



Detecting and Preventing Fraud, Waste and Abuse

Effective May 2007

Policy

It is the obligation of Federation of Organizations to prevent and detect any fraud, waste and abuse in its Organization related to Federal and State Health Care Programs (Medicaid, Medicare, and other governmental payor programs).

To this end, Federation of Organizations has developed and maintains a vigorous Compliance Program to educate its workforce regarding the importance of submitting accurate claims and reports to Federal and State governments, as well as regarding the requirements, rights and remedies of Federal and State laws governing the submission of false claims. This includes the rights of employees to be protected as whistleblowers under such laws. Federation of Organizations' Compliance Program has been developed to protect clients from abuse and to prevent fraud within the Agency. Federation of Organizations will only conduct business in an ethically acceptable manner and will comply with regulations that have been identified by the local, State, and Federal governments. Corporate Compliance is a systematic effort to prevent, detect, and report violations of law throughout the Organization. The purpose of Corporate Compliance is to ensure that employees, business associates and consultants of Federation of Organizations conduct themselves in conformance with all applicable legal requirements.

Federation of Organizations' Corporate Compliance Plan consists of eight (8) core elements:

(1) Code of Conduct/Code of Ethics, (2) Assignment of a Compliance Officer/Corporate Compliance Committee, (3) Education and Training for employees including education/training regarding false claims and acceptable Medicaid/Medicare documentation, (4) Communication with Corporate Compliance Officer, which includes anonymous and confidential reporting, (5) Discipline for failure to report suspected fraud, which permits noncompliant behavior, (6) Routine identification of compliance risk areas, including auditing and monitoring, (7) System for responding to compliance issues as they are raised; how to correct such noncompliance, and reporting noncompliance to

Medicaid/Medicare and any other necessary governmental agencies and refunding overpayments, and (8) Non-retaliation (whistleblower protection).

Federation of Organizations focuses on the prevention of fraud in Federal and State Health Care Plans by protecting against noncompliance, accidental or deliberate. Federation of Organizations seeks to promote full compliance with all legal duties applicable to it, to foster and ensure ethical conduct, and to provide guidance and education to each employee of Federation of Organizations on his/her conduct. Federation of Organizations intends to detect noncompliance if it occurs, to discipline those involved in such noncompliance, to remedy the effects of noncompliance, and to prevent future noncompliance. All employees have been educated about compliance requirements in the health care industry as it relates to guidance provided by the Center for Medicare and Medicaid Services (CMS); United States Department of Health and Human Services Office of Inspector General (HHS-OIG); and the New York State Office of the Medicaid Inspector General (NYS OMIG).

Compliance Standards and Procedures

Numerous Federal and State laws and regulations define and establish obligations for the health care industry with which Federation of Organizations must comply. Any Federation of Organizations' employee who violates these laws and/or regulations risks individual criminal prosecution and penalties, civil actions for damages and penalties, and subjects Federation of Organizations to these same risks and penalties. Any Federation of Organizations' employee who violates these laws may be subject to immediate termination of his/her employment.

Federation of Organizations' assigned Corporate Compliance Officer is responsible for overseeing the Compliance Program, receives all compliance concerns and is responsible for responding to these concerns in a professional and timely manner. The Corporate Compliance Officer, in conjunction with the Compliance/Quality Management Department, is responsible for assessing program risk areas, trending, assisting in the implementation of corrective action plans, investigating noncompliance and assisting with determining when overpayments may have occurred, communicate these concerns, and assist in the decision-making towards resolution of the issue.

Communication with Corporate Compliance Officer; Anonymous and Confidential Reporting

Communication is the key to effective compliance. Staff is responsible to report any individual who is suspected of violating compliance. Reports are made to direct Supervisors or directly to the Corporate Compliance Officer.

In addition, Federation of Organizations provides all staff with an outside anonymous and confidential toll-free 24-hour supervised Corporate Compliance Hotline telephone number which is operated by an external consulting agency:

Hotline #: 1 (866) 580-2736

All staff has been provided training and education related to appropriately contacting the hotline.

In addition, staff may report suspected incidences of fraud and abuse via email, which is also operated by an external consulting agency. This method of communication is confidential, but not anonymous:

Email Address: Contact@thecomplianceconsortium.org

An investigation will be conducted within 24 hours by the Compliance/Quality Management Department in conjunction with the Corporate Compliance Committee. The appropriate follow-up and/or disciplinary action will be taken and documented. Failure to report illegal, unethical, or activities of noncompliance will result in appropriate corrective and disciplinary action.

Monitoring and Auditing

The OIG identifies internal monitoring and auditing among the fundamental components of an effective Compliance Program. At a minimum, annual audits will be conducted to determine whether: (1) Federation of Organizations' policies and procedures are current and complete; and (2) Federation of Organizations' claims submission practices comply with applicable requirements (that bills are accurately coded and accurately reflect the services provided, documentation is being completed correctly, that services provided are reasonable and necessary, and if any incentives for unnecessary services exist). To this end, the Accounts Receivable Department conducts monthly claims auditing prior to submission for reimbursement.

Other Audit Areas

The Compliance/Quality Management Department will conduct a review of Federation of Organizations' Compliance Program on an annual basis, at a minimum, to evaluate its effectiveness, and to identify problems or weaknesses in its design and/or implementation. The review will include an examination of whether the Compliance Program's various elements have been satisfied. In addition, self-assessments of the Compliance Program are conducted on an annual basis as well as the creation of an annual Compliance Work Plan.

Federation of Organizations' finance policies and procedures will be audited on an annual basis, at a minimum, by appropriate outside financial auditors.

Client Records and Documentation

Monitoring and Auditing

Federation of Organizations has a robust Monitoring and Auditing Program. The OIG identifies internal monitoring and auditing among the fundamental components of an effective Compliance Program. Monitoring of documentation assists the programs in verifying that billing requirements have been met (as applicable) and ensures that the Agency's largest risk areas are assessed. Monitoring also assists in safeguarding the Agency by confirming that all services documented were actually rendered, that services provided are medically necessary, and that documentation is sufficient in evidencing that services were performed by qualified and licensed staff (if applicable).

Federations of Organizations' programs are required to follow the Agency's "Monitoring and Auditing Policy". In the first and third quarters of each year, programs are required to conduct either full chart reviews or review designated Characteristics of Interest of clients' documentation utilizing their programs' "Monitoring Tool" for a random percentage of client case records. This information is submitted to the Compliance/Quality Management Department for review. Programs may break up their chart reviews as they see fit; however, monitoring of documentation must occur monthly.

In the second and fourth quarters of each year, the Compliance/Quality Management Department will hold a conference call with the Program Managers/Team Leaders, Directors, and Associate Directors. During this conference call, the documentation deficiencies (error rates) that were identified in the previous quarter will be discussed. As a team, the attendees of the call will determine appropriate corrective action in order to rectify the areas that require improvement, as applicable. Upon completion of the call, the Program

Managers/Team Leaders are responsible to submit a plan of corrective action to the Compliance/Quality Management Department for review and approval. This will ensure that similar issues are prevented from occurring in the future.

Additionally, throughout the second and fourth quarters of the year, the Program Managers/Team Leaders are responsible to spot check case records for new admissions as a way to monitor that the corrective actions are taking place and to determine if additional staff training and education, support, and oversight are needed. The Associate Directors will monitor throughout the quarter to ensure that the corrective actions are being overseen by the Program Managers/Team Leaders and that they are being implemented and enforced accordingly. The Associate Directors are also responsible to spot check case records for new admissions as a way to monitor that the corrective actions are taking place. The Compliance/Quality Management Department will follow-up with the programs to ensure that their benchmarks for documentation compliance are being met.

Upon the completion of monitoring of documentation, it may be necessary for the Compliance/Quality Management Department or program staff to conduct a more detailed audit by reviewing a larger sample of client records to determine the reasons such deficiencies are occurring and to assist in determining where additional corrective actions are necessary.

