COMPLIANCE CONNECTION Newsletter

OCTOBER 2026

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

COMPLIANCE TEAM

Michelle Pendergrass, MBA, CHC
Chief Compliance Officer/Privacy Officer
P: 432-221-1972
Michelle.Pendergrass@midlandhealth.org

Regenia Blackmon, *Compliance Auditor*
Regenia.Blackmon@midlandhealth.org

Melissa Sheley, *Senior Compliance Analyst*
Melissa.Sheley@midlandhealth.org

Office of Public Affairs
U.S. Department of Justice

The Villages Health System LLC Agrees to $541.5M Settlement to Resolve False Claims Act Allegations

The Villages Health System LLC (TVH), a healthcare provider group headquartered in The Villages, Florida, has agreed to a $541.5 million settlement to resolve self-disclosed allegations that it violated the False Claims Act by causing the submission of false diagnosis codes in order to increase payments that they received from the Medicare Advantage program.

"The Medicare Advantage program relies on accurate diagnoses to protect the federal fisc," said Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "The settlement reflects that we will hold accountable entities that inflate payments through invalid diagnoses; at the same time, we will continue to credit organizations that disclose wrongdoing, take appropriate remedial actions, and fully cooperate with the government's investigation."

"The Villages Health System LLC knowingly submitted false diagnosis codes to increase their payments from the Medicare Advantage program and increase their profits," said U.S. Attorney Gregory W. Kehoe for the Middle District of Florida. "Our Office will continue protecting the integrity of the Medicare program and hold those who seek to defraud federal health care programs accountable."

"The accuracy of diagnosis information submitted to Medicare Advantage is vital to protecting taxpayer dollars," said Acting Deputy Inspector General for Investigations Miranda L. Bennett of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). "This case underscores that entities will be held accountable when they submit unsupported information that inflates payments. The provider's use of the OIG Self Disclosure Protocol and its cooperation were important factors in resolving this matter, and the protocol remains available for managed care entities and other providers that bill managed care entities that seek to disclose potential liability."

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, Medicare beneficiaries may opt out of traditional Medicare and enroll in private health plans offered by insurance companies known as Medicare Advantage Organizations, or MAOs. The Centers for Medicare & Medicaid Services (CMS) pays the MAOs a fixed monthly amount for each Medicare beneficiary enrolled in their plans. CMS adjusts these monthly payments to account for various "risk" factors that affect expected health expenditures for the beneficiary. In general, CMS pays MAOs more for sicker beneficiaries expected to incur higher healthcare costs and less for healthier beneficiaries expected to incur lower costs. To make these "risk adjustments," CMS collects medical diagnosis codes from the MAOs. The diagnoses must be supported by the medical record from a face-to-face visit between a patient and a provider……

Read entire article:
https://www.justice.gov/opa/pr/villages-health-system-llc-agrees-5415m-settlement-resolve-false-claims-act-allegations

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

MIDLAND HEALTH • PT POLICYTECH® Policy & Procedure Management

Materials Management Purchasing Code of Ethics Gifts and Gratuities

Purpose: Identify the overall purpose and scope of the Purchasing Code of Ethics, to include guidelines for accepting gifts and gratuities.

1. Give first consideration to the objectives and policies of the institution.
2. Strive to obtain the maximum value for each dollar of expenditure.
3. Decline personal gifts and gratuities.
4. Grant all competitive suppliers equal consideration insofar as state or federal statute and institutional policy permit.
5. Conduct business with potential and current suppliers in an atmosphere of good faith, devoid of intentional misrepresentation.
6. Demand honesty in sales representation whether offered through the medium of a verbal or written statement, an advertisement, or a sample of the product.
7. Accord a prompt and courteous reception insofar as conditions permit to all who call on legitimate business missions.
8. Cooperate with trade, industrial and professional associations and governmental and private agencies for the purposes of promoting and developing sound business methods.
9. Foster fair, ethical and legal trade practices.

Strive for standardization to reduce cost and further the development of products and methods that reflect high quality, safety and effectiveness of care.

