



Fraud Waste & Abuse Policies

Federal & New York statutes relating to filing false claims

I. FEDERAL LAWS

- 1) Federal False Claims Act (31 USC §§3729-3733)

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

- 1) New York False Claims Act (State Finance Law §§187-194)
- 2) Social Services Law, Section 145-b - False Statements
- 3) Social Services Law, Section 145-c - Sanctions

B. CRIMINAL LAWS

- 1) Social Services Law, Section 145 - Penalties
- 2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
- 3) Social Services Law, Section 145-c - Sanctions
- 4) Penal Law Article 175 - False Written Statements
- 5) Penal Law Article 176 - Insurance Fraud
- 6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

- 1) Federal False Claims Act (31 U.S.C. §3730(h))
- 2) New York State False Claim Act (State Finance Law §191)
- 3) New York State Labor Law, Section 740
- 4) New York State Labor Law, Section 741

IV. FEDERAL LAWS

- 1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:

§ 3729. False claims

- A) Liability for certain acts.--
- 2) In general.--Subject to paragraph (2), any person who—
- C) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

- D) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- E) Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
- F) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered less than all of that money or property;
- G) Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- H) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
- I) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C.2461) note; Public Law 104-410, plus 3 times The amount of damages which the Government sustains because of the act of that person.

1. Reduced damages. If the court finds that:

- 1. The person committing the violation of this subsection furnished
 - 2.
 - A) Such person fully cooperated with any Government investigation of such violation; and
 - B) At the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times
 - C) the amount of damages which the Government sustains because of the act of That person.
- (I) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.
 - (a) Definitions.--For purposes of this section--
 - (I) the terms "knowing" and "knowingly" --
 - (A) mean that a person, with respect to information--

- (i) has actual knowledge of the information;
 - (ii) acts in deliberate ignorance of the truth or falsity of the information; or
 - (iii) acts in reckless disregard of the truth or falsity of the information; and
 - (B) require no proof of specific intent to defraud;
- (2) the term "claim"--
- (C) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--
 - (iv) is presented to an officer, employee, or agent of the United States; or
 - (v) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-
- (I) provides or has provided any portion of the money or property requested or demanded; or
 - (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
- (D) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;
- {3} the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and
- (4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.
 - (5) Exemption from disclosure.--Any information furnished pursuant to subsection (a) (2) shall be exempt from disclosure under section 552 of title 5.

- (6) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)

- (2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

1) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801-3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving

the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

V. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§187-194)

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more

serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

Social Services Law, Section 145-c - Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.

a. Any person who obtains or attempts to obtain, for himself or others, medical

assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3) Penal Law Article 155 - Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This statute has been applied to Medicaid fraud cases.

1. Fourth degree grand larceny involves property valued over \$1,000. It is a class E felony.

1. Third degree grand larceny involves property valued over \$3,000. It is a class D felony.

2. Second degree grand larceny involves property valued over \$50,000. It is a class C felony.
3. First degree grand larceny involves property valued over \$1 million. It is a class B 4.

4) Penal Law Article 175 - False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

2. §175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor.

1. §1 75.10 - Falsifying business records in the first degree includes the elements of the

§1 75.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.

- c. §175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.

- d. §1 75.35 - Offering a false instrument for filing in the first degree includes the

elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes

3. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.

4. Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000. It is a class E felony.

1. Insurance fraud in the 3rd degree is filing a false insurance claim for over \$3,000. It is a class D felony.

- d. Insurance fraud in the 2nd degree is filing a false insurance claim for over \$50,000. It is a class C felony.

- e. Insurance fraud in the 1st degree is filing a false insurance claim for over \$1 million. It is a class B felony.

- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

5. Health care fraud in the 5th degree - a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.

1. Health care fraud in the 4th degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

1. Health care fraud in the 3rd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.

1. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.

1. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

VI. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. §3730(h))

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA, 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

2) New York State False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

4) New York State Labor Law, Section 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

UNITED STATES CODE TITLE 42

Section 1396a (a) (68)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must-

{68} provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall-

1. establish written policies for all employees of the entity (including management),

and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b(f) of this title);

1. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

1. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

New York Social Services Law

363-d. Provider compliance program.

1. The legislature finds that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. The legislature accordingly declares that it is in the public interest that providers within the medical assistance program implement compliance programs. The legislature also recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics. At the same time, however, the legislature

determines that there are key components that must be included in every compliance program and such components should be required if a provider is to be a medical assistance program participant. Accordingly, the provisions of this section require providers to adopt effective compliance program elements, and make each provider responsible for implementing such a program appropriate to its characteristics.

2. Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program. The office of Medicaid inspector general shall create and make available on its website guidelines, which may include a model compliance program, that reflect the requirements of this section. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required pursuant to this section may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements:
 - (a) Written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;
 - (b) Designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program;
 - (c) Training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;
 - (d) Communication lines to the responsible compliance position, as described in paragraph (b) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;
 - (e) Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:
 - (1) failing to report suspected problems;

- (2) participating in non-compliant behavior; or
 - (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;
 - (f) A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self- evaluations and audits;
 - (g) A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;
 - (h) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.
3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section.
- (a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section, so long as such plans adequately address medical assistance program risk areas and compliance issues.
 - (b) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.
4. The Medicaid inspector general, in consultation with the department of health, shall promulgate regulations establishing those providers that shall be subject to the provisions of this section including, but not limited to, those subject to the provisions of articles twenty-eight and thirty-six of the public health law articles sixteen and thirty-one of the mental hygiene law, and other providers of care, services and supplies under the medical assistance program for which the medical assistance program is a substantial portion of their business operations.



Tel: 716.557.1100 Fax: 716.557.1200
www.committedhc.com
info@committedhc.com
222 Route 59, Suite 302
Suffern, NY 10901