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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

Compliance Director Pleads Guilty in Kickback Scheme; Gift Cards Were Given to Patients

A compliance director who wore several hats—including Medicaid biller and medical records director—is one of two people who have pleaded guilty in a case about gift cards for Medicaid patients.

Keke Komeko Johnson, the compliance director of Life Touch LLC, a substance abuse treatment provider in North Carolina, and Francine Sims Super, an office manager, copped a plea in a scheme to pay kickbacks to patients, the U.S. Attorney's Office for the Eastern District of North Carolina said Aug. 25.[1] Patients who kept showing up for substance use disorder treatment were given gift cards of $45 to $60 a week, depending on how often they came, according to the criminal information filed against the compliance director.[2] Johnson also allegedly lied to auditors and investigators, saying a third party dispensed the gift cards independently. Hart Miles, an attorney for Johnson, declined to comment.

The case shouldn't leave compliance professionals with the impression that gift cards for patients are always bad news, said Tony Burba, a former trial attorney in the health fraud unit at the U.S. Department of Justice (DOJ). "There's a world in which conduct very similar to this would be perfectly acceptable," he said. For example, addicts may be unreliable and gift cards could help keep them in treatment, said Burba, with Barnes & Thornburg. As long as they're not awarded to patients for recruiting other patients—another allegation in the criminal information—Burba said he's comfortable

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Prior Authorization Is Coming to ASCs in Original Medicare Dec. 15, With Echoes of WISeR

CMS is wading deeper into prior authorization in original Medicare, but this time it's for ambulatory surgery centers (ASCs). In a Sept. 3 announcement, CMS said prior authorization will be required at ASCs in 10 states for five procedure categories starting Dec. 15.[1]

The program has features of both the longstanding, national hospital outpatient prior authorization process and the new Wasteful and Inappropriate Services Reduction (WISeR) model, which requires providers in six states to request prior authorization of 15 procedure categories.[2] ASC prior authorization will take place in California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia and New York.

The five procedure categories targeted in the ASC prior authorization program are blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation. If they sound familiar, it's because they're also in the hospital outpatient prior authorization process. And Medicare administrative contractors (MACs) again will run the show. That's not the case with WISeR, however, which calls for CMS to hire contractors to make prior authorization decisions based on artificial intelligence.

As with WISeR, CMS calls the ASC program "voluntary" in the sense that providers could bypass prior authorization. But if they take that route, ASCs will be subject to prepayment medical review of claims for procedures after they're performed. The

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upshot is that prior authorization isn't a condition of ASC payment the way it is in the national, mandatory hospital outpatient process, said Ronald Hirsch, M.D., vice president of R1 RCM. "If you don't ask for authorization, you don't get paid," he said. "It creates a burden for every provider submitting a claim, and it delays cash flow significantly."

Without prior authorization, payment for physician services associated with the five procedures at the ASC is also out the window, Hirsch said. Associated services include anesthesiology services and/or physician services, among others. "That's clearly going to help get cooperation" from physicians, he noted.

ASCs and their physicians/practitioners will hear about the ins and outs of prior authorization because MACs are required to educate them about it, using an introductory letter provided by CMS, according to a Sept. 4 Medicare transmittal (13,396).[3] CMS also provided a list of codes subject to prior authorization.[4]

Volume of Five Procedures Is Way up at ASCs

The motivation for the ASC demonstration is that the five procedures may be provided for cosmetic, rather than medically necessary, reasons, and data shows a spike in utilization at ASCs, according to FAQs.[5] "Implementing prior authorization in the ASC setting would help improve methods for the investigation and prosecution of fraud and may prevent that shift in unnecessary utilization," CMS said.

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"We also see the demonstration as another step in our overall approach to enhancing our ability to separate problematic providers from those providers proactively working to comply with our coverage and documentation requirements, thus helping prevent fraud, waste, and abuse."

With more hospital procedures performed on outpatients—a reality that will be magnified by CMS's proposal to end the inpatient-only list—it stands to reason that prior authorization would come to ASCs, Hirsch said. But ASCs probably will scramble more than hospitals to comply with the prior authorization program because they're not accustomed to it in original Medicare, he said. "It's not a common occurrence," Hirsch noted. "ASCs in those states will have to make some major personnel adjustments to do this."

