

**FRAUD AND ABUSE COMPLIANCE TRAINING**

**VIP HEALTH SERVICES, INC.**

**AND**

**VIP HEALTH CARE SERVICES**

**MISSION STATEMENT  
VIP HEALTH SERVICES, INC.**

VIP Health Services, a certified home health agency, is dedicated to giving comprehensive, high quality home care in the patient's place of residence. Educating patients and families to make informed decisions about health concerns related to their unique physical and psychological health care needs is of primary importance.

VIP Health Services, provides home health services that help patients achieve a level of well being consistent with their lifestyle and environment. This is accomplished through the collaborative effort of agency personnel, the patient, family, and involved community resources.

**MISSION STATEMENT  
VIP HEALTH CARE SERVICES, INC.**

VIP Health Care Services, a Home Care Services Agency licensed by the New York State Department of Health, has as its primary mission the provision of the highest quality patient care services to the clients that are served by the Company. This service is to be provided in the client's home so that he/she may remain a part of his/her family, and in turn, a member of society, and to maintain a normal lifestyle as long as possible.

**Our Philosophy**

VIP Health Services, and VIP Health Care Services (collectively referred to as "VIP") is dedicated to the provision of comprehensive, high quality home care and community support services centered around the client's place of residence in the community. Services are focused on meeting each client's unique health care, physical and psychological needs within their own familiar surroundings.

VIP provides home health and home care services that help the client achieve a level of well-being consistent with his or her lifestyle and environment. This is accomplished through the collaborative effort of VIP, the client, the family and available community resources.

VIP is also dedicated to educating the client and family to enable them to make informed decisions about concerns affecting their health and well-being and to achieve a sense of community resource awareness.

### **Our Values/Objectives**

1. To provide essential health and welfare services.
2. To serve as a resource for the client, the client's family and community.
3. To provide the highest quality health care and supporting services in familiar surroundings.
4. To facilitate the attainment of optimal rehabilitation and well being.
5. To assist the client and family in maintaining as normal a lifestyle as possible.

## VIP'S ETHICS PROCESS

In order for the Ethics Process to work successfully, each employee must recognize that he or she has assumed a number of responsibilities by joining VIP'S staff. If all employees live up to their responsibilities, the Ethics Process can succeed. What responsibilities do you as an employee have?

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First, each employee is responsible for making sure his or her conduct is totally in conformity with the Standards of Conduct. If at any time you have a question as to whether a procedure or action is appropriate under the Standards, then you should ask your immediate supervisor. If you do not feel comfortable discussing the situation with your supervisor, or if you have discussed the matter and remain unclear as to what is appropriate conduct, then you should go for help to:

The procedure manuals available throughout the office.

The Compliance Officer.

The Compliance Officer position was created so that any employee who has a question about what was proper conduct can confidentially consult the Compliance Officer for informed guidance. Our Compliance Officer can take whatever action is necessary to investigate a complaint and institute corrective action if required. It is also part of the Compliance Officer's responsibilities to answer questions about the Standards of Conduct and resolve disputed interpretations. You should have no hesitation whatsoever in consulting the Compliance Officer if you believe it necessary.

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Second, it is the responsibility of each employee to report any violations of the Standards of Conduct of which the employee is aware. You can satisfy this reporting obligation in several ways. One way is to make a report on the VIP hotline number (718/847-WORK Ext. VIP). Your report will be evaluated by the Compliance Officer to determine whether an investigation is warranted. A second alternative is to send a letter to the Compliance Officer or to drop a note in any of VIP'S suggestion boxes. You may choose to identify yourself or remain anonymous.

All letters to the Compliance Officer, notes to the suggestion boxes and hotline reports will be handled on a strictly confidential basis. Whether you contact the Compliance Officer or make use of a suggestion box or the hotline, you may choose to remain anonymous.

VIP will not retaliate against any person for filing a complaint, participating in an investigation, or opposing any unlawful act relating to suspected fraud and abuse.

