First Tier, Downstream, or Related Entity (FDR) and Affiliate Compliance Guide
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FDR and Affiliate Compliance Guide Purpose

This FDR and Affiliate Compliance Guide is a resource designed to assist our FDRs and Affiliates with understanding and complying with VA Premier CompleteCare’s Compliance Program and requirements. This Guide will help you with the following:

- Demonstrate VA Premier CompleteCare’s commitment to responsible corporate conduct;
- Set forth the FDRs and Affiliates compliance requirements;
- Publicize mechanisms for reporting fraud, waste, abuse and compliance issues;
- Communicate information about the VA Premier CompleteCare’s Vendor Code of Conduct and the compliance policies in place to detect, prevent, correct, and monitor fraud, waste, abuse and inefficiencies;
- Define and provide examples of fraud, waste and abuse; and
- Provide information about relevant laws and regulations.

VA Premier CompleteCare Compliance Plan

VA Premier CompleteCare and its related programs are dedicated to conducting all facets of its operations in compliance with all applicable Federal and State laws, regulations, policies and procedures. VA Premier CompleteCare is committed to the reduction of fraud, waste and abuse and takes a zero-tolerance approach for every aspect of our business.

The Corporate Compliance and Program Integrity Plan has been formulated based on the elements of a model compliance program, as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG), including a comprehensive strategy to prevent, detect, and ameliorate fraud, waste and abuse (FWA) in the Medicaid, Medicare and Part D programs. The plan outlines VA Premier CompleteCare’s strong and explicit organizational commitment to conducting business ethically, with integrity and in compliance with applicable laws, regulations and requirements. VA Premier CompleteCare requires its healthcare providers and business partners to uphold a similar commitment to ethical conduct and assure that they, their employees, and downstream entities comply with the guiding principles outlined in this plan.

What is an FDR or Affiliate?

As defined in Chapters 9 and 21 of the Compliance Program Guidelines published by CMS, an FDR is a First Tier, Downstream or Related entity.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative
services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

**Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

**Related Entity:** Any entity that is related to a Medicare Advantage Organization or Part D plan sponsor by common ownership or control and:

1) Performs some of the Medicare Advantage Organization or Part D plan sponsor’s management functions under contract or delegation;
2) Furnishes services to Medicare enrollees under an oral or written agreement; or
3) Leases real property or sells materials to the Medicare Advantage Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period.

**Affiliate:** A person, provider or entity who provides care, services or supplies under the Medicaid program, or a person who submits claims for care, services or supplies for, or on behalf of, another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

**FDR & Affiliate Compliance Requirements**

As an integral part of VA Premier CompleteCare, the Compliance department guides and ensures the organization’s commitment to ethical business practices, adherence to applicable Federal and State laws and regulations, and the Code of Conduct. Additionally, the Compliance department is responsible for ensuring that all FDRs and Affiliates are in compliance with applicable Federal and State laws and regulations.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with this policy and all applicable Federal and State laws and regulations.

FDRs and Affiliates must maintain supporting documentation of compliance with the following requirements for a period of ten (10) years and must furnish evidence to VA Premier CompleteCare upon request for monitoring and auditing purposes.

I. **Annual FDR and Affiliate Compliance Attestation**

An authorized representative from each FDR and Affiliate is required to complete the VA Premier CompleteCare FDR and Affiliate Compliance Attestation (on behalf of his or her organization) upon contract and on an annual basis to attest to comply with the Vendor Code of Conduct, standards of conduct, compliance policies, fraud waste and abuse training, OIG and
GSA exclusion screening, and publication of FWA and compliance reporting mechanisms requirements.

An authorized representative is an individual who has responsibility, directly or indirectly, for all employees, contracted personnel, providers/practitioners, and vendors who provide healthcare or administrative services under Medicaid and/or Medicare. Authorized representatives may include, but are not limited to, a Compliance Officer, Chief Medical Officer, Practice Manager/Administrator, Executive Officer, Owner or equivalent authoritative representative.

VA Premier CompleteCare will send a notification to each FDR and Affiliate to communicate the deadline for completion of the annual Attestation. All FDRs and Affiliates must complete Attestations within the designated timeframe.

