PRESS RELEASE

False Claims Act Settlements and Judgments Exceed $2.68 Billion in Fiscal Year 2023

Thursday, February 22, 2024

For Immediate Release

Office of Public Affairs

Highest Number of Settlements and Judgements in History

Settlements and judgments under the False Claims Act exceeded $2.68 billion in the fiscal year ending Sept. 30, 2023, Acting Associate Attorney General Benjamin C. Mizer and Civil Division Principal Deputy Assistant Attorney General Brian M. Boynton announced today. The government and whistleblowers were party to 543 settlements and judgments, the highest number of settlements and judgments in a single year. Recoveries since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than $75 billion.

“Protecting taxpayer dollars from fraud and abuse is of paramount importance to the Department of Justice – and these enforcement figures prove it,” said Acting Associate Attorney General Mizer. “The False Claims Act remains one of our most important tools for rooting out fraud, ensuring that public funds are spent properly, and safeguarding critical government programs.”

The False Claims Act imposes treble damages and penalties on those who knowingly and falsely claim money from the United States or knowingly fail to pay money owed to the United States. The False Claims Act thus serves to safeguard government programs and operations that provide access to medical care, support our military and first responders, protect American

businesses and workers, help build and repair infrastructure, offer disaster and other emergency relief, and provide many other critical services and benefits.

“As the record-breaking number of recoveries reflects, those who seek to defraud the government will pay a high price,” said Principal Deputy Assistant Attorney General Boynton, head of the Justice Department's Civil Division. “The American taxpayers deserve to know that their hard-earned dollars will be used to support the important government programs and operations for which they were intended.”

Of the more than $2.68 billion in False Claims Act settlements and judgments reported by the Department of Justice this past fiscal year, over $1.8 billion related to matters that involved the health care industry, including managed care providers, hospitals, pharmacies, laboratories, long-term acute care facilities, and physicians. The amounts included in the $1.8 billion reflect recoveries arising only from federal losses, but in many of these cases, the department was instrumental in recovering additional amounts for state Medicaid programs. The recoveries in fiscal year 2023 also reflect the department’s focus on key enforcement priorities, including fraud in pandemic relief programs and alleged violations of cybersecurity requirements in government contracts and grants.

In 1986, Congress strengthened the False Claims Act by increasing incentives for whistleblowers to file lawsuits alleging false claims on behalf of the government. These whistleblower, or qui tam, actions comprise a significant percentage of the False Claims Act cases that are filed. Qui tam cases may be pursued by the government or the whistleblower, and this past year significant recoveries were obtained by both. When a qui tam action is successful, the whistleblower, also known as the relator, typically receives a portion of the recovery ranging between 15% and 30%. Whistleblowers filed 712 qui tam suits in fiscal year 2023, and this past year the Justice Department reported settlements and judgments exceeding $2.3 billion in these and earlier-filed suits.

Representative examples of False Claims Act matters pursued by the government and whistleblowers are discussed below.

HEALTH CARE FRAUD

In fiscal year 2023, health care fraud remained a leading source of False Claims Act settlements and judgments. These recoveries restore funds to federal programs such as Medicare, Medicaid, and TRICARE, the health care program for service members and their families. But just as important, enforcement of the False Claims Act deters others who might try to cheat the system for their own gain, and in many cases, also protects patients from medically unnecessary or potentially harmful actions. As in years past, the act was used to pursue matters involving a wide array of health care providers, goods, and services.

Medicare Advantage Matters

The Justice Department continued to pursue cases alleging false claims in the Medicare Advantage (or Medicare Part C) program, including allegations that organizations participating in the program knowingly submitted or caused the submission of inaccurate information or knowingly failed to correct inaccurate information about the health status of beneficiaries enrolled in their plans to increase reimbursement. As Medicare Part C is now the largest component of Medicare, both in terms of federal dollars spent and the number of beneficiaries, the work of the Justice Department in this area is of critical importance.

