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ST. BARNABAS HOSPITAL

COMPLIANCE PROGRAM MANUAL

**CODE OF CONDUCT
AND COMPLIANCE GUIDELINES**

OUR MISSION AND VALUES

St. Barnabas Hospital is committed not only to providing patients with high quality and caring medical services, but also to providing those services pursuant to the highest ethical, business, and legal standards. These high standards must apply to our interactions with everyone with whom we deal. This includes our patients, other health care providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety.

In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Hospital. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Compliance Program has become an integral part of our corporate mission and business operations.

The attached Compliance Program's Code of Conduct provides guidance to ensure that all of our work is done in an ethical and legal manner. Please review it thoroughly. Your adherence to its spirit, as well as its specific provisions, is absolutely critical to our future. In your daily work, if you encounter a situation or proposed course of conduct, and you are unsure whether it is allowed by the Code of Conduct, raise the issue with your supervisor, with a member of the Compliance Staff at the numbers listed in the last section of the Code of Conduct, or over the Compliance Hotline. It is a basic principle of our Compliance Program that there will be no retribution for asking questions, raising concerns about the Code, or reporting possibly improper conduct.

I. INTRODUCTION

1. Compliance Manual. This Corporate Compliance Manual sets forth standards of conduct that personnel employed by or associated with St. Barnabas Hospital (the “Hospital”) are expected to follow.

In creating this Manual, the Hospital’s goal is to ensure compliance with the myriad laws, rules and regulations that govern our daily operations, including, among other things, those relating to: (i) the quality of medical services we provide; (ii) our coding, billing and documentation of the services; (iii) our general business practices; and (iv) our referral relationships. The Hospital also wants to ensure that we are operating pursuant to the highest ethical, legal and moral standards.

2. Questions and Concerns. Neither this Manual nor our overall Compliance Program can cover every situation that you might face. As a result, if you are unsure of what the proper course of conduct might be in a specific situation, or if you believe that any of our standards of conduct or procedures (whether set forth in this Manual or elsewhere) may have been violated, then you are urged to contact the Hospital’s “Compliance Officer,” Keith Wolf at (718) 960-6500, or the dedicated voice mail Compliance Helpline at (718) 960-3705.

You may contact the Compliance Officer at any time, either in person or in writing, with any compliance-related question or concern you may have. Questions or concerns may be raised anonymously, if you wish. All reports to the Compliance Officer will be held in the strictest confidence possible, consistent with the need to investigate the matter.

II. CODE OF CONDUCT

The Hospital has adopted the following Code of Conduct as a central part of our Compliance Program. Compliance with the Hospital's Code of Conduct is a condition of employment, and violation of these standards will result in discipline being imposed, up to and including possible termination.

1. Honesty and Lawful Conduct. Personnel and Hospital affiliated physicians must be honest and lawful in all of their business dealings and avoid doing anything that could create even the appearance of impropriety. They must comply with the Code of Conduct, and report any action they think *may be* unlawful.

2. Cooperation with the Compliance Program. Because of the importance of the Compliance Program, we require that each of you cooperate fully with this effort. The Compliance Program will work effectively only if everyone works together to ensure its success, understands what is required under the law and our own Code of Conduct, and works to ensure that those standards are being followed. In particular, personnel and physicians must cooperate with all compliance-related inquiries and actively work to correct any unethical, illegal, or improper practices that are identified.

3. Compliance with Federal and State Laws Regarding the Submission of Claims. It is the Hospital's policy that all personnel (including employed physicians and management), and contractors and agents shall comply with all applicable Federal and New York State laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) New York State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in Appendix A to this Manual.

4. Billing, Coding and Documentation for Services. All federal and state regulations governing billing, coding and documentation will be fully followed for all physician, hospital, or other medical services billed by the Hospital. Thus, all billing and coding for services must be accurate and truthful, and no personnel should ever misrepresent charges or services to, or on behalf of, a patient or third-party payor. Deliberate or reckless misstatements to government agencies or other payors will expose the personnel involved to termination and criminal penalties.

Only those medical services that are consistent with accepted standards of medical care may be billed. In this regard, billing and coding must always be based on adequate *documentation* of the medical justification for the service provided and for the bill submitted, and this medical documentation must comply with all applicable regulations. Only those codes that correspond to the service rendered and documented should be selected.

