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Practice Update

False Claims Act 2022 in Review

April 18, 2023

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The U.S. government continued to earn its longstanding reputation for its vigorous enforcement of the False Claims Act (FCA)[1] in 2022, either directly or through relator proxies. The Department of Justice (DOJ) recorded the second-highest number of FCA-related case resolutions (*i.e.*, settlements and judgments) for a calendar year—351.[2] Notably, this near-record pace did not result in record-setting recoveries, as the $2.2 billion recovered in 2022 was the lowest government bounty for FCA matters since 2008.[3] Among 2022 FCA resolutions, the healthcare industry once again dominated. Seventy-seven percent, exceeding $1.7 billion of all 2022 recoveries, involved healthcare.[4]

Within healthcare, the government's recoveries reveal at least five enforcement trends:

- FCA enforcement continued its years-long trend of pursuing FCA cases that involve allegations of unnecessary healthcare services and improper billing;
- resolutions increasingly included individual liability;
- pharmaceutical and medical device manufacturers continued to dominate large DOJ recoveries;
- there was a heightened focus on fraud in telemedicine and the electronic health record technology field because of the increasing use of and expanding payments for technologies in healthcare; and
- there was a spike in enforcement of fraud in pandemic relief programs.

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Ultimately, as the healthcare industry remains the largest area of FCA-related recoveries, leaders and decisionmakers in the healthcare field should pay close attention to these trends and enforcement areas and plan their compliance programs and resources accordingly.

Unnecessary Healthcare Services and Improper Billing

About seventeen percent of published healthcare-related resolutions were against providers who allegedly fraudulently billed federal health programs for medically unnecessary services or improperly billed for services. The DOJ noted that providing medically unnecessary services can expose patients to harmful procedures and treatments or can cause them to forego potentially more effective treatments.[5] For example, Physician Partners of America, LLC (PPOA), its founder (Rodolfo Gari), and its former chief medical officer (Dr. Abraham Rivera) agreed to pay $24.5 million to resolve allegations that PPOA submitted false claims for urine drug tests that were medically unnecessary.[6] Relators contended that PPOA ordered multiple tests per patient at once without reviewing the results of initial screenings.[7] PPOA also allegedly required patients to take genetic and psychological testing without any proper basis.[8]

Similarly, UC San Diego Health and Springbok Health, Inc., a Colorado-based substance abuse treatment center, also settled a matter involving unnecessary testing.[9] UC San Diego Health System agreed to pay $2.98 million to resolve allegations that it ordered and billed Medicare for unnecessary genetic tests.[10] Springbok Health agreed to resolve allegations of unnecessary medical evaluations by paying a range of $125,000 to $335,494, depending on future revenue.[11]

Separately, the DOJ resolved allegations of unnecessary services and improper billing by Carter Healthcare, LLC, a home health provider, and its affiliates, CHC Holdings and Carter-Florida (collectively, Carter Healthcare), and their President (Stanley Carter) and Chief Operations Officer (Bradley Carter).[12] Notably, defendants agreed to pay $7.175 million to resolve allegations of billing Medicare for medically

unnecessary services and overbilling for therapy by upcoding patients' diagnoses.[13]

These resolutions collectively demonstrate to practitioners that the DOJ is actively investigating medically unnecessary services and overbilling for services and is including individual practitioners and corporate executives in these settlements with more regularity.

Individual Liability under the FCA

At least since publication of the "Yates Memorandum" in 2015, the DOJ has had an increased focus on holding culpable individuals, along with corporate enterprises, accountable for FCA violations.[14] The Yates Memorandum announced the DOJ's intention to increase FCA prosecution against individuals and highlighted that corporate resolution of FCA concerns would not protect individual actors.[15] In 2022, resolution of FCA cases continued to reflect this enhanced focus on individual conduct, as at least ten practitioners faced individual liability for fraudulently billing for unnecessary services or improperly billing for services. Separately, the DOJ initiated a suit against at least fifteen individual defendants, including laboratory executives and employees at True Health Diagnostics, LLC and Boston Heart Diagnostics Corporation (even amending the complaint a month later to add six physicians[16]), for patient referrals allegedly in violation of the Anti-Kickback Statute and the Stark Law and for improper billing for (allegedly) medically unnecessary laboratory testing.[17] Ultimately, this matter settled for over $32 million.[18] Individual defendants were required to pay between $41,000 and $582,522.[19]