The Cigna Group agreed to pay $172 million to resolve allegations that it knowingly submitted and failed to withdraw inaccurate and untruthful diagnosis codes for its Medicare Advantage Plan enrollees to increase its payments from Medicare. The United States alleged that while Cigna engaged in a "chart review" program to submit additional diagnosis codes to Medicare for reimbursement, it failed to withdraw inaccurate or untruthful diagnosis codes previously submitted. The United States further alleged that Cigna paid vendors to conduct in-home assessments of enrollees, and then improperly reported diagnosis codes based solely on forms completed by those vendors without performing or ordering the diagnostic testing or imaging necessary to reliably diagnose the serious conditions reported.

Martin's Point Health Care Inc. agreed to pay $22.5 million to resolve allegations that it knowingly submitted inaccurate diagnosis codes for its Medicare Advantage Plan enrollees that were not supported by the patients' medical records to increase reimbursements from Medicare.

In addition to securing these settlements, the Justice Department continued to litigate a number of other cases involving the Medicare Advantage program, including actions against **UnitedHealth Group**, **Independent Health Corporation**, **Elevance Health (formerly Anthem)**, and the **Kaiser Permanente** consortium.

Unnecessary Services and Substandard Care

The Justice Department also pursued and resolved matters in which providers billed federal health care programs for medically unnecessary services and substandard care. The provision of such medical services not only wastes taxpayer funds but also can expose patients to harmful procedures and treatments or cause them to forego other potentially more effective treatments.

Cornerstone Hospital Medical Center and related entities agreed to pay $21.6 million to resolve allegations that the former long-term acute care facility knowingly submitted claims for services performed by unlicensed and unauthorized students, and services that were not provided or effectively worthless.

Smart Pharmacy Inc., SP2 LLC, and Gregory Balotin agreed to pay at least $7.4 million to resolve allegations that they unnecessarily added the antipsychotic drug aripiprazole to topical

compounded pain creams to boost federal reimbursement for the compounded creams and waived patient copayments. The United States alleged that the defendants crushed aripiprazole pills approved for oral use and included them in compounded creams used topically for pain treatment, while knowing that there was not an adequate clinical basis to do so.

Saratoga Center for Rehabilitation and Skilled Nursing Care, related entities, and operators and owners Leon Melohn, Alan "Ari" Schwartz, Jeffrey Vegh, and Jack Jaffa agreed to pay $7.1 million to resolve allegations that Saratoga Center delivered worthless services to residents, resulting in medication errors, unnecessary falls, and the development of pressure ulcers, and that the facility's physical conditions deteriorated to such a degree that the facility did not consistently maintain hot water, have an adequate linen inventory, or dispose of solid waste.

Opioid Epidemic

The Justice Department has continued its pursuit of health care providers, pharmaceutical companies, pharmacies, and other entities that have played a role in contributing to and exacerbating the opioid crisis.

This year, the Justice Department filed a complaint in intervention in a whistleblower lawsuit against **Rite Aid Corporation** and various subsidiaries alleging that Rite Aid filled unlawful prescriptions for controlled substances in violation of the False Claims Act and the Controlled Substances Act. The United States alleges that from May 2014 through June 2019, Rite Aid knowingly filled unlawful prescriptions for controlled substances that lacked a legitimate medical purpose, were not for a medically accepted indication, or were not issued in the usual course of professional practice. These unlawful prescriptions included, for example, prescriptions for the dangerous and highly abused combination of drugs known as "the trinity," prescriptions for excessive quantities of opioids, such as oxycodone, fentanyl, and prescriptions issued by prescribers whom Rite Aid pharmacists had repeatedly identified internally as writing illegitimate prescriptions.

The Justice Department filed a proof of claim in the Chapter 11 bankruptcy action commenced by **Endo Health Solutions Inc.** and related corporate entities, alleging that Endo violated the FCA and caused hundreds of millions of dollars of losses to federal health care programs by causing the submission of false and fraudulent claims for prescriptions of Opana ER, a Schedule II opioid. The Department alleged that Endo used an aggressive marketing scheme that marketed Opana ER to high volume prescribers of opioids, including many prescribers who Endo knew were prescribing Opana ER or other opioids for non-medically accepted indications.