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The Standards of Conduct must be followed by all VIP employees and independent contractors. This obligation applies to every employee of VIP, no matter what their position, whether staff or supervisory and any individual providing services as an independent contractor to VIP.<sup>1</sup> Any violation of the Standards is a serious matter. Under appropriate circumstances, and after proper procedures have been followed, employees may be subject to disciplinary actions, up to and including termination, for violations of these Standards. Independent contractors may have their contracts terminated.

VIP'S Standards of Conduct is not an employment contract between VIP and the employee. The Standards of Conduct should not be interpreted as a promise of continued employment.

#### ANTI-RETALIATORY POLICY

VIP will not retaliate against any person for filing a complaint, participating in an investigation, or opposing any unlawful act relating to Fraud and Abuse Compliance.

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All references to “employees” in this Compliance Program shall be deemed to include independent contractors providing services to VIP.

## **I. STANDARDS OF CONDUCT**

### **A. Standard No. 1: Client Care and Comfort**

VIP is dedicated to offering the finest quality home care and community support for our clients. Our services are provided by VIP employees in accordance with the mission and values of VIP, as well as with federal and State laws and regulations. Our business is oriented to the individuals we serve. VIP stands behind the products it provides and pledges to make treatment and support services as caring and well-coordinated as possible.

#### **Standards of Conduct**

1. VIP's purpose is to provide the highest quality of care for persons requiring nursing, therapy, social work, nutrition, aide services, necessary medical supplies, and coordination of other health services provided to them in their home and for persons requiring community-based care and support services in their home. In discharging that responsibility, the safety and well-being of our clients must be the paramount considerations.
2. We deal with each client on an individual basis. When VIP staff communicate with and attend to clients, they will respect each client's dignity. We also pledge to ensure that every client understands the reasons for any recommended treatment or service, how the treatment or service will be accomplished, what follow-up will be required by family or other caregivers, under what circumstances VIP services will be discontinued and how the discontinuation of services will be handled. We welcome the participation of family members and other caregivers in assisting the client with his or her treatment or community care regime.
3. We will furnish each client, no matter what the payment source or level of reimbursement, with the same high level and cost-effective services.
4. VIP employees will be properly licensed and credentialed, as appropriate, and will be skilled at the services they perform. In addition, all supervisory employees will have the training, education, experience and credentials appropriate to their position.
5. VIP complies with all federal and state laws and regulations regarding its clients' rights. If requested by federal or state authorities, VIP will facilitate obtaining permission from a client to allow a government surveyor to visit a client in his home. A written consent from a client also will be obtained when a nurse trainee, who is not yet an employee of VIP, accompanies a nurse on a client visit.
6. Clients approved to receive home health care services will be given a copy of VIP's "Client's Bill of Rights and Responsibilities" and information regarding Advance Directives. We will undertake to ensure that before any client consents to receive services from VIP, the client has been fully informed of the benefits of, and possible alternatives to, receiving care in a "home" setting.

