March 14, 2025

Mr. Elon Musk, Chair
Department of Government Efficiency
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Mr. Musk:

I write to share with you and the Department of Government Efficiency (DOGE) a very significant recommendation that would recover hundreds of millions for the United States Government's Medicare system.

On November 12, 2024, President-elect Trump selected you to head the DOGE, with a distinct and direct agenda to "dismantle Government Bureaucracy, slash excess regulations, cut wasteful expenditures, and restructure Federal Agencies" to make life better for all Americans. With the recent invitation to the general public to bring forth insights into additional areas of waste and abuse, and as a Nurse Practitioner with 35 years of non-profit Medicare Certified Hospice Directorship, I would like to share one particular hiding place for theft of government funds I am most certain has not been fully brought to your attention for examination: **Hospice Medicare Fraud**

Mr. Musk, as you read this letter, please consider:

-taking a stand against CMS hospice fraud, thus improving care for vulnerable patients

- turning CMS's Hospice Division upside down with the formation of a task force to investigate and remedy the CMS Hospice Division's irresponsibility and incompetence

- holding hospices that commit fraud accountable to return full funds to the government while revoking their licenses to operate

The first hospice in the United States began caring for patients in 1974, with others forming shortly thereafter. Duplicating England's Dame Cicily Saunders founding hospice mission, the US hospices were composed predominantly of non-profit charitable organizations staffed by volunteers. In the 1980s, Ronald Reagan authorized Medicare to cover the costs of hospice care after advocates argued that it would be cheaper than paying for the aggressive treatments that so many patients received up until they died. In 1986, the Medicare Hospice Benefit was introduced, paving the way for those charitable hospices to receive payment for the compassionate care they delivered to dying patients.

Since the inception of the Medicare Hospice Benefit in 1986, this country has unfortunately witnessed a surge in the numbers of Hospices, predominantly for-profit companies, run by investors seeking to profit from the vulnerabilities of those experiencing terminal illness. Regrettably, this surge of for-profit hospice investors has also resulted in a surge of Medicare Hospice Fraud.

Hospice fraud involves exploiting Medicare benefits through false claims, inappropriate billing, and enrolling patients who are not terminally ill into hospice care to improperly claim funds. Many of the patients targeted are our nation's elderly living with chronic diseases, most often residing in nursing facilities, including those with dementia. Concealed behind the altruistic mission of providing care to the dying, Medicare certified hospices have become great hiding places for those intent on committing fraud. (see Attachment A. Deceptive Hospice Fraud Practices)

Since the Clinton administration, as the number of for-profit hospices swelled, the growing national dialogue around hospice abuse fell on deaf ears. The Centers for Medicare Services (CMS) did nothing to mitigate the lack of oversight and the profit motive. Time and again MedPAC, the congressional advisory panel on Medicare spending, endorsed modifying the hospice payment structure to reduce part of the financial incentive for enrolling ineligible patients, however little change occurred. The Inspector General's office at the Department of Health and Human Services announced many times over the years that curbing the abuse of hospice patients was among its "top *unimplemented* recommendations".

No longer is "hospice" equated with the charitable, nonprofit, mission driven organizations of the early 1980's. **In 2022, Medicare paid $23.7 billion for hospice care, an increase of 2.7% from the previous year.**

Today, there are 6,000 hospice providers in the US, and over 75% are for-profit companies run by investors. Many of these hospices have branches in multiple states, seeking locations across the country heavily populated by elderly citizens. Last year alone, CMS reported that 1.8 million Americans received end-of-life care through Medicare's hospice benefit. At the same time, the federal government reported the total number of deaths in the United States in 2023 (of all ages and from all causes) to be 3,090,964. Are we really to believe more than ½ of our nation's deaths occurred on hospices? This fact alone is highly suspicious knowing that many hospices admit patients who are not terminal, only to discharge them several months (or years!) later after tapping into their Medicare Hospice Benefit for monies.

CMS admits to the fact that the influx of for-profit hospices has resulted in fraud and mismanagement and abuse of government funds, with an estimate that **inappropriate hospice billing costs Medicare hundreds of millions per year.** CMS also cited the growing popularity of schemes in which hospice providers, often listed at false addresses, fraudulently claim they are providing hospice care for patients who are not terminally ill or may already be deceased.