Finally, whenever the Hospital has learned or knows that it has received payments for which it was not entitled from a governmental or private payor, the payments will be refunded to the appropriate payor as soon as possible.

5. Billing Rules and Standards for Clinic Visits. Hospital personnel must take special care to ensure our compliance not only with Medicare and other third party payor rules, but also with all applicable rules and regulations set forth by the New York State Medicaid Program and the Department of Health.

a. Generally. These rules and regulations include, but are not limited to, those rules governing the operation of full and part time clinics; billing for clinic services; the implementation of an appropriate quality assurance program; the provision of appropriate supervision and oversight of all clinics and services; and the assurance of proper continuity of care to all patients in all of our programs. All Hospital Clinic supervisors and managers will familiarize themselves with those regulations that apply to their areas of responsibility.

b. Specific Medicaid Billing Rules. In compliance with the Medicaid rules, Hospital Clinics will bill for only one threshold clinic visit per patient per day. A threshold visit, including all part-time clinic visits, occurs each time a patient crosses the threshold of one of our clinics to receive care, without regard to the number of services provided during that visit. For a clinic visit to be billed, an appropriate and documented service must have been actually provided.

Services ordered on additional days or at another location for the convenience of the patient or the provider, or to complete a service already begun, will be billed as part of the original threshold visit. Additional services will *not* be ordered on additional days merely to create the appearance of a new threshold visit.

6. Services Provided by Teaching Physicians. As a teaching institution, the Hospital has the added concern that all teaching physicians associated with it adhere to the federal and state regulations governing when teaching physicians may bill Medicare or Medicaid when they supervise medical services provided by interns, residents or fellows. Thus, all teaching physicians associated with the Hospital, and all personnel who are *in any way* involved with the billing process for teaching physicians, are *required* to be aware of, understand, and adhere to the federal regulations as to physical presence, documentation and billing.

7. Business Practices. The Hospital will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of our services.

a. Business Transactions. Business transactions and joint ventures with other health care providers will be aimed at enhancing the quality or continuity of care provided to patients. Financial investments in such transactions and ventures, and any return on investments, will be based on the bona fide financial value of the investment and its positive impact on the Hospital's ability to deliver medical services. Such

investments will *not* be based on an intent to induce or reward referrals to or from another provider.

b. Business Records. Management must ensure that all business records are accurate and truthful, with no material omissions; that the assets and liabilities of the Hospital are accounted for properly in compliance with all tax and financial reporting requirements, and that no false records are made. Similarly, all reports submitted to governmental agencies, insurance carriers, or other entities will be accurately and honestly made.

c. Cost Report. The Institutional Cost Report will be prepared in compliance with all applicable state and federal regulations. Costs will be claimed when based on appropriate and accurate documentation; unallowable costs will not be claimed for reimbursement; and all costs will be properly allocated to the appropriate cost centers based on verifiable information and data.

d. Credit Balances. On a periodic, regular basis, the Hospital will generate reports of the status of any credit balances of refunds owing to Medicare and other third-party payors. Such refunds will then be made to the appropriate payor in a timely and reasonable manner.

8. Purchasing and Competitive Bidding Policy. All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for the Hospital or its patients at the most reasonable price. No purchasing decision may be made based on any consideration that any employee, officer or trustee — or any family member or friend of any of them — will benefit by the transaction. Rather, the sole criteria behind all purchasing decisions must be only the best interests of the Hospital. Nor can any service or item be purchased in return for a referral of patients from another or with a view towards inducing another to refer patients. In purchasing items or contracting for services, the Hospital's competitive bidding and pricing rules must be followed.

9. Payments and Gifts. No personnel will engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to influence or reward favorable decisions of any patient, physician, government representative, contractor, vendor, or any other person in a position to benefit the Hospital or the employee in any way.

10. Compliance with Federal and State Anti-Referral Laws. Federal and state law make it unlawful to pay any individual on the basis of the value or volume of referrals of patients. This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral. In compliance with the federal and state anti-referral laws, the Hospital does not pay incentives to any personnel based upon the number of persons admitted for treatment or the value of services provided. Nor does the Hospital pay physicians, or anyone else, either directly or indirectly, for patient referrals. The decision to refer patients is a separate and independent clinical decision made by the referring physician or health care provider.

