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

APPROVED: June 2, 2021
REFERENCE: Section 6032 of the Deficit Reduction Act of 2005

PURPOSE

Section 6032 of the Deficit Reduction Act of 2005, effective January 1, 2007, requires entities 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. These policies must be disseminated to employees, agents and contractors. Additionally, the employees, agents and contractors must, in performing work for the Albany Med Health System, adopt and abide by the policies. The Albany Med Health System'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 and related to any Albany Med Health System entity may be reported anonymously by calling the Compliance Hotline at 518-264-TIPP (518-264-8477).

POLICY STATEMENT

It is the policy of the Albany Med Health System 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. Various laws define these terms differently; however fraud, waste and abuse have been generally described as:

- ***Fraud*** – an intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself, herself or to some other person.
- ***Waste*** – means an over-utilization of services or misuse of resources not caused by criminally negligent actions, yet result in the expenditure of resources in excess of program needs and unnecessary costs.
- ***Abuse*** – practices inconsistent with sound fiscal, business or medical practices that result in unnecessary cost, the reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care.

  Fraud, waste and abuse also includes any act defined as constituting fraud, waste or abuse under applicable Federal or State law.

It is the policy of the Albany Med Health System that each entity receiving Medicaid funds in excess of $5 million annually will disseminate information to its employees, management, contractors and agents regarding:

- The Albany Med Health System policies and procedures for detecting and preventing fraud, waste and abuse, and related whistleblower protections pertaining to the laws discussed in this policy.

- Federal laws and administrative remedies, and State laws, including those 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.

ALBANY MED HEALTH SYSTEM'S FRAUD, WASTE AND ABUSE PREVENTION AND DETECTION MEASURES AND WHISTLEBLOWER PROTECTIONS

Unless otherwise stated, the information below is applicable to the following Albany Med Health System entities: Albany Med Health System, Albany Medical College (including the Albany Med Faculty Physicians Group), Albany Medical Center Hospital (including Main Campus and South Clinical Campus), The Columbia Memorial Hospital, The Saratoga Hospital, Glens Falls Hospital, Saratoga Care, Inc., Healthcare Partners of Saratoga, Ltd., Center for Donation and Transplant, Albany Medical Center Foundation, Albany Medical Center Kidskeller Albany Medical Center Auxiliary, 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 - The Albany Med Health System 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 for lead affiliate entities;, the Trust in Principled Performance Compliance Program for Albany Medical Center, Columbia Memorial Hospital, Glens Falls Hospital, The Saratoga Hospital, and affiliated entities; and the Conflict of Interest Policy.

   Education - Various departments including but not limited to Corporate Compliance & Audit Department, provide education through a number of initiatives. These initiatives include: billing and coding compliance education; annual compliance education; an intranet website containing educational material; and sponsoring audio conferences on various compliance topics. In addition, Albany Med Health System 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: 518-264-TIPP (518-264-8477) on an anonymous basis. In addition, reporting can be made directly to the Entity Compliance Officer, members of the Entity's Compliance Program Council, or the Corporate Compliance & Audit Department.

   Background Checks - Criminal background checks are performed 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. Each lead affiliate 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. Legally required steps are taken with regard to individuals and entities appearing on a list.

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

2. Detection Measures

   Billing and Coding Edits – Entities of the Albany Med Health System have 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.

   Internal Reviews - Compliance Program Resources across the System perform reviews of medical record documentation to ensure compliance with the billing requirements of Federal health care programs. In addition, Corporate Compliance & Audit staff perform 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, in the NYS Office of the Medicaid Inspector General's Medicaid Work Plan, and other areas of special concern identified through applicable regulatory investigative and audit functions.

   Investigations – The Entity Compliance Officer, Corporate Compliance & Audit Department members, and other identified Compliance Program Resources perform 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 a System Entity using another individual's Medicaid card. When there is an external investigation, affected Individuals are informed not to destroy any pertinent documents and to assist the Albany Med Health System in responding appropriately.

3. Albany Med Health System Whistleblower Protections
   Albany Med prohibits retaliation and intimidation against anyone who reports a concern made in good faith (meaning the individual has reason to believe there is a factual basis for the concern). All reported concerns and claims of retaliation or intimidation will be investigated and any individual who has engaged in acts of retaliation or intimidation will be subject to appropriate corrective action.

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

(I) Federal Laws

A. Civil and Administrative Laws

False Claims Act (31 U.S.C. §§ 3729-3733)
The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; 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, or conspires to commit such acts, is liable to the United States Government for a civil penalty of not less than $11,803, and not more than $23,607 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person. The Patient Affordability and Accountability Care Act, which is the health care reform act signed into law in March 2010, makes it mandatory that any funds a person receives or retains under the Medicare or Medicaid program, which the person after applicable reconciliation is not entitled to, must be reported and returned by the later of sixty days after the date the overpayment was identified or the date any corresponding cost report is due, if applicable. This means that a False Claims Act violation can be found if an overpayment is not timely reported and returned. The health care reform act also made a claim for items or services resulting from a violation of the federal Anti-Kickback law described below a violation of the False Claims Act.

