SUBJECT: Fraud, Waste and Abuse Policy

1.0	**POLICY/PURPOSE**	Classification:	Compliance
2.0	**APPLICABILITY**	Policy#:	9120-0014
3.0	**GENERAL INFORMATION**	Effective Date:	January 1, 2007
4.0	**PROCEDURE**	Revised Date:	1/31/2024
5.0	**REFERENCES**		
6.0	**ATTACHMENTS**		
7.0	**APPROVAL**		

1.0 POLICY/PURPOSE

1.1 Section 6032 of the Deficit Reduction Act of 2005 ("DRA") requires Centers that receive Medicaid payments 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 members of the Center's employees, as well as contractors, consultants, and vendors who perform services for, or on behalf of, or supply products to, the Center. Center for Disability Services and St. Margaret's Center (collectively, the "Center") are committed to compliance with the DRA, and to the prevention and detection of fraud, waste and abuse. Questions regarding this policy may be directed to the Corporate Compliance Department at (518) 944-2129.

1.2 It is the policy of the Center to comply with the DRA and other applicable Federal and State laws targeting fraud, waste and abuse in Federal health care programs.

2.0 APPLICABILITY

2.1 This policy applies to all Center for Disability Services, St. Margaret's Center and Prospect Center employees and affiliates (hereinafter known as the Center).

3.0 GENERAL INFORMATION

3.1 For purposes of this policy, the term "Affected Individuals" shall have the meaning set forth at 18 NYCRR § 521-1.2(b)(1) and includes Directors, Officers, employees, interns, externs, contractors, and volunteers of the Center.

3.2 The Center will disseminate to its Affected Individuals:

- 3.2.1 The Center's policies and procedures for preventing and detecting fraud, waste and abuse, and related whistleblower protections; and
- 3.2.2 Federal and State laws, administrative remedies, and whistleblower protections, and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

3.3 Summary of Relevant Laws:

- 3.3.1 Federal Law: False Claims Act (31 U.S.C. §§ 3729-3733). The False Claims Act ("FCA") provides, in pertinent part, that any person who knowingly:

- presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- 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
- 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 $12,537, and not more than $25,076, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus three times the amount of damages that the Government sustains. For purposes of the FCA, 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.

  - The FCA applies to, among other things, claims submitted for payment by Federal health care programs, including Medicare and Medicaid. Examples of actions that violate the FCA include:
    - Billing for services that were not actually rendered;
    - Charging more than once for the same services;
    - Billing for medically unnecessary services;
    - Falsifying records used to bill or retain payments from Medicaid or Medicare; and
    - Not timely reporting and returning an overpayment.

3.3.2 Federal Law: Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812).

- This law authorizes administrative recoveries by Federal agencies. If any person submits a claim that the person knows is false or contains false information, or omits material information, then agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency also may recover twice the amount of the claim. Unlike the FCA, a violation of this law occurs when a false claim is submitted, rather than when it is paid, and the determination of whether a claim is false, and the imposition of fines and penalties, is made by the administrative agency.

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

- This statute prohibits, with certain exceptions, a physician from making a referral to an entity with whom 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 be made by Medicare or Medicaid.

3.3.4 Federal Criminal Law: 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 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.

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

- The New York False Claims Act ("NYFCA") is similar to the Federal FCA. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from the State or any local government, including health care programs such as Medicaid. It also has a provision similar to the Federal FCA in which a person or entity is liable for making or using false statements or records in order to retain money obtained from the State or any local government to which the person or entity is not entitled. The penalty for filing a false claim is $6,000 to $12,000 per claim, plus three times the amount of the damages sustained by the State or any local government sustains, among other costs.

3.3.6 State Law: Social Services Law § 145-b False Statements.

- Makes it unlawful 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 or representation, deliberate concealment of any material fact, or other fraudulent scheme or device. The State or local Social Services district may recover three times the amount incorrectly paid, with increased penalties for certain repeat violations involving more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services. The Department of Health also may impose a civil penalty of up to $10,000 per violation.

