

## Hospice Care in the Crosshairs: The Growing Fraud and Abuse Enforcement Threat to Hospice Providers

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### Introduction

Authorized in 1982, the Medicare hospice benefit has grown steadily and, with that growth, has attracted ever-increasing fraud and abuse scrutiny and enforcement. Now more than half of individuals who die while covered by Medicare use the benefit before death.<sup>2</sup> From 2003 to 2011, the number of Medicare beneficiaries receiving hospice care has risen from 729,000<sup>3</sup> to 1.2 million individuals<sup>4</sup>. Over the same period, Medicare payments for hospice care more than doubled, climbing from \$5.9<sup>5</sup> to \$13.7 billion<sup>6</sup>.

As Medicare expenditures for hospice care continue to soar, the federal government has assumed an increasingly active role in combating perceived problems of hospice fraud. The Department of Health & Human Services Office of Inspector General and the Department of Justice contend that many hospice providers have pursued a variety of illicit schemes to improperly obtain hospice benefit payments. False Claims Act lawsuits alleging hospice fraud 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. This past May the Department of Justice grabbed headlines when it intervened in a whistleblower lawsuit against VITAS, the largest for-profit hospice chain in the country.

Relators' counsel have taken notice of recent legal developments and a simple internet search for "hospice whistleblowers" now turns up numerous websites actively recruiting hospice employees for potential whistleblower suits. A press release from Corporate Whistleblower Center, for example,

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<sup>2</sup> David G. Stevenson, *Growing Pains for the Medicare Hospice Benefit*, 367 New Eng. J. Med. 1863 (Nov. 1, 2012).

<sup>3</sup> OIG, *Memorandum Report: Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224 (Sept. 22, 2010).

<sup>4</sup> OIG, *Memorandum Report: Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, p. 2 (May 3, 2013).

<sup>5</sup> Medicare Payment Advisory Committee, *Report to the Congress: New Approaches in Medicare*, p. 140 (June 2004).

<sup>6</sup> OIG, *Memorandum Report: Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, p. 2 (May 3, 2013).

encourages hospice 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 . . .”.<sup>7</sup>

Penalties for erroneous hospice claims are severe, including treble damages and civil penalties between \$5,500 and \$11,000 for each False Claims Act violation. To avoid the risk of costly litigation and crippling fines, hospice providers should carefully monitor their compliance with Medicare requirements. This article provides an overview of Medicare conditions of participation, major risk areas for noncompliance, and recent legal actions involving hospice providers to help guide decision-makers in crafting effective compliance programs.

### **Conditions of Eligibility & Participation**

The objective of hospice care is to assist terminally ill beneficiaries to live comfortably and provide support to caregivers and families throughout the end stage of a terminal disease. In support of these goals, coverage under the Medicare hospice benefit includes nursing care, physical or occupational therapy, speech-language pathology, medical social services, home health aide services, homemaker services, medical supplies (including drugs and biologicals) and the use of medical appliances for palliative care, physicians' services, short-term inpatient care, and counseling.

Medicare Part A beneficiaries diagnosed with a terminal illness and a life expectancy of six months or less may elect to receive hospice benefits in lieu of standard Medicare coverage for treatment of the underlying terminal condition. In making such election, the beneficiary must agree to forego curative care in favor of palliative care to manage pain and symptoms. A hospice care beneficiary waives all rights to Medicare Part B payments for services related to the treatment and management of the underlying terminal illness or a related illness for any period of time in which the hospice benefit election is in force,<sup>8</sup> but a beneficiary may revoke his or her election and return to standard Medicare coverage at any time.<sup>9</sup> Throughout the hospice election period, Medicare continues to cover services provided by the patient's attending physician, which may include a nurse practitioner.

Hospices provide and oversee services rendered to a beneficiary through an interdisciplinary group (IDG) comprising a physician and other professionals responsible for various aspects of care.

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<sup>7</sup> “The Corporate Whistleblower Center Urges All Hospice Insiders with Proof of Medicare Billing Fraud to Contact Them Immediately for Compensation Info,” <http://www.prweb.com/releases/2013/9/prweb11095725.htm> (last visited on Dec. 4, 2103).

<sup>8</sup> 42 U.S.C. §§ 1395d(d)(2)(A), 1395x(dd)(1); 42 C.F.R. § 418.24.

<sup>9</sup> 42 U.S.C. 1395d(d)(2)(B); 42 C.F.R. § 418.28.

Hospice care may be provided to beneficiaries and their families in a variety of settings, including the home or a nursing facility. Hospice benefits are allotted in terms of coverage periods. Beneficiaries receive coverage for two 90-day periods, followed by an unlimited number of 60 day periods.

