HEALTH CAPITAL Topics
Volume 16
Issue 2
February 2023
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2022 DOJ False Claims Act Recoveries Surpassed $2.2 Billion

On February 7, 2023, the U.S. Department of Justice (DOJ) announced their recovery of $2.2 billion in settlements and judgments from civil cases involving the False Claims Act (FCA) for fiscal year (FY) 2022.[1] The overall recoveries in FY 2022 were far less than the DOJ's FY 2021 recoveries of $5.6 billion.[2] Of the $2.2 billion recovered in FY 2022, over $1.7 billion was recouped from the healthcare industry alone (much less than the over $5 billion recovered from the industry in FY 2021), and included recoveries from drug and medical manufacturers, home health and managed care providers, hospitals, pharmacies, hospice organizations, and physicians.[3] Healthcare industry settlements far outstripped recoveries from defense, energy, construction, and other industries.[4] The recoveries for FY 2022 reflect the DOJ's focus on new enforcement priorities, including violations of cybersecurity requirements in government funded grants and contracts, and fraud in pandemic relief programs.[5]

The DOJ pursued a number of cases related to providers allegedly billing federal healthcare programs for unnecessary medical services.[6] Such services waste taxpayer money and can potentially expose patients to harmful treatments or procedures.[7] Claims for unnecessary medical services were filed against the following organizations:

- **The American Health Foundation (AHF), AHF's management corporation, and three nursing home affiliates** were pursued for providing skilled nursing care that was substandard from 2016 through 2018. The government alleged that the nursing homes involved in the suit failed to meet standards of care in multiple ways, including failure to follow appropriate infection control protocol and not having adequate staffing.
- **Providence Health & Services Washington,** a healthcare system operating in several states in the Western U.S., paid $22.7 million to resolve federal allegations that they billed federal healthcare programs for neurosurgeries that were unnecessary.
- **Eargo Inc.,** a hearing aid device seller and dispenser, paid $34.4 million to resolve FCA and common law allegations that they submitted claims containing hearing-loss diagnosis codes that were not supported to a federal healthcare program for device reimbursement.
- **Carrefour Associates LLC** and related companies paid $5.5 million to resolve allegations that they had knowingly submitted claims to Medicare for hospice services for patients that were not terminally ill.
- **Signature Home Health Services of Florida LLC** paid $2.1 million to resolve allegations that they had provided services to beneficiaries of Medicare who were not homebound, not in need of skilled care, and who did not have enough face-to-face encounters to warrant home health services.
- **Hayat Pharmacy** paid $2.05 million to resolve allegations that they submitted false claims to Medicaid and Medicare for prescription drugs that were switched to higher costing medications without any valid need.
- **Physician Partners of America LLC** paid $24.5 million to resolve allegations that they had billed federal healthcare programs for unnecessary genetic, psychological, and urine drug screenings. The DOJ alleged that physicians ordered multiple tests without a valid reason and claimed to not partake in illicit activity when receiving Paycheck Protection Program (PPP) funding.
- **MD Spine Solutions LLC** paid $16 million to resolve allegations that they similarly submitted false claims for unnecessary urine drug tests, and **Radeas LLC** paid $11.6 million to resolve allegations that they submitted false claims billing Medicare for urine drug testing that was medically unnecessary, while running multiple tests on the same urine sample.[8]

Several lawsuits were resolved in 2022 related to unlawful kickbacks. For example, the DOJ filed suit against a chiropractor, alleging that the defendant had offered physicians the opportunity to invest in the chiropractor's labs in exchange for referring their patients there for the treatment of their peripheral arterial disease.[9] **Biogen Inc.** paid $843.8 million to address allegations that the company paid and offered kickbacks in multiple forms to physicians that had attended company-sponsored programs relating to Biogen's multiple sclerosis drugs.[10] **Phillips RS North America**

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LLC (formerly Respironics, Inc.), paid $24.8 million to resolve allegations that they provided kickbacks to medical equipment suppliers to induce the selection of **Respironics'** equipment.[11] **Flower Mound Hospitals Partners LLC** paid $18.2 million to resolve allegations that they had knowingly submitted claims to federal healthcare programs that resulted from violations of the Anti-Kickback and the Stark Law.[12] According to the government, the physician-owned hospital repurchased shares from physician-owners over the age of 63, and resold the shares to physicians that were younger, and the number of shared offered were dependent on volume of patients the physician was referring to the hospital.[13] **Kaleo Inc.** paid $12.7 million over false claims related to their drug used to reverse opioid overdoses; illegally remunerating physicians and their office staff; and directing physicians to send prescriptions for their drug to preferred pharmacies, where the pharmacy would file false and misleading prior authorizations to insurers.[14]

