Annals of Health Law and Life Sciences

Volume 33
Issue 2 *Summer 2024*

Article 4

Summer 2024

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INTRODUCTION

Advocates for health equity frequently point to telemedicine as a promising way to achieve greater health access, and by extension, equity. This viewpoint, however, often fails to account for the ways in which the increased use of telemedicine—if accompanied by fraud—could adversely impact health equity. This article argues that while telemedicine is an important tool in achieving health equity, the fraud-related risks that come with it need to be examined. To be clear, this article does not argue against telemedicine as a potential path to achieving greater health equity; rather it simply notes the fraud-related risks that accompany it and highlights some efforts to address those risks.

This article proceeds as follows. Part I examines the potential benefits of telemedicine and explains the ways in which it could enhance health equity. Given some of these benefits—the rules around telemedicine were relaxed during the COVID-19 public health emergency (PHE). It then considers whether given these potential benefits and the recent COVID-19 PHE-related increased use of telemedicine, it could be a panacea—of sorts—to health inequity.

Part II cautions embracing this approach too quickly. Part II.A discusses the apparent increased incidence of fraud relating to telemedicine by giving an overview of recent Department of Justice (DOJ) national enforcement actions and Centers for Medicare and Medicaid (CMS) administrative actions, a special fraud alert by the Department of Health and Human Services Office of Inspector General (HHS-OIG), and a study by a public-private partnership focused on studying fraud. Part II.B explains why telemedicine is at risk of fraud by explaining why health care in general is susceptible to fraud. Part II.C discusses why telemedicine is particularly vulnerable to fraud. It argues that three features of telemedicine make it an ideal candidate for fraud schemes primarily because these features make telemedicine schemes difficult to investigate and prosecute, thus exacerbating the "low risk, high reward" nature of health care fraud. These three features are that telemedicine

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schemes are: (1) as Professor Katrice Bridges Copeland has explained, easily scalable, i.e., they can reach more beneficiaries (and thus result in billing for more claims) in a shorter period than non-telemedicine fraud schemes, (2) involve multiple different isolated parties, and (3) target beneficiaries who might be complicated witnesses.

Part III then discusses how the increased use of telemedicine—if accompanied by fraud—could damage efforts to achieve health equity, particularly given that many telemedicine schemes target vulnerable populations who are the intended recipients of health equity efforts. This harm could occur in several ways: (1) by at the moment of the fraud, depriving patients of the care they may actually need; (2) by subsequent to the fraud, making it more difficult for patients to access legitimate services, if, for instance, they meet their coverage caps as a result of the prior fraud, and by exposing the programs that enable them to access care to additional attacks and funding cuts; and (3) by increasing distrust of the health care system among the populations on which health equity efforts are focused.

Finally, the Conclusion argues that if efforts are not made to deter and detect fraud in telemedicine, the expanded use of telemedicine could have the unintended consequence of exacerbating health disparities by harming the very patients that health equity advocates seek to help. It recommends that law enforcement and those seeking to achieve health equity devote attention to understanding and addressing fraud within telemedicine, including by developing tools to address common features of these schemes. These features include limited or no patient interaction, occurrence across multiple jurisdictions, and the targeting of certain types of items and services.

I. TELEMEDICINE AS A PATH TO ACHIEVING HEALTH EQUITY?

Before going further, a few definitions—specifically of health equity, telemedicine, and telehealth—are useful. Health equity is the state in which "everyone has a fair and just opportunity to attain their optimal level of health," regardless of factors such as race, ethnicity, geography, and socioeconomic status.[1] Social determinants of health such as poverty and access to health care negatively contribute to health equity.[2] Indeed, in the United States (and likely many other countries), poor people, people of

[1] CTRS. FOR MEDICARE & MEDICAID SERVS., *Strategic Plan: Health Equity* (last updated May 2023), https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.
[2] *Id.*

color, and people in rural areas are more likely to have access to lower quality health care.[3]

Telehealth is broadly understood to mean remote health care services that include but go beyond clinical services.[4] In other words, telehealth includes online sources that do not involve clinical interactions.[5] Telemedicine on the other hand, is a subset of telehealth; it is remote health care services that are limited to clinical services.[6] Thus, telemedicine is "the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location, with or without an intervening healthcare provider."[7] Telehealth and telemedicine are sometimes used interchangeably,[8] but for clarity, this article will refer to telemedicine as defined above.[9]

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[3] Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KFF (Apr. 21, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers.

[4] *What is Telehealth?*, HEALTH RES. & SERVS. ADMIN. (Mar. 2022), https://www.hrsa.gov/telehealth/what-is-telehealth ("Telehealth is defined as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health.").

[5] *See e.g.*, Danny Bonvissuto & Shawna Seed, *What is Telemedicine?*, WEBMD, https://www.webmd.com/covid/how-does-telemedicine-work (last visited Jan. 25, 2024).

[6] CONG. RSCH. SERV., TELEHEALTH AND TELEMEDICINE: FREQUENTLY ASKED QUESTIONS 1-2 (Mar. 12, 2020) ("Telehealth generally refers to a health care provider's use of information and communication technology (ICT) in the delivery of clinical and nonclinical health care services" … "Telemedicine generally refers to a health care provider's use of ICTs in the delivery of only clinical health care services").

[7] FED'N STATE MED. BDS., *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine,* 3 (Apr. 2022), https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf.

[8] *See What is Telehealth?*, NEJM CATALYST (Feb. 1, 2018), https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268; *see also* Deborah Farringer, *A Telehealth Explosion: Using Lessons from the Pandemic to Shape the Future of Telehealth Regulation*, 9 TEX. A&M L. REV. 3, 6 (2021) (explaining that some health insurance programs might use telehealth more when referring to what this article refers to as telemedicine); 42 U.S.C. § 1834 (stating that Medicare defines "telehealth service" in part as "professional consultations, office visits, and office psychiatry services.").

[9] *See* FED'N STATE MED. BDS., *supra* note 7. It is worth noting that for discussions about health care fraud, the only relevant telemedicine or telehealth is that which can be billed to health insurance companies, and thus the subject of fraud. *See, e.g.*, 18 U.S.C. § 1347 (addressing fraud against "any health care benefit program"); 18 U.S.C. § 1347(b) (defining health care benefit program as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes

A. The Potential Benefits of Telemedicine

Telemedicine has many potential benefits that could improve access to health care. As discussed below, these benefits can be grouped into three categories.

First, telemedicine can facilitate greater and quicker access to health care by increasing access to primary care physicians in underserved areas.[10] This could be especially beneficial for rural areas, which have struggled with physician shortages.[11] In addition, telemedicine could increase access not only to primary care, but to specialists in all areas.[12] Areas with adequate access to primary care physicians may not have similar access to certain specialists.[13] For those with rare disorders who live far from specialists, it could allow patients to access more specialized care more quickly.[14] Further, telemedicine could realistically improve healthcare by providing easier access to patients by reducing the need for traveling.[15] A patient who has to travel far to access care may be less likely to access that care if the patient has to take leave (especially if unpaid leave, thus losing income) from work, and/or the patient has to find childcare (for which the patient may also have to pay for thus incurring additional costs).[16] For patients with specific medical conditions for whom travel is difficult, telemedicine makes it possible to access care.[17] The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) puts it best: "For most, telehealth expansion is viewed positively, offering opportunities to increase access to services, decrease burdens for both patients and providers, and enable better care, including enhanced mental health care."[18]

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any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."). Telemedicine—i.e., care limited to clinical services—are the only types of remote care that are likely to be billable.

[10] Katrice Bridges Copeland, *Telemedicine Scams*, 108 IOWA L. REV. 69, 71 (2022); *see Healthcare Fraud Prevention Partnership*, *Exploring Fraud, Waste, and Abuse Within Telehealth* 13 (2023), https://www.cms.gov/files/document/hfpp-white-paper-exploring-fraud-waste-abuse-within-telehealth.pdf [hereinafter *HFPP White Paper*].

[11] Regina A. Bailey, *The Legal, Financial, and Ethical Implications of Online Medical Consultations*, 16 J. TECH. L. & POL'Y 53, 61 (2011).

[12] *HFPP White Paper*, *supra* note 10, at 13.

[13] Bailey, *supra* note 11, at 61.

[14] *Id.*

[15] *HFPP White Paper*, *supra* note 10, at 13.

[16] *Id.*

[17] Copeland, *supra* note 10, at 76.

[18] Christi A. Grimm, *Principal Deputy Inspector General Grimm on Telehealth*, U.S. DEP'T HEALTH & HUM. SERVS., OFF. INSPECTOR GEN. (Feb. 26, 2021), https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp.

