OIG Report Has Clues For 2024 Healthcare Fraud Enforcement

By **Mackenzie Wortley, Elizabeth Nevins and Megan Miller** (January 16, 2024)

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In late 2023, the U.S. Department of Health and Human Services and the U.S. Department of Justice released the Health Care Fraud and Abuse Control Program Annual Report for fiscal year 2022, highlighting continued enforcement and recovery actions under the program.[1]

During fiscal year 2022, over $1.7 billion was returned through the HCFAC program's enforcement actions.[2]

The HCFAC program uses advanced data analytics to monitor and target high-risk public and private healthcare programs, providers and trends to identify HHS' most significant risk areas and to better target fraud, abuse and waste.

The fiscal year 2022 report highlighted several key enforcement initiatives, including telemedicine fraud and exploitation, unnecessary COVID-19 testing and services along with fraudulently obtained COVID-19 relief funds, and opioid and prescription drug abuse.

We believe that the HCFAC program will continue to focus on these key priority enforcement areas in the coming year.

Enforcement Highlights for Fiscal Year 2022

The HCFAC program has operated for 26 years as a joint program of HHS and DOJ, conducted by HHS' Office of the Inspector General. The HCFAC program coordinates federal, state and local law enforcement activities related to healthcare fraud and abuse.

In fiscal year 2022, the DOJ opened more than 809 new criminal healthcare fraud investigations and more than 774 new civil healthcare fraud investigations.[3]

HHS-OIG conducted investigations resulting in 661 criminal actions against individuals related to Medicare and Medicaid, as well as 726 civil actions, including false claims, unjust enrichment lawsuits and civil monetary penalty settlements.[4]

The report highlights a number of major civil and criminal enforcement actions across a broad range of healthcare practices and fields.

The most significant actions noted in fiscal year 2022 include fraud and abuse related to COVID-19, diagnostic testing, durable medical equipment, genetic testing, home health providers, hospice care, laboratory testing, managed care, medical devices, nursing homes, pharmacies, physicians and other practitioners, prescription drugs and opioids, substance use treatment centers, and telemedicine.

Future Enforcement Areas

In the report, HHS-OIG noted that the HCFAC program will continue to focus on several major enforcement initiatives. These enforcement initiatives align with the investments HHS-OIG has made across its programs and the cross-agency teams that HHS-OIG is utilizing to target nationwide concerns.

We anticipate that the HCFAC program will continue to deploy its resources in the coming year to address fraud, waste and abuse, along with program integrity in Medicare and Medicaid; strengthen its partnerships with other agencies; and deploy its strike force teams to address nationwide priority issues.

We also anticipate that the HCFAC program will continue to focus its efforts on COVID-19 fraud, opioid abuse and telemedicine fraud.

Medicare and Medicaid Program Integrity

In the report, the HCFAC program noted its plans to strengthen Medicare and Medicaid program integrity, including working with state partners to enhance the effectiveness of the Medicaid Fraud Control Units.

The DOJ and HHS-OIG established the Health Care Fraud Prevention and Enforcement Action Team, which focuses on Medicare and Medicaid fraud and abuse and seeks opportunities for new enforcement initiatives and areas for increased oversight and prevention.

Recently, these initiatives have involved using state Medicaid Fraud Control Units, with these units taking part in 10 enforcement cases during fiscal year 2022.[5]

Additionally, the HCFAC program plans to enhance program integrity in noninstitutional care settings, such as home health and hospice care.

In response to changes in the healthcare system, the HCFAC program highlighted its plans to strengthen oversight of nursing homes, Medicare Advantage managed care plans, Medicaid managed care programs, value-based models, Medicare hospital payments efficiency, telehealth and other remote care expansion, and cybersecurity.

Continuing Specialized Fraud and Abuse Targeting Using Strike Force Teams

The HCFAC program uses cross-agency teams and units to investigate and prosecute healthcare fraud and abuse in these areas.

The Health Care Fraud Strike Force Teams are interagency teams that investigate and prosecute major, complex healthcare fraud and abuse issues.

Not only are there regional and industry-specific strike force teams, but there is also the National Rapid Response Strike Force, which targets large-scale, nationwide fraud happening in specific industries and priority areas like telemedicine, unlawful opioid distribution, sober homes and COVID-19 schemes.

The strike force teams have had much success in recent years conducting major enforcement actions that address fast-developing healthcare fraud and abuse issues.

HHS-OIG is likely to continue to invest in and use the strike force teams.

COVID-19 Fraud, Waste and Abuse

COVID-19 fraud, waste and abuse have been a target of the HCFAC program, especially as substantial amounts of funding have been available for services and programs related to COVID-19.

The HCFAC program and the strike force teams are targeting fraud and abuse through the utilization of additional and unnecessary services, unnecessary laboratory testing, healthcare technology schemes and fraudulently obtained COVID-19 healthcare relief funds.

In fiscal year 2022, criminal charges were brought against 21 defendants for their alleged activities exploiting COVID-19 programs.[6]

Opioid Abuse

There are multiple partners within the HCFAC program targeting opioid abuse and unlawful opioid distribution.

The strike force teams have been heavily engaged in this work over the last several years, with an Appalachian Regional Prescription Opioid Strike Force created in 2018. Additionally, the OIG has an Opioid Fraud and Abuse Detection Unit.

