AMERICAN BANKRUPTCY INSTITUTE

2021 Winter Leadership Conference

Health Care Fraud: Pandemic Impacts and Financial Implications for the Industry

Hosted by the Health Care and Commercial Fraud Committees

Mark E. Andrews
Trinity River Advisors; Dallas

Carol L. Fox
B. Riley Advisory Services; Fort Lauderdale, Fla.

J. Richard Kiefer
Dentons; Indianapolis

Frederick J. Kohm, Jr.
Grant Thornton LLP; Philadelphia

CONCURRENT SESSION

2021

Increase in Healthcare Fraud During the Pandemic -

Background and Type of Schemes

2

Healthcare Fraud - Background

Health care fraud is an intentional act to defraud a health care benefit program or to obtain, through false representations, money or other property owned by these programs. This involves a deception or misrepresentation made by an individual or entity, knowing it could result in an unauthorized benefit to the individual, entity, or some other party.

National Health Expenditures grew 4.6% to $3.8 trillion in 2019, or $11,582 per person. This accounted for 17.7 percent of GDP. Centers for Medicare and Medicaid Services (CMS) projected national health spending to grow at an average annual rate of 5.4 percent for 2019 to 2028 and reach $6.2 trillion by 2028. The National Health Care Anti-Fraud Association estimates that health care fraud costs the nation anywhere from $68 to $230 billion annually.

3

Healthcare Fraud - Background

Compensation types and ways providers are paid:

- Fee for service – when providers receive payment for each service rendered.
- Capitation – providers receive one lump sum for each patient that they treat, regardless of how many services the provider renders to each patient.
- Episode of Care – providers receive one lump sum for all the services they provide related to a condition or disease (rather than capitation, which is a lump sum per patient).
- Compensation – Salary or derived method of payment – when governments directly operate health care facilities, it is common to pay providers a basic salary rather than offer service-based compensation.

4

Types of Schemes – Provider Fraud

Provider fraud consists of practices by health care providers that cause unnecessary costs to health care programs or patients through reimbursement for unnecessary or excessive services, or services that do not meet the recognized standards for health care.

Scheme Examples:

Fictitious providers: The obtaining and use of another provider's identification information to then steal or purchase lists of patient identifying information. The perpetrator then submits bills using the fictitious provider's information to insurance providers or government health care programs for 'services' performed.

Fictitious services: Provider's charge or bill a health care program for services that were not rendered at all.

Rolling labs: Mobile labs solicit individuals to participate in health screening tests at no cost to the patient. After conducting the test though, the lab bills the insurance provider or a health care program.

Over-utilization: This occurs when physicians prescribe unnecessary or excessive patient services.

Red Flags:

- Pressure for rapid processing of bills or claims
- Unusual charges for a given service
- Charges submitted for payment with no supporting documentation available

5

Types of Schemes – Inflated Billings

The inflation of costs of medical services rendered.

Scheme Examples:

Altered Claims: Changing amounts, dates, patient names, etc on a valid claim to allow a non-covered expense or claimant to become covered.

Added Services: The adding on of services never rendered to dates of actual services.

Code Manipulation: Manipulating the codes assigned to various diagnoses and procedures (which determine costs and payments for services rendered) to the benefit of the provider.

Red Flags

- Excessive claims for services above an acceptable level
- Alterations, erasures, ink changes, etc. on an original bill

6

Types of Schemes – Kickbacks

While there are a variety of kickback types, competition in the medical community has been steep and kickbacks made with the goal to gain new patients has been on the rise.

Scheme Examples:

Payment for referral of patients: Payments in the form of rewards to recruit new patients. To make up for the kickback, the provider may submit false claims or an unnecessary billing of medical expenses.

Waiver of Deductibles and Copayments: Providers paying for or waiving the patient's deductible in the hope of making up for that cost in additional business.

Payment for Additional Medical Coverage: For patients with long-term care, physicians may improperly obtain additional medical coverage for a patient, such as by purchasing additional insurance contracts for them. This ensures the provider will be paid and the patient has no out of pocket expenses.

Payment for Vendor Contracts: Companies doing business with medical practitioners will pay a "consulting" fee for referring business to them or using their supplies.

Payments to Adjusters: To quickly settle claims, patients may bribe adjusters to speed up the payment of the claim.

Red Flags:

- Unusual payments by the physician that don't appear to be correlated to any provided services
- Unusually close relationships between physicians and vendors

7

Types of Schemes – Fraud by Medical Institutions

Many schemes by medical institutions are similar to those by patients or providers. Some additional examples of fraud related to medical institutions are provided below.

