NYC HEALTH+ HOSPITALS

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Operating Procedure 50-2

POLICY ON FRAUD, WASTE, & ABUSE, AND FALSE CLAIMS

TO: All NYC Health + Hospitals Workforce Members, and Distribution "E"[1]

FROM: Mitchell Katz, M.D.
President and Chief Executive Officer

DATE: September 20, 2019

I. POLICY: It is the policy of NYC Health + Hospitals (also referred to herein as the "System")[2] to establish, monitor, and maintain an effective Corporate Compliance and Ethics Program, which includes, without limitation, the System's commitment to taking action to have its operations and business practices conducted in a manner that complies with all applicable Federal, state, and local laws.

II. PURPOSE: The purpose of this Operating Procedure ("OP" or "Policy") is to articulate policies and procedures that must be followed for compliance with the applicable Federal and New York State ("State" or "NYS") laws, including the requirements to:

A. Establish written policies and procedures that are designed to support compliance with various Federal and State[3] laws pertaining to, at minimum, false claims; fraud, waste, and abuse; and improper actions that could result in civil monetary penalties;

B. Provide a general overview of Federal and State laws pertaining to civil and criminal penalties and administrative actions, including remedies for false claims, fraudulently obtaining funds, and whistleblower protections under such laws; and

C. Ensure compliance with Section 6032 of the Deficit Reduction Act ("DRA") of 2005.[4]

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[1] *See* Operating Procedure 10-11 for the titles of the individuals covered under Distribution "E."
[2] "NYC Health + Hospitals" and the "System" are used interchangeably throughout this Operating Procedure, and refer to the New York City Health and Hospitals Corporation, a public benefit corporation created pursuant to McKinney's New York Unconsolidated Law §§ 7381 *et seq.*, including all NYC Health + Hospitals' facilities, units, and entities described in § III of this Policy, *infra*.
[3] For purposes of this OP, the State laws include all applicable New York State and local laws.
[4] *See generally* 42 U.S.C. § 1396a(a)(68).

IMPORTANT: This OP summarizes complex laws covering the submission of false claims and the commission of health care fraud. Workforce Members and Business Partners should contact either the Office of Corporate Compliance or the Office of Legal Affairs with questions about these laws.

III. SCOPE: This OP governs acts and prohibited acts related to the submission of false claims and other types of health care fraud, waste, and abuse at all NYC Health + Hospitals facilities, units, and entities including the following:

A. All acute care facilities and associated clinics;

B. All diagnostic and treatment centers ("D&TCs") including those D&TCs designated as Federally Qualified Health Centers ("FQHCs") and associated extension clinics;

C. All long-term acute care facilities and skilled nursing facilities;

D. All home and community based services and programs, including Community Care; and

E. All NYC Health + Hospitals' Central Office locations.

IV. APPLICABILITY:

A. This OP shall serve as the written policy for all NYC Health + Hospitals Workforce Members, as defined in Subdivision "B" of this Section, and any NYC Health + Hospital contractor or Agent, to provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act). This Policy will also provide detailed provisions regarding the System's policies and procedures for detecting and preventing fraud, waste, and abuse; and the System's policies and procedures for detecting and preventing fraud, waste, and abuse.

B. Workforce Member: For purposes of this OP, the term "Workforce Member" shall mean any of the following System individuals, whether serving in a temporary or permanent capacity on the System's premises or remotely, who perform System duties, functions or activities on a full-time, part-time, or *per diem* basis:

i. Employees;

ii. Executives;

iii. Affiliate employees;[5]

iv. Members of the medical staff of any System facility, unit or entity;

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[5] The term "affiliate employees" shall mean all affiliate employees and other affiliate personnel who, pursuant to an affiliation agreement with the System, serve as *Contract Service Providers* and perform on behalf of the System *Contract Services,* as both of these italicized terms are defined under such corresponding affiliation agreement.

v. Members of the NYC Health + Hospitals Board of Directors and their designees;

vi. Directors of NYC Health + Hospitals wholly owned subsidiaries;

vii. Members of the Gotham Health FQHC, Inc. Board of Directors;

viii. Interns, residents and fellows employed by or under contract with the System;

ix. Trainees;

x. Students;

xi. Volunteers; and

xii. Any individual whose conduct, in the performance of work functions and duties on behalf of the System, is under the direct control of the System, whether or not he/she is paid by the System.