Several matters discussed above also required individuals to make substantial payments. PPOA included allegations against the Chief Medical Officer and its founder as part of the settlement.[20] In the Springbok Health, Inc. matter, the owner and Chief Executive Officer (Mark Jankelow) was also jointly and severally liable in the settlement and was required to pay a portion of at least $125,000.[21] In the Carter Healthcare matter, the DOJ mandated that two individuals, the entity's President (Stanley Carter) and

Chief Operating Officer (Bradley Carter), individually pay $75,000 and $175,000, respectively, of the $7 million plus settlement amount.[22]

In yet another matter, Vinay K. Malviya, M.D., a gynecologic oncologist, personally agreed to pay $775,000 to resolve alleged fraudulent billings to federal healthcare programs for unnecessary medical services, such as radical/modified hysterectomies, when simple hysterectomies were sufficient, and excessive chemotherapy services.[23] Dr. Malviya also agreed to a three-year exclusion from participation in all federal healthcare programs.[24]

Dr. Minas Kochumian agreed to pay $9,486,287 to resolve allegations of false claims submitted to Medicare and Medi-Cal for procedures, services, and tests[25] that were never conducted or administered to patients.[26] Dr. Vijesh Patel and his office manager (and wife), Laju Patel, agreed to pay $422,789 to resolve allegations of illegal kickbacks in return for referrals for laboratory testing.[27]

Accordingly, the DOJ's FCA enforcement activity in 2022 clearly shows that the DOJ continues to follow the principles expounded in the Yates Memorandum. The government (directly and through relator proxies) will continue to make allegations against individuals as part of FCA matters, and the government may require individuals to participate meaningfully in settlement payments for cases to resolve.[28]

Pharmaceutical Companies/Wholesalers and Medical Device Manufacturers

One-third of the healthcare-related DOJ resolutions in 2022 concerned pharmaceutical wholesalers and retailers or medical device manufacturers and particularly focused on Anti-Kickback and Stark violations. Manufacturers of medical devices and equipment were heavily represented this past year in FCA matters involving allegations of fraudulent inducement of providers to use (or refer use of) their equipment. For instance, Biotronik, Inc. agreed to pay nearly $13 million to settle allegations that it paid kickbacks to physicians to induce and reward the use of their implantable cardiac devices (such as pacemakers

and defibrillators).[29] Philips RS North America LLC, a manufacturer of durable medical equipment (DME), paid a settlement of over $24 million to resolve allegations of illegal inducements to DME suppliers by providing them free physician-prescribing data, which could assist suppliers with marketing efforts.[30] Similarly, in *U.S. ex rel. Everest Principals, LLC v. Abbott Laboratories, Inc.*, a relator filed suit against the lab company alleging that it provided kickbacks in the form of cash, cash equivalents, lavish meals, and free marketing to providers who utilized their patented technology for cardiac procedures that ultimately yielded (according to the Complaint) thousands of false claims to Medicare, Medicaid, and TRICARE.[31]

In September 2022, the DOJ announced a $900 million settlement with Biogen Inc. for its alleged submission of false claims to Medicare and Medicaid by paying kickbacks (including speaker honoraria, speaker training fees, consulting fees, and meals) to induce providers to prescribe Biogen's multiple sclerosis drugs.[32]

Similarly, a relator sued McKesson Corporation, McKesson Specialty Distribution LLC, and McKesson Specialty Care Distribution Corporation (collectively McKesson) for an alleged kickback scheme in which it offered business-management tools to specialty oncology practices who joined McKesson programs that required the oncology practices to purchase a large portion of their drugs from McKesson.[33]

Finally, the DOJ also settled an FCA matter with Bayer Corporation, a manufacturer of pharmaceutical products, requiring Bayer to pay $40 million to resolve allegations that it (a) paid kickbacks to hospitals and physicians to induce them to prescribe particular drugs; and (b) marketed these drugs for off-label uses not approved by the Food and Drug Administration.[34]

Fraud in Telemedicine and the Electronic Health Record Technology Field

The use of telehealth during the COVID-19 public health emergency increased dramatically in response to the skyrocketing demand for virtual health services and CMS' temporary waiver of the government's geographic

or location limitations required for providers to receive payment for telemedicine sessions.[35] Consequently, fraud enforcement in telemedicine likewise escalated.