Unlimited Bites at the Affirmation Apple

The prior authorization process will start with ASCs submitting a "prior authorization request" (PAR) to the MACs. PARs must include proof the service complies with Medicare rules and documentation to support medical necessity. When MACs receive PARs, they will send the provider a unique tracking number (UTN), according to the FAQs. To get paid, providers are required to put UTNs on claims.

The MACs will say yes or no to the PAR in seven days for a standard review and two days for an expedited review. Possible responses from the MACs are:

- A provisional affirmation decision means the claim probably satisfies Medicare's coverage, coding and payment requirements.
- A non-affirmation decision is a preliminary finding that the claim probably doesn't comply with Medicare coverage, coding and payment requirements.
- A provisional partial affirmation decision means the MAC provisionally affirmed one or more service(s) on the PAR but turned down others.

MACs will inform the ASC of their decision in a letter, explaining, if applicable, the reasons for non-affirmation. "Providers should review the information provided and consider if there is additional documentation that could address the non-affirmation decision upon resubmission of the prior authorization request," CMS said.

ASCs have unlimited bites at the affirmation apple, but non-affirmations aren't appealable. However, if ASCs bill Medicare for a procedure that was non-affirmed and it's denied, ASCs regain their appeal rights. And if ASCs don't submit a PAR at all, "they still have appeal rights," Hirsch said. In other words, a tactic is to not request prior authorization and wait for the additional documentation request for a prepayment medical review if the ASC is confident its services are medically necessary and the claim will get paid, he said.

Although ASCs won't face additional reviews of claims with a provisional affirmation, CMS said they could wind up in targeted reviews by MACs or unified program integrity contractors if the ASCs show signs of gaming or fraud. ✧

Endnotes

1 Centers for Medicare & Medicaid Services, "Prior Authorization Demonstration for Certain Ambulatory Surgical Center ASC Services," last modified September 4, 2025, https://go.cms.gov/47XIUMQ.
2 Nina Youngstrom, "CMS Expands Prior Authorization in Original Medicare, Will Audit New Contractors," *Report on Medicare Compliance* 34, no. 25 (July 14, 2025).
3 Centers for Medicare & Medicaid Services, "Provider Education for Prior Authorization (PA) of Certain Services in the Ambulatory Surgical Center (ASC) Setting," Pub 100-20, One-Time Notification, Transmittal 13,396, September 4, 2025, https://go.cms.gov/3Vyl3vL.
4 Centers for Medicare & Medicaid Services, "List of Ambulatory Surgical Center Services For Prior Authorization," Attachment A, accessed September 5, 2025, https://go.cms.gov/3VxGX27.
5 Centers for Medicare & Medicaid Services, "Prior Authorization Demonstration for Certain Ambulatory Surgical Center Services," FAQs, accessed September 5, 2025, https://go.cms.gov/4gc4244.

OCR Will Police Part 2 Instead of DOJ; 'There's Teeth to That Enforcement'

About six months before the revised regulation on the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) takes effect Feb. 16, HHS said it will be enforced by the HHS Office for Civil Rights (OCR) instead of the U.S. Department of Justice (DOJ).[1]

That could bring fines, penalties and corrective actions because DOJ apparently never dropped the hammer on Part 2 providers for violations of Part 2 regulations, attorneys say. With HHS delegating enforcement of Part 2 to OCR, which is also the HIPAA watchdog, attorneys expect the enforcement landscape to change.

"There's teeth to that enforcement ready to go when that compliance date hits," said attorney Jennifer Pike, with Alston & Bird. "I think we'll see a lot more action from OCR on the civil side than DOJ would ever have taken on the criminal side." No criminal fines were imposed in the 50 years of Part 2's life span.

According to HHS's Aug. 16 notice, OCR will levy civil money penalties for Part 2 noncompliance; implement resolution agreements, monetary settlements and corrective action plans to resolve "indications of noncompliance"; and use subpoenas for witness testimony and evidence production related to matters under investigation or compliance review. Patients also now can file complaints directly with OCR, said attorney Robert Trusiak, with Trusiak Law PLLC.

