HOSPICE AND THE FALSE CLAIMS ACT: PARADOXES IN END-OF-LIFE CARE

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The growing need for hospice care in end-of-life scenarios has led to an increase in for-profit hospice providers receiving Medicare hospice benefit reimbursements. Though governed by the False Claims Act, these reimbursements carry a problematic risk of fraud due to the nature of hospice care. Many providers have been charged under the False Claims Act, as analyzed in this Article, however the systemic problems presented by for-profit hospice care will continue to plague the system and burden taxpayers until large-scale changes are made to the law. Such changes must include increased oversight of reporting standards, a reconsideration of the hospice care standard itself, and a reduction in for-profit provider certification.

Introduction

Studies have consistently shown that 80 percent of Americans say they want to die peacefully at home surrounded by friends and family.[1] Despite the overwhelming preference to die at home, only 20 percent of Americans do so.[2] Sixty percent of individuals die in acute-care hospitals and the remaining 20 percent pass in nursing homes.[3] Although the

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1. *Where do Americans Die?*, STAN. SCH. MED.: PALLIATIVE CARE, https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/ (last visited Mar. 28, 2021).
2. *Id.*
3. *Id.*

public overwhelmingly supports the idea of dying at home with the assistance of hospice care, only a minority of people use hospice at the end of their life.[4] Additionally, those who use hospice do so only in the last three to four weeks of their life.[5]

Although the rate of hospice use is low relative to those eligible for subsidized government benefits, use has significantly increased in the last twenty years. Many experts anticipate hospice benefit use will grow exponentially as baby boomers age. Still, there are many threats to hospice care generally, and the Medicare hospice benefit precisely. This Article examines fraudulent hospice practices and critically questions the role of for-profit hospice organizations receiving hospice benefit reimbursements through Medicare. It does so by reviewing Federal False Claim Act cases from the last ten years to illustrate the problematic nature of for-profit hospices. In particular, the cases highlight hospice employees' claims that their employer falsely represented hospice patients to extend or misrepresent eligible Medicare payments. The impetus of this paper is to examine the current state of hospice and to provide solutions to help maintain the viability of the Medicare hospice benefit. In particular, this analysis makes a case for limiting for-profit hospice licenses.

The Article proceeds in four parts. Part I introduces hospice, the Medicare hospice benefit, and the False Claims Act. Part II presents and analyzes False Claims Act federal cases from the last ten years. Part III examines the upcoming challenges for the hospice benefit. Last, in Part IV, suggestions for policy changes are presented.

I. Hospice History & Evolution

A. Hospice History & Principles

Generally, hospice care is premised on making the best of the time remaining for a terminal patient, rather than continuing life at all costs.[6] While hospice care is known and accepted today, that acceptance is relatively recent.[7] First appearing in the 1960s and 1970s, hospices

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4. *Id.*
5. *Id.*
6. *What is Hospice?*, NAT'L HOSPICE & PALLIATIVE CARE ORG., https://www.nhpco.org/wp-content/uploads/2019/04/What_is_Hospice.pdf (last visited Mar. 28, 2021) [hereinafter *What is Hospice?*].
7. Kathy L. Cerminara, *Pandora's Dismay: Eliminating Coverage-Related Barriers to Hospice Care*, 11 FL. COASTAL L. REV. 107, 113 (2010).

breached the traditional, institutionalized way the medical community approached death at that time.[8] Instead of viewing death as something to be contravened at all costs, practitioners began to recognize that the final stage of life should be embraced and managed instead of feared and avoided. Thus, rather than hospitalizing terminal patients until the inevitable end of their life, medical professionals realized terminal patients' social, emotional, and physical comfort was tantamount to continued life-preserving care.[9] The general principles of hospice include death with dignity, a medical team approach to care, pain management, emotional and spiritual support tailored to the patient's needs, and support for both the patient and the patient's loved ones.[10]

1. HOSPICE EVOLUTION—NON-PROFIT TO FOR-PROFIT

When hospice care was introduced into the mainstream a half-century ago, a majority of hospice care organizations were not-for-profit (and often associated with religious organizations).[11] Once hospice care became federally funded, for-profit hospices began to enter the marketplace at increasing speed. By 2008, the hospice-care market was evenly split between for-profit and non-profit providers.[12] Today, for-profit hospice organizations now outnumber non-profit hospices.[13] Based on recent trends, for-profit hospice growth will continue to substantially outpace non-profit sector growth. For instance, from 2001 to 2008, the for-profit industry grew by 128 percent, while the non-profit hospice sector grew by 1 percent.[14]

2. HOSPICE VS. PALLIATIVE CARE

There are many misconceptions about the difference between hospice care and palliative care. In a study of more than 250 participants discussing end-of-life wishes and decisions, most individuals did not

