COMPLIANCE CONNECTION

APRIL 2025

This newsletter is prepared monthly by the Midland Health Compliance Department and is intended to provide relevant compliance issues and hot topics.

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Feature Article:
Saint Vincents Catholic Medical Centers of New York Agrees to Pay $29M to Resolve Alleged False Claims Act Violations

Midland Health PolicyTech: Policy #8690 Compliance Program Plan *(See Page 2)*

FRAUD & ABUSE LAWS

The five most important Federal Fraud and Abuse Laws that apply to physicians are:

1. ***False Claims Act (FCA):*** *The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.*
2. ***Anti-Kickback Statute (AKS):*** *The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).*
3. ***Physician Self-Referral Law (Stark law):*** *The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.*
4. ***Exclusion Statute:*** *OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.*
5. ***Civil Monetary Penalties Law (CMPL):*** *OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation.*

Resource:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

MIDLAND HEALTH

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Saint Vincents Catholic Medical Centers of New York Agrees to Pay $29M to Resolve Alleged False Claims Act Violations

SVCMC Inc., formerly known as Saint Vincents Catholic Medical Centers of New York (Saint Vincent), has agreed to pay $29 million to resolve allegations that it violated the False Claims Act by knowingly retaining erroneously inflated payments received from the Department of Defense for healthcare services provided to retired military members and their families.

Saint Vincent is one of six health plans participating in the Uniformed Services Family Health Plan (USFHP) program, which is a federal health insurance program funded by the Defense Health Agency (DHA), a component of the Department of Defense. Under the USFHP program, DHA pays Saint Vincent capitated rates to provide healthcare services to military personnel, retirees, and their families. The complaint alleged that, in 2012, Saint Vincent learned that errors had been made in the calculation of the capitated rates resulting in substantial overpayments to Saint Vincent and the other five USFHP plans over the preceding four years. According to the government's complaint, instead of notifying the government of the overpayments or repaying the funds, Saint Vincent, along with the other five USFHP plans, took steps to conceal the existence of the overpayments from DHA, continued to submit invoices at the inflated payment rates, and conspired to avoid paying the money back. Today's settlement resolves the government's claims against Saint Vincent.

"Those who receive public funds, including participants in government health care programs, must return funds to which they are not entitled," said Acting Assistant Attorney General Brett A. Shumate, head of the Justice Department's Civil Division. "Together with our partners across the federal government, we will hold accountable those who knowingly violate this obligation to the American taxpayers."

"I want to thank the Justice Department for resolving this case on behalf of TRICARE and the Defense Health Agency," said Dr. David C. Krulak, Director, TRICARE Health Plan, DHA. "Providing excellent health care to our 9.5 million beneficiaries worldwide is essential to maintaining force readiness and keeping our promise to our family members and retirees, while being good stewards of taxpayer dollars at the same time." The civil settlement resolves claims brought under the qui tam or whistleblower provisions of the False Claims Act by Jane Rollinson and Daniel Gregorie in the District of Maine. From 2007 to 2015, Ms. Rollinson worked at Martin's Point Health Care, one of the health plans participating in the USFHP program, including as its Interim Chief Financial Officer.

Read entire article:
https://www.justice.gov/opa/pr/saint-vincents-catholic-medical-centers-new-york-agrees-pay-29m-resolve-alleged-false-claims

MIDLAND HEALTH Compliance HOTLINE
855•662•SAFE (7233)
ID#: 6874433130
ID# is required to submit a report.
You can make your report or concern ANONYMOUSLY .

MIDLAND HEALTH

MIDLAND HEALTH POLICYTECH

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COMPLIANCE PROGRAM PLAN

PURPOSE

Midland County Hospital District d/b/a Midland Memorial Hospital is a Texas governmental entity, established under the Texas Constitution by the Texas Legislature, to provide medical care to the residents of its District. In pursuit of its legislative purpose, Midland Memorial Hospital supports and promotes charitable, educational and scientific purposes through the hospital as well as its through its maintenance and support of its physician corporations and various corporate affiliations which support this mission. Midland Health (MH) is the entire system through which Midland Memorial Hospital conducts its activities in pursuit of its charitable, educational and scientific purposes.