Second, telemedicine could lead to better quality care. By giving the provider better insight into the patient's home situation, it could better situate the provider to make treatment recommendations.[19] Moreover, direct access to primary care physicians could result in earlier interventions, which could result in earlier medical interventions and improve patient health.[20]

Relatedly, telemedicine could reduce health care costs. As noted, access to primary care physicians could result in earlier interventions, which would improve patients' health, but also could avoid the need for costly care later down the road.[21] Telemedicine could lower health care costs simply by reducing the number of emergency room visits.[22] Given that "79% of emergency room visits are for routine and non-emergency problems,"[23] it could reduce the incidence of unnecessary and expensive emergency room care.[24] Theoretically, this would also translate into better care to others as it would reduce the wait times for those who may be in greater dire need of emergency care.[25]

B. COVID-19 Led to Expanded Use of Telemedicine

In 2019, the United States, was impacted by Coronavirus Disease 2019 ("COVID-19"). In response, in January 2020, the United States government declared a Public Health Emergency (PHE),[26] which stayed in effect through May 2023.[27] As set out below, the pandemic resulted in many health insurance plans, with the government's encouragement,

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[19] *HFPP White Paper*, *supra* note 10, at 13.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] Bailey, *supra* note 11, at 61.
[24] *Id.*
[25] *See id.* (noting that the use of the emergency room for non-emergency visits "caus[es] a 40% increase in wait times for the people that need immediate attention in an emergency room.").
[26] *Determination That a Public Health Emergency Exists*, U.S. DEP'T HEALTH & HUM. SERVS., ADMIN. FOR STRATEGIC PREPAREDNESS & RESPONSE (Jan. 31, 2020), https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx.
[27] *Infectious Diseases, Coronavirus Disease 2019 (COVID-19)*, CMS.GOV (Sept. 6, 2023, 4:51 PM), https://www.cms.gov/about-cms/what-we-do/emergency-response/past-emergencies/infectious-diseases (showing that the COVID-19 PHE was renewed multiple times between Jan. 27, 2020 and Feb. 9, 2023); *see also Current Emergencies*, CMS.GOV, https://www.cms.gov/about-cms/what-we-do/emergency-response/current-emergencies) (last updated Nov. 7, 2023) (noting that the COVID-19 PHE ended on May 12, 2023).

relaxing the rules to make telemedicine more easily reimbursable.[28] The highly contagious nature of the disease, along with its potentially deadly outcomes, made it difficult for patients to see their healthcare providers in-person.[29] The concerns with seeing COVID-19 patients in-person were many.[30] They included concerns that such visits risked spreading the virus to other patients as well as providers, and could result in non-COVID-19 patients foregoing health care out of fear that they would be exposed to the virus at the provider's facility.[31] To address these problems, health insurance plans loosened their rules to permit providers to obtain reimbursement even when they did not treat patients in-person.[32]

For instance, prior to the pandemic, Medicare permitted coverage for telemedicine services only under certain strict conditions.[33] These conditions required (1) the beneficiary to live in a rural or health professional shortage area;[34] (2) the services to be delivered in an interactive audio and video telecommunication system;[35] (3) the originating site for the telemedicine visit to be a practitioner's office or a specified medical facility;[36] and (4) only certain providers—including physicians, physician assistants, and nurse practitioners—to provide the telemedicine services.[37]

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[28] Annalisa Merelli, *Telehealth Fraud Has Cheated the US of Billions in the Pandemic*, YAHOO!FINANCE (June 4, 2021), https://finance.yahoo.com/news/telehealth-fraud-cheated-us-billions-204030356.html.
[29] Farringer, *supra* note 8, at 3.
[30] *Id.*
[31] *Id.*; *see also HFPP White Paper*, *supra* note 10, at 3-4.
[32] Nandita Khera et al., *Payment and Coverage Parity for Virtual Care and In-Person Care: How Do We Get There?*, TELEMED REP. (May 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10240289/ ("[I]n the wake of the COVID-19 pandemic, telehealth use surged because Medicare and private payers eased payment restrictions."). For a detailed discussion of the changes various insurance plans made, *see* Farringer, *supra* note 8, at 22-35; *See also HFPP White Paper*, *supra* note 10, at 9-10.
[33] Copeland, *supra* note 10, at 79-82 (summarizing pre-COVID-19 PHE Medicare telemedicine coverage); *HFPP White Paper*, *supra* note 10, at 6.
[34] 42 C.F.R. § 410.78(b)(4)(i)–(iii) (specifying that an originating site must be "([L]ocated in a health professional shortage area (as defined under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) that is either outside of a Metropolitan Statistical Area (MSA) as of December 31st of the preceding calendar year or within a rural census tract of an MSA . . . as of December 31st of the preceding calendar year, or (ii) [l]ocated in a county that is not included in a [MSA] . . . as of December 31st of the preceding year, or (iii) [a]n entity participating in a Federal telemedicine demonstration project that has been approved by, or receiving funding from, the Secretary as of December 31, 2000, regardless of its geographic location.")); Copeland, *supra* note 10, at 80.
[35] 42 C.F.R. § 410.78(a)(3) (2024); Copeland, *supra* note 10, at 80.
[36] *Id.* at § 410.78(b)(3); Copeland, *supra* note 10, at 80-81.
[37] Copeland, *supra* note 10, at 81.

During the pandemic, however, these strict rules were waived or relaxed.[38] For instance: (1) beneficiaries no longer had to live in rural or professional shortage areas to qualify for telemedicine services; (2) care, even for first-time patients, could be delivered via audio-only mediums (thus "alleviating some concerns about disparate access to broadband and electronic devices"[39]; (3) the originating site for the telemedicine visit no longer had to be a practitioner's office or a specified medical facility, but instead could be the patient's home[40]; and (4) the types of providers who could provide telemedicine services was expanded to include other providers such as occupational therapists.[41]

In light of these relaxed rules, "the number of telemedicine visits skyrocketed during the first year of the pandemic."[42] Prior to the declaration of a PHE by the United States, telemedicine visits accounted for a small percentage of total care visits, but within the first six months of the PHE, total telemedicine visits increased by more than 2,000 percent.[43] After the COVID-19 PHE expired in May 2023, CMS announced changes to Medicare's telemedicine policies.[44] The majority of the relaxed rules would extend only until December 31, 2024, after which telemedicine would generally be allowed for behavioral care but would revert to the initial stricter rules for non-behavioral care.[45]

C. Telemedicine as the Panacea to Health Inequities?

Given the potential benefits set out in Part I.A, telemedicine has been cited—before and after the declaration of the COVID-19 public health

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[38] *See HFPP White Paper*, *supra* note 10, at 8-9; Copeland, *supra* note 10, at 71, 83-89 (summarizing changes to Medicare telemedicine coverage during the COVID-19 PHE).
[39] Copeland, *supra* note 10, at 71.
[40] *Id.* at 84.
[41] *Id.* at 81, 85.
[42] *Id.* at 71.
[43] FED'N STATE MED. BDS., *supra* note 7 (noting that "Certain specialties, such as psychiatry, endocrinology and neurology, saw greater increases in telemedicine utilization than others."); *see HFPP White Paper*, *supra* note 10, at 11 ("HFPP Partner-reported data for Medicare, Medicaid, and private payers combined also showed an increase in the total days in which healthcare was delivered via telehealth by a provider by 5,753% between February 2020 and April 2020").
[44] DEP'T HEALTH & HUM. SERVS., *Telehealth Policy Changes After the COVID-19 Public Health Emergency*, https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency (last updated Dec. 19, 2023).
[45] *Id.*; CTRS. FOR MEDICARE & MEDICAID SERVS., *Frequently Asked Questions: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency*, at 7 (May 19, 2023), https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf.

emergency—as a promising "way to increase access to healthcare in underserved communities" and thereby improve health equity.[46] Proponents describe it as a way to "ameliorat[e] some of the stresses on" the health care system including access to primary care physicians and other specialists.[47] The CMS Strategic Plan on Health Equity includes as one of its "actions to date" an effort to increase access to health care in rural areas by "creating flexible telehealth policies for people to access care.[48] The Federation of State Medical Boards has also lauded the potential benefits of telemedicine with respect to health inequity, albeit with the caveat that structural barriers to accessing telemedicine would need to be addressed.[49] It stated "[w]hen utilized and deployed effectively as a seamlessly integrated part of healthcare delivery, telemedicine can improve access and reduce inequities in the delivery of healthcare."[50]

Reflecting this hope that telemedicine could serve as a solution to health equity issues, lawmakers and presidents have sought to take action to expand the use of telemedicine. For instance, in August 2020, then-President Trump issued an executive order that emphasized the need to improve access to health care through telehealth, particularly in rural areas.[51] Later that year, in November 2020, "congressional lawmakers submitted a bill titled the Expanded Telehealth Access Act," which they reintroduced in a few months later.[52] The bill "aim[ed] to permanently

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[46] Copeland, *supra* note 10, at 71; *see* Farringer, *supra* note 8, at 6-22 (presenting a detailed overview of telemedicine technologies and the evolution of telemedicine). Criticisms of telemedicine often focused on structural issues (such as broadband access) that limited the ability of patients to access it. *See, e.g.*, Laura C. Hoffman, *Reconnecting the Patient: Why Telehealth Policy Solutions Must Consider the Deepening Digital Divide*, 19 IND. HEALTH L. REV. 351, 351 (2022); Priya Bathija & Sarah E. Swank, *Digital Health Equity: Narrowing the Digital Divide By Ensuring A Fair, Equitable, and Just Opportunity to Access Digital Health*, 16 J. HEALTH & LIFE SCIS. L. 26, 26 (2022); Brian L. VanderBeek, *Telemedicine and the Exacerbation of Health Care Disparities*, JAMA OPHTHALMOLOGY (Sept. 23, 2021), https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2784461.

[47] Claire Cain Miller, *The Virtual Visit May Expand Access to Doctors*, HERALD-TRIBUNE (Dec. 21, 2009), https://www.heraldtribune.com/story/news/2009/12/21/the-virtual-visit-may-expand/28911917007/.

[48] CTRS. FOR MEDICARE & MEDICAID SERVS., *CMS Strategic Plan: Health Equity*, 2 (2023), https://www.cms.gov/files/document/health-equity-fact-sheet.pdf; *see* CTRS. FOR MEDICARE & MEDICAID SERVS., *About Us*, https://www.cms.gov/about-cms (last visited Apr. 8, 2024). CMS's strategic plan is relevant because it "is the federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace."

[49] FED'N STATE MED. BDS., *supra* note 7, at 11.

[50] *Id.*

[51] Exec. Order No. 13,941, 85 Fed. Reg. 47, 881 (Aug. 6, 2020).

[52] Farringer, *supra* note 8, at 4.

expand Medicaid coverage for certain services for which restrictions were waived during the pandemic."[53]

II. NOT SO FAST: IS TELEMEDICINE UNIQUELY VULNERABLE TO FRAUD?

Notwithstanding telemedicine's potential promise as a path to improving access to health care, its intersection with fraud suggests we should proceed with caution. In recent years, government and private entities have highlighted the incidence of fraud in telemedicine.[54]

A. A "Telefraud Explosion"?[55]

What follows is an overview of recent DOJ national enforcement actions and Centers for Medicare and Medicaid administrative actions, a special fraud alert by the Department of Health and Human Services Office of Inspector General (HHS-OIG), and a study by a public-private partnership focused on studying fraud.[56] These actions, alerts, and study help illustrate the occurrence of fraud in telemedicine.

1. DOJ Takedowns and CMS Enforcement Actions

Since 2019, DOJ has announced five nationwide coordinated law enforcement actions, commonly referred to as "takedowns," that were focused on telemedicine fraud schemes and that together have involved over $9 billion in fraud.[57] These schemes were similar in that they

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[53] *Id*. at 34-38 (discussing various efforts to make telemedicine waivers permanent); Letter from Richard J. Pollack, President & Chief Exec. Officer, Am. Hosp. Ass'n, to Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs. (June 26, 2020), https://www.aha.org/system/files/media/file/2020/06/aha-urge-cms-to-extend-certain-covid-19-flexibilities-letter-6-26-20.pdf (recommending that certain telemedicine waivers be made permanent).

[54] *See, e.g.*, Miranda Hooker et al., *Fraud Emerges as Telehealth Surges*, ABA WHITE COLLAR CRIME COMM. NEWSL. 1 (2021) ("[A]s an uptick in Department of Justice (DOJ) prosecutions of telemedicine arrangement indicates, telemedicine fraud and abuse risks abound."), https://www.americanbar.org/content/dam/aba/publications/criminaljustice/2021/telehealth_fraud.pdf.; Merelli, *supra* note 28; *see infra* Part II.A.

[55] *See* Farringer, *supra* note 8. This is a play on the title of Professor R. Farringer's article.

[56] *See infra* Part II.A; *HFPP White Paper*, *supra* note 10, at 16 (noting that bad actors have taken advantage of the increased use of telemedicine by "repurpose[ing] previously existing fraud, waste, and abuse schemes or creat[ing] new ones.").

[57] Press Release, U.S. Dep't Just., Off. Pub. Affs., Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud, Nationwide Coordinated Law Enforcement Action to Combat Telemedicine, Clinical Laboratory, and Durable Medical Equipment (July 20,

typically involved supply or testing companies paying kickbacks to providers, through a diffuse network of marketers, to induce the providers to make referrals for medically unnecessary items or services—often for elderly or otherwise vulnerable patients—that would be billed for by the supply or testing company and that were ostensibly justified based on telemedicine visits.[58] In addition, they covered multiple states and jurisdictions and often included internationally-based participants.[59]

The first of these takedowns occurred in April of 2019, when the DOJ announced Operation Brace Yourself.[60] This takedown targeted a $1.2 billion scheme by durable medical equipment (DME) companies that paid kickbacks to providers to incentivize them to refer or prescribe medically unnecessary back, shoulder, wrist, and knee braces using telemedicine.[61] The referrals were typically issued to elderly and disabled patients, and where patient interaction existed, took the form of a brief telephone conversation between patients providers they had never interacted with before.[62]

Of note, these schemes affected 17 jurisdictions and had an international dimension to them in that they targeted beneficiaries through "call centers in the Philippines and throughout Latin America." [63]

Then in September of 2019, the DOJ announced Operation Double Helix.[64] This takedown targeted a $2.1 billion scheme by telemedicine

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2022), https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud (discussing 2022 and four prior takedowns and noting that four prior takedowns involved "over $8 billion in fraud").

[58] *See infra* notes 60, 64, 69, 74, and 77; *see also* Press Release, Off. Inspector Gen., U.S. Dep't Health & Hum. Servs., Statement of Principal Deputy Inspector General Grimm on Telehealth (Feb. 26, 2021), https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp ("In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests.").

[59] *See infra* notes 60, 64, 69, 74, and 77.

[60] FED. BUREAU INVESTIGATION, *Billion-Dollar Medicare Fraud Bust: FBI Announces Results of Operation Brace Yourself*, (Apr. 9, 2019), https://www.fbi.gov/news/stories/billion-dollar-medicare-fraud-bust-040919; Press Release, U.S. Dep't Just., Off. Pub. Affs., Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over $1.2 Billion in Losses (Apr. 9, 2019), https://www.justice.gov/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes [hereinafter DOJ Federal Indictments Press Release].

[61] DOJ Federal Indictments Press Release, *supra* note 60.

[62] *Id.*

[63] *Id.*

[64] Press Release, U.S. Dep't Just., Off. Pub. Affs., Federal Law Enforcement Action Involving Fraudulent Genetic Testing Results in Charges Against 35 Individuals

companies and cancer genetic testing laboratories.[65] Like the April takedown, the schemes involved paying kickbacks to providers to induce them to make medically unnecessary referrals, but this time for cancer genetic tests.[66] The schemes also targeted "hundreds of thousands" of elderly and disabled patients, and patient interaction (where it existed) was limited to brief telephone conversations with patients providers had not previously seen.[67] The schemes "spanned multiple jurisdictions."[68]

Next, in 2020, the DOJ announced Operation Rubber Stamp.[69] This enforcement action involved variety of schemes, with $4.5 billion of the $6 billion attributed to telemedicine schemes.[70] Similar to the 2019 targets, these schemes involved executives of telemedicine programs paying kickbacks to medical providers to induce them to refer medically unnecessary items and services—specifically "durable medical equipment, genetic and other diagnostic testing, and pain medications."[71] Once again, providers made referrals with patient interaction, where it existed, limited to brief telephone calls with patients the providers had never met or seen.[72] This takedown spanned conduct in 51 federal jurisdictions.[73]

A little over a year later, in September 2021, the DOJ announced a National Health Care Enforcement Action involving $1.4 billion in alleged fraud, $1.1 billion of which focused on telemedicine services.[74] Like the

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Responsible for Over $2.1 Billion in Losses in One of the Largest Health Care Fraud Schemes Ever Charged (Sept. 27, 2019), https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against.

[65] *Id.*

[66] *Id.*

[67] *Id*.

[68] *Id.*

[69] *See* Operation Rubber Stamp: Major health care fraud investigation results in significant new charges, U.S. Atty' Off. (Oct. 7, 2020), https://www.justice.gov/usao-sdga/pr/operation-rubber-stamp-major-health-care-fraud-investigation-results-significant-new (discussing Southern District of Georgia cases in the takedown); Press Release, U.S. Dep't of Just., Off. of Pub. Affs., National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than $6 Billion in Alleged Fraud Losses (Sept. 30, 2020), https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud.

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., National Health Care Fraud Enforcement Action Results in Charges Involving over $1.4 Billion in Alleged Losses (Sept. 17, 2021), https://www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion.

others, the schemes involved telemedicine executives paying kickbacks to medical providers to induce them to refer medically unnecessary DME, genetic and other diagnostic testing, and pain medications with patient interaction, when present, taking the form of brief telephonic conversations with patients providers had not previously met or seen.[75] The conduct in this takedown cut across 11 jurisdictions.[76]

Less than a year later, in July 2022, the DOJ announced a "nationwide coordinated law enforcement action to combat telemedicine, clinical laboratory, and durable medical equipment fraud."[77] This takedown involved more than $1.2 billion in fraudulent telemedicine, cardiovascular and cancer genetic testing, and DME schemes.[78] Like the prior takedowns, these schemes involved the laboratory and DME companies and marketers paying kickbacks to medical providers to induce them to issue medically unnecessary items and services—here DME and testing.[79] These schemes also targeted elderly and disabled patients, spanned 13 jurisdictions, and also involved a telemarketing network that was partly located outside the United States.[80]

In each of these takedowns, the Centers for Medicare & Medicaid Services, Center for Program Integrity (CMS/CPI) announced that it took administrative action against the supply companies and providers.[81]

