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 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 working in departments related to the revenue cycle 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.

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 redistributed, as required.

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

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 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.

	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 False Claims Act, the Program Fraud Civil Remedies Act and certain relevant State laws.

Federal False Claims Act

The Federal False Claims Act, 31 USC §3279, *et seq*, 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 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 government; or
- conspiring to defraud the Federal government by getting a false or fraudulent claim allowed or paid.

Under the Federal False Claims Act, 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 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.

The False Claims Act allows a private person to file a *qui tam* lawsuit on behalf of the Federal government. This person, also called a relator or whistleblower, must file his or her lawsuit under seal in a federal district court. The government may decide to intervene with the lawsuit, in which case the United States Department of Justice will direct the prosecution. If the government does not decide to intervene, the relator may still continue the lawsuit independently.

If a *qui tam* lawsuit is successful, the relator may receive between 10 to 30% of the recovery, depending on the level of the government's participation and other factors, as well as reasonable attorney's fees and costs. In addition, there can be no retaliation against the relator for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

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.

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.

New York State Laws

New York State does not currently have a State False Claims Act that allows for participation by private persons as *qui tam* relators or whistleblowers. However, New York State law prohibits false claims. Certain relevant portions of the New York State Code are summarized below.

Under **New York Social Services Law §145-b**, it is unlawful 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.

Under **New York Social Services Law §366-b (2),** 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.

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.

New York law also affords protections to employees who may notice and report inappropriate activities. Under **New York Labor Law §740,** 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, or which 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. 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. 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.