7. We operate a sound continuous quality improvement program and, on a periodic basis, review and evaluate our training programs, procedures, medical standards and treatment results to ensure that our care remains of the highest quality.
8. Home health care services clients will be admitted, treated, and discharged from home care pursuant to the requirements of all pertinent federal and New York State statutes and regulations. Such clients will not receive any treatment from VIP staff or contractors prior to admission to VIP. Notification of a client's discharge date will be communicated to all staff providing services to the client.
9. Employees within each division of VIP work together to provide high-quality care consistent with VIP's Mission Statement and this Standard of Conduct. When a client receives services from multiple disciplines, interdisciplinary team conferences will be conducted periodically to coordinate and evaluate services rendered.
10. VIP will employ and train sufficient staff and supervisors to provide quality services that lead to optimal rehabilitation and well-being.
11. The Director of Education will develop an orientation program for new staff and an inservice program for all staff and supervisors to include, as appropriate, the areas of Medicare and Medicaid coverage requirements and clinical topics. Inservice training will be conducted on a periodic basis. The Director of Education also will be responsible for establishing a system to share information from conferences attended by VIP employees and the distribution of conference materials.
12. As appropriate, VIP employees will receive inservice training on documentation of services provided to clients.
13. Periodic staff meetings will be held with VIP staff located at adult care facilities where VIP is providing services.
14. VIP will provide sufficient supervision of all staff. Supervision will include:
  - a. Visits on a regular basis by Field Supervisors to adult care facilities where VIP is providing services;
  - b. Unannounced visits by Clinical Service Supervisors at the adult care facilities where VIP is providing services;
  - c. As appropriate, VIP employees will be required to keep a record of the amount of time spent with a client during each visit by recording the time at the beginning and end of the visit, and requesting the client to verify the time spent with his/her signature;

- d. Clinical Service Supervisors will conduct case conferences with nursing staff biweekly; and
  - e. VIP will maintain a system to identify the number of clients assigned to a nurse and/or home health aide at any given time.
15. Periodically, supervisory personnel will visit a client when the home health aide is not present in order to ascertain whether the client has any complaints about the aide.
  16. When VIP is responsible for creating a Plan of Care for a client, the Plan of Care will be individualized to meet the unique needs of the client.
  17. Where applicable, clinical notes reflecting services actually performed will be submitted to the Clinical Services Supervisor within seven days of the visit to the client, and will be reviewed by supervisors within the context of the medical chart.
  18. For those clients receiving home health care services, VIP will maintain a policy for the maintenance of medical records which promotes appropriate availability of the information contained in the medical records to the staff members responsible for the client's care. Criteria for creating a community or working chart will be established for use by staff in the client's homes or in an adult care facility.
  19. VIP will encourage communication and exchange of information among staff working in the community and staff working in adult care facilities.

**B. Standard No. 2: Compliance with Laws and Regulations**

While providing home health care and community support services is our primary goal, it is not the only responsibility VIP assumes. VIP will furnish treatment in accordance with all pertinent federal and New York State laws. We will ensure that all our dealings with physicians, staff, and suppliers are in conformity with pertinent laws and regulations.

**Standards of Conduct:**

1. Treatment recommended and implemented by VIP will be medically necessary as judged by the relevant professional standards.
2. VIP will not pay to or offer any person, or any entity, consideration or free services in return for referral of clients. Such "kickbacks" are illegal and will not be tolerated.
3. It is also illegal, contrary to the Medicare/Medicaid Fraud and Abuse statutes and contrary VIP's standards of conduct to offer any financial inducement, gift or bribe to prospective clients in order to encourage them to accept services from VIP.