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[75] *Id.*
[76] *Id.*
[77] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud, Nationwide Coordinated Law Enforcement Action to Combat Telemedicine, Clinical Laboratory, and Durable Medical Equipment (July 20, 2022), https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud.
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Fed. Indictments & L. Enf't Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Med. Equip. Marketing Executives Results in Charges Against 24 Individuals Responsible for Over $1.2 Billion in Losses (Apr. 9, 2019), https://www.justice.gov/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes; Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Fed. L. Enf't Action Involving Fraudulent Genetic Testing Results in Charges Against 35 Individuals Responsible for Over $2.1 Billion in Losses in One of the Largest Health Care Fraud Schemes Ever Charged (Sept. 27, 2019), https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against (Sept. 2019 Takedown); Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Nat'l Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than $6 Billion in Alleged Fraud Losses (Sept. 30, 2020), https://www.justice.gov/criminal/criminal-fraud/hcf-2020-takedown/press-release (2020 Takedown); Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Nat'l Health Care Fraud Enf't Action Results in Charges Involving over $1.4 Billion in Alleged Losses

2. Special Fraud Alert on Telemedicine

On the same day as the July 2022 takedown was announced, HHS-OIG took the additional step of issuing a Special Fraud Alert that warned medical providers to exercise caution before working with telemedicine companies.[82] The alert was only one of 17 that HHS-OIG has issued since 1994.[83] It highlighted the growing incidence of telemedicine fraud and expressed concerns about bad actors who were "exploit[ing] the growing acceptance and use of telehealth."[84]

The alert noted that the schemes involved a wide range of individuals and types of entities, "including international and domestic telemarketing call centers, staffing companies, Practitioners, marketers, brokers, and others."[85] It explained that although the schemes varied in design and operation, they followed similar patterns.[86] Those patterns, which are similar to those described in the last subsection, were as follows: (1) the telemedicine company hires marketers to identify and/or recruit patients; (2) the company or marketers pay kickbacks to providers to induce them to issue referrals; (3) the providers, so incentivized, then issue referrals for items or services for patients with whom they have likely had "limited, if any, interaction," and "without regard to medical necessity" and often without even being provided the patients' medical records; (4) indeed, the telemedicine company might instruct the providers to "order or prescribe a preselected item or service, regardless of medical necessity or clinical appropriateness"; and (5) the telemedicine company sells the order or

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(Sept. 17, 2021), https://www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion (2021 Takedown); Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Just. Dep't Charges Dozens for $1.2 Billion in Health Care Fraud, Nationwide Coordinated L. Enf't Action to Combat Telemedicine, Clinical Lab'y, and Durable Med. Equip. (July 20, 2022), https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud (2022 Takedown).

[82] DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., HHS-OIG, SPECIAL FRAUD ALERT: OIG ALERTS PRACTITIONERS TO EXERCISE CAUTION WHEN ENTERING INTO ARRANGEMENTS WITH PURPORTED TELEMEDICINE COMPANIES (July 20, 2022) [hereinafter *HHS-OIG 2022 SFA*], https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pdf.

[83] *See generally, Special Fraud Alerts, Bulletins, and Other Guidance,* U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., HHS-OIG, https://oig.hhs.gov/compliance/alerts. Notably, two others were focused on telemarketing efforts (as distinguished from telemedicine) by durable medical equipment suppliers (noting the Jan. 13, 2010 and Mar. 3, 2003 alerts).

[84] *HHS-OIG 2022 SFA supra* note 82, at 1. As noted, this acceptance and use grew in response to the COVID-19 PHE. *See supra* Part I.B.

[85] *Id.*

[86] *Id.* at 1, 3.

prescription generated by the providers to other individuals or entities that then fraudulently bill for the unnecessary items and services.[87]

3. Healthcare Fraud Prevention Partnership Study on Telemedicine

In 2023, the Health Care Fraud Prevention Partnership (HFPP), in collaboration with the Stanford University School of Medicine, issued a study focused on "telehealth"[88] fraud entitled "Exploring Fraud, Waste, and Abuse Within Telehealth."[89] HFPP describes itself as "a voluntary, public-private partnership between the federal government, state and local agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations," that encourages the exchange of data and information among its members in an effort to proactively identify and address healthcare fraud.[90]

The study found that although the increased use and acceptance of telemedicine services helped the health care sector adapt to the challenges of COVID-19, it also resulted in bad actors using telemedicine either to broaden the reach of existing fraud schemes and "create novel ones."[91] Schemes varied, but often involved telemedicine companies using telemarketing to target beneficiaries, paying health care providers kickbacks to order or prescribe medically unnecessary items or services, and/or using a telemedicine visit to steal a beneficiary's identity to use it for future fraudulent billing.[92]

In sum, these takedowns, the special fraud alert, and this HFPP study indicate that the increased use of telemedicine was accompanied by increased fraud. The schemes typically involved multiple individuals and entities located in multiple domestic and sometimes international jurisdictions, often included paying kickbacks to providers who had little

[87] *Id.* at 1, 4. The Special Fraud Alert described other suspect characteristics of provider arrangements with telemarketing companies, such as payments based on the volume of items ordered or prescribed, that could suggest greater risk for fraud.
[88] *See HFPP White Paper*, *supra* note 10, at 3-4 (using telehealth primarily as telemedicine is defined in this article).
[89] *Id.*; *see also* Healthcare Fraud Prevention Partnership, *Healthcare Fraud Prevention Partnership Releases White Paper on Telehealth-Related Fraud, Waste, and Abuse*, PR NEWSWIRE (May 10, 2023), https://www.prnewswire.com/news-releases/healthcare-fraud-prevention-partnership-releases-white-paper-on-telehealth-related-fraud-waste-and-abuse-301820451.html [*hereinafter HFPP Press Release]*.
[90] *About the Partnership*, CTRS FOR MEDICARE & MEDICAID SERVS. (Jan. 30, 2024), https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership/about.
[91] *HFPP White Paper*, *supra* note 10, at 4.
[92] *Id.* at 4. ("HFPP Partners listed primary care, E/M services, behavioral health, physical therapy, occupational therapy, and speech therapy as specific service areas of concern for fraudulent activity.").

or no interaction with beneficiaries to induce them to issue referrals for medically unnecessary DME and testing, and frequently targeted vulnerable beneficiaries, such as the elderly and low-income.

B. Does Fraud Thrive in Telemedicine?

Fraud flourishes in the United States health care system—within and outside of telemedicine,[93] because it is perceived as a low-risk, high-reward undertaking.[94] It is relatively easy to commit, with low chances of getting caught (or even if caught, low chances of getting prosecuted, or getting a meaningful sentence), and high chances of making a lot of money in the process.[95] Indeed, this low-risk, high-reward nature has reportedly led to the Mafia switching from drug dealing and other violent crimes to health care fraud.[96] Accordingly, health care fraud is estimated to account for between three to 10 percent of health care spending in the United States,[97] which in 2021, with $4.3 trillion spent on health care, translated to $129 billion and $430 billion respectively in spending lost to health care fraud in just that year.[98]

To understand why telemedicine fraud might be particularly vulnerable to fraud, one must first understand why and how health care (more generally) is susceptible to fraud. Briefly, health care fraud thrives

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[93] *See The Challenge of Health Care Fraud*, NAT'L HEALTH CARE ANTI-FRAUD ASS'N., https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/; Chinelo Dike-Minor, *The Devil Made Me Do It: An Argument for Expanding the Anti-Kickback Statute to Cover Private Payers*, 56 CONN. L. REV. 87, 95 (2023).
[94] *Health Insurance: Legal and Resources Constraints Complicate Efforts to Curb Fraud and Abuse*, U.S. GEN. ACCT. OFF. (Feb. 4, 2003), https://www.gao.gov/assets/t-hrd-93-3.pdf ("Only a fraction of the fraud and abuse committed against the health care system is identified and prosecuted and that which has been detected has involved substantial sums").
[95] *See, e.g.*, United States v. Howard, 28 F.4th 180, 209 (11th Cir. 2022); United States v. Kuhlman, 711 F.3d 1321, 1328 (11th Cir. 2013).
[96] Edecio Martinez, *Health Care Goodfellas: Mafia Turns to Medicare Fraud*, CBS NEWS, (Oct. 7, 2009), https://www.cbsnews.com/news/health-care-goodfellas-mafia-turns-to-medicare-fraud/ (discussing the prosecution of Mafia members for health care fraud and stating that "For criminals, Medicare schemes offer a greater payoff and carry much shorter prison sentences than offenses such as drug trafficking or robbery"); *Id.* ("A Medicare scammer could easily net at least $25,000 a day while risking a relatively modest 10 years in prison if convicted on a single count. A cocaine dealer could take weeks to make that amount while risking up to life in prison"); Press Release, U.S. Dep't of Just., Off. of Pub. Affs., 73 Members and Associates of Organized Crime Enterprise, Others Indicted for Health Care Fraud Crimes Involving More Than $163 Million, (Oct. 13, 2010), https://www.justice.gov/opa/pr/73-members-and-associates-organized-crime-enterprise-others-indicted-health-care-fraud-crimes.
[97] *The Challenge of Health Care Fraud, supra* note 93; Dike-Minor, *supra* note 93, at 8.
[98] Dike-Minor, *supra* note 93, at 8.

because health care (1) relies on trust; (2) is a high-volume business, which to operate with limited delays requires automated processes which necessarily means limited review of claims; and (3) operates in a very complex environment with complicated and dense laws and rules, high levels of decentralized and fragmentation, and heavy documentation, which makes detecting, investigating, and prosecuting it very challenging.[99] The following subsections discuss each of these features in more detail.