8. *Id.* at 112.
9. *Id.* at 113.
10. *What is Hospice?*, *supra* note 6.
11. Cerminara, *supra* note 7, at 115.
12. *Id.* at 116.
13. Joshua E. Perry & Robert C. Stone, *In the Business of Dying: Questioning the Commercialization of Hospice*, 39 J. L. MED. & ETHICS 224, 227 (2011) ("Approximately 52 percent of hospices are for-profit, 35 percent are non-profit, and 13 percent are owned by the government.").
14. *Id.*

realize the difference between the types of care.[15] Additionally, study participants had many misconceptions about hospice care services, including a belief that hospice patients would be left to die if they developed a simple infection.[16] These differences between the two categories of care and the societal misconceptions surrounding them are significant because palliative care is primarily financed by the individual and his or her family, while hospice care is a federally funded Medicare benefit (for qualified recipients).[17] Unlike hospice care, palliative care can begin at the time of diagnosis and can include curative treatments.[18] Ideally, a patient will move from palliative care to hospice care when the patient chooses not to undergo curative treatments.[19] This choice should occur when it is clear that his or her illness is not responding to medical attempts to cure or slow the terminal disease's progress.[20]

3. HOSPICE LICENSING REQUIREMENTS

Organizations wishing to enter the state health care market and provide hospice services (and qualify for Medicare reimbursement) must acquire a certificate of need ("CoN") with the state.[21] The state agency will review the CoN application based on the quality of the developers, the experience of the parties, the availability of other providers, and the effect on competition for health services.[22] Once an organization is certified, it is required to undergo continuous oversight by the Health Care Fraud and Abuse Control Program ("HCFAC").[23] Nursing home facilities must undergo continuous certification procedures every fifteen months, and home health agencies require recertification every

15. Andrea South & Jessica Elton, *Contradictions and Promise for End-of-Life Communication among Family and Friends: Death over Dinner Conversations*, 7 BEHAV. SCI. 1, 10 (2017).
16. *Id.* at 8.
17. *Palliative Care or Hospice?*, NAT'L HOSPICE & PALLIATIVE CARE ORG. (2019) https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf.
18. *Id.*
19. *See id.*
20. *What Are Palliative Care and Hospice Care?*, NAT'L INST. ON AGING (reviewed May 17, 2017), https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care.
21. 147 AM. JUR. TRIALS 525 § 7 (2016).
22. *See id.*; 42 C.F.R. § 418.100 (2009).
23. § 418.100; *see also* Amanda Jacobowski. *Calculating Death: Implications of the Six-Month Prognosis Certification Requirement for the Medicare Hospice Benefit.* 19 ELDER L.J. 187, 209–10 (2011).

thirty-six months.[24] When a hospice program is an independent organization, however, the Centers for Medicare & Medicaid Services ("CMS") only require recertification every six years.[25] Certified hospices are required to provide nursing and physician services, and have drugs and biologicals available on a 24-hour basis, seven days a week.[26]

B. Medicare Hospice Benefit

The Medicare hospice benefit pays the hospice organization a predetermined fee for each day a terminally ill patient receives hospice care.[27] A patient is terminally ill if the patient "has a medical prognosis such that his or her life expectancy is [six] months or less if the disease runs its normal course."[28] The hospice receives payment regardless of the number of services furnished on any given day, although there is a cap on annual per patient reimbursements.[29]

Because Medicare only pays for hospice care if a patient is terminally ill, a terminal prognosis must be certified.[30] Additionally, the certification must be signed by two physicians, including the patient's primary care physician and the medical director of the hospice.[31] Patients enrolled in hospice have a right to all care and services for two 90-day periods and unlimited subsequent 60-day periods.[32] During the first two 90-day periods of eligibility, the physician does not have to examine the patient physically.[33] The physician can base their diagnosis on the patient's chart.[34] The physician is then required to provide a narrative of the diagnosis along with his or her signature.[35] Yet, if the patient's hospice care is to be extended beyond the two 90-day periods,

24. *Id.* at 212.
25. *Id.* at 211.
26. § 418.100; *see also Hospices*, CTR. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospices.html (last modified Sept. 9, 2015 1:47 AM).
27. *Id.*
28. 42 C.F.R. §418.3 (2019).
29. 42 C.F.R. §418.302(e)(1) (2015).
30. 42 C.F.R. §418.22 (2021).
31. 42 C.F.R. §418.22(a)(4) (2020).
32. 42 C.F.R. § 418.22(c) (2020).
33. 42 C.F.R. § 418.22(a)(4) (2020).
34. *See id.*
35. 42 C.F.R. § 418.22(b)(3) (2020).

the physician must meet with the patient face-to-face.[36] Other items required for a terminal certification include a written certification form, a physician narrative statement and an attestation statement.[37]

C. False Claims Act (31 U.S.C. § 3729)

The False Claims Act[38] ("FCA") is the Federal Government's primary tool for recovering losses from government fraud and abuse, and has resulted in billions of recouped funds.[39] In the 2018 fiscal year, the federal government recovered 2.8 billion dollars from FCA cases.[40]

The FCA subjects "any person who…knowingly presents, or caused to be presented, a false or fraudulent claim for payment or approval" to civil liability.[41] To be held liable under the FCA, a defendant must be found to have acted "knowingly." Specifically, the person or entity must have: (1) "actual knowledge of the information"; (2) "act in deliberate ignorance of the truth or falsity of the information"; or (3) "act in reckless disregard of the truth or falsity of the information."[42]