Prior to submitting a hospice benefit claim to Medicare, a provider must ensure that each of the following conditions are satisfied:

- The hospice is certified by Medicare.<sup>10</sup>
- The patient is entitled to Medicare Part A benefits.<sup>11</sup>
- The beneficiary is diagnosed with a terminal illness, defined as a life expectancy of 6 months or less if the illness runs its normal course.<sup>12</sup>
  - At initiation of treatment, the beneficiary's terminal prognosis must be certified by the patient's attending physician (if there is one), *and* the hospice's medical director (or the physician member of the hospice's IDG).<sup>13</sup>
  - At the start of each subsequent 90 or 60 day period of hospice care, the hospice medical director or physician member of the IDG must recertify that the beneficiary is terminally ill and has a life expectancy of 6 months or less.<sup>14</sup>
  - A brief narrative of the clinical findings that support a life expectancy prognosis of 6 months or less must be provided as part of each certification and recertification.<sup>15</sup>
  - Effective January 1, 2011, a hospice physician or nurse practitioner must conduct a face-to-face encounter with each beneficiary prior to the 180th day recertification of terminal illness, and each subsequent recertification, to determine continued eligibility, and must attest that such visit occurred.<sup>16</sup>

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<sup>10</sup> 42 U.S.C. §§ 1395f(a), 1395cc; 42 C.F.R. § 418.116(a)

<sup>11</sup> 42 C.F.R. § 418.20.

<sup>12</sup> 42 C.F.R. §§ 418.3, 418.20, 418.22.

<sup>13</sup> 42 C.F.R. 418.22(c).

<sup>14</sup> 42 C.F.R. § 418.22(a)(1), (c).

<sup>15</sup> 42 C.F.R. § 418.22(b)(3).

<sup>16</sup> 42 C.F.R. § 418.22.

- The patient must elect in writing to receive hospice care and waive curative care coverage during the hospice coverage period. The election statement must acknowledge that the patient was given a full understanding of hospice care and comprehends that certain Medicare services are waived by the election.<sup>17</sup>
- The hospice must designate one or more IDGs to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patient and family. At minimum, an IDG must include: a medical doctor or osteopath employed by or under contract with the hospice, a registered nurse, a social worker, and a pastoral or other counselor.<sup>18</sup>
- All hospice care and services furnished must follow an individualized written plan of care established by the IDG in collaboration with the beneficiary's attending physician (if any), the patient, and the primary caregiver. The IDG, in collaboration with the patient's attending physician (if any) must review, revise and document the plan of care as frequently as the patient's condition requires, but no less than every 15 days.<sup>19</sup>
- Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.<sup>20</sup>

Failure to comply with any one of these requirements may result in serious adverse consequences to a hospice provider. Services that are improperly documented or rendered in a non-compliant manner are not recoverable from Medicare and billing Medicare for such services is considered a violation of the FCA. A provider further may be liable for FCA violations if it becomes aware that it has received payment from Medicare for noncompliant or improperly documented services and fails to notify the government and return any overpayments. As detailed below, certain conduct may be perceived as violative of state or federal anti-kickback laws.

## Levels of Care

The Medicare hospice benefit includes the following four levels of care:<sup>21</sup>

- **Routine Home Care**, the least expensive level of care, includes routine services provided to the hospice patient in the patient's home or a facility in which the patient resides.

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<sup>17</sup> 42 C.F.R. § 418.24.

<sup>18</sup> 42 C.F.R. § 418.58(a).

<sup>19</sup> 42 C.F.R. § 418.56.

<sup>20</sup> Medicare Claims Processing Manual Ch. 11.10 (Jan. 31, 2013).

<sup>21</sup> 42 C.F.R. § 418.302.

- **Continuous Home Care**, the most expensive level of care, is paid only during a period of crisis as necessary to maintain the beneficiary in his or her residence. A minimum of 8 hours of care must be provided within a 24 hour period and must include nursing care by a registered nurse or licensed practical nurse for more than half of the period during which care is provided.
- **Inpatient Respite Care** may be provided in a hospital, skilled nursing facility, hospice facility, or nursing facility when a caregiver requires a temporary reprieve. A registered nurse must be available to provide direct patient care 24 hours a day. Payment may be made for a maximum of 5 days after which the patient must be converted to another level of care. More than 1 respite period is available per 60 or 90 day benefit period.
- **General Inpatient Care**, the second-most expensive level of care, is provided for periods during which a beneficiary requires admission to an inpatient facility for pain control or symptom management.

The two levels of inpatient hospice care may be provided in an inpatient hospice facility, a hospital or a skilled nursing facility (SNF).

Each level of care has an all-inclusive, daily rate that is paid to the hospice through Part A for each day of care, regardless of the quantity of services provided. There are two annual caps on hospice reimbursement. First, the total number of days of inpatient care (general or respite) provided by a hospice may not exceed 20% of the hospice's total patient care days.<sup>22</sup> The second cap limits the total reimbursement that a hospice may receive in any given year to a set per-patient cap multiplied by the number of beneficiaries who elected to receive hospice care from that hospice during the annual cap period.<sup>23</sup>

Separate payment for some physician services relating to the terminal illness is available through Part A or Part B, depending on the physician's relationship with the hospice.<sup>24</sup> Where a beneficiary's attending physician is an employee of or under contract with the hospice provider, the hospice receives payment for the physician services under Part A and, in turn, compensates the physician through salary or other arrangement. In such instances, the Part A hospice claims must include a code for physician services in a line item separate from the daily rate.

<sup>22</sup> 42 U.S.C. § 1395x(dd)(2)(A)(iii); 42 C.F.R. § 418.302(f).

<sup>23</sup> 42 U.S.C. § 1395f(i)(2); 42 C.F.R. § 418.309.

<sup>24</sup> 42 C.F.R. § 418.304.

