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Gavel to Gavel: DOJ and HHS re-establish a False Claims Act Working Group

By: Isabel Mulino // GableGotwals // August 27, 2025

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The Department of Justice ("DOJ") and the Department of Health and Human Services ("HHS") announced the re-establishment of a DOJ-HHS False Claims Act ("FCA") Working Group, originally created in 2020, to combat healthcare fraud in the United States. The working group is jointly led by senior officials from both agencies, including the HHS Office of General Counsel, the Centers for Medicare & Medicaid Services Center for Program Integrity, the HHS Office of Inspector General, and DOJ's Civil Division. This partnership reflects the government's ongoing commitment to use the FCA as a central enforcement tool against fraud, waste, and abuse in federal healthcare programs.

Under the FCA, any person who knowingly submits false claims to the government may be liable for up to three times the actual damages, plus additional penalties for each violation. In 2024, the federal government secured over $2.9 billion in settlements and judgments related to fraudulent claims. Yet only $93 million involved HHS cases, representing the lowest recovery amount since 2009. The working group is expected to meet monthly and expand the use of whistleblower incentives and advanced analytical tools, including artificial intelligence and data mining, to accelerate investigations and pinpoint fraudulent activity earlier.

The Working Group identified the following priority areas:

- 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 impact patient safety
- Manipulation of Electronic Health Records systems to drive inappropriate utilization of Medicare covered products and services

Stronger cross-agency collaboration is expected to streamline FCA investigations, increasing the use of tools such as pre-liability payment suspensions which can pose significant financial risks to healthcare providers well before a prosecution is completed. This approach signals more aggressive and selective enforcement and may lead to an increase in swift dismissals to focus resources on high-impact cases.

Healthcare payers and providers, particularly those in priority sectors, should enhance compliance programs, especially data analytics and internal reporting, to address increased scrutiny, evolving enforcement tactics, and mitigate risk.

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