Although there are numerous types of FCA claims available (tax-related, environmental, safety, etc.), two general types of FCA claims relate to healthcare. The first type of claim (not covered in the current analysis) is related to allegations against pharmaceutical companies.[43] The second type, and the most pertinent to the current examination, are claims related to medical necessity-based fraud.[44] Specifically, fraud that occurred because the care administered and billed for was not medically necessary.[45]

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36. *Id.*
37. *Id.*
38. 31 U.S.C. §§ 3729–33 (2019).
39. James B. Helmer, Jr. & Erin M. Campbell, *Jury Instructions for False Claims Act Cases*, 84 U. CIN. L. REV. 943, 943 (2016).
40. Press Release, U.S. Dep't of Just., Justice Department Recovers Over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018 (Dec. 21, 2018).
41. 31 U.S.C. § 3729(a)(1)(A) (2019).
42. 31 U.S.C. § 3729(b)(1)(B) (2019).
43. Isaac D. Buck, *A Farewell to Falsity: Shifting Standards in Medicare Fraud Enforcement*, 49 SETON HALL L. REV. 1, 7 (2018) (explaining that the first type of claims featuring allegations against pharmaceutical companies tends to center around the direct conflict between False Claims Act falsity standards and the standards of the Food, Drug, and Cosmetic Act).
44. *Id.*
45. *Id.*

1. QUI TAM AND RELATORS

Under the FCA, qui tam claims allow persons and entities with evidence of fraud against federal programs or contracts to sue the wrongdoer on behalf of the United States government.[46] Individuals who bring qui tam motions are referred to as *relators*. When the FCA was signed into law in 1863 the term whistleblower did not exist,[47] however courts continue to use relator in court documents.[48] In common vernacular the term whistleblower and relator are synonymous.

2. QUI TAM PROCEDURE AND REWARD

Qui tam suits under the FCA are initially filed under seal—that is, they are not disclosed to the public and are not served on the defendant. The complaint is served upon the attorney general of the United States and upon the United States attorney in the district where the action is filed.[49] During the seal period, the Department of Justice evaluates the case on its merits and determines whether the United States should intervene. If the government decides to intervene, it assumes responsibility for prosecuting the case. But, the relator continues as plaintiff and retains a right to between 15 and 25 percent of any recovery.[50] The relator may continue to play an active role in the case at the direction of the U.S. prosecutors (unless the government seeks and or receives a court order restricting the relator's role).[51]

46. 31 U.S.C. § 3730 (2019).

47. James F. Barger, Jr., *Life, Death, and Medicare Fraud: The Corruption of Hospice and What the Private Public Partnership Under the Federal Claims Act is Doing About It*, 53 AM. CRIM. L. REV. 1, 20 (2016) (citing James F. Barger et al., *States, Statutes, and Fraud: An Empirical Study of Emerging State False Claims Acts*, 80 TUL. L. REV. 465, 470 (2005) ("[T]he Civil War Era statute was prompted by '[d]iseased mules, defective muskets, and an iconic President's frustration' in an attempt to give 'the federal government a way to combat fraud suffered by the Union Army when it received deliveries of defective supplies.'")).

48. *False Claims Act (Qui Tam) Whistleblower FAQ*, NAT'L WHISTLEBLOWER CTR., https://www.whistleblowers.org/faq/false-claims-act-qui-tam/ (last visited Mar. 28, 2021).

49. 31 U.S.C. § 3729(b).

50. 31 U.S.C. § 3730(d)(1)–(3) (showing that a relator's share may be reduced in extraordinary instances below 15–25% when evidence is based on publicly disclosed information or where the relator was a participant in the fraud).

51. 31 U.S.C. § 3730(c)–(d).

II. FEDERAL CASES

The cases discussed in this analysis and brought forward by relators and federal government agencies in the last ten years are related to the following issues: wrongful certifications, hospice patient enrollment shortcuts, inappropriate recruitment and enrollment incentives, and falsifying billing and the number of individual hospice visits. As demonstrated in the following cases, federal courts have oscillated when it comes to the evidentiary standard required for summary judgment and proving the falsity of claims.

In *United States ex rel. Landis v. Hospice Care, LLC.*, Landis, an employee of Hospice Care of Kansas Inc. ("HCK"), brought an action under the FCA claiming that HCK and its parent company, Voyager, knowingly submitted false or fraudulent claims to Medicare in violation of the Act.[52] Landis claimed that HCK incentivized staff to maintain an average daily census of patients and instructed staff not to document discharge planning or specific chart phrases such as "stable," "slow decline," or "may not be appropriate for hospice."[53] Additionally, outside consultants expressed concern that roughly one-third of patients at one particular HCK branch were ineligible for hospice benefits.[54] The complaint identified twenty-seven patients that were not terminally ill but for whom HCK submitted Medicare claims.[55] In support of their motion to dismiss for failure to state a claim, HCK and Voyager asserted (among other things) that medical opinions regarding patients' terminally ill status are subjective medical opinions that cannot be false.[56] The court found that Landis met the standard for providing specific factual allegations regarding the alleged claims and denied HCK and Voyager's motion to dismiss.[57] In particular, the court noted that qui tam plaintiffs are not required to provide a factual basis for every allegation; nor must every allegation contain the necessary information.[58] The allegations in the complaint are sufficiently specific when identifying "the who, what, when, where, and how of the alleged claims."[59]

