



Notice Pursuant to Deficit Reduction Act of 2005 §6032

INTRODUCTION:

It is the policy of Mohawk Valley Health System (“MVHS”) that all Affected Individuals, including employees, medical staff, contractors, subcontractors, independent contractors, agents, governing body and corporate officers, shall comply with all applicable Federal and New York State false claims laws and regulations and whistleblower protections. As part of this MVHS Compliance Program, employees and others receive training on these laws, which are summarized below, and should consult with MVHS’s Chief Compliance Officer if they have any questions about the application of these laws to their job.

MVHS also provides this notice to its contractors and agents in order to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005, and 18 NYCRR SubPart 521-1.4(a)(2)(ix), which requires healthcare entities to establish written policies and procedures informing their Affected Individuals about federal and state false claims acts and whistleblower protection and how MVHS is working to detect and prevent healthcare fraud, waste and abuse. Below is a summary of those efforts and laws. A complete description follows this summary.

For purposes of Section 6032 and SubPart 521-1, contractors or agents not associated with the provision of healthcare items or services, such as copy or shredding services, grounds maintenance, snow plowing, hospital cafeteria or gift shop services, are excluded from the definition of Affected Individuals.

All Affected Individuals are responsible for reporting to MVHS any suspected fraud, waste, abuse, violations of false claims laws, or any other suspected unlawful conduct or violations of MVHS policies, including the MVHS Code of Conduct. MVHS encourages reporting of suspected violations to the MVHS Chief Compliance Officer at 315-624-5050 or tenigk@mvhealthsystem.org. Suspected violations may also be reported anonymously to the MVHS Compliance Hotline at 1-800-954-9418. All concerns reported in good faith are protected under MVHS’s non-retaliation and non-intimidation policy.

COMPLIANCE PROGRAM:

MVHS is committed to detecting and preventing healthcare fraud, waste and abuse. In an effort to support this commitment, MVHS has a Compliance Program in place which improves the MVHS Network/System’s ability to operate in such a manner and to perform its mission. The Compliance Program helps ensure that service is delivered to patients and business is conducted with third party payors, employees, independent contractors, and other individuals who are representing MVHS using honest and ethical behavior.

MVHS and its entities provide many services. There are complex, ever-changing rules and regulations that guide each particular type of service that MVHS follows to help ensure compliant behavior.

Fraud is when a dishonest provider (i.e. hospital, physician, diagnostic center) or consumer (i.e. patient) submits on purpose, or causes someone else to submit, false or misleading information that is used in deciding how much health care benefits should be paid.

The purpose of the Compliance Program is to include into policies and procedures appropriate processes that will help ensure regular compliance with Federal and State laws and regulations, and guarantee efforts in seeking to prevent and detect violations of the law by employees and other individuals who are representing MVHS.

FEDERAL LAW:

False Claims Act:

The Federal False Claims Act can punish and fine individuals and businesses that bill Medicare, Medicaid and other federal health care programs for false or fraudulent claims.

The Act also allows a private person to file a lawsuit in federal court against an individual or business, just as if they were a federal prosecutor. If the person who filed the lawsuit wins, he or she can receive 25% - 30% of the money awarded if the government did not participate in the lawsuit, or 15% - 25% if the government did participate in the lawsuit.

Administrative Remedies for False Claims:

The Administrative Remedies for False Claims is a law that allows the government to take back money from a person or business that submits a bill that is false, has false information in it or leaves information out of it. The government agency that receives that bill can impose a punishment for each bill they receive.

This law is different from the Federal False Claims Act because a person can break this law by just submitting the bill, even if the bill is not paid. In addition, to decide whether or not someone broke this law, a government agency makes the decision, not the federal court.

NEW YORK STATE (NYS) LAW:

In NYS some of the laws apply to people who receive false services (i.e. patients) and some of the laws apply to people to bill false services (i.e. hospitals, physicians, diagnostic centers). While most of the laws are specific to Medicare and Medicaid, some of the crimes apply to everyone.

In NYS there are two types of laws. The first group is administrative and civil laws and the second group are criminal laws.

Administrative/Civil Laws – *Social Service Law, Social Service Law False Statements, Finance Law:*

The administrative and civil laws say that any person who applies for or receives public assistance, including Medicaid, by making a false or a misleading statement on purpose, or intending to make a false or misleading statement, the person, or the person's family may not have their needs taken care of for a specific period of time.

In addition, under these laws, it is illegal to obtain or try to obtain on purpose payment for items or services performed under any Social Service program, including Medicaid, by using a false statement, hiding information or other fraudulent plans. If any of this were to happen and the person was found guilty, the state or social services may punish the person(s) for each crime.

The New York False Claims Act, like the federal False Claims Act, imposes penalties and fines on individuals and entities that file false claims for payment from any state or local government program, including Medicaid. This act also allows a private person to file a lawsuit in state court, in the place of state or local authorities. If the person who filed the lawsuit wins, he or she can receive a percentage of the money awarded by the court.