"Now there's a clear enforcement direction" both because OCR is in charge and because the Part 2 rule incorporates the definition of a breach from the HIPAA Breach Notification Rule, which defines a breach as a violation that compromises the privacy or security of protected health information.

"We have an agency that is well versed in investigations involving patient records, particularly those that are sensitive and are owed special confidentiality," Pike said. While there's the prospect of more enforcement under OCR, "the flip of that coin is the Part 2 amendments also made some things easier." The Part 2 regulation, which was finalized Feb. 16, 2024, for the first time allows patients in substance use disorder (SUD) programs to sign one consent form that allows all future disclosures for treatment, payment and operations (TPO), similar to HIPAA's authorization, although patients can revoke consent.[2] Patients also can say no to the broader consent in favor of a limited consent that only allows Part 2 providers to disclose SUD information to a specific health plan, for example.

Even if patients sign a consent for all future TPO, the rule requires the Part 2 program to get a separate written consent from the patient before their SUD records may be used in a civil, criminal or administrative proceeding against them.

Jointly developed by OCR and the Substance Abuse and Mental Health Services Administration, the amended Part 2 rule also lifts the prohibition on redisclosures of patient information. To the extent that patients sign "a general written patient consent covering all future uses and disclosures for TPO as permitted by HIPAA," the rule allows redisclosure for TPO consistent with HIPAA. And there are now extra protections for a new category dubbed "SUD counseling notes," which are analogous to psychotherapy notes under HIPAA. Patient notices also got an overhaul in the Part 2 rule. There are content requirements, including uses and disclosures, patient rights and duties of Part 2 programs.

No Patient Right of Access Under Part 2

The definition of a Part 2 program is broad and applies to federally assisted programs that fall into three categories: standalone SUD clinics and hospitals that hold themselves out as providing diagnosis, treatment or referral for treatment of SUDs; general medical facilities with units for diagnosing, treating or referral for treatment of SUDs; and medical personnel in a general medical facility whose primary function is providing diagnosis, treatment or referral for SUD treatment.

"A lot of what Part 2 amendments meant to do was streamline with HIPAA requirements so we didn't have two different regulatory schemes because there's so much overlap with entities subject to HIPAA and Part 2 providers," Pike explained. But some differences remain. For example, people don't have a right of access to their records under Part 2.

HHS: More Information Blocking Enforcement

In another enforcement development, HHS said Sept. 3 it will heighten enforcement of information

blocking rules. "HHS will take an active enforcement stance against health care entities that restrict patients' engagement in their care by blocking the access, exchange, and use of electronic health information."[3]

And the HHS Office of Inspector General on Sept. 4 released an "Enforcement Alert" on information blocking.[4] "The Office of Inspector General (OIG) and the Office of the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) are issuing this enforcement alert to signal our joint commitment to intensify enforcement activity, dedicate additional resources, and take decisive action to detect and end information blocking," OIG stated. Consequences of information blocking for providers include OIG civil monetary penalties and CMS "disincentives" (e.g., a hospital wouldn't be able to earn three quarters of the annual market basket increase in connection with qualifying as a meaningful electronic health record user).

Patients who think their information has been blocked can report it to the Information Blocking Portal.

Contact Pike at jennifer.pike@alston.com. ✧

Endnotes

1 Department of Human Services, Office of the Secretary, Statement of Delegation of Authority, 90 Fed. Reg. 41,833 (Aug. 27, 2025), https://bit.ly/3VvKhe7.

2 Office for Civil Rights, Office of the Secretary, Department of Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services, Confidentiality of Substance Use Disorder (SUD) Patient Records, 89 Fed. Reg 12,472 (Feb. 16, 2024), https://bit.ly/3wpT20l.

3 U.S. Department of Health and Human Services, "HHS Announces Crackdown on Health Data Blocking," news release, September 3, 2025, https://bit.ly/3HJ1PAv.

4 U.S. Department of Health and Human Services, Office of Inspector General, "Enforcement Alert: Information Blocking," September 4, 2025, https://bit.ly/41xoKp6.