For example, in July 2022, the DOJ announced charges against dozens of defendants, including telemedicine companies and individual healthcare providers accused of participating in telemedicine schemes totaling $1 billion in allegedly fraudulent bills submitted to government programs.[36] When announcing the results of the nationwide coordinated law enforcement action to combat fraud, Assistant Attorney General Kenneth A. Polite, Jr., of the DOJ's Criminal Division stated, "The Department of Justice is committed to prosecuting people who abuse our healthcare system and exploit telemedicine technologies in fraud and bribery schemes."[37]

More specifically, the charges centered around two primary means of fraud: (1) the payment of kickbacks to telemedicine companies for either blank or prefilled signed prescriptions used for medically unnecessary medication, genetic testing, or DME that was billed to Medicare, and (2) the acceptance of payments or kickbacks by physicians (or other providers with prescription privileges) for writing prescriptions for medically unnecessary medications, testing, or DME for patients with whom the providers had no treatment relationship.[38]

For instance, in the Middle District of Tennessee, John Manning, a physician, was indicted for conspiracy to commit healthcare fraud and for healthcare fraud. Dr. Manning allegedly submitted false claims to Medicare worth more than $41 million while working with multiple telemedicine companies.[39] Dr. Manning allegedly signed orders and prescriptions for DME, topical creams, and cancer genetic testing without establishing a doctor-patient relationship or examining the Medicare beneficiaries.[40] He reportedly only had brief telephone conversations with the patients and did not properly consider medical necessity.[41]

Many telemedicine fraud cases from the July 2022 coordinated enforcement action are still pending as of this publication. But others resolved through guilty pleas in 2022. For instance, Vincent R. Sperti II pleaded

guilty to conspiracy to defraud the United States and pay and receive kickbacks for his involvement in a $400,000 kickback scheme to pay kickbacks to telemedicine companies to obtain signed physician orders for resale.[42] Mr. Sperti also pleaded guilty to possession of a Schedule III controlled substance with the intent to distribute.[43] Mr. Sperti's guilty plea resulted in a sentence of forty-six months of imprisonment for each count (to run concurrently), a supervised release term of three years, and restitution.[44]

Moreover, FCA resolutions this past year addressed alleged misconduct connected with electronic health record (EHR) technology in the healthcare industry. The DOJ announced in press statements that it focused on this area of fraud because EHR technology is utilized heavily in decision-making for patient health.[45] Therefore, the DOJ posited, EHR technology should be free from the improper influence of financial inducements so that providers (and consumers) can trust services that maintain sensitive patient information.[46]

In this context, Modernizing Medicine, Inc. (ModMed), an EHR technology vendor, paid $45 million for allegedly violating the FCA through marketing programs, including soliciting and receiving kickbacks from Miraca Life Sciences, Inc. (Miraca), in exchange for recommending their pathology lab services.[47] ModMed also purportedly conspired with Miraca to donate ModMed's EHR to healthcare providers in an effort to increase lab orders for Miraca and add customers to ModMed's user base.[48]

Comprehensive Health Services, LLC (CHS) paid $930,000 to resolve allegations of false representations to the State Department and the Air Force for improper compliance with contract requirements for an EHR system.[49] CHS submitted claims to the State Department for the cost of an EHR system. But in so doing, CHS allegedly failed to disclose to the government that CHS failed to store patients' medical records on a secure EHR system or that CHS had failed to keep private the scanned medical records that it uploaded onto its EHR system.[50]