V. LEGAL REQUIREMENTS:

A. As an entity that receives annual payments under the Medicaid program of at least $5,000,000, NYC Health + Hospitals must: (i) establish written policies for all of its employees (including management), and of its contractors or Agents, which provide detailed information about the Federal False Claims Act ("Federal FCA") established under 31 U.S.C. §§ 3729 - 3733, administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs; and (ii) include as part of such written policies, detailed provisions regarding the System's policies and procedures for detecting and preventing fraud, waste, and abuse.[6]

B. To be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, NYC Health + Hospitals, must adopt and implement an effective compliance program.[7] Such compliance program shall, among other things, be applicable to billings to and payments from the medical assistance program.[8] An element of an effective compliance program includes written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved.[9]

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[6] *See generally* § 6032 of the DRA codified at 42 U.S.C. § 1396a(a)(68).
[7] *See* N.Y. Social Services Law § 363-d(2); 18 NYCRR § 521.1.
[8] *See* N.Y. Social Services Law § 363-d(1).
[9] *See* 18 NYCRR § 521.3(c)(1).

VI. DEFINITIONS:

A. **Agent:** for purposes of this OP, and as defined by the Centers for Medicare and Medicaid Services' ("CMS") guidance, means any contractor, subcontractor, agent, or other person which or who, on behalf of the System, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. Depending on their functions and duties, Agents may fall under the definition of the term Workforce Member or Business Partner.

B. **Business Partner:** for purposes of this OP, means any non-Workforce Member contractor, subcontractor, vendor or other third-party (collectively "Third Party" or "Third Parties") that is required by law or contract to comply with this OP including, without limitation, the following Third Parties:

i. Any Third Party that, in acting on behalf of NYC Health + Hospitals, engages in activities, functions, and duties that:
   a. Contribute to the System's entitlement to receive payment from Federal Health Care Programs or Third Party Payors;
   b. May place the System in a position to commit significant noncompliance with Federal Health Care Programs or Third Party Payor requirements, or fraud, waste, and abuse prohibitions including, for example, those Third Parties that: [10]
      1. Provide billing or coding functions;
      2. Monitor the health care provided by the System;
      3. Establish and administer the formulary of the System and medical benefit coverage policies and procedures;
      4. Review beneficiary claims and services submitted for payment to Federal Health Care Programs or Third Party Payors;
      5. Exercise decision making authority (*e.g.*, clinical decisions, coverage determinations, appeals and grievances, health plan enrollment/disenrollment functions, the processing of pharmacy or medical claims) in administration of Federal Health Care Programs or Third Party Payor health plans; and

ii. OneCity Health Delivery System Reform Incentive Payment ("DSRIP") Program Performing System Partners.

C. **Federal Health Care Program:** for the purposes of this OP, means any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the U.S. Government.

D. **Third Party Payor:** for the purposes of this OP, means those third parties that deliver, furnish, prescribe, direct, order or otherwise provide health care items and/or services and who obtain payments for such.

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[10] *See* Centers for Medicare and Medicaid Services "*Employee Education About False Claims Recovery – Frequently Asked Questions*" (March, 20, 2007), FAQ # 23, p. 6.

VII. RESPONSIBILITIES:

A. **Chief Corporate Compliance Officer ("CCO"):** The CCO is responsible for implementing this OP as part of the CCO's responsibilities in establishing an effective compliance program, which provides that NYC Health + Hospitals is diligent in preventing, detecting and deterring fraud, waste and abuse, and false claims.

B. **Office of Corporate Compliance ("OCC"):** The OCC, under the guidance of the CCO is responsible for, among other things, assisting the CCO in implementing this OP and:

i. Establishing and monitoring System compliance with any applicable requirement set forth under the any relevant Federal or State law including but not limited to the obligations set forth under the Deficit Reduction Act of 2005 ("DRA")[11] and any obligations implemented and administered by the New York State Office of the Medicaid Inspector General ("OMIG"), CMS, U.S. Department of Health and Human Services ("HHS"), and HHS Office of Inspector General ("OIG");

ii. Establishing and disseminating written policies and procedures that inform all Workforce Members, Business Partners and Agents about the System's internal policies and procedures concerning:[12]

a. The prevention and detection of fraud, waste, and abuse;
b. The Federal FCA and any similar State law that governs false claims and statements;
c. The Federal administrative remedies for false claims and statements;
d. Any applicable State law pertaining to civil or criminal penalties for false claims and statements; and
e. Applicable whistleblower protections under Federal and State laws;

iii. Periodically monitoring, in collaboration with the System's Division of Talent Acquisition and/or senior human resources administrative personnel, all System employee handbooks for the purpose of ensuring that all such handbooks include the required information under the DRA;

iv. Providing appropriate training as required or recommended under the DRA, OMIG regulations, and OIG guidance, and maintenance of evidence of such in accordance with applicable record retention requirements;

v. Facilitating the timely completion of any certification requirements established by the OMIG, and the DRA;

vi. Guiding the implementation of appropriate corrective actions, procedures, and/or internal controls, consistent with Federal and State law, to mitigate future incidents of fraud, waste and abuse;

vii. Functioning as the authorized person for the NYC Health + Hospitals in any Federal or State self-disclosure protocol.