52. United States *ex rel*. Landis v. Hospice Care, LLC., No. 06-2455-CM, 2010 U.S. Dist. LEXIS 129484 (D. Kan. Dec. 7, 2010); *see* 31 U.S.C. § 3729(a)(1).
53. *Landis*, 2010 LEXIS 06-2455-CM, at *7.
54. *Id.* at *2.
55. *Id.* at *10.
56. *Id.* at *14.
57. *Id.* at *19.
58. *Id.*
59. *Id.*

In *United States ex rel. Willis v. Angels of Hope Hospice, Inc.*,[60] Willis (the plaintiff/relator) complained that Angels of Hope Hospice (Angels), a Georgia Medicare-certified for-profit hospice provider committed and concealed multiple fraudulent acts in violation of the FCA.[61] In particular, Willis claimed that Angels aggressively recruited what the organization titled "undupes" (individuals who had never elected hospice care) to help Angels reach an aggregate cap to avoid repaying Medicare payments in excess of the maximum aggregate cap.[62] Willis also claimed Angels backdated paperwork, violated anti-kickback statutes, and fraudulently submitted claims for patients ineligible for Medicare hospice benefits.[63] Willis asserted that all the fraudulent practices he witnessed, and was required to be a part of to maintain his employment, were FCA violations.[64] Angels moved to dismiss, asserting that Willis's facts were insufficient to show that patients were ineligible or that patient backdating occurred.[65] The court found Willis's claims were specific enough to satisfy the requirements of the FCA and denied Angels' motion to dismiss the claim.'[66]

In *Grane Hospice Care v. Dep't of Pub. Welfare*,[67] the Department of Public Welfare initially directed Grane Hospice Care to reimburse the Department $71,630.25 for eighteen months of payments made to Grane for services provided to R.H., a patient enrolled in medical assistance.[68] The Department ordered the reimbursement after the determination that R.H. was not at the end of his life, thus making the hospice services he received medically unnecessary (according to hospice standards).[69] Grane argued that they complied with all regulations related to hospice care eligibility.[70] In particular, they contended that no one could know

60. United States *ex rel.* Willis v. Angels of Hope Hospice, Inc., No. 5:11-CV-041(MTT), 2014 U.S. Dist. LEXIS 20959 (M.D. Ga. Feb. 21, 2014).
61. *Id.* at 1.
62. *Id.*
63. *Id.* at 4.
64. *Id.* at 4–5.
65. *Id*. at 5.
66. *Id.* at 13.
67. Grane Hospice Care, Inc. v. Dep't of Pub. Welfare, 74 A.3d 1094 (Pa. Commw. Ct. 2013).
68. *Id.* at 1095–96.
69. *Id.* at 1096.
70. *Id.* at 1095.

with certainty if someone will die within six months, even with physician certification.[71] The court overturned the Department of Public Welfare's adjudication decision and concluded that Grane complied with regulations for determining hospice care eligibility.[72]

In *United States ex rel. Fowler v. Evercare Hospice, Inc.*,[73] Evercare moved to dismiss relator Fowler's (with the United States' partial intervention) qui tam action alleging that Evercare knowingly submitted, or caused to be submitted, claims for ineligible patient Medicare hospice benefits.[74] Evercare, a for-profit hospice operating in thirteen states, incentivized employees to violate procedures for certifying hospice patients so it would appear that Evercare was complying with Medicare hospice admission requirements.[75] In particular, when a patient was referred to an Evercare hospice, a nurse first evaluated the patient to determine whether or not to admit them.[76] The nurse then verbally communicated their findings to the medical director on duty, who then issued a verbal order to admit the patient.[77] After the verbal order, a medical director would sign the required terminal illness certification.[78] Thus, both the nurse and the medical director who signed off on the terminal illness often did so without seeing the patient or even evaluating their medical records.[79] The court denied Evercare's motion to dismiss.[80] Ultimately, the court was not persuaded by Evercare's argument that the claims against them were objectively false or fraudulent. The court found sufficient and substantial evidence that Evercare discouraged discharge, pressured certifying physicians to provide certifications without seeing patients, and attempted to reverse-engineer billing and audits.[81]

In *United States v. Aseracare Inc.*,[82] contrary to the court decisions discussed above, the court ruled in favor of a provider's argument concerning the falsity of claims. Aseracare, a hospice provider, was granted

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71. *Id.*
72. *Id.*
73. United States *ex rel.* Fowler v. Evercare Hospice, Inc., No. 11-CV-00642-PAB-NYW, 2015 WL 5568614 (D. Colo. Sept. 21, 2015).
74. *Id.* at *1.
75. *Id.* at *2.
76. *Id.*
77. *Id.* at *2–3.
78. *Id.*
79. *Id.* at *7–8.
80. *Id.* at *49.
81. *See id.* at *38–39.
82. *Id*. at *38–39.