If the beneficiary's attending physician is not an employee of or under contract with the hospice, the physician must bill Medicare Part B directly for services rendered to the hospice patient.<sup>25</sup>

### Compliance Risk Areas

Hospice compliance program guidelines published by OIG in 1999 identify multiple noncompliance risk areas for hospice providers.<sup>26</sup> The following examples of wrongdoing identified in the OIG guidance warrant close attention as they are among the most common practices alleged in FCA and anti-kickback litigation against hospice providers:

- Obtaining uninformed consent by the beneficiary to elect the Medicare hospice benefit;
- Admitting patients to hospice care that are not terminally ill;
- Arrangement with another health care provider, such as a nursing facility, that a hospice knows is submitting claims for services already covered by the Medicare hospice benefits;
- Under-utilization, *i.e.*, the knowing denial of needed care in order to keep costs low;
- Falsified medical records or plans of care;
- Untimely and/or forged physician certifications on plans of care;
- Inadequate or incomplete services rendered by the IDG;
- Insufficient oversight of patients, in particular those patients receiving more than 6 consecutive months of hospice care;
- Hospice incentives such as gifts or free services to actual or potential referral sources (*e.g.*, physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or analogous state or federal statute;

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<sup>25</sup> 42 C.F.R. § 418.304(c).

<sup>26</sup> Compliance Program Guidance for Hospices, 64 Fed. Reg. 54031 (Oct. 5, 1999).

- 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;
- Billing for a higher level of care than was necessary;
- Knowingly billing for inadequate or substandard care;
- Exertion of pressure on a patient to revoke the Medicare hospice benefit when the patient is still eligible, but the care has become too expensive for the hospice to deliver;
- High-pressure marketing of hospice care to ineligible beneficiaries; and
- Sales commissions to hospice employees based on length of stay in hospice.

In addition, OIG recently has investigated and issued reports concerning improper billing for inpatient respite care, duplicative billing of physician services for hospice beneficiaries, potential overutilization of general inpatient care, and hospice beneficiaries residing in nursing homes.

- An analysis conducted of inpatient respite care utilization in 2005 uncovered inappropriate billing practices, including submission of claims for respite care received for more than 5 consecutive days and billing of respite care to beneficiaries residing in nursing facilities.<sup>27</sup>
- An OIG investigation of duplicative billing for physician services to hospice beneficiaries in 2009 revealed that Medicare paid nearly \$566,000 through Part B for services performed by the same physician for the terminal illness and paid to the hospice under Part A.<sup>28</sup>
- An analysis conducted of general inpatient level of care in 2011 suggests overutilization of this second-most costly level of hospice care. OIG found that of the 23% of Medicare hospice beneficiaries that received general inpatient care in 2011, one-third received general inpatient care over a period exceeded 5 days, with 11% receiving such care for 10 days or more. Hospices that utilized their own inpatient units provided general inpatient care to more of their beneficiaries and for longer periods of time than hospices that used other settings, such as hospitals. OIG concluded that long lengths of care and use of general inpatient care

<sup>27</sup> OIG, *Memorandum Report: Hospice Beneficiaries' Use of Respite Care*, OEI-02-06-00222 (Mar. 2008).

<sup>28</sup> OIG, *Memorandum Report: Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224 (Sept. 2010).

in hospice inpatient units require further review to ensure that hospices are providing the appropriate level of care.<sup>29</sup>

OIG has shared these findings with CMS and recommended that they be considered when conducting hospice claim reviews and audits. Accordingly, hospice providers should take particular caution in structuring their operations to avoid conduct deemed wrongful or suspicious in OIG reports.

### Compliance Issues with Respect to Beneficiaries Residing in Nursing Homes

From 2005 to 2009, the number of Medicare hospice care beneficiaries residing in nursing facilities increased 40%, from 240,000 individuals to 337,000.<sup>30</sup> During this same period Medicare spending on hospice care for nursing facility residents grew by nearly 70%, from \$2.55 billion to \$4.31 billion.<sup>31</sup> As of 2009, 31% of all Medicare hospice beneficiaries resided in nursing homes.<sup>32</sup> In light of this growth, hospice care provided in nursing homes has become a subject of OIG investigations.

According to the OIG, arrangements between hospices and nursing homes are uniquely vulnerable to fraud and abuse because nursing home operators have discretion to choose which hospices may provide services to residents of their facilities.<sup>33</sup> Nursing home patients are particularly financially desirable from a hospice's perspective because the residents receiving hospice care have, on average, longer lengths of stay than patients residing in their own homes, and may, as result, generate higher revenues per patient.<sup>34</sup> As discussed further below, the OIG contends that a bargaining disparity between nursing homes and hospice providers generates incentives for nursing home operators to seek kick-backs.

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

<sup>29</sup> OIG, *Memorandum Report: Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490 (May 3, 2013).

<sup>30</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, pp. i, 8 (July 2011); OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221 (Sept. 2009)

<sup>31</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, pp. 1-2 (July 2011).

<sup>32</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, p. 8 (July 2011).

<sup>33</sup> 64 Fed. Reg. 54031, 54040; OIG, *Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements with Hospices* (Mar. 1998).

<sup>34</sup> 64 Fed. Reg. 54031, 54040; OIG, *Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements with Hospices* (Mar. 1998).