II. Standards of Conduct and Compliance Information

VA Premier CompleteCare requires each FDR and Affiliate to establish and sustain a culture of compliance. VA Premier CompleteCare FDRs and Affiliates must either (1) establish and publicize comparable Standards of Conduct that meet CMS requirements set forth in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) and reflect a commitment to preventing, detecting, and correcting noncompliance or (2) adopt and distribute to all employees and contractors VA Premier CompleteCare’s Standards of Conduct which can be found in this Guide.

In addition to the Standards of Conduct, each FDR and Affiliate must distribute compliance information to all of its employees and contractors upon hire/contract and annually thereafter. VA Premier CompleteCare provides compliance information in this Guide that can be utilized. If an FDR or Affiliate opts to use different material, it must include, at minimum, a description of the Compliance Program, instructions on how to report suspected noncompliance, the requirement to report potential noncompliance and FWA, disciplinary guidelines for noncompliant behavior, a non-retaliation provision, a FWA training requirement, and an overview of relevant laws and regulations (such as the Deficit Reduction Act of 2005, False Claims Act, and HIPAA).

FDRs and Affiliates must maintain records (i.e., attestations, logs, sign-in sheets, etc.) to document that each employee and contractor has received, read, understood, and will comply with the written standards of conduct and compliance policies upon hire/contract and annually thereafter.

III. Fraud, Waste and Abuse and General Compliance Training

VA Premier CompleteCare has adopted important training documentation published by CMS. The training file includes two training portions: Medicare Part C and D Fraud, Waste and Abuse Training and General Compliance Training.

VA Premier CompleteCare highly recommends FDRs use this training file to simplify their training process. FDRs and Affiliates are required to complete both the FWA training and General Compliance training within 90 days of contract/hire and annually thereafter. The training
requirement extends to all employees and contractors. Each FDR and Affiliate will be required to attest that all employees and contractors have satisfied the FWA and General Compliance training.

Additionally, each FDR and Affiliate is responsible for maintaining evidence of FWA and General Compliance training, which may include training logs, attestations and training programs.

**Accessing the CMS Training File**

2) Scroll to the “Downloads” section,
3) Click on “Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training,”
4) Select “Open” or “Save”; the training is available in both PDF and PowerPoint formats.

*Note*: The PowerPoint training file includes both Medicare Parts C and D FWA Training and Medicare Parts C and D General Compliance Training.

**IV. OIG and GSA Exclusion Screening**

Federal law prohibits the payment by Medicare, Medicaid or any other federal healthcare program for any item or service furnished by a person or entity excluded from participation in these federal programs. Therefore, prior to hire and/or contract and monthly thereafter, each FDR and Affiliate must perform a check to confirm that employees and contractors are not excluded from participation in Federally-funded healthcare programs according to the OIG and GSA exclusion lists.

The following websites should be utilized to perform the required screening.

- General Services Administration (GSA) database of excluded individuals/entities: [https://www.sam.gov/portal/public/SAM/#1](https://www.sam.gov/portal/public/SAM/#1)

If an employee or contractor is on an exclusion list he or she must be removed from any work related directly or indirectly to federal healthcare programs and appropriate corrective action must be taken.

FDRs and Affiliates must maintain evidence of exclusionary checks (i.e., logs or other records) to document that each employee and contractor has been screened in accordance with current regulations and requirements.

**V. Reporting All Suspected Fraud, Waste, Abuse and Compliance Issues**

VA Premier CompleteCare FDRs and Affiliates have a responsibility to report any suspected or alleged compliance issues, fraud, waste and abuse, and/or conflict of interest issues that
involves VA Premier CompleteCare. If you suspect fraud, waste, or abuse in the healthcare system, you must report it to VA Premier CompleteCare immediately. Your actions may help to improve the healthcare system and reduce costs for our members, customers, and business partners. FDRs and Affiliates may confidentially report a potential violation of our compliance policies or any applicable regulation by utilizing the reporting functions detailed below.

