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POLICY ON FRAUD, WASTE AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

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INTRODUCTION

The Federal government has enacted a law, Section 6032 of the Deficit Reduction Act of 2005, effective January 1, 2007 requiring entities such as Albany Medical Center (“AMC”) that receive Medicaid funds in excess of \$5 million annually to establish written policies providing detailed information about fraud, waste and abuse in Federal health care programs. Albany Medical Center must disseminate these policies to its employees, agents and contractors. Additionally, the employees, agents and contractors must, in performing work for Albany Medical Center, adopt and abide by the policies. Albany Medical Center’s policy on this topic is provided below. The policy, as well as updates and changes to the policy, may also be accessed at www.amc.edu.

If after you review this policy you have questions, contact the Corporate Compliance & Audit Department at 518-262-4692. Concerns potentially implicating the laws cited in the policy may be reported anonymously to Albany Medical Center by calling 518-262-HELP.

POLICY STATEMENT

It is the policy of Albany Medical Center to comply with all applicable Federal and State laws pertaining to fraud, waste and abuse in Federal health care programs including Section 6032 of the Deficit Reduction Act of 2005 and disseminate information to its employees, including management, and to its contractors and agents regarding:

- Federal laws and administrative remedies and State laws related to false claims and statements, and whistleblower protections under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs, and
- Albany Medical Center’s policies and procedures for detecting and preventing fraud, waste and abuse, and related whistleblower protections pertaining to the laws discussed in this policy.

SUMMARY OF FEDERAL AND STATE LAWS RELATED TO FRAUD, WASTE AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

(I) Federal Laws

False Claims Act (31 U.S.C. §§ 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 (7) 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, 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; (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.

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.

Administrative Remedies for False Claims (31 U.S.C. §§ 3801 – 3812)

Federal law¹ also provides for administrative remedies for situations in which a person or entity submits a claim if the claimant has reason to know such claims are false or are supported by a materially false statement. “Administrative remedies” means that a Federal agency is responsible for enforcement and conducts the investigation and proceedings, determines whether the claim is false and imposes fines and penalties, instead of prosecution of the matter in the Federal court system. The law applies to all claims made to the Federal government including Medicaid claims because Medicaid is partially funded by the Federal government. Unlike the FCA, a violation of this law occurs when a false claim is submitted, not when it is paid. The consequence of violating this law is that the violator will be subject to a civil penalty of up to \$5,000 for each false claim and an assessment of damages up to twice the amount of the claim. There is no *qui tam* (private enforcement) provision under this law. Under the administrative process, the Federal agency conducts an investigation of the allegations and, if the agency believes there is sufficient evidence to support the allegations, the matter is sent to the U.S. Attorney General who may send it on to an administrative law judge for a hearing. If an administrative hearing is conducted, it is similar to court proceedings (with the right to counsel, to know the evidence, to confront and cross-examine witnesses and to offer a defense). There is also an appeals process. The penalty or assessment against the violator, if upheld, is then recovered by the U.S. Attorney General.

(II) NY 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

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

The NY False Claims Act closely tracks 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.

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.

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 needs are not taken into account in determining that person's need, or that of his or her family for 6 months if a first offense, 12 months if a second, 18 months if a third (or once if benefits received are over \$3,900) and five years for 4 or more offenses.

B. Criminal Laws

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.

Social Services Law § 366-b Penalties for Fraudulent Practices

1. 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.
2. 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.

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.

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

- d. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

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:

- a. § 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.
- 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 an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176 Insurance Fraud

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

- 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 \$1million. It is a Class B felony.
- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177 Health Care Fraud

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

- a. 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.
- b. Health care fraud in the 4th degree is filing false claims and annually receiving over \$3,000 in the 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 the 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 the 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 the aggregate. It is a Class B felony.

(III) Whistleblower Protection

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.

NY False Claims Act (State Finance Law § 191)

The False Claims 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.

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.

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.