Fraud in Pandemic Relief Programs

During the COVID-19 pandemic, Congress authorized billions of dollars in emergency funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[51] As part of this relief effort, Congress established the Paycheck Protection Program (PPP), providing businesses with economic relief by funding up to eight weeks of payroll costs, including benefits, as well as funds for mortgages, rent, and utilities for small businesses to continue operations.[52] Although these programs were crucial for many during the pandemic, alleged fraud arose from these economic relief opportunities.[53] Commentators at the time predicted that the FCA would be used as an enforcement mechanism to police (alleged) fraudulent PPP activity. 2022 proved those commentators prescient, with at least thirty-five PPP-related resolutions yielding recoveries of approximately $6.8 million.[54]

PPP-related fraud enforcement overlapped with healthcare. MorseLife Health System, Inc. (MorseLife), for example, agreed to pay $1.75 million to resolve allegations that it provided COVID-19 vaccinations to hundreds of individuals who were ineligible under the Centers for Disease Control and Prevention's Pharmacy Partnership for Long-Term Care Program's protocols.[55] This program was designed to vaccinate long-term care facility residents and staff to protect this particularly vulnerable population.[56] MorseLife allegedly immunized board members, donors, and their families and friends as "staff" and "volunteers" to allow them to receive the vaccination during a time when COVID-19 vaccines were extremely limited.[57]

Last year, FCA settlements also reached employers who allegedly failed to comply with proper health and safety measures related to COVID-19.[58] For example, one relator claimed that a rehabilitation and long-term nursing care facility failed to comply with safety protocols during the pandemic, such as wearing masks properly and cleaning/disinfecting the facility, resulting in a spread of COVID-19 amongst the residents.[59]

Conclusion

To summarize the federal government's focus on FCA enforcement in 2022, just "follow the money." Healthcare fraud cases continued to dominate the field of FCA defendants last year, when healthcare spending constituted 18.3 percent of the nation's Gross Domestic Product.[60] Two years following enactment of the $2.2 trillion federal economic stimulus package known as the CARES Act, enforcement against fraud involving pandemic relief programs spiked significantly. Since the beginning of the COVID-19 public health emergency, America's healthcare system has relied more heavily than ever on telemedicine and EHRs, and CMS relaxed its requirements for billable telemedicine visits because of the immediate need for virtual services. Consequently, the federal government heightened its focus on telemedicine and EHR fraud enforcement to recover at least $1 billion in 2022. Pharmaceutical and medical device manufacturers produce expensive medications and DME, and those industries continued to dominate large FCA recoveries last year. The federal government also continued to pursue improper billing for medically unnecessary medical services and products and to focus on individual accountability vis-à-vis the Yates Memo last year.

As FCA enforcement activity evolves and individual accountability increases, it is essential that decisionmakers in the healthcare industry are knowledgeable about these recovery trends and judgments when planning compliance activities and allocating resources. FCA compliance is crucial to sustain America's healthcare system and to ensure that patients receive the right care for the right reasons.[61]

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[1] 31 U.S.C. §§ 3729-3733.

[2] *False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022*, U.S. Dep't of Just.: Off. of Pub. Affairs (Feb 7, 2023), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Physician Partners of America to Pay $24.5 Million to Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and a False Statement in Connection with COVID-19 Relief Funds*, U.S. Dep't of Just.: Off. of Pub. Affairs (April 12, 2022), https://www.justice.gov/opa/pr/physician-partners-america-pay-245-million-settle-allegations-unnecessary-testing-improper (Principal Deputy Assistant Attorney General Boynton commented in reaction to this settlement, "[b]illing federal healthcare programs for services that providers know are unnecessary or unreasonable undermines the quality of care that patients receive and increases the costs of these taxpayer-funded programs," and the DOJ is committed to ensuring providers are focused on patients' needs as opposed to their own financial interests.).

[7] *Id.* (This resolution arose from multiple actions filed by relators against these parties. The relators are current or former employees of PPOA or its affiliated entities. The *qui tam* cases are captioned *United States ex rel. Haight v. Physician Partners of Am.*; *United States ex rel. Baker v. Physician Partners of Am LLC*; *United States ex rel. Lupi v. Physician Partners of Am. LLC*; and *United States ex rel. Dookwah-Roberts v. Physician Partners of Am. LLC*).