VA Premier CompleteCare Reporting

Hotline: 1-800-620-1438
Fax: 804-819-5187

Electronically: https://www.compliancehelpline.com/welcomePageVCUHS.jsp

Mail: CONFIDENTIAL, Compliance Officer, 600 E. Broad Street, Suite 400, Richmond, VA 23219

Medicare Reporting

Office of Inspector General (OIG): 1-800-HHS-TIPS (1-800-447-8477), TTY 1-800-377-4950

Centers for Medicare and Medicaid (CMS) Phone: 1-800-Medicare (1-800-633-4227), TTY 1-877-486-2048

CMS Mail: Attention: Medicare, Beneficiary Contact Center, P.O. Box 39, Lawrence KS, 66044

For additional information on how to detect and report Medicare fraud, you may access this link at www.stopmedicarefraud.gov.

You may remain anonymous, if you prefer. All information received or discovered by the Compliance Department will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, or VA Premier’s senior management).

Virginia Medicaid Reporting

Fraud Hotline: 1-800-371-0824

VA Fraud Hotline: 804-371-0779

Email: MFCU_mail@oag.state.va.us

Reporting Mechanism

VA Premier CompleteCare requires each FDR and Affiliate to publicize confidential reporting mechanisms for all employees and contractors. If an FDR and Affiliate does not maintain a confidential reporting mechanism, the VA Premier CompleteCare Confidential Hotline and website information must be distributed to encourage reporting of suspected compliance issues,
fraud, waste, abuse, conflict of interests, violations of compliance policies and/or any applicable regulation.

**VA Premier CompleteCare Vendor Code of Conduct**

VA Premier CompleteCare is committed to an environment of uncompromising integrity and ethical conduct. Our ethical standards are the foundation for our decisions and actions. Operating under consistently high standards of conduct is critical to VA Premier CompleteCare’s success, and all individuals, companies or others, working for, or on behalf of, VA Premier CompleteCare, directly or indirectly, are expected to conduct themselves accordingly. This includes VA Premier CompleteCare’s suppliers, vendors, health care providers, pharmacies, and First Tier, Downstream and Related Entities and Affiliates (collectively, Vendors) and their employees, agents, contractors, consultants, temporary workers, volunteers and employees of subcontractors (Workforce Members). Vendors are responsible for ensuring that their Workforce Members comply with the standards of conduct as described in this Vendor Code of Conduct. VA Premier CompleteCare will request information, as necessary, from the Vendor to ensure compliance.

**Compliance with the Laws**

VA Premier CompleteCare is committed to complying with all applicable laws, regulations and standards, both on the state and federal level, including the Affordable Care Act, HIPAA Privacy and Security Rules, and Medicare and Medicaid program requirements. Vendors are expected to conduct their business in the same manner while performing services for, or representing, VA Premier CompleteCare. Appropriate steps must be taken to effectively communicate regulatory requirements to Workforce Members, including providing, and requiring participating in, appropriate training necessary to meet regulatory and contractual requirements, particularly with respect to our members’ information. Examples of key legal, regulatory and other requirements are described in this FDR and Affiliate Compliance Guide.

**Code of Ethics**

VA Premier CompleteCare is committed to an environment of uncompromising integrity and ethical conduct. Our ethical standards are the foundation for our decisions and actions. VA Premier CompleteCare and associated Vendor actions will be guided by these principles and values:

*Respect*: Respect individuals, diversity and rights of others.

*Honesty*: Act and communicate honestly and candidly.

*Excellence*: Strive for excellence in all that we do.

*Responsibility* and *Accountability*: Be responsible and accountable for our decisions and actions.

*Stewardship*: Be good stewards of the resources entrusted to Virginia Premier.
Compliance: Understand and comply with the codes, laws, regulations, policies and procedures that govern our activities.