Where a beneficiary is dually eligible for Medicare and Medicaid, Medicaid reimburses the hospice for room and board at a rate of at least 95% of the room and board rate that the State would have otherwise reimbursed the nursing facility. The hospice, in turn, pays the nursing facility for the room and board. In such circumstances, the hospice and the nursing facility are required to execute a written agreement under which the hospice controls the course of the beneficiary's hospice care and the facility agrees to provide room and board.<sup>35</sup>

Nursing facilities are staffed by professional caregivers and are required to provide services that are similar to hospice services reimbursed under the Medicare hospice benefit.<sup>36</sup> Accordingly, there may be overlap between services provided by the hospice and the nursing home, providing an opportunity for one of the entities to reduce services. Fewer services provided by the hospice may result in higher profits because hospices receive fixed daily payment at the appropriate level of care regardless of the number of services or location of care.<sup>37</sup>

A 2009 Medicare Payment Advisory Commission (MedPAC) report to Congress concluded that hospices and nursing facilities both have incentives to refer and to admit hospice beneficiaries likely to have long stays.<sup>38</sup> MedPAC also identified concerns regarding the aggressive marketing of hospice services to nursing facility residents through 'trolling' for clients in those facilities and through distribution of marketing materials which omitted reference to the terminal illness requirement for Medicare hospice coverage.<sup>39</sup>

A subsequent OIG investigation of Medicare hospice benefit claims from 2006 found that 82% of claims for beneficiaries in nursing facilities, representing \$1.8 billion in payments, did not meet Medicare coverage requirements.<sup>40</sup> OIG's analysis uncovered the following deficiencies:

- 33% of claims did not meet election requirements. Most commonly, the statements failed to explain that hospice care was palliative rather than curative or that beneficiaries waived coverage of certain services. 9% of the non-compliant election statements contained misleading language regarding the beneficiaries' right to revoke the election of hospice care. There were no election statements for 4% of claims.<sup>41</sup>

<sup>35</sup> 42 C.F.R. §§ 418.112(b)-(c); CMS, Medicare Benefit Policy Manual, Pub. 100-02 ch. 9, § 20.3 (June 1, 2012).

<sup>36</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, p. iii (July 2011).

<sup>37</sup> 64 Fed. Reg. 54031, 54040; OIG, *Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements with Hospices* (Mar. 1998).

<sup>38</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, p. 1 (July 2011).

<sup>39</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, p. 1 (July 2011).

<sup>40</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, p. 1 (July 2011); OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221 (Sept. 2009).

<sup>41</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, pp. 11-12 (Sept. 2009).

- 63% of claims did not meet plan of care requirements. For 1% of claims, the hospices did not establish plans of care for the beneficiaries. The remaining noncompliant plans suffered from one or more of the following deficiencies: the plan was not established by an interdisciplinary group; the plan did not include necessary components (such as detailed description of the scope and frequency of services); or the plan did not specify intervals for review.<sup>42</sup>
- For 31% of claims, the hospice provided fewer services than outlined in beneficiaries' plans of care.<sup>43</sup>
- 4% of claims did not meet terminal illness certification requirements.<sup>44</sup>

In light of these findings, OIG recommended that CMS strengthen its compliance monitoring practices, especially with respect to establishing plans of care and providing services consistent with these plans.

A second OIG analysis of hospice beneficiary records from 2006 through 2009 determined that, on average, for-profit hospices were reimbursed 29% more per beneficiary than nonprofit hospices and 53% more per beneficiary than government-owned hospices.<sup>45</sup> Almost 8% of hospices, dubbed "high percentage hospices" by OIG, had two-thirds or more of their patients residing in nursing facilities.<sup>46</sup> Compared to typical hospices, high-percentage hospices received more Medicare payments per beneficiary and served beneficiaries who spent more time in care.<sup>47</sup>

- Medicare paid an average of \$3,182 more per beneficiary for beneficiaries served by high-percentage hospices than it paid per beneficiary for those served by hospices overall.

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<sup>42</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, pp. 13-16 (Sept. 2009).

<sup>43</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, p. 15 (Sept. 2009).

<sup>44</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, p. 16 (Sept. 2009).

<sup>45</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, pp. i-ii (July 2011).

<sup>46</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, pp. i-ii, 13 (July 2011).

<sup>47</sup> OIG, *Medicare Hospices that Focus on Nursing Facility Residents*, OEI-02-10-00070, pp. iii, 15 (July 2011); see also OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*; OEI-02-06-00220 (Dec. 2007) (finding that, on average, beneficiaries residing in nursing homes received longer periods of hospice care and were associated with higher Medicare payments than beneficiaries in other settings).

- Medicare beneficiaries served by high percentage hospices received hospice care for a median of 3 weeks longer than the typical hospice beneficiary.
- High-percentage hospices enrolled beneficiaries whose diagnoses required less complex care (i.e., patients with ill-defined conditions and mental disorders) by a ratio of 51% to 32%.

Based on these findings, OIG concluded that certain hospices were intentionally seeking out beneficiaries (often found in nursing homes) with particular characteristics, including those with conditions associated with longer but less complex care. By serving these beneficiaries for extended periods, the hospices receive more Medicare payments per beneficiary, resulting in higher profits. OIG recommended that CMS target monitoring efforts on hospices with a high percentage of beneficiaries in nursing facilities and scrutinize whether these hospices are meeting Medicare requirements.