a new trial after the appellate court determined that the lower court submitted improper instructions to the jury.[83] The issue in contention concerned what is legally necessary and sufficient to find that the claims were false.[84] As the court notes, "one of the undecided areas of law in the Eleventh Circuit is the legal standard for falsity in a case like this one, where the Government alleges that the hospice provider's medical records do not support its hospice eligibility certifications, and therefore the allegations are false."[85] The case did not hinge on well-established false claims such as forged physician signatures, or billed services for phantom patients. Instead, the Government made a claim supported by one physician that patients' medical records did not match patients' prognoses.[86] The appeals court vacated the lower court's order granting judgment as a matter of law pertaining to the patients included in the original complaint, and gave notice to the parties that it would consider summary judgment *sua sponte* for Aseracre pursuant to Federal Rule of Civil Procedure 56(f)(3).[87] As the court noted, "the Government painted itself into a corner by failing to disclose to Aseracare during discovery that it would use anything other than [one doctor's] testimony and the medical records to prove the falsity of the claim."[88]

In *United States ex rel. v. Hinkle*,[89] Hinkle, an employee of Caris Healthcare, brought a qui tam motion alleging that Caris routinely submitted claims for payment to Medicare for services ineligible for hospice care reimbursement.[90] Caris, a for-profit hospice provider, was accused of creating aggressive census targets for employees to recruit and retain certifiable hospice patients—with financial incentives for the employees to achieve these targets.[91] The government provided additional evidence that Caris admitted ineligible patients, falsified health records with fictitious conditions, and fired nurses and medical directors who

83. United States v. Aseracare Inc., 153 F. Supp. 3d 1372 (N.D. Ala. 2015).
84. *Id.* at *1387.
85. *Id.* at *1375.
86. *Id.* at *1376.
87. *Id.* at *1387.
88. *Id.* at *1376.
89. *Id.* at *1385–87.
90. *Id.* at *1386.
91. United States *ex rel.* v. Hinkle, No: 3:14-CV-212-TAV-HBG, 2017 U.S. Dist. LEXIS 144187, at *1 (E.D. Tenn. May 30, 2017).

refused to admit patients whom they believed to be ineligible for hospice care.[92] Caris moved to dismiss, and the motion was denied after the court determined Hinkle and the government's allegations met the standards related to falsity, materiality, and particularity.[93]

In the most recent federal district court ruling regarding the False Claims Act and hospice care, *Druding v. Care Alternatives, Inc.*,[94] former employees of Defendant Care Alternatives, Inc. (Defendant Care), brought qui tam claims "alleging that Defendant Care fraudulently billed Medicare and Medicaid by admitting and recertifying inappropriate patients for hospice care."[95] Defendant Care moved for summary judgment and filed a motion to dismiss on the grounds that the relators failed to comply with statutory requirements for FCA motions.[96] The court granted the motion of summary judgment and denied the motion to dismiss after finding the government was actually harmed by the deficient written disclosure statement and there was no evidence that omissions in the statement were the result of deliberate bad faith or willfulness on the relators' part.[97]

Universal Health Services v. United States ex rel. Escobar[98] a recent U.S. Supreme Court case, examined the implied false certification theory as a basis for liability under theFCA. The court determined "liability can attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant's noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances, liability may attach if the omission renders those representations misleading."[99] The Court of Appeals' judgment was vacated and the case was remanded for further proceedings consistent with the opinion.[100] This case is vital to hospice organizations relying on Medicare reim-

92. *Id.* at *4.
93. *Id.* at *5–6.
94. *Id.* at *6–7.
95. *Id.* at *28–29.
96. Druding v. Care Alts., Inc., 346 F. Supp. 3d 669 (D.N.J. 2018), *vacated sub nom.* United States *ex rel.* Druding v. Druding, 952 F.3d 89 (3d Cir. 2020).
97. *Id.* at 671.
98. Universal Health Servs. v. United States *ex rel*. Escobar, No. 15-7, 2016 U.S. LEXIS 3920 (U.S. June 16, 2016).
99. *Id.* at *348.
100. *See generally id.*

bursements because it relaxes the assumption that any material statutory, regulatory, or contractual requirement renders a claim false under the FCA.

As indicated from the FCA cases discussed, qui tam claims against (primarily for-profit) hospice providers are likely to survive summary judgment and motions to dismiss. In only three cases did the court side in favor of the hospice organization. First, in *Aseracare*, the court dismissed the qui tam claims because the evidence was based on the testimony of one certifying physician.[101] Second, in *Escobar*, the Supreme Court relaxed the standard of evidence by denying the premise that any falsity in a claim automatically made the claim an FCA violation.[102] Third, in *Grane*, the court overturned the decision in favor of an administrative agency.[103] Overall, from the totality of the FCA hospice cases in the last ten years, there is clear evidence that significant oversight and regulation are required to ensure for-profit hospice agencies are appropriately certifying and discharging patients. The profit margins for these agencies are razor thin, which further encourage abuse and fraud.[104] The next Section presents upcoming procedural and demographic changes likely to result in further qui tam claims.

III. UPCOMING CHALLENGES

The future of federally funded hospice care faces several challenges. Specifically, the Medicare hospice benefit, a benefit that puts hospice care within financial reach for all Americans, is in jeopardy. The most pressing challenges include fluctuating licensing and certification requirements, Medicare reimbursement requirements, and a massive change in American demographics.