The Hospital also does not accept any form of remuneration in return for referring our patients to other health care providers. Rather, in discharging patients and referring them to other providers, it is the Hospital's policy: (i) that such referrals will be based on the patient's documented medical need for the referred service and the ability of the referred provider to meet that need; and (ii) that the patient's freedom to choose the provider is at all times respected and honored.

All contracts, leases, and other financial relationships with other healthcare medical providers who have a referral relationship with the Hospital will be based on the fair market value of the services or items being provided or exchanged, and *not* on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

11. Emergency Room Patients and Medical Screening. The Hospital will provide an appropriate medical screening examination to each person who comes to a dedicated emergency department of the Hospital with any medical condition, and to any person on Hospital property who exhibits a condition which a prudent layperson would believe may be an emergency medical condition, to determine whether the individual has an emergency medical condition. In an emergency situation, financial and demographic information will be obtained only after the immediate needs of the patient are met and the patient is stabilized. We do not admit or discharge patients based on their ability to pay. Appropriate medical screening and treatment to stabilize an emergency medical condition will be provided in a non-discriminatory fashion, regardless of the patient's payment status, race, sex, national origin or other suspect classification.

In compliance with applicable federal regulations, a patient will be transferred to another hospital only at his or her request or if the medical benefits expected as a result of transfer outweigh the risks. Patients may only be transferred after they have been stabilized and are formally accepted by the alternate facility.

12. Confidentiality of Patient Information. In compliance with federal and state privacy laws, all personnel will keep patient information confidential, except when disclosure is authorized by the patient or permitted by law.

13. Duty of Loyalty. All personnel owe a duty of loyalty, honesty and fidelity to the Hospital. This duty particularly requires compliance with the following Hospital policies:

a. Conflicts of Interest. All Hospital personnel are to disclose to the Compliance Officer any conflicts of interest in outside companies, entities or concerns. Conflicting interests can include both financial interests and non-financial relationships with entities that compete or do business with the Hospital, and include any interests that otherwise could create an *appearance* that the personnel's conduct on behalf of the Hospital might be compromised in some way by the competing interest. Conflicts must be reported even if the conflict arises because only an immediate family member has the interest in the other entity.

b. Gifts and Hospitality. Personnel may not accept gifts and hospitality from patients, patient family members, vendors or contractors doing business with the Hospital if doing so would create an appearance that the gift or hospitality is being provided to induce the personnel to act in his or her own benefit (over the Hospital's). *Cash may not be accepted under any circumstance.* Personnel may accept business entertainment consistent with what is reasonable under the circumstances, as long as the offered entertainment is not for the purpose of improperly influencing the personnel's business behavior. Items of nominal value such as holiday cookies or candy that are tokens of appreciation, may be accepted.

If you have any question or concern whether the acceptance of an offer of a gift or hospitality may be improper, you should immediately raise your concern with the Compliance Staff.

14. Responsibilities. All personnel, including employees, officers, and supervisors have the following responsibilities under the Compliance Program:

- Employees must know and follow the federal and state laws, rules and regulations that apply to their jobs; comply with the standards set forth in the Hospital's Code of Conduct and any applicable department compliance protocols; and recognize that any violation of these standards of conduct will result in disciplinary action.
- Department Heads, Supervisors and Managers must create and maintain a work environment in which ethical concerns can be raised and openly discussed. They also must ensure that staff understand the importance of the Compliance Program and the Hospital's Code of Conduct, and that staff are aware of the reporting procedures for suspected unlawful activity.
- Contractors and Other Providers. All persons and entities with which the Hospital contracts will receive a copy of the Hospital's Compliance Manual and will be asked to cooperate with our Compliance Program. This includes individual physicians, physician groups, vendors, contractors, and other healthcare providers. These other parties will also be encouraged to adopt their own Compliance Programs where appropriate.

15. Other Policies and Procedures. In addition to the Code of Conduct and Compliance Procedures set forth in this Manual, the Hospital has topic- or department-specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to compliment the procedures and standards set forth in this Manual.