Scheme Examples:

False Cost reports: The submission of false cost reports by hospitals to obtain higher reimbursements or funding than permitted.

Billing for Experimental Procedures: Billing for experimental use of new medical devices that have not yet been approved by health care authorities.

Revenue Recovery Firms: Billing consultants review patient's bills long after treatment was completed to look for missed charges. However, it's alleged that oftentimes these firms pad medical bills by adding on fictitious charges since the more charges added to the bill, the more the firm will be paid.

Red Flags:

- Billings and charges made years after a patient's treatment that don't appear to correspond with the services provided
- Billings for treatments or devices that have not yet received required approvals

8

Types of Schemes – Fraud in Special Care Facilities

Special care services constitute areas such as nursing homes and psychiatric hospitals. Many of these schemes are revealed after patients report strange charges or other red flags. Patients in these facilities though are especially vulnerable to fraud due to their unique status.

Scheme Examples:

Nursing Homes: Multiple fraud schemes have occurred involving nursing homes, including fraudulent or abusive billings for unnecessary or undelivered services. There are also instances in which provider representatives enter nursing homes and offer to handle the entire transaction for patients with little to no involvement or oversight by the nursing home which can lead to fraud schemes occurring.

Psychiatric Hospital Fraud: Since mental health can be a more subjective area, it can be difficult to determine when persons are in need of hospitalization for psychiatric treatment. This can lead to abuse in the admissions process, fraud in the treatment process, abusive marketing practices, etc.

Red Flags:

- Questionable provider credentials
- Treatment documentation is lacking

9

Types of Schemes – Insured and Beneficiary Fraud

Scheme Examples:

Fictitious claims: If health care programs allow an insured to submit reimbursement claims, then there is a risk of fraudulent claim submission. For instance, medical bills could be photocopied repeatedly with the perpetrator changing the date and amounts and resubmitting the bills for payment.

Multiple claims: Beneficiaries with medical coverage under multiple programs or insurance policies may be allowed to submit claims to more than one insurer. The fraud risk is when a patient makes a claim for a covered expense without revealing they have already been paid for that expense.

Doctor shopping: Patients may “shop around” for multiple doctors who will provide controlled substances, with doctors not always realizing that another doctor has already prescribed the drug.

Misrepresentation on application: Certain health care programs restrict coverage for pre-existing medical conditions. Individuals are required to disclose these but in some cases may intentionally fail to list all prior medical conditions to circumvent coverage restrictions.

Red Flags:

- Pressure by claimants to pay a claim quickly
- Dates of service just prior to termination of coverage or after coverage begins
- Identical claims for the same patient in different months or years

10

Healthcare Fraud Case Studies

11

Case Study – False Claims Act

Background: A healthcare practice in Nevada was billing federal healthcare programs, including Medicare and the U.S. Department of Veterans Affairs, for surgical services not actually provided to patients. They were also billing for more expensive surgical and evaluation and management services than those actually provided to patients. This took place over the course of 5 years.

Violation: These allegations entail a violation of the False Claims Act. This act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program. This includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system. Examples of false claims include billing for services not provided, billing for the same service more than once or making false statements to obtain payment for services.

Result: The healthcare practice agreed to pay $1.5 million to settle the False Claim Act allegations.

12

Case Study – Fraudulent Medicare Claims

Background: Two individuals were exploiting Medicare emergency codes and flexibilities that were designed to ensure that patients had access to medications during the COVID-19 pandemic. The individuals used COVID-19 emergency override billing codes in order to submit fraudulent claims for expensive cancer medication that were never provided, ordered or authorized by medical professionals. They also allegedly acquired control of more than a dozen New York pharmacies by paying others to pose as the owners of the pharmacies and hiring pharmacists to pretend to be supervising in order to obtain pharmacy licenses.

Violation: These individuals falsely received over $30 million for claims where the medication was never purchased by the pharmacies, prescribed by physicians or given to patients during periods when pharmacies were non-operational, and using doctors' names of prescriptions without their permission. They also used pass-through entities with names that closely resembled real pharmaceutical wholesalers to launder proceeds of the fraud.

Result: Both individuals were charged with conspiracy to commit health care fraud and wire fraud, and conspiracy to commit money laundering. They were each separately charge with concealment money laundering.