Excluded Individuals

Federation of Organizations will not willingly employ any individual that has been excluded from Medicaid. The Human Resources Department shall conduct exclusion checks for all newly hired employees as well as conduct monthly checks thereafter of all current employees to determine if the employee has been excluded from Medicaid. Each new employee will be asked to indicate any Medicaid-related fraud, arrests, sanctions or convictions. Employment will be determined based upon this information.

In addition, the Human Resources Department will conduct exclusion checks for all Business Associates on a monthly basis. These exclusion checks shall be conducted on the following websites: <http://oig.hhs.gov>, <http://omig.state.ny.us> and <https://www.sam.gov>. Documentation is maintained within the Human Resources Department as evidence that these exclusion checks take place.

Whistleblower Protections

An internal whistleblower is an employee, former employee, or member of Federation of Organizations, who reports misconduct, in this case, health insurance fraud, to those that have the power to take corrective action (a superior within Federation of Organizations).

An external whistleblower is any private party outside of Federation of Organizations that may report fraud to outside persons or entities on behalf of the United States government.

Any person may bring a *qui tam* action (a person who brings a suit on behalf of the government). The False Claims Act provides protection to any person who brings a *qui tam* action on behalf of the government and who may be, as a result, discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of whistleblowing. Remedies include reinstatement of one's employment with comparable seniority, two times the amount of any back pay, interest on back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

State and Federal Fraud and Abuse Detection, Prevention and Employee Protection

Discussion of Applicable Legal Standards

Below are some major Federal and State statutes specifically applicable to health care providers, which are not all inclusive. They are designed to effectively combat all Federal Health Care Program fraud. Any employee who is uncertain about applicable laws should always consult with the Corporate Compliance Officer.

Federal Laws

The False Claims Act (31 U.S.C. §§ 3729-3733)

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government 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; (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or

decrease an obligation to pay or transmit money or property to the Government, ... (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government,

...is liable to the U.S. 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; (3) acts in reckless disregard of the truth or falsity of the information; and no proof of specific intent to defraud is required.

In sum, the False Claims Act (FCA) imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. Lastly, the FCA imposes liability on an individual who obtains money from the federal government to which he or she may not be entitled and uses the false statements or records in order to retain the money.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf on 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% but not more than 25% 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 not be less than 25% and not more than 30%.

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 admits 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 FCA, a violation of this law occurs when it is submitted, not when it is paid. Also, unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties are made by the administrative agency, not by prosecution in the federal court system.

New York State Laws

Civil and Administrative Laws

New York State False Claims Act (State Finance Law §§187-194)

The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes 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 (2) and three (3) times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 15% - 30% of the proceeds, depending upon whether the government participated in the suit. The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

Social Service 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 up to three (3) times the amount of the incorrectly paid claim. In the case of non-monetary false statements, the local Social Service district or State 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 five (5) years, a penalty up to \$7,500 may be imposed if they involve more serious

violations of the Medicaid rules, billing for services not rendered, or providing excessive services.

Social Service 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 and the person's family needs are not taken into account for a period of six months to five years, depending upon the number of offenses.

Criminal Laws

Social Service 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 Service Law § 366-b, Penalties for Fraudulent Practices

Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which he/she is legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor. 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.

Social Service 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 and the person's family needs are not taken into account for a period of six (6) months to five (5) years, depending upon the number of offenses.

Penal Law Article 175, Written False Statements

There are four (4) crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information, altering an agency's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent, a person may be guilty of a Class A misdemeanor or a Class E felony.

Penal Law Article 176, Insurance Fraud

This Article applies to claims for insurance payment, including Medicaid or other health insurance. The six (6) crimes in this Article involve intentionally filing a false insurance claim. Under this article, a person may be guilty of a felony for false claims in excess of \$1,000.

Penal Law Article 177, Health Care Fraud

This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), he/she knowingly provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which he/she is not entitled. Health Care Fraud is punished with fines and jail time based on the amount of payment inappropriately received due to the commission of the crime.

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 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 (2) 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' fee.

New York False Claims Act (State Finance Law §191)

The New York False Claims Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two (2) 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.