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Hospice in the government's cross-hairs

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The federal government has been cracking down on fraud in the area of hospice services. Even a quick review of the list of 2017 criminal and civil enforcement activities on the OIG's website evidences that hospice is on the government's short list of provider types to be investigated. Recent reported cases include allegations of billing Medicare for medically unnecessary hospice services and payment of kickbacks for patient referrals and physician certifications of hospice eligibility. Below is a summary of some of these recent cases involving hospice providers.

In April 2017, the U.S. Attorney's Office for the Northern District of Texas announced a $12.2 million settlement with several hospice companies doing business under the names Curo Health Services and Hospice Plus. The allegations were brought against the defendants by three whistleblowers who previously worked for the companies in marketing, care coordination and/or operations. The settlement stemmed from allegations that the hospices paid kickbacks in the form of sham loans, a free equity interest in another company, stock dividends and free rental space to a physician house-call company in exchange for patient referrals to the hospices. The whistleblowers also alleged a second scheme involving kickbacks including cash, gift cards, happy hours and meals, sporting event tickets, cars, guns, manicures and pedicures, and free nursing services to physicians, nurses, hospitals and long-term care facilities in exchange for their referrals to the hospices. While the government

settled the case with the companies, it intervened to separately proceed against two former company executives/owners who allegedly paid the kickbacks to induce patient referrals to the hospices.

July 2017 was a busy month for cases against hospice providers. On July 6, 2017, U.S. Attorney's Offices in New Jersey, Pennsylvania and Georgia all announced settlements with hospice providers. The U.S. Attorney's Office for the Eastern District of Pennsylvania announced an $8 million settlement with the owners/operators of a now-closed Philadelphia hospice company, Home Care Hospice, Inc. (HCH), to resolve allegations that it submitted false claims and records to Medicare for hospice care for patients who were not terminally ill, as well as for crisis care services that were not necessary or not actually provided. This settlement follows criminal cases against three of HCH's owners/executives and 19 other individuals employed by or associated with HCH who were involved in the fraud. The civil case against HCH's owners/operators was filed by two former HCH employees who discovered the fraud.

Also on July 6, 2017, the U.S. Attorney's Office for the District of New Jersey announced a $2 million settlement with Compassionate Care of Gwynedd to resolve allegations brought by two whistleblowers that the hospice provided unnecessary hospice services to patients who were admitted to hospice using the "soft" diagnosis of "debility" that was not medically justified. That same day, the U.S. Attorney's Office for the Northern District of Georgia announced a $2.4 million settlement with Compassionate Care of Gwynedd's parent company, Compassionate Care Hospice Group, Inc., to resolve allegations raised by the same whistleblowers (who were former case managers/nurses in the Georgia hospice) that the hospice company submitted or caused the submission of false Medicare and Medicaid claims that were tainted by improper financial relationships with physicians that violated the Anti-Kickback Statute. According to the government's press release, the illegal remuneration to five physicians took the form of payments to a medical director in exchange for referrals and sham contracts with associate medical directors in exchange for referrals.

On July 17, 2017, the Department of Justice announced a $19.5 million settlement with three companies, including Tridia Hospice Care Inc., and their executives to resolve allegations that included claims that Tridia billed Medicare for hospice services provided to patients who were ineligible for the hospice benefit because Tridia failed to conduct proper certifications and medical examinations as required by the Medicare rules for hospice services. The settlement also resolved allegations that the company executives solicited and received kickbacks to refer patients from the skilled nursing facilities managed by companies they owned/controlled. This settlement resolves allegations contained in two separate whistleblower lawsuits brought by former company employees who will share about $3.6 million of the government's recovery.

And just this week, two criminal cases involving hospice providers in Missouri and Nevada were announced. On August 14, 2017, the U.S. Attorney's Office for the Northern District of Missouri announced that a physician had been sentenced to 39 months in prison and three years of supervised release and ordered to pay almost $2 million in restitution to the Medicare program in connection with his guilty plea and admission that he referred patients for hospice services that were not hospice appropriate. In that case, the government alleged that the physician received payments in return for referrals to the two hospices where he served as medical director. The owner of the hospices previously pled guilty to conspiracy to commit health care fraud and admitted to using patient recruiters, which she paid as much as $800 per patient, and to paying cash kickbacks to the hospice medical director for him to sign hospice orders for patients that he knew were not hospice appropriate. A billing clerk at the hospices was also sentenced to one year and one month of incarceration and ordered to pay more than $1 million in restitution after pleading guilty to conspiracy to commit health care fraud. This case was brought to the government's attention as a result of fraud tips provided to the HHS-OIG Hotline.

Also on August 14, 2017, the U.S. Attorney's Office for the District of Nevada announced the indictment of a former physician and his business partner in a $7.1 million Medicare fraud scheme. The indictment includes allegations that the former physician and his business partner (1) filed false Medicare enrollment documents to operate hospice and home care agencies through nominees because the former physician, who was an owner of the hospices and home care agencies, was excluded from participating in federal health care programs and would not have been permitted to obtain Medicare provider numbers for the hospices and home care agencies if his ownership in the hospices and home care agency had been disclosed; and (2) submitted hospice claims to Medicare for individuals who were not terminally ill and did not qualify for the hospice benefit. This case is ongoing.

In addition to these recent criminal and civil cases, the OIG recently announced an update to its 2017 Work Plan to add a hospice-related audit. In its prior audit report, published in 2012, the OIG concluded that Medicare was likely frequently paying twice for prescription drugs for hospice patients—once under the Part A per diem rate and then again under Part D. In that report, the OIG recommended that CMS perform oversight to ensure that Part D is not paying for drugs already covered under the per diem payments made to hospices and require Part D sponsors to implement controls to identify prescription drugs covered by the hospice per diem payment. As a follow up to the 2012 audit report, the OIG announced a new audit to once again review the appropriateness of Part D drug claims for individuals receiving hospice benefits under Part A and whether those drugs should have been covered under the per diem payments made to hospice organizations.

With the government currently focused on hospice, hospice providers would be well-advised to review their operations and practices to ensure they are compliant with

the law. This review might include an analysis of existing admission processes to ensure that only hospice-eligible patients are admitted and an audit of marketing practices and relationships with potential referral sources to ensure they do not violate the Anti-Kickback Statute.