 vaccine were in limited supply, MorseLife was alleged to have arranged vaccines for members of MorseLife's Board of Directors and individuals whom MorseLife targeted for donations to its private foundation.

CYBERSECURITY INITIATIVE

Malicious cyber activity threatens the health and safety of the American people, and the national and economic security of our country. In

October 2021, the department announced its Civil Cyber-Fraud Initiative, which is dedicated to using the False Claims Act to combat new and emerging cyber threats.

This year marked the department's first settlement under this initiative. **Comprehensive Health Services, LLC**, (CHS) located in Cape Canaveral, Florida, paid $930,000 to resolve allegations that it falsely represented to the State Department and the Air Force that it had complied with contract requirements relating to the provision of medical services at State Department and Air Force facilities in Iraq and Afghanistan. The allegations included that CHS submitted claims to the State Department for the cost of a secure electronic medical record system to store all patients' medical records, including confidential identifying information of U.S. service members, diplomats, officials, and contractors working and receiving medical care in Iraq. The government alleged that CHS failed to disclose that it had not consistently stored patients' medical records on a secure system, and instead put copies of some records on an internal, unsecured, network drive.

OTHER FRAUD RECOVERIES

The judgments, settlements, and lawsuits announced during fiscal year 2022 reflect the diversity of fraud recoveries and enforcement efforts arising under the False Claims Act. For example:

Various air carriers entered into settlement agreements resolving allegations that, in connection with contracts with the U.S. Postal Service for the carriage of mail internationally, they falsely reported that mail receptacles were delivered to specified destinations or the time of such deliveries. This year, **Air France** and **KLM Airlines** paid $3.9 million to resolve such claims, and **Delta Airlines Inc.** paid $10.5 million. To date, the United States has recovered more than $84 million as a result of its investigation of such misconduct.

TriMark USA, LLC paid $48.5 million to resolve allegations that its subsidiaries improperly manipulated federal small business set-aside contracts. TriMark used a subsidiary, rather than the awardee, to perform substantially all the work, while the awardee small business only served as the face of the contract, billed the government, and used its small business status to obtain the contract. The settlement amount constitutes the largest False Claims Act recovery based on allegations of small business contracting fraud.

TracFone Wireless paid $13.4 million to settle allegations under the False Claims Act and the common law that it improperly signed up more than 175,000 ineligible customers in connection with the Federal Communications Commission's Lifeline Program. Third-party agents exploited a glitch in TracFone's software, but TracFone failed to adequately review applications and investigate reports of clearly ineligible customers. The Lifeline Program provides nearly $2 billion each year to assist low-income consumers with their telecommunication needs, including mostly free monthly cell phone service.

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. Such efforts deter future fraud, incentivize changes in both corporate and individual behaviors, ensure that the proper parties are held responsible, and promote the public's confidence in our justice system. As noted above, the PPOA, MD Spine Solutions, STF, Modern Vascular, and MSO cases were all resolutions or lawsuits that included claims against individuals. The following are additional examples of recoveries involving individuals.

Dr. Minas Kochumian, from Los Angeles, California, paid $9.5 million to resolve allegations that he submitted false claims to Medicare and Medi-Cal for procedures and tests never performed, including injections of medication designed to treat osteoarthritis and osteoporosis, drainage of cysts, and removal and destruction of various growths.

Dr. Harry Doyle and his wife and office assistant Sonya Doyle, of Philadelphia, paid $3 million to resolve allegations of submitting false claims to the U.S. Department of Labor's Office of Worker's Compensation Program (OWCP) for psychiatric services that were not provided, as well as upcoding and double-billing patient claims. This is the largest recovery against a single psychiatrist in the history of the OWCP. Dr. Doyle also agreed to voluntary exclusion from federal health care programs for 25 years.

In addition, the United States obtained a $1 million settlement with pharmacist **Riad Zahr** and two specialty pharmacies Zahr owned and operated – **Plymouth Towne Care Pharmacy doing business as People's Drug Store** and **Shaska Pharmacy LLC doing business as Ray's Drugs** – for submitting false and misleading prior authorization requests for Evzio.

RECOVERIES IN WHISTLEBLOWER SUITS

Of the $2.2 billion in settlements and judgments reported by the government in fiscal year 2022, over $1.9 billion arose from lawsuits that were filed under the qui tam provisions of the False Claims Act and pursued by either the government or whistleblowers. During the same period, the government paid out over $488 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 652 qui tams filed this past year – an average of more than 12 new cases every week.

“We are grateful for the hard work and courage of those private citizens who bring evidence of fraud to the Department’s attention, often putting at risk their careers and reputations,” said Principal Deputy Assistant Attorney General Boynton. “Our ability to protect citizens and taxpayer funds continues to benefit greatly from their actions.”

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.

***

On behalf of the Civil Division, Principal Deputy Assistant Attorney General Boynton also expressed appreciation for the dedication and work over the past year by the many public servants who supported the department’s efforts to protect the public. “As ever, we are indebted to all those who work tirelessly to protect the public fisc from fraud: those in the Fraud Section of 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 that support this important work.”

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 FY2022 Statistics

Component(s):
Civil Division

Topic(s):
Servicemembers Initiative
False Claims Act
Health Care Fraud

Press Release Number:
23-149

Updated February 7, 2023