BlueCross BlueShield Minnesota

Blue Cross and Blue Shield of Minnesota and Blue Plus - Medicare and Medicaid Compliance and Fraud, Waste and Abuse Training

General Compliance & Fraud, Waste and Abuse (FWA) training for first tier, downstream, and related entities, including providers

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

TRAINING OUTLINE

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- Introduction

- Part 1: FWA
- Part 2: Compliance
- Part 3: Examples of FWA and Non-Compliance
- Part 4: How Do I Report FWA and Non-Compliance
- Part 5: Compliance and FWA Knowledge Test

- Resources

LEARNING OBJECTIVES

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Understand Blue Cross and Blue Plus's commitment to ethical business behavior	Provide information on how to report potential FWA and non-compliance
Provide information on the scope of FWA and non-compliance and understand how a compliance program operates	Provide information on laws pertaining to FWA and non-compliance
Explain obligation of everyone to detect, prevent and correct FWA and non-compliance	Meet the regulatory requirement for training and education

INTRODUCTION

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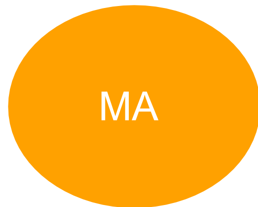
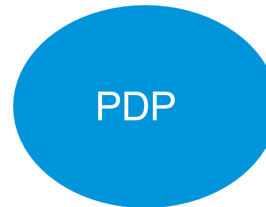
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees Medicare and Medicaid programs.

CMS contracts with Blue Cross and Blue Shield of Minnesota*, Blue Plus** and other health plans to offer:





- Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) plans (Part C or Part C & D)
- Prescription Drug Plans (PDP) (Part D)
- 1876 Cost Plans with or without Prescription Drug coverage (Cost)

* Blue Cross" refers to BCBSMN, Inc. d/b/a Blue Cross and Blue Shield of Minnesota

** Blue Plus" refers to HMO Minnesota d/b/a Blue Plus, a licensed affiliate of Blue Cross

WHERE DO I FIT IN?

FDRs, including providers, that provide health or administrative services to an MA, MA-PD, Cost, or PDP enrollee are either a:

- First Tier Entity
  - Examples: pharmacy benefit manager (PBM), claims processing company, contracted sales agent, multispecialty health clinic

- Downstream Entity
  - Example: psychologist

- Related Entity
  - Example: entity that has a common ownership or control of a MA, MA-PD, Cost, or PDP plan sponsor

Every action you take potentially affects Medicare and Medicaid beneficiaries, the Medicare and Medicaid programs or the Medicare trust fund

WHAT ARE MY RESPONSIBILITIES?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance and possible FWA.

FIRST you are required to comply with all applicable statutory, regulatory and other MA, MA-PD, Cost, or PDP requirements, including adopting and implementing an effective compliance program

SECOND you have a duty to the Medicare and Medicaid programs to report any violations of laws that you may be aware of

THIRD you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior

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PART 1:
FRAUD, WASTE AND ABUSE (FWA)

UNDERSTANDING FWA

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TO DETECT FWA, YOU NEED TO KNOW THE LAW!!!

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CRIMINAL FRAUD

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Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

18 U.S.C. §1347

What Does That Mean?

Intentionally submitting false information to the Government or a Government contractor to get money or a benefit is considered criminal fraud.

WASTE AND ABUSE

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WASTE

- Over-utilization of services, or other practices that directly or indirectly result in unnecessary costs to the Medicare Program.
- Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

ABUSE

- Includes actions that may directly or indirectly result in unnecessary costs to the Medicare Program.
- Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

DIFFERENCE BETWEEN FRAUD, WASTE AND ABUSE

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The primary difference between fraud, waste and abuse depends on circumstances, intent and knowledge.

- **Fraud** requires the person to have an *intent* to obtain payment and the *knowledge* that their actions are wrong
- **Waste** and **abuse** may involve obtaining an improper payment, but are not accompanied by the same intent and knowledge

HOW DO I PREVENT FWA?