4. Reliance on Trust

The health care system relies in large part on trust—trust between the provider and patient, and trust between the provider and health insurance company.[100] This trust is a necessary feature of the system because providers are more likely to render timely health services if they receive, or can expect to receive, prompt payment for their work.[101] Indeed, it would be unworkable and significantly delay patients' treatment and care if every visit to a provider or referral by a provider was subject to pre-

[99] *See* Malcolm K. Sparrow, *Fraud Control in the Health Care Industry: Assessing the State of the Art*, NAT'L INST. OF J. RSCH. IN BRIEF 1, 5-6 (Dec. 1998), https://www.ojp.gov/pdffiles1/172841.pdf (providing a more complete discussion of the features of the health care system that make the detection of fraud particularly difficult).

[100] *See* Pamela H. Bucy, *Fraud By Fright: White Collar Crime By Health Care Providers*, 67 N.C. L. REV. 855, 875 (1989) ("The patient-physician relationship epitomizes such trust. Often in pain, fearful of death, the sick have a special thirst for reassurance and vulnerability to belief."); David Mechanic, *Some Dilemmas in Health Care Policy*, 59 MILBANK MEM'L FUND Q. 1, 4 (1981) ("Feeling highly dependent on such relationships, the typical patient has a strong need to see [his own physician] as an ally"); *Health Care Fraud*, GAO WATCHDOG REP., AUDIO INTERVIEW BY GAO STAFF WITH KATHLEEN M. KING, at 4:42 to 5:10 (Feb. 22, 2016), https://www.gao.gov/podcast/health-care-fraud ("Part of the reason that we don't have a reliable estimate [of health care fraud] at this point is because providers could do things that look legitimate on their face. For example, they could be properly enrolled in Medicare and they could submit a bill or a claim that looks perfectly legitimate. But if it is for a service that has never been provided or if they bill for a higher level of service than the one they provided, [it is] very difficult to tell that through the claims process"); *Howard*, 28 F.4th at 209 ("Just as insurance companies must rely on the honesty and integrity of medical practitioners in making diagnoses and billing, the government must rely on them when it's administering health care programs like Tricare").

[101] Medicare adopted a rapid payment system because Congress feared that providers would refuse Medicare patients without a prompt payment agreement in place. *See* Michael Loucks & Carol Lam, PROSECUTING & DEFENDING HEALTH CARE FRAUD CASES, 2d, Chap. 1, at 4-5 (BUREAU OF NAT'L AFF., 2001) [hereinafter LOUCKS & LAM]; *Howard*, 28 F. 4th at 209 (quoting a Tricare witness who describe "the [Tricare] system is based on trust").

authorization by health insurance plans.[102] Accordingly, health insurers must rely on providers to be honest when treating patients.[103]

5. High Volume Business

Relatedly, health care is a high-volume business with health insurers "adjudicat[ing] over three billion medical claims each year across commercial and governmental lines of business."[104] In view of the number of claims processed by health insurance plans, many of the checks on fraud occur after health care services have been rendered and payment made.[105] To avoid delaying patient care, payments are largely made automatically and immediately.[106] Reviews of billed claims often take the form of post-payment random audits that target only a very small number of claims.[107] Thus, much fraud can go undetected.

6. Complex Environment

When fraud is detected, the complexity inherent in these cases makes investigating and prosecuting them particularly difficult.[108] This complexity comes in multiple forms including the subject matter, the

[102] *See Howard*, 28 F.4th at 209 (noting that TRICARE proceeds on trust because not doing so would "put red tape in the way of veterans getting the care that they need); Andis Robeznieks*, Once Just a Burden, Prior Authorization Has Become a Nightmare*, AMA (May 3, 2023), https://www.ama-assn.org/practice-management/prior-authorization/once-just-burden-prior-authorization-has-become-nightmare; Kevin B. O'Reilly, *1 in 3 Doctors Has Seen Prior Auth Lead to Serious Adverse Event*, AMA (Mar. 29, 2023), https://www.ama-assn.org/practice-management/prior-authorization/1-3-doctors-has-seen-prior-auth-lead-serious-adverse-event.
[103] *Howard*, 28 F.4th at 209. (alterations and citations omitted).
[104] Peter Orszag & Rahul Rekhi, *Real-Time Adjudication for Health Insurance Claims*, 1% STEPS FOR HEALTH CARE REFORM, 2 https://onepercentsteps.com/wp-content/uploads/brief-rta-210208-1700.pdf (citing Council for Affordable Quality Healthcare (CAQH). 2020. "2019 CAQH INDEX® A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings." Council for Affordable Quality Healthcare).
[105] Malcolm K. Sparrow*, Fraud in the U.S. Health-Care System: Exposing the Vulnerabilities of Automated Payments Systems*, 75 SOCIAL RESEARCH 1151, 1153-54 (2008).
[106] *See* Loucks & Lam, *supra* note 101, at 5 ("The sheer volume of claims processed by Medicare annually requires that the overall system be structured to pay claims promptly.").
[107] *See* Malcolm K. Sparrow, LICENSE TO STEAL: HOW FRAUD BLEEDS AMERICA'S HEALTH CARE SYSTEM 84 (updated ed. 2000) (arguing that even those audits that are done do not adequately identify fraud since a well-documented fraudulent claim can evade detection. The health care billing system does have several pre-payment checks, but they do not capture significant amounts of fraud.); Joan H. Krause, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J.L. & MED. 343, 364-65 (2010).
[108] Loucks & Lam, *supra* note 101, at 2.

health system, the regulations and laws governing health care, and the sheer volume of documents in a case.

To begin, determining whether health care fraud has been committed often requires a basic understanding of health care, something many prosecutors, as lawyers, lack. For instance, in a compounding pharmaceutical fraud case a prosecutor would need to understand the difference between compounded drugs and non-compounded drugs.[109] The prosecutor would also need to obtain some basic understanding of the ingredients in these drugs to explain why they have no medical value.[110] Similarly, in a controlled substance prescription case, a prosecutor would need to understand the different types of controlled substances, when they might be prescribed, and the dangers in prescribing combinations.[111] Health care fraud cases assigned to prosecutors can range from fraud in ambulance and transportation services to pharmaceutical companies, to durable medical equipment, to genetic testing to home health services to hospice care to controlled substances, and more.[112] Each type of case requires some basic level of understanding of the health service (or more likely, health services) in question before a prosecutor can effectively investigate and prosecute the case.

Next, understanding the fraudulent scheme in question also requires an understanding of how the particular health service being investigated is structured and administered. The United States health care system is what Professor Joan Krause has described as "decentralized."[113] It is a

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[109] *FDA's Human Drug Compounding Progress Report: Three Years After Enactment of the Drug Quality and Security Act*, U.S. FOOD & DRUG ADMIN. (Jan. 26, 2024), https://www.fda.gov/drugs/guidance-compliance-regulatory-information/human-drug-compounding.

[110] *See, e.g.*, U.S. Motion in Limine to Preclude Proposed Expert Testimony, United States v. Paul Roberts MD, et al, No. 2:18-cr-00470 doc. 117 (N.D. Ala. Sep 26, 2018), ECF No. 117 (describing ingredients use and function of ingredients in in various compounded drugs to attack legitimacy of defense expert).

[111] *See, e.g.*, Autumn Amber Wolf, *The Perfect Storm: Opioid Risks and 'The Holy Trinity'*, PHARMACY TIMES (Sept. 24, 2014), https://www.pharmacytimes.com/view/the-perfect-storm-opioid-risks-and-the-holy-trinity.

[112] Criminal Division, U.S. Dep't of Just., Recent Enforcement Actions, https://www.justice.gov/criminal/criminal-fraud/recent-national-enforcement-actions (providing descriptions of enforcement actions regarding a variety of schemes); CMS, CALENDAR YEARS 2021-2022: HEALTH CARE FRAUD PREVENTION PARTNERSHIP BIENNIAL REPORT TO CONGRESS 14 (2023), https://www.cms.gov/files/document/hfpprtc92023.pdf (describing types of schemes HFPP issues alerts on); U.S. DEP'T. OF HEALTH & HUM. SERVS. & THE DEP'T OF JUST., Health Care Fraud & Abuse Control Program Annual Reports (FY 1997 to 2020), https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/health-care-fraud-and-abuse-control-program-report-fiscal-year-1997/ (click "Previous Fiscal Years" and select specific year for respective report, such as "Fiscal Year 1997" for the 1997 report).

[113] Krause, *supra* note 107, at 349.

fragmented system, with multiple payers who generally work with multiple third-party administrators, all of whom have their own rules and payment systems.[114] This additional layer of complexity means that a prosecutor has to understand how a health benefit is administered in order to accurately identify where relevant evidence could be found. Take, for instance, an office visit upcoding case—i.e., a case involving allegations that a physician submitted billing codes for more extensive visits than s/he actually rendered. To get a more complete understanding of the physician's conduct, a prosecutor might need to get information not just from Medicare or other government health programs,[115] but also the various private health insurance companies that physician billed, those companies' third-party administrators, and the physician's billing company. Indeed, this complexity exists even when the fraud is focused on just one payer.[116] For instance, in a prescription fraud case, an investigator or prosecutor may need to look to not just the health insurance company for relevant documents, but also its pharmacy benefit manager (PBM), and in some instances, the insurance company or PBM's pharmacy services administrative organization (PSAO).[117] Accordingly, a prosecutor tasked with addressing health care fraud is challenged not only by subject matter complexity, but also by administrative complexity.