13

Case Study – Special Care Facility

Background: Merida Group, a chain of hospice and home health agencies throughout Texas, falsely convinced thousands of patients with long-term incurable diseases they had less than six months to live in order to enroll the patients in hospice programs for which they were otherwise unqualified, increasing revenue to the company.

Scheme: Over a period of 9 years, the vast majority of Merida Group patients did not qualify for services. Rather, physicians were bribed with illegal kickbacks, under the pretense of medical directorships, to falsely certify unqualified patients for services. Employees were instructed to falsify medical records, making non-terminal patients appear to be terminally ill and declining. One manager admitted to participating in the scheme, facilitating kickback payments to physicians, and directing employees to falsify medical records. The financial impact of the scheme was determined to be around $150 million.

Result: 4 individuals involved in the scheme were indicted. 3 so far have received prison sentences ranging from 27 months to 20 years as well as payment of restitution.

14

Case Study – Bribes and Kickbacks

Background: Specialty Drug Testing, LLC was paying bribes and kickbacks, resulting in improper billings to Medicare of approximately $117 million. Individuals were unlawfully enriching themselves by soliciting and paying kickbacks and bribes in return for patient DNA specimens and physicians' orders for cancer genetic tests and pharmacogenetic testing. The indictment alleges that individuals in the company created and transmitted invoices and spreadsheets reflecting the kickback and bribe payments owed by Specialty and used email and other forms of communication to inform each other of Medicare reimbursements, the payment of kickbacks and bribes, and other matters related to the scheme to defraud.

Violation: These allegations entail a violation of the Anti-Kickback statute. This is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce or reward the referral of business reimbursable by federal health care programs. Examples of prohibited kickbacks include receiving financial incentives for referrals, free or very low rent for office space, or excessive compensation for medical directorships.

Result: While the trial is ongoing, if convicted, the defendant faces up to five years in prison for each count of conspiracy to defraud health care program. They also face 10 years in prison for illegal kickbacks. They face up to 5 years of supervised release, a $250,000 fine, forfeiture and restitution.

15

THE CARES ACT, PROVIDER RELIEF FUNDS, AND PRF REPORTING

On March 27, 2020, the $2.2 trillion Coronavirus Aid, Relief, and Economic Security ("CARES") Act was signed into law. Critically, the CARES Act allocated several sources of funding for health care providers including the Provider Relief Funds ("PRF") which were specifically designated to reimburse eligible health care providers for health care related expenses and lost revenues attributable to COVID-19 and to help health care providers prevent, prepare for, and respond to COVID-19. The initial allocation in March 2020 totaling $178 billion was augmented by a supplemental allocation totaling $25.5 billion in September 2021. As a condition of receiving PRF, recipients were not permitted to bill out of network rates for COVID-19 care.

Starting in April 2020, the Department of Health and Human Services ("HHS") began to release appropriated funds totaling $178 billion in two tranches, a general distribution to all providers who billed Medicare fee-for-service in 2019 and a targeted distribution (i.e., skilled nursing facility, safety net hospital, rural, tribal, and high impact facilities). The distribution methodology varied based on whether the distribution was general or targeted as well as the phase in which the distribution was received.

Like the Paycheck Protection Program ("PPP"), HHS' goal was to disburse the general distribution to providers hard hit by the impacts COVID-19 as expediently possible. The general distribution was initially based on a formula set forth by the Centers for Medicare & Medicaid Services ("CMS") of the provider's 2019 percentage of fee-for-service Medicare payments (determined by dividing the provider's 2019 fee-for-service Medicare payments by total 2019 Medicare payments) and supplemented based on the provider's most recent actual revenue. This method did not go without criticism. A recent report published in the Journal of American Medicine ("JAMA") Health Forum on October 22, 2021 "Association Between COVID-19 Relief Funds and Hospital Characteristics in the US" found that "...initial funding allocations disproportionally went to hospitals with more cash on hand." On November 9, 2021, JAMA further reported:

> *"Several large nonprofit and for-profit health care systems that received funds said they did not need the money because they recovered sooner than expected or had acquired experience managing operations and expenses as the pandemic progressed. Large health systems that have returned funds include HCA Healthcare ($1.6 billion returned), Kaiser Permanente ($500 million), and the Mayo Clinic ($156 million)."*

For those providers who retained PRF payments under the general or targeted distributions, this white paper serves as a primer for reporting the use of the PRF funds to HHS.

WHO IS REQUIRED TO REPORT?

Health care organizations that received aggregate PRF funds exceeding $10,000 must report the use of the funds received to Health Resources & Services Administration ("HRSA"). Reporting is on a quarterly basis and, as set forth in the following table, the reporting periods vary based on when the funding was received.

