SUNY DOWNSTATE MEDICAL CENTER

POLICY AND PROCEDURE

No: _____

Subject: **Complying with the Deficit Reduction Act of 2005: Detection & Prevention of Fraud, Waste & Abuse** **Page** 1 **of** 4

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Approved by:	Compliance & Audit Oversight Committee	**Issued by:**	**Office of Compliance & Audit Services**

I. Purpose: SUNY Downstate Medical Center (DMC) is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005 (DRA) and to detecting and preventing fraud, waste or abuse. This policy is intended to comply with the DRA and will be modified, as necessary, based upon any Federal or State guidance promulgated regarding Section 6032.

II. Policy: DMC prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. This policy provides information regarding Federal & State statutes pertaining to false claims and statements, whistleblower protections under these laws and DMC's policies and procedures for detecting and preventing fraud, waste and abuse.

A. Federal and State Statutes & Whistleblower Protections- Detailed information regarding these laws are delineated in Appendix A of this policy.

B. DMC's Policies & Procedures- DMC maintains a comprehensive Compliance Program which sets forth, in detail, its compliance policies and processes for detecting and preventing fraud, waste and abuse. Information regarding DMC's Compliance Program is

provided to employees and is available on the Office of Compliance & Audit Services (OCAS) website at www.downstate.edu/compliance.

C. Education- DMC strives to educate its workforce on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments, as well as complying with all elements of DMC's Compliance Program. This policy applies to DMC:

1. Employees;
2. Residents and fellows;
3. Physicians and allied health professionals appointed to DMC's Medical Staff;
4. Faculty; and
5. Contractors, subcontractors or agents who, on behalf of DMC, furnish or authorize the furnishing of health care items or services, perform billing or coding functions, or who monitor the health care provided by DMC.

III. Procedure:

A. Dissemination of Information to Employees

1. **DRA Brochure-** The DRA Brochure containing a specific discussion of the Federal & State fraud and abuse laws, as well as whistleblower protections and DMC's policies and procedures for detecting and preventing fraud, waste and abuse will be provided to current DMC employees, as well as to new employees at Orientation.

2. **DRA Online Training Program-** Employees will be required to complete DMC's online DRA training program. The training program will capture employees' receipt of acknowledgement regarding the DRA laws and DMC's related policies and procedures.

3. **Compliance Program Information-** A Compliance Program Manual is posted on the Office of Compliance & Audit Services website at www.downstate.edu/compliance and includes the following information:

    a. Code of Ethics & Business Conduct;
    b. Compliance Program Oversight Responsibilities;
    c. Employee Training;
    d. Monitoring and Auditing;
    e. Reporting System;
    f. Enforcement & Discipline;
    g. Response & Prevention.

B. Dissemination of Information to Contractors- DMC will disseminate information regarding the DRA and applicable laws to its contractors and will require their adoption of such. The term "contractors" include contractors, subcontractors or agents who, on behalf of DMC, furnish or authorize the furnishing of health care items or services, perform billing or coding functions, or who monitor the health care provided by DMC.

1. **Existing Contracts-** For existing contracts with vendors that meet the definition of the term "contractor", as defined above, the Office of Contracts & Procurement will send "Appendix A: Federal Deficit Reduction Act of 2005 (DRA)- Federal & State Statutes", as

well as the "Letter to Vendor: Compliance with Deficit Reduction Act of 2005". Documentation supporting the dissemination of the DRA information will be maintained.

2. **New Contracts-** For new contracts with vendors that meet the definition of the term "contractor", as defined above, the underlying agreement will include general language requiring such contractors to comply with the DRA provisions. "Appendix A: Federal Deficit Reduction Act of 2005 (DRA)- Federal & State Statutes" will be included in these agreements and acceptance of DMC's DRA policies will be a condition for approval of the agreements.

C. Revisions of DRA Information- DMC will revise "Appendix A: Federal Deficit Reduction Act of 2005 (DRA)- Federal & State Statutes", as necessary, to comply with Federal and State regulatory changes and guidance. The information will be available electronically on the OCAS website at www.downstate.edu/compliance.

D. Reporting of Potential Fraud, Waste or Abuse- To assist DMC in meeting its legal and ethical obligations, any employee who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste or abuse related to a Federally or State funded health care program is required to report such information.