- Make sure you are up to date with laws, regulations and policies
- Verify information provided to you
- Be on the lookout for suspicious activity
- Ensure you coordinate with other payers
- Ensure data/billing is both accurate and timely

POLICIES AND PROCEDURES

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Blue Cross and Blue Plus must have policies and procedures (P&Ps) in place to address FWA

- P&Ps are intended to help detect, correct and prevent FWA
- Make sure you are familiar with our organization's P&Ps and Code of Conduct

HOW DO I CORRECT ISSUES?

If FWA has been detected within your organization, it must be promptly corrected. Correcting the problem saves the Government and members money and ensures you are in compliance with CMS' requirements.

- Once issues have been identified, a plan to correct the issue needs to be developed.
- Consult your compliance officer or Blue Cross' and/or Blue Plus's compliance officer to find out the process for the corrective action plan development.
- The actual corrective action plan will vary, depending on the specific circumstances.

LAWS

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The following slides provide high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and associated regulations concerning the law.

CIVIL FRAUD

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CIVIL FALSE CLAIMS ACT

Prohibits:

- Presenting a false or fraudulent claim for payment or approval
- Making or using a false record or statement in support of a false or fraudulent claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the Government
- Certifying receipt of property without knowing if it's true
- Buying public property from an unauthorized Government officer
- Knowingly concealing or improperly avoiding or decreasing an obligation to pay the Government

DAMAGES AND PENALTIES

Penalties:

Any person who knowingly submits false or fraudulent claims to the Government is liable for three times the amount of the Government's damages (treble damages), plus civil penalties.

CRIMINAL FRAUD PENALTIES

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If an individual knowingly defrauds any health care benefit program or obtains, through false or fraudulent manner, money or property under control of any health care benefit program, the individual shall be:

- Fined, imprisoned, or both
- If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both

18 U.S.C. § 1347

ANTI-KICKBACK STATUTE

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Prohibits:

Soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) in return for referrals for (or the purchasing, ordering, arranging or recommendation of) services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

Penalty:

Any person who knowingly accepts such remuneration will be fined up to $100,000, imprisoned up to 10 years, or both. Significant civil monetary penalties may also apply. Further, conviction results in mandatory exclusion from participation in federal health care programs.

42 U.S.C. § 1320a-7b

STARK STATUTE
PHYSICIAN SELF-REFERRAL LAW

Prohibits:

- A physician making a referral for certain designated health services payable by Medicare to an entity in which the physician (or a member of his or her immediate family) has a financial relationship (ownership, investment interest or compensation arrangement), unless an exception applies.
- The entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third-party payer) for those referred services.

Penalty:

Any individual/entity who knowingly participates in a prohibited referral arrangement may be fined, among other amounts and penalties:

- Up to a $15,000 fine for each fraudulent claim
- Up to a $100,000 fine for each arrangement or scheme

42 U.S.C. § 1395nn

CIVIL MONETARY PENALTIES

The Office of Inspector General (OIG) may seek Civil Monetary Penalties for a wide variety of conduct.

For example, penalties may be applied to organizations that offer or give something of value to a Medicare beneficiary, such that the organization knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service which may be paid entirely or in part by Medicare.

42 U.S.C. § 1320a-7a

EXCLUSION

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No federal health care program payment may be made for any item or service furnished, ordered or prescribed by an individual or entity excluded by the OIG.

42 U.S.C. § 1395y(e)(1)(B)

42 C.F.R. Part 1001

PRIVACY - HIPAA

Health Insurance Portability and Accountability Act of 1996 (HIPAA), as modified by the Health Information Technology for Economic and Clinical Health Act (HITECH)

As an individual with access to Protected Health Information, you are responsible for adhering to HIPAA/HITECH.