	Payment Received Period [Payments Exceeding $10m000 in Aggregate Received]	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2023 to March 31, 20223

* Grace period until November 30, 2021. For more information, please see HRSA's announcement available at https://www.hhs.gov/about/news/2021/09/10/hhs-announces-theavailability-of-25-point-5-billion-in-covid-19-provider-funding.html.

The reporting requirement applies to the reporting entity and its subsidiaries.

REPORTING REQUIREMENTS

The reporting requirements set forth by HRSA are extensive. Notably, the reporting requirements vary based on the type of health care provider. For example, the reporting requirements for a skilled nursing facility differ from that of a rural hospital. Providers should refer to the authoritative guidance published on the HRSA website at https://www.hhs.gov for the applicable reporting structure.

The following section provides a general outline of the information HRSA is requiring from the reporting entity:

2. Other assistance received
    a. Treasury/Small Business Administration – e.g., PPP loans
    b. FEMA programs
    c. Local, State, and Tribal Government Assistance
    d. Business insurance
    e. Other insurance – e.g., pandemic insurance

2. Health care expenses incurred as a result of COVID-19[1]
    a. General and administrative expenses – e.g., mortgage/rent, salaries wages and benefits, utilities, insurance
    b. Health care related expenses – e.g., personal protective equipment ("PPE"), telemedicine, equipment (ventilators, negative pressure rooms, etc.), and capital improvements
        i. Qualified equipment purchases include purchased equipment or equipment for which there is a commitment to pay during the reporting period.
        ii. Qualified capital improvements must be placed in service during the reporting period.
    c. The provider must maintain formal documentation (e.g., invoices, contracts, payroll registers, purchase orders, packing slips) for each claimed expense.

*1. HHS Guidance evolved such that only the **additional costs incurred** as a result of COVID-19 are an acceptable expense.*

3. Lost revenues
    a. The reporting organization is required to apply funds received first to health care expenses related to COVID-19. If provider has not expended 100% of the PRF retained, they may apply the unexpended portion to lost revenues using one of the following methodologies:
        i. 2019 actual revenue using Generally Accepted Accounting Principles ("GAAP")
        ii. 2020 budgeted revenue as approved by the board of directors
        iii. An alternative reasonable methodology
            - An explanation of the reasons the alternative should be used to calculate revenue and a description of the methodology is required

4. Personnel, patient, and facility metrics
    a. Personnel metrics (bifurcated between clinical and non-clinical) – fulltime, parttime, contractor, furloughed, separated, and hired
    b. Patient metrics – inpatient admissions, outpatient visits (bifurcated between in-person and virtual), and emergency department visits
    c. Facility metrics (only necessary if the reporting entity or its subsidiaries operate or support staffed beds) – medical/surgical, critical care, and other

An important consideration with respect to other assistance received (i.e., funds from other sources) is that, during the reporting period a provider was permitted to seek funding from other sources (e.g., PPP funds), however a provider may not use PRF funds to reimburse expenses or losses that were reimbursed from other sources. Using the PPP loan as an example, if during the reporting period a provider funded payroll with a PPP loan, payroll up to the amount of the PPP loan is ineligible for PRF reimbursement.

AUDIT AND TAX IMPLICATIONS

Commercial (for profit) organizations that expended $750,000 or more in annual awards are subject to one of the following: (a) an audit conducted in accordance with Generally Accepted Auditing Standards ("GAAS Audit") or (b) an audit in conformance with the requirement of 45 CFR 74.514 ("Single Audit"). Additionally, newly released HHS guidance states that providers will receive a 1099 for the PRF payment that was received and retained during a calendar year. Further, the PRF funding retained is included as gross revenue under section 61 of the Internal Revenue Code and is taxable income.

While timely-filed tax returns for providers who received and retained PRF funds are due in 2021 and the first round of PRF reporting is due by November 30, 2021, the GAAS Audits or Single Audits will not be filed and reviewed by HHS until at least 2022. As such, the final word on the acceptable use of PRF funds and the impact of the PRF funding received on the provider's operations will not be known or quantifiable in the short term.

Carol Fox, *Senior Managing Director*
Office (954) 859-5075 | Mobile (954) 494-2856 | cfox@brileyfin.com

大成 DENTONS

The Cares Act, SBA Audits and DOJ Prosecutions

By J. Richard Kiefer
Co-leader, Dentons' national White Collar Crime and Government Investigations practice group

The Small Business Administration has announced that it will audit all Paycheck Protection Program loans of $2 million or more, and it may audit other loans as it deems appropriate. But the SBA has given little guidance about how it is conducting these audits, what it is looking at, what factors may lead it to make a criminal referral, or what borrowers can do to influence the SBA's decisions.

The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), PL 116-136, March 27, 2020, 134 Stat 281, 15 U.S.C. § 9001, created the Paycheck Protection Program ("PPP") and appropriated $349 billion to fund it. Subsequent legislation increased the appropriation to $806 billion. In a recent report, the Small Business Administration ("SBA") reports that it has approved PPP loans of just under $800 billion. The SBA has also announced that it will audit all PPP loans of $2 million or more, and it may audit other loans as it deems appropriate. Audits began earlier this year and are expected to continue into next year.

If the SBA determines in an audit that a borrower was eligible for the full amount of its PPP loan and that it spent the loan proceeds as authorized by the CARES Act, the SBA will forgive the loan and pay the bank that made the loan the full amount of the loan plus interest. If, on the other hand, the SBA determines that the borrower was not eligible for the PPP loan, or was not eligible for the entire amount of the loan, or did not spend any or all of the loan proceeds as authorized by law, it can require the borrower to repay all or a portion of the loan, with interest. Worse, if the SBA suspects fraud, it will refer the borrower to the Department of Justice ("DOJ") for potential criminal prosecution. To date, the DOJ has brought over 300 indictments and has obtained over 60 convictions for PPP loan fraud.

These prosecutions may be the tip of the iceberg. The Deputy Chief of the DOJ Fraud Section in Washington, D.C. told us recently that they have a "huge backlog" of PPP loan fraud cases to investigate and prosecute, and United States Attorneys' Offices throughout the country report similar backlogs. Now that the FBI and other agents are back to work from COVID-19 furloughs, the number of criminal investigations and prosecutions will likely skyrocket.

SBA audits of PPP loans thus create both significant risks and offer tremendous potential rewards to borrowers. But the SBA has given little guidance about how it is conducting these audits, what it is looking at, what factors may lead it to make a criminal referral, or what borrowers can do to influence the SBA's decisions. Since SBA audits are confidential, knowledge about them is limited to those involved in the audits themselves. Our CARES Act SBA Audit Defense Team has represented borrowers across the country in audits ranging from $150,000 to $10 million and has gained insight into the SBA audit process, key issues, and decision-making. This paper is based on what we have learned from SBA PPP loan audits of clients in New York, Massachusetts, California, Pennsylvania, Texas, Arizona, Kansas, Indiana, Illinois, and other states.

Key Audit Issues

SBA audit practice varies from loan to loan. In some audits, the SBA simply notifies the borrower's bank that it is "reviewing" (a/k/a "auditing") the loan and requiring the bank to notify the borrower and upload to the SBA electronic portal all documents relating to the PPP loan within fifteen (15) business days. No extensions of time are granted. In these types of audits, the SBA does not notify the bank or borrower of any specific issues under consideration. In

other audits, the SBA notifies the bank that the SBA requires the borrower to provide responses to specific issues. Borrowers in such audits need to understand that even if the SBA has identified one or more issues, the SBA audit may cover issues not identified and thus borrowers should provide to the SBA all information and documents relevant to any potential issue. In the event of an adverse SBA audit decision, an appeal would be based on what is in the SBA file at the time of the adverse decision. Thus, failure to produce essential information or documents could jeopardize a subsequent appeal. There is no right to supplement the record on appeal, and the CARES Act places the burden of proof on borrowers.

Loan Necessity

Loan necessity is one of the most frequent issues in PPP loan audits. The CARES Act required borrowers to certify that, due to the coronavirus, "the uncertainty of current economic conditions makes necessary the loan request to support the ongoing operations of the eligible recipient." Congress did not define what conditions make PPP loans "necessary," but it delegated to the SBA the promulgation of regulations and issuance of guidance on PPP loan issues. In Frequently Asked Question ("FAQ") #31, the SBA provided this advice to borrowers:

> "Borrowers must make this certification in good faith, taking into account their current business activity and their ability to access other sources of liquidity sufficient to support their ongoing operations in a manner that is not significantly detrimental to the business. For example, it is unlikely that a public company with substantial market value and access to capital markets will be able to make the required certification in good faith, and such a company should be prepared to demonstrate to SBA, upon request, the basis for its certification." (Emphasis added)

Shortly after the SBA issued this guidance in April 2020, a number of companies repaid PPP loans, concluding that their access to private equity or other sources of revenue made them ineligible. For those businesses that kept their PPP loan proceeds or that applied after the SBA issued FAQ #31, proving loan necessity during an audit is critical to obtaining loan forgiveness.

