Fraud Claims Against Hospice Providers Increase

What every hospice and nursing home provider should know

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The surge in growth of the Medicare hospice benefit over the last decade and expanding profile of the palliative care industry has attracted ever-increasing scrutiny from the media, government agencies, and employee "whistleblowers" seeking to cash in during a tightened enforcement regime.

As Medicare expenditures for hospice care continue to soar, from $5.9 billion in 2003 to $15 billion in 2012, the federal government has assumed an increasingly active role in combating perceived problems of hospice fraud. False Claims Act lawsuits alleging illicit schemes to improperly obtain hospice benefit payments are increasing both in frequency and amount in controversy, resulting in recent settlements of up to $25 million. This trend shows no sign of slowing. On August 28, 2014, the Department of Justice grabbed headlines when it intervened in a whistleblower lawsuit against a UnitedHealth hospice care company, OptumHealth. This announcement came on the heels of the DOJ's 2013 intervention against VITAS, the largest for-profit hospice chain in the country.

This summer, the Washington Post published a three-part series entitled the "Business of Dying," further tarnishing the reputation of an industry that strives to provide dignified end-of-life care.

Attorneys seeking to profit off of would-be whistleblowers have taken notice of the increased scrutiny. A simple internet search for "whistleblower" now turns up numerous websites actively recruiting healthcare workers for potential whistleblower suits. A press release from Corporate Whistleblower Center, a lawyer referral service, encourages employees to contact them directly "for information about possible reward programs" and warns against engaging their employers regarding perceived fraud, advising that "any suggestion of exposure might result in instant job termination . . . .".

Penalties for erroneous hospice claims are severe, and include treble damages, civil penalties between $5,500 and $11,000 for each False Claims Act violation, and exclusion from federal health care programs. To avoid the risk of costly litigation and crippling fines, hospice providers must carefully monitor their compliance with applicable Medicare regulations.

Hospice provider compliance program guidelines published by the Department of Health and Human Services identify a litany of noncompliance risk areas for hospice providers. Indeed, many of the following practices highlighted by the Department have resulted in False Claims Act and anti-kickback lawsuits costing providers millions in litigation fees and settlement costs.

- Obtaining uninformed consent by the beneficiary to elect the Medicare hospice benefit
- Admitting patients to hospice care that are not terminally ill
- Under-utilization, which is the knowing denial of needed care in order to keep costs low
- Untimely and/or forged physician certifications on plans of care
- Hospice incentives such as gifts or free services to actual or potential referral sources (for example, physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or analogous state or federal statute
- Billing for a higher level of care than was necessary
- High-pressure marketing of hospice care to ineligible beneficiaries
- Sales commissions to hospice employees based on length of stay in hospice

Arrangements between hospices and nursing homes have drawn heightened government scrutiny in part due to the discretion nursing homes enjoy in choosing which hospices may provide services to residents of their facilities. The Department of Health and Human Services contends that such relationships are uniquely vulnerable to fraud and abuse because residents receiving hospice care have, on average, longer lengths of stay than patients residing in their own homes and are more financially desirable from a hospice's perspective.

When a hospice beneficiary resides in a nursing home, the facility provides room, board and care unrelated to the terminal illness. The hospice, on the other hand, provides, and is reimbursed solely for, hospice services. Overlap in the services provided by the hospice

and a nursing home, which results in insufficient care provided by a hospice to a nursing home resident, is viewed as a red flag government regulators. It is therefore advisable that hospice providers develop policies and procedures to prevent such overlap, as well as the following practices, which, depending on the facts and circumstances, could be viewed as potential unlawful kickbacks:

- Offering of free or below fair market value goods by the hospice to induce a nursing home to refer patients to the hospice;
- Payment of excessive "room and board" expenses by the hospice to the nursing home;
- Providing staff at the hospice's expense to the nursing home to perform duties that otherwise would be performed by the nursing home; and
- Referring a hospice patient to a nursing home to induce the nursing home to refer its patients to the hospice.

This is by no means a comprehensive list of practices viewed with suspicion by government enforcement agencies and providers should seek advice of counsel if questions arise as to the propriety of any particular conduct.

The spate of recent whistleblower cases reflects a growing focus on alleged fraud and abuse within the palliative care industry and underscores the importance of compliance programs which address the risk areas discussed above.