Hospice fraud has placed a huge financial burden on our healthcare systems. Historically, on the rare occurrence that a Medicare certified hospice agency is investigated and found guilty of fraud, the hospice signs a corporate integrity agreement, gets a slap on the hand from CMS, pays back an EXTREMELY SMALL percentage of what they stole, and continues to admit new hospice patients, allowing the cycle of fraud to begin again. CMS's hospice division has delivered little consequence for bad behavior. (see Attachment B. Hospice Fraud Cases as Listed on The U.S. Department of Health and Human Services Office of Inspector General)

Furthermore, CMS still only requires Medicare certified hospices to receive a federal inspection once every three years, with an archaic inspection process that does NOT screen the correct data to uncover fraud.

Mr. Musk, Medicare increases hospice reimbursement by 2% every October, a practice that draws in investors with bad intentions. CMS has threatened to withhold these annual increases, but for decades never followed through. Now that DOGE has gained access to key payment and contracting systems at CMS, this letter provides you with insight into a very broken CMS Hospice Division in desperate need of critical reform.

In the interest of taking aggressive action against CMS and Hospice Fraud, to ensure sustainable spending, protect taxpayer dollars, curb abusive practices by predominantly for -profit hospices, and most importantly preserve the dignity and the integrity of care while protecting the system for those truly experiencing terminal illness, please consider turning CMS's Hospice Division upside down. Upholding DOGE's mission to dismantle excessive government bureaucracy, reduce unnecessary regulations, cut wasteful expenditures, and restructure federal agencies, please consider detailed evaluation of CMS's Hospice Division, while also holding hospices that commit fraud accountable to return full funds to the government while revoking their licenses to operate.

When you take a stand against hospice fraud, you are improving care for vulnerable patients, protecting the Medicare system, and ensuring a fair playing field for honest providers. Hospice care, when done well, is hugely beneficial to those that sadly require such care.

Please consider the formation of a task force to investigate and remedy the CMS Hospice Division's irresponsibility and incompetence.

I would be pleased to share additional information and to work with DOGE on these matters and know many other honest hospice providers who have dedicated their careers to caring for the terminally ill and would gladly support these efforts.

Thank you in advance for your commitment to make life better for all Americans.

Sincerely,

Cristen

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ATTACHMENT A.
EXAMPLES OF DECEPTIVE HOSPICE FRAUD PRACTICES

- **Fraudulent Patient Enrollment-**Hospice providers enroll patients who are not terminally ill who do not meet Medicare's criteria for hospice eligibility—to unlawfully claim benefits. This practice often targets patients with dementia and patients in skilled nursing facilities, or patients with limited family support.
- **Billing for Higher Levels of Care-**Some providers overcharge Medicare by claiming they provided more expensive services and higher levels of care, when in fact the hospice did not provide such services.
- **Incentives and Kickbacks-** Illegal payments or incentives are often offered to physicians, referral agencies, or nursing homes to improperly funnel patients into hospice care programs that might not be medically necessary. Hospices commonly employee "marketers" to seek out patients to enroll into hospice. Many hospice agencies provide "bonuses" to marketers who enroll higher numbers of patients into hospice care.
- **High-Pressure Marketing Tactics -** Certain providers use aggressive tactics to push vulnerable patients or families to accept hospice care. Often these patients do not qualify for end-of-life services and often reside in senior care facilities.
- **Providing Non-Covered Benefits -** Perks like housekeeping services or gifts are sometimes offered to patients as an incentive to enroll in hospice care. These practices violate Medicare rules and create compliance risks.
- **Failing to Obtain Physician Certification on a Plan of Care -**Medicare requires proper physician documentation certifying that a patient is terminally ill and qualifies for hospice services. Often physician documentation is circumvented, resulting in higher admissions to hospice care, and fraudulent claims submission.
- **Providing Inadequate Services-** Hospice organizations cut corners by not complying with the hiring of all hospice disciplines required under Medicare law, resulting in subpar care to patients, all while continuing to bill Medicare for full services of all disciplines.