Compliance Faces Quandary of De-Escalating Risks of 'Unlawful' DEI

Courts will eventually decide whether "unlawful" diversity, equity and inclusion (DEI) programs give rise to violations of the False Claims Act (FCA), but compliance officers have a more immediate hot potato in their hands. They are faced with assessing the risks stemming from the anti-DEI posture long before lawyers argue in specific cases about materiality, which is required to prove FCA violations, a former federal prosecutor said. And contrary state laws add a twist.

"There's a multi-faceted solution that starts with the compliance officer identifying risk rather than waiting on some type of materiality view that will make it all go away downstream," said attorney Robert Trusiak, with Trusiak Law PLLC. "Materiality is a litigation concept, not a real-time compliance concept, and the thing you want to do most of all in compliance is avoid litigation."

The challenge deepens in states with laws that conflict with President Donald Trump's executive order (EO) on unlawful DEI and U.S. Department of Justice (DOJ) memos trotting out ways it could be hit with enforcement actions. Trusiak said 16 states—Arizona, California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Oregon, Rhode Island and Vermont—have laws that are contrary to the Trump administration's interpretations of DEI. "Their attorneys general issued guidance affirming that DEI programs remain legal if properly designed," Trusiak said. Other states, such as Ohio and Florida, have laws that "are in harmony" with administration edicts.

"Setting aside political stripes, this administration is forceful and laser focused," Trusiak said. "It's with crystal clarity" the administration has advanced its position on discrimination and DEI. First there was a Jan. 21 executive order (EO 14,173) and various DOJ memos.[1] The threat of enforcement became clearer in a July 29 memo from U.S. Attorney General Pam Bondi that sheds more light on how federal antidiscrimination laws apply to unlawful DEI practices.[2] Entities that get federal funds are required to ensure their programs don't discriminate based on race, color, national origin, sex, religion or other protected characteristics, regardless of the labels and goals of their programs. The memo spells out the practices that could provoke enforcement actions, including unlawful preferential treatment and training that promotes discrimination or hostile environments.

The memo came out about two months after DOJ announced a Civil Rights Fraud Initiative. It points the FCA at federal contractors and recipients of federal funds that "knowingly" violate civil rights laws and falsely certify compliance with these laws.[3]

In light of the EO and memos, health care organizations have a clear and present danger with respect to federal grants and contracts and whether they comport with Title VII and other civil rights laws (or the Trump administration's interpretation of them).

'You Want to Identify Areas of Risk'

Lawyers have expressed doubt that DOJ or whistleblowers will connect the dots from DEI to the FCA by way of materiality. Although materiality is a touchstone in an FCA case, it isn't resolved until a lawsuit has gone down the long path to discovery, Trusiak said. Instead of focusing on the merits of an FCA lawsuit, it makes more sense for compliance officers to view the DEI threat from a risk-mitigation perspective. "The materiality argument is one step removed from a compliance officer

doing the work now to even avoid a FCA case," Trusiak noted. He suggests compliance officers team with senior leaders, outside counsel and the board to thread the discrimination needle, especially in states with laws that advocate for DEI.

"You want to identify areas of risk" and ways to reduce them (see box, p. 6).

For one thing, Trusiak suggested compliance officers review DEI-related language in the employee handbook, current and past policies, board meeting minutes and website references. "I would get that quantum of evidence and do a search and find on diversity, equity and inclusion."

He hopes organizations don't have to scrub documents of all references to DEI, "but be careful how you phrase it. It's common sense to say we value the work effort and merit of all employees and seek to foster an environment in which everyone contributes to the mission and goal of the organization." The idea is to promote inclusivity without running afoul of the way the Trump administration defines discrimination.

Another thing to look at is DEI committees. "You can walk the tightrope but make sure words that will poke the federal government in the eye and invite scrutiny are phrased in another way, not for the purpose of obfuscating form over substance but in the sense of advancing inclusivity consistent with Title VII," Trusiak said. The same applies when organizations rework their handbook and policies.