These laws:

- Create greater access to health care insurance, protection of privacy of health care data and promote standardization and efficiency in the health care industry
- Create safeguards to prevent unauthorized access to Protected Health Information
- Promote the adoption of meaningful use of health information technology
- Address privacy and security concerns associated with the electronic transmission of health information, in part through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules

CMS DATA USE AGREEMENT

As part of the annual contracting process with CMS, Blue Cross and Blue Plus are required to attest that they (and their FDRs and providers) will:

- Restrict the use and disclosure of Medicare data obtained from CMS information systems to those purposes directly related to the administration of MA, MA-PD, Cost, and/or PDP Plan(s)

- Only maintain data obtained from CMS information systems that is necessary to administer such plan(s)

- Not re-use or provide other entities access to the CMS information systems, or data obtained from the systems, to support any line of business other than the MA, MA-PD, Cost, and/or PDP Plan(s)

- Limit the use of information obtained from Medicare plan members to those purposes directly related to the administration of the plan(s)

CODE OF CONDUCT

CONFLICTS OF INTEREST

A Conflict of Interest (COI) is a financial, business, or other relationship which puts you at odds with Blue Cross and/or Blue Plus's interests or conflicts with your assigned duties.

- Any COIs must be disclosed upon hiring and annually thereafter
- Any changes to COIs during the year should be immediately reported to your compliance team or Blue Cross and/or Blue Plus
- Upon disclosure, each COI is reviewed to determine appropriate steps to mitigate the associated risk

Gifts and gratuities, in general, may not be:

- Requested or accepted from Government employees or contractors
- Provided or offered to Government employees or contractors

OTHER APPLICABLE LAWS

- Title XVIII of the Social SecurityAct
- Patient Protection and Affordable CareAct
- The Beneficiary Inducement Statute
- Fraud Enforcement and RecoveryAct
- Federal Criminal False Claim Statutes

CONSEQUENCES OF COMMITTING FWA

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The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of License
- Exclusion from Federal Health Care Programs

PART 2: COMPLIANCE

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COMPLIANCE IS EVERYONE'S RESPONSIBILITY

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ETHICS

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As a part of the Medicare and Medicaid programs, it is important that you conduct yourself in an ethical and legal manner.

COMPLIANCE IMPACT

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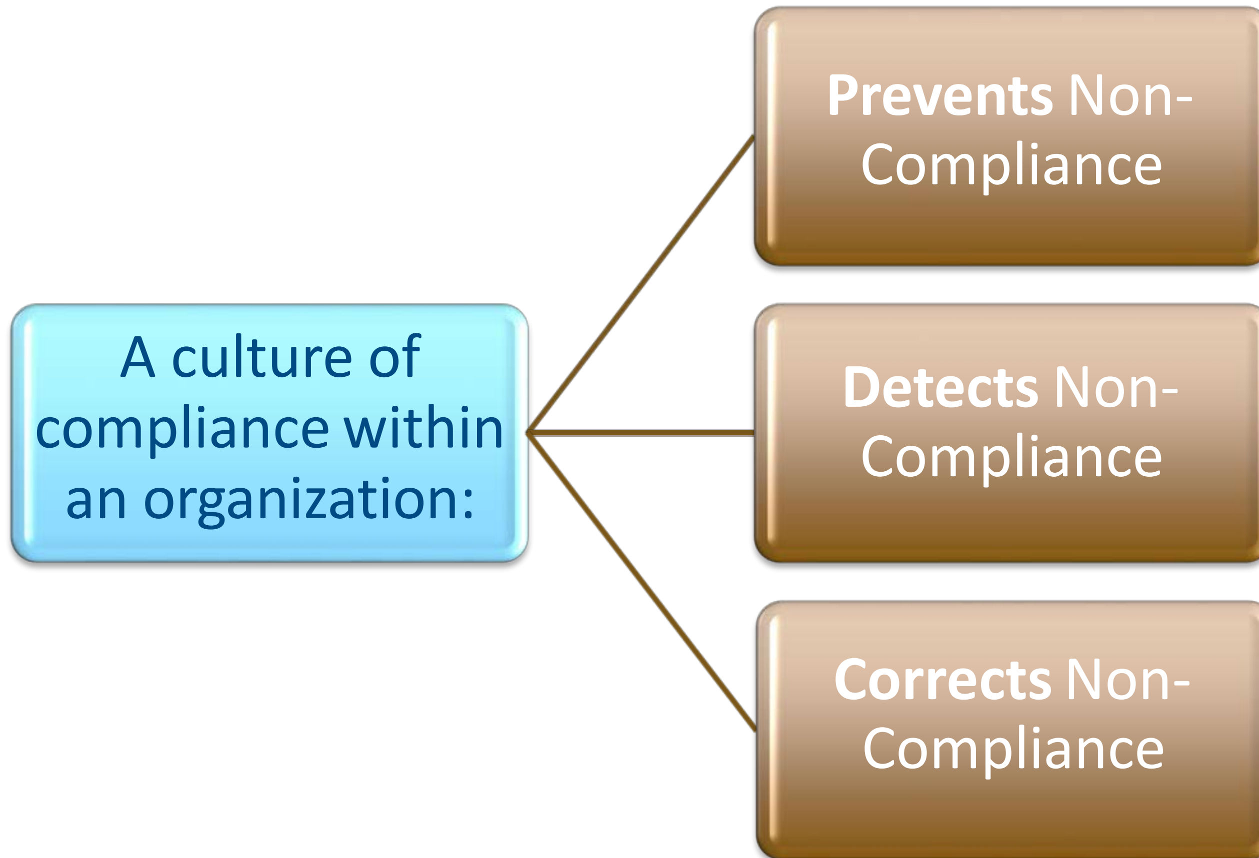