ATTACHMENT B.
HOSPICE FRAUD CASES
As Listed On The
U.S. Department of Health and Human Services Office of Inspector General

The following list captures ***a very limited number*** of hospice agencies, hospice physicians, and hospice employees involved in some of the largest fraud cases in the United States from 2012 to the present date.

Keep in mind, the sum paid back to resolve the case represents ***only a small fraction*** of the total amount the hospices have stolen from the Federal Government.

For a complete list of OIG Hospice Fraud Cases dating back to 2004, or to read more on the cases listed below, go to: www.justice.gov

2012

September 6, 2012; U.S. Department of Justice

United States Intervenes in False Claims Act Lawsuit Against Orlando, Florida-area Hospice The government has intervened in a whistleblower lawsuit against Hospice of the Comforter Inc. (HOTCI) alleging false Medicare billings, the Justice Department announced today. The 2012 lawsuit alleged that HOTCI submitted false Medicare claims. HOTCI submitted $33 million in false claims. HOTCI settled the lawsuit in 2013 for $3 million.

November 20, 2012; U.S. Department of Justice

South Carolina-based Harmony Care Hospice Inc. and CEO/Owner Daniel J. Burton to Pay U.S. $1.286 Million to Resolve False Claims Act Allegations Harmony Care Hospice submitted false claims to Medicare for patients under care at its hospice facilities. Harmony Care knowingly submitted to Medicare false claims for patients who did not have a prognosis that warranted hospice care and so were not eligible for hospice Medicare benefits.

2013

March 20, 2013

Hospice of Arizona and Related Entities Pay $12 Million to Resolve False Claims Act Allegations Hospice of Arizona L.C., along with a related entity, American Hospice Management LLC, and their parent corporation, American Hospice Management Holdings LLC, have agreed to pay $12 million to resolve allegations that they violated the False Claims Act by submitting or causing the submission of false claims to the Medicare program for ineligible hospice services.

May 2, 2013; U.S. Department of Justice

United States Files False Claims Act Lawsuit against the Largest For-Profit Hospice Chain in the United States

The United States has filed suit against Chemed Corporation and various wholly owned hospice subsidiaries, including Vitas Hospice Services LLC and Vitas Healthcare Corporation, alleging false Medicare billings for hospice services. Vitas is the largest for-profit hospice chain in the United States and provides hospice services to patients in 18 states (Alabama, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin) and the District of Columbia. Chemed, which is based in Cincinnati, Ohio and also owns Roto-Rooter Group Inc., a national drain cleaning and plumbing service company, acquired Vitas in 2004. The OIG audit covered 50,850 claims for which Vitas received Medicare reimbursement totaling $210 million for certain fraudulent hospice services provided during the period April 2017 through March 2019. Vitas paid $ 75 million to resolve their claim. Vitas was permitted to retain its license to operate as a Medicare Certified Hospice.

2014

March 12, 2014; U.S. Department of Justice

Amedisys Agreed to Pay $1.9 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Hospice Services without Proper Certification

Amedisys Agreed to Pay $1.9 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Hospice Services without Proper Certification

After it self-disclosed conduct to OIG, Amedisys, Inc. (Amedisys), West Virginia, agreed to pay $1,974,812.00 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Amedisys, on behalf of its wholly-owned subsidiaries West Virginia, LLC, d/b/a Amedisys Hospice of Parkersburg (Amedisys-Parkersburg) and Tender Loving Care Health Care Services of West Virginia, LLC d/b/a Amedisys Hospice (Amedisys-St. Clairsville), submitted claims for hospice services for which the certification documents did not meet Federal health care program requirements. OIG contends the contracted medical directors at Amedisys-Parkersburg and Amedisys-St. Clairsville pre-signed blank medical forms, including certificates of terminal illness and face-to-face visit forms, which were later completed by Amedisys staff members.

April 23, 2014; U.S. Department of Justice

Amedisys Home Health Companies Agree to Pay $150 Million to Resolve False Claims Act Allegations

Amedisys Inc. and its affiliates (Amedisys) have agreed to pay $150 million to the federal government to resolve allegations that they violated the False Claims Act by submitting false home healthcare billings to the Medicare program, the Department of Justice announced today. Amedisys, a Louisiana-based for-profit company, is one of the nation's largest providers of home health services and operates in 37 states, the District of Columbia and Puerto Rico. Amedisys was permitted to retain its license to operate as a Medicare Certified Hospice.

