Trends in Fraud and Abuse Investigations since COVID

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by Jack Wenik

For healthcare providers such as hospitals, physician groups, nursing homes, etc. and the executives and employees who run them, we are at a unique moment in history. The, hopefully, tail-end of the pandemic related to COVID-19 has coincided with a change in administration via the election of President Biden. These two momentous events have had an enormous effect on fraud and abuse enforcement at both the state and federal levels. Some of these changes in direction and emphasis are readily apparent while others are only starting to emerge.

In this article, I identify and describe a handful of trends in fraud and abuse enforcement and provide some practical insights as to what these changes mean for the healthcare industry. This article does not cover fraud investigations emanating from the enormous relief funds enacted to protect the healthcare system and the economy at large from the economic dislocation caused by COVID-19. To be sure, the CARES Act signed on March 27, 2020 included billions of dollars for such measures as the Provider Relief Fund to assist healthcare providers from lost revenues attributable to COVID-19 as well as billions more in the Paycheck Protection Program to provide relief to businesses and their employees more generally. There can be little doubt that many abused these programs and investigations and prosecutions will surely follow. However, this is to be expected with any large-scale relief program. What is more intriguing, and the focus of this article, is how COVID-19 and the change in administrations has altered the landscape of fraud and abuse investigations more generally.

A Shift Away from Beneficiaries

Prior to COVID-19 and the election of President Biden, there was a large scale movement to impose work requirements on Medicaid beneficiaries. CMS issued guidance soliciting proposals for "Work for Medicaid" pilot programs on January 11, 2018. On February 1, 2018, CMS approved Indiana's detailed Work for Medicaid program[1]. A growing list of states soon followed with similar programs receiving CMS approval. Litigation challenging the implementation of these programs ensued and in July 2020, the Department of Health and Human Services sought the Supreme Court's ruling on the matter.[2]

The common theme of these Work for Medicaid programs was that in order to receive Medicaid benefits, beneficiaries had to either work or participate in "community engagement activities." Community engagement activities could include a range of options such as: skills training, education, job search, caregiving, volunteer service or substance disorder treatment. There would be exemptions from these requirements for various categories of beneficiaries including, for example, pregnant women and "medically frail" individuals.

On one level the resistance to Work for Medicaid was surprising. Work requirements for the receipt of benefits by indigent individuals had been established as part of welfare reform during the Clinton era. Indeed, the Work for Medicaid requirements were modeled after those which have been required for years to receive benefits under the Supplemental Nutrition Assistance Program ("SNAP").[3] The legal challenges to Work for Medicaid seemed likely to fail. Many legal practitioners, the undersigned included, expected a wave of enforcement activity targeting fictitious or fraudulent "community engagement activities" and fraudulently obtained exemptions such as doctors falsely certifying that beneficiaries were "medically frail."

COVID-19 and Joe Biden's election to President changed all of this. First and foremost, the health emergency created by COVID stopped any momentum by regulatory authorities to scrutinize Medicaid rolls and/or the legitimacy of beneficiaries. Indeed, as part of the response to the pandemic, application processes were streamlined and it became easier for providers and beneficiaries alike to become part of the Medicaid program. Prosecutions of beneficiaries for fraudulently obtaining Medicaid benefits have been few and far between during the pandemic, and this trend will most likely continue for some time.

Second, as part of President Biden's progressive agenda, the federal government has made an about face on Work for Medicaid requirements. CMS has begun withdrawing the approvals it granted to the pilot programs established by a growing number of states.[4] In February 2021, the Solicitor General acted to remove the issue from the Supreme Court's docket.[5] Thus, while many states are still in favor of imposing a Work for Medicaid requirement, the actions of the Biden Administration have effectively killed this idea for the time being.

Given that COVID is still with us and the current political environment is leaning progressive, except in the most egregious circumstances, we can expect few fraud and abuse investigations of Medicaid beneficiaries. That being said, it cannot go unnoticed that the expenditures associated with coping with COVID-19 have been enormous at both the state and federal level. When you couple this fact with the reality that 39 states have opted for Medicaid Expansion, bringing millions of able-bodied, childless, working age individuals into the program, it becomes apparent that budgetary constraints will, at some point, cause enormous challenges to maintain the current levels of Medicaid expenditures. For example, Medicaid spending in New York alone is expected to reach $80.3 billion in fiscal 2021 with the state's contribution amounting to $24.9 billion despite massive federal COVID-19 relief.[6] At some point, regulators will have to turn their attention to the sheer size of Medicaid rolls.