Comparing State to Federal Rules With T Ledger

How compliance officers address DEI risks depends partly on the state they're located in. Providers that operate in states that view inclusivity with a different lens than the Trump administration will find that a one-size-fits-all approach is contrary to the state or federal government, Trusiak said. Because both have FCAs, organizations don't want to trade one risk for another. He suggests compliance officers do a T ledger analysis. "If you accept state dollars tied to DEI compliance, you must follow the state's DEI-related mandates if they are part of the conditions of payment under state law," Trusiak explained. "If you accept federal funds, you must comply with federal nondiscrimination rules, which flow through Title VII and related executive orders or DOJ/AG guidance." When state and federal rules conflict, "you can't use federal money to advance DEI in a way the federal government prohibits even if the state requires it," he said. In other words, organizations are required to comply with state DEI conditions of payment tied to state funds, but they can't represent these DEI efforts as if they were conditions of federal payment when that would "clash" with Title VII or executive dictates.

The effect on the corporate culture is also something to consider. "What will be the blowback" if employees are informed that the organization has deleted all references to DEI and fired the DEI officer? "There's no conversation that can occur today on a professional or personal basis that doesn't have a political partisan aspect to it implicitly or explicitly," Trusiak said. "This subject requires compliance officers to be dispassionate and to strip away personal partisan views relative to whether this is right or wrong."

Contact Trusiak at robert@trusiaklaw.com. ✧

Endnotes

1 Nina Youngstrom, "Trump, AG Warn of Investigations for 'Illegal' DEI Programs, Mention FCA 'Materiality,'" *Report on Medicare Compliance* 34, no. 7 (February 24, 2025).

2 U.S. Department of Justice, Office of the Attorney General, "Guidance for Recipients of Federal Funding Regarding Unlawful Discrimination," memorandum, July 29, 2025, https://bit.ly/46FFkX8.

3 Nina Youngstrom, "DOJ Ties FCA to Civil Rights Violations; 'Hard Cases to Prove,'" *Report on Medicare Compliance* 34, no. 20 (June 2, 2025).

Compliance Director Pleads Guilty

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with small-dollar gift cards. "I don't think the takeaway is you can never give cards to incentivize them to receive preventive care." For example, if a provider gave a $15 gift card to patients who get a Shingles vaccine, "I would say that's a low risk under the Anti-Kickback Statute and also satisfies the exception" for incentives for preventive care, he said. Patients only get one Shingles vaccine, "and only people over 50 are qualified to get it, so there's zero risk of overutilization."

Beneficiary inducements are generally prohibited under the Anti-Kickback Statute (AKS) and Civil Monetary Penalties Law (CMPL), but there are exceptions. The AKS has an exception for promoting access to care when the remuneration poses a low risk of harm to patients and federal health care programs. Although the HHS Office of Inspector General (OIG) carved out a nominal-value exception in a special advisory bulletin, allowing Medicare or Medicaid providers to offer beneficiaries inexpensive gifts without running afoul of the CMPL, it doesn't apply to cash or cash equivalents, such as gift cards.[3] OIG later defined "nominal value" as no more than $15 per item or $75 total annually per patient.[4]

But never say never. In a 2020 advisory opinion, OIG greenlit gift cards given out by a federally qualified health center "to incentivize certain pediatric patients to attend rescheduled preventive and early intervention care appointments."[5]

Organizations shouldn't take gift cards and other inducements lightly, said David Traskey, former OIG senior counsel. "It's important to have a compliance program that has appropriate policies and procedures" to address the AKS and gifts and benefits, among other things, said Traskey, with Garfunkel Wild PC. "That's the first line of defense." But it can be harder to set the tone at the top or enforce policies and procedures when compliance professionals wear multiple hats, as was the case with Johnson. "My initial reaction is this person may have been identified as a compliance director because the entity had to identify someone to fill that role, but I would question whether or to what extent this person provided meaningful compliance activities on behalf of the entity," Traskey said. "In most entities, the compliance officer role is focused on the compliance function exclusively."

Smaller organizations, however, may have compliance officers with multiple responsibilities,

Checklist to Help Compliance Officers Evaluate DEI Risks

Organizations are at risk of enforcement actions, such as False Claims Act (FCA) lawsuits, for what the Trump administration calls "unlawful" diversity, equity and inclusion (DEI) practices. This checklist is designed to help compliance officers evaluate DEI risks, a process that's complicated by laws in some states that conflict with the federal government's dictates, said attorney Robert Trusiak (see story, p. 4). Contact Trusiak at robert@trusiaklaw.com.