101. United States v. Aseracare Inc., 153 F. Supp. 3d 1372 (N.D. Ala. 2015).
102. Universal Health Servs., 2016 U.S. LEXIS 3920.
103. Grane Hospice Care v. Dep't of Pub. Welfare, 72 A.3d 322, 2013 Pa. Commw. LEXIS 281 (Pa. Commow. Ct. July 25, 2013).
104. Joshua E. Perry & Robert C. Stone, *Cost and End-of-Life Care: In the Business of Dying: Questioning the Commercialization of Hospice*, 39 J.L. Med. & Ethics 224 (2011).

A. Tenuous Affordable Care Act Requirements

Requirements implemented under the Obama administration as part of the Affordable Care Act ("ACA") continue to be debated, deleted, or abandoned, creating significant uncertainty for hospice organizations dependent on Medicare reimbursement. For example, the implementation of the 2010 ACA "narrative requirement" has been especially contested.[105] The narrative requirement is a regulation requiring physicians to document that a face-to-face encounter occurred and explain why the clinical findings made during that encounter support a determination for the terminally ill patient.[106] The stakes are high for whether or not a narrative is appropriately documented. If it is deemed that a hospice organization did not provide a sufficient explanation in the document, the result is a denial of Medicare reimbursement.[107] The purpose of adding the requirement to already existing certification rules was to protect against waste, fraud, and abuse.[108] The following case illustrates the problematic enforcement of the additional measures implemented by the Obama administration (used to increase oversight and compliance).

National Association for Home Care & Hospice v. Burwell,[109] examines what it means to "document" that a face-to-face hospice visit takes place under the Affordable Care Act "narrative requirement" regulation. The case was brought by the National Association for Home Care & Hospice Inc.—a trade association representing over six thousand home-health agencies. The court ruled in favor of the rulemaking administrative agency—the Department of Health and Human Services ("HHS")—after conducting a two-part Chevron analysis, the court decided that the narrative requirement was within the HHS's broad delegation of authority to issue regulations concerning documentation for Medicare reimbursement.[110]

Although the certifying physician requirement for hospice reimbursement continues today, the face-to-face narrative requirement sup-

105. 42 C.F.R. § 424.22 (2020).
106. Nat'l Ass'n for Home Care & Hospice v. Burwell, No.14-cv-00950(CRC), 2015 U.S. Dist. LEXIS 148456 (D.D.C. Nov. 3, 2015).
107. *Id.* at *132.
108. *Id.*
109. *Id.*
110. *Id.*

ported by *Burwell* is no longer a requirement for hospice Medicare reimbursements.[111] The deletion of this requirement encourages hospice providers to use the certifying physician requirement as a shield; and for-profit hospice providers continue to be able to submit reimbursements for services that may or may not have taken place.[112]

B. Medicare Value-Based Reimbursement

The goal of value-based programs is to reward healthcare providers with incentive payments for the quality of care they provide.[113] Ideally, this will result in better care for individuals, better care for populations, and lower costs.[114] Initially, there were five value-based programs related to renal care, hospital purchasing, hospital readmission reduction, the physician value-based modifier program, and the hospital-acquired conditions reduction program.[115] These value-based programs continue to be adjusted as long-term empirical studies become available and cite the values that are cost-effective and advantageous.[116]

Value-based programs present a challenge to the hospice care benefit because there are still many ways to use the value-based programs to game the system and take advantage of additional monetary incentives.[117] In a March 2017 report, the Medicare Payment Advisory Commission (MedPAC) reported significant concerns with the initial set of values and measures outlined for certified hospice programs.[118] It is likely that the payment policies for hospice Medicare reimburse-

111. James F. Barger, Jr., *Life, Death, and Medicare Fraud: The Corruption of Hospice and What the Private Public Partnership Under the Federal False Claims Act is Doing About It*, 53 AM. CRIM. L. REV. 1, 8 (2016).
112. *Id.*
113. *CMS' Value-Based Programs*, CTR. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html (last visited Mar. 28, 2020).
114. *Id.*
115. *Id.*
116. Joan M. Teno & Irene Higginson, *Paying for Value: Lessons from the Medicare Hospice Benefit*, HEALTH AFFAIRS (May 2, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180427.522132/full/.
117. *Id.*
118. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2017), http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

ments will continue to change— creating unpredictability. Thus, creating payment and reimbursement uncertainty for both patients and hospice providers.

C. Preparing for the Baby Boomer Generation

By 2020, 20 percent of the population will be 65 or older, and by 2040, the annual death rate in the United States will double to about 4.1 million deaths per year.[119] Unless funding is substantially increased or restructured, oversight of hospice organizations that are prone to fraudulent activities will overburden the system. The result may be a decrease in the number of days or services that a terminal patient may receive, and an increase in qualifying conditions (i.e., patients have three months to live versus six months to live). These results will further erode the fundamental tenets of hospice which are to provide compassionate care in the final weeks and months of life.