Unlawful Kickbacks

Kickbacks paid or received by health care providers undermine the integrity of federal health care programs by tainting medical decision-making, increasing health care costs, and adversely affecting competition. Federal law prohibits the willful solicitation or payment of illegal

remuneration to induce the purchase of a good or service paid for by a federal health care program.

The Justice Department filed claims against multiple **Modern Vascular** office-based labs, affiliated companies, and its owner Yury Gampel, alleging that Gampel and the Modern Vascular defendants offered referring physicians various forms of remuneration, including the opportunity to invest in Modern Vascular office-based labs with the prospect of large monetary distributions, to induce them to refer their patients to Modern Vascular for the treatment of peripheral arterial disease. The complaint also alleged that Gampel pressured vascular surgeons and interventional radiologists employed at the Modern Vascular office-based labs to increase the number of invasive surgical procedures performed.

Cardiac Imaging Inc. and its founder, owner, and CEO Sam Kancherlapalli, agreed to pay $85.5 million to resolve allegations that, with Kancherlapalli's oversight and approval, Cardiac Imaging paid kickbacks to cardiologists in the form of above-fair market value supervision fees, to induce those doctors to refer their patients to Cardiac Imaging for PET scans. The United States alleged that these fees substantially exceeded fair market value for the doctors' services and included time the doctors were away from the Cardiac Imaging mobile scanning units or were not even on site.

Carter Healthcare LLC and its President Stanley Carter and Chief Operations Officer Bradley Carter agreed to pay $22.9 million to resolve allegations that Carter Healthcare improperly paid renumeration to physicians under the guise of medical directorships to induce referrals of home health patients.

The Justice Department announced two resolutions involving kickbacks relating to electronic health records (EHR). **Modernizing Medicine Inc.** (ModMed) agreed to pay $45.4 million to resolve allegations that it improperly solicited and received kickbacks from a lab company in exchange for recommending and arranging for ModMed's users to utilize the lab company's pathology lab services, conspired with the lab company to improperly donate ModMed's EHR technology to health care providers, and paid kickbacks to its customers and other influential sources to recommend ModMed's technology and refer potential customers to ModMed. The government further alleged that ModMed knew that its EHR technology did not always allow physician users to electronically record medical records using the required standard vocabularies, thereby causing certain of its users to submit false claims for incentive payments under the Department of Health and Human Services' EHR Incentive Programs. **NextGen Healthcare Inc.** agreed to pay $31.2 million to resolve allegations that it misrepresented the capabilities of certain versions of its EHR software by using an auxiliary product that was designed only to meet government certification criteria and otherwise was lacking in critical functionality. The government further alleged that NextGen provided unlawful remuneration in the form of credits, often worth as much as $10,000, along with tickets to sporting events and

entertainment, that it gave to current customers whose recommendation of NextGen's software led to a new sale.

The Justice Department also resolved numerous matters involving laboratories and their recruiters allegedly paying doctors kickbacks disguised as legitimate payments. Five corporate entities and ten individuals paid over $2.6 million to settle allegations of kickbacks for laboratory referrals, including sham investment distributions from management service organizations (MSOs). For example, executive **Peggy Borgfeld** agreed to pay $325,000 and be excluded from federal healthcare programs for five years to resolve allegations that she falsely certified to Medicare that certain laboratory testing claims complied with the Anti-Kickback Statute, and **Dr. Chad Shelton**, **Dr. Michael Boedefeld**, and their medical practice agreed to pay $396,360 to settle allegations of receiving MSO kickbacks in return for their laboratory referrals. These settlements are part of an ongoing investigation that to date has resulted in settlements with 43 physicians and recoveries of over $46 million.

Other Health Care Fraud

The Justice Department continued to pursue claims arising from alleged fraud in California's Medicaid program in connection with coverage of the previously uninsured "Adult Expansion" population under the Patient Protection and Affordable Care Act. Santa Barbara San Luis Obispo Regional Health Authority, doing business as **CenCal Health, a county-organized health system, and seven providers in the system, Cottage Health System, Sansum Clinic, Community Health Centers of the Central Coast**, **Lompoc Valley Medical Center**, **Dignity Health, as well as Twin Cities Community Hospital and Sierra Vista Regional Medical Center**, two subsidiaries of Tenet Healthcare Corporation, agreed to pay a combined total of $95.5 million to resolve allegations that they made or received payments that were not for "allowed medical expenses" under CenCal's contract with the state, were pre-determined amounts that did not reflect fair market value, were duplicative of services already required to be rendered, and were unlawful gifts of public funds in violation of the state constitution.