Other Eligibility Issues

Other eligibility issues must be addressed by many borrowers. In addition to loan necessity, eligibility requires a consideration of the Affiliation Rules for borrowers with affiliate, subsidiary and parent companies; the number of employees; and for some borrowers, the SBA's alternate eligibility standard of having tangible net worth of under $15 million and average net income of under $5 million for the two prior years before applying for the loan.

Myriad other potential issues could arise in a PPP loan audit and borrowers must anticipate what issues the SBA may review and provide the SBA with whatever information and documentation is needed to obtain a favorable decision during an audit. Because borrowers have the burden of proof on all issues in an audit, they are well advised to consider an audit as an opportunity to present their case, from start to finish, as if they were presenting a case to a judge or jury in a trial. This includes submitting affidavits to document decision-making, in addition to producing all necessary documents to support the borrower's eligibility and expenditures. Doing so gives borrowers their best chance for obtaining loan forgiveness, and avoiding a referral to the DOJ.

DOJ Prioritizes PPP Loan Fraud

The Department of Justice has made CARES Act and PPP loan fraud a top priority and has directed that each U.S. Attorney's Office throughout the country create a CARES Act Prosecutor. On March 16, 2020, the Attorney General issued a memorandum directing every U.S. Attorney's Office "to prioritize the detection, investigation, and prosecution of all criminal conduct related to the current pandemic." Within days, each of the 94 U.S. Attorneys' Offices throughout the United States identified and appointed one prosecutor to serve as the office's Coronavirus Coordinator to ensure that those cases were given the highest priority."

In a Joint Statement by then-Associate Deputy Attorney General William Hughes and the U.S. Attorney for the District of New Jersey, the DOJ's position was outlined: "To be clear, the Department will not tolerate any bad actors who seek to treat the pandemic as an opportunity to defraud their fellow citizens or the government."

In a speech on Feb. 17, 2021 to the Federal Bar Association Qui Tam Conference, then-Acting Assistant Attorney General Brian M. Boynton said: "It is clear to me and my colleagues in the Civil Division – and I am sure to all of you – that the False Claims Act will play a significant role in the coming years as the government grapples with the consequences of this pandemic." The DOJ Civil Fraud Section reportedly intends to actively pursue civil FCA cases against borrowers who it believes misrepresented the "necessity" for their PPP loans, lied in loan applications or loan forgiveness applications, submitted false supporting documents, or spent PPP loan proceeds other than how the CARES Act authorized.

The DOJ has already filed hundreds of individual prosecutions of PPP loan fraud in over 45 federal judicial districts. Prosecutions have charged defendants with violating 15 different federal criminal statutes. The most frequently cited statutes are the wire fraud statute, 18 U.S.C. 1343; the bank fraud statute, 18 U.S.C. 1344; the loan application fraud statute, 18 U.S.C. 1014; the money laundering statute, 18 U.S.C. 1957; and the attempts and conspiracy statute, 18 U.S.C. 1349.

The Select Subcommittee on the Coronavirus Crisis, U.S. Congress, issued a Report on March 25, 2021, in which it estimated that there has been "nearly $84 billion in potential fraud" of CARES Act loans and grants.

Expect More Criminal Investigations and Prosecutions

There are new DOJ criminal investigations and prosecutions every month, and often every week. Prosecutions of fraud following the Troubled Asset Relief Program ("TARP") – which was established in response to the 2008 Great Recession -- lasted over 10 years and resulted in hundreds of corporate executives being convicted and sentenced to prison. The economic bailout initiated by the CARES Act is several times larger than the TARP program. Given the number of prosecutions thus far and the estimates of the total amount of fraud, companies should expect a significant increase in the number of criminal investigations and prosecutions over the next several years now that grand juries have reconvened, and FBI and other law enforcement agents and federal prosecutors have returned to work after receiving COVID-19 vaccinations. Many investigations had been put on hold because agents could not conduct field investigations, execute search warrants, and make arrests. As those agents return to work, expect a significant increase in fraud investigations and prosecutions. Likewise, with grand jury activities resuming, prosecutors are likely to begin issuing subpoenas aimed at obtaining evidence of suspected fraud.