WHY IMPLEMENT A COMPLIANCE PROGRAM?

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CMS requires Blue Cross and Blue Plus to implement an effective compliance program

- An effective compliance program should:

Provide guidance on how to identify and report compliance violations

Provide guidance on how to handle compliance questions and concerns

Articulate and demonstrate an organization's commitment to legal and ethical conduct

COMPLIANCE PROGRAM REQUIREMENTS

- A compliance program is a series of internal controls and measures to ensure that Blue Cross and Blue Plus are following state and federal laws, including regulations that govern the program
- Many functions may be delegated to an FDR or provider, however, Blue Cross and Blue Plus cannot delegate compliance
- While an FDR or provider may perform compliance related activities as part of its contract with Blue Cross and/or Blue Plus, we maintain ultimate responsibility for the compliance program
- In this training, you will learn more about what Blue Cross and Blue Plus are doing to fulfill the compliance requirements and what your compliance obligations are as an FDR and provider

COMPLIANCE PROGRAM REQUIREMENTS (cont.)

At a minimum, a compliance program must include the following 7 elements, and must incorporate measures to detect, prevent and correct fraud, waste and abuse:

1. Written Policies, Procedures and Standards of Conduct
2. Compliance Officer, Compliance Committee and High-Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS

Element 1: Written Policies, Procedures and Standards of Conduct

- Blue Cross and Blue Plus have written P&Ps and standards of conduct to demonstrate how they comply with all applicable standards. They require their FDRs and providers to do the same
- P&Ps must reflect current requirements and must be revised whenever there are changes or updates to regulations, or at least annually, whichever comes first

  What you can do:

  - Ensure that you follow applicable P&Ps and standards of conduct
  - Ensure that your organization’s P&Ps are consistent with Blue Cross’ and Blue Plus's P&Ps, kept up to date, and used in day-to-day activities

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 2: Compliance Officer, Compliance Committee, and High-Level Oversight

- Blue Cross and Blue Plus have a designated compliance officer and board committees that oversee compliance with Medicare program and other requirements

What you can do:

- Your organization may also have a designated compliance officer and compliance committee

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 3: Effective Training and Education

- Training and education requirements must be applied to all Blue Cross and Blue Plus employees, and if required in your contract, to FDRs and providers who provide benefits or services for the MA, MA-PD, Cost, and PDP plans

What you can do:

- Ensure that you complete required compliance training and education in a timely manner, if required in your contract
- Keep record of trainings that occur

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 4: Effective Lines of Communication

