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Enforcers: COVID-19 Fraud Cases Take New Turns; Private Equity's Impact Is Debated

By Nina Youngstrom

The owner of a Massachusetts nursing home who "didn't think COVID was a real thing" and allegedly failed to implement infection-control procedures has agreed, along with his nursing home, to pay $175,000 and stay out of the long-term care business in the state forever in a settlement announced Nov. 3, according to Toby Unger, the chief of the Medicaid Fraud Division in the Office of the Massachusetts Attorney General (AG). Sea View Retreat Inc., and its owner, Stephen Comley II, were sued under the state False Claims Act and Consumer Protection Act, with the state alleging they didn't do surveillance COVID-19 testing, cohort residents who tested positive, train staff on the use of personal protective equipment and comply with other requirements.[1] "We alleged at least one individual died because of that," Unger said Nov. 8 at the Health Care Compliance Association's Enforcement Compliance Conference.

The settlement is an example of the steady stream of COVID-19 fraud cases coming out of state and federal enforcement agencies and the manifold forms they take. COVID-19 cases continue to be a high priority for law enforcement, along with fraud involving Medicare Advantage (MA) plans and opioids, top officials from the U.S. Department of Justice (DOJ), HHS Office of Inspector General (OIG) and Massachusetts Medicaid Fraud Division said. The enforcers also spoke about the implications of the increased presence of private equity in health care and how cases now before the U.S. Supreme Court may affect the use of the False Claims Act (FCA).

COVID-19 cases are playing out in the criminal, civil and administrative arenas and evolving over time. Criminal cases have come in two forms, said Jacob Foster, acting principal assistant chief at DOJ's criminal division. "There's been a lot of enforcement in the lab testing area," he said. For example, when people came for COVID-19 tests, perpetrators tacked on medically unnecessary genetic, allergy and other tests or medically unnecessary evaluation and management visits.

There's also the "intersection of health care fraud and financial fraud," Foster noted. For example, in September, a jury convicted Mark Schena, the president of a Silicon Valley-based medical technology company, of conspiracy to commit health care fraud, conspiracy to commit wire fraud, health care fraud, conspiracy to pay kickbacks, payment of kickbacks and securities fraud in connection with a COVID-19 and allergy testing scam, the U.S. Attorney's Office for the Northern District of California said.[2] Schena, who was president of Arrayit Corp., was involved in a scheme to defraud Arrayit's investors "by claiming that he had invented revolutionary technology to test for virtually any disease using only a few drops of blood," the U.S. attorney's office said. "In furtherance of the scheme, the evidence at trial showed that Schena, among other things, failed to release Arrayit's SEC [Securities and Exchange Commission]-required financial disclosures and concealed that Arrayit was on the verge of bankruptcy. Schena lulled investors who were concerned that the company was a 'scam' by inviting them to private meetings and issuing false press releases and tweets stating that Arrayit had entered into lucrative partnerships with companies, government agencies, and public institutions, including a children's hospital and a major California health care provider." Schena also coordinated a scheme involving fraudulent claims to Medicare and private payers for unnecessary allergy testing.