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[11] *See* 42 U.S.C. § 1396a(a)(68).
[12] *See* 42 U.S.C. §§ 1396a(a)(68)(A) and (B).

C. **Human Resources/Labor Relations:** Human Resources/Labor Relations will confer with the CCO to include in the employee handbook, a specific discussion of the laws described in this policy and whistleblower protections under such law.

D. **Office of Legal Affairs ("OLA"):** OLA will work with the OCC to, where applicable, assist in determining violations of relevant Federal or State law, exclusionary statutes, and/or laws requiring the return of an overpayment.

E. **Workforce Members and Business Partners:** are responsible for, among other things:

i. Refraining from engaging in any conduct or activity that violates any of the Federal or State laws outlined in this OP, or Prohibited Acts defined under OP 50-1: *Corporate Compliance and Ethics Program.*[13]

ii. Cooperating with all internal investigations including those performed by the OCC, OLA and NYC Health + Hospitals' Office of the Inspector General ("IG");

iii. Complying with mitigation efforts or corrective actions that may stem from an investigation of a violation of this OP or the *Corporate Compliance and Ethics Program*; and

iv. Reporting any violations or suspected violations of this OP to the OCC.

VIII. CIVIL AND CRIMINAL LAWS RELATED TO THE SUBMISSION OF FALSE CLAIMS AND THE COMMISSION OF HEALTH CARE FRAUD

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

i. The Federal FCA makes it illegal for any person to knowingly submit a false claim to the government, cause another to submit a false claim to the government, or knowingly make a false record or statement to get a false claim paid by the government. Under the Federal FCA, it is prohibited, among other things, to knowingly:[14]

a. Present or cause to be presented to the Federal government a false or fraudulent claim for payment or approval;
b. Make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim;
c. Make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government; and/or
d. Conceal and/or improperly avoid or decrease an obligation to pay or transmit money or property to the government.[15]

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[13] *Note:* Workforce Members and Business Partners need not have actual knowledge for an act to be deemed a prohibited act, violation of the Corporate Compliance and Ethics Program, or the law. This means the System strictly bars any prohibited act committed in deliberate ignorance or reckless disregard of the truth or falsity of the information.
[14] 31 U.S.C. §§ 3729(a)(1)(A), (B), and (G).
[15] *See* 31 U.S.C. § 3729(a).

Under the Federal FCA, the terms "knowing" and "knowingly" mean that a person has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts with reckless disregard of the truth or falsity of the information. A specific intent to defraud is not required.[16]

ii. Violators of the Federal FCA are liable to the Federal government for a civil penalty of greater than $5,000 (adjusted annually for inflation as well as changes in the law) per claim plus three times the amount of damages the Federal government sustains.[17] Violators may also be liable for any costs the government incurs while bringing the civil action to recover any such penalty or damages.[18]

B. The Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 - 3812)

i. The Program Fraud Civil Remedies Act ("PFCRA") establishes administrative remedies for false claims or written statements made to certain Federal agencies, including HHS. A person (including an entity) violates the PFCRA if the person makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know:[19]
   a. Is false, fictitious, or fraudulent;
   b. Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
   c. Includes or is supported by any written statement that:
      1. Omits a material fact;
      2. Is false, fictitious, or fraudulent as a result of such omission; and
      3. Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
   d. Is for payment for the provision of property or services which the person has not provided as claimed.

ii. A PFCRA violation by an individual or entity carries a civil penalty, generally (subject to revision), of up to $5,000 for each wrongfully filed claim, plus a potential assessment of up to two times the amount of the claim.[20] Submitting an improper statement under PFCRA carries similar penalties for each improper statement.[21]

C. Criminal Health Care Fraud Statute (18 U.S.C. §§ 1346, 1347, & 1349)

i. The Criminal Health Care Fraud Statute makes it illegal for a person to knowingly and willfully execute, or attempt or conspire to execute, a scheme or artifice:[22]
   a. To defraud any health care benefit program;[23] or