BioTelemetry Inc. and its subsidiary CardioNet LLC, agreed to pay nearly $45 million to resolve allegations that they submitted claims for heart monitoring tests that were evaluated, in part, outside the United States, in violation of federal law. The United States further alleged that most of the offshore technicians tasked with reviewing heart test data did not have the basic qualifications to evaluate the tests in question.

Lincare Holdings Inc. agreed to pay $29.0 million to resolve allegations that it fraudulently billed Medicare Advantage plans and Medicare Part B for oxygen equipment rental payments. While many Medicare Advantage plans and Medicare Part B "capped" oxygen equipment rental payments at 36 months, Lincare admitted that it improperly billed government health care plans for oxygen equipment rental payments and co-payments after it had already received three years of payments. Lincare not only admitted to improperly billing Medicare for oxygen

equipment rentals, but also admitted to improperly collecting co-pays from beneficiaries and, as part of the settlement, agreed to timely identify and refund all beneficiary co-pays that it had improperly collected, and to implement additional corrective actions in order to ensure appropriate billing going forward.

Advanced Bionics LLC, agreed to pay more than $11.0 million to resolve allegations that it misled federal health care programs regarding the radio-frequency (RF) emissions generated by some of its cochlear implant processors, which can potentially interfere with other devices that use the same RF spectrum, such as telephones, alarm and security systems, televisions, and radios. The settlement resolved allegations that the company, in submitting pre-market approval applications to the Food and Drug Administration for the company's Neptune and Naida cochlear implant processors, made false claims regarding the methods it used in its RF emissions tests.

PROCUREMENT FRAUD

The government continued its pursuit of fraud matters involving the purchase of goods and services in connection with military and similar programs. Fraud in these programs not only squanders government funds, but also potentially puts servicemembers at risk.

In one of the largest procurement settlements ever, **Booz Allen Hamilton Holding Corporation** paid $377 million to resolve allegations that it improperly billed its government contracts for costs incurred in its non-governmental commercial and international contracts. The government alleged that Booz Allen improperly allocated to government contracts indirect costs associated with its non-government contracts that either had no relationship to the government contracts or were allocated to those contracts in disproportionate amounts. Further, the United States alleged that Booz Allen failed to disclose to the government the method by which it accounted for costs supporting its commercial and international businesses. As a result, Booz Allen was alleged to have obtained reimbursement from the United States for the costs of non-governmental activities that provided no benefit to the United States.

L3 Technologies Inc. agreed to pay $21.8 million to resolve allegations that in contract proposals for equipment provided to the military, L3 included the cost of certain items, such as nuts and bolts, twice.

The Boeing Company agreed to pay $8.1 million to resolve allegations that it submitted false claims and made false statements in connection with U.S. Navy contracts to manufacture the V-22 Osprey, a military aircraft. The United States alleged that Boeing failed to comply with certain contractual manufacturing specifications in fabricating composite components for the V-22, including failing to perform monthly testing on autoclaves used in the composite cure process.

PANDEMIC FRAUD

In response to the COVID-19 crisis, Congress authorized historic levels of emergency funding for federal agencies to provide direct financial assistance to individuals, businesses, and state, local, and Tribal governments. The Justice Department's efforts in this area have included the pursuit of cases involving improper payments under the Paycheck Protection Program (PPP), which was enacted to provide loans guaranteed by the U.S. Small Business Administration (SBA) to eligible small businesses for payroll, rent, utility payments, and other business-related costs. Over the last year, the department has resolved approximately 270 False Claims Act matters, recovering over $48.3 million in connection with improper PPP loans. The department has also pursued other pandemic related fraud, including schemes by health care providers to profit from the pandemic by billing for unnecessary tests and services.

