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Vitas Hospice and Chemed Corporation Settle Largest-Ever FCA Claim Against a Hospice

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Vitas Hospice, the largest for-profit hospice chain in the United States, and its owner, Chemed Corporation, agreed to pay $75 million to settle allegations that Vitas Hospice submitted false claims for hospice services between 2002 and 2013. The settlement announced October 30, 2017, is the largest amount ever recovered from a hospice provider under the False Claims Act. In conjunction with the settlement, Vitas and Chemed entered into a five-year Corporate Integrity Agreement with the Office of Inspector General that included a requirement that the hospice retain an independent review organization to review its claims. The settlement also resolved three additional qui tam lawsuits that had been pending against the hospice in Illinois, Texas, and California.

Medicare pays for palliative services rendered by hospices to patients with terminal illnesses who have a life expectancy of six months or less. A patient who elects to receive hospice services agrees to forego all curative care related to the terminal illness. A physician must certify that the patient's prognosis is terminal with a life expectancy of less than six months at the initiation of hospice care and at periodic intervals thereafter. Medicare pays a per diem rate for hospice care, and reimbursement is based on four different categories of service.

One category of service, continuous home care, is available to hospice patients in crisis who require at least eight hours of predominantly nursing care per day to achieve palliation and management of acute medical symptoms in order to remain at home. Due to the intensity of services provided, continuous home care is reimbursed at a much higher rate than routine home care services. The primary allegation in the case against Vitas stemmed from the contention that Vitas billed Medicare for continuous home care services for patients who did not require that level of care. The government alleged that Vitas set aggressive goals for providing continuous home care services to patients, and that it billed Medicare for continuous home care services for patients who were not in crisis and who did not require care beyond routine home care.

In addition, the government alleged that Vitas had submitted claims for hospice services for patients who were not terminally ill, whose life expectancy was greater than six months, or who could still benefit from curative treatment. The allegations included reports that non-clinical staff members received bonuses for hospice admissions and that hospice management pressured clinicians to admit or re-admit patients who did not qualify for hospice care. In both cases, the government alleged that Vitas failed to ensure its staff was adequately trained on the criteria for hospice admissions and the criteria for initiating continuous home care.

The case against Vitas is one of several cases brought against hospices in recent years that turn on the accuracy of determinations that patients are terminally ill. In addition to these cases, the OIG issued a report in March 2016 that identified more than $250 million in inappropriate payments for medically unnecessary general inpatient services, the next most costly level of hospice care services. The OIG findings suggest a continued focus on hospice providers in the future.

In another case involving the accuracy of determinations of terminal illness, a federal district judge overturned a jury verdict against the hospice provider AseraCare, stating that a difference of opinion among experts was

insufficient to support a determination that a claim for hospice services was false. A closely watched appeal is pending before the Eleventh Circuit in that matter.