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[16] *See* 31 U.S.C. § 3729(b)(1).
[17] 31 U.S.C. § 3729(a)(1).
[18] 31 U.S.C. § 3729(a)(3).
[19] 31 U.S.C. § 3802(a)(1).
[20] *Id.*
[21] 31 U.S.C. § 3802(a)(2).
[22] 18 U.S.C. § 1346.
[23] 18 U.S.C. § 1347(a)(1).

b. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services.[24]

ii. Any person who violates the Criminal Health Care Fraud Statute shall be fined or imprisoned not more than ten (10) years, or both. If the violation results in serious bodily injury, such person shall be fined or imprisoned not more than twenty (20) years, or both; and if the violation results in death, such person shall be fined or imprisoned for any term of years or for life, or both.[25] A person need not have actual knowledge or specific intent to commit a violation of the Criminal Health Care Fraud Statute.[26]

D. Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a)

i. The Civil Monetary Penalties Law ("CMP Law") authorizes the Secretary of HHS to impose civil monetary penalties ("CMPs") and assessments on a person or entity that defrauds Medicare or Medicaid or engages in certain other prohibited activities, including prohibited activities that the person or entity knows or should have known were occurring. The CMP Law also authorizes the Secretary to exclude persons from participating in Federal Health Care Programs for violations of certain health care laws and regulations. CMPs can be imposed for violations of Federal fraud, waste and abuse laws in situations which include, without limitation, the following:

a. Knowingly (or should know) submitting or causing the submission of a false or fraudulent claim for health care items or services that the person knew or should have known were not provided as claimed, including but not limited to the use of improper codes in order to receive a greater payment for services rendered;[27]

b. Knowingly (or should know) submitting claims for services provided by a physician who is not properly licensed or credentialed including:

1. A physician who obtained a license through misrepresentation of a material fact, including cheating on an examination required for licensing; or

2. A physician who misrepresents his/her medical specialty certification status to patients under his/her care at the time the services were furnished; [28]

c. Knowingly (or should know) employing or contracting with an individual excluded from participation in a Federal Health Care Program for the provision of items or services for which payment may be made under such a program;[29]

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[24] 18 U.S.C. § 1347(a).
[25] 18 U.S.C. § 1347(a)(2).
[26] 18 U.S.C. § 1347(b).
[27] *See* 42 U.S.C. §§ 1320a-7a(a)(1)(A), (B). *See also* 42 CFR § 1003.200(a)(1), (2).
[28] *See* 42 U.S.C. § 1320a-7a(a)(1)(C); 42 CFR § 1003.200(a)(4)
[29] *See* 42 U.S.C. § 1320a-7a(a)(6); 42 CFR § 1003.200(b)(4).

d. Knowingly (or should know) giving false or misleading information that could reasonably be expected to influence the decision of when to discharge an individual from a hospital;[30]
e. Having an excluded party as an officer or managing employee of an entity participating in a Federal Health Care Program;[31]
f. Offering remuneration to knowingly (or should know) induce beneficiaries of a Federal Health Care Program to use particular providers, practitioners, or suppliers;[32]
g. Submitting claims for items or services that are known, or should have been known, not to be medically necessary, and which are part of a pattern of such claims;[33]
h. Offering, soliciting, or receiving remuneration to induce referrals for items or services paid for, in whole or in part, by a Federal Health Care Program;[34]
i. Knowingly making or using a false record or statement that is material to a false or fraudulent claim for payment for items or services under a Federal Health Care Program;[35]
j. Failing to grant timely access to the OIG for audits, investigations, evaluations, or other statutory functions of the OIG;[36]
k. Ordering or prescribing medical care, services or supplies while being excluded from participation in a Federal Health Care Program;[37]
l. Knowingly making false statements, omissions, or misrepresentations of a material fact in a Federal Health Care Program provider or supplier enrollment application;[38]
m. Knowingly retaining an overpayment from a Federal Health Care Program for more than 60 days;[39]
n. Failing to provide appropriate medical screening and stabilization of an emergency condition for an individual who comes to an emergency department (*i.e.*, violating the Emergency Medical Treatment and Active Labor Act ("EMTALA"));[40]
o. Knowingly (or should know) presenting claims for designated health services furnished by an individual or entity pursuant to a referral from a physician with whom the he/she, or someone in his/her immediate family, has a financial relationship;[41]
p. A hospital making a payment to a physician as an inducement to reduce or limit medically necessary services to a Medicare or Medicaid beneficiary;[42]
q. Misusing certain HHS and CMS words, letters, symbols, or emblems including those that convey "that an advertisement, a solicitation, or other item was authorized, approved, or endorsed by [HHS or CMS] or that such