Congress expedited the PPP loan program to get federal monies to small businesses as quickly as possible to avert economic hardship and keep workers employed. As part of the emergency relief effort, the CARES Act suspended the requirement that lenders investigate borrower applications. Rather, banks were authorized to rely on borrower certifications and were granted immunity if errors occurred. Similarly, businesses rushed to apply for PPP loan funds as they faced eminent layoffs and possible closure of their businesses if they did not immediately obtain emergency relief.

Although the government's expeditious rollout of the CARES Act programs is laudable, and the rush to apply for those funds by businesses is understandable, when everyone acts with haste, mistakes invariably occur. And, to make matters worse, there was widespread confusion as to eligibility for PPP loans, how to calculate a company's number of employees, application of the Affiliation Rules, determination of the loan amount, and myriad other issues. Now, with the benefit of 20:20 hindsight, federal prosecutors must determine whether those were honest mistakes, or fraud. How a company handles an SBA Audit or DOJ investigation could have a tremendous impact on whether the company and its corporate executives are prosecuted.

Contacts

J. Richard Kiefer
Partner and Co-Leader of national White Collar and Government Investigations practice
D +1 317-968-5516
richard.kiefer@dentons.com

© 2021 Dentons. This publication is not designed to provide legal or other advice and you should not take, or refrain from taking, action based on its content. Attorney Advertising. Please see dentons.com for Legal Notices. Dentons is a global legal practice providing client services worldwide through its member firms and affiliates.

Faculty

Mark E. Andrews is a managing director with Trinity River Advisors in Dallas and has more than 35 years of experience representing clients in all aspects of insolvency work, including out-of-court restructurings and representations in state and federal court with a focus on bankruptcy-related matters. He previously was a named partner in a prominent Dallas-based bankruptcy boutique, then joined Cox Smith, later Dykema, where he served on its management committee and was head of the firm's bankruptcy and creditors' rights section. Mr. Andrews has worked on behalf of debtors, secured lenders, unsecured creditors, creditors' committees and trustees. He has also represented investors and buyers of assets in bankruptcy court. Mr. Andrews has represented clients in the aviation, energy, health care, restaurant chain retail chain industries. He has appeared in cases in courts across the U.S., including New York, Wilmington, Del., Chicago, New Orleans, Oklahoma City, Albuquerque, N.M., and in courts all over Texas. His representative lender clients have included JP Morgan Chase, Comerica Bank, City Bank Texas and Texas Capital Bank, among others, and his typical representations were as secured lender with cash-collateral and post-petition-financing issues. As debtor's counsel in energy cases, he most recently represented New Emerald Energy, Murphy Energy and Northstar Energy, and he has experience in E&Ps, midstream and specialized energy servicers. As debtor's counsel in health care cases, he has represented a number of physicians' practice groups and retirement communities, and he has represented investors in the acquisition of restaurant chains in Texas and California. In addition, he has advised corporations on the effect of bankruptcy on their business, including Hunt Oil, General Motors, a private company in the restaurant-supply business, a private company in telecommunications business, and many others. Mr. Andrews is a trained mediator and periodically mediates disputes. He is admitted to practice law in the State of Texas, and is admitted to practice before Federal District Courts in Texas, New Mexico, Louisiana, Delaware and New York. Mr. Andrews is a Fellow in the American College of Bankruptcy and has been listed in *The Best Lawyers in Texas* and *The Best Lawyers in America* for many years. He also is ranked in *Chambers USA*. Mr. Andrews received his Bachelor's degree in American/United States Studies/Civilization in 1980 from Georgetown University and his J.D. in 1983 from Tulane University.

Carol L. Fox, CPA, CIRA, CFA is a senior managing director with B. Riley Financial in Fort Lauderdale, Fla., and has more than 30 years of private and public accounting experience. She previously was with GlassRatner and Kapila & Company, where she focused on forensic accounting, litigation support and bankruptcy. For more than 20 years, Ms. Fox's practice has focused on providing bankruptcy, restructuring and forensic services to a wide range of industries with a specific focus on the health care sector. She has provided restructuring and bankruptcy-related services for distressed situations in the health care, life sciences, mining, transportation, e-commerce, real estate, telecommunications, hospitality, agriculture and marine sectors. In addition, she has led high-profile investigations of investment schemes, fraud investigations, internal corporate investigations, due-diligence assignments and matters involving business disputes and quantification of damages. Ms. Fox currently serves as case-by-case subchapter V trustee in the Southern District of Florida, serves on the Board of Directors for the International Women's Insolvency & Restructuring Confederation's (IWIRC's) Florida Chapter, was named one of the U.S. Top Women Dealmakers by Global M&A Network in 2019, and was recognized in 2021 by the *ABF Journal* as one of the Top Women in Asset-Based Lending. Ms. Fox received her B.S. in accounting from the University of Florida.