- Blue Cross and Blue Plus have established lines of communication within all levels of our organizations and with our FDRs, including providers
- Blue Cross' and Blue Plus's systems include methods to receive, record and respond to compliance questions and reports of potential or actual non-compliance while maintaining confidentiality
- FDRs, including providers, are expected to report compliance concerns and/or FWA involving MA, MA-PD, Cost and PDP Plans to Blue Cross and/or Blue Plus

What you can do:

- Regularly review communications from your organization and Blue Cross and Blue Plus related to Medicare and Medicaid plans and ask questions
- Speak up. Report suspected or known non-compliance
- Having "effective lines of communication" means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns, such as in person, by email or anonymously

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 5: Well-Publicized Disciplinary Standards

- Blue Cross and Blue Plus have P&Ps that describe enforcement standards and disciplinary guidelines
- These standards apply to all FDRs, their staff and providers

- **What you can do:**
- Be familiar with disciplinary guidelines
- Abide by Blue Cross' and Blue Plus's or your organization's similar code of conduct and P&Ps, as well as state and federal laws

- **Disciplinary Guidelines:**

  Violations of the P&Ps or standards of conduct will result in disciplinary action, up to and including termination of an FDR contract

CONSEQUENCES OF NON-COMPLIANCE

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Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-compliant behavior should, as appropriate, be subject to any of the following:

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 6: Effective System for Routine Monitoring and Identification of Compliance Risks

- Blue Cross and Blue Plus have established audit and monitoring P&Ps
- The audit and monitoring activities are based on an established workplan. The workplan includes:
  - Oversight activities of internal operations, FDRs and providers
  - Identification of audits of operational areas, FDRs and providers based on a risk assessment or random selection
  - Depending on the scope of services provided, annual audits of some FDRs and providers
- Blue Cross and Blue Plus regularly review the following lists to ensure we do not employ or contract with excluded individuals or entities:
  - General Services Administration's (GSA) Excluded Parties List System (EPLS)
  - Office of the Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE)

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

Element 6: Effective System for Routine Monitoring and Identification of Compliance Risks (cont.)

What you can do:

- Conduct and report on your own internal monitoring
- Cooperate with auditing and monitoring activities
- Share your concerns with the compliance team

Your organization should regularly review the GSA and OIG exclusion lists to ensure that an excluded individual/entity does not perform services in support of services you provide to MA, MA-PD, PDP, or Cost plans.

SEVEN ELEMENTS OF COMPLIANCE PROGRAMS (cont.)