May 27, 2014; U.S. Department of Justice

Illinois Hospice Executive, Three Former Employees and Company Indicted for Allegedly Falsely Elevating Level of Patients' Care

An owner and three former employees of an Illinois hospice company, as well as the company itself, were indicted on federal health care fraud charges for allegedly engaging in an extensive scheme to obtain higher Medicare and Medicaid payments by fraudulently elevating the level of hospice care for patients. In many instances, the level of hospice care allegedly exceeded what was medically necessary or actually provided, including for some patients who did not have terminal illnesses or who were enrolled far longer than the required life expectancy of six months or less.

August 28, 2014; U.S. Department of Justice

United States Intervenes in False Claims Act Lawsuits against Evercare Hospice and Palliative Care, Now Known as Optum Palliative Care and Hospice & Minnesota-Based Hospice Provider to Pay $18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill The United States has partially intervened against defendants in two whistleblower lawsuits in the Federal District Court for the District of Colorado alleging Evercare Hospice and Palliative Care (Evercare) submitted false claims for the Medicare hospice benefit. Evercare is now known as Optum Palliative and Hospice Care, which provides hospice services across the United States. One of the suits names Evercare's parent companies, including UnitedHealth Group Inc.

2015

February 26, 2015; U.S. Department of Justice

Former Hospice COO Charged with Health Care Fraud, Lying to a Federal Grand Jury

A Louisiana woman has been indicted by a federal grand jury in Pittsburgh on charges of health care fraud and making false declarations before a grand jury, United States Attorney David J. Hickton announced today.

June 18, 2015; U.S. Department of Justice

Covenant Hospice Inc. to Pay $10.1 Million for Overcharging Medicare, Tricare and Medicaid for Hospice Services
On June 18, Covenant Hospice Inc. agreed to pay $10,149,374 to reimburse the government for alleged overbilling of Medicare, Tricare and Medicaid for hospice services, the Department of Justice announced today. Covenant Hospice Inc. is a non-profit hospice care provider which operates in Southern Alabama and the Florida Panhandle.

September 3, 2015; U.S. Department of Justice
Hospice Facility and Its Manager/Majority Owner to Pay Approximately $5.86 Million to Resolve Continuous Home Care Hospice Fraud Allegations St. Joseph Hospice Entities, which consists of 13 hospice facilities in Mississippi, Louisiana, Texas and Alabama, and Patrick T. Mitchell, its majority owner and manager, have agreed to pay the United States $5,867,518 under the False Claims Act to resolve allegations that they submitted false claims for delivery of continuous home care hospice services to patients who were not entitled to receive continuous care hospice level treatment.

October 22, 2015; U.S. Department of Justice
Community Health United Home Care Agreed to Pay $9.8 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Services that Lacked Proper Certifications and Other Hospice Requirements After it self-disclosed conduct to OIG, Community Health United Home Care, LLC (CHUHC), Alabama, agreed to pay $9,800,707 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that CHUHC submitted claims to Medicare for two of its locations without certifications of terminal illness, face-to-face encounters, and/or physician narratives as required by regulations.

December 22, 2015; U.S. Department of Justice
Dallas-Based Home Health Company Owners and Nurses Charged for Roles in $13.4 Million Medicare Fraud Scheme The co-owners of a home health company in Dallas and two nurse employees were charged in an indictment unsealed yesterday for their alleged participation in a $13.4 million health care fraud scheme involving fraudulent claims for home health services.
Iowa Hospice to Pay More than $1 Million to Resolve False Claims Act Allegations

2016
July 13, 2016; U.S. Department of Justice
Minnesota-Based Hospice Provider to Pay $18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill Evercare Hospice and Palliative Care will pay $18 million to resolve False Claims Act allegations that it claimed Medicare reimbursement for hospice care for patients who were not eligible for such care because they were not terminally ill, the Justice

Department announced today. Evercare, now known as Optum Palliative and Hospice Care, is a Minnesota-based provider of hospice care in Arizona, Colorado and other states across the United States.

