Relator Fees and Settlements in Hospice Care Fraud Cases

In 2017, Caris Healthcare LLC and Caris Healthcare, L.P. (collectively, "Caris"), a for-profit hospice chain, entered into a settlement agreement to resolve allegations that Caris submitted false claims and improperly retained payments from Medicare for services provided to patients who were ineligible for hospice benefits because they were not terminally ill. Caris agreed to pay **$8.5 million** to resolve its alleged liability. *See* 2017 OIG Annual Report.

In March of 2017, top executives of Passages Hospice, which was at one time one of the largest hospices in Illinois, were sentenced on fraud and obstruction of a federal audit charges. The former administrator and co-owner of Passages was sentenced to **6 years and 6 months in prison** for charges relating to falsely billing Medicare for intensive hospice services despite multiple red flags that the billing was improper. Among other types of fraud, Passages and its administrator falsely claimed that a large proportion of their hospice patients were on a high level of care called general inpatient care, even though they knew that the patients neither were qualified for nor were receiving that type of care. The government entered into a consent judgment and settlement with the defendant for **$18 million to resolve state and federal FCA liability.** *See* 2017 OIG Annual Report.

In April 2017, International Tutoring Services, LLC, f/k/a International Tutoring Services, Inc., and d/b/a Hospice Plus; Goodwin Hospice, LLC; Phoenix Hospice, LP; Hospice Plus, L.P.; and Curo Health Services, LLC f/k/a Curo Health Services, Inc. agreed to pay approximately **$12.1 million to settle federal civil FCA allegations** that they paid kickbacks in exchange for patient referrals. The government alleged that Hospice Plus, Phoenix Hospice, and Goodwin Hospice, which are now consolidated under the Hospice Plus brand and operate primarily in and around Dallas, Texas, paid kickbacks to a physician house call company and medical providers in violation of the Anti-Kickback Statute to induce referrals of hospice patients. *See* 2017 OIG Annual Report.

In July of 2017, defendants—a co-owner of the defunct Home Care Hospice, Inc. (HCH) and his wife— agreed to pay money and release their interest in property valued at over **$7 million to settle FCA allegations** that they and HCH falsely claimed and received taxpayer dollars for hospice services that were either unnecessary or never provided. The government alleged the defendants knowingly submitted false claims and records (including fabricated records) to Medicare for

purported hospice care for patients who were not terminally ill and thus not eligible for the Medicare hospice benefit and knowingly submitted or caused the submission of false claims and records (including fabricated records) to Medicare for crisis care services that were not necessary or not actually provided. *See* 2017 OIG Annual Report.

In August of 2017, a Cleveland, Mississippi doctor was sentenced to 3 years and 3 months in prison followed by 3 years supervised release and ordered to pay **$1.9 million in restitution** to the Medicare program. The sentencing stems from the doctor's guilty plea to a multi-count indictment charging him with referring patients to hospice that were not hospice appropriate and receiving kickbacks. The doctor admitted to referring patients who were not hospice appropriate to Milestone Hospice and Sandanna Hospice which led to $1.9 million in Medicare payments to Milestone and Sandanna. The doctor also admitted to receiving payments from the hospice owner. *See* 2017 OIG Annual Report.

In April of 2016, HCH also agreed to pay **$8 million** to settle claims for falsely billing Medicare for hospice services. HCH billed for services their nurses and health aides provided to hospice patients who resided at nursing homes, hospitals, and private residences but who did not meet the Medicare criteria for hospice care. In addition to restitution and the settlement agreement, approximately **$11 million** worth of assets belonging to the defendant were **seized by the government** pursuant to an injunction. In June 2016, the owner of California Hospice Care ("CHC"), based in Covina, California was sentenced to 8 years in prison for defrauding Medicare and Medicaid. *See* 2016 OIG Annual Report.

In July of 2016, Evercare Hospice and Palliative Care, a Minnesota based provider, paid **$18 million** to resolve civil FCA allegations that it admitted and recertified patients for hospice care who were not eligible for such care because they were not terminally ill. The government alleged that Evercare's business practices, which included discouraging physicians from recommending that ineligible patients be discharged from hospice, were designed to maximize the number of patients for whom it could bill Medicare without regard to whether the patients were eligible for and needed hospice. *See* 2016 OIG Annual Report.

In February of 2015, the whistleblower received $680,000 of the settlement proceeds when Good Shepherd Hospice Inc. and Related Entities agreed to pay **$4 million** to settle claims that the companies submitted false claims to federal health care programs. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, United

States Settles False Claims Act Suit Against Good Shepherd Hospice Inc. and Related Entities (Feb. 6, 2015), http://www.justice.gov/opa/pr/2015/February/15-civ-150.html.

In February of 2015, a federal district court judge approved a settlement requiring two hospice companies to pay the United States nearly **$5 million** and the State of New York **$1.68 million.** *See* Press Release, U.S. Attorney's Office, S. Dist. of N.Y., U.S. Dep't of Justice, Manhattan U.S. Attorney Settles Civil Fraud Claims Against Compassionate Care Hospice For Fraudulently Billing Medicare And Medicaid For Hospice Nursing Services Not Adequately Provided (Feb. 18, 2015), http://www.justice.gov/usao-sdny/pr/2015/February/15-civ-046.html.