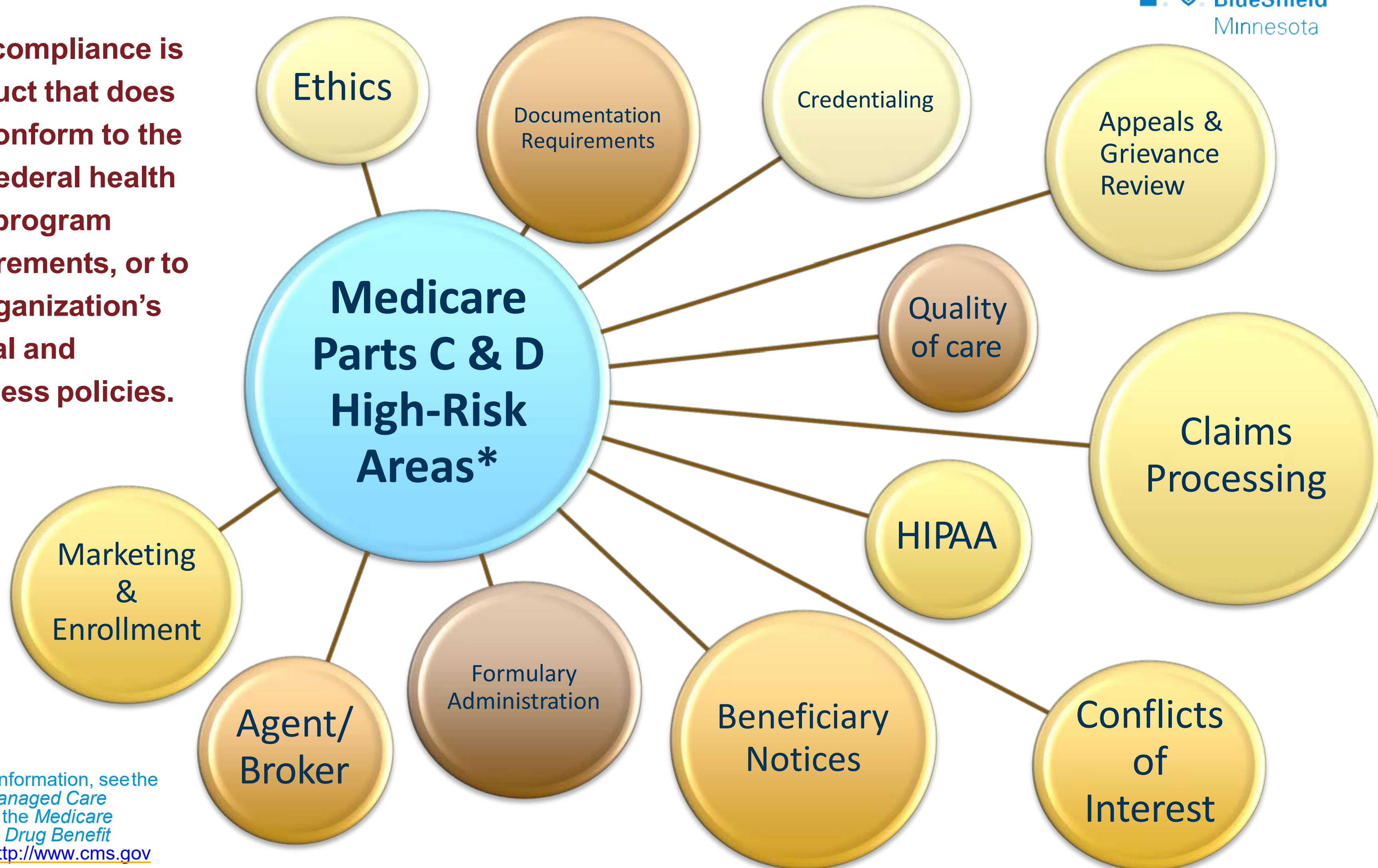
Element 7: Procedures and System for Prompt Response to Compliance Issues

- Blue Cross and Blue Plus conduct timely and reasonable inquiries into detected offenses
- Operational day-to-day processes support the identification and remediation of issues
- Escalation P&Ps define what will occur and who is notified when a compliance issue has been identified

- **What you can do:**
  - Report potential issues
  - Cooperate with investigations and corrective action plans

WHAT IS NON-COMPLIANCE?

Non-compliance is conduct that does not conform to the law, federal health care program requirements, or to an organization's ethical and business policies.



* For more information, see the *Medicare Managed Care Manual* and the *Medicare Prescription Drug Benefit Manual* at http://www.cms.gov

WHAT HAPPENS NEXT?

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After non-compliance has been detected, it must be investigated immediately and promptly corrected.

Correcting Non-Compliance:

- Avoids the recurrence of the same types of non-compliant behavior
- Promotes efficiency and effective internal controls
- Protects enrollees
- Ensures ongoing compliance with CMS requirements

HOW DO I KNOW NON-COMPLIANCE WON'T HAPPEN AGAIN?

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Once non-compliance is detected and corrected, an on-going evaluation process is critical to ensure the non-compliance does not reoccur.

- **Monitoring Activities:** regular reviews that confirm on-going compliance, ensuring corrective actions are fully implemented and effective
- **Auditing:** formal review of compliance within a set of standards (e.g. policies & procedures; laws & regulations) used as base measures

PENALTIES FOR COMPLIANCE VIOLATIONS

CMS and other federal agencies can impose civil, criminal and monetary penalties on Blue Cross and Blue Plus for compliance violations relating to applicable requirements or laws, including violations by an FDR or provider. CMS may also impose such penalties on FDRs and providers.

