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Promising Too Much: Activities That Can Land Hospices and Their Referral Sources in Hot Water

Recently, we have heard reports that some hospices may be participating in activities that could raise serious legal and ethical issues for the hospice itself, as well as for the other health care providers, such as hospitals, nursing homes and physicians, who refer patients to the hospice. These reports have included three types of alleged conduct: (1) hospices promising hospitals that they will provide 24-hour care to discharged hospital patients; (2) hospices promising prospective patients that they will not be responsible for any costs; and (3) in return for referrals, hospices promising physicians that they will provide services to the physicians' patients, but will delay admitting the patients to hospice until after the physicians complete expensive treatment.

Each of these practices has potentially serious legal consequences for both the hospice and the referral sources who participate in the activities. Below we have provided a brief discussion of some of the federal laws that are implicated by these activities. However, this discussion is not exhaustive, and it is also important to remember that each state's laws may impose additional restrictions.

Promising to Provide Continuous Care

Promising to provide 24-hour care (continuous home care) to all patients, without considering whether it is necessary for each individual patient, could violate the Medicare Conditions of Participation for Hospice, which require a hospice to provide each patient with an individualized care plan.[1] The care plan must assess the individual's needs and identify the services required to meet those needs.[2] Furthermore, Medicare guidance has stressed that standardized care plans do not meet this requirement.[3] Providing continuous care to all patients discharged from the hospital, regardless of whether each individual needs this level of care, would not meet the requirements for individualized care planning.

Additionally, if a hospice were to bill Medicare for continuous home care for all patients discharged from the hospital, it would run the risk of violating Medicare billing requirements and expose itself to liability under the False Claims Act. There are very specific limitations on the circumstances in which continuous home care may be billed to Medicare.[4] Continuous home care is only available during "brief periods of crisis," which are periods in which the individual requires continuous

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care to achieve the palliation and management of acute medical symptoms. To qualify for continuous home care payments, a hospice must provide at least eight hours of care during a 24-hour day, which begins and ends at midnight. The number of hours is measured in 15-minute increments (i.e. the hospice cannot round up to the nearest hour to fulfill the time requirements). More than half of the care provided must be nursing care provided by a registered nurse or licensed practical nurse, and care provided by a home health aide or homemaker may not be discounted or provided "at no charge" to meet this requirement. Given its high reimbursement rate and increasing utilization, regional home health and hospice intermediaries have closely monitored continuous home care billing.

Medicare may deny claims that do not meet these billing requirements. In addition, failing to meet these requirements and billing Medicare for continuous home care can subject a hospice to liability under the Federal Civil False Claims Act, 31 U.S.C. § 3729 et seq, which prohibits submitting false or fraudulent claims to the government. This statute applies when the person actually knows that the claim is false, or acts in reckless disregard of whether the information is true or false.[5] The government or private citizens may file complaints under the False Claims Act. Violations of the False Claims Act may result in paying treble damages and a $5,000 to $10,000 civil penalty per claim.

This practice also raises concerns under the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and potentially under any state anti-kickback laws that may exist. Under the federal Anti-Kickback Statute, it is illegal for any person to offer, pay, solicit, or receive "any remuneration" (i.e. anything of value) in exchange for referrals for items or services which will be paid for under a federal health care program. If a hospice guarantees continuous home care in order to solicit referrals, it is possible that both the hospice and the hospital could be convicted of violating this law. Conviction under the Anti-Kickback Statute is a felony that may result in up to $25,000 in fines or as many as five years in prison, or both.

Promising to Provide Services at No Charge

Promising prospective patients that there will be no cost for the services they receive is too broad of a statement. Although the Medicare and Medicaid hospice benefits generally cover all services related to the terminal illness, they do not cover services unrelated to the terminal illness. Furthermore, private insurance plans vary in terms of their coverage of hospice services and patients may need to pay for some of the services themselves. Also, patients who are uninsured and do

not qualify for Medicare or Medicaid will need to pay for their care, unless they qualify for free or reduced-rate care based on their financial need.

Unless it is provided pursuant to a need-based, sliding scale that is consistently applied, providing free services can potentially violate the False Claims Act. If a hospice routinely provides free care to private patients, but charges Medicare or Medicaid for the same services, it could be seen as attempting to obtain government reimbursement at levels that are substantially in excess of what it ordinarily charges, violating the False Claims Act. Providing free services may also violate the Civil Monetary Penalties statute, which prevents offering or transferring remuneration to Medicare or Medicaid beneficiaries in order to influence their choice of health care provider.[6] The Office of the Inspector General, one of the federal agencies that enforces federal fraud and abuse laws, has issued a Special Advisory Bulletin which explains the legal implications of offering inducements to beneficiaries to influence their selection of a health care provider.[7]

On the other hand, if a hospice claims that patients will not have to pay for any of the hospice's services, but does in fact charge patients for these services, then promising patients that there will be "no cost" would be incorrect, potentially violating consumer protection laws. These laws, which vary by state, generally prohibit false or deceptive advertising.

Promising to Delay Hospice Admissions in Exchange for Physician Referrals

This is a practice that would not be looked upon favorably by government regulators, as the arrangement appears to have no purpose other than maximizing the physicians' profits and the hospice's referrals. Although this article focuses on the legal implications for the hospice in such a situation, physicians should remember that such an arrangement could implicate a number of their own legal and ethical duties as well. This practice raises numerous fraud and abuse concerns. It appears that the hospice would be providing free care in order to influence the physician's referral, as well as the patient's choice of hospice. Providing free care to these patients in an attempt to influence their decision to receive hospice services from a particular hospice may violate the Civil Monetary Penalties statute. As discussed above, this statute prevents offering or transferring remuneration to beneficiaries in order to influence their choice of health care provider.[8]

Additionally, there is a risk that patients would not be informed about this arrangement and its purposes and implications. Hospices have an obligation to obtain informed consent from each patient they treat. Specifically, the Medicare Conditions of Participation require hospices to obtain informed consent forms for each patient that specifies the type of care that will be provided.[9] Hospices should not overlook these requirements.

Conclusion

In an era of increased government scrutiny, hospices must be vigilant in ensuring that they comply with all fraud and abuse laws, the Medicare Conditions of Participation, and billing regulations. Furthermore, other health care providers, such as hospitals, nursing homes or physicians, who engage in the type of conduct described above may be exposing themselves to government investigation and significant penalties. Questionable arrangements should be closely scrutinized to ensure compliance with all applicable laws.

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[1] See 42 C.F.R. § 418.58. This Condition of Participation applies to all patients, whether they are Medicare patients or not. See Medicare State Operations Manual, CMS Pub. 100-07, Appendix M, Tag L133.
[2] 42 C.F.R. § 418.58.
[3] Medicare State Operations Manual, CMS Pub. 100-07, Appendix M, Tag L101.
[4] These requirements can be found in the following sources: 42 C.F.R. §§ 418.302(b), 418.204(a); Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 9, Section 40.2.1; Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 11, Section 30.1.
[5] 31 U.S.C. § 3729(b).
[6] 42 U.S.C. § 1320a-7a(a)(5).
[7] This bulletin can be found online at http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf.