DOJ-HHS Collab Crystallizes Focus On Health Enforcement

By **Gregory Rosen and Cindy Lopez** (July 30, 2025)

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In a move that should command the attention of every healthcare provider, pharmaceutical company and managed care organization, the U.S. Department of Justice and the U.S. Department of Health and Human Services recently announced a strategic partnership aimed at intensifying enforcement of the False Claims Act in the healthcare space.

Specifically, on July 1, the DOJ **announced** the creation of a DOJ-HHS working group intended to combat healthcare fraud and abuse, which "depletes taxpayer funds, corrodes public health and safety, and undermines the integrity of the federal healthcare system."[1] The working group's priority enforcement areas are:

- Medicare Advantage;
- Drug, device or biologics pricing, including arrangements for discounts, rebates, service fees, and formulary placement and price reporting;
- Barriers to patient access to care, including violations of network adequacy requirements;
- Kickbacks related to drugs, medical devices, durable medical equipment and other products paid for by federal healthcare programs;
- Materially defective medical devices that affect patient safety; and
- Manipulation of electronic health record systems to drive inappropriate utilization of Medicare-covered products and services.[2]

While DOJ-HHS cooperation is not new, and in fact, this level of coordination has previously occurred, the announcement crystallizes the focus and prioritization.

In other words, this collaboration is not just bureaucratic fanfare. It is a policy and enforcement alignment that signals that the DOJ means business — and has every intention of continuing to aggressively pursue government and whistleblower-driven FCA cases in the healthcare sector.

The DOJ has long made the FCA one of its primary tools in combating fraud against the federal government. Nowhere is this more pronounced than in the healthcare industry, where Medicare and Medicaid spending creates fertile ground for fraud, abuse and regulatory overreach.

Add in the recent passage of the One Big Beautiful Bill Act,[3] with dramatic changes anticipated in the healthcare field and subsequent compliance challenges, this new initiative reinforces a trend already taking shape over the last few years — the institutional commitment to FCA enforcement.

By aligning enforcement resources and priorities across the DOJ's Civil Division and HHS' Office of Inspector General, the agencies are not just sharing data — they're streamlining case development, investigative lead and whistleblower intake mechanisms. This is the sort of operational synergy that makes for faster investigations and more impactful settlements.

While it takes serious effort to create this unity, the creation of an actual enforcement task force suggests a more coordinated, top-down approach, and less press release fanfare. In this environment, companies should expect quicker-than-anticipated action.

This new partnership comes at a moment when the DOJ has good reason to be emboldened. On April 29, a federal jury **found** that CVS Health Corp. caused the submission of false claims by its subsidiary, Omnicare Inc., which dispensed thousands of prescriptions to long-term care facility residents without proper physician authorization.[4]

On July 9, the U.S. District Court for the Southern District of New York **imposed** a whopping $948.8 million in penalties and damages,[5] in a case that will most certainly be appealed. The case, and the imposition of severe damages,[6] shows that the government is capable of winning large, complex healthcare fraud trials, even against well-resourced defendants and extremely competent counsel.

This win follows a multiyear trend of high-dollar recoveries, often driven by qui tam whistleblowers and relators, including the following.

- In July 2024, two mental healthcare providers, Texas Behavioral Health PLLC and United Psychiatry Institute LLC, agreed to pay over $1 million to resolve FCA allegations regarding claim submissions over the course of three years of false billing to Medicare Part B.[7]

- In November, the U.S. Department of Justice, alongside 18 state attorneys general, **announced** a settlement with QOL Medical LLC, involving $47 million related to kickbacks and FCA allegations.

- In March, the DOJ **announced** that Seoul Medical Group Inc. and its partner radiology group, Advanced Medical Management Inc., agreed to pay over $62 million to resolve claims of false diagnosis codes to increase Medicare Part C payments.[9]

These results unquestionably reinforce the incentive structure Congress created through the FCA's relator provisions, as amended in 1986, and likely bolster the department's focus on such fraud.

In a world of changing, and perhaps narrowed, white collar prioritizations, stakeholders should take note of these recent developments. Recoupment of more than $2.9 billion in 2024, including $1.7 billion related to healthcare, outpaced the 2023 recovery of $2.7 billion, $1.8 billion of which related to healthcare.[10]

The DOJ continues to pursue greater fines and penalties, likely searching for the holy grail of recoveries, like in 2021, when the DOJ recouped more than $5 billion in total.[11]

In addition to these civil recoveries, the DOJ's Criminal Division recently **announced** the results of the "2025 National Health Care Fraud Takedown."[12]

This nationwide takedown involved criminal charges against 324 individuals, including 96 licensed medical professionals, and alleged over $14.6 billion in intended losses to federal programs.[13] Charges include kickbacks, billing for medically unnecessary services, and fraudulent telemedicine schemes.[14]

The DOJ-HHS partnership should also be understood as a strategic investment in whistleblower development.[15] The government has been vocal in recent months about its desire to encourage more insiders to come forward in several areas, such as antitrust violations and DEI,[16] and this partnership adds muscle to that policy objective.