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[30] *See* 42 U.S.C. § 1320a-7a(a)(3); 42 CFR § 1003.200(b)(2).
[31] *See* 42 U.S.C. § 1320a-7a(a)(4); 42 CFR § 1003.200(b)(3)(ii).
[32] *See* 42 U.S.C. § 1320a-7a(a)(5); 42 CFR § 1003.1000(a).
[33] *See* 42 U.S.C. § 1320a-7a(a)(1)(E); 42 CFR § 1003.200(a)(5).
[34] *See* 42 U.S.C. § 1320a-7a(a)(7); 42 CFR § 1003.300(d).
[35] *See* 42 U.S.C. § 1320a-7a(a)(8); 42 CFR § 1003.200(a)(9).
[36] *See* 42 U.S.C. § 1320a-7a(a)(9); 42 CFR § 1003.200(b)(10).
[37] *See* 42 U.S.C. § 1320a-7a(a)(8). *So in original. Two pars. (8) were enacted*; 42 CFR § 1003.200(a)(3) and (b)(6).
[38] *See* 42 U.S.C. § 1320a-7a(a)(9). *So in original. Two pars. (9) were enacted*; 42 CFR § 1003.200(b)(7).
[39] *See* 42 U.S.C. § 1320a-7a(a)(10); 42 CFR § 1003.200(b)(8).
[40] *See* 42 U.S.C. § 1395dd(d)(1); 42 CFR § 1003.500(a).
[41] *See* 42 U.S.C. §§ 1395nn(g)(3) and (4); 42 CFR §§ 1003.300(b) and (c).
[42] *See* 42 U.S.C. § 1320a-7a(b)(1).

person or organization has some connection with or authorization from [HHS or CMS]";[43]

r. A physician knowingly accepting a payment from a hospital to reduce or limit medically necessary services provided to a Medicare or Medicaid beneficiary;[44]
s. Failing to make required reports to the *National Practitioner Data Bank* ("NPDB)";[45] and
t. A physician knowingly executing a document falsely certifying that a Medicare beneficiary meets the requirements for home health services.[46]

ii. CMP Law penalties vary based on the specific activities involved, and are regularly adjusted for inflation.[47] Penalties for improperly filed claims can be significant per individual violation, false record, or statement, as applicable, and subject to treble damages.[48]

E. NYS False Claims Act (State Finance Law §§ 187-194)

i. Similar to the Federal FCA, the NYS False Claims Act ("State FCA") makes it illegal for any person[49] to, among other things, knowingly:
a. Present, or cause to be presented, a false or fraudulent claim for payment or approval;
b. Make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; or
c. Conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the State or a local government or conspiring to do the same.[50]

The term "knowingly" under the State FCA includes not only actual knowledge, but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.[51]

ii. Violators of the State FCA can face a penalty of up to three times the amount of damages incurred by the State or local government plus an additional penalty of greater than $6,000 per claim.[52]

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[43] 42 CFR § 1003.600(a).
[44] *See* 42 U.S.C. § 1320a-7a(b)(2).
[45] *See generally* 45 CFR Part 60.
[46] *See* 42 U.S.C. § 1320a-7a(b)(3)(A). *See also* 42 CFR § 1003.200(c).
[47] *See* 82 Fed. Reg. 9174 (Feb. 3, 2017) (HHS' final rule issued to adjust for inflation civil monetary penalties assessed on or after February 3, 2017, and whose associated violations occurred after November 2, 2015).
[48] *See* 82 Fed. Reg. 9174 (Feb. 3, 2017); 42 U.S.C. § 1320a-7a(a); 42 CFR § 1003.210(a)(1), (7).
[49] *See* State Finance Law § 189 (stating persons may be found liable under the State False Claims Act); State Finance Law § 188(8) (defining "Person" to mean "any natural person, partnership, corporation, association or any other legal entity or individual, other than the state or a local government"; and § 188(6) (defining local government to include "any New York county, city, … [or] local public benefit corporation or other municipal corporation … of such local government.").
[50] State Finance Law §§ 189(1)(a), (b), and (h).
[51] *Id.* at § 188(3).
[52] *Id.* at § 189(1)(h).