(b) For purposes of the False Claims Act, the terms "knowing" and "knowingly" mean that a person, with respect to information: has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. The term "claim" means any request or demand for money or property that is presented to an officer, employee or agent of the United States or that is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government provides or has provided any portion of the money or property requested or demanded, or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

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 presents a claim to the federal government or to a contractor, grantee or other recipient to advance a government program or interest, where the federal government has provided any portion of the money or property requested or received, 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) are 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 which obtains interim payments from Medicare or Medicaid 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 or Medicaid 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 fifteen percent but not more than twenty-five 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 twenty-five percent and not more than thirty percent.

Administrative Remedies for False Claims (31 U.S.C. §§ 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, 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 rather than 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.

Prohibition of Certain Physician Referrals (42 U.S.C. § 1395nn commonly known as the Stark Law)

This statute, with certain limited exceptions, prohibits a physician from making a referral to an entity with which the physician, or an immediate family member of such physician, has a financial relationship, if the referral is for certain designated health services for which payment would otherwise be made by Medicare or Medicaid. The Stark Law is a strict liability statute which means that intent is not relevant to the determination that the statute has been violated; prohibited conduct absent intent is sufficient to violate this law.

B. Criminal Laws

Criminal Penalties for Acts Involving Federal Health Care Programs; Illegal Remuneration (42 U.S.C. § 1320a-7b(b) commonly known as the Anti-Kickback Law)

This statute, except for certain limited safe harbors, makes it a crime to knowingly and willfully solicit or receive any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for making a referral for, arranging for, purchasing, leasing, ordering or recommending any item or service for which payment may be made by a Federal health care program. Violation of this law is a felony and carries a fine of not more than $25,000 or a possible prison term of not more than five years, or both. The health care reform law enacted in 2010 states that a person need not have actual knowledge of the Anti-Kickback law or specific intent not to comply in order to be guilty of a violation.

(II) NY State Laws

New York State False Claims laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to health care or Medicaid, however some "common law" crimes apply to other interactions with the government.

A. Civil and Administrative Laws

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

The New York False Claims Act is similar to the federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act may be liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent 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 ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations 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 needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs, or that of his or her family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

Public Health Law § 587 Prohibited Practices (State Anti-Kickback Law)

Subject to limited exceptions, no provider shall solicit, receive, accept or agree to receive or accept any payment or other consideration in any form to the extent such payment or other consideration is given for the referral of services to a clinical laboratory; nor shall the provider participate in the division, transference, assignment, rebate, or splitting of fees with any clinical laboratory or any other provider in relation to clinical laboratory services.

Public Health Law Section § 238-a Prohibition of Financial Arrangements and Referrals (State Stark Law)

Subject to limited exceptions, a practitioner authorized to order certain designated health services may not make a referral for such services to a provider authorized to provide such services where the practitioner or immediate family member of such practitioner has a financial relationship with such health care provider.

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 a 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. This statute has been applied to Medicaid fraud cases.

a. § 155.30, Fourth degree grand larceny involves theft of property valued over $1,000. It is a Class E felony.

b. § 155.35, Third degree grand larceny involves theft of property valued over $3,000. It is a Class D felony.

c. § 155.40, Second degree grand larceny involves theft of property valued over $50,000. It is a Class C felony.

d. § 155.42, First degree grand larceny involves theft of 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 in the second degree 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

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes.

a. § 176.10, 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. § 176.15, Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. § 176.20, Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. § 176.25, Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. § 176.30, Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

f. § 176.35, Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177 Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment and it includes six crimes.

a. § 177.05, Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a Class A misdemeanor.

b. § 177.10, Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a Class E felony.

c. § 177.15, Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a Class D felony.

d. § 177.20, Health care fraud in the 2nd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a Class C felony.

e. § 177.25, Health care fraud in the 1st degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a Class B felony.

(III) Whistleblower Protection

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

The Federal False Claims Act provides protection to *qui tam* relators (individuals who commence a False Claims action) 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 lawful furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with the same 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 State False Claims Act (State Finance Law § 191)

The New York State False Claims Act also provides protection to *qui tam* relators (individuals who commence a False Claims action) 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 lawful furtherance of an action under the Act. Remedies include reinstatement with the same 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 State 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 State 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 the employer's policies, practices or activities 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.

EFFECT ON OTHER POLICIES

The Board of Directors of the Albany Med Health System (formerly Albany Medical Center) accepted, at its July 10, 2019 meeting, the delegated duty to centrally manage the TIPP Compliance Program including oversight of the Policy on Fraud, Waste, and Abuse in Federal Health Care Programs. Upon approval, this Policy supersedes the comparable Policy in effect at each System Entity.

This Policy does not preclude more restrictive policies which may be adopted by the System or any System Entity including as required by law or regulation, or in the interest of effective patient care or other components of the System's mission.