August 19, 2016; U.S. Department of Justice
Pasadena Doctor Sentenced to 4 Years in Prison for Falsely Certifying Patients Were Terminally Ill as Part of Healthcare Fraud Scheme A doctor from Pasadena who falsely certified that at least 79 Medicare and Medi-Cal patients were qualified for hospice care because they were terminally ill - when, in fact, the vast majority of them were not dying - has been sentenced to four years in federal prison.

2017
June 16, 2017; U.S. Department of Justice
Genesis Healthcare, Inc. Agrees To Pay Federal Government $53.6 Million To Resolve Allegations Of Medically Unnecessary Rehabilitation Therapy And Hospice Services
SAN FRANCISCO- The Justice Department announced today that Genesis Healthcare, Inc. (Genesis) will pay the federal government $53,639,288.04, including interest, to settle six federal lawsuits and investigations regarding the submission of false claims for medically unnecessary therapy and hospice services, and grossly substandard nursing home care. Genesis, headquartered in Kennett Square, Pennsylvania, owns and operates through its subsidiaries skilled nursing facilities, assisted/senior living facilities, and a rehabilitation therapy business. According to the allegations in the lawsuits, companies and facilities acquired by Genesis violated the False Claims Act. The settlement announced today resolves the claims and investigations into the allegations.

October 30, 2017; U.S. Department of Justice
Chemed Corp. and Vitas Hospice Services Agree to Pay $75 Million to Resolve False Claims Act Allegations Relating to Billing for Ineligible Patients and Inflated Levels of Care
Chemed Corporation and various wholly-owned subsidiaries, including Vitas Hospice Services LLC and Vitas Healthcare Corporation, have agreed to pay $75 million to resolve a government lawsuit alleging that defendants violated the False Claims Act (FCA) by submitting false claims for hospice services to Medicare. Chemed, which is based in Cincinnati, Ohio, acquired Vitas in 2004. Vitas is the largest for-profit hospice chain in the United States.

2019

November 6, 2019; U.S. Department of Justice

Three Individuals, Including A Former Texas Mayor, CEO and Owner, Found Guilty in a $154 Million Money Laundering and Health Care Fraud Scheme

A federal jury found three individuals associated with dozens of hospice and home health companies guilty today for their roles in a $154 million health care fraud scheme, one of which was a mayor in Texas at the time.

November 13, 2019; U.S. Department of Justice

Louisiana Department of Health to Pay $13.42 Million to Settle Alleged False Medicaid Claims for Nursing Home and Hospice Care The Louisiana Department of Health has agreed to resolve allegations that it submitted false and inflated Medicaid claims for long-term nursing home and hospice care, the Department of Justice announced today. Under the settlement agreement, the state agency has agreed to pay $13,422,550.

2020

July 8, 2020; U.S. Department of Justice

Hope Hospice Agrees To Pay $3.2 Million To Settle False Claims Act Liability

United States Attorney Maria Chapa Lopez announces today that Hope Hospice has agreed to pay the United States $3.2 million to resolve allegations that it knowingly submitted false claims to Medicare, Medicaid, and TRICARE for hospice care provided to beneficiaries who did not qualify for the service.

December 10, 2020; U.S. Department of Justice

Health care company owner to pay $1 million to settle False Claims Act case

The former owner of Providence Home Health and Providence Hospice has agreed to pay $1.05 million to settle claims she knowingly and willfully paid improper kickbacks for referrals of Medicare patients to her businesses, announced U.S. Attorney Ryan K. Patrick along with Special Agent in Charge Miranda Bennett of the Department of Health and Human Services - Office of Inspector General (DHHS-OIG).

2021

January 19, 2021; U.S. Department of Justice

Hospice, home health agency and owners pay over $1.8M to resolve claims concerning physician payments The founders of an Edinburg hospice and related home health agency have paid to resolve allegations they submitted claims to Medicare that resulted from unlawful referrals, announced U.S. Attorney Ryan K. Patrick.