4. All billing and client records will be accurate and complete, and as detailed as required by government standards. All verbal orders will be documented in the medical chart, where applicable.
5. All requests for reimbursement submitted to federally- funded insurance programs (such as Medicare, Medicaid, or CHAMPUS) as well as to any private insurance provider will contain only true and accurate data, and no services will be billed unless fully justified by instructions from VIP staff and reflected in client records.
6. All contracts will be reviewed by VIP's counsel for conformity with all federal and New York State laws and regulations.
7. VIP will be forthright and candid in dealing with any governmental inquiries. Any requests for information will be responded to with complete, factual and accurate information tendered in a cooperative attitude.
8. Any decision to offer VIP's services at other than its usual charges, including VIP's services at other than its usual charges rendered in connection with managed care contracts, will be made only by the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable, or with the express agreement of that individual. Decisions to offer charity care shall be made pursuant to VIP's policies and procedures. All decisions to waive or reduce charges will be fully documented and appropriate documentation placed in VIP's file.
9. VIP will provide employees with all information they need to comply with pertinent federal and New York State laws and regulations. VIP will also afford employees involved in billing with appropriate internal and external training as necessary in VIP's judgment to keep abreast of new laws, regulations, and directives.
10. VIP requires that all professional and paraprofessional staff, whether employed directly or engaged on contract, continuously be in compliance with the federal and New York State requirements relating to their respective disciplines.
11. The services of any Intake Coordinators on the staff of VIP Health Services, Inc. will be charged to the Medicare program in compliance with the requirements of Provider Reimbursement Manual, HCFA Publication 15-1, § 2113 *et seq.*
12. VIP will comply with the reporting obligations and substantive requirements of the Safe Medical Device Act as required by 42 C.F.R. § 484.10; 60 Fed. Reg. 33201 (6/27/95).
13. VIP will advise its clients of the availability of the toll-free New York State Department of Health Hotline, its hours of operation, and its purpose to receive complaints or questions about local home health agencies pursuant to 42 C.F.R. 484.10(f).
14. In New York State, "adult care facilities" include "adult homes" as defined in 18 NYCRR Social Services § 487.2, "residences for adults" as defined in 18 NYCRR Social Services § 490.2, and "assisted living programs" as defined in 18 NYCRR Social Services § 494.2.

Each of these programs have defined "resident services" which the adult care facility must provide and personnel requirements including staff/resident ratios. VIP will ensure that clients admitted to home care in adult care facilities are eligible for home care services pursuant to Medicare, Medicaid or private payor requirements and that VIP is not providing services which are the responsibility of the adult care facility.

**C. Standard No. 3: Business Conduct and Billing Practices**

In order to satisfy the laws and regulations within which VIP operates, it is essential that our daily business practices maintain the highest standards.

**Standards of Conduct:**

1. All business records must be accurate. All employees must record and report information accurately and honestly. All client records, whether medical or for billing purposes, must contain only accurate information. No entry to any VIP record should hide or disguise any fact. If any employee has a question about whether any entry to a client or billing document is appropriate, that employee should discuss the matter with a supervisor, or the Administrator of VIP Health Services, Inc. or the Director of Licensed Services of VIP Health Care Services, as applicable.
2. All documents and records should be maintained in accordance with the rules contained in VIP's record retention program. No documents or records should be destroyed unless destruction is specified in VIP's document destruction guidelines. No documents or records should be retained for a period longer than that specified in the guidelines. Copies of the guidelines for document retention and destruction are attached as Appendix D.
3. All VIP records and documents are of a highly confidential nature. They should not be disclosed to anyone who is not employed by VIP without the written permission of the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable. Client records and documents are particularly sensitive and may not be disclosed to anyone who is not employed by VIP Health Service without the written authorization of the individual client in addition to the permission of the Administrator or Director . This obligation continues even if you leave employment with VIP.
4. VIP employees must respect and protect VIP property. No VIP property may be used for personal purposes. No VIP property may be removed from VIP without the permission of the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable.
5. VIP will employ and train sufficient qualified staff to ensure proper billing of all claims. Employees required to make Medicare coverage or coding decisions will be properly trained.

6. If VIP determines that services provided to a client are not covered or no longer qualify for payment by the Medicare program, where applicable the client will be given a Facility Denial Letter indicating the specific services which VIP determined to be not covered. A copy of this letter will be sent to the attending physician and to the fiscal intermediary when requested or required. The letter must state that the client may request VIP to file a claim with Medicare. If the client makes such a request the claim will be submitted to the fiscal intermediary with a demand code 20. The medical record will be documented to explain why VIP determined that the services are not or no longer are covered by the Medicare program.
7. Where VIP is billing third party payors for services, VIP will ensure that claims are billed to the appropriate payor. For example, home health aide claims that should be split between Medicare and Medicaid will be billed accordingly.
8. VIP will ensure that communication and coordination exists between the Billing and Clinical components of the agency. For example, any change in the client's plan of care regarding frequency and type of visit will be communicated timely to the billing department.
9. Senior management who have administrative responsibilities in VIP's programs will account for their time pursuant to a methodology agreed to by the fiscal intermediary so that the costs of their services are borne by the appropriate program.
10. All costs reports submitted to the Medicare and Medicaid programs will be prepared consistent with federal and New York State requirements and contain only information supported by the books and records of the facility.

