# DOJ enforcement activity 5 years after the COVID-19 public health emergency

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**DECEMBER 19, 2024**

The Secretary of Health and Human Services ("HHS") officially declared COVID-19 to be a public health emergency nearly five years ago on Jan. 27, 2020. As the pandemic continued to spread, HHS and Congress responded by enacting regulatory waivers and delivering relief funding for health care providers. Since early in the pandemic, the Department of Justice ("DOJ") made clear that it would prioritize enforcement actions targeting fraudulent activity related to these emergency measures. On March 22, 2020, DOJ announced that it had already filed its first such enforcement action.

After nearly five years, DOJ has pursued a handful of complex False Claims Act ("FCA") cases relating to pandemic fraud, but many cases involved less complex fraudulent schemes and there remain broad areas where DOJ, and whistleblowers, have brought relatively few enforcement actions. As we approach the half-decade mark since the pandemic began, open questions remain as to whether DOJ has more complex FCA cases in the pipeline as part of a backlog of pandemic fraud actions, or if DOJ has largely exhausted its work in this space.

## DOJ's specialized task forces and initiatives to address pandemic fraud

DOJ has taken several actions to prioritize addressing pandemic fraud. In 2021, DOJ created a COVID-19 Fraud Enforcement Task Force intended to focus its efforts on addressing pandemic fraud in coordination with other federal agencies. This Task Force then established "strike forces" in five US Attorneys' Offices.

DOJ's Health Care Fraud Unit also established a Provider Relief Fund ("PRF") Initiative focused on addressing fraud involving the PRF, which is a $178 billion pandemic relief fund that Congress created to compensate health care providers for expenses incurred or revenues lost due to the pandemic.

DOJ has also prioritized fraud enforcement relating to the Health Resources and Services Administration's ("HRSA") COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program ("Uninsured Program"), which reimbursed providers for testing, diagnosing, treating, or vaccinating uninsured individuals for COVID-19.

Additionally, DOJ's Health Care Fraud Unit created a COVID-19 Interagency Working Group designed to coordinate multi-agency efforts to address pandemic fraud involving health care programs. DOJ has worked to publicize the fruits of these various targeted efforts, issuing public press releases this year touting their achievements.

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To date, however, these specialized task forces and initiatives have resulted largely in indictments and settlements targeting blatant theft, rather than the type of nuanced compliance risks that more typically can arise for even well-meaning health care providers. For example, on May 26, 2021, DOJ announced the COVID-19 Interagency Working Group helped to bring criminal charges against 14 defendants involving $143 million in fraudulent billings, including for COVID-19 tests, as well as more traditional fraud schemes relating to medically unnecessary cancer genetic testing.

On April 20, 2022, DOJ announced that another coordinated interagency effort resulted in criminal charges against 18 defendants relating to $149 million in theft from pandemic relief programs and false claims for medically unnecessary office visits submitted to Medicare alongside claims for COVID testing.

A year later, DOJ announced another COVID-19 set of indictments, including one generated through the work of the PRF Initiative relating to a fraudulent application for PRF funds that were then misappropriated to purchase luxury vehicles and vacations. The work of these DOJ task forces has overwhelmingly focused on criminal conduct that can be readily prosecuted.

## Enforcement actions related to more complex pandemic fraud schemes

In contrast, there has been a fairly limited set of civil pandemic-related enforcement actions involving more complicated regulatory violations and theories of FCA liability.

Some of those actions have related to abuse of certain waivers created by the Centers for Medicare and Medicaid Services ("CMS") to give health care providers additional flexibility to address COVID-19. For example, in April of 2024, DOJ and the State of California reached a $7 million FCA settlement with ReNew Health Group ("ReNew"), which operates skilled nursing facilities ("SNFs"), relating to ReNew's alleged abuse of a waiver applicable to SNFs. Medicare will reimburse a patient's stay at a SNF, but only if the patient first had a hospital stay of three days or more. During the pandemic, however, a CMS waiver removed this requirement in an effort to increase availability of hospital beds and to ensure patient continuity of care.