F. NYS Social Services Law §§ 145-B, 145-C, and 366-B

i. Under NYS Social Services Law § 145-B any person or entity that engages in any of the following prohibited activities in order to obtain, or attempt to obtain, public assistance, including Medicaid, is guilty of a misdemeanor:[53]
   a. Making a false statement or representation;
   b. Deliberately concealing a material fact; or
   c. Impersonation or the use of another fraudulent device.

ii. NYS Social Services Law § 145-B prohibits knowingly obtaining (or attempting to obtain) payment from a Social Services program, such as Medicaid, by way of a false statement or other fraudulent action.[54] Prohibited activities under NYS Social Services Law § 145-B include, without limitation, the following:
   a. "[P]roviding or ordering care, services or supplies that [are] medically improper, unnecessary or in excess of the documented medical needs of the person to whom they [are] furnished;"[55]
   b. Submitting claims for "care, services or supplies [that] were not provided as claimed;"[56]
   c. The receipt of payment for services or supplies that were not provided;[57] or
   d. Ordering or prescribing care, services or supplies by a person who, at the time the care, services or supplies were provided, was excluded or suspended from participation in the Medicaid program, and where such care, services or supplies were "medically improper, unnecessary or in excess of the documented medical need of the person to whom they were furnished."[58]

iii. Under NYS Social Services Law § 145-B, the State may recover three times the amount incorrectly paid.[59] In addition, the State Department of Health may impose significant civil penalties per violation and increased penalties per violation if repeat violations occur.[60]

iv. NYS Social Services Law § 145-C allows for the application of sanctions against any person who applies for or receives public assistance and is found to have: (a) made a false or misleading statement or misrepresented, concealed, or withheld facts; or (b) committed any act intended to mislead, misrepresent, conceal, or withhold facts or propound a falsity, for the purpose of obtaining Medicaid.

v. Similarly, under NYS Social Services Law § 366-B criminal penalties may be imposed for any person "who knowingly makes a false statement or representation" or by way of other fraudulent acts obtains, attempts to obtain, or assists another to obtain medical assistance, to which he/she is not entitled, or for any person who knowingly submits a false claim or false information to

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[53] N.Y. State Social Services Law § 145(1).
[54] *See* N.Y. Social Services Law § 145-B(1)(a).
[55] *Id.* at § 145-B(4)(a)(i).
[56] *Id.* at § 145-B(4)(a)(ii).
[57] *Id.* at § 145-B(4)(a)(iv).
[58] *Id.* at § 145-b(4)(a)(iii).
[59] *See id.* at § 145-b(2).
[60] *See id.* at § 145-b(4)(b).

defraud the Medicaid program or to receive higher Medicaid compensation than entitled.

vi. A person who violates NYS Social Services Law § 145 or § 366-B shall be guilty of a misdemeanor, unless such act constitutes a violation of a provision of the Penal Law of the State of New York, in which case they shall be punished in accordance with the penalties fixed by such law.[61]

G. NYS Penal Law Article 177

i. Article 177 provides that a person is guilty of health care fraud 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 for a health care item or service, and, as a result of such information or omission, receives payment to which he/she is not entitled.[62]

ii. Article 177 of the Penal Law defines "person" as any individual or entity, other than a recipient of a health care item or service under a health plan unless such recipient acts as an accessory to such individual or entity.[63]

iii. Penalties for violating Article 177 vary based on the amount of fraudulent monies received, and range from a Class A misdemeanor to a Class B felony.[64]

H. NYS Penal Law Article 155

i. Article 155 provides that 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. Larceny has been applied to Medicaid fraud cases. Larceny includes four levels of severity, depending on the amount of property stolen.
   a. Fourth degree grand larceny involves property valued over $1,000, and is a Class E felony.[65]
   b. Third degree grand larceny involves property valued over $3,000, and is a Class D felony.[66]
   c. Second degree grand larceny involves property valued over $50,000, and is a Class C felony.[67]
   d. First degree grand larceny involves property valued over $1 million, and is a Class B felony.[68]

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[61] N.Y. Social Services Law §§ 145(1); 366-b(1).
[62] *See* State Penal Law Article 177.
[63] N.Y. Penal Law § 177.00(2).
[64] *See* N.Y. Penal Law §§ 177.05, 177.10, 177.15, 177.20 and 177.25.
[65] N.Y. Penal Law § 155.30.
[66] N.Y. Penal Law § 155.35.
[67] N.Y. Penal Law § 155.40.
[68] N.Y. Penal Law § 155.42.