[8] *Id.* (This matter also involved pandemic-related fraud (to be discussed below), as PPOA allegedly increased unnecessary evaluations and improperly over-billed for these evaluations to make up for lost revenue, during a time when Florida's state government had suspended all non-emergency medical procedures to reduce transmission of COVID-19. Further, to obtain a $5.9 million loan through the PPP, PPOA falsely represented it was not involved in unlawful overbilling.).

[9] *UC San Diego Health Pays $2.98 Million to Resolve Allegations of Ordering Unnecessary Genetic Testing*, U.S. Dep't of Just.: Off. of Pub. Affairs (Jan. 11, 2022), https://www.justice.gov/opa/pr/uc-san-diego-health-

pays-298-million-resolve-allegations-ordering-unnecessary-genetic-testing.

[10] *Id.*

[11] *Colorado Substance Abuse Treatment Clinic and Owner Agree to Settle False Claims Act Allegations*, U.S. Dep't of Just.: Off. of Pub. Affairs (April 18, 2022), https://www.justice.gov/opa/pr/colorado-substance-abuse-treatment-clinic-and-owner-agree-settle-false-claims-act-allegations (the value of the resolution is dependent on acquired revenue from 2021-2025).

[12] *Carter Healthcare Affiliates and Two Senior Managers to Pay $7.175 Million to Resolve False Claims Act Allegations for False Florida Home Health Billings*, U.S. Dep't of Just.: Off. of Pub. Affairs (Oct. 18, 2022), https://www.justice.gov/opa/pr/carter-healthcare-affiliates-and-two-senior-managers-pay-7175-million-resolve-false-claims.

[13] *Id.*

[14] Memo from Sally Yates, Dep. Att'y Gen., U.S. Dep't of Just., to Assist. Att'ys Gen., Dir. of FBI, Dir. of Exec. Off. for U.S. Trs., U.S. Att'ys (Sept. 9, 2015) [hereinafter "Yates Memo"], *available at* https://www.justice.gov/archives/dag/file/769036/download.

[15] *Id.*

[16] *Justice Department Files False Claims Act Complaint Against Six Physicians in Texas Relating to Alleged Kickbacks and Improper Laboratory Testing Claims*, U.S. Dep't of Just.: Off. of Pub. Affairs (May 26, 2022), https://www.justice.gov/opa/pr/justice-department-files-false-claims-act-complaint-against-six-physicians-texas-relating.

[17] *Justice Department Files False Claims Act Complaint Against Two Laboratory CEOs, One Hospital CEO and Others Across Texas, New York, and Pennsylvania,* U.S. Dep't of Just.: Off. of Pub. Affairs (April 4, 2022), https://www.justice.gov/opa/pr/justice-department-files-false-claims-act-complaint-against-two-laboratory-ceos-one-hospital.

[18] *Fifteen Texas Doctors Agree to Pay over $2.8 Million to Settle Kickback Allegations*, U.S. Dep't of Just.: Off. of Pub. Affairs (June 28, 2022), https://www.justice.gov/opa/pr/fifteen-texas-doctors-agree-pay-over-28-million-settle-kickback-allegations.

[19] *Id.*

[20] *Physician Partners of America to Pay $24.5 Million to Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and a False Statement in Connection with COVID-19 Relief Funds*, U.S. Dep't of Just.: Off. of Pub. Affairs (April 12, 2022), https://www.justice.gov/opa/pr/physician-partners-america-pay-245-million-settle-allegations-unnecessary-testing-improper.

[21] *Colorado Substance Abuse Treatment Clinic and Owner Agree to Settle False Claims Act Allegations*, U.S. Dep't of Just.: Off. of Pub. Affairs (April 18, 2022), https://www.justice.gov/opa/pr/colorado-substance-abuse-treatment-clinic-and-owner-agree-settle-false-claims-act-allegations (the value of the resolution is dependent on acquired revenue from 2021-2025).

[22] *Carter Healthcare Affiliates and Two Senior Managers to Pay $7.175 Million to Resolve False Claims Act Allegations for False Florida Home Health Billings*, U.S. Dep't of Just.: Off. of Pub. Affairs (Oct. 18, 2022), https://www.justice.gov/opa/pr/carter-healthcare-affiliates-and-two-senior-managers-pay-7175-million-resolve-false-claims.

[23] *Michigan Doctor to Pay $775,000 to Resolve False Claims Act Allegations*, U.S. Dep't of Just.: Off. of Pub. Affairs (April 14, 2022), https://www.justice.gov/opa/pr/michigan-doctor-pay-775000-resolve-false-claims-act-allegations.

[24] *Id.*

[25] These payments include nearly $5.5 million paid as criminal restitution following his guilty plea to one count of healthcare fraud, in a separate criminal case.

[26] *Los Angeles Doctor to Pay $9.5 Million to Resolve Allegations of Fraud Against Medicare and Medi-Cal*, U.S. Attorney's Off.: E. District of Cal., https://www.justice.gov/usao-edca/pr/los-angeles-doctor-pay-95-million-resolve-allegations-fraud-against-medicare-and-medi. (Dr. Kochumian's fraudulent billing practices were also the subject of an independent federal criminal investigation and culminated in Dr. Kochumian pleading guilty to one count of federal healthcare fraud, and on May 2, 2022, he was sentenced to a prison term of three years and five months.).

[27] *Physician and Office Manager Agree to Pay Over $420,000 to Settle Kickback Allegations Involving New Jersey, Texas and South Carolina Laboratories*, U.S. Dep't of Just.: Off. of Pub. Affairs (Dec. 14, 2022), https://www.justice.gov/opa/pr/physician-and-office-manager-agree-pay-over-420000-settle-kickback-allegations-involving-ne-1.

[28] Note that criminal FCA liability is beyond the scope of this article.

[29] *Medical Device Manufacturer Biotronik Inc. Agrees To Pay $12.95 Million To Settle Allegations of Improper Payments to Physicians*, U.S. Dep't of Just.: Off. of Pub. Affairs (July 22, 2022), https://www.justice.gov/opa/pr/medical-device-manufacturer-biotronik-inc-agrees-pay-1295-million-settle-allegations-improper.

[30] *Philips Subsidiary to Pay Over $24 Million for Alleged False Claims Caused by Respironics for Respiratory-Related Medical Equipment*, U.S. Dep't of Just.: Off. of Pub. Affairs (Sept. 1, 2022), https://www.justice.gov/opa/pr/philips-subsidiary-pay-over-24-million-alleged-false-claims-caused-respironics-respiratory.

[31] *U.S. ex rel. Everest Principals, LLC v. Abbott Laboratories, Inc.*, No. 3:20-cv-286-W (AGS), 2022 WL 3567063, at *1 (S.D. Cal. Aug. 18, 2022).

[32] *Biogen Inc. Agrees to Pay $900 Million to Settle Allegations Related to Improper Physician Payments*, U.S. Dep't of Just.: Off. of Pub. Affairs (Sept. 26, 2022),

https://www.justice.gov/opa/pr/biogen-inc-agrees-pay-900-million-settle-allegations-related-improper-physician-payments.

[33] *U.S. ex rel. Hart v. McKesson Corp.*, 602 F. Supp. 3d 575, 579 (S.D.N.Y. 2022) (Defendant's motion to dismiss was granted in this matter due to Plaintiff's failure to allege the requisite scienter, but Plaintiff was granted leave to amend.).

[34] *Bayer to Pay $40 Million to Resolve the Alleged Use of Kickbacks and False Statements Relating to Three Drugs*, U.S. Dep't of Just.: Off. of Pub. Affairs (Sept. 2, 2022), https://www.justice.gov/opa/pr/bayer-pay-40-million-resolve-alleged-use-kickbacks-and-false-statements-relating-three-drugs. (In this press release, U.S. Attorney Philip R. Sellinger of New Jersey commented that this settlement should "send a message to the pharmaceutical industry that such conduct undermines the integrity of federal healthcare programs and jeopardizes patient safety.").