Further, understanding whether the suspected fraudulent scheme violates a law requires an understanding of the health care laws, many of which are complex.[118] For instance, a prosecutor considering a kickback

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[114] *Id*.; Loucks & Lam, *supra* note 101, at 3. With respect to systems, some use fee-for-service payment systems, while others use managed care models. The former typically involve payment per service, while the latter might include a capped fee per patient.; Diké-Minor, *supra* note 93, at 25; *Glossary: Fee for Service*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/fee-for-service/; Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 GA. L. REV. 373, 373 (1997).

[115] *See* Wylie Wong, *Advanced Analytics Is Changing How Agencies Fight Fraud*, FEDTECH (June 7, 2023), https://fedtechmagazine.com/article/2023/06/advanced-analytics-changing-how-agencies-fight-fraud.

[116] An investigator who does not understand the particular administrative structure of a health insurance company may look to the wrong entity for information and fail to obtain the necessary information.

[117] *See* Indictment ¶¶ 25-28, United States v. Adams, No. 6:19-cr-00219 (N.D. Ala. Apr. 24, 2019); U.S. GOV'T ACCOUNTABILITY OFF., GAO-13-176, PRESCRIPTION DRUGS: THE NUMBER, ROLE, AND OWNERSHIP OF PHARMACY SERVS. ADMIN. ORGS. (Jan. 29, 2013), https://www.gao.gov/products/gao-13-176; Krause, *supra* note 107, at 349-50.

[118] Diké-Minor, *supra* note 93, at 13-17, 33-38 (discussing criminal laws addressing health care fraud and their complications); Pamela H. Bucy, Litigating Health Care Fraud: From Quackery to Computers, 10 CRIM. JUST. 20, 20 (1995) ("Over the last twenty-five years, prosecutions of health care fraud have become increasingly complex.").

case needs to be familiar with the multiple exceptions, or "safe harbors" written into laws like the Anti-Kickback Statute and EKRA.[119] It also requires an understanding of the relevant payer and third-party payer regulations to determine whether the conduct in question violated their rules, which would inform whether it violated the law.[120] Given the decentralized nature of the health care system, these regulations and rules are diverse and voluminous. For instance, the rules governing compounded pharmaceuticals are different from those governing non-compounded (manufactured) pharmaceuticals.[121] Similarly, the rules governing Medicare Part A claims (pertaining to in-hospital and related claims) are different from those governing Medicare Part B claims (pertaining to outpatient care), which are also different from those pertaining to Part C (the private plan option for Medicare), which are further different from those governing Part D (pertaining to prescription drug coverage).[122] Further, the Medicare rules are different from the rules governing Medicaid, TRICARE, or the many different private health insurance programs.[123] Indeed, given the number of private health

[119] Diké-Minor, *supra* note 93, at 13-17; 42 U.S.C. § 1320a-7b(b)(3) (AKS statutory safe harbors); 42 C.F.R. § 1001.952 (AKS regulatory safe harbors); 18 U.S.C. § 220(b) (EKRA statutory safe harbors); 42 U.S.C. § 1395nn(b)-(e) (Stark Law statutory safe harbors or exceptions).

[120] *See, e.g.*, Information ¶ 11, United States v. Rodney Logan, No. 3:16-cr-00212 (N.D. Ala. July 6, 2016) (discussing Medicare regulations prohibiting reimbursement for bulk pharmaceutical powders); Indictment ¶ 29, United States v. Adams, No. 6:19-cr-00219 (N.D. Ala. Apr. 24, 2019).

[121] AM. PHARMACISTS ASS'N, *Frequently Asked Questions About Pharmaceutical Compounding*, https://www.pharmacist.com/Practice/Patient-Care-Services/Compounding/Compounding-FAQs; *FDA's Human Drug Compounding Progress Report: Three Years After Enactment of the Drug Quality and Security Act*, *supra* note 109, at 4-5.

[122] *See* CONG. RSCH. SERV., *Medicare Overview* (May 21, 2020), https://crsreports.congress.gov/product/pdf/IF/IF10885/ (providing an overview of the Medicare program and its various components); *see also* Krause, *supra* note 107, at 347-48 (noting that in approximately 2000, "it was estimated that the rules governing Medicare alone exceeded 130,000 pages" and that the "number is likely even larger now given the new and complex Medicare drug benefit program" and that the "proliferation of easily updated internet guidance materials makes it nearly impossible to calculate a static total") (citations omitted).

[123] Briefly, Medicare is a federal health coverage program for persons age 65 and older and certain persons with disabilities. Medicaid is joint federal and state health coverage program for low-income Americans, who often have to meet additional criteria. TRICARE is the health coverage program for uniformed service members, retirees, and their families around the world. *See* CONG. RSCH. SERV., RL32237, *Health Insurance: A Primer* 1, 12-13 (Jan. 8, 2015), https://crsreports.congress.gov/product/pdf/RL/RL32237.

insurance programs, the complexity of rules is "magnified in the private sector."[124]

In addition, the health care system relies heavily on documentation to support whether the care a provider gave is appropriate, which makes prosecuting fraud cases a "tedious" and resource-intensive effort.[125] Putting aside for a moment, the complexity of the contents of the documentation (which could range from provider rules and agreements to medical records, to billing records, to bank records) the volume of the documentation itself creates difficulties.[126] For instance, identifying relevant evidence can be challenging where that evidence is buried within voluminous irrelevant evidence.[127] Doing this review can require significant time and manpower.[128] This is true even with the DOJ's more recent emphasis on using data mining as a way to detect health care fraud.[129] To prosecute a case, prosecutors have to go far beyond data mining and review the documentary evidence.

Given these significant challenges, government officials acknowledge that "only a fraction of the fraud and abuse committed against the health

[124] Krause, *supra* note 107, at 350 ("Medicare carriers and intermediaries may adopt slightly different local coverage policies, but they all interpret the same federal laws and regulations and use the approved federal claim forms. By contrast, private insurers and managed care organizations use different - and, they argue, proprietary - payment methodologies, coverage rules, provider networks, recordkeeping, and processing software, and claims forms, just to name a few.").
[125] *Id.* at 345-49 (discussing the characteristics of the health care system that make it an attractive target for fraud); Richard R. Kusserow, U.S. DEP'T HEALTH & HUM. SERVS., OFF. INSPECTOR GEN., Semiannual Report to Congress, at 155 (Oct. 1, 1982-Mar. 31, 1983) (describing health care investigations as "tedious").
[126] Krause, *supra* note 107, at 350; Bucy, *supra* note 100, at 877.
[127] Krause, *supra* note 107, at 348 ("The ability to hide wrongdoing within a complex set of documents or electronic communications is one of the key reasons investigating health care fraud is such a resource-intensive endeavor."); Bucy, *supra* note 100, at 877 ("In addition to the unsuspecting naivete of victims, the fact that the crime is usually hidden in voluminous documentary materials also makes white collar crime difficult to investigate and prove.").
[128] Debra Cassens Weiss, *Government Fights Health Care Fraud with Aid of Data Analytics*, ABA J. (Oct. 22, 2019), https://www.abajournal.com/news/article/government-fights-health-care-fraud-with-aid-of-data-analytics.
[129] Wong, *supra* note 115.

care system is identified and prosecuted,"[130] which creates part of the "low risk" for those seeking to engage in fraud.[131]

C. Telemedicine: All The Challenges of Health Care Fraud Plus More

Telemedicine fraud schemes combine the complexity of most health care fraud schemes with other difficulties that make these schemes more difficult to investigate and prosecute and thus more susceptible to fraud.[132] Specifically, telemedicine schemes (1) are easily scaled up, (2) tend to involve multiple but isolated participants, and (3) target elderly and low-income patients.

7. Easily Scaled Up

A particularly unique feature of telemedicine is that, as Professor Katrice Bridges Copeland has observed it, "makes it easier to conduct fraud on a large scale because without in-person visits, medical providers can reach many more beneficiaries in a short period of time."[133] This means that a scheme—with all the complexities discussed below—could easily grow and result in much greater losses and harm to the health care system and beneficiaries.

8. Decentralized Complex Schemes with Multiple Isolated Participants

More so than a non-telemedicine fraud scheme (and because of their scalability), telemedicine fraud schemes often involve multiple actors across multiple states—and possibly countries—each with different responsibilities, often with limited communication.[134] The HHS-OIG

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[130] GAO TESTIMONY BEFORE THE SUBCOMM. ON CRIME & CRIMINAL JUSTICE COMM. ON THE JUDICIARY, H.R., GAO/T–HRD–93–3, *Health Insurance: Legal and Resources Constraints Complicate Efforts to Curb Fraud and Abuse*, at 4 (Feb. 4, 1993) (statement of Janet L. Shikles, Director of Health Financing and Policy Issues Human Resources Division). Indeed, it is likely that most low fraud amount health care fraud cases go unprosecuted because the time and effort required to investigate these cases is only worthwhile for cases with a significant impact. *Cf. Kuhlman,* 711 F.3d at 1328 ("[H]ealth care fraud is so rampant that the government lacks the resources to reach it all.").

[131] Low sentences also create that low risk perception. *See Howard*, 28 F.4th at 209; *Kuhlman,* 711 F.3d at 1328.

[132] Franklin Baumann, *Telemedicine Leave Space Open for FWA*, SMARTLIGHT ANALYTICS SMARTLIGHT BLOG (Aug. 1, 2021), https://smartlightanalytics.com/telemedicine-leaves-space-open-for-fwa/.

[133] Copeland, *supra* note 10, at 69.