February 3, 2021; U.S. Department of Justice

CEO Sentenced for $150 Million Health Care Fraud and Money Laundering Scheme

The CEO of a Texas-based group of hospice and home health entities was sentenced today to 15 years in prison for falsely telling thousands of patients with long-term incurable diseases they had less than six months to live in order to enroll the patients in hospice programs for which they were otherwise unqualified, thereby increasing revenue to the company.

April 21, 2021; U.S. Department of Justice

Manager of Hospice and Home Health Companies Sentenced to Prison for Role in $150 Million Health Care Fraud Scheme A Texas man was sentenced today to 27 months in prison for his role in a conspiracy at the Merida Group, a chain of hospice and home health agencies throughout Texas, to falsely convince thousands of patients with long-term incurable diseases they had less than six months to live in order to enroll the patients in hospice programs for which they were otherwise unqualified, thereby increasing revenue to the company.

November 1, 2021; U.S. Department of Justice

Geisinger Community Health Services Agrees To $18 Million Civil Settlement

The United States Attorney's Office for the Middle District of Pennsylvania announced that Geisinger Community Health Services (GCHS) has agreed to pay $18,513,621.05 to resolve allegations of civil liability for submitting claims to Medicare for hospice and home health services that violated Medicare rules and regulations. GCHS voluntarily disclosed the violations.

November 5, 2021; U.S. Department of Justice

Visiting Nurse Association and Hospice of Vermont and New Hampshire Agreed to Pay $2.3 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Home Health That Lacked Proper Orders After it self-disclosed conduct to OIG, Visiting Nurse Association and Hospice of Vermont and New Hampshire, Inc. (VNH), Vermont, agreed to pay $2,389,706.26 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that VNH submitted claims for home health services based on orders signed by a qualified clinician but not cosigned by a physician or allowed practitioner.

December 1, 2021; U.S. Department of Justice

Crossroads Hospice Agrees to Pay $5.5 Million to Settle False Claims Act Liability

Memphis, TN – Carrefour Associates LLC; Crossroads Hospice of Cincinnati LLC; Crossroads Hospice of Cleveland LLC; Crossroads Hospice of Dayton LLC; Crossroads Hospice of Northeast Ohio LLC; and Crossroads Hospice of Tennessee LLC ("Crossroads Hospice"), operating in Ohio and Tennessee, have agreed to pay $5.5 million to resolve allegations that they violated the False Claims Act by submitting claims to Medicare for non-covered hospice services.

2022

February 24, 2022; U.S. Department of Justice

Attorney General Bonta Announces Arrests in Alleged Inland Empire Hospice Scam Defrauding Medicare and Medi-Cal Programs of More Than $4.2 Million

RANCHO CUCAMONGA – California Attorney General Rob Bonta today announced the arrests of 14 individuals who were charged in San Bernardino County Superior Court in connection with two hospice companies accused of stealing more than $4.2 million from the federal Medicare and state Medi-Cal programs.

March 8, 2022; U.S. Department of Justice

Santa Paula Doctor and Lancaster Patient Recruiter Arrested in Hospice Fraud Scheme that Received Over $30 Million from Medicare

Authorities today arrested a physician and a marketer on federal charges stemming from a scheme that bilked Medicare out of more than $30 million for medically unnecessary hospice services provided to patients who were obtained through illegal kickbacks.

August 19, 2022; U.S. Department of Justice

Hospice Agrees To Pay Nearly $1M To Settle False Claims Liability

CORPUS CHRISTI, Texas – A Corpus Christi health care company has agreed to pay $990,478.46 to resolve allegations they violated the False Claims Act by submitting claims to Medicare for non-covered hospice services, announced U.S. Attorney Jennifer B. Lowery.

2023

March 3, 2023; U.S. Department of Justice

Summit Hospice To Pay Over $1M To Settle False Claims Liability

Salt Lake City, Utah – A Salt Lake County, Utah health care company has agreed to pay $1,045,944.42 to resolve allegations they violated the False Claims Act by submitting claims to Medicare and Medicaid for non-covered hospice services.

April 3, 2023; U.S. Department of Justice

Man Pleads Guilty To $3.1M Medicare Fraud Scheme

A Southern California man pleaded guilty today to submitting false enrollment applications to Medicare that hid the real owners of a fraudulent hospice company, which then submitted over $3.1 million in false and fraudulent claims to Medicare.