[35] *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, Centers for Medicare & Medicaid Services (updated May 24, 2021), *available at* COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov).

[36] *Justice Dep't Charges Dozens for $1.2 Billion in Health Care Fraud*, U.S. Dep't of Just. (July 20, 2022), *available at* Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud | OPA | Department of Justice.

[37] *Id.*

[38] *Telemedicine Case Studies: Summary of Criminal Charges*, U.S. Dept. of Justice (July 20, 2022), *available at* Telemedicine Case Summaries (justice.gov).

[39] *Telemedicine Case Summaries: Summary of Criminal Charges*, U.S. Dep't of Just. (July 21, 2022), https://www.justice.gov/criminal-fraud/telemedicine-case-summaries.

[40] *Id.*

[41] *Id.*

[42] *U.S. v. Sperti*, No. 6:22-cr-114-GAP-ELK (M.D. FL. Oct. 25, 2022), ECF Nol. 37 (Judgment in a Criminal Case).

[43] *Id.*

[44] *Id.* at 2, 3, 5.

[45] *Modernizing Medicine Agrees to Pay $45 Million to Resolve Allegations of Accepting and Paying Illegal Kickbacks and Causing False Claims*, U.S. Dep't of Just.: Off. of Pub. Affairs (Nov. 1, 2022), https://www.justice.gov/opa/pr/modernizing-medicine-agrees-pay-45-million-resolve-allegations-accepting-and-paying-illegal.

[46] *Id.*

[47] *Id.*

[48] *Id.*

[49] *Medical Services Contractor Pays $930,000 to Settle False Claims Act Allegations Relating to Medical Services Contracts at State Department and Air Force Facilities in Iraq and Afghanistan*, U.S. Dep't of Just.: Off. of Pub. Affairs (Mar. 8, 2022), https://www.justice.gov/opa/pr/medical-services-contractor-pays-930000-settle-false-claims-act-allegations-relating-medical.

[50] *Id.*

[51] 15 U.S.C. Ch. 116: Coronavirus Economic Stabilization (CARES Act).

[52]*Paycheck Protection Program*, U.S. Dep't of the Treasury, https://home.treasury.gov/policy-issues/coronavirus/assistance-for-small-businesses/paycheck-protection-program.

[53] *See MorseLife Nursing Home Health System Agrees to Pay $1.75 Million to Settle False Claims Act Allegations for Facilitating COVID-19 Vaccinations of Ineligible*

Donors and Prospective Donors, U.S. Dep't of Just.: Off. of Pub. Affairs (June 30, 2022), https://www.justice.gov/opa/pr/morselife-nursing-home-health-system-agrees-pay-175-million-settle-false-claims-act.

[54] *False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022*, U.S. Dep't of Just.: Off. of Pub. Affairs (Feb 7, 2023), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022.

[55] *MorseLife Nursing Home Health System Agrees to Pay $1.75 Million to Settle False Claims Act Allegations for Facilitating COVID-19 Vaccinations of Ineligible Donors and Prospective Donors*, U.S. Dep't of Just.: Off. of Pub. Affairs (June 30, 2022), https://www.justice.gov/opa/pr/morselife-nursing-home-health-system-agrees-pay-175-million-settle-false-claims-act.

[56] *Id.*

[57] *Id.* ("In one instance, MorseLife's CEO sent a text message to an ineligible individual stating, 'I will find you when you come in the morning and we're going to make you an employee of Morse . . . Guarantee you get the vaccine.'").

[58] *Conte v. Kingston NH Operations LLC*, 585 F. Supp. 3d 218, 225 (N.D.N.Y. 2022).

[59] *Id.* at 226-27 (The U.S. District Court granted the Defendant's motion to dismiss due to the relator's failure to meet the high standards for a claim under the FCA.).

[60] *NHE Fact Sheet*, Centers for Medicare & Medicaid Services (last modified Feb. 17, 2023), *available at* https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202021%3A,21%20percent%20of%20total%20NHE

[61] The authors would like to thank Marcy Hahn-Saperstein and Sidney S. Welch for their contributions to this article.
