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False Claims Act Roundup Series: Q2 2026 – Federal and State Agencies Use Data to Operationalize Enforcement

Health Care Law Brief on **September 23, 2026**

In our Q1 2026 update, we reported on the Trump Administration's new fraud-enforcement initiatives — the creation of the FCA Working Group, the National Fraud Enforcement Division, and the White House Task Force on fraud reduction — and the record-setting $6.8 billion in False Claims Act ("FCA") recoveries for fiscal year 2025.

In Q2 2026, the Department of Justice ("DOJ") operationalized that new architecture. The use of data analytics is a common thread linking DOJ's newest enforcement initiatives. Data analytics are key to DOJ's multi-district strike forces, Medicare Advantage ("MA") risk-adjustment actions, *qui tam* prioritization, and State Medicaid enforcement. The government's message is clear: the same data that health care providers, digital health platforms, managed care organizations, and others in the industry are collecting and reporting to the government are being used to drive enforcement actions against these stakeholders.

From Enforcement Architecture to Enforcement Engine: DOJ's FOCUS Initiative and Data-Driven FCA Strategy

On April 30, 2026, DOJ's Civil Division announced the FOCUS Initiative (Fraud Oversight through Careful Use of Statistics), an anti-fraud program designed to reinforce the Department's relationship with data-miner whistleblowers — relators who file *qui tam* complaints based on publicly available government data rather than personal, insider knowledge. DOJ's FOCUS Initiative responds to a rapid increase in data-analytics-driven *qui tam* filings and follows other data analytics initiatives including the National Fraud Detection Center, the Health Care Fraud Data Fusion Center, and the Centers for Medicare & Medicaid Services' ("CMS") explainable-AI challenge to detect anomalies in Medicare claims data.

DOJ reported that more than 780 *qui tam* complaints have already been filed in fiscal year 2026. FOCUS will prioritize high-quality data miner *qui tam* actions and provide guidance to relators and their counsel on how to frame data-driven complaints. For health care providers and other federal funding recipients, the risk is not merely more enforcement; rather, it is more enforcement based on the same publicly available data patterns that are simultaneously accessible to regulators, analytics vendors, and relators.

Key Takeaways

Providers and other federal funding recipients should:

- Conduct reviews of publicly available data associated with your organization to identify anomalies with potential data-miner relators in mind.
- Monitor DOJ priority areas and FOCUS guidance for signals about which data patterns are attracting enforcement attention.
- Evaluate and possibility remediate anomalous billing or certification patterns before those patterns become the focus of government attention.

DOJ Turns West: The West Coast Health Care Fraud Strike Force

As we've previously covered, DOJ announced the West Coast Health Care Fraud Strike Force, a multidistrict initiative uniting the Fraud Division's Health Care Fraud Section with the U.S. Attorneys' Offices for Arizona, Nevada, and the Northern District of California, along with HHS's Office of Inspector General ("OIG"), the Federal Bureau of Investigation, and the Drug Enforcement Administration. DOJ described an "urgent and undeniable" need for coordinated action and a "whole-of-government" approach, citing the migration of fraud schemes to Arizona and Nevada and characterizing Silicon Valley as "ground zero" for technology-driven health care fraud.

DOJ cited enforcement actions already taken in the region, including Arizona wound graft schemes, the conviction of two executives of a digital technology company arising from a $100 million illegal Adderall distribution and health care fraud scheme, and an alleged Arizona Medicaid scheme involving a Pakistan-based medical billing company. DOJ's focus on telehealth platforms, digital prescribing models, and technology-enabled fraud signals heightened scrutiny for digital health companies and their investors. For example, in June 2026, San Francisco-based Circle Medical Technologies agreed to pay $3.3 million to settle allegations that its telemedicine platform submitted claims under the names of physicians who did not actually provide or supervise the telehealth services rendered.

Key Takeaways

- Providers, platforms, and investors in the West should monitor the enforcement environment and take proactive steps to avoid government scrutiny.
- Billing data, marketing arrangements, online prescribing models, and executive oversight will face heightened scrutiny.
- Telehealth platforms should expect particular attention to provider supervision requirements, proper credentialing, and accurate identification of rendering providers on claims — as illustrated by the Circle Medical settlement and the ongoing Done Global, Inc. prosecution.

MA Risk Adjustment: Enforcement Intensifies Beyond the Headline Settlements

Building on the record Q1 settlements involving Aetna and Kaiser, Q2 brought further enforcement targeting the accuracy of MA diagnosis codes. On June 3, 2026, DOJ announced that Matrix Medical Network, HealthFair, and HealthFair founder Shahriah "James" Ekbatani agreed to pay $56.5 million to resolve FCA allegations involving their false or invalid diagnosis codes submission to the MA program. To resolve those allegations, Matrix will pay $36.5 million, HealthFair $5 million, and Ekbatani $15 million. The cases[1] were brought by two *qui tam* relators, who will receive $7.3 million and $3.6 million, respectively.

As part of the resolution, DOJ specifically alleged that Matrix used in-home health assessments to report chronic conditions — including proliferative diabetic retinopathy, drug-induced polyneuropathy, atrial fibrillation, rheumatoid arthritis, and COPD — without sufficient clinical information or supporting provider diagnoses. HealthFair allegedly reported unsupported diagnoses including HIV/AIDS, metastatic cancer, Myasthenia Gravis, and congestive heart failure contradicted by testing. DOJ emphasized that diagnosis codes must be "supported by the beneficiaries' medical records and be accurate, complete, and truthful, based on the best knowledge, information, and belief" of the MA organization ("MAO").