ALBANY MEDICAL CENTER'S FRAUD, WASTE AND ABUSE PREVENTION AND DETECTION MEASURES AND WHISTLEBLOWER PROTECTIONS

Unless otherwise stated, the information below is applicable to the following Albany Medical Center entities: Albany Medical Center, Albany Medical College, Albany Medical Center Hospital, Albany Medical Center – South Clinical Campus, Center for Donation and Transplant, Albany Medical Center Foundation, Albany Medical Center Kidskeller and Madison Avenue Services Corporation; and to members of their Board(s) of Directors, non-Board members of Board Committees, employees, volunteers, non-employed practitioners who have assigned their billing rights to any of the above entities and individuals who through a contractual arrangement hold positions of responsibility within any of the above entities.

1. Prevention Measures

Compliance Program - Albany Medical Center has a Compliance Program, the following aspects of which pertain to the prevention and detection of false claims and statements and impermissible financial transactions which result in health

care fraud and abuse: the Code of Conduct, the Corporate Compliance Plan, the Conflict of Interest Policy and the Laboratory Compliance Plan.

Education - Various departments including the Corporate Compliance & Audit Department, the Faculty Practice and Health Information Services provide education through a number of initiatives including the following: providing in-person and on-line individual or group billing and coding compliance education; publishing a periodic informational newsletter featuring articles designed to prevent fraud, waste and abuse associated with Federal health care programs; providing annual compliance education to all employees and volunteers through AMC's mandatory Annual Education Module; maintaining an intranet website containing billing compliance educational material; disseminating educational information supplied by Medicare and Medicaid through e-mails, mailings and links to monthly bulletins on the AMC intranet; sponsoring audio conferences focusing on billing compliance topics; participating in AMC events such as the Annual Education Fair and National Corporate Compliance & Ethics Week to heighten compliance awareness; and distributing an Annual Laboratory Compliance Notice to ordering practitioners which gives examples of situations to avoid in order to prevent false claims. In addition, Albany Medical Center employs a number of individuals who have earned coding certification through accrediting bodies such as the American Health Information Management Association and the American Academy of Professional Coders.

Reporting Mechanisms - Anyone may report concerns through the Compliance Hotline: 518- 262-HELP (518-262-4357) on an anonymous basis. In addition, reporting can be made directly to the Corporate Compliance & Audit Department staff.

Background Checks - Beginning March 2004, the AMC Security Department performs criminal background checks on individuals following an offer of employment, but prior to the individual starting work. Based on the results of the criminal background check, an individual's offer of employment may be rescinded. The Corporate Compliance & Audit Department also checks all employees, vendors, volunteers (including members of the Board of Directors and Board Committees) and members of the medical staff against various lists published by Federal and New York State agencies. These lists identify, among other things, individuals and entities who have been convicted of health care fraud. Appropriate steps are taken with regard to individuals and entities appearing on a list.

Legal Review of Contracts - Business transactions with external parties are reviewed by the AMC Legal Department. This review includes attention to compliance with fraud and abuse laws.

2. Detection Measures

Billing and Coding Edits - Albany Medical Center has implemented various billing and coding edit software packages to assist in detecting billing and coding which is not compliant with rules associated with Federal health care programs.

Audits - The Corporate Compliance & Audit Department, the Faculty Practice and Health Information Services all perform audits of medical record documentation to ensure compliance with the billing requirements of Federal health care programs. In addition, Corporate Compliance & Audit performs periodic internal audits designed to detect fraud, waste and abuse. Many of these audits focus on high-risk areas such as those identified in the U.S. Office of Inspector General's Annual Work Plan and in Medicare's Focused Medical Reviews.

Investigations - The Corporate Compliance & Audit Department performs investigations based upon reports of possible fraud, waste or abuse associated with Federal health care programs. When appropriate, the department involves outside agencies, such as in instances where a patient presents at AMC using another individual's Medicaid card.

3. AMC Whistleblower Protections

There will be no retaliation against anyone who internally reports a concern made in good faith (meaning the individual has reason to believe there is a factual basis for the concern). Concerns are reported to the Corporate Compliance & Audit Department staff. All reported concerns and claims of retaliation will be investigated and any individual whom AMC believes has engaged in acts of retaliation will be subject to appropriate corrective action.

¹ 31 U.S.C. § 3802