- Penalties may include:
  - Monetary penalties
  - Suspension of payment of services
  - Exclusion from participation in the Medicare program
- Payment sanctions remain in effect until CMS is satisfied the deficiency is corrected and not likely to recur
- To ensure compliance and avoid these penalties, Blue Cross and Blue Plus expect FDRs and providers to comply with applicable requirements

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PART 3:
EXAMPLES OF FWA AND NON-COMPLIANCE

INDICATORS OF POTENTIAL FWA AND NON-COMPLIANCE

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- Now that you know what FWA and non-compliance are, you need to be able to recognize the signs of someone committing FWA or non-compliance.
- The following slides provide areas to keep an eye on, depending on your role as an FDR, provider, or other individual/entity involved in the MA, MA-PD, Cost, and/or PDP Plans.

KEY INDICATORS

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POTENTIAL BENEFICIARY ISSUES

Ask yourself:

- Does the beneficiary's medical history support the services being requested?
- Is the service appropriate based on the beneficiary's other services?
- Is the person receiving the service the actual beneficiary (identity theft)?

KEY INDICATORS (cont.)

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POTENTIAL PROVIDER ISSUES

Ask yourself:

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's services/prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?
- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill Blue Cross and Blue Plus for services not provided, such as increased service time, level of service or level of practitioner performing service?

KEY INDICATORS (cont.)

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POTENTIAL DURABLE MEDICAL EQUIPMENT (DME) & SERVICE ISSUES

Ask yourself:

- Is the DME out of date, fake or illegal?
- Do you see prescriptions for DME or services being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled?
- Are generics provided when the prescription requires a specific brand be dispensed?
- Are claims being submitted for DME and services not utilized or picked up?
- Are DME or services being diverted (DME or services meant for nursing homes, hospice, etc.) being sent elsewhere?

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PART 4: HOW DO I REPORT FWA AND NON-COMPLIANCE?

REPORTING POTENTIAL FWA OR NON-COMPLIANCE

You do not need to determine if an issue is FWA or non-compliance before you report it.

I AM AFRAID TO REPORT FWA OR NON-COMPLIANCE

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There can be NO retaliation against you for reporting in good faith suspected FWA or non-compliance.

Blue Cross and Blue Plus must offer reporting methods that are:

REPORTING FWA OR NON-COMPLIANCE TO BLUE CROSS OR BLUE PLUS

Blue Cross and Blue Plus have comprehensive plans to detect, correct and prevent fraud, waste and abuse within our community. If you know of or suspect any type of insurance fraud, call the Fraud Hotline between 8 a.m. and 4:30 p.m., Monday through Friday. If you are calling after hours, please leave a voicemail message. Reporters may identify themselves or remain anonymous.

- **Hotline #:** 651-662-8363 or 1-800-382-2000, ext. 28363
- **TTY #:** 711
- **Online:** https://bcbsmnfraud.alertline.com/gcs/welcome
- **Email:** reportfraud@bluecrossmn.com
- **By Mail:**

  Blue Cross and Blue Shield of Minnesota Special Investigations Unit
  PO Box 64560
  St Paul, MN 55164-0560

REQUIREMENT TO REPORT FWA OR NON-COMPLIANCE

- Everyone is required to report actual or suspected Medicare program non-compliance or potential FWA. Blue Cross/Blue Plus and your organization must clearly state this obligation in their Codes of Conduct.
- Blue Cross and Blue Plus are committed to the compliance of our programs and strongly encourage reports to the contacts indicated on the previous slide.
  - We understand that there may be circumstances in which you are not comfortable reporting to these contacts. You may also make reports at the federal level.