Expect Substantial Fraud and Abuse Focus on Telehealth

The Department of Justice's ("DOJ") annual healthcare fraud "takedowns" have become an expected ritual viewed by lawyers and consultants who practice in the fraud and abuse area. Calendar year 2020 was no different with DOJ touting its largest takedown ever. Of particular note was the DOJ's assertion that $4.5 billion of the alleged $6 billion in fraud accounted for by the 2020 takedown was related to "telemedicine."[7]

The fraud at issue here is what I call "traditional" telehealth fraud. While they vary in size and detail, the general modus operandi of these schemes is the use of corrupt physicians by fraudulent telehealth companies. The telehealth companies pay rogue doctors to issue orders, prescriptions or certifications for unnecessary medical treatment provided to Medicaid or Medicare beneficiaries, who have been identified by call centers or misleading advertising. Typically, the doctors have no actual doctor-patient relationship with the beneficiaries and, indeed, may never even have met them.

Medicare/Medicaid is charged for prescription medications, durable medical equipment or laboratory testing that is of no real benefit. In recent months, expensive genetic testing for Medicare beneficiaries has been a focus of DOJ enforcement. In many instances the Medicare beneficiary is not even aware of the services that have been submitted for reimbursement in his/her name.

To be sure, given the lucrative nature of fraudulent Medicare/Medicaid reimbursements on a large scale, state and federal authorities will continue to pursue this sort of "traditional" telehealth fraud and abuse. The fact that so many individuals were home bound during COVID-19 means that the sheer volume of this sort of fraud has increased as more individuals provided their Medicare information in response to telemarketing calls, misleading television advertisements and direct mail solicitations. We can expected an elevated level of prosecutions for this type of fraud for many months to come.

What's most intriguing in the telehealth area is the prediction of a "new" type of telehealth fraud by many practitioners, the undersigned included, in the telehealth field. This new genre of fraud is expected to bring increased scrutiny by regulators/prosecutors and more civil and criminal cases.

Prior to COVID-19 CMS imposed onerous requirements/limitations on the reimbursement under Medicare for telehealth services. In order to cope with the pandemic, CMS dramatically eased these restrictions allowing a wide array of medical services to be provided remotely. This included not just telehealth visits/consultations but also "Virtual Check-ins," "E-visits," and "Audio-only" consultations.[8]

The same trend happened at the state level. For example, in New Jersey, regulators authorized a wide range of healthcare services to be provided via telehealth.[9] Healthcare professionals and Medicare/Medicaid beneficiaries embraced telehealth during COVID-19. In 2020, telehealth's share of Primary Care Visits for Medicare beneficiaries went from 0.19% to 43.5% of such visits.[10] Finally, it seems very likely that this dramatic expansion of the use and reimbursement of telehealth will become a permanent part of the healthcare landscape.[11]

With telehealth as an accepted part of federal healthcare programs it seems inevitable that there will be those who abuse it and/or commit outright fraud. Rather than the "traditional" telehealth fraud of shady telehealth companies recruiting unsuspecting beneficiaries to obtain unnecessary healthcare services, the "new" telehealth fraud will involve the same types of fraud and abuse seen in the context of regular, in-person provision of services. All of the potential problems that arise from billing for in-person visits/consultations: up-coding, phantom services, unnecessary services, deficient documentation, etc. will apply with equal vigor to telehealth. Indeed, the lack of an office setting probably increases the opportunities for fraud and abuse and makes it harder to detect same. For example, time based billing codes in behavioral health would be especially subject to fraud and abuse in the telehealth context.

We should thus expect increased audits/scrutiny of telehealth services for the foreseeable future.[12] Criminal prosecutions will surely follow as investigations play out. One recent DOJ prosecution, *United States v. Michael Stein, et. al,* 21 CR 20321 (S.D. Fl), is notable for being the first to include allegations of improper telehealth billing in addition to fraudulent genetic testing. No doubt, free-standing telehealth prosecutions are in the pipeline.