Victory Automotive Group Inc. agreed to pay more than $9 million to resolve allegations that it provided false information in support of a PPP loan forgiveness application. Although the company's application certified it was a small business with fewer than 500 employees, Victory shared common operational control with dozens of automobile dealerships across the country, totaling more than 3,000 employees. For that reason, it was not eligible for the PPP loan it received, which was later forgiven in full.

Coyne Public Relations LLC paid $2.24 million to resolve allegations that it received a PPP loan even though it was ineligible for the loan because it was a required registrant under the Foreign Agent Registration Act.

John Seasholtz and four agricultural companies he owns agreed to pay more than $600,000 to resolve allegations that they violated the False Claims Act by improperly inflating the employee headcount on the companies' PPP loan applications by impermissibly including non-employee contract workers who were, in fact, employed by other, unrelated entities. The companies also agreed to repay loan funds relating to the ineligible contractors, thereby relieving the SBA of liability for approximately $1.8 million in loan guarantees.

In April 2023, the Department filed two proofs of claim in the Chapter 11 bankruptcy action commenced by Kabbage Inc., doing business as KServicing, alleging violations of the FCA in connection with thousands of federally guaranteed PPP loans that were approved or processed by Kabbage. In the **first proof of claim**, the United States alleged that Kabbage systemically miscalculated tens of thousands of PPP loans, causing the SBA to guarantee loans in inflated amounts that exceeded what borrowers were eligible to receive under program rules. In its **second proof of claim**, the United States alleged Kabbage knowingly failed to implement appropriate fraud controls to comply with applicable Bank Secrecy Act/Anti-Money Laundering (BSA/AML) requirements, resulting in fraudulent claims for PPP processing fees, in addition to false claims for loan forgiveness and guarantees on fraudulent loans. The United States alleged that as a result of these schemes the government suffered losses in excess of $60 million.

The Justice Department filed claims against **Patrick Britton-Harr**, Provista Health LLC, and multiple laboratory companies owned by him for submitting claims for laboratory tests that were not ordered by health care providers, not medically necessary, or not performed. In its complaint, the United States alleged Britton-Harr owned and operated multiple corporate entities that allegedly sought to profit from the COVID-19 pandemic by offering COVID-19 tests to nursing homes as a way to bill Medicare for a wider array of medically unnecessary respiratory pathogen panel tests, many of which were never ordered by treating physicians.

CYBER-FRAUD INITIATIVE

The Department's effort to combat cybersecurity threats includes the Civil Cyber-Fraud Initiative, which was announced in October 2021. The Initiative is dedicated to using the False Claims Act to promote cybersecurity compliance by government contractors and grantees by holding them accountable when they knowingly violate applicable cybersecurity requirements.

Jelly Bean Communications Design LLC and its manager paid $293,771 to resolve allegations that they failed to secure personal information on a federally funded Florida children's health insurance website, which Jelly Bean created, hosted, and maintained. The settlement resolved allegations that, contrary to its representations and commitments, Jelly Bean did not provide secure hosting of applicants' personal information and instead knowingly failed to properly maintain, patch, and update the software systems. The site was attacked, potentially exposing the information of 500,000 applicants.

The Justice Department also settled for over $4 million with **Verizon Business Network Services LLC**, which disclosed and remediated cybersecurity failures on contracts to provide trusted internet connections to the General Services Administration. In connection with the settlement, the company took a number of significant steps entitling it to credit for cooperating with the government, including providing the government with a written self-disclosure, initiating an independent investigation and compliance review of the issues, and providing the government with multiple detailed supplemental written disclosures.

OTHER FRAUD RECOVERIES

The judgments, settlements, and lawsuits announced during fiscal year 2023 involved a variety of other programs and schemes that reflect the diversity of the government's False Claims Act enforcement efforts.

GCI Communications Corp. agreed to pay $40 million to resolve allegations that it inflated its prices and violated Federal Communications Commission competitive bidding regulations in connection with GCI's participation in the FCC's Rural Health Care Program. The program provides funding each year to assist rural health care providers with their telecommunications needs. The United States alleged that GCI failed to comply with FCC regulations that governed how telecommunications companies must competitively bid for these contracts and how prices

must be calculated to receive subsidies, and as a result GCI received inflated subsidy payments.