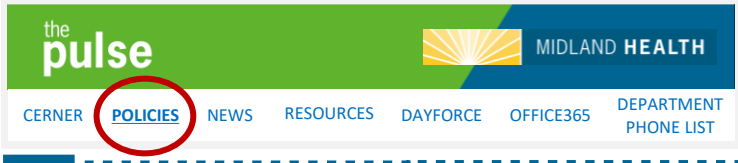
No employee shall accept gifts, personal loans, entertainment or other special considerations from vendors the Hospital is currently doing business with or prejudice the hospital's reputation. Gifts of nominal value may be acceptable on special occasions (such as holidays or significant Hospital milestone events) and must be evaluated and approved by the Director of Materials Management on a case-by-case basis.

Association with supplier representatives at business organization meetings is helpful in establishing better business understanding and is neither questionable nor unethical, provided the employee keeps himself free of obligations.

Read entire Policy:
Midland Health PolicyTech #371
"Materials Management Purchasing Code of Ethics Gifts and Gratuities"

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
Hacking Incidents Announced by Rehabilitative Care Providers and Senior Living Facilities
https://www.hipaajournal.com/hacking-incidents-rehabilitative-care-providers-senior-living-facilities/

LINK 2
Azul Vision Settles HIPAA Right of Access Case for $50,000
https://www.hipaajournal.com/azul-vision-hipaa-right-access-penalty/

LINK 3
Oncology Firm Novocure Announces Cyberattack and Data Breach
https://www.hipaajournal.com/novocure-data-breach/

LINK 4
OSF Healthcare System Pays $552,250 to Settle OCR HIPAA Investigation
https://www.hipaajournal.com/osf-healthcare-hipaa-penalty/

FALSE CLAIMS ACT *(FCA)*

Medicare Advantage Provider Complete Health to Pay $14,100,000 to Settle False Claims Act Suit

Complete Health Partners Holdings, headquartered in Jacksonville, Florida, has agreed to pay $14,100,000, to resolve allegations that they violated the False Claims Act by causing the submission of false diagnosis codes in order to increase payments that they received from the Medicare Advantage program.

"As the Medicare Advantage program continues to grow, providers who participate in the program must be held to account when they attempt to improperly profit at the taxpayer's expense," said Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "This settlement reflects the Department's commitment to protecting taxpayer money and ensuring that Medicare payments are based on information that is true and accurate."

"Health care fraud enforcement has long been a cornerstone of the mission of this office," said U.S. Attorney Gregory W. Kehoe for the Middle District of Florida. "This settlement sends a strong message to our district, its residents, and medical providers doing business here, that our focus on this vital practice area has not wavered."

"Companies that attempt to improperly boost their own profits by reporting bogus medical conditions of Medicare Advantage enrollees — as alleged in this case — will be held responsible for their actions," said Special Agent in Charge Isaac M. Bledsoe of the Department of Health and Human Services Office of Inspector General (HHS-OIG). "Today's settlement demonstrates our office's commitment to safeguarding the integrity of federal health care programs, including Medicare Advantage, which exist to provide necessary care to enrollees, not as a vehicle for improper financial gain."

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, Medicare beneficiaries may opt out of traditional Medicare and enroll in private health plans offered by insurance companies known as Medicare Advantage Organizations, or MAOs. The Centers for Medicare & Medicaid Services (CMS) pays the MAOs a fixed monthly amount for each Medicare beneficiary enrolled in their plans. AO. kind of misconduct and hold accountable those who put greed above patient care."

Read entire article:
https://www.justice.gov/opa/pr/medicare-advantage-provider-complete-health-pay-14100000-settle-false-claims-act-suit

OCTOBER 2026
Health Observances Calendar

OCT 4-10	Mental Illness Awareness Week
OCT 4-10	National Primary Care Week
OCT 6-12	National PA Week
OCT 12-20	Bone and Joint Health Action Week
OCT 18-24	International Infection Prevention Week
OCT 18-24	National Healthcare Quality Week
OCT 18-24	National Pharmacy Week
OCT 18-24	Respiratory Care Week
OCT 19-23	Medical Assistants Recognition Week
OCT 19-23	National Health Education Week
OCT 23-31	Red Ribbon Week

https://b2b.healthgrades.com/insights/blog/2026-health-observances-calendar/

Do you have a hot topic or interesting* COMPLIANCE NEWS *to report?

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

Regenia Blackmon
Compliance Auditor
Regenia.Blackmon@midlandhealth.org