COMPLIANCE OFFICER DEI RISK ASSESSMENT

This is a diversity, equity and inclusion (DEI) risk assessment checklist that a compliance officer can use to preliminarily evaluate False Claims Act (FCA)-related exposure in light of federal executive orders (EOs) and conflicting state mandates:

1. Employee Handbook/Code of Conduct. Does the handbook identify DEI, anti-racism or equity programming as an express obligation of employees? Is DEI tied to performance evaluations or discipline? If DEI is framed as a mandated behavioral condition, it may be harder to later characterize it as merely "aspirational" or non-material to federal funding.
2. Written Policies/SOPs. Do HR, procurement, contracting, hiring or vendor-selection policies contain DEI requirements, quotas, or scoring criteria? Formal policy requirements are more likely to be viewed as "material representations" under Escobar if the organization receives federal funds.
3. Board Minutes and Committee Reports. Has the board publicly adopted resolutions or internal statements committing the organization to DEI as a core principle? Have directors described DEI as essential to mission or funding? Explicit board-level endorsement suggests the organization "certified" DEI as important—raising potential false certification concerns if executive orders prohibit such use.
4. Existence of DEI Officer/Team. Does the entity employ a Chief Diversity Officer, DEI Director or designate DEI responsibilities to another officer (e.g., VP HR, Compliance, Legal) "wearing that hat"? The existence of a dedicated DEI function indicates institutionalization, signaling to government funders that DEI is an operational priority. This may be material (or seen as such) under Escobar.
5. Public Statements and Website Content. Does the organization's website, marketing, or annual reports highlight DEI as central to its operations or a requirement of doing business? External messaging can be used as evidence of an "implied certification" where federal funds are involved. May contradict later arguments that DEI was immaterial.
6. Identify federal funding streams impacted by the EOs, Equal Employment Opportunity Commission, Deputy Attorney General memo and Attorney General memo.
    a. Identify the grant/contract underlying the federal funding stream. The ultimate legal question is whether the government actually refused to pay the claim had it known of the violation. How do we assess that question from a due diligence perspective and then w/ input from counsel?
        i. Key factors:
            1. Is the requirement expressly designated as a condition of payment?
                a. Many agencies have not incorporated those clauses into their payment conditions consistently.
                b. The EO language is aspirational or policy-oriented, not tied to statutory funding conditions.
                c. Unless the EO is expressly incorporated into the funding statute, regulation or contract as a payment condition, a violation of that policy is unlikely to be "material" under Escobar. So while the EOs may guide enforcement discretion (i.e., what types of FCA cases the U.S. Department of Justice chooses to pursue), they do not, standing alone, create new FCA liability — unless an agency goes the further step of:
                    i. explicitly tying DEI compliance to payment eligibility, and demonstrating an actual pattern of withholding payment for such violations.
            2. Has the government historically denied payment for such violations?
            3. How does the government behave after becoming aware of any alleged violation?
            4. Preserve Documentation of State-Law Obligations. Maintain clear records demonstrating that DEI initiatives are undertaken pursuant to binding state requirements, rather than discretionary organizational policy.
            5. Prior to submitting claims for federal funds, assess and memorialize:
                a. how DEI activities satisfy state legal mandates, and whether they conflict with any current, enforceable federal payment provisions.

Mere labeling or the fact that something is "important" does not make it material.

In short: know your obligations, know your funding language, and make sure your governance artifacts tell a story you can defend.

he noted. "The more jobs and duties you have, the more difficult it is to focus on compliance because you're pulled in different directions."

Provider Allegedly Gave Out $1M in Gift Cards

According to the criminal information charging Johnson with conspiracy to commit health care fraud, Life Touch was a North Carolina Medicaid provider of substance abuse services starting in October 2009, with a person identified only as B.S. as its member. Life Touch had a contract with Eastpointe Human Services, a managed care organization (MCO), to provide substance abuse services to Medicaid patients. A person identified as K.S. also formed 1st Choice Healthcare Services LLC and enrolled it in NC-Medicaid in late 2019.

Life Touch, which had locations in Goldsboro and Kinston, contracted to provide services to Eastpointe's comprehensive and intensive outpatient substance abuse treatment programs.