Standards of Conduct

1) Treat members, with respect and dignity.
2) Deal openly and honestly with fellow employees, members, providers, representatives, agents, government entities, and others.
3) Adhere to federal and state laws and regulations, and VA Premier CompleteCare policies and procedures in all business and personal dealings whether at work or outside work.
4) Exercise discretion in the processing of claims regardless of provider, practitioner, and vendor source.
5) Use supplies and services in an efficient manner to reduce cost to the health plan.
6) Misuse of VA Premier CompleteCare resources or influence in such a way as to discredit the reputation of VA Premier CompleteCare is prohibited.
7) Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste and abuse.
8) Adhere to both the spirit and letter of applicable federal, state and local laws and regulations.
9) Practice good faith in transactions occurring during the course of business.
10) Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings.
11) Preserve patient confidentiality unless there is written permission to divulge information, except as required by law.
12) Refuse any illegal offers, solicitations, payment or other remuneration to induce referrals of the members we serve for an item of service reimbursable by a third party.
13) Disclose financial interests/affiliations with outside entities to Virginia Premier as required by the Conflict of Interest Policy.
14) Hold all contracted parties to the same Standards of Conduct as part of their dealings with VA Premier CompleteCare.
15) Notify the Corporate Compliance Officer of any instances of noncompliance immediately and cooperate with all investigation efforts by Virginia Premier and other state and federal agencies.

Reporting Violations

A Vendor is responsible for reporting any incidents they know, or reasonably suspect, are in violation with the Vendor Code of Conduct, Standards of Conduct, any law, regulation or standard, in connection with work performed for VA Premier CompleteCare. Failure to report a known violation may result in action up to, and including, termination of a contract and relationship with VA Premier CompleteCare.
Anonymous reports may be made through the Compliance Helpline at 1800-620-1438 or online at [https://www.compliancehelpline.com/welcomePageVCUHS.jsp](https://www.compliancehelpline.com/welcomePageVCUHS.jsp). Reported violations will remain completely confidential.

**Violations of the Vendor Code of Conduct**

Our Code represents our commitment to "doing the right thing." Each Vendor is expected to know and abide by the Vendor Code of Conduct and the associated policies and procedures, including the Standards of Conduct, in all their dealings with members, fellow vendors, providers and Workforce Members. Vendor violations of the Vendor Code of Conduct, Standards or Conduct, or any state or federal laws or regulations may result in action up to, and including, termination of a contract and relationship with VA Premier CompleteCare.

**Non-Retaliation Policy**

VA Premier CompleteCare does not permit retaliation against any Vendor who reports a violation, or potential compliance violation, in good faith. Retaliation is also not permitting in the event a Vendor provides information to, or cooperates with, law enforcement or other regulatory agency in the context of an investigation, or if the Vendor participates in, or conducts, self-evaluations, audits or remedial actions. However, self-reporting any violations to VA Premier CompleteCare does not exempt a Vendor from resulting ramifications of non-compliant activity.

**VA Premier CompleteCare Commitment to Compliance**

VA Premier CompleteCare has systems, policies, and procedures in place to detect, correct, prevent, and monitor suspected and actual issues of noncompliance.

**Monitoring and Auditing**

VA Premier CompleteCare routinely monitors and periodically audits first tier entities to ensure compliant administration of the Medicare and Medicaid contracts as well as applicable laws and regulations. All FDRs and Affiliates will be audited annually, at a minimum. Each first tier entity is required to cooperate and participate in the monitoring and auditing activities. If a first tier entity performs its own audits, VA Premier CompleteCare may request the audit results affecting VA Premier CompleteCare business. In addition, first tier entities are expected to routinely monitor and periodically audit their downstream entities.

If VA Premier CompleteCare determines that an FDR or Affiliate is not in compliance with any of the requirements set forth in this policy, the FDR or Affiliate will be required to develop and submit a Corrective Action Plan (CAP). VA Premier CompleteCare will assist the FDR or Affiliate in addressing the issues identified. All monitoring and auditing activities must be documented and retained for a ten (10) year period. VA Premier CompleteCare may require evidence of monitoring and auditing for future oversight and/or auditing purposes.
VA Premier CompleteCare Investigations