Additionally, there is evidence to suggest that baby boomers have a higher expectation for the type of care that they should receive. As noted by Matthew E. Misichko in his article regarding ACA reform and comfort for the aging Baby Boomer population, "many hospice patients are satisfied with care, special food, and time with loved ones as a simple comfort at the end of life. It would be naïve to ignore hospice's future for baby boomers needing care and having high expectations for the type of care they receive."[120] On the upside, baby boomers are also more knowledgeable about the benefits of palliative care.[121] Palliative and hospice care are much more cost effective than individuals living their last days in a hospital where hospital staff administers life-saving care until the end of life.[122]

IV. POLICY CHANGE SUGGESTIONS

Overall, the goal of hospice is noble—to provide compassionate care to the dying and their families. As a society, we have decided that this care should be a benefit to everyone—regardless of income or lot

119. Matthew E. Misichko, *A HELP-ing Hand: How Legislation Can Reform the Affordable Care Act and Hospice Care to Prioritize Comfort and Prepare for the Baby Boomer Generation*, 21 ELDER L.J. 419, 452 (2014).
120. *Id.* at 462.
121. *Id.*
122. *Id.* at 437–38.

in life. To balance the importance of compassionate dying and the government's ability to continue providing benefits without deleterious financial consequences, the following policy changes are suggested: (1) improved hospice reporting standards; (2) extension of the current six-month prognosis requirement; and (3) limits on reimbursements to for-profit organizations providing hospice care.

A. Improved Reporting Standards and Oversight

In 2016, the Office of Inspector General ("OIG") within HHS filed a report stating a deficient certification accompanied 14 percent of general inpatient stays, in violation of federal rules.[123] In 10 percent of stays studied by the OIG, the certifying physician did not include a narrative at all or included only the beneficiary's diagnosis.[124] Additionally, a 2014 report published by the Journal of Palliative Medicine reviewed more than one million Medicare records and found that more than one-third of patients who were released alive from hospices did not re-enroll in a hospice and were still alive months after being released.[125]

The Obama-era reporting changes, including the "narrative requirement" ensuring all hospice visits are documented, were a step in the right direction to ensure that hospice visits were not fraudulently billed.[126] Yet, the HHS has since abandoned the ACA iteration of the narrative requirement.[127] The HHS justified the abandonment by citing complications in certification and arbitrary evidence that the requirement reduced fraud.[128] The timing of the abandonment, however, conveniently fell in line with an administration change and no empirical

123. SUZANNE MURRIN, OEI-02-10-00492, DEP'T OF HEALTH & HUM. SERVS.: HOSPICES SHOULD IMPROVE THEIR ELECTION STATEMENTS AND CERTIFICATIONS OF TERMINAL ILLNESS, (Sept. 2016).

124. *Id*.

125. Joan M. Teno et al., *A National Study of Live Discharges from Hospice*, 17 J. PALLIATIVE MED. 1081 (2014).

126. *See generally* Emily E. Bajcsi et al., *Hospice and Home Health Update: Recent Legislative and Regulatory Efforts Continue to Change the Regulatory Landscape for Hospice and Home Health Providers*, EPSTEIN BECKER GREEN (Nov. 2014), https://www.ebglaw.com/content/uploads/2014/11/Client-Alert-Hospice-and-Home-Health-Update.pdf.

127. *Id*.

128. Nat'l Ass'n for Home Care & Hospice, Inc. v. Burwell, 142 F. Supp. 3d 119, 123 (D.D.C. 2015) ("In November 2014, HHS eliminated the narrative requirement in order to simplify the face-to-face regulations and reduce the burden on physicians and home-health agencies.") (internal quotations omitted).

evidence was made publicly available to support these determinations against the effectiveness of the narrative requirement.[129] It would behoove agencies to not throw the baby out with the bath water. To reduce waste and fraud, HHS implemented an additional requirement mandating a more detailed explanation of each visit or event between the hospice organization and the patient.[130] While the goals of HHS in eliminating these requirements are worthwhile, the time and resource costs of the increased narrative and paperwork requirements are negligible compared to the cost of fraudulent reimbursements for services that may or may not have occurred.

B. Refinement of the Six-Month Prognosis Requirement

To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as terminally ill by a physician with a prognosis of six months or less if the disease runs its normal course.[131] As discussed in preceding paragraphs, a third of patients were released alive from hospice and were still alive after being released.[132] Clearly, the six-month prognosis requirement is not functioning as intended.

The six-month prognosis has been a controversial requirement that is vulnerable to fraud.[133] Since the provision is so susceptible to fraud, many physicians and nursing facilities do not openly encourage hospice enrollment.[134] The issue is further complicated because the standard requires physicians to guess to the best of their ability whether or not the person will die of their terminal illness within six months.[135] This requirement comes at the detriment of hospice providers, certifying physicians, and patients. Hospice care providers are damaged by the requirement because it makes them vulnerable to liability under the

129. Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies, 79 Fed. Reg. 38366-01 (July 2014).

130. David E. Thiess, *The Medicare Hospice Benefit After Health Reform: Cost Controls, Expanded Access, and System-Induced Pressures*, 3 J. HEALTH & LIFE SCI. L. 39, 46 (2010).

131. 42 C.F.R.§ 418.20 (2020).

132. *Id.*

133. United States v. AseraCare, Inc., 938 F.3d 1278, 1291 (11th Cir. 2019).

134. Amanda Jacobowski. *Calculating Death: Implications of the Six-Month Prognosis Certification Requirement for the Medicare Hospice Benefit.* 19 ELDER L.J. 187 (2011).

135. *Id.* at 189.