J. Richard Kiefer is co-chair of Dentons' national White Collar Crime & Government Investigations Practice Group and is based in Indianapolis. A veteran of approximately 100 jury trials in state and federal courts and dozens of state and federal appeals throughout the country and over 200 internal investigations, he has experience representing clients in cases involving health care fraud, tax fraud, mail fraud, wire fraud, money laundering, currency structuring violations, securities fraud, antitrust violations, environmental crimes, public corruption and bribery, and myriad other federal and state criminal offenses. Mr. Kiefer is a former international banker in both the U.S. and London and a former manager of a foreign exchange trading department. His health care practice includes representing clients in both civil and criminal health care fraud investigations and litigation, including alleged violations of the False Claims Act, Anti-Kickback statute, and myriad health care fraud criminal statutes. His clients have included Fortune 500 companies, some of the nation's largest long-term-care chains and assisted living companies, durable-medical-equipment companies, home health care companies, hospitals, physicians, psychiatrists, pharmacists, eye surgeons, dentists, podiatrists, chiropractors, nurses and other health care providers, as well as business executives, public officials and professional athletes. Mr. Kiefer chairs a CARES Act SBA Audit & Government Investigations Defense Team that has represented clients throughout the country in SBA audits of Paycheck Protection Program (PPP) loans. He has conducted webinars and has written extensively on preparing for and defending PPP loan audits, specific audit issues, strategic considerations and statutory and regulatory legal issues. Much of Mr. Kiefer's practice involves joint defense efforts in multidefendant cases in which lawyers for various targets or charged defendants cooperate in a joint defense strategy to defend their respective clients. He has experience in representing clients in complex cases involving inter-related criminal, civil and administrative proceedings. He also advises corporate clients on corporate compliance programs and has negotiated national Corporate Integrity Agreements with the Office of Inspector General of the U.S. Department of Health and Human Services, and he has represented clients in investigations by and proceedings before the Department of Justice, Department of Defense, Department of Homeland Security, Environmental Protection Agency, Department of Agriculture, Drug Enforcement Administration, Securities and Exchange Commission, and numerous state governmental agencies. Mr. Kiefer is a life member of the National Association of Criminal Defense Lawyers (NACDL) and is a former president of the Indiana Association of Criminal Defense Lawyers and Chairman of the Criminal Justice Section of the Indiana State Bar Association. He also is a frequent faculty member at national seminars on criminal defense, health care fraud and trial strategy, and he has authored numerous articles in professional publications. Mr. Kiefer received his B.A. in political science and international relations from Purdue University in 1970 and his J.D. *cum laude* in 1975 from Indiana University Robert H. McKinney School of Law.

Frederick J. Kohm, Jr., CPA, CFF is partner in the Forensic Advisory Services practice of Grant Thornton LLP in Philadelphia. In this capacity, he leads large complex investigations, forensic accounting services and corporate compliance engagements in various industries for public, privately held and nonprofit organizations. Mr. Kohm has more than 25 years of financial and accounting experience across various industry sectors. Prior to joining Grant Thornton, he was a senior managing director for an international public accounting firm, where he led its business valuation and forensic advisory services practice in Philadelphia. He has also held financial accounting positions in the private sector. As an expert witness, Mr. Kohm has testified in federal and state court in both bench and jury trials. He has testified as an expert in arbitration and assisted clients in mediation. In addition, he has been appointed independent monitor by federal regulators, and appointed inspector by

the Bermuda Monetary Authority. In addition, he has also served clients as an independent arbitrator, assisting clients with purchase-price and working-capital disputes. While leading large complex forensic accounting and investigative engagements, Mr. Kohm serves his clients by providing consulting expertise and managing engagement teams in the U.S. and across the globe. In this capacity, he regularly works with colleagues in the U.S. and other countries investigating corporate compliance matters, bribery and corruption, and white-collar crime. Mr. Kohm has served on committees for the Pennsylvania Institute of Certified Public Accountants (PICPA), including the Forensic and Valuation Committee, Financial Services Committee and Insurance Industry Committee. He currently is chair of the PICPA Insurance Industry Committee and a frequent speaker at professional events and Philadelphia-area universities. Mr. Kohm received his B.S. in business administration from Millersville University.