### **Anti-Kickback Concerns with Respect to Arrangements Between Nursing Homes and Hospice Providers**

The ability of a nursing home operator to exclude hospice providers from its premises presents Anti-kickback Statute risks. It is therefore advisable that hospice providers develop policies and procedures governing their arrangements with nursing homes to prevent the following practices, which depending on the facts and circumstances could be viewed as potential kickbacks:<sup>48</sup>

- 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 “room and board” expenses by the hospice to the nursing home in excess of what the nursing home would have received directly from Medicare had the patient not been enrolled in hospice care;
- Payment by the hospice of above fair market value for “additional non-core services that Medicaid does not consider included in its “room and board” payments to the nursing home;
- Referring a hospice patient to a nursing home to induce the nursing home to refer its patients to the hospice;

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<sup>48</sup> 64 Fed. Reg. 54031, 54040.

- Providing free or below market value care to a nursing home patient, for whom the nursing home is receiving payment under the Medicare SNF benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospices services from that hospice;
- Providing staff at the hospice's expense to the nursing home to perform duties that otherwise would be performed by the nursing home; and
- Arrangements whereby a hospice reimburses a nursing facility for (1) the full Medicaid nursing facility per diem rate for non-hospice patient (which covers pharmacy services) as well as a (2) separate payment for drugs used by dually eligibles in connection with their terminal illness.<sup>49</sup>

## Recent Settlements and Pending Litigation

The scale of recent litigation and settlements arising from alleged noncompliance with Medicare hospice benefit requirements underscores the necessity of adopting an effective compliance program. The recent lawsuits and settlements summarized below reflect a growing focus on hospice operations by both the government and disgruntled employees availing themselves of the FCA's *qui tam* provisions.

### Settlements

- **October 2013 - Hospice of the Comforter - \$3 Million Settlement, Corporate Integrity Agreement & 3 Year Exclusion from Medicare of Former CEO**

In October 2013, a Florida federal judge approved, over objections of the Relator, a \$3 million settlement between the United States and Hospice of the Comforter, Inc. (HOTCI), an Orlando, Florida-based hospice resolving FCA claims. The *qui tam* action, in which the United States intervened in September 2012, alleged \$11 million in erroneous Medicare billings. The relator, HOTCI's former vice-president of finance, alleged that HOTCI's chief executive officer instructed HOTCI employees improperly to admit Medicare beneficiaries to hospice care in the absence of a determination that the patients were eligible for the hospice benefit.<sup>50</sup> The settlement agreement requires an upfront payment of \$750,000 with the balance to be paid over a 5 year period. As part

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<sup>49</sup> OIG Advisory Opinion No. 01-20 (Nov. 14, 2001) (acknowledging, however, that it may be appropriate for a hospice to provide separate reimbursement for palliative drugs used by hospice patient that are not included in the State's Medicaid daily nursing rate).

<sup>50</sup> U.S. Department of Justice, "United States Intervenes in False Claims Act Lawsuit Against Orlando, Florida-area Hospice," <http://www.justice.gov/opa/pr/2012/September/12-civ-1080.html> (last visited on Oct. 7, 2013).

of the deal, HOTCI also entered into a Corporate Integrity Agreement with HHS/OIG. Its former CEO also will be excluded from the Medicare program for 3 years. In rejecting the relator's contention that the settlement was unreasonably low, the court relied, in part, on a government-produced financial analysis of HOTCI's ability to pay. Finding it unsurprising that revenues would dip following cessation of a fraudulent scheme designed to boost revenues, the court was not persuaded by the relator's contention that HOTCI had intentionally impeded its growth to make it appear unprofitable during pendency of the legal action.<sup>51</sup> *U.S. ex rel. Stone v. Hospice of the Comforter, Inc.*, (No. 6:11-cv-1498-ORL-22-AAB, M.D. Fla.).

- **March 2013 - Hospice of Arizona - \$12 Million Settlement & Corporate Integrity Agreement**

In March 2013, Hospice of Arizona, L.C. (HOA), a related entity, American Hospice Management LLC (AHM), and their parent, American Hospice Management Holdings LLC (AHH) agreed to pay \$12 million to resolve allegations that HOA and its related entities submitted or caused to be submitted false Medicare claims between September 2002 and December 2010. A *qui tam* complaint filed by a registered nurse formerly employed by HOA asserted that AHH was engaged in a national business strategy of enrolling non-qualified hospice patients and/or providing and billing for care at a higher level than permitted under the Medicare hospice benefit. Specifically, the relator alleged that patient charts reflected incomplete documentation by physicians, overuse of general inpatient level of care status, and that supervisors at HOA ordered medical directors to change beneficiaries' level of care from inpatient respite care to general inpatient care for the sole purpose of maximizing reimbursement without regard to patients' actual medical conditions. As part of the settlement, AHH also entered into a Corporate Integrity Agreement with HHS/OIG.<sup>52</sup> *U.S. ex rel. Momeyer v. Hospice of Arizona LC, et al.*, (Case No. 1:10-cv-00280-RDB, D. Md.).