International Vitamins Corporation agreed to pay $22.8 million for defrauding the United States by misclassifying more than 30 of its vitamin and nutritional supplements under the Harmonized Tariff Schedule in order to avoid paying customs duties. IVC admitted that even after it retained a consultant who informed IVC of its wrongful conduct, IVC did not implement the correct classifications for over nine months and never remitted duties that it had underpaid to the United States because of its misclassification.

Yale University and Dr. John Krystal agreed to pay $1.5 million to resolve allegations that they failed to disclose certain patents and failed to share patent royalties with the Department of Veteran Affairs (VA) for inventions made by Dr. Krystal when he worked for both institutions. Dr. Krystal was employed part time both at Yale and the VA, and those institutions agreed to promptly disclose to each other all joint inventions.

HOLDING INDIVIDUALS ACCOUNTABLE

The Justice Department continued its commitment to use the False Claims Act to deter and redress fraud by individuals as well as corporations. Such efforts deter future fraud, incentivize changes in both corporate and individual behaviors, ensure that the proper parties are held responsible, and promote the public's confidence in our justice system. In addition to some of the recoveries identified above, the following are further examples of recoveries involving individuals.

Dr. Joel Aronowitz, Daniel Aronowitz, and Joel A. Aronowitz, M.D., a medical corporation, and other parties paid $23.9 million to resolve allegations that, among other things, they falsified the place of service for skin grafts to fraudulently maximize reimbursements and failed to properly dispose of unused portions of single-use skin graft materials and, instead, used and billed them in later procedures involving other Medicare and Medicaid beneficiaries.

Margarita Howard and her company HX5 LLC, along with affiliated joint venture HX5 Sierra LLC, paid the United States approximately $7.8 million to resolve allegations that they knowingly provided false information to the SBA relating to HX5's and HX5 Sierra's eligibility for federal set-aside contracts intended for small businesses owned and controlled by socially and economically disadvantaged individuals.

Dr. John Y. Chung and his practice Skin Cancer & Cosmetic Dermatology Center, P.C. agreed to pay $6.6 million to resolve allegations that they submitted false claims for Mohs dermatological procedures that were billed as if both the surgery and pathology portions of the procedures were performed by the doctor, when in fact at least one portion was often performed by other individuals.

RECOVERIES IN WHISTLEBLOWER SUITS

Of the more than $2.68 billion in settlements and judgments reported by the government in fiscal year 2023, over $2.3 billion arose from lawsuits that were filed under the qui tam provisions of the False Claims Act and pursued by either the government or whistleblowers. During the same period, the government paid out over $349 million to the individuals who exposed fraud and false claims by filing qui tam actions.

The number of lawsuits filed under the qui tam provisions of the act has grown significantly since 1986, with 712 qui tams filed this past year — an average of more than 13 new cases every week.

“We are grateful for the hard work and courage of whistleblowers who play a critical role in identifying fraud, often at substantial risk to themselves,” said Principal Deputy Assistant Attorney General Boynton. “Our efforts to ensure that public funds are spent properly continues to benefit greatly from their actions.”

In 1986, Senator Charles Grassley and Representative Howard Berman led the successful efforts in Congress to amend the False Claims Act to, among other things, encourage whistleblowers to come forward with allegations of fraud. In 2009 and 2010, further improvements were made to the False Claims Act and its whistleblower provisions.

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Principal Deputy Assistant Attorney General Boynton also expressed appreciation for the many public servants over the past year who supported the Department’s enforcement efforts. He said, “The accomplishments announced today are a testament to the extraordinary dedication and skill of individuals across the nation who work tirelessly to protect taxpayer dollars from fraud and abuse. These individuals serve in the Fraud Section of the Civil Division, the U.S. Attorneys’ Offices, the agency Offices of Inspector General and Offices of General Counsel, and many other federal and state agencies that support this important work.”

Except where indicated, the government’s claims in the matters described above are allegations only and there has been no determination of liability. The numbers contained in this press release may differ slightly from the original press releases due to accrued interest.

FY2023 Statistics

Updated February 22, 2024

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