



To: All Americare Employees, Contractors and Vendors

From: Miri Bank, Director of Compliance

Date: July 22, 2016

Re: Compliance Program and Federal Deficit Reduction Act

Americare, CSS is committed to its role in preventing health care fraud, waste and abuse and complying with all applicable State and Federal Laws related to health care fraud and abuse. In support of this commitment, Americare, CSS has established a Compliance Program.

The purpose of the Compliance Program is to establish appropriate controls that will help ensure consistent compliance with the federal and State laws which govern our activities, and to detect violations of the law by employees and others affiliated with Americare, CSS.

Elements of Americare's Compliance Program include:

- A Compliance Officer who is responsible for the day-to-day operations of the Compliance Program.
- Written standards of conduct, policies and procedures that describe compliance expectations and promote Americare's commitment to compliance for all employees, contractors, vendors and members of the Medical Staff.
- A Compliance Committee that operates and monitors the Compliance Program and initiates the necessary actions to correct any compliance problems.
- Regular, effective education and training programs for all employees
- Procedures to encourage employees to bring to the Compliance Committee's attention any situation that may be a violation of law or the Compliance Program without fear of threats, retaliation or punishment.
- A system that allows for confidential and anonymous reporting of compliance issues or concerns.
- A system to respond to allegations of improper or illegal activities and the enforcement of appropriate disciplinary action against employees who have violated the Compliance policies.
- Compliance audits and/or other evaluation techniques to monitor compliance and assist in the reduction of potential problem areas.

The program provides that if an employee discovers an event that may be a violation of the False Claims Act or any other Medicare or Medicaid law, the employee is required to communicate with the Agency's Compliance Officer so that the matter can be investigated. The Agency will not retaliate against any employee for informing the Agency or an applicable government authority of a possible violation of these laws. An employee with any questions concerning the application of these laws should communicate with the Compliance Officer or the individual's immediate supervisor.

A goal of the Compliance Program is to educate appropriate employees and others affiliated with Americare CSS with respect to federal and State statutes and regulations with which they must comply. In this regard, the federal Deficit Reduction Act ("DRA") was recently passed into law.

The DRA requires Americare CSS to provide all employees and others affiliated with Americare CSS

- The federal administrative remedies associated with the False Claims Act
- New York State laws pertaining to civil or criminal penalties for false claims and statements
- Whistleblower protections provided under federal and State laws
- The role of federal and State laws in preventing and detecting fraud, waste and abuse

This letter provides you with the information required by the DRA.

Federal and New York Statutes Related to Filing False Claims and Whistleblower Protections

Numerous federal and State laws prohibit health care providers from submitting "false" or "fraudulent" claims to Medicare and Medicaid and other government - funded health care programs. Presented below is a listing and description of various federal and State statutes related to the filing of false Medicare and Medicaid claims.

Federal Laws

1. False Claims Act, 31 V.S.C. 3729-3733.

The federal False Claims Act imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from Medicare, Medicaid, or other federal health programs. The penalty for knowingly filing a false claim is \$10,781 to \$21,563 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claims filer may have to pay the government's legal fees.

The False Claims Act allows private individuals to file lawsuits in federal court. If the suit eventually concludes with payments back to the government, the person who started the case can recover a percentage of the proceeds based on whether the government did or did not participate in the suit.

2. Administrative Remedies for False Claims. 31 U.S.C. 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, then the agency receiving the claim may impose a penalty of up to \$10,781 for each claim. The agency may also recover twice the amount of the claim.

A violation of this law occurs when a false claim is submitted, not 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 bringing lawsuits in the federal court system.

New York State Laws

New York false claims laws fall into two categories: administrative and civil laws, and criminal laws. Many of the laws overlap. Some apply to recipient false claims and some apply to provider false claims.

A. Administrative and Civil Laws

1. Finance Law Article 13, New York False Claims Act.

The New York False Claims Act imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from Medicaid or other State health programs. The potential penalty for knowingly filing a false claim is (1) \$6,000 - \$12,000 per claim, (2) payment of between two and three times the State's damages, (3) payment of between two and three times the damages sustained by a local government, and (4) payment of the State's legal fees.

The New York False Claims Act allows private individuals to file lawsuits in State court. If the suit eventually concludes with payments back to the State, the person who started the case can recover a percentage of the proceeds based on whether the State did or did not participate in the suit.

2. Social Services Laws 145-c. If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement or misrepresenting, concealing or withholding facts (or committing an act intended to mislead, misrepresent, conceal or withhold facts), then the person's needs shall not be taken into account in determining his or her need or the person's family's need, for six months if a first offense, 12 months if a second offense (or for any offense if the benefits received are \$1,000 - \$3,900), 18 months if a third offense (or for any offense if the benefits received are over \$13,900) and five years for four or more offenses.

3. Social Services Law 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 \$2,000 per violation. If repeat violations occur within five years, a penalty up to \$7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

B. Criminal Laws

1. Services Law 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 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 any false or fraudulent claim for furnishing services, knowingly submits false information in order 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. 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.

4. Penal Law Article 175, False Written Statements. Four crimes in this Article relate to filing false information or claims that have been applied in Medicaid fraud prosecutions.

a. 175.05, Falsifying business records in the second degree 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.

b. 175.10, Falsifying business records in the first degree includes the elements of the 175.05 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. 175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include intent to defraud the State or a political subdivision. It is a Class E felony.

5. Penal Law Article 176, Insurance Fraud. Six crimes in this Article apply to claims for insurance payment, including Medicaid or other health insurance.
 - a. Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
 - b. Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000. It is a Class E felony.
 - c. 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 the commission of insurance fraud more than once. It is a Class B felony.

6. Penal Law Article 177, Health Care Fraud. Five crimes apply to claims for health insurance payment, including Medicaid.
 - a. Health care fraud in the 5th degree is knowingly filing, with the intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
 - b. Health care fraud in the 4th degree is filing false claims and annually receiving over \$3,000 in aggregate. It is a Class E felony.
 - c. Health care fraud in the 3rd degree is filing false claims and annually receiving over \$10,000 in aggregate. It is a Class D felony.
 - d. Health care fraud in the 2nd degree is filing false claims and annually receiving over \$50,000 in aggregate. It is a Class C felony.
 - e. Health care fraud in the 1st degree is filing false claims and annually receiving over \$1 million in aggregate. It is a Class B felony.

Whistleblower Protections

1. New York Labor Law 740/741. 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 (1) is in violation of a law that creates a substantial and specific danger to the public health and safety; or (2) has committed health care fraud (as defined in Penal Law Article 177). 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 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.

2. Federal False Claims Act (31 U.S.c. 3730(h)) and New York False Claims Act (Finance Law 191). An employee who is "discharged, demoted, suspended, threatened, harassed or in any manner discriminated against" because of the employee's lawful acts under the federal or New York False Claims Acts is entitled to reinstatement, double back pay with interest, special damages, and litigation costs and attorneys' fees.

If you become aware of any compliance issues or have any questions regarding the information contained in this letter, please contact Miri Bank, Americare, CSS Director of Compliance, at 718-535-3100 ext 3280.

If you choose to report anonymously, you can access Americare Compliance Hot Line by dialing 800-452 1897.