These developments mean healthcare providers should exercise the same care as when they bill for in-person services: document thoroughly, beware of "impossible days" of too many telehealth visits, scrutinize outliers/high volume billers, educate staff as to proper codes/modifiers to be used with telehealth claims, and maintain distinctions between new vs. established patients.

continued on page 28

continued from page 27

COVID-19 Fraud Investigations/Prosecutions Will Continue

With a general five year statute of limitations for criminal prosecutions and a six year statute of limitations for False Claims Act suits, we can expect COVID-19 related fraud and abuse actions to continue for some time. There has been a rash of prosecutions and actions by other federal agencies, such as the Federal Trade Commission, ("FTC") against a host of individuals/companies peddling fake COVID cures and treatments. In a related context, there have also been securities related fraud cases tied to bogus COVID technologies.

For healthcare providers, the COVID-19 fraud and abuse that appears most widespread is the bundling of COVID-19 testing with other, often unnecessary testing, to increase Medicare reimbursement rates. In this sense the fraud and abuse here is much the same as we have seen in the past for drug abuse testing, genetic testing and blood panels that include an appropriate test with a slew of more expensive, unnecessary ones.

One interesting matter is a criminal complaint filed in the Northern District of California, *United States v. Juli Mazi,* (N.D.Ca. July 13, 2021), in which a Naturopathic doctor is accused of providing COVID-19 vaccination cards to individuals who never received the vaccination. It was probably inevitable, given the growing necessity to have proof of vaccination for travel, continued employment, and to attend sporting and other events, that vaccination cards would become a thing of value attracting fraudulent conduct.

Healthcare providers should scrutinize carefully orders for COVID testing that are part of a wider order for expensive testing. Vaccination cards should be treated as a valuable record that needs to be safeguarded. Accordingly, healthcare providers should: track inventory of vaccination cards, establish procedures for issuing/monitoring replacement cards, limit access to blank cards, and establish procedures for who can fill out and distribute cards.

Expect Increased Antitrust Enforcement Activity in Healthcare

During the height of the pandemic with lock-downs and fear, many individuals postponed all but emergency health care. This jeopardized the financial stability of many healthcare providers to the point where federal relief funds were required by many. While antitrust enforcement activity did not cease entirely during COVID-19, there was a precipitous decline as regulators were more concerned with the financial survival of healthcare practitioners and organizations.

In this regard, dramatic change is on the horizon. On July 9, 2021, President Biden issued his "Executive Order on Promoting Competition in the American Economy." The Order singled out healthcare, contending that Americans paid far more for healthcare than residents of other countries and that hospital consolidation left communities with inadequate healthcare options. The President urged DOJ, the FTC and other agencies to vigorously enforce antitrust laws.

That the President means business has been accentuated by his new FTC Chair, Lina Khan. Ms. Khan has already taken actions to increase the Agency's powers and authority. She has written in the past on the need to increase antitrust enforcement and has commented on the need for increased scrutiny of the healthcare industry.

With the financial burdens of COVID-19 lessening we can expect increased antitrust scrutiny of hospital mergers, physician practice acquisitions and private equity investment in healthcare. Attorney General Merrick B. Garland stated that healthcare was a key sector for antitrust enforcement and specifically noted the need to promote competition via telehealth.[13] There can be little doubt that criminal antitrust charges will also be brought as needed against those who subvert competition for healthcare services.

Conclusion

If for no other reason than that healthcare fraud and abuse enforcement generates substantial revenues for federal and state governments in the form of fines, penalties and forfeitures, healthcare providers can expect a continued high level of enforcement activity. As the country emerges from COVID-19 greater scrutiny will be applied to innovations such as telehealth as well as the provision of treatment in response to COVID. Now is the time to dedicate more resources to compliance and risk management and for healthcare providers to be ever vigilant that their practices comport with the law and applicable regulations.

About the Author

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Footnotes

[1] *See* CMS Approval of Healthy Indiana Plan, Expenditure Authority No. 11-W-00296/5, February 1, 2018.

[2] *See* HHS Petition for Writ of Certiorari in *Azar v. Gresham, et al.* No. 20-37, July 2020.

[3] *See, e.g.,* New York Office of Temporary and Disability Assistance Fact Sheet for SNAP Work Requirements, Pub-5105 (Rev. 02/21) (setting forth work requirements and exemption categories similar to those in states' Work for Medicaid pilot programs).

[4] *See, e.g.,* March 17, 2021 CMS letter to Dawn Stehle of Arkansas Department of Human Services.

[5] *See* February 2021 Motion of Solicitor General in *Cochran v. Gresham,* No. 20-37.

continued on page 29