III. COMPLIANCE PROCEDURES

1. Compliance Personnel And Procedures. The following compliance personnel and procedures are available to all Hospital employees.

a. Compliance Officer. The Compliance Officer is presently Keith Wolf, and he is responsible for receiving and responding to all reports, complaints, and questions about compliance issues. He is also responsible for tracking new developments, ensuring appropriate compliance reviews are performed, and conducting compliance training.

b. Board Committee. The Compliance Officer will present an annual report to a subcommittee of the Board of Trustees on the Compliance Program that includes: i) the Compliance Program's goals, objectives and work plan; (ii) an assessment of risk areas and how resources should be allocated to address such risks; and (iii) a review of how goals and objectives were or were not met for the prior year.

c. Compliance Committee. A Committee comprised of the Compliance Officer, members of senior management and certain department heads will meet at least on an annual basis to review the implementation and progress of the Compliance Program. As necessary, the Committee will meet more frequently to address any specific Compliance-related concerns or issues that may arise.

d. Reporting and Complaint Procedures. All personnel can and should raise any question they might have about potentially unethical or illegal conduct with the Compliance Officer.

e. Confidentiality and the Compliance Helpline. Your report or question may be raised anonymously, if you choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. Personnel who do not wish to contact the Compliance Officer directly, may instead raise an issue or report a compliance concern by calling the dedicated voice mail "Compliance Helpline."

f. Inquiry by the Compliance Officer. Upon receiving a report of possible unethical or illegal conduct, the Compliance Officer will conduct an inquiry, as appropriate, in consultation with outside counsel, if necessary.

g. No Retaliation Allowed. Retaliation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is itself a serious violation of the Code of Conduct.

2. Corrective Action And Discipline.

a. Corrective Action. Violations of the Code of Conduct may warrant corrective action, including, but not limited to:

- refunding overpayments;
- additional training for personnel;
- personnel being disciplined, including discharged;
- suspension of billing for a particular provider or a particular of service;
- modification or improvement of the Hospital's business practices; and
- modification or improvement of the Compliance Program itself to better ensure continuing compliance with applicable federal and state laws and regulations.

b. Discipline. All personnel are expected to adhere to this Code of Conduct and compliance standards. If the Compliance Officer concludes, after an appropriate investigation, that these standards have been violated, then appropriate discipline (including, as appropriate, a warning, suspension and/or discharge) may be imposed. The imposition of discipline can be based on the personnel's:

- unlawful or unethical actions,
- condoning or failing to report unlawful actions by others,
- retaliation against those who report suspected wrongdoing, or
- other violation of the Code of Conduct and Compliance Standards.

3. Compliance Assurance Monitoring. The Compliance Officer will be responsible for continued monitoring of compliance with this Manual and all applicable federal and state rules, laws, and regulations.

a. Tracking New Developments. On a continuing basis, the Compliance Officer will keep abreast of, and review, all new regulatory or legal requirements issued by the federal or state government, including, but not limited to

- the monthly Medicare Information Resource;
- Department of Health Medicaid Updates;
- all new rules governing the documentation, coding and billing of serviced provided by the Hospital;
- annual updates to the Current Procedural Terminology (CPT); and

- New Fraud Alerts issued by the Office of Inspector General

Based on any relevant new developments, the Compliance Officer will review existing policies and procedures to ensure that the Hospital is in compliance with federal and state requirements.

b. Ongoing Compliance Reviews. On a regular basis, the Compliance Officer will cause audits to be conducted, which may include, but will not be limited to, ensuring that:

- the documentation and coding for both in-patient and out-patient services being billed by the Hospital are accurate and complete, including the documentation and coding of physician services, out-patient testing or procedures, clinic services, or other Hospital services;
- computer systems do not automatically insert information that is not supported by the documentation;
- if patterns of claims denials exist, they are detected; evaluated to determine the cause and appropriately corrected;
- third-party audits are reviewed to determine if those results reflect any systemic deficiency or problem in the Hospital's compliance with state or federal rules, regulations, or laws;
- credit balances are tracked and refunded to appropriate payors;
- personnel conform to appropriate policies concerning marketing and the giving or receiving of gifts and business entertainment;
- the Hospital's competitive bidding policies are appropriately followed;
- the Hospital's business practices are in compliance with applicable laws, rules and regulations. Such audits might include a review of the Hospital's credit balance, its practice of waiving co-payments or providing professional courtesy, and the fair market value of leases, equipment rental agreements, or personal service contracts with other providers.

c. Exclusion Reviews. On an annual basis, the Compliance Officer or a designee will review the OIG's and GSA's exclusion databases to ensure that the Hospital does not employ or contract with anyone who has been excluded from participating in federal healthcare programs. These databases will also be reviewed upon hiring of new personnel/contracting with new individuals or entities.