Life Touch's organizational charts named Johnson the compliance director and quality management/medical records director. She was also described in the criminal information as the office manager in Goldsboro and the Medicaid biller for Life Touch and 1st Choice. A third unidentified person, F.S., who is the mother of K.S. and B.S., also worked at Life Touch as an office manager.

Starting no later than January 2018 and lasting at least until Nov. 16, 2023, Life Touch, "by and through B.S., K.S., F.S., JOHNSON, and others," routinely gave gift cards to NC-Medicaid recipients allegedly to encourage them to get substance abuse services at Life Touch, according to the criminal information. Patients were told they could get a gift card for every week of treatment, and some patients got an extra one for bringing in a new patient.

"Although exact amounts varied, recipients who attended treatment five times per week generally received a $60 gift card; recipients who attended four times per week generally received a $50 gift card; and recipients who attended three times per week generally received a $45 gift card," the criminal information alleged. During the time it handed out $1 million in gift cards to patients, Life Touch collected as much as $25 million in NC-Medicaid payments.

Audits Began After Complaints About Gift Cards

Medicaid auditors did a series of audits of Life Touch after they were tipped off about the gift cards. The compliance director and others allegedly lied to auditors and pretended the gift cards were distributed by independent third parties.

For starters, Eastpointe audited Life Touch in 2018 after an NC-Medicaid patient alleged they were approached by a person who said if the patient gave their Medicaid number to Life Touch and went to its substance abuse classes, the patient would get a Visa gift card for every class attended.

Eastpointe auditors concluded that Life Touch's Medicaid billing wasn't in compliance with all federal and state laws and rules, the criminal information alleged. "Specifically, Eastpointe substantiated that Life Touch had provided gift cards with monetary value between $45 to $60 to Life Touch patients" and recommended recoupment of $14,325 in Medicaid payments.

Although auditors informed Life Touch in writing of the verification of gift card allegations and OIG guidance on incentives, Life Touch allegedly continued to give out gift cards through its employees, including its compliance director, according to the criminal information.

NC-Medicaid got another complaint about gift cards and Eastpointe initiated a second audit in 2020.

CMS Transmittals and *Federal Register* Regulations, August 22-September 4, 2025

Transmittals

Pub. 100-04, Medicare Claims Processing

- Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes, Trans. 13,398 (Sept. 4, 2025)
- Allowing Additional Revenue Codes for Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury (AKI) beginning in Calendar Year (CY) 2025, Trans. 13,395 (Sept. 2, 2025)
- Enhancing Compliance and Payment Accuracy for Physician Services in Skilled Nursing Facilities, Trans. 13,391 (Aug. 27, 2025)

Pub. 100-15, Medicaid Program Integrity

- Updates of Chapter 3 and the Appendices Chapter in Publication (Pub.) 100-15, Including Updates to the Medicaid Proactive Project Development Process, Trans. 13,385 (Aug. 28, 2025)

Pub. 100-19, Demonstrations

- Transforming Episode Accountability Model (TEAM) 3-Day Skilled Nursing Facility (SNF) Waiver – Implementation, Trans. 13,399 (Sept. 4, 2025)

Pub. 100-20, One-Time Notification

- Provider Education for Prior Authorization (PA) of Certain Services in the Ambulatory Surgical Center (ASC) Setting, Trans. 13,396 (Sept. 4, 2025)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)—January 2026 Update—CR 2 of 2, Trans. 13,383 (Aug. 26, 2025)

Federal Register

Final rule

- Standards of Conduct; Revocation of Superseded Regulations; Revision of Residual Provisions, 90 Fed. Reg. 40,975 (Aug. 22, 2025)

Proposed rule

- Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies, 90 Fed. Reg. 41,940 (Aug. 28, 2025)

In response, Life Touch, by and through its agents and employees, allegedly tricked Eastpointe and its own patients into thinking the gift cards no longer came from Life Touch and instead were bestowed by a third party, "Refuge House of God." To further that impression, the compliance director allegedly crafted a document called "Refugee Incentive Letter.doc" that purportedly offered incentives to patients who were making considerable progress toward recovery, according to the criminal information. Refuge House of God was a nonprofit corporation established by B.S.'s grandmother.