1. **Internal Reporting Process**

   a. An employee who suspects a violation should report concerns to the appropriate Supervisor or Department Head; or

   b. The employee should report the concern to:

      i. **DMC's Compliance Line:** *Call:* 877-349-SUNY (7869)
      Web- Report: Go to www.downstate.edu and click on "**Compliance Line"** link.

      ii. **DMC's Office of Compliance & Audit Services:** 718-270-4033

   c. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the employee's obligations to DMC and may result in disciplinary action.

2. **Non- Retaliation-** Any employee of DMC who reports information regarding potential fraud, waste or abuse will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under internal DMC Compliance policies, as well as under Federal and State law.

3. **Investigations-** DMC commits itself to investigate any suspicions of fraud, waste or abuse swiftly and thoroughly and will initiate the appropriate action against any employee who has committed a violation.

E. Compliance Monitoring- In accordance with DMC's Compliance Program and related Work- Plan, the Office of Compliance & Audit Services will monitor DMC's compliance with Federal and State false claims statutes.

IV. Responsibilities: The Office of Compliance & Audit Services is responsible for administering DMC's Compliance Program. It is the responsibility of the entire DMC

workforce to comply with the Compliance Program and related policies and to report any suspicions of fraud, waste or abuse via the appropriate internal reporting process.

V. Reasons for Revision- Regulatory requirements

VI. Attachments- Appendix A: Federal Deficit Reduction Act of 2005 (DRA)- Federal & State Statutes, Letter to Vendor: Compliance with Deficit Reduction Act of 2005

VII. References- Deficit Reduction Act of 2005, Sec. 6032; False Claims Act 31 U.S.C. 3729-3733; Program Fraud Civil Remedies Act of 1986 31 U.S.C. 3801-3812; New York State Finance Law §197-194; New York Social Services Law §145-b & §366-b(2); New York Penal Law §177; New York Labor Law §740; Centers for Medicare and Medicaid Services Letter to State Medicaid Directors- December 13, 2006 and March 22, 2007; New York State Plan Amendment- effective January 1, 2007; Department of Justice Description of Federal False Claims Act; New York State Office of Medicaid Inspector General Deficit Reduction Act Documents- July 2007.

	Revision	Required	Responsible Staff Name and Title
	Yes	No	
	Yes	No	
	Yes	No	
	Yes	No	

SUNY DOWNSTATE Medical Center

APPENDIX A: FEDERAL DEFICIT REDUCTION ACT OF 2005 (DRA)- FEDERAL & STATE STATUTES

The following is a summary of the Federal & New York False Claims Acts, the Program Fraud Civil Remedies Act and other relevant State laws.

I. Federal False Claims Act & New York False Claims Act (FCA)

The Federal False Claims Act, 31 USC §3279, *et seq*, and the New York False Claims Act, State Finance Law §187-194, establishes liability for any person who engages in certain acts, including:

- knowingly presenting or causing to be presented a false or fraudulent claim to the Federal, State or local government for payment;
- knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal, State or local government;
- conspiring to defraud the Federal, State or local government by getting a false or fraudulent claim allowed or paid; or
- knowingly making, using, or causing a false statement to conceal, avoid or decrease an obligation to pay money to the Federal, State or local government.

Under the Federal & NY False Claims Acts, a person acts "knowingly" if s/he:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

There is no requirement that the person specifically intended to defraud the government through his or her actions.

Under the Federal False Claims Act, a "claim" is any request or demand for money or property if the Federal, State or local government provides any portion of the money or property in question. This includes requests or demands submitted to a contractor of the Government and includes Medicaid and Medicare claims.

A violation of the Federal False Claims Act results in a civil penalty between $5,500 and $11,000 for each false claim submitted, plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in Federal health care programs.

A violation of the NY False Claims Act results in a civil penalty between $6,000 and $12,000 for each false claim submitted, plus three times the amount of damages sustained by the State and three times the amount of damages sustained by a local government because of the violation.

In sum, the FCA imposes liability on any person who submits a claim to the government that s/he knows or should know is false. An example may be a physician billing Medicare/ Medicaid for medical services not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example may be a government contractor who submits false records that indicate compliance with contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the 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 who obtains interim payments from Medicare 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 program.