April 6, 2023; U.S. Department of Justice
Former Hospice Care Owner Convicted Of Defrauding Medicare
LAFAYETTE, La. – A federal jury has returned a guilty verdict against Kristal Glover-Wing, 50, of Broussard, Louisiana, for one count of conspiracy to commit health care fraud and three counts of health care fraud following a trial that lasted nearly four weeks, announced United States Attorney Brandon B. Brown. Dr. Gary M. Wiltz and Dr. Charles H. Louis were each acquitted on their charges in the indictment. Judge Robert R. Summerhays presided over the trial.

September 28, 2023; U.S. Department of Justice
Hospice Medical Director Sentenced For $150 Million Hospice Fraud Scheme
A hospice medical director was sentenced yesterday to four years and two months in prison for his role in a scheme that involved the submission of over $150 million in false and fraudulent claims to Medicare for hospice and other health care services.

November 8, 2023; U.S. Department of Justice
Jury Convicts Hospice Owner for Defrauding Medicare
U.S. Attorney Duane A. Evans announced that on November 6, 2023, a federal jury convicted SHIVA AKULA, age 67, of New Orleans, of health care fraud related to fraudulent claims billed to Medicare. AKULA owned and oversaw the day-to-day operations of Canon Healthcare, LLC, a hospice facility with offices in the New Orleans area, Baton Rouge, Covington, and Gulfport, Mississippi. Between January 2013 and December 2019, Canon's New Orleans area office billed Medicare approximately $62 million and was paid approximately $47 million.

2024
February 16, 2024; U.S. Department of Justice
Doctor Convicted of $2.8M Medicare Fraud Scheme
A federal jury convicted a California man yesterday for his role in a scheme to defraud Medicare by billing $2.8 million for hospice services that patients did not need.

March 29, 2024; U.S. Department of Justice
Two Men Sentenced for Role in $9M Hospice Fraud Scheme
The owner of two California-based hospice companies, along with his biller and consultant, were sentenced yesterday for their respective roles in a scheme that resulted in stealing over $9 million from Medicare in false and fraudulent claims for hospice services.

May 1, 2024; U.S. Department of Justice

Elara Caring Agrees To Pay $4.2 Million To Settle False Claims Act Allegations That It Billed Medicare For Ineligible Hospice Patients

Elara Caring, and its wholly owned subsidiaries JHH/CIMA Holdings Inc., CIMA Healthcare Management Inc., CIMA Hospice of Texarkana L.L.C., CIMA Hospice of East Texas L.L.C. and CIMA Hospice of El Paso L.P., have agreed to pay $4.2 million to resolve allegations that they violated the False Claims Act by knowingly submitting false claims and knowingly retaining overpayments for the care of hospice patients in Texas who were ineligible for the Medicare hospice benefit because they were not terminally ill.

May 16, 2024; U.S. Department of Justice

Hospice Owner Sentenced To 240 Months Imprisonment And Ordered To Repay $42,000,000 For Defrauding Medicare

U.S. Attorney Duane A. Evans announced that on May 15, 2024, U.S. District Judge Lance Africk sentenced SHIVA AKULA ("AKULA"), age 68, of New Orleans, to 240 months of imprisonment, three years of supervised release and $2,300 in mandatory special assessment fees, in relation to an extensive health care fraud scheme orchestrated by AKULA. In November 2023, a federal jury convicted AKULA of all 23 counts of his underlying indictment. AKULA owned and oversaw the day-to-day operations of Canon Healthcare, LLC, a hospice facility with offices in the New Orleans area, Baton Rouge, Covington, and Gulfport, Mississippi.

June 7, 2024; U.S. Department of Justice

Five Individuals Arrested For Defrauding Medicare Of Over $15M Through Sham Hospices And Money Laundering

Five individuals were arrested yesterday in Los Angeles on criminal charges related to their roles in a years-long scheme to defraud Medicare of more than $15 million through sham hospice companies and then to launder the fraud proceeds.

