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Hospital Settles Case Over Free Discharge Planning from Home Health Agencies

Lahey Health System agreed to pay $1.923 million in a civil money penalty settlement over allegations it accepted free discharge planning services from four home health agencies. The HHS Office of Inspector General alleged the conduct violated CMP law provisions related to the anti-kickback law.

According to the settlement, Lahey Clinic Hospital in Burlington, Mass., allegedly "received remuneration" from home health agencies "in the form of free administrative services related to discharge planning." The services were provided by "liaisons" working for the home health agencies (HHAs) without a written contract. Some of the duties performed by the HHA employees normally would have been performed by Lahey discharge planners or other Lahey employees, and therefore the free services were improper remuneration as defined by the anti-kickback statute (42 U.S.C. Sec.1320a-7b(b)), OIG alleged. Two of the HHAs are Northeast Senior Health Corporation (NSH) and Visiting Nurse Association of Middlesex-East, Inc. (VNAME).

"All the recent emphasis on care coordination and collaboration notwithstanding, health care providers need to be extremely careful that their collaborative efforts do not cross the line into illegal kickbacks, or the consequences can be severe," says Washington, D.C., attorney Daniel Hettich, with King & Spalding.

It appears Lahey Health System didn't own the HHAs at the time but later acquired and/or affiliated with them, according to the settlement. Lahey allegedly accepted free discharge planning services from NSH from Oct. 18, 2010, to May 1, 2012. NSH was a subsidiary of Northeast Health System, Inc., which combined with Lahey Clinic Foundation, Inc. on May 1, 2012, and formed Lahey Health as a new common parent. NSH is now a direct subsidiary of Lahey Health. Lahey allegedly received free discharge planning services from VNAME between April 1, 2009, and June 21, 2013. On Oct. 1, 2014, an affiliation agreement between VNAME and Lahey Health took effect and "Lahey Health became the sole corporate member of VNAME," the settlement states.

Lahey Health System reported the situation voluntarily, and was accepted into the OIG's Self-Disclosure Protocol in May 2015. The settlement includes a release from permissive exclusion. Although Lahey was required to pay a substantial amount of money, OIG rewarded the self-disclosure, says Harrisburg, Pa., attorney Paula Sanders, with Post & Schell. The message OIG has been sending — that providers with effective compliance programs greatly reduce their exclusion risk by coming forward with potential violations — was reinforced in its new guidance on permissive exclusions, she notes *(RMC 4/25/16, p. 1)*.

Andrew Mastrangelo, director of media relations for Lahey Health, said "this resolution is a result of a voluntary self-disclosure that Lahey Health made on March 31, 2015, and we are pleased to bring closure to this matter." He had no other comment.

Steering, Freebies Are Concerns

The government was "very aggressive" in pursuing Lahey, Hettich says. On one level, there was a potential steering violation. The Medicare conditions of participation require hospitals to give patients a choice of HHAs during discharge planning and generally prohibit them from "steering" patients to any particular HHA. "The theory is hospitals have a captive patient population, so you're supposed to simply give them a list of available HHAs without registering a preference," he says. "Obviously with HHAs doing discharge planning, it's not a huge leap to imagine they might steer patients to their own HHAs." The preamble to the 2004 inpatient prospective payment system regulation also suggests that hospitals themselves should be counseling patients during discharge planning, he notes. The preamble states that "we expect hospital discharge planners to be able to assist patients in identifying the HHAs and [skilled nursing facilities] appropriate to fit the patients' needs" (69 FR 49226). But messing these things up would be CoP deficiencies, which usually aren't catastrophic. "You can generally fix CoP violations and continue to participate in Medicare," Hettich says.

In the Lahey Health case, however, OIG "upped the ante considerably in alleging violations of the anti-kickback statute, which prohibits parties from 'knowingly and willfully' exchanging remuneration for the purpose

of inducing referrals," he notes. "The OIG was going after much bigger fish."

Hospitals have to act with an abundance of caution when working with post-acute care (PAC) providers if they are not part of the same corporate entity, Hettich and Sanders say. "This case acts as a cautionary tale about the limits on how hand in glove you can be and where to keep appropriate boundaries for unrelated parties," Hettich says. It could pass muster when hospitals own HHAs, which may decrease the risk of alleged kickbacks because everyone is sharing from the same pot, or where hospitals work closely with HHAs on the hospital readmission reduction program or bundled payments for episodes of care, which may provide some room to maneuver in certain areas (e.g., the relaxing of the prohibition against steering).

But they have to be analyzed on a program-by-program basis, Hettich says. For example, the comprehensive joint replacement (CJR) model, which took effect April 1, holds hospitals financially accountable for the quality and cost of an episode of care, which begins with admissions for hip and knee replacements and ends 90 days after discharge from the hospital, and includes related items and services paid under Medicare Part A and Part B *(RMC 12/7/15, p. 1)*. Medicare will continue to pay hospitals and their "collaborators" — physicians and PAC providers — on a fee-for-service basis, but hospitals will receive an episode payment at the end of every "performance period" that they can share with physicians and PAC providers. To enable hospitals to share payments with physicians and PAC providers, which have referral relationships with hospitals, CMS and OIG published fraud and abuse waivers.

But "the CJR anti-kickback waivers for gainsharing payments and alignment payments would not encompass an arrangement like the one at issue in the Lahey settlement," Hettich says. "For one thing, the CJR waiver specifically prohibits any type of 'in-kind' remuneration, such as the provision of personal services."

The problem is, providers may lose their bearings when they affiliate and consolidate and wind up running afoul of the Stark and anti-kickback laws. "As these programs and their associated waivers become more common, the confusion may increase," he says. But it's pretty clear hospitals should be counseling their patients themselves during discharge planning.

"As we start looking at more of these attempts to build networks and affiliations where hospitals want to be able to track the condition of their patient as they are being discharged, this points to the risks of not dotting i's and crossing t's," Sanders says. "If they are entering relationships and receiving services, they have to still comply with Stark and the anti-kickback laws."

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