In fiscal year 2022, criminal charges were brought against 14 defendants for their alleged involvement in unlawful opioid distribution.[7]

The HCFAC program also noted its plans to prioritize protecting beneficiaries from prescription drug abuse and opioid abuse in its Medicare and Medicaid fraud, waste and abuse programs, and to continue engaging with partners, such as the FBI, to target issues like the prescription opioid abuse epidemic that affect public safety and patient harm.

Telemedicine Fraud

Recently, HHS-OIG has been watching developments in telemedicine closely, bringing several enforcement actions against individuals alleged to have perpetrated telemarketing schemes with clinical laboratory testing or durable medical equipment companies.

In 2022, the DOJ charged 36 defendants for more than $1.2 billion in alleged fraud and recovered more than $8 million in cash.[8]

Moreover, during the last several years, the DOJ has charged more than $10 billion in fraud involving the use of telemedicine, and engaged in large-scale, nationwide enforcement actions in this area.[9]

These cases involve allegations of using telemedicine to offer low-cost or free products or testing to beneficiaries, ordering these products or tests, and then selling those items to a medical equipment company or laboratory, which then provides a kickback to the telemedicine company.

Looking Ahead

While 2022's recoveries are lower compared to prior years, over the last three years the HCFAC program has returned $2.90 for every $1 expended.[10]

And the DOJ recently announced plans to increase its number of prosecutors specializing in healthcare fraud from its current roster of 75.[11] The HCFAC program also continues to increase its data analytics capacity and cross-agency partnerships.

Given the success of the HCFAC program's enforcement actions, along with plans to increase prosecutors, we expect to see continued enforcement targeting healthcare fraud and abuse in the coming year.

The enforcement trends outlined in the report complement the ideals set forth in OIG's strategic plan for 2020-2025, thereby giving teeth to HHS' vision of promoting efficiency, effectiveness and integrity of its programs.[12]

Moreover, the increase of enforcement actions in the areas of managed care, telehealth and COVID-19 programs reveals that government oversight in these areas is not an anomaly, but rather is part of a larger and ongoing effort by HHS to target fraud and abuse.

Enrollment in Medicare and Medicaid managed care programs surged during the pandemic years in 2020-2022, which is largely attributed to the continuous enrollment condition, which tied certain federal funding to maintaining all Medicaid enrollments during the public health emergency.

According to the OIG, higher enrollment also heightens risk of abuse, therefore requiring increased government scrutiny.[13] Indeed, OIG audits of health plans conducted during the first half of 2023 seeking to validate risk-adjusted payments made by CMS unveiled approximately $377 million in potential overpayments.[14]

Notably, however, the growth in managed care enrollment reached an inflection point in 2023 following the expiration of the continuous enrollment condition as mandated in the Consolidated Appropriations Act passed in 2022.

The unwinding of the continuous enrollment provision has had widespread implications for the entire healthcare ecosystem. As Medicaid enrollees grapple with the uncertainty of their enrollment status, managed care plans, providers and the states that operate these programs face administrative and financial burdens as they redetermine enrollment eligibility for millions of Americans.

With the expiration of the continuous enrollment provision also comes the end of certain Medicare and Medicaid waivers and broad flexibilities for healthcare providers that were granted during the public health emergency period.

And, amid an already overwhelmed healthcare system during this transition period, HHS and OIG continue to enhance policing of managed care. On Aug. 28, 2023, HHS and OIG issued a strategic plan for oversight of managed care for Medicare and Medicaid aimed at investigating the life cycle of Medicare Advantage and Medicaid managed care contracts from plan establishment through enrollment, reimbursement, services and renewal.[15]

Despite the end of the federal COVID-19 emergency declarations, the healthcare system will not return to its pre-pandemic state. The widespread implementation of telemedicine, increased diagnostic testing and screening, and enhanced access to mental and behavioral health services will remain integral to healthcare.

Likewise, government scrutiny in these areas will not dissipate. The pandemic placed a permanent spotlight on the healthcare system, exposing its limitations and vulnerabilities.

As such, HHS-OIG will likely enhance its efforts to prevent, detect, and address waste, fraud, mismanagement and abuse.

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[1] Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2022, The Department of Health and Human Services and the Department of Justice (2023).

[2] Id. at 1.

[3] Id.

[4] Id.

[5] Id. at 12.

[6] Id. at 11.

[7] Id.

[8] Telemedicine Enforcement Action, U.S. DEPARTMENT OF JUSTICE (Dec. 19, 2023), https://www.justice.gov/criminal/criminal-fraud/telemedicine-enforcement-action.

[9] Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2022, supra note 1, at 10.

[10] Id. at 8.

[11] Michael Paddock, Bill Mateja, Kate Rumsey, and Megan Miller, Increased Enforcement in Healthcare? DOJ to Add More Prosecutors, SHEPPARD MULLIN (November 9, 2023), https://www.whitecollarlawblog.com/2023/11/increased-enforcement-in-healthcare-doj-to-add-more-prosecutors/.

[12] OIG-HHS Strategic Plan 2020-2025, https://oig.hhs.gov/documents/root/7/OIG-Strategic-Plan-2020-2025.pdf.

[13] Strategic Plan for Oversight of Managed Care for Medicare and Medicaid, HHS (Aug. 28, 2023), https://oig.hhs.gov/reports-and-publications/featured-topics/managed-care/Strategic_Plan_Managed_Care.pdf.

[14] Id.

[15] Id.