**D. Standard No. 4: Conflicts of Interest**

VIP employees may not participate in any activities or business endeavors which could pose a conflict with their responsibilities to VIP. Whenever personal interests or activities of the employee may affect the employee's ability to act in the best interest of VIP and its clients, a conflict of interest situation has arisen. Employees should avoid even the appearance of a conflict of interest.

**Standards of Conduct:**

1. Loyalty to VIP and its mission is an underlying principle of employment and an employee must constantly review his or her conduct to make sure that not even the appearance of a conflict exists.
2. All decisions made by the employee should be in the best interests of VIP and its clients -- no considerations can be allowed to undermine this fundamental employee commitment.

3. Employees should avoid placing business, or recommending that business be placed, with a company in which they, their families or close personal friends have an interest, unless the nature of this relationship is fully disclosed to management.
4. In situations in which management approves business relationships with related parties, such relationships will be disclosed pursuant to pertinent federal and New York State rules and regulations.
5. Employees shall inform the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable, if they recommend the hiring of a close family member.
6. Except for the occasional modest expressions of gratitude from clients, employees should refuse gifts, loans or anything of value offered by outside individuals or companies if accepting such gifts might make the employee believe he or she has an obligation to the giver of the gift or loan. Receipt of any gift or loan from an outside source should be approved by the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable. Under no circumstances may gifts or loans be accepted from outside individuals or organizations that currently conduct business with VIP or which wish to conduct business with VIP.
7. Employees must not own, directly or indirectly, an interest in any business that competes with VIP, unless the Administrator of VIP Health Services, Inc. or the Director of VIP Health Care Services, as applicable, has given written approval.
8. No outside employment will be permitted if it will interfere or conflict with employment by VIP. For example, no mention of the employee's association with VIP can be made in connection with securing or conducting a second job or undertaking self-employment. In addition, employees may not use VIP time, assets, facilities, materials, influence or services for their own outside activities, including charitable work, unless approved by the Administrator of VIP Health Services or the Director of VIP Health Care Services, as applicable, and recorded, in writing, in the employee's personnel file. All outside employment must be disclosed to VIP.
9. All board members and management personnel must disclose any existing or potential conflict of interest. When VIP elects to place business with an organization in which VIP officers or board members, management personnel or their families have an interest, the Controller will be informed of the situation to ensure that the transaction with the related organization is reported properly on VIP's cost reports.

**II. IMPLEMENTING THE CODE--THE COMPLIANCE OFFICER AND THE COMPLIANCE OVERSIGHT COMMITTEE**

A Compliance Officer has been designated. She will be supervised and assisted in her duties as Compliance Officer by the Compliance Oversight Committee, consisting of the following:

President/Chairperson of the Board  
Administrator/Director of Patient Services, VIP  
Health Services  
Administrator/Director of Patient Services, VIP  
Health Care Services  
Director Quality Assurance – VIP Health Services  
Vice President - Human Resources  
Vice President - Program Support Services  
Vice President - Finance  
Billing & Payroll Manager

Both the Compliance Officer and the Compliance Oversight Committee will be responsible for the discharge of their respective responsibilities under the compliance plan to the Chairperson of the Board of Directors.

### **III PERTINENT FEDERAL AND NEW YORK STATUTES AND REGULATIONS**

#### **FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS**

##### **I. FEDERAL LAWS**

###### **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 (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,

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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.

## **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, 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 live 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.**

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment and 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 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.

## **II. 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.

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.

### **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.

### **III. 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**

##### **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.

##### **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.

##### **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.