I. NYS Penal Law Article 176

i. Penal Law Article 176 applies to claims for insurance payments, including Medicaid or other health insurance. Insurance fraud contains six crimes that range from a misdemeanor to a felony depending on the amount of the insurance claim.

a. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false, and is a Class A misdemeanor.[69]
b. Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000, and is a Class E felony.[70]
c. Insurance fraud in the third degree is filing a false insurance claim for over $3,000, and is a Class D felony.[71]
d. Insurance fraud in the second degree is filing a false insurance claim for over $50,000, and is a Class C felony.[72]
e. Insurance Fraud in the first degree is filing a false insurance claim for over $1 million, and is a Class B felony.[73]
f. Aggravated insurance fraud is committing insurance fraud on more than one occasion, and is a Class D felony.[74]

IMPORTANT: Penalties (civil, criminal and financial) noted under the various Federal and State laws referred to in this section are subject to change. Workforce Members and Business Partners should contact the OCC or OLA with any specific questions as to any changes in the law which may apply to them.

IX. FRAUD, WASTE AND ABUSE PREVENTION AND DETECTION EFFORTS

A. NYC Health + Hospitals is committed to maintaining an effective compliance program, as required under both Federal Guidance and State Social Services Law,[75] which includes policies and procedures designed to prevent, detect, deter and mitigate any fraud, waste and abuse. The System's *Corporate Compliance and Ethics Program* includes promoting and fostering an environment of ethical conduct and compliance with the law.

B. The System's *Corporate Compliance and Ethics Program* is designed to focus on areas of fraud, waste, and abuse prevention and detection including:[76]

i. Financial transactions;

ii. Billing, coding and claims submissions;

iii. Claims reimbursement and payments;

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[69] N.Y. Penal Code §176.10
[70] N.Y. Penal Code §176.15
[71] N.Y. Penal Code §176.20
[72] N.Y. Penal Code §176.25
[73] N.Y. Penal Code §176.30
[74] N.Y. Penal Code §176.35
[75] *See* OIG, *Compliance Program Guidance for Hospitals*, (63 Fed. Reg. 8987 (Feb. 23, 1998)) and N.Y. Social Services Law § 363-d.
[76] *See* OP 50-1 § 4(A).

iv. Cost reporting;
v. Federal Health Care Program conditions of participation, as well as Third Party Payor requirements;

vi. Information governance;

vii. Risk identification, assessment, and prioritization; and

viii. Corporate governance.

C. NYC Health + Hospitals has established effective internal controls and systems to prevent, deter and mitigate potential fraud, waste, and abuse, by:

i. Assessing, prioritizing, and mitigating System-wide risks on a routine and recurring basis;

ii. Developing an annual compliance work-plan designed to evaluate any potential or identified risks;

iii. Maintaining a system for reporting compliance concerns or violations including those related to potential fraud, waste, and abuse;

iv. Investigating compliance or fraud, waste, and abuse concerns, violations or allegations;

v. Developing and enforcing violations of the System's Principles of Professional Conduct (*i.e.* Code of Conduct);

vi. Providing Workforce Members and Business Partners training and education, including information on the *Corporate Compliance and Ethics Program*, the System's *Principles of Professional Conduct* and Federal and State fraud, waste and abuse laws; and

vii. Exercising due diligence and action (where warranted) as they apply to situations including:
   a. Fraud, waste, and abuse;
   b. Theft and corruption;
   c. Intentional or reckless violations (or attempted violations) of fraud, waste, and abuse laws;
   d. Falsification of official System business records including, without limitation, medical records, billing records, employment records, and financial records;
   e. Offering of bribes or kickbacks, or the engagement of official misconduct or other corrupt activities;
   f. Refusal to cooperate with a compliance investigation or other review, or otherwise interfere with an internal or external investigation;
   g. Violations of the System's non-retaliation/whistleblower protection policies; and
   h. Potential or actual conflicts of interest.

D. As set forth in the System's *Corporate Compliance and Ethics Program*, an essential component of the System's policies and procedures related to the detection of fraud, waste, and abuse and other compliance issues includes board oversight, whose responsibilities include:

i. Ensuring that systems are in place to keep it informed of compliance issues as they arise; and

ii. Providing reasonable assurances of compliance.

E. NYC Health + Hospitals includes information on, among other things, the System's *Corporate Compliance and Ethics Program*, *Principles of Professional Conduct*, relevant Federal and State laws and the System's policies and procedures as they relate to fraud, waste, and abuse, false claims and whistleblower protections in its employee handbooks.