3.3.7 State Law: 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.

3.3.8 State Law: Public Health Law Section § 238-a Prohibition of Financial Arrangements and Referrals.

- 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.

3.3.9 State Criminal Law: 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.

3.3.10 State Criminal Law: Social Services Law § 366-b Penalties for Fraudulent Practices.

- 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.
- 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.

3.3.11 State Criminal Law: 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.
- Fourth degree grand larceny involves theft of property valued over $1,000, and is a Class E felony;
- Third degree grand larceny involves theft of property valued over $3,000, and is a Class D felony;
- Second degree grand larceny involves theft of property valued over $50,000, and is a Class C felony; and
- First degree grand larceny involves theft of property valued over $1 million, and is a Class B felony.

3.3.12 State Criminal Law: Penal Law Article 175 False Written Statements. Four crimes in this Article have been applied in Medicaid fraud prosecutions:

- Falsifying business records in the second degree is a Class A misdemeanor and involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud;

- Falsifying business records in the first degree is a Class E felony and includes the elements above, with the intent to commit another crime or conceal its commission;
- Offering a false instrument for filing in the second degree is a Class A misdemeanor and involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information; and
- Offering a false instrument for filing in the first degree is a Class E felony and includes the elements above, with the intent to defraud the State or a political subdivision.

3.3.13 State Criminal Law: Penal Law Article 176 Insurance Fraud. This law applies to claims for insurance payments, including Medicaid or other health insurance, and includes the following:

- Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false, and is a Class A misdemeanor;
- Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000, and is a Class E felony;
- Insurance fraud in the third degree is filing a false insurance claim for over $3,000, and is a Class D felony;
- Insurance fraud in the second degree is filing a false insurance claim for over $50,000, and is a Class C felony;
- Insurance fraud in the first degree is filing a false insurance claim for over $1 million, and is a Class B felony; and
- Aggravated insurance fraud is committing insurance fraud more than once, and is a Class D felony.

3.3.14 State Criminal Law: Penal Law Article 177 Health Care Fraud. This statute was designed to address the specific conduct by health care providers. Medicaid is considered to be a single health plan under this statute:

- Health care fraud in the fifth degree is a Class A misdemeanor and occurs when, with intent to defraud a health plan, a person knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan;
- Health care fraud in the fourth degree is a Class E felony and occurs when a person files false claims on more than one occasion and annually receives more than $3,000;
- Health care fraud in the third degree is a Class D felony and occurs when a person files false claims on more than one occasion and annually receives more than $10,000;
- Health care fraud in the second degree is a Class C felony and occurs when a person files false claims on more than one occasion and annually receives more than $50,000; and
- Health care fraud in the first degree is a Class B felony and occurs when a person files false claims on more than one occasion and annually receives more than $1,000,000.

3.3.15 Whistleblower Law: Federal False Claims Act (31 U.S.C. § 3730(h)).

- The FCA 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.

3.3.16 Whistleblower Law: New York State False Claims Act (State Finance Law § 191).

- The NYFCA 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.

3.3.17 Whistleblower Law: New York State Labor Law § 740.

- An employer may not take retaliatory action against a covered person if he or she discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures include those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health or safety. Subject to certain exceptions, a covered person's disclosure is protected only if he or she first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation.

3.3.18 Whistleblower Law: 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 include those that assert that, in good faith, the employee believes the employer's policies, practices or activities constitute improper quality of patient care. Subject to certain exceptions, a covered person's disclosure is protected only if he or she first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation.