Eastpointe auditors asked the compliance director to explain the incentive program. "In response, Johnson told auditors, 'We don't do the incentives; it is a third party, Refuge House of God. We are not physically with them; they are there for like clothing and food,'" the criminal information alleged. "In truth and in fact, Life Touch had continued to provide gift cards to clients throughout this time period."

Partly because of allegedly false information from the compliance director and others, the Eastpointe audit was closed with no material findings on the gift cards. But the auditing wasn't over. Complaints kept surfacing, which led to a 2021 audit and more sleight of hand, the criminal information alleged. Employees and agents of the provider made it appear that another third party, "Changing Lives," was providing gift cards to Life Touch patients, although the information alleges that Changing Lives was a shell.

When Eastpointe asked the compliance director about incentives in 2022, she responded on Life Touch letterhead that "Life Touch LLC agency does not give its members motivational incentives." Because of the allegedly fraudulent statements, there were no audit findings. But the matter was referred to the Medicaid Investigations Division (MID), which is North Carolina's Medicaid Fraud Control Unit.

As part of the MID's civil investigation of Life Touch, it requested policies on incentives and other documents. Life Touch produced phony consent forms that made it seem like it released documents to Changing Lives to facilitate incentives for the patients. When the compliance director was interviewed by the MID, she allegedly made false statements, such as "Life Touch was no longer giving gift cards."

But Life Touch continued to give patients gift cards during the civil investigation, according to the criminal information. The U.S. attorney also alleged that Johnson and Super got kickbacks from 1st Choice Healthcare Services LLC, a lab company they used for drug testing Life Touch patients. Because they didn't report this as income, Johnson and Super also pleaded guilty to failure to file a tax return.

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Endnotes

1 U.S. Department of Justice, U.S. Attorney's Office for the Eastern District of North Carolina, "Compliance Director and Office Manager of Substance Abuse Company Convicted in Scheme to Pay Medicaid Kickbacks to Patients," news release, August 25, 2025, https://bit.ly/4paBzQn.

2 United States v. Keke Komeko Johnson, No. 4:25-cr-00027-UA (E.D. N.C. 2025), https://bit.ly/4niXtPD.

3 U.S. Department of Health and Human Services, Office of Inspector General, "Offering Gifts And Other Inducements To Beneficiaries," special advisory bulletin, August 2002, https://bit.ly/46jiR1e.

4 U.S. Department of Health and Human Services, Office of Inspector General, "Office of Inspector General Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries," December 7, 2016, https://bit.ly/4p8wFmY.

5 U.S. Department of Health and Human Services, Office of Inspector General, "Re: OIG Advisory Opinion No. 20-08," December 23, 2020, https://bit.ly/3UXjeZc.

NEWS BRIEFS

◆ **A new job posting for HHS Deputy Associate General Counsel for Program Enforcement has been posted to the usajobs.gov website.**[1] It describes the job duties as "establishing and managing a new Program Enforcement Group within the CMS Division of [the Office of General Counsel], including direct oversight of the new Fraud Prosecutor Program. The role is responsible for providing and supervising a team of 50 or more attorneys that defend CMS in various enforcement actions. Participates in the resolution and handling of cases that are important, difficult, or controversial, and provides authoritative advice on appeals to the Departmental Appeals Board, debt reviews, False Claims Act issues, subpoenas—including Touhy and FOIA matters—and payment suspension reviews. Determines which matters have broad policy implications or are sensitive enough to warrant elevation for higher-level review. Ensures consistent legal interpretations across the division and works to effectuate administrative procedures and regulations that support CMS's enforcement mission."

◆ **CMS has updated its MLN Fact Sheet on compliance with Medicare signature requirements.**[2] For one thing, it accounts for artificial intelligence (AI). "If you use a scribe, including artificial intelligence technology, sign the entry to authenticate the documents and the care you provided or ordered," CMS said. The MLN Fact Sheet also elaborates on signature attestations or logs requested by Medicare auditors.

Endnotes

1 USAJobs.com, "Deputy Associate General Counsel for Program Enforcement (CMSD)," September 4, 2025, https://bit.ly/41GzHER.

2 Centers for Medicare and Medicaid Services, "Complying with Medicare Signature Requirements," MLN Fact Sheet, MLN905364, July 2025, https://go.cms.gov/3I7H816.