It is VA Premier CompleteCare’s policy to thoroughly and objectively investigate any specific allegation of misconduct, fraud or abuse involving VA Premier CompleteCare employees, accounts or operations. VA Premier CompleteCare holds individuals responsible for violations of VA Premier CompleteCare’s policies, breaches of ethical behavior or illegal acts committed against VA Premier CompleteCare, on VA Premier CompleteCare’s behalf, on VA Premier CompleteCare premises, or during hours of, or within the scope of VA Premier CompleteCare business operations ("Misconduct"). The source of any allegation of wrongdoing, whether the VA Premier CompleteCare hotline, an email, telephone or in person report, or any other source, is irrelevant to VA Premier CompleteCare’s obligation to investigate. VA Premier CompleteCare will conduct all investigations in a manner that protects the rights of those who may be the subject of allegations of wrongdoing as well as those who, in good faith, make such allegations. VA Premier CompleteCare requires the cooperation of FDRs and Affiliates during any investigations that may involve, directly or indirectly, their organization or individuals associated with their organization. The investigation will be initiated by a representative of VA Premier CompleteCare and continue until the investigation is completed. Coordination of investigations which involve any regulatory agency will be handled in accordance with their requests.

VA Premier CompleteCare is required to refer potential fraud or misconduct related to the Medicare program to the HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC) for fraud and misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to the any Virginia state-funded programs are reported to the Attorney General’s Office.

Non-Retaliation

VA Premier CompleteCare is committed to a culture that promotes the prevention, detection, investigation and remediation of violations of the VA Premier CompleteCare Compliance Program, as well as all applicable laws. To support this culture, VA Premier CompleteCare has established a strict non-retaliation policy to protect employees, FDRs and Affiliates who, in good faith, report known or suspected Misconduct, Fraud, Waste and/or Abuse. Each FDR and Affiliate must adopt a policy of non-retaliation and publicize the policy to all employees and contractors.

Fraud, Waste and Abuse

**Fraud**: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

**Waste**: The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.
**Abuse**: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It includes enrollee practices that result in unnecessary cost.

**Common Methods of Fraud, Waste, and Abuse**

**Fabrication of Claims**: In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed.

**Falsification of Claims**: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled.

**Unbundling**: Provider submits a claim reporting comprehensive procedure code (e.g. Resection of small intestine) along with multiple incidental procedure codes (e.g. Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

**Fragmentation**: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

**Duplicate Claim Submissions**: Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

**Fictitious Providers**: There has been fraud where perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

**Indicators of Fraud**

There are many indicators of fraud, which, if noticed by VA Premier CompleteCare Vendors or Workforce Members, should be brought to the attention of the Compliance department. A list of the most common indicators is included below:

1) Addition of services to bill
2) Claims for more than one pharmacy for the same member in a short period of time
3) Claims for non-emergency services on weekends and holidays
4) Claims that have been handwritten or changes made by hand
5) Diagnosis inconsistent with age or sex
6) Eligibility file date of birth does not match date of birth on claim (indication ID card has been shared)
7) Impossible or unlikely services for age or sex
8) Inconsistency between provider type and/or specialty and services rendered
9) Inconsistency between services billed and medical history
10) Indication that coinsurance has been waived (illegal)
11) Large distance between providers and member location
12) Provider advertisement for free services, drugs, supplies or durable medical equipment
13) Providers demanding immediate payment for claims
14) Providers with more than a few lost or stolen checks
15) Reluctance or failure to submit medical records when requested
16) Submission of identical claims for more than one member or family member

**Relevant Laws and Regulations**

**Deficit Reduction Act**

As a participant in the Medicaid Program, we must comply with the terms of the Deficit Reduction Act of 2005 (the “DRA”). The DRA, specifically Section 6033, entitled “Employee Education About False Claim Recovery,” which was effective January 1, 2007, requires any organization that receives $5 million or more in Federal Medicaid funds annually, including payments from managed care companies such as VA Premier CompleteCare, to adopt a compliance program in accordance with Federal law and to inform its employees and any contractor or agent of the terms of the False Claims Act. Any organization that does not comply with the requirements may be denied Medicaid reimbursement. You should carefully consult with your attorney to determine if you are subject to this requirement.

**False Claims Act**

The False Claims Act is a Federal law that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (but the act does not cover tax fraud).

In addition to the Federal False Claims Act, Virginia has enacted similar laws. In Virginia, false claims investigations are the responsibility of the Attorney General’s Office.