- **July 2012 – Altus Healthcare & Hospice - \$555,472 Settlement**

In July 2012, Altus Healthcare & Hospice Inc. n/k/a AHH Historic Inc., of Atlanta, Georgia agreed to pay \$555,472 to resolve a *qui tam* complaint alleging submission of general inpatient hospice care claims to Medicare between March 2008 and October 2010 and Medicaid between March 2008 and October 2011 for beneficiaries who did not qualify for that level of care.<sup>53</sup> *U.S. ex rel. Boal v. Altus Healthcare and Hospice, Inc., et al.*, (Case No. 1:10-cv-1380-WBH, N.D. Ga.).

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<sup>51</sup> Linda Chiem, *Fla. Hospice's \$3M FCA Settlement Gets Court OK*, Law 360, Oct. 28, 2013,

<http://www.law360.com/employment/articles/483993/fla-hospice-s-3m-fca-settlement-gets-court-ok> (last visited Oct. 29, 2013).

<sup>52</sup> U.S. Department of Justice, "Hospice of Arizona and Related Entities Pay \$12 Million to Resolve False Claims Act Allegations," <http://www.justice.gov/opa/pr/2013/March/13-civ-326.html> (last visited on Oct. 7, 2013).

<sup>53</sup> Federal Bureau of Investigation, "Altus Healthcare & Hospice Settles Allegations of Inappropriate Use of Inpatient Hospice," <http://www.fbi.gov/atlanta/press-releases/2012/altus-healthcare-hospice-settles-allegations-of-inappropriate-use-of-inpatient-hospice> (last visited on Oct. 7, 2013).

- **June 2012 – Hospice Care of Kansas – \$6.1 Million Settlement**

In June 2012, Hospice Care of Kansas, LLC and its parent company, Voyager HospiceCare, Inc. agreed to pay \$6.1 million to resolve alleged FCA violations arising from submission of false hospice care claims between January 2004 and December 2008 for beneficiaries who did not have a terminal prognosis of six months or less.<sup>54</sup> *U.S. ex rel. Landis v. Hospice Care of Kansas, LLC*, (Case No. 06-2455-CM, D. Kan.).

- **May 2012 – Hospice Family Care - \$3.7 Million Settlement & 7 Year Exclusion**

In May 2012, Hospice Family Care Inc. (HFC) of Arizona agreed to pay \$3.7 million to resolve allegations that it violated the FCA by submitting claims for patients who were either completely or partially ineligible for hospice benefit or were provided a higher level of hospice care than was necessary or allowable. The hospice's co-owners also agreed under the settlement agreement to be excluded from all federal health programs for a period of seven years.<sup>55</sup>

- **February 2012 – Odyssey HealthCare - \$25 Million Settlement & 5-year Corporate Integrity Agreement**

In February 2012, Odyssey HealthCare, a subsidiary of Gentiva, agreed to pay \$25 million to resolve *qui tam* allegations that Odyssey submitted false claims to Medicare between 2006 and 2009 for continuous home care services that were either unnecessary or performed in a non-compliant manner. As part of the settlement, Odyssey entered into a 5-year Corporate Integrity Agreement with HHS/OIG.<sup>56</sup> *U.S. ex rel. Rouse et al. v. Odyssey Health Care, Inc.* (Case No. 08-C-0383, E.D. Wisc.); *U.S. ex rel. Dingus v. Odyssey Health Care, Inc.*, (Case No. 09-C-0254, E.D. Wisc.); and *U.S. ex rel. Smithwick v. Odyssey Health Care, Inc.*, (Case No. 09-C-1851, E.D. Wisc.).

- **December 2011 – Diakon Hospice - \$10.56 Million Settlement**

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<sup>54</sup> U.S. Department of Justice, "Hospice Care of Kansas and Texas-based Parent Company to Pay \$6.1 Million to Resolve Allegations of False Claims," <http://www.justice.gov/opa/pr/2012/June/12-civ-768.html> (last visited on Oct. 7, 2013).

<sup>55</sup> U.S. Department of Justice, "Arizona Hospice To Pay \$3.7 Million To Resolve False Claims Allegations," [http://www.justice.gov/usao/az/press\\_releases/2012/APR/PR\\_05312012\\_Hospice\\_Family\\_Care.html](http://www.justice.gov/usao/az/press_releases/2012/APR/PR_05312012_Hospice_Family_Care.html) (last visited on Oct. 7, 2013).

<sup>56</sup> U.S. Department of Justice, "Hospice Provider Odyssey Healthcare Agrees to Pay \$25 Million to Resolve False Claims Act Allegations," <http://www.justice.gov/opa/pr/2012/March/12-civ-272.html> (last visited on Oct. 7, 2013).

In December 2011, Diakon Lutheran Social Ministries d/b/a Diakon Hospice Saint John (Diakon) agreed to pay \$10.56 million to resolve FCA claims arising from erroneous claims for hospice care provided between 2004 and 2010 to individuals ineligible for the Medicare hospice benefit. Specifically, Diakon impermissibly submitted Medicare claims for outlier patients who: (1) were eligible for hospice benefits at the time of admission but subsequently stabilized and should have been discharged; (2) were ineligible for hospice coverage at admission, but whose disease process subsequently progressed to the point that they became Medicare eligible; (3) were eligible for coverage for a shorter duration than billed; or (4) were never eligible for hospice coverage. Diakon voluntarily disclosed to federal authorities that it had received improper Medicare and Medicaid payments to avail itself of an FCA provision which provides for reduced penalties of double damages to encourage cooperation and settlement.<sup>57</sup>