June 20, 2024; U.S. Department of Justice

Tapestry Hospice Settles Healthcare Kickback Claims For $1.4 Million

Tapestry Hospice of Northwest Georgia, LLC, and its owners and managers, David Lovell, MD, Stephanie Harbour, Ben Harbour, and Andrew Nall (collectively "Tapestry"), agreed to pay $1.4 million to resolve allegations that they violated the False Claims Act by entering into kickback arrangements with medical directors in exchange for referrals of hospice patients to Tapestry.

July 18, 2024; U.S. Department of Justice

<u>Kindred And Related Entities Agree To Pay $19.428M To Settle Federal And State False Claims Act Lawsuits Alleging Ineligible Claims For Hospice Patients</u>
Gentiva, successor to Kindred at Home, has agreed to pay $19.428 million to resolve allegations that Kindred at Home and related entities (Kindred) knowingly submitted false claims and knowingly retained overpayments for hospice services provided to patients who were ineligible to receive hospice benefits under various federal health care programs. Gentiva's hospice operations, headquartered in Atlanta, include entities that previously operated Kindred at Home hospice locations under the names Avalon, Kindred, SouthernCare and SouthernCare New Beacon.

August 20, 2024; U.S. Department of Justice
<u>Nationwide Home Healthcare And Hospice Provider To Pay $3.85M To Resolve False Claims Act Allegations</u> Intrepid U.S.A. Inc., headquartered in Dallas, and various wholly-owned subsidiaries (Intrepid) have agreed to pay $3,850,000 to resolve allegations that Intrepid violated the False Claims Act in connection with two lines of its business: first, that Intrepid knowingly submitted claims to Medicare for home healthcare services for patients who did not qualify for the Medicare home healthcare benefit or where services otherwise did not qualify for Medicare reimbursement; and second, that Intrepid knowingly submitted claims to Medicare for patients who did not qualify for the hospice benefit. **The settlement is based on Intrepid's ability to pay.**

December 12, 2024; U.S. Department of Justice
<u>Glendale Woman And Lakewood Man Found Guilty Of $3.2 Million Hospice Fraud Scheme Involving Kickbacks For Patient Referrals</u>
LOS ANGELES – A Glendale woman and a Lakewood man have been found guilty by a jury of paying and receiving hundreds of thousands of dollars in illegal kickbacks for patient referrals that resulted in the submission of approximately $3.2 million in fraudulent claims to Medicare for purported hospice care, the Justice Department announced today.

2025
January 31, 2025; U.S. Department of Justice
<u>Arizona Couple Pleads Guilty to $1.2B Health Care Fraud</u>
An Arizona couple pleaded guilty for causing over $1.2 billion of false and fraudulent claims to be submitted to Medicare and other health insurance programs for expensive, medically unnecessary wound grafts that were applied to **elderly and terminally ill patients**. According to court documents, Alexandra Gehrke, 39, and her husband, Jeffrey King, 46, both of Phoenix, conspired with others to orchestrate the massive scheme. Gehrke ran two companies, Apex Medical LLC and Viking Medical Consultants LLC, that contracted with medically untrained "sales

representatives" to locate elderly patients, **including hospice patients**, who had wounds at any stage and order amniotic wound grafts from a specific graft distributor.

February 3, 2025; U.S. Department of Justice
Man Pleads Guilty in Connection with $17M Medicare Hospice Fraud and Home Health Care Fraud Schemes A California man pleaded guilty today to health care fraud, aggravated identity theft, and money laundering in connection with a years-long scheme to defraud Medicare of more than $17 million through sham hospice companies and his home health care company.

February 21, 2025; U.S. Department of Justice
Saad Healthcare Agrees to Pay $3M to Settle False Claims Act Allegations That It Billed Medicare for Ineligible Hospice Patients
Saad Enterprises Inc., doing business as Saad Healthcare, has agreed to pay $3 million to resolve allegations that it violated the False Claims Act by knowingly submitting false claims for the care of hospice patients in Alabama who were ineligible for the Medicare hospice benefit because they were not terminally ill. The settlement resolves allegations that between 2013 and 2020 Saad submitted, or caused the submission of, false claims to Medicare for 21 patients who did not meet the eligibility requirements for the Medicare hospice benefit as defined by statute and regulation, despite Saad knowing the patients were ineligible for the Medicare hospice benefit.