4. Training. The Compliance Officer will ensure that all personnel receive compliance and ethics training.

a. **Compliance Manual.** The Compliance Officer is responsible for ensuring that this Compliance Manual is distributed to all personnel and for maintaining a file containing each person's signed acknowledgment form. All newly hired personnel should also receive a copy of this Manual and submit a signed acknowledgment form to the Compliance Officer.

b. **Annual Training.** The Compliance Officer is responsible for ensuring that an annual review occurs for all staff regarding this Compliance Manual and the requirements of the Compliance Program. In addition, the Compliance Officer will develop a schedule of occasional training on compliance issues, as necessary, for new and existing personnel. The Compliance Officer will maintain a record of all personnel who have attended such training.

c. **Remedial Training.** Finally, the Compliance Officer will be responsible for any remedial training that is required as part of the Compliance Program.

5. **Compliance Contacts And Numbers.** Hospital personnel may contact the Compliance Office with any compliance question or issue. The people and telephone numbers to call are:

- **The Compliance Officer.** The Compliance Officer is Keith Wolf; he can be reached at (718) 960-6500.
- **The Compliance Coordinator.** The Compliance Coordinator is Deborah Schneider; she can be reached at (718) 960-5813.
- **Compliance Hotline.** The dedicated voicemail Hotline number is (718) 960-3705.
- **Compliance Fax Number.** The Compliance fax number is (718) 960-6615.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Compliance Manual for St. Barnabas Hospital's Compliance Program.

I agree to read the Manual, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the Code of Conduct, and to cooperate with management in carrying out the objectives of the Compliance Program.

Acknowledged and agreed:

Signature

Print name

Job Title or Description

_____, 200__
Today's Date

APPENDIX A

Policy Name: Compliance with Applicable Federal and State False Claims Laws	Date:
Revision:	Date:

POLICY

It is the Hospital’s policy that all employees (including management and employed physicians) and contractors and other agents (including consultants and non-employed physicians associated with the Hospital) shall comply with all applicable Federal and New York State false claims laws and regulations. The Hospital has instituted various procedures, which are set forth in Section III of the Hospital’s Compliance Manual, to ensure compliance with these laws and to assist the Hospital in preventing fraud, waste and abuse in Federal health care programs.

I. FEDERAL LAWS

A. The Federal False Claims Act (31 USC §§3729-3733)

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

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease 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 \$10,000,¹ plus 3 times the amount of damages which the Government sustains because of the act of that person

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information;

¹ Although the statutory provisions of the False Claims Act authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation and increased by regulation to not less than \$5,500 and not more than \$11,000. 28 *CFR* §85.3(a)(9).

(2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

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 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) is 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 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 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.

B. 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, then 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, 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 prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. Civil And Administrative Laws

i) NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000 - \$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit, or 15-25% if the government did participate in the suit.

ii) 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 5 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.

iii) Social Services Law §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 person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over \$3,900) and five years for 4 or more offenses.

B. Criminal Laws

i) Social 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.

ii) Social Services Law § 366-b -- Penalties for Fraudulent Practices

- 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.
- Any person who, with intent to defraud, presents for payment any 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.

iii) 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. It has been applied to Medicaid fraud cases.

- Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.
- Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.
- Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.
- First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

iv) 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:

- §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.

- § 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.
- §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.
- §175.35, 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.

v) **Penal Law Article 176 -- Insurance Fraud**

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

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

vi) **Penal Law Article 177 -- Health Care Fraud**

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

- Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
- 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.

- Health care fraud in the 3rd degree is filing false claims and annually receiving over \$10,000 in the aggregate. It is a Class D felony.
- Health care fraud in the 2nd degree is filing false claims and annually receiving over \$50,000 in the aggregate. It is a Class C felony.
- Health care fraud in the 1st degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

A. Federal False Claims Act (31 U.S.C. §3730[h])

The FCA provides protection to *qui tam* relators 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.

B. NY False Claim Act (State Finance Law §191)

The False Claim Act also provides protection to *qui tam* relators 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.

C. New York Labor Law §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.

D. New York Labor Law §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.