- **December 2011 – Hospice Homecare - \$2.7 Million Settlement**

In December 2011, the United States reached a \$2.7 million settlement with Hospice Homecare, Inc. of Arkansas for allegedly billing Medicare for general inpatient care when beneficiaries actually received routine home care.<sup>58</sup>

- **November 2009 – Kaiser Northwest - \$1.83 Million Settlement**

In November 2009, the United States reached a \$1.83 million settlement with Kaiser Foundation Hospitals – Kaiser Sunnyside Medical Center, Kaiser Foundation Health Plan of the Northwest and Northwest Permanente, P.C., Physicians & Surgeons (Kaiser NW) to resolve FCA liability. The settlement resulted from Kaiser NW's disclosure to HHS that it billed Medicare between 2000 and 2004 for hospice services rendered without obtaining requisite written certifications of terminal prognosis of 6 months or less.<sup>59</sup>

- **January 2009 – SouthernCare - \$24.7 Million Settlement & Corporate Integrity Agreement**

In January 2009, SouthernCare Inc. agreed to pay \$24.7 million in resolution of two *qui tam* lawsuits by former employees alleging violations of the FCA. At the time of the settlement, SouthernCare operated approximately 99 hospice locations in 15 states. Relator Romeo, a registered nurse and

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<sup>57</sup> U.S. Department of Justice, "Pennsylvania Hospice To Pay U.S. \$10.56 Million Settlement," [http://www.justice.gov/usao/pam/news/2011/Diakon\\_12\\_01\\_2011.htm](http://www.justice.gov/usao/pam/news/2011/Diakon_12_01_2011.htm) (last visited on Oct. 7, 2013).

<sup>58</sup> U.S. Department of Justice, "Hospice Home Care to Pay \$2,700,000 Settlement in Medicare Fraud Case," [http://www.justice.gov/usao/are/news/2011/December/Hospice\\_quitam\\_settle\\_120911.html](http://www.justice.gov/usao/are/news/2011/December/Hospice_quitam_settle_120911.html) (last visited on Oct. 4, 2013).

<sup>59</sup> U.S. Department of Justice, "Oregon Hospice Pays U.S. \$1.83 Million to Settle False Claims Act Liability," <http://www.justice.gov/opa/pr/2009/November/09-civ-1215.html> (last visited on Oct. 7, 2013).

internal auditor at SouthernCare alleged that the company systematically targeted and enrolled non-terminal patients in hospice care and marketed hospice services to non-terminal patients. Among other things, Romeo asserted that SouthernCare: (1) altered documents to falsely reflect eligibility for Medicare hospice coverage; (2) submitted certification and recertification papers at odds with the patients' physicians' actual diagnoses; (3) enrolled non-terminally ill patients on the amorphous basis of "failure to thrive" or "general debility"; (4) marketed hospice services to non-terminally ill patients with the promise of medication and durable medical equipment fraudulently paid for by Medicare; and (5) enrolled patients that continued to undergo curative treatment while in hospice care. Relator Rice alleged similar claims, adding that SouthernCare misrepresented itself to physicians as a "home health care" company in order to gain access to records of patients who were not terminally ill and induce them to enroll for hospice coverage for which they were ineligible. As part of the settlement, SouthernCare entered into a Corporate Integrity Agreement with HHS/OIG.<sup>60</sup> *U.S. ex rel. Romeo v. SouthernCare, Inc.* (Case No. CV-07-J-2325-S, N.D. Ala.); *U.S. ex rel. Rice v. SouthernCare, Inc.* (Case No. CV-05-B-0873-S, N.D. Ala.).

## Pending Litigation

- ***United States v. VITAS Hospice Services, LLC, et al.* – Ongoing FCA Litigation**

In May 2013, the United States filed a complaint alleging that Cincinnati-based Chemed Corp. and its subsidiary, VITAS Hospice LLC, submitted false claims for unnecessary hospice services between 2004 and 2012, which resulted in tens of millions of dollars in erroneous Medicare payments. The complaint alleges that Chemed and VITAS, the largest for-profit hospice chain in the country: (1) engaged in marketing campaigns that misrepresented the purpose of hospice care; (2) improperly encouraged employees to render continuous home care services to ineligible hospice patients; (3) submitted or caused to be submitted hospice claims to Medicare for patients who were not terminally ill; (4) submitted or caused to be submitted claims for continuous home care services that were unnecessary, not actually rendered, or were not performed in compliance with Medicare requirements; and (5) paid bonuses to staff based on the number of patients enrolled in the program and which rewarded them for patients with longer lengths of stay.<sup>61</sup> *United States v. VITAS Hospice Services, LLC, et al.*, (Case No. 4:13-cv-00449-BCW, W.D. Mo.)

- ***United States, et al. v. AseraCare Inc. et al.* – Ongoing FCA Litigation**

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<sup>60</sup> U.S. Department of Justice, "Alabama-Based Hospice Company Pays U.S. \$24.7 Million to Settle Health Care Fraud Claims," <http://www.justice.gov/opa/pr/2009/January/09-civ-043.html> (last visited on Oct. 7, 2013).

