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Feds Target Health Care Fraud, COVID-19 Schemes

The Department of Health and Human Services (HHS) and The Department of Justice (DOJ) have released their jointly prepared annual report on health care fraud and abuse in both public and private-sector health plans for fiscal year (FY) 2020. Much of the report focuses on traditional, well known health care fraud schemes, but the report also draws attention to innovative, new schemes associated with the COVID-19 pandemic.

According to the report, during FY 2020, the federal government won or negotiated more than $1.8 billion in health care fraud judgments and settlements. Because of these efforts, as well as prior year efforts, almost $3.1 billion was returned to the federal government or paid to private individuals. Of this amount, $2.1 billion was returned to the

Medicare Trust Funds, and $128 million in fraudulent Medicaid claim payments was returned to the Treasury Department's coffers.

With respect to health care fraud and abuse in general, the report provides numerous examples of specific cases in which bad actors, including physicians, hospitals, clinics, pharmacies, and other medical providers, were charged and convicted for various common fraudulent health care schemes such as over-billing, up-coding, unbundling of services, and billing for services not provided or which were not medically necessary.

In addition to these common fraudulent health care schemes, HHS and DOJ have identified new, innovative schemes associated with the COVID-19 pandemic. These include: robo-callers that offer fake COVID-19 cures in exchange for money or protected health information (PHI), fake websites that offer to sell surgical masks, gloves, and other high-demand COVID related supplies, labs that bundle the cost of COVID-19 tests with other more expensive lab tests, and schemes that, because of the rise of pandemic-related telemedicine, attempt to acquire PHI, and Medicare or private health insurance ID numbers.

Relaxed government policies and pandemic-related waivers have created new fraud risks to federal health care programs such as Medicare and Medicaid. HHS and DOJ have vowed to hold bad actors accountable for using deceptive tactics to profit from the COVID-19 pandemic

Full text of report: Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control (HCFAC) Program FY 2020 (HHS, DOJ, July 2021)

https://oig.hhs.gov/publications/docs/hcfac/FY2020-hcfac.pdf

Links to prior years' HCFAC reports (FY 1997 to FY 2019) (DOJ)

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https://www.justice.gov/criminal-fraud/health-care-fraud-and-abuse-control-program

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