MISSION Leading healthcare for greater Midland.

VISION Midland will be the healthiest community in Texas.

CORE VALUES:

Pioneer Spirit...

- We tell the truth and honor commitments.
- We innovate and embrace change.
- We are careful stewards of our resources.
- We overcome problems without complaining.
- We exceed quality and safety expectations through teamwork and partnerships.

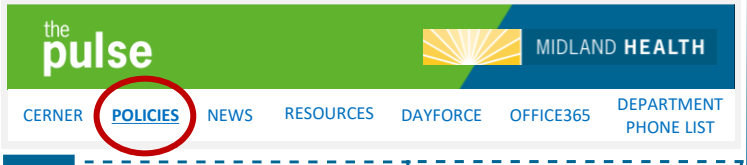
Healing Mission...

- We do our best to improve the health and well-being of our community.
- We are continuous learners.
- We create an environment that supports the healing process.
- We care for ourselves so we are able to care for others.
- We find joy in our work and have fun together.

Read entire Policy: Midland Health PolicyTech #8690 "Compliance Program Plan"

Midland Health PolicyTech Instructions

Click this link located on the Midland Health intranet "Policies"
https://midland.policytech.com/dotNet/noAuth/login.aspx?ReturnUrl=%2f



IN OTHER COMPLIANCE NEWS

LINK 1
Warby Parker to Pay $1.5 Million To Resolve HIPAA Violations

https://www.hipaajournal.com/warby-parker-hipaa-penalty/

LINK 2
Is Saying Someone Died a HIPAA Violation?

https://www.hipaajournal.com/saying-someone-died-hipaa-violation/

LINK 3
Iowa Doctor Jailed for Unauthorized Medical Record Access

https://www.hipaajournal.com/iowa-doctor-pleads-guilty-to-hipaa-violations/

LINK 4
OCR HIPAA for Therapists

https://www.hipaajournal.com/hipaa-for-therapists/

FALSE CLAIMS ACT (FCA)

Iowa 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.

Hospice care is special, end-of-life care intended to comfort terminally ill patients. Patients admitted to hospice care generally stop receiving traditional medical care designed to cure their terminal condition and instead receive medical care focused on providing them with relief from the symptoms, pain, and stress of a terminal illness. Medicare patients are considered to be terminally ill and hospice-eligible when they have a life expectancy of six months or less if their illness runs its normal course.

"Respectful and appropriate end-of-life care is the crux of the hospice benefit under Medicare," said Principal Deputy Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "The Department will hold accountable those who exploit this benefit for their own gain."

"Caring for terminally ill people is a responsibility the United States and the Medicare program take seriously," said Acting U.S. Attorney Keith A. Jones for the Southern District of Alabama. "Patients and taxpayers deserve not to be cheated, and the Department of Justice will continue to protect them."

Read entire article:
https://www.justice.gov/opa/pr/saad-healthcare-agrees-pay-3m-settle-false-claims-act-allegations-it-billed-medicare

DEPARTMENT OF HEALTH & HUMAN SERVICES

HHS Delays Effective Date of HIPAA Final Rule Implementing Modified Retail Pharmacy Standard

In December 2024, the Department of Health and Human Services published a final rule in the Federal Register modifying the National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards and the Medicaid Pharmacy Subrogation Standard. The effective date for those modifications was initially set as February 11, 2025; however, the HHS has now delayed the effective date until April 14, 2025.

The final rule adopted updated versions of the retail pharmacy standards for electronic transactions for health care claims or equivalent encounter information; eligibility for a health plan; referral certification and authorization; and coordination of benefits, and the adoption of a modified standard for the Medicaid pharmacy subrogation transaction.

The delay to the effective and compliance dates is due to President Trump's January 20, 2025, Presidential memorandum, titled "Regulatory Freeze Pending Review." Dorothy A. Fink, Acting Secretary of the Department of Health and Human Services, said the 60-day postponement of the effective date was made "for the purpose of reviewing any questions of fact, law, and policy."

Read entire article:
https://www.hipaajournal.com/hhs-delays-effective-date-hipaa-final-rule-modified-retail-pharmacy-standard/

Do you have a hot topic or interesting Compliance News to report?

If so, please email an article or news link to:

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