4.0 PROCEDURE

4.1 Prevention and Detection measures; whistleblower protections:

4.1.1 Prevention Measures:

- Corporate Compliance Program. The Center has a Corporate Compliance Program dedicated to prevention and detection of false claims and statements, and impermissible financial transactions, which result in health care fraud, waste and abuse.
- Education/Training. Various departments, including, but not limited to, Corporate Compliance, provide education/ training through a number of initiatives. These initiatives include annual compliance education, corporate trainings, and an intranet website containing standards of conduct, policies, procedures and educational materials.
- Reporting Mechanisms. Concerns related to the Center that potentially implicate the laws cited in this policy may be reported to the Corporate Compliance Department at (518) 944-2129 or anonymously to the Corporate Compliance Hotline at (518) 437-5871. In addition, reporting can be made in accordance with the Center's Whistleblower Policy.
- Background Checks. When required by law, criminal background checks are performed on individuals following an offer of employment, but prior to the individual starting work. In addition, checks are performed on vendors, volunteers, and certain employees against various exclusion lists published by Federal and State agencies. These lists identify, among other things, individuals and entities who have been convicted of health care fraud.
- Legal Review of Contracts. Contractual arrangements to which the Center is party are reviewed by the Legal Department.

4.1.2 Detection Measures:

- Billing Safeguards. The Center utilizes software designed to assist in the proper documentation of billable services.
- Internal Reviews/Audits. Corporate Compliance Program performs reviews/audits across the Center to ensure compliance with the billing requirements of Federal health care programs. In addition, Corporate Compliance performs periodic internal reviews/audits designed to detect fraud, waste and abuse. Many of these reviews/audits focus on high-risk areas such as those identified in the United States Office of Inspector General's Annual Work Plan, in the New York State Office of the Medicaid Inspector General's Medicaid Work Plan, Risk Assessment and other areas of special concern identified through investigative and audit functions.
- Investigations. The Corporate Compliance Department performs reviews and investigations based upon reports of possible fraud, waste or abuse associated with Federal health care programs. When appropriate, the Center may

refer a matter to an outside law enforcement and/or regulatory agency.

4.1.3 Whistleblower Protections:

- Under the Center's Whistleblower Policy, retaliation against anyone who reports a concern in good faith is prohibited. Reported concerns and claims of retaliation will be reviewed and, if required, investigated. Any individual who has engaged in acts of retaliation will be subject to appropriate disciplinary action, which may include termination of employment or other relationship with the Center.

5.0 REFERENCES

5.1 False Claims Act (31 U.S.C. §§ 3729-3733)
5.2 Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)
5.3 Prohibition of Certain Physician Referrals (42 U.S.C. § 1395nn, commonly known as the Stark Law)
5.4 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)
5.5 New York False Claims Act (State Finance Law §§ 187-194)
5.6 Social Services Law § 145-b False Statements
5.7 Public Health Law § 587 Prohibited Practices (State Anti-Kickback Law)
5.8 Public Health Law Section § 238-a Prohibition of Financial Arrangements and Referrals
5.9 Social Services Law § 145 Penalties
5.10 Social Services Law § 366-b Penalties for Fraudulent Practices
5.11 Penal Law Article 155 Larceny
5.12 Penal Law Article 175 False Written Statements
5.13 Penal Law Article 176 Insurance Fraud
5.14 Penal Law Article 177 Health Care Fraud
5.15 Federal False Claims Act (31 U.S.C. § 3730(h))
5.16 New York State False Claims Act (State Finance Law § 191)
5.17 New York State Labor Law § 740
5.18 New York State Labor Law § 741

6.0 ATTACHMENTS

6.1 Whistleblower Policy
6.2 Auditing and Monitoring Policy
6.3 Reporting and Investigations of Compliance Concerns

7.0 POLICY APPROVAL

Role	Name/ Title	Date Approved
Revision Author	Sarah Quist, Compliance Officer	1/31/2024
Department Approver	Sarah Quist, Compliance Officer	1/31/2024

Sanction Statement: Non-compliance with this policy may result in disciplinary action, up to and including termination.

Compliance Statement: As part of its ongoing auditing and monitoring process in its Compliance Program, Center for Disability Services will review this policy based on changes in the law or regulations, as Center for Disability Services' practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with Center for Disability Services' Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.
Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

Record Retention Statement: Center for Disability Services will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.