[134] U.S. DEPT. HEALTH & HUM. SERVS., OFF. INSPECTOR GEN., Special Fraud Alert: OIG Alerts Practitioners To Exercise Caution When Entering Into Arrangements With Purported

2022 Special Fraud Alert specifically noted this feature when it described telemedicine schemes as involving "a wide range of different individuals and types of entities, including international and domestic telemarketing call centers, staffing companies, practitioners, marketers, brokers, and others."[135]

This decentralized complexity makes it difficult to investigate and prosecute telemedicine schemes and to pinpoint the criminally responsible actors. To illustrate the point, it helps to understand how a basic telemedicine fraud scheme would work.[136]

First, an individual, or more likely, several individuals create or purchase a company—or more likely, companies. The companies, which I will refer to as "Companies X" may be owned by the same individual (or that individual's family members in name-only) and the services in question might be some form of testing, e.g., genetic or urine testing, or some sort of DME, e.g., braces. [137]

Second, Companies X hire or identify other companies who hire marketers (often called "recruiters") to identify and/or recruit beneficiaries, i.e., individuals with paying health insurance.[138] The recruiters, based in multiple states to ensure the broadest access to providers and beneficiaries, reach out to beneficiaries either through a call center (which could be based anywhere, including internationally), or through web solicitations, or the good old-fashioned way, by talking to and recruiting beneficiaries in person. [139]

Third, Companies X's owners or the recruiters pay kickbacks to multiple medical providers to generate referrals for Companies X's items and services. Given the nature of telemedicine, the medical providers and/or patients will be based in multiple different states.[140] So induced, the medical providers issue referrals, either without or with having some interaction with the patient and in the latter event, doing so via a brief audio call.[141] To ensure the biggest bang for the kickback buck, the company

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Telemedicine Companies (July 20, 2022), https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pdf; Copeland, *supra* note 10, at 71.

[135] *Id.*; *supra* Part II.A.2.

[136] *Id.*

[137] CRIM. DIV. U.S. DEP'T. OF JUST., 2022 Telemedicine Enforcement Action: Telemedicine, Clinical Laboratories, and DME 2022 Enforcement Action: Example of Telemedicine Fraud Scheme (Aug. 11, 2023), https://www.justice.gov/criminal/criminal-fraud/telemedicine-enforcement-action.

[138] *Id.*

[139] *Id.*

[140] *Id.*

[141] *Id.*

owners and recruiters will take the additional step of strongly suggesting (or directing) that the medical providers make referrals for Companies X's highest-billing items or services. [142] In some instances, the recruiters may also pay beneficiaries kickbacks to receive the services or simply steal their identities.[143]

Fourth, Companies X bill for the services. Recall that Companies X most likely take the form of multiple related organizations. The medical providers may or may not bill for the purported consultation with the medical provider, i.e., the telemedicine visits. [144]

Imagine yourself as the prosecutor responsible for the case. Pre-trial, you likely have a team of one attorney (you) or two attorneys along with investigators. The scheme you are tasked with responsibility for prosecuting (and supervising the investigation of) involves multiple participants, including multiple owners who may operate through multiple entities, potentially in different states; recruiters who may work with different recruiting companies and are located in different states or maybe even countries; providers with different practices and in different states; and various other staff and participants in these or other locations including technicians for the supplies or items and billers for the items or services or office visits. Further, the scheme would involve beneficiaries in multiple different states, and likely with different forms of health insurance. In addition, the various companies and company owners, recruiters, providers, and staff would have different bank accounts, health record systems, methods of communications (e.g., phones and email accounts), etc. This complexity could exist in non-telemedicine schemes, but the ability of these schemes to reach patients and providers in multiple states, through a variety of marketing methods greatly increases the number of participants, and thus the complexity.

As the prosecutor, you are charged with prosecuting this scheme with its multiple participants in multiple locations. In assessing how to gather the documentary evidence to prove that a scheme exists, you will need to consider whether to issue subpoenas to all of the various supplier or service companies (the Companies X's), the marketing/recruiter companies, and their medical providers involved in the scheme. Seeking evidence through

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[142] U.S. GOV'T ACCOUNTABILITY OFF., GAO/T-OSI-00-15, HEALTH CARE FRAUD: SCHEMES TO DEFRAUD MEDICARE, MEDICAID, AND PRIVATE HEALTH CARE INSURERS (July 25, 2000), https://www.gao.gov/products/t-osi-00-15.

[143] CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHCARE FRAUD PREVENTION PARTNERSHIP WHITE PAPER: EXPLORING FRAUD, WASTE, AND ABUSE WITHIN TELEHEALTH 4.

[144] CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., COVERAGE TO CARE: TELEHEALTH FOR PROVIDERS: WHAT YOU NEED TO KNOW (2023).

subpoenas, albeit a relatively straightforward option (process-wise),[145] comes with the risk that responses from any entities involved in the scheme will be incomplete or risk making your investigation public sooner than is best for the investigation. Alternatively, to have greater confidence in the completeness and accuracy of the records, you might prefer to execute search warrants and would need to consider how to coordinate the execution of multiple search warrants on multiple entities in multiple locations[146]—ideally simultaneously to avoid the destruction of records. Further, if the scheme involves an international call center, you would need to consider whether the possibility of obtaining valuable evidence is worth the approvals and diplomatic risks that come with seeking evidence from persons in a foreign country.[147] Other relevant documentary evidence might include emails, web-based communications, and bank records, all of which would come from a variety of sources.

You would also need to assess who to interview and how to interview them. To begin, you may want to interview the staff and beneficiaries who are likely located in multiple different states. You could have the agents who are actively investigating the case conduct the interview, but that comes with the expense of flying them halfway across the country for potentially unsuccessful interviews. Alternatively, you could seek the assistance of field agents in the state in which the staff or beneficiary lives. This approach, although cheaper, comes with the concern that those agents are not as familiar with your case as your case agent would be and may not understand the scheme enough to confront the interviewee on an obvious lie. Ultimately, you might decide to issue grand jury subpoenas to require the individuals you wish to interview to come before the grand jury to be questioned.[148] That approach, however, although eliminating the need for travel by agents, puts that burden on witnesses and further, is also

[145] *See* Fed. R. Crim P. 6 & 17.
[146] *See, e.g.*, Press Release, U.S. Dep't of Just., Off. of Pub. Affs., Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over $1.2 Billion in Losses (Apr. 9, 2019), https://www.justice.gov/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes (noting that the scheme involved executing "over 80 search warrants in 17 federal districts.")
[147] *See* U.S. DEP'T OF JUST., Justice Manual §9-13.510 (last updated June 2018) (noting that efforts to gather evidence abroad can constitute a violation of another nation's sovereignty or criminal law); *Id.*, §9-13.525 (requiring prosecutors to obtain approval from the DOJ office of International Affairs before issuing or applying for a subpoena or other legal process directed at a person or entity in a foreign country; 28 U.S.C. § 1783 (setting out process for issuing subpoena to a person in a foreign country).
[148] Fed. R. Crim P. 6 & 17.

expensive in that it requires payment of the witnesses' travel costs along with a small per diem.[149]

Except for the evidence from the international call center, the evidence described here is similar to the evidence that would be needed in a non-telemedicine health care fraud case. What complicates telemedicine cases, however, is that the ease with which the schemes can be scaled-up and their ability to reach people in locations far from providers results in many more participants (and thus sources of evidence) than a non-telemedicine case.[150]

9. Challenging Witnesses

Telemedicine schemes often target beneficiaries who are of low income and/or over the age of 65.[151] There are several possible reasons for this. First, the low-income elderly are often dually eligible for Medicare and Medicaid, which gives them access to more insurance coverage than individuals covered by just one.[152] The low-income and elderly may also be less likely to review their billing claims in part because they may not have adequate access to technology.[153] Accordingly, they are less likely to notice and/or raise concerns about suspicious conduct.[154] Further, elderly beneficiaries in particular are ideal targets because they may be perceived as having less reliable memories and therefore more easily deceived.

The last of these concerns about the reliability of a beneficiaries' memory can make elderly beneficiaries challenging witnesses. It can make it more difficult to gather evidence because the beneficiaries may not remember whether they had a consultation with a provider and if they did, whether it was meaningful, i.e., whether it went beyond clicking a few buttons on a website. A prosecutor faced with these witnesses has a genuine concern that this group of beneficiaries may not be believed by a jury given perceptions about their memory, or that they may moderate their testimony on cross-examination, and hesitate about whether they had a consultation that they did not.

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[149] *See* 28 U.S.C. § 1821 (1948) (discussing $40 per diem and travel payment for grand jury witnesses).
[150] Copeland, *supra* note 10, at 69. The point of the above illustration is not to exhaustively discuss the ways in which a telemedicine scheme might be investigated, but rather, to illustrate the complexities of an investigation involving telemedicine fraud.
[151] *HFPP White Paper*, *supra* note 10, at 18; *see supra* Part II.A.1 (discussing DOJ takedowns and noting many schemes target the elderly).
[152] *HFPP White Paper*, *supra* note 10, at 18.
[153] *Id.*
[154] *Id.*

These three features of telemedicine schemes—scalability, the many actors involved in these schemes, and the targeting of beneficiaries who can be challenging witnesses—make these cases more difficult to investigate and prosecute. That challenge makes it difficult to deter telemedicine schemes with the threat of prosecution, thus making them a promising area of fraud from the bad actor's perspective.[155]

III. COULD TELEMEDICINE HARM HEALTH EQUITY?

Telemedicine—when accompanied by unchecked fraud—could exacerbate health inequities in several ways. This is particularly true, if as indicated by the HFPP study and the DOJ takedowns, telemedicine fraudsters specifically target the elderly and those of lower socio-economic status, i.e., populations that experience health inequity.[156]

Telemedicine could exacerbate health inequities in a number of ways. First, by depriving patients of the care they may need at the moment fraud occurs, which could lead to immediate physical or mental harm. Second, after the fraud, by making it more difficult for patients to access legitimate services, if, for instance, they meet their coverage caps as a result of the prior fraud, and by exposing the programs that enable them to access care to additional attacks and funding cuts. Third, by increasing distrust of the health care system among the populations on which health equity efforts are focused.