Criminal Laws - *Social Service Law Penalties, Social Services Law Penalties for Fraudulent Practices, Penal Laws – Larceny, False Written Statements, Insurance Fraud, Health Care Fraud:*

- Social Service Law Penalties -- Any person, who sends in false information or hides information on purpose in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
- Social Service Law, Penalties for Fraudulent Practices – Any person who gets or attempts to get for himself or others, medical assistance using a false statement, hides the truth, pretends to be someone else, or uses another fraudulent plan is guilty of a misdemeanor.
- Penal Law, Larceny – Larceny applies to someone who takes away property or withholds

property on purpose using things such as tricks, stealing or false promises. There are four degrees of grand larceny and each level depends on what the property is worth. This crime is a felony.

- Penal Law, False Written Statements – This law applies to someone that sends in false information on a bill. This law includes business records and bills requesting payment for services provided. This crime is a misdemeanor or felony.
- Penal Law, Insurance Fraud – This law applies when someone sends in a false bill to an insurance company, including Medicaid or other health insurance and has six crimes. This crime is a felony.
- Penal Law, Health Care Fraud – This law applies when someone sends in a bill for a health insurance payment knowing that the bill has false information in it or has information left out of the bill. The insurance payments include Medicaid and the law has five crimes. This crime is a misdemeanor or felony.

WHISTLEBLOWER PROTECTION:

New York Labor Law: An employer may not punish, threaten or intimidate an employee that has reported a concern against the employer to a regulator, law enforcement, public official, or other similar agency. The concern that the person reports says that the employer has violated the law and that it creates a danger to the public health and safety. The employee is protected under this law only when he or she has brought the concern to the employer's attention and allowed the employer the chance to correct the believed violation.

New York False Claims Act: Employees that are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment are provided protections. Solutions include employment with comparable seniority as the employee would have had before they were discriminated against, two times the amount of any back pay, interest on any back pay, and reimbursement for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Federal False Claims Act: An employee who is fired, demoted, suspended, threatened, harassed or discriminated against because the employee reported a concern under the False Claims Act, is entitled to full reimbursement.

*****Intentionally Left Blank*****

Compliance Program Summary

MVHS is committed to preventing and detecting healthcare related fraud, waste and abuse. In an effort to support this commitment, MVHS has a Compliance Program in place which improves the System's ability to operate in such a manner and to perform its mission. The Compliance Program helps ensure that service is delivered to patients and business is conducted with third party payors, employees, independent contractors, and other individuals who are representing MVHS using honest and ethical behavior.

MVHS and its entities provide many services that include, but are not limited to, medical and surgical services, home health, outpatient dialysis, behavioral health, and physician clinical services. There are difficult, frequently changing rules and regulations that guide each particular type of service that MVHS follows to help ensure compliant behavior.

The Compliance Program is approved and supported by the MVHS's Board of Trustees and Executive Leadership Team. The purpose of the Compliance Program is to include into policies and procedures appropriate processes that will help ensure regular compliance with Federal and State laws and regulations, and guarantee efforts in seeking to prevent and detect violations of the law by employees and other individuals who are representing MVHS. This includes but is not limited to board members, members of its medical staff, volunteers, students, and independent contractors.

Some of the parts in MVHS's Compliance Program include:

- A Compliance Officer who is responsible for the day-to-day operations of the Compliance Program.
- Written standards of conduct, as well as written policies and procedures that describe compliance expectations and promote MVHS's commitment to compliance for all employees and members of the Medical Staff.
- A Compliance Committee that is responsible for operating and monitoring the program, as well as working to correct any problems encountered.
- Regular education and training for all employees whose job descriptions could involve situations where violations of the law could arise.
- Procedures to encourage employees to bring to management's attention any situation that may be violation of a law without fear of threats or punishment.
- A way for employees and the public to report compliance issues or concerns confidentially and anonymously.
- A way to respond to claims of improper or illegal activities and the enforcement of appropriate disciplinary action against employees who have violated the Compliance policies.
- Audits and/or other evaluation methods to monitor compliance and assist in the decrease of identified problem areas.

If at any time you should have a concern or question, you should feel comfortable bringing your concerns forward. We encourage you to voice your concerns with your immediate supervisor or the leader of your service area, or the MVHS representative that you work with; however, if you feel uncomfortable speaking with him or her, or do not feel that your concern is being addressed properly, you may contact Tanya Enigk, Chief Compliance Officer, by phone at 315-624-5146 or by email at tenigk@mvhealthsystem.org.

If you do not feel comfortable voicing your concerns to any of those individuals, MVHS has a Compliance Hotline, managed by an independent third party, which allows callers to report concerns anonymously and without fear of punishment or intimidation. Calls are not traced. The Compliance Hotline number is 1-800-954-9418.

For more information, contact the MVHS Compliance Office at 315-624-5050.

Federal and New York State Statutes Related 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 (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G) or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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 a 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.

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. Administrative and Civil Laws

1. 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 of 15-25% if the government did participate in the suit.

2. 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.
3. 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

1. 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.
2. 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.
3. 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.
4. 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, altering, erasing, obliterating, deleting, removing, or destroying a true entry in the business record, omitting material information or altering an enterprise's business records, and preventing the making of a true entry or causes the omission thereof in the 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.
5. 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 \$1 million. It is a Class B felony.
 - f. Aggravated insurance fraud is committing insurance fraud, and has been previously convicted within the preceding five years of any offense, an essential element of which is the commission of a fraudulent insurance act. It is a Class D felony.
6. 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.

III. Whistleblower Protection

1. 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 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.

2. 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.
3. 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.
4. 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.