Separately, OIG's May 2026 audit found that CMS potentially overpaid MAOs $462 million for certain unsupported acute stroke diagnosis codes. For all 97 sampled enrollees, high-risk acute stroke codes submitted to CMS were not supported by medical records. OIG recommended that CMS implement procedures to prevent overpayments when acute stroke codes appear on physician data records without corresponding inpatient or outpatient hospital data records. CMS has completed its phase-in of the 2024 CMS-HCC model in calendar year 2026, expanded RADV audits, and stated it plans to deploy advanced data analytics to review records and flag potentially unsupported diagnoses.

Key Takeaways

- MA risk-adjustment oversight should be enterprise-wide and be vendor-management focused, in addition to coding-focused.
- Organizations using in-home health assessments or third-party coding vendors should audit the clinical basis for submitted diagnoses.
- Regulations requiring annual data-accuracy attestations and the 60-day overpayment return obligation create ongoing exposure for organizations that delay internal auditing.

Qui Tam Developments: Whistleblower Prioritization, Fast-Track Review, and Retaliation Protections

On May 27, 2026, DOJ issued an *Accelerating Review and Enhancing Enforcement in Benefits Fraud Matters* memorandum, which created a fast-track process for whistleblower complaints involving federally funded, state-administered benefits programs. Under the new process, DOJ aims to complete review of these complaints within 60 days — and no later than 120 days — before deciding whether to give primary responsibility to the whistleblower, investigate further, or seek dismissal.

Meanwhile, the Supreme Court declined to review Eli Lilly's challenge to a $193 million Medicaid drug fraud judgment[2]. Eli Lily's *certiorari* petition raised an Article II challenge to the constitutionality of the *qui tam* mechanism. While the Court declined to address this issue now, the Article II challenge remains live in other FCA disputes (covered here and here)[3]. Meanwhile, the Ninth Circuit in *Adelstein* vacated summary judgment against a physician's FCA retaliation claim, holding that the physician's internal complaint about fraudulent billing and Medicaid fraud constituted protected activity under 31 U.S.C. § 3730(h) and that sufficient evidence supported a genuine dispute regarding retaliation.[4]

Key Takeaways

- The fast-track review process means certain *qui tam* complaints may move to active investigation more quickly, compressing the window for voluntary self-disclosure.
- The Ninth Circuit's broad reading of protected activity under section 3730(h) of the FCA reinforces the need for compliance programs that treat internal fraud complaints as potential whistleblower-protected conduct from the outset.

State Medicaid Enforcement and State Attorneys General: Multi-Front Exposure Grows

State enforcement activity in Q2 signals continued aggressive enforcement from State Medicaid Fraud Control Units ("MFCUs"). Massachusetts Attorney General Andrea Joy Campbell sued UnitedHealthcare, alleging it falsely manipulated MassHealth Senior Care Options members' health statuses to obtain higher payments. The complaint estimates at least $100 million in alleged MassHealth fraud, alleging that United improperly classified members at higher-acuity levels using unsupported diagnoses, failed to disclose or repay inflated payments after internal reviews, and misrepresented members' need for daily skilled nursing services. Elsewhere, the West Virginia Attorney General announced a $325,000 Medicaid fraud settlement with Muhammad Salman and Bridgeport Pharmacy, and an Ohio dentist agreed to pay $500,000 to resolve allegations of billing Medicaid for services provided by an excluded provider.

The federal government has also been active in the Medicaid space. HHS and CMS announced a deferral of Medicaid funding from California and a six-month moratorium on new Medicare enrollments for hospices and home health agencies nationwide, stating it would use the moratorium period to intensify targeted investigations and deploy advanced data analytics to identify bad actors. DOJ also announced the 2026 National Health Care Fraud Takedown at the end of June. This coordinated DOJ/OIG enforcement action resulted in charges against 455 defendants involving over $6.5 billion in false claims across 56 federal districts, with 50 MFCUs participating, over $182 million in asset seizures, CMS suspensions of 1,079 providers, and revocation of billing privileges for 1,403 providers.

Key Takeaways

- Multi-state providers and payors with Medicaid managed care, senior care, or in-home service exposure should expect state AGs to pursue risk-adjustment and payment-accuracy theories parallel to — and independent of — federal enforcement.
- The CMS enrollment moratorium and California Medicaid deferral demonstrate that CMS is willing to use administrative tools alongside litigation to discipline program participation.
- The scale of the National Health Care Fraud Takedown underscores that coordinated federal-state enforcement is now a permanent feature of the FCA landscape.

Q2 2026 confirms that data is the common thread across the enforcement landscape. Federal and state agencies are using data analytics to power *qui tam* filings, data fusion centers to support strike forces, data-driven audits of risk-adjustment submissions, and data-informed state enforcement actions. For health care organizations, the imperative is to treat your own data as the government and relators already do: as a map to potential liability and a catalyst for self-evaluation and, where necessary, repayment and/or self-disclosure.

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[1] *United States ex rel. Cahill v. Matrix*, No. 19-CV-11153 (S.D.N.Y.); *United States ex rel. Oristaglio v. Community Care Health Network, Inc.*, No. 4:22-CV-00133 (E.D. Tex.)

[2] *Eli Lilly and Co. v. United States ex rel. Streck*, No. 25-1126 (May 18, 2026).

[3] The 11th Circuit issued its opinion in *Zafirov* on September 1, 2026. The Court upheld the constitutionality of the *qui tam* provision. Slip Op. at 3.

[4] *Adelstein v. PeaceHealth, Inc.*, No. 25-605 (9th Cir. Apr. 17, 2026).

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