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A whistleblower filed a *qui tam* complaint under the FCA alleging that ReNew submitted claims for SNF stays to Medicare to cover "observation" of residents who might have been exposed to COVID-19, when the patients did not actually need skilled nursing services.

As another example, DOJ reached a $24.5 million settlement with Physician Partners of America ("PPOA") related to allegations that PPOA required its physicians to schedule unnecessary telehealth appointments during the pandemic, in order to offset lost revenue from cancelled elective procedures. By doing so, PPOA allegedly sought to take advantage of waivers that facilitated expanded Medicare reimbursement for telehealth services. This settlement, announced in April of 2022, was one of the first DOJ civil settlements related to abuse of CMS's telehealth waivers from the pandemic.

Another target of pandemic fraud enforcement has been HRSA's Uninsured Program. In June of 2024, DOJ announced a $12 million settlement with an urgent care provider for allegedly failing to properly confirm that individuals were uninsured prior to submitting reimbursement claims to the Uninsured Program. CityMD also allegedly caused third-party laboratories to submit false claims to the Uninsured Program because CityMD shared forms with these laboratories inaccurately stating that certain patients were uninsured. DOJ has also investigated and closed multiple similar investigations.

Other enforcement actions have involved allegations that began prior to the pandemic. For example, in December of 2023, DOJ announced a settlement with Total Access Urgent Care ("TAUC") related to allegations spanning from 2017 through 2021. Beginning in 2017, TAUC allegedly submitted upcoded reimbursement claims that stated a physician performed a service that was actually performed by a non-physician. And during part of the pandemic, TAUC also allegedly submitted upcoded reimbursement claims to the Uninsured Program. Cases such as these demonstrate how DOJ investigations that are initially unrelated to pandemic emergency relief efforts could lead to additional allegations related to pandemic fraud that are uncovered through discovery.

While several of these cases involve DOJ joining cases that were initially filed by FCA whistleblowers, DOJ has not joined all such cases. For example, in June of 2023, a *qui tam* complaint was unsealed against Hudson Hospital, a New Jersey hospital system. The complaint alleged that Hudson Hospital overstated its number of patients with COVID-19 when applying for funds from the PRF. The complaint further alleged that Hudson Hospital then used these PRF funds for impermissible purposes, such as renovating its facilities.

In its motion to dismiss the complaint, Hudson Hospital argued it used proper methods for calculating the number of patients with COVID-19 and it followed HRSA's guidelines for spending PRF funds. DOJ declined to intervene in this case.

## Potential upcoming enforcement actions related to pandemic relief measures

It is not currently clear whether DOJ has more complex pandemic fraud investigations in the pipeline, or if DOJ has largely exhausted its fraud inquiries on this subject. It may be the case that providers were largely successful in navigating the significant regulatory flux brought on by the temporary CMS waivers and pandemic relief funds, and there is little more for DOJ to target beyond the low-hanging fruit pursued by the task forces.

For example, in February of 2024, the HHS Office of Inspector General ("HHS OIG") released a report assessing the accuracy of $1.4 billion in Medicare reimbursements related to certain pandemic telehealth waivers. The report concluded that "providers generally met Medicare requirements" and "unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Department of Health and Human Services Office of Inspector General, a-01-21-00501, Medicare generally paid for evaluation and management services provided via telehealth during the first nine months of the COVID-19 public health emergency that met Medicare requirements (2024).

Although the full pandemic time period remains within the FCA's statute of limitations, the relatively slow pace to date, even as DOJ

has had time to ramp up after the official end of the public health emergency, suggests the volume of future enforcement may be less than expected half a decade ago.

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## About the authors



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**This article was first published on Reuters Legal News and Westlaw Today on December 19, 2024.**