Healthcare Fraud in the Early Days of the Biden Administration

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This is our eighth and final post in our First 100 Days series examining important trends in white collar law and investigations in the early days of the Biden administration. Our previous entry was on pandemic-related fraud. Join us in the weeks and months ahead as we return to periodic posting on new developments and emerging trends.

Health care fraud is widely considered a bipartisan focus for federal prosecutors; it was a priority for federal prosecutors during the prior administration and will remain so under President Biden. Here, we highlight a few trends we have observed in recent months, as we anticipate how the Biden Administration will tackle health care fraud in the coming years.

Telemedicine

2020 saw a dramatic rise in telehealth services as a result of the COVID-19 pandemic. As we mentioned in our recent article about Pandemic Fraud, we can expect a corresponding uptick in investigations and charges relating to telehealth treatment schemes.

Fraud involving telemedicine became an explicit prosecutorial focus even prior to the pandemic, with the Department of Justice's (DOJ) 2019 "Operation Brace Yourself" Telemedicine and Durable Medical Equipment Takedown, in which DOJ charged 24 individuals responsible for over $1.2 billion in losses related to telehealth care schemes. Perhaps unsurprisingly, whether resulting from increased telehealth services during the pandemic or the DOJ's increased focus on the area, 2020's charges compounded those numbers. In September 2020, the Department of Justice published a release documenting the "Largest Health Care Fraud and Opioid Enforcement Action" in the Department's history, charging 345 defendants with submitting over $6 billion in false and fraudulent claims to federal health care programs and private insurers. Of that total, over $4.5 billion was connected to telemedicine, involving 86 defendants in 19 judicial districts.

Although the remote environment of 2020 may not persist to the same degree in coming years, it seems likely that telehealth services will continue at a greater rate than prior to the pandemic. With that, we can expect DOJ to maintain its focus on telemedicine schemes going forward.

Settlements Incorporating Public Document Repositories

Investigating and charging opioid-related health care fraud remains a priority for state and federal regulators. The early months of the Biden administration brought new developments in the resolution of sweeping opioid litigation against pharmaceutical companies, brought by local governments, state attorneys general, and the DOJ. In particular, recently inked settlement deals will require the public disclosure of millions of pages of pharmaceutical companies' internal documents.

As part of its plea deal with the DOJ, for example, Purdue Pharma agreed to create a public repository of documents produced during the investigations, following the completion of Purdue's bankruptcy proceedings. Other pharmaceutical companies have agreed to similar disclosures to resolve opioid-related litigation. In late March 2021, the University of California, San Francisco, in collaboration with Johns Hopkins University, launched an online archive of opioid litigation documents, which will include documents made public as part of settlements with government regulators.

Settlements requiring public disclosure of documents collected during government investigations are not without precedent, although they are rare. Over two decades ago, the master settlement agreement between major tobacco manufacturers and state attorneys

general created a public document archive of the manufacturers' documents produced in discovery.

It remains to be seen whether public document repositories will be deployed as components of settlements in health care fraud cases more generally, or if they are a settlement tool confined to historically large-scale litigation impacting public health. State attorneys general have signaled an increased reliance on public disclosure of their investigation targets' documents, so we do expect to see this trend continue in some fashion.

Data Analytics and Whistleblower Actions

Health care fraud investigations and charges most commonly begin with whistleblowers, often inside health care providers who file False Claims Act cases with the incentive of obtaining large rewards should the government prevail. In the 2019 fiscal year, whistleblowers filed 633 of these suits (called *qui tam* actions), resulting in the recovery of over $2.1 billion. In 2020, although the number of whistleblowers increased to 672—nearly 13 new cases every week—the number of False Claims Act cases arising *without* whistleblowers also increased. To identify cases without whistleblowers, DOJ has expanded its reliance on data analysis, with a focus on Medicare data, to uncover potential fraud schemes without relying on whistleblowers. In his February 2021 remarks, Acting Assistant Attorney General Brian Boynton told the Federal Bar Association's Qui Tam Conference that DOJ uses data analytics to identify high risk physicians in each state and federal district, assess how much they are costing the Medicare program, and even "quantify sophisticated relationships, such as a physician offering controlled substance prescriptions to a patient who is likely to divert them." (You can read more about trends in False Claims Act cases in our prior article here.) Based on these trends and AAG Boynton's February statements, we can expect that DOJ's reliance on data analytics is likely to continue in the health care arena and expand to other areas as well.

There is undoubtedly more to come in these and other areas in 2021. We look forward to bringing you these updates as they arise.

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