<sup>61</sup> Law 360, "Chemed Hospice Units Want Medicare Scam Suit Nixed," <http://www.law360.com/articles/475598/chemed-hospice-units-want-medicare-scam-suit-nixed> (last visited on Oct. 7, 2013); Law 360, "US Accuses Chemed Hospice Units of Medicare Fraud," <http://www.law360.com/articles/438358/us-accuses-chemed-hospice-units-of-medicare-fraud-> (last visited on Oct. 7, 2013).

In January 2012, the United States intervened in a *qui tam* FCA lawsuit against AseraCare Inc., a for-profit entity with approximately 65 hospice locations in 19 states, and its parent, GGNSC Administrative Services d/b/a Golden Living. The Complaint alleges that AseraCare improperly billed Medicare for hospice benefits provided to individuals who were not entitled to such services. Relators, a former Admissions Nurse, a Patient Care Coordinator, and a registered nurse, assert that AseraCare violated the FCA through a variety of schemes. First, AseraCare's Director of Clinical Services allegedly admitted ineligible patients against the advice of the Relator, a registered nurse, and directed personnel with inadequate Medicare compliance training to sign patient admission and retention documents. AseraCare management also allegedly directed physicians to sign certifications of terminal illness and interdisciplinary plan of care forms in blank and then used the pre-signed forms to bill Medicare for unqualified patients. The complaint further contends that Golden Living directed AseraCare centers to admit new patients that did not meet the standards for hospice care to manipulate the census of patients from which the company's annual Medicare cap was calculated and avoid refunding Medicare payments in excess of the cap. The lawsuit is currently in the discovery stage. *United States, et al. v. AseraCare Inc. et al.*, (Case No. 2:12-cv-00245-KOB, N.D. Ala.)

- ***United States and the State of Illinois ex rel. Geschrey, et al. v. Generations Healthcare, LLC, et al.* – Ongoing FCA Litigation**

Two former chaplains of Generations HealthCare LLC, an Illinois hospice provider, filed a complaint in April 2010 against Generations and its parent, Odyssey HealthCare, Inc., asserting FCA and Illinois state law claims arising from Generations' alleged practice of routinely recruiting and erroneously certifying as eligible for Medicare hospice benefits patients who were not terminally ill. The complaint contends that since its inception in 2002, Generations employed a variety of schemes to bilk Medicare and the State of Illinois of approximately \$17,150,000 in fraudulent payments. Generations employees allegedly recruited non-terminally ill individuals from housing projects and induced them to enroll in hospice care with offers of free medical supplies and other perks while failing to explain that election of hospice care would render them ineligible for curative treatment. Relators allege that certifications and recertifications of terminal illness were not based on the clinical judgment of doctors. Rather, registered nurses completed the certification forms based on second-hand information and the Medical Director signed off without ever having seen the patient. The complaint further contends that management directed nurses to alter patient notes to support hospice eligibility, routinely billed Medicare for higher levels of care than actually provided, and that Generations retained inappropriate patients in hospice care only to discharge them when provision of care became too expensive. The complaint survived a motion to dismiss and the case is currently in the discovery stage. *United States and the State of Illinois ex rel. Geschrey, et al. v. Generations Healthcare, LLC, et al.*, (Case No. 1:10-cv-02413, N.D. Ill.).

- ***U.S. ex rel. Wall v. Vista Hospice Care, Inc.* – Ongoing FCA Litigation**

Wall, a social worker employed at Vista Hospice Care, Inc. d/b/a VistaCare's Denton, Texas office from 2003 until April 2005, filed a *qui tam* complaint in September 2009 alleging FCA violations by VistaCare and its parent, Odyssey Healthcare, Inc. Among other things, the complaint asserts that VistaCare: (1) improperly enrolled and sought reimbursement from Medicare and Medicaid for patients ineligible to receive hospice services; (2) accepted and retained payments from the government for hospice services not actually provided to patients; (3) made false claims for unnecessary durable medical equipment; and (4) violated the Federal Anti-Kickback Statute by engaging in various schemes including payment of kickbacks and offering extra services to patients and their families to induce enrollment in hospice care and payment of kickbacks to nursing home employees for patient referrals. The United States opted not to intervene. In an order dated March 9, 2011, the United States District Court for the Northern District of Texas granted in part and denied in part the defendants' motion to dismiss. The court granted the motion with respect to the presentment and false record theories of improper enrollment because Relator's allegations did not satisfy the heightened Federal Rule of Civil Procedure 9(b) pleading standards. The court also dismissed Relator's claim that defendants' billed the government for services not provided for failure to meet the FCA materiality requirement. The court, however, permitted Relator to replead both theories. The court dismissed the allegations relating to unnecessary claims for medical equipment, noting that Relator had conceded that defendants' per diem hospice benefit payment was not affected by the amount of equipment ordered. The court declined to dismiss Relator's anti-kickback claims. On September 6, 2013, Relator filed a fourth amended complaint which Vista Hospice Care answered on September 27, 2013. A motion to dismiss was filed that same day by Odyssey and is pending as of the time of this writing. *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*, (Case No. 3:07-CV-604-M, N.D. Tex.).

## Conclusion

The spate of recent FCA litigation reflects a growing focus on alleged fraud and abuse within the hospice industry and underscores the importance of compliance programs which address the particular risk areas highlighted throughout this article. A properly implemented compliance program, which includes policies, training and monitoring efforts, can substantially reduce a hospice provider's exposure to allegations of fraudulent conduct and costly litigation.