In general, under the Federal & NY False Claims Acts, private parties may bring an action on behalf of the United States. These private parties, known as "qui tam relators" or "whistleblowers", may share in a percentage of the proceeds from an FCA action or settlement. Both the Federal & NY False Claims Acts provide that when the Federal, State or local government intervenes in the lawsuit, the qui tam relator, with some exceptions, shall receive at least 15% but not more than 25% 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 Federal, State or local government does not intervene, the relator shall receive an amount that the court decides is reasonable and shall be not less than 25% and not more than 30%.

In addition, under both the Federal and NY False Claims Acts, an employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment as a result of the furtherance of an action under the FCA is entitled to all relief necessary to make the individual whole. 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 plus interest and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. At the same time, though, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

However, as Downstate Medical Center is a component of the State University of New York, and thus is a State agency, the United States Supreme Court has held that private persons may NOT be eligible to file qui tam/ whistleblower lawsuits against State agencies and may NOT be entitled to a share of the proceeds of any FCA recoveries.

II. Federal Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986, 31 USC §§3801, *et seq,* is similar to the False Claims Act, establishing an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent to certain Federal agencies, including HHS, and again, includes Medicaid and Medicare claims.

Similar to the False Claims Act, a person who "knows or has reason to know" is defined as one who:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

Once again, there is no necessary proof of specific intent to defraud the government. Unlike the False Claims Act, however, a violation of this law occurs when a false claim is submitted, not when it is paid.

A violation of the Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to $5,500 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing after investigation by HHS and approval by the United States Attorney General.

III. Additional New York State Laws

There are additional New York State laws, both civil/ administrative and criminal, that prohibit false claims. Some apply to recipient false claims and some apply to provider false claims. While most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

Under **New York Social Services Law §145, §145-b & §145-c**, it is a misdemeanor to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. For a violation of this law, the local Social services district or the State has a right to recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Service district or State may recover three times the damages (or $5,000, whichever is greater) sustained by the government due to the violation.

The law also empowers the New York State Department of Health to impose a monetary penalty on any person who, among other actions, causes Medicaid payments to be made if the person knew or had reason to know that:

- the payment involved care, services, or supplies that were medically improper, unnecessary, or excessive;
- the care, services or supplies were not provided as claimed;
- the person who ordered or prescribed the improper, unnecessary, or excessive care, services, or supplies was suspended or excluded from the Medicaid program at the time the care, services, or supplies were furnished; or
- the services or supplies were not in fact provided.

The monetary penalty shall not exceed $2,000 for each item or service in question, unless a penalty under the section has been imposed within the previous five years, in which case the penalty shall not exceed $7500 per item or service.

If a person applies for or receives Medicaid by intentionally making a false or misleading statement or by intending to do so, the person's and his/her family's needs are not taken into account for a period of 6 months upon the first offense; for a period of 12 months upon the second offense or an offense for which benefits have already been received totaling over $3,900; and for 5 years upon 4 or more offenses.

Under **New York Social Services Law §366-b,** any person who attempts to obtain Medicaid by means of a false statement, concealment, impersonation or other fraudulent means and any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the

purpose of obtaining compensation greater than that to which s/he is legally entitled for furnishing services or merchandise shall be guilty of a class A misdemeanor. If such an act constitutes a violation of a provision of the penal law of the state of New York, the person committing the act shall be punished in accordance with the penalties fixed by such law.

Under **New York Penal Law §155**, 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 law has been applies to Medicaid fraud cases.

- 4th degree grand larceny (Class E felony) involves property valued over $1,000.
- 3rd degree grand larceny (Class D felony) involves property valued over $3,000.
- 2nd degree grand larceny (Class C felony) involves property valued over $50,000.
- 1st degree grand larceny (Class B felony) involves property valued over $1 million.

Penal Law §175 contains four crimes related to filing false information or claims, which have been applied in Medicaid fraud prosecutions:

- Falsifying business records, involving entering false information, omitting material information or altering an enterprise's business records with the intent to defraud is a Class A misdemeanor.
- Falsifying records in the 1st degree, which includes the elements above and the intent to commit another crime or conceal its commission is a Class E felony.
- Offering a false instrument for filing in the 2nd degree, which involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information, is a Class A misdemeanor.
- Offering a false instrument for filing in the 1st degree, which includes the elements above and the intent to defraud the state or a political subdivision is a Class E felony.

