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.

IN THIS ISSUE

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
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ID# is required to submit a report.
You can make your report or concern ANONYMOUSLY .

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