The DOJ recovered significant sums from a number of entities related to Medicaid fraud, including:

- **Mallinckrodt ARD LLC (previously Questor Pharmaceuticals Inc.)** paid $260 million to resolve allegations relating to a drug their company manufactured, which was approved to treat acute exacerbations of multiple sclerosis and infantile spasms. The government alleged that the company underpaid rebates to the Medicaid program by designating the drug as "new," in contrast to a previous product that cost significantly more. Separately, the government also alleged that Mallinckrodt used a foundation to subsidize the drug's copays so their drug could be marketed as "free" while prices increased significantly.
- **Gold Coast Health Plan (a health system comprised of three of its providers)** paid $70.7 million to resolve claims that they had knowingly submitted false claims to the Medicaid program in California. The government alleged that payments were not for expenses that were approved in the contract between the state and the plan, did not reflect fair market value, and were unlawful gifts of public funding (in violation of California's state constitution).[15]

In addition to pursuing cases related to Medicaid fraud, the DOJ intervened in cases related to Medicare Advantage (also known as Medicare Part C) plans. Because Medicare Advantage pays providers a set amount per enrolled patient, which amount is then adjusted by a number of risk factors that affect expected healthcare expenditures (i.e., a plan with more higher-risk patients would receive more reimbursement), the government has a strong interest in ensuring that providers do not manipulate the risk adjustment process. One case was filed against **Cigna**, and other cases continued to be litigated against **UnitedHealth Group**, **Independent Health Corporation**, **Elevance Health**, and the **Kaiser Permanente group**.[16]

During the COVID-19 pandemic, Congress authorized emergency funding to provide financial assistance directly to state, local, and Tribal governments, as well as to businesses and individuals. The DOJ has pursued cases involving improper payment from the PPP, which provided forgivable loans to small businesses for payroll, rent, and other operational costs. In FY 2022, the department resolved 35 FCA matters related to improper loans from the PPP, recovering $6.8 million and avoiding nearly $1.5 million in losses.[17] The DOJ also pursued cases against lenders that improperly dispersed PPP funds and against others that misused pandemic-related funding and resources.

Money recovered by the DOJ through healthcare fraud enforcement is crucial in returning assets back to federally-funded programs such as Medicare, Medicaid, and TRICARE. Of the $2.2 billion recovery, $1.9 billion resulted from lawsuits that were filed under the qui tam provisions of the FCA.[18] The number of lawsuits filed under the qui tam provisions[19] has grown significantly since 1986, with 652 qui tams filed in FY 2022, an increase from the 598 qui tams filed in FY 2021.[20] Nevertheless, the DOJ's continued active interest and involvement in fraud and abuse cases in 2022 suggests that FCA enforcement will remain high going forward.

1 "False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022" Office of Public Affairs, Department of Justice, February 7, 2023, https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022 (Accessed 2/8/23).
2 *Ibid*; "Fraud Statistics – Overview" Department of Justice, https://www.justice.gov/opa/press-release/file/1467811/download (Accessed 2/22/23).
3 Office of Public Affairs, Department of Justice, February 7, 2023.
4 *Ibid*.
5 *Ibid*.
6 *Ibid*.
7 *Ibid*.
8 *Ibid*.
9 *Ibid*.
10 *Ibid*.
11 *Ibid*.
12 *Ibid*.
13 *Ibid*.
14 *Ibid*.
15 *Ibid*.
16 *Ibid*.
17 *Ibid*.
18 *Ibid*.
19 Not only does the FCA give the U.S. government the ability to pursue fraud, it also enables private citizens to file suit on behalf of the federal government through what is known as a "qui tam" or "whistleblower" suit.
20 Office of Public Affairs, Department of Justice, February 7, 2023; "Fraud Statistics – Overview" Department of Justice, https://www.justice.gov/opa/press-release/file/1467811/download (Accessed 2/22/23).

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Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

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