Penal Law §176 contains six crimes and applies to claims for health insurance payment, including Medicaid:

- 5th degree insurance fraud (Class A misdemeanor) involves intentionally filing a health insurance claim knowing that it is false.
- 4th degree insurance fraud (Class E felony) is filing a false insurance claim for over $1,000.
- 3rd degree insurance fraud (Class D felony) is filing a false insurance claim for over $3,000.
- 2nd degree insurance fraud (Class C felony) is filing a false insurance claim for over $50,000.
- 1st degree insurance fraud (Class B felony) is filing a false insurance claim for over $1 million.
- Aggravated insurance fraud (Class D felony) is committing insurance fraud more than once.

In addition, **New York Penal Law §177** establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), s/he knowingly and willfully provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which s/he is not entitled. Health Care Fraud is punished with fines and jail time based on the amount

of payment inappropriately received due to the commission of the crime; the higher the payments in a one year period, the more severe the punishments, which currently range up to 25 years if more than $1 million in improper payments are involved.

- 5th degree health care fraud (Class A misdemeanor) is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions.
- 4th degree health care fraud (Class E felony) is filing false claims and annually receiving over $3,000 in the aggregate.
- 3rd degree health care fraud (Class D felony) is filing false claims and annually receiving over $10,000 in the aggregate.
- 2nd degree health care fraud (Class C felony) is filing false claims and annually receiving over $50,000 in the aggregate.
- 1st degree health care fraud (Class B felony) is filing false claims and annually receiving over $1 million in the aggregate.

New York law also affords protections to employees who may notice and report inappropriate activities. Under **New York Labor Laws §740 & §741,** an employer shall not take any retaliatory personnel action against an employee because the employee:

- discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, constitutes improper quality of patient care or constitutes health care fraud;
- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or
- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

To bring an action under this provision, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice, 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. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back-pay and compensation of reasonable costs. 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. The law also provides that employees who bring an action without basis in law or fact may be held liable to the employer for its attorney's fees and costs.

LETTER TO VENDOR: COMPLIANCE WITH DEFICIT REDUCTION ACT OF 2005

SUNY DOWNSTATE Medical Center

To: All Contractors

Date:

Re: Compliance with Deficit Reduction Act of 2005

SUNY Downstate Medical Center (DMC) is committed to conducting business in compliance with all applicable laws. To this end, we have an extensive Compliance Program in place to be followed by all employees and certain persons or entities with which we have contractual agreements.

As a participant in the Medicaid Program, we are obligated to comply with the terms and requirements of the Deficit Reduction Act of 2005 (DRA). In accordance with the DRA, we have adopted written polices for all employees that provide detailed information about the Federal & New York False Claims Acts, the Program Fraud Civil Remedies Act, other relevant state laws, the whistleblower protections under such laws and DMC's policies for detecting and preventing waste, fraud and abuse.

The DRA also requires that we provide this information to all contractors and agents for your adoption. Accordingly, we are attaching "Appendix A: Federal Deficit Reduction Act of 2005 (DRA)- Federal and State Statutes" and are providing you with information regarding our Compliance Program which sets forth, in detail, our compliance policies and processes for detecting and preventing fraud, waste and abuse. In addition, DMC has a Code of Ethics & Business Conduct that outlines the expected legal and ethical conduct of its personnel.

Please note that the Compliance Program and related materials are living documents that are subject to change as new regulations become effective and as policies & procedures are revised. In order to ensure that you are utilizing the most up-to-date version, you may always access our Compliance materials on our website at www.downstate.edu/compliance.

DMC has established a 24/7 Compliance Line as a mechanism for reporting activities, confidentially and anonymously, that may involve ethical violations or criminal conduct:

DMC COMPLIANCE LINE: 877-349-SUNY

DMC has a no tolerance policy for employees, agents, or vendors who are involved in any unlawful activity. To that end, we expect that you share our goals of eradicating fraud and abuse and, therefore, will comply with your obligations under the DRA.