REPORTING FWA OR NON-COMPLIANCE AT THE FEDERAL LEVEL

Office of the Inspector General Hotline:

- **Phone:** 1-800-HHS-TIPS (1-800-447-8477)
- **TTY:** 1-800-377-4950
- **Fax:** 1-800-223-8164
- **Online:** https://oig.hhs.gov/fraud/report-fraud/index.asp
- **Email:** HHSTips@oig.hhs.gov
- **Mail:** U.S. Department of Health and Human Services
Office of Inspector General
Attn: OIG Hotline Operations
P.O. Box 23489 Washington, DC 20026

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RESOURCES

DEFINITIONS

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Plan Sponsor- An entity that has a contract with CMS to offer one or more of the following Medicare Products:

- Medicare Advantage (MA) Plans
- Medicare Advantage Prescription Drug Plans (MA-PD)
- Prescription Drug Plans (PDP) and
- 1876 Cost Plans

First-Tier Entity- A party that enters a written arrangement, acceptable to CMS, with Blue Cross and Blue Plus to provide administrative services or health care services for a Medicare eligible individual under the Medicare Part C or Part D programs. Examples may include Pharmacy Benefits Manager (PBM), contracted hospitals, clinics and allied providers.

DEFINITIONS (cont.)

Downstream Entity- A party that enters a written arrangement, acceptable to CMS, with persons or entities involved in the Medicare Part C or Part D benefit, below the level of the arrangement between Blue Cross and Blue Plus and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include pharmacies, marketing firms, quality assurance companies, claims processing firms and billing agencies.

Related Entity- An entity that is related to Blue Cross and Blue Plus by common ownership or control and performs some of Blue Cross and Blue Plus's management functions under contract or delegation, furnishes services to Medicare enrollees under an oral or written agreement, or leases real property or sells materials to Blue Cross and Blue Plus at a cost of more than $2,500 during a contract period.

MEDICARE RESOURCES

- Medicare Managed Care Manual
- Medicare Prescription Drug Benefit Manual
- 42 C.F.R. 422 (Medicare Advantage)
- 42 C.F.R. 417 (1876 Cost)
- 42 C.F.R. 423 (Part D)
- www.cms.gov

GOVERNMENT RESOURCES

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- National Benefit Integrity MEDIC: http://www.healthintegrity.org/contracts/medic/index.html
- The Patient Protection and Affordable Care Act: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
- Compliance Guidance for Medicare + Choice Organizations: http://oig.hhs.gov/fraud/docs/complianceguidance/111599.pdf
- Office of the Inspector General, Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

GOVERNMENT RESOURCES (cont.)

- Fraud Alerts, Bulletins and Other Guidance from the OIG: http://oig.hhs.gov/compliance/alerts/index.asp
- False Claims Act: http://www.justice.gov/jmd/ls/legislative_histories/pl99-562/pl99- 562.html
- Health Insurance Portability and Accountability Act (HIPAA): http://aspe.hhs.gov/admnsimp/pl104191.htm
- Anti-Kickback Statute (see section 1128B(b)): http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f
- Stark Law (Physician Self-Referral): https://www.cms.gov/PhysicianSelfReferral/
- Department of Health and Human Services Office of Inspector General (OIG): www.oig.hhs.gov/fraud

ADDITIONAL RESOURCES

LAWS GOVERNING MEDICARE

- Title XVIII of the Social Security Act
- Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
- Civil False Claims Act (31 U.S.C. §§ 3729-3733)
- Criminal Fraud/False Claims laws (18 U.S.C. §§ 287,1001)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b)
- Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
- Sanctions for contracting with or employing excluded individuals/entities (42 U.S.C. 1395w-27(g)(1)(G))
- HIPAA and HITECH (45 C.F.R Part 160 and Part 164, subparts A, E and C; 45 CFR Part 164, subpart D)

ADDITIONAL RESOURCES (cont.)

- Health Care Administrators Association (HCAA): http://www.hcaa.org/
- Heath Care Compliance Association (HCCA): http://www.hcca-info.org
- Society of Corporate Compliance and Ethics (SCCE): http://www.corporatecompliance.org
- American Health Lawyers Association (AHLA): http://www.healthlawyers.org
- National Health Care Anti-Fraud Association (NHCAA): http://www.nhcaa.org
- Institute for Health Care Improvement (IHI): http://ihi.org
- Corporate Responsibility and Health Care Quality – A Resource for Health Care Boards of Directors, U.S. Dept. of Health and Human Services Office of the Inspector General, and The American Health Lawyers Association: http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf
- Link to OIG Exclusions Database: http://exclusions.oig.hhs.gov/