Both federal and state False Claims Acts (FCA) apply when a company or person:

1) Knowingly presents, or causes to be presented, to the Federal Government a false or fraudulent claim for payment;
2) Knowingly uses, or causes to be used, a false record or statement to get a claim paid by the Federal Government;
3) Conspires with others to get a false or fraudulent claim paid by the Federal Government;
4) Knowingly uses, or causes to be used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government.
Penalties for Violation of the False Claims Act (Federal and Civil)

Those who defraud the government can end up paying triple (or more than) the damage done to the government or a fine (between $5,500 and $11,000) for every false claim, in addition to the claimant’s costs and attorneys’ fees. These monetary fines are in addition to potential incarceration, revocation of licenses, and/or becoming an “excluded” individual, which prevents an individual from being employed in any job that receives monies from the Federal Government, the State Government, or both. Federal FCA matters may be brought only in Federal court.

Whistleblower Protections under False Claims Act (Federal and Civil)

The False Claims Act allows everyday people to bring suits against organizations or individuals who are defrauding the government (but the act does not cover tax fraud). These individuals are commonly known as “Whistleblowers.” If the government moves forward with a case, the individual who brings the suit is generally entitled to receive a percentage of any recovered funds once a decision has been made. If the government decides not to pursue it, then the individual must pursue the issue on his or her own and, if successful, then he or she would be entitled to a percentage of any recovered funds as well.

Federal statutes and related State and Federal laws shield employees from retaliation for reporting illegal acts of employers. An employer cannot retaliate in any way, such as discharging, demoting, suspending or harassing the whistleblower. If an employer does retaliate, the employee may be entitled to file a charge with a government agency, sue the employer, or both.

Stark Law

The Stark Law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician, or a member of the physician’s immediate family, has a financial relationship – unless an exception applies. It also prohibits an entity from presenting, or causing to be presented, a bill or claim to anyone for a health service furnished as a result of a prohibited referral. Violations of the Stark Law and the practice of Physician self-referral are to be reported to the Centers for Medicare and Medicaid Services via their self-disclosure process.
Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other Federal or State funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital, and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any goods or services from any healthcare facilities, programs, or providers.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Privacy

The HIPAA Privacy rule requires providers to take reasonable steps to protect and safeguard the Protected Health Information (“PHI”) of members/patients. A member’s PHI is subject to the protections established by the Privacy Rule and under the contractual relationship between VA Premier CompleteCare and the member, and between VA Premier CompleteCare and the provider or FDR. PHI includes information regarding enrollment with VA Premier CompleteCare, medical records, claims submitted for payment, etc. Such PHI must be safeguarded and held in strict confidence, so as to comply with applicable privacy provisions of State and Federal laws, including the Health Insurance Portability and Accountability Act (HIPAA). Ways in which a provider can protect member/patient PHI include ensuring that only authorized provider office employees have access to member/patient charts; including limited information on member/patient sign-in sheets; and restricting nonemployees from being in areas of the office that contain member/patient records.

HIPAA Security

The HIPAA Security Rule requires covered entities to adopt national standards for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information (e-PHI) that is collected, maintained, used or transmitted by a covered entity. As a covered entity, you must ensure that you have the appropriate administrative, technical, and physical safeguards in place to protect the data that is being electronically accessed by our workforce. You must (A) ensure the integrity and confidentiality of the information, (B) protect against any reasonably anticipated (i) threats or hazards to the security or integrity of the information and (ii) unauthorized uses or disclosures of the information. This can be accomplished by establishing appropriate policies and procedures that outline your compliance with the Rule and your expectations of your workforce in complying with the Rule. Compliance with the Security Rule is not a one-time goal, but instead an ongoing process that requires periodic risk analyses and audits of covered entities’ employees’ devices to confirm their compliance with your established policies.

A member’s PHI must be safeguarded and only those employees of the covered entity who have a business need to access the information should be permitted to do so. Access to member PHI should be role-based. This means that access should only be granted to a covered entity’s employees based on their job duties and responsibilities within the organization.
Additional References

VA Premier CompleteCare: https://www.vapremier.com/providers/completecare/

OIG Exclusion Database and Information: https://oig.hhs.gov/exclusions/index.asp

U.S. Dept. of Health & Human Services: www.hhs.gov

Centers for Medicare & Medicaid Services http://cms.gov/