By making it easier to refer complaints, share documentation and process qui tam disclosures, the DOJ and HHS are effectively making the path smoother for whistleblowers — which could yield more results for government counsel too.

This should serve as a continued wake-up call for the healthcare industry. The whistleblower who may have once feared silence and inaction is now empowered by a federal apparatus that is more operationally aligned and incentivized to act. Whether more whistleblowers actually result in more investigations and litigation is yet to be seen.

But while the DOJ and HHS continue to sharpen their focus, this development further encourages whistleblowers of all kinds to speak up and do so loudly. Similarly, the use of data mining and artificial intelligence to detect fraud, coupled with the subsequent use of HHS' payment suspension mechanism, could yield quick turnarounds on initial investigations.

For healthcare providers, the implications are nonetheless clear. The traditional approach of treating FCA risk as a remote litigation issue no longer suffices. Instead, compliance programs must be proactive and well resourced, but nonetheless nimble.

This includes regularly updating internal controls and training materials; enhancing reporting mechanisms that allow employees to flag issues internally before they escalate; and auditing billing practices, medical documentation and contractual relationships when appropriate.

Moreover, providers must consider their exposure from past conduct. Cases that might have once been too resource-intensive to pursue may now find traction from within the department.

This partnership signals more than an interagency handshake. It reveals a long-term enforcement horizon in which the DOJ will not only continue to prioritize FCA cases in healthcare, but will likely increase the speed and sophistication of its investigations.

While the private sector continues to wait and see how the second Trump administration will handle corporate crime, this message appears unmistakable: The DOJ sees FCA enforcement not as a legacy initiative, but as a future-facing tool to recover government funds and deter fraud, and whistleblowers are listening.

For healthcare entities, the time to reassess compliance infrastructure is now. For whistleblowers, the pathway to being heard — and rewarded — has never been clearer. The DOJ and HHS have drawn the initial road map. The question is whether industry will take notice.

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[1] U.S. Department of Justice, Press Release: "DOJ-HHS False Claims Act Working Group" (July 1, 2025), available at https://www.hhs.gov/sites/default/files/hhs-doj-false-claims-act-working-group.pdf.

[2] Id.

[3] Pub. L. No. 119-21.

[4] U.S. Department of Justice, Press Release: "Statement Of U.S. Attorney Jay Clayton On The Verdict In U.S. V. Omnicare And CVS Health Corporation" (Apr. 29, 2025), available at https://www.justice.gov/usao-sdny/pr/statement-us-attorney-jay-clayton-verdict-us-v-omnicare-and-cvs-health-corporation.

[5] Healthcare Dive, Dive Brief: "CVS Omnicare ordered to pay $949 million in government fraud case" (July 9, 2025), available at https://www.healthcaredive.com/news/cvs-omnicare-949-million-government-fraud-penalty/752544/.

[6] Id. ("Under the federal False Claims Act, the Government is entitled to three times the amount of these assessed damages, or $406,778,442, plus statutory penalties to be determined by the Court.").

[7] U.S. Department of Justice, Press Release: "Mental health services providers pay over a million to settle false claims liability" (July 24, 2024), available athttps://www.justice.gov/usao-sdtx/pr/mental-health-services-providers-pay-over-million-settle-false-claims-liability.

[8] https://www.regulatoryoversight.com/2025/02/doj-and-18-states-reach-false-claims-act-settlement-with-qol/.

[9] U.S. Department of Justice, Press Release: "Medicare Advantage Provider Seoul Medical Group and Related Parties to Pay Over $62M to Settle False Claims Act Suit" (Mar. 26, 2025), available at https://www.justice.gov/opa/pr/medicare-advantage-provider-seoul-medical-group-and-related-parties-pay-over-62m-settle.

[10] U.S. Department of Justice, Fraud Statistics - Overview, available

at https://www.justice.gov/archives/opa/media/1384546/dl.

[11] Id.

[12] U.S. Department of Justice, Press Release: "National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud" (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[13] Id.

[14] Id.

[15] Supra note 1 at 2 (encouraging whistleblowers for healthcare fraud, waste, abuse, and mismanagement).

[16] U.S. Department of Justice, Press Release: "Justice Department's Antitrust Division Announces Whistleblower Rewards Program" (July 8, 2025), available at https://www.justice.gov/opa/pr/justice-departments-antitrust-division-announces-whistleblower-rewards-program; U.S. Department of Justice, Press Release: "Justice Department Establishes Civil Rights Fraud Initiative" (May 19, 2025), available at https://www.justice.gov/opa/pr/justice-department-establishes-civil-rights-fraud-initiative.