False Claims Act if a significant percentage of patients do not die within six months. It is harmful to certifying physicians if their predictions are inconsistent and wrong. It is detrimental to patients because they are reluctant to elect hospice care if the six-month prognosis seems like a death wish or they think that admitting that they will die within six months is giving up on life-saving technologies.

It is a delicate balancing act to make a stricter provision to curb fraud on the one hand while encouraging patients to enter hospice early on the other. While it is impossible to solve this imbalance completely, a sliding scale of benefits could help alleviate the problem. In the case of hospice care, the patient, along with a certifying physician, could begin some hospice benefits (what we would currently consider palliative care) 65 percent of the time after a terminal diagnosis. The palliative services could be increased or decreased based on the prognosis of the patient. Once the physician determines a patient is likely to die within four months, the patient would then move onto full hospice benefits and services. This sliding scale would increase the use of palliative care, without substantially increasing hospice costs since the hospice period would be reduced from six months to four months. Obviously, the plan would need to be vetted by actuaries, and significant work would need to be done to determine the types of palliative care that would be covered, but the general idea does solve some of the issues that the six-month prognosis requirement creates. Overall, for the future of the Medicare hospice benefit and compassionate care for the dying, the integration of palliative care and hospice care is imperative.

C. Limits on For-Profit Hospice

The False Claims Act cases discussed in this analysis involved for-profit hospice organizations. This is no accident. There are no known federal FCA hospice cases in the last ten years involving non-profit hospice organizations. There are simply too many incentives to cut corners to squeeze small profits out of the Medicare hospice benefit program.[136]

Some proponents claim that for-profit hospices can reach individuals (usually low-income) because they are willing to recruit patients that would not be reached by non-profit agencies because of a lack of

136. *See generally* Joshua E. Perry & Robert C. Stone, *Cost and End-of-Life Care: In the Business of Dying: Questioning the Commercialization of Hospice*, 39 J. L. MED. & ETHICS 224 (2011).

resources for marketing and hiring recruiters.[137] There are some advantages to a system where organizations are financially encouraged to actively recruit underserved patients; however, the disadvantages far outweigh the benefits of increased outreach. States should cap or limit new for-profit hospice certifications. A calculation should be determined based on each state's numbers for yearly applications. Of those applications, percentages of for-profit organizations should be reduced to, at the very least, 50 percent non-profit to 50 percent for-profit hospice programs.

In addition to the fact that for-profit hospices recruit more heavily than non-profit organizations, they also incentivize their employees to retain hospice patients.[138] According to a study conducted by MedPAC, "hospices with longer lengths of stay are more profitable, and for-profit hospices have a length of stay about forty-five percent longer than non-profit hospices."[139] As we have seen from the cases discussed in this analysis, the longer stays are often associated with questionable certifying and re-certifying practices.

Overall, although for-profit hospices may recruit more patients into hospice, often for financial gain, societal ethics should not be compromised. As noted by Hugh Westbrook—a minister who was the first to commercialize hospice and became a multi-millionaire in the process, "I don't think the entrance of venture capital and private equity into the hospice world in a very aggressive way is good for what hospice is about and what hospice tries to do. . . I think it's a threat."[140] It was also noted that, "for-profit hospice providers whose business model appears at its core to have an ethical conflict of interest between shareholders doing well and terminal patients dying well."[141]

137. *Id.*
138. United States *ex rel.* Hinkle, No. 3:14-CV-212-TAV-HBG, 2017 U.S. Dist. LEXIS 144187, at *5 (E.D. Tenn. May 30, 2017) (finding hospices set targets for staff pertaining to the number of patients admitted and retained).
139. *Report to the Congress: Reforming the Delivery System*, MEDPAC (June 2008), http://www.medpac.gov/-documents-/reports?op=OR&SortBy=YEAR&SortDirection=DESC&FilterByYear=2008 .
140. James F. Barger Jr., *Life, Death, and Medicare Fraud: The Corruption of Hospice and What the Private Public Partnership Under the Federal False Claims Act is Doing About it*, 53 AM. CRIM. L. REV. 1, 8 (2016).
141. *See* Perry & Stone, *supra* note 136.

CONCLUSION

Hospice care has been accepted as a societal good to enable a peaceful end-of-life experience. Still, the Medicare hospice benefit is in jeopardy because of an anticipated exponential rise in hospice benefits claims and fraudulent activity perpetrated by for-profit hospice organizations attempting to elicit profit from shoestring profit and loss calculations. Although there are reasons to continue to allow for-profit hospice organizations in the market, the propensity for fraud should be reduced by increased oversight of reporting standards, a re-calculation of the six-month standard, and a reduction in the number of for-profit hospices allowed to be certified and qualify for Medicare hospice benefit reimbursement. Most importantly, it is time that we recognize the threat that for-profit hospices present. As noted by Barger, "Today, it cannot be credibly argued that hospice bears any resemblance to the once humbled, beloved, charity-based arm of the healthcare industry; rather, it is big business and a major source of investor revenue in the United States."[142] For the future of public good and benefit, for-profit hospice certifications need to be reduced and more financial incentives should be provided to non-profit and government-owned hospice programs.

142. *See* Barger Jr., *supra* note 140.