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[155] Courts of appeals have emphasized that general deterrence is the primary objective of sentencing in health care fraud cases. *See, e.g.*, *Howard*, 28 F.4th at 209 (describing health care fraud as "rampant" and noting that the government lacks the resources to reach all health care fraud, making deterrence more important); *Id.* ("'[W]hen the government obtains a conviction' in a health care kickback prosecution, 'one of the primary objectives of the sentence is to send a message' to others who contemplate such schemes that their crime is a serious one 'that carries with it a correspondingly serious punishment.'" (quoting *United States v. Kuhlman*, 711 F.3d 1321, 1328 (11th Cir. 2013)).

[156] *HFPP White Paper, supra* note 10, at 18; *Strategic Plan: Health Equity*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last updated May 2023), https://www.cms.gov/files/document/health-equity-fact-sheet.pdf; Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KAISER FAM. FOUND. (Apr. 21, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

A. *Depriving Patients of Care They Need or Delaying Care*

Health care fraud (beyond just telemedicine fraud) can result in real harm to patients.[157] A 2020 study that included a study sample of 8,204 Medicare beneficiaries concluded that beneficiaries who received medical care from fraud and abuse perpetrators were more likely to die and to experience emergency hospitalization within 3 years after receiving that care.[158]

That potential harm exists in telemedicine fraud as well. In its 2022 Special Fraud Alert, HHS-OIG noted that telemedicine fraud could harm beneficiaries who received medically unnecessary care, or where it resulted in delayed care for medically needy patients.[159] The 2023 HFPP study echoed those concerns, stating that fraud in telemedicine could result in physical harm to patients.[160] The study explained that a telemedicine scheme that causes a patient to receive inappropriate medications could cause "a severe allergic reaction or worsen a pre-existing condition."[161] These harms are magnified where a telemedicine scheme can be scaled up easily.[162]

B. Burdening Patients' Ability to Access Future Care

Telemedicine fraud can burden patients' ability to access future care. For instance, telemedicine fraud can result in beneficiaries being personally responsible for expenses, because those expenses were not previously approved by their health insurance.[163] Further, it can result in a patient using up a one-time benefit (such as genetic testing) which then is unavailable if the patient needs it in the future.[164]

In addition, telemedicine fraud can burden patients' ability to access future care by exposing programs that seek to improve health equity to

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[157] *See e.g.*, U.S. DEP'T OF JUST., OFF. PUB. AFF., U.S. DEPARTMENT OF JUSTICE HEALTH CARE FRAUD REPORT FISCAL YEARS 1995 & 1996, at 2-3 (1997), https://www.justice.gov/archives/opa/us-department-justice-heatlh-care-fraud-report-fiscal-years-1995-1996, (observing that health care fraud can result in unnecessary deaths); *see also* Diké-Minor, *supra* note 93, at 9-10.
[158] Lauren Hersch Nicholas et al., *Association Between Treatment by Fraud and Abuse Perpetrators and Health Outcomes Among Medicare Beneficiaries*, JAMA INTERNAL MED. 66 (2020).
[159] Publication of OIG Special Fraud Alerts, 87 Fed. Reg. 51683, 51686 (Aug. 23, 2022), https://www.federalregister.gov/documents/2022/08/23/2022-18063/publication-of-oig-special-fraud-alerts.
[160] *HFPP White Paper*, *supra* note 10, at 16.
[161] *Id.*
[162] Copeland, *supra* note 10, at 69.
[163] *HFPP White Paper, supra* note 10, at 17.
[164] Copeland, *supra* note 10, at 73-74.

attack and funding cuts. Fraud results in overutilization and unnecessary spending,[165] and can lead to health insurance costing more in the form of higher premiums and out of pocket costs so that insurance companies can make up the money lost to fraud.[166] Unnecessary spending in programs designed to help disadvantaged groups in society can expose these programs to additional attacks and criticism from those who oppose them, putting these programs—and thus efforts to achieve health equity—at greater risk.[167]

C. Exacerbating Distrust and Cynicism

Telemedicine fraud could also harm health equity by increasing distrust of the health care system and exacerbating patient cynicism and mistrust of telemedicine.[168] Trust is key to minimizing the stress associated with illness and facilitating compliance with treatment plans.[169] Patients who suspect that their providers are not primarily motivated by the patients' health interests are unlikely to trust their providers.[170] This is particularly harmful to efforts to achieve health equity if it occurs within the very populations on which health equity efforts are focused. Indeed, studies report that concerns about fraud in telemedicine caused older patients to become more cautious about—and to subsequently refuse to use—telemedicine.[171]

CONCLUSION

As noted in the Introduction, this article does not argue against telemedicine as a potential path to achieving greater health equity. Indeed, it emphasizes that telemedicine can have great benefits. It does, however, seek to illustrate how telemedicine is susceptible to fraud. It does this to

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[165] *See* Diké-Minor, *supra* note 93, at 7.
[166] *HFPP White Paper, supra* note 10, at 17; Diké-Minor, *supra* note 93, at 20-21.
[167] Allison Orris & Sarah Lueck, *Congressional Republicans' Budget Plans Are Likely to Cut Health Coverage*, CTR. ON BUDGET & POL'Y PRIORITIES (Mar. 20, 2023), https://www.cbpp.org/research/health/congressional-republicans-budget-plans-are-likely-to-cut-health-coverage.
[168] Oswald A.J. Mascarenhas et al., *Hypothesized Predictors of Patient–Physician Trust and Distrust in the Elderly: Implications for Health and Disease Management*, 1 CLINICAL INTERVENTION AGING 175, 187-88 (2006) ("Distrust of doctors and the healthcare system may be a significant barrier to seeking proper medical care, enforcing effective preventive care and following treatment regimens.")
[169] *Id.* at 176.
[170] *Id.* at 178.
[171] *HFPP White Paper*, *supra* note 10, at 17.

encourage those seeking to mitigate health inequities to understand and consider these risks when they seek to use telemedicine to address health inequities by increasing access to health care.

The good news is that efforts are already being made to study and address these risks. For instance, HHS-OIG has identified indicators of fraud in telehealth.[172] It has used these indicators to identify providers who pose a high risk to Medicare.[173] As already noted, entities like HFPP have also dedicated time and effort to understanding telemedicine fraud.[174]

As these and other efforts to identify indicators of fraud continue, they should pay attention to the fact that telemedicine schemes tend to have some commonalities.[175] As discussed in Part II.A, they tend to involve limited or no patient interaction, occur across multiple jurisdictions, and appear to target certain types of items and services, specifically DME and testing.[176] These features suggest some potential ways to curb telemedicine fraud. They include requiring the initial visit with a telemedicine provider to be in-person to help ensure some interaction with patients.[177] In addition, they should include facilitating the ability of prosecutors to understand the national scope of a crime by creating a national all-payer database—i.e. "a single source for claims and enrollment data across all (or most) sources of insurance coverage within a single state." [178] Several states have already done this but there is no similar national database that reflects information from all payers, not just Medicare and Medicaid. Finally, these efforts should involve dedicating

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[172] U.S. DEP'T. HEALTH & HUM. SERV., OFF. INSPECTOR GEN., OEI-02-20-00720, MEDICARE TELEHEALTH SERVICES DURING THE FIRST YEAR OF THE PANDEMIC: PROGRAM INTEGRITY RISKS (2022).
[173] *Id.*
[174] *Id.*
[175] *See supra* Part II.A.
[176] *Id.*
[177] Farringer, *supra* note 8, at 62, 83-84 (noting that various medical groups support in-person first visits to protect patient care); *See also* eRisk Working Group in Health Care (consortium of professional liability carriers, medical societies, and state licensure board representatives); iHealth Alliance & PDR Group, eRisk Guidelines for Online Communication, THEDOCTORSCOMPANY, http://www.tennlegal.com/files/430/File/eRisk_Guidelines_electronic_communication.pdf. Guidelines provide that online communication should be limited to patients that the physician has already seen and evaluated in the office. This has the significant downside of limiting the accessibility of telemedicine. Farringer, *supra* note 8, at 11.
[178] Katherine Grace Carman et al., *The History, Promise and Challenges of State All Payer Claims Databases Background Memo for the State All Payer Claims Database Advisory Committee to the Department of Labor*, RAND HEALTH CARE, at 1 (2021). https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/200696/apcd-background-report.pdf.

resources focusing on improving flags and alerts on claims for DME and testing items and services.

These and other efforts need to be encouraged in order to seek to prevent telemedicine fraud from occurring, but at a minimum catch it when it does occur.