X. RETALIATION AND INTIMIDATION WHISTLEBLOWER POLICIES

A. **Requirements:** NYC Health + Hospitals is responsible for, among other things, ensuring the development of policies and procedures which provide information on remedies for false claims actions, whistleblower protections and policies of non-intimidation and retaliation for *good faith* reporting of or participation in the investigation of potential violations of the law, regulations, internal policies and procedures or the *Corporate Compliance and Ethics Program.*[77]

B. **Protections Against Retaliation:** The Federal FCA and State FCA both afford protections against retaliatin to individuals who report, commence action, or are involved in the investigation of violations of applicable fraud, waste, and abuse laws.[78] Additionally, NYC Health + Hospitals strictly prohibits intimidation and retaliation, in any form, against any Workforce Member or Business Partner that, *in good faith*, participates in the *Corporate Compliance and Ethics Program* which includes reporting potential non-compliance or violations of laws and regulations. Any individual or entity that engages in retaliatory conduct against an individual or entity who *in good faith* reports potential compliance issues or violations or participates in the investigation of such, shall face disciplinary action, up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals.

IMPORTANT: Workforce Members and Business Partners should refer to OP 50-1 *Corporate Compliance and Ethics Program* and the System's *Principles of Professional Conduct* for information about reporting compliance concerns or violations and policies on non-retaliation and intimidation.

C. **Qui Tam Actions:** Under both the Federal FCA and State FCA, individuals may bring a civil action on behalf of themselves and the United States government, the State of New York, or a local government for violations of the applicable false claims act.[79] These actions by a whistleblower on behalf of the government are referred to as "*qui tam*" actions. The government may choose whether to proceed with the prosecution of

[77] *See* 42 U.S.C. §§ 1396a(a)(68)(b), (c); *see also* 18 NYCRR § 521.3(c)(8).
[78] *See* 31 U.S.C. §§ 3730(h)(1), (2); State Finance Law § 191(1).
[79] *See* 31 U.S.C. § 3730(b)(1); State Finance Law § 190(2).

such action, and in any event, the individual commencing the action may choose to continue with the action.[80] The whistleblower is entitled to a percentage of any recoveries that result from the action brought.[81]

D. **Remedies:** Under both the Federal FCA and the State FCA, as well as NYS Labor Law, individuals retaliated against are entitled to remedies of relief that in general may include:

i. Reinstatement into the same position or authority level as previously occupied;

ii. Two times the amount of back pay, lost wages, and interest on the back pay; and

iii. Compensation for any special damages sustained as a result of the discrimination or retaliation, including litigation costs and reasonable attorneys' fees.[82]

Whistleblower remedies are also provided for under State Labor Law, which specifically allow employees retaliated against to bring a civil action against the employer for, among other things, certain reliefs or remedies similar to those under the Federal FCA and State FCA. Labor Law § 741, which specifically applies to health care providers, offers similar protections to employees.[83]

XI. MANDATORY COMPLIANCE: Any Workforce Member or Business Partner that fails to adhere to this OP in any manner will be subject to disciplinary action up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals.

XII. MANDATORY REPORTING:

A. **Mandatory Reporting:** All Workforce Members and Business Partners that know or have reason to believe that another person has violated this Policy, the procedures established hereunder, or any of the laws or regulations listed throughout this OP, has an affirmative duty to report the matter promptly to the CCO. All reported matters will be investigated, and if appropriate, steps will be taken to remedy the situation.

B. **Reporting Procedure:** All reports required to be made pursuant to this OP shall be made by phone, e-mail, facsimile or mail, as follows:

NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10038
Telephone: (646) 458-5632
Facsimile: (646) 458-5624
E-mail: compliance@nychhc.org
Confidential Compliance Helpline: 1-866-HELP-HHC (1-866-435-7442)

NYC Health + Hospitals/OneCity Health or a violation by any OneCity Health Partner, such violation may be reported anonymously at: 1-844-805-0105

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[80] *See* 31 U.S.C. § 3730(c)(3).
[81] *See* 31 U.S.C. § 3730(d); State Finance Law § 190(6).
[82] *See* 31 U.S.C. § 3730(h)(2). *See also* generally State Finance Law §§ 191(1)(a) – (e) and Labor Law §§ 740 and 741 .
[83] *See* Labor Law § 741(2).

MetroPlus Health Plan ("NYC Health + Hospitals/MetroPlus" or "MetroPlus"), such violation may be reported anonymously at: 1-888-245-7247

Medicare fraud, waste or abuse, or suspected violations of law, such violations or suspicions may be reported by contacting CMS at 1-800- MEDICARE (1-800-644-4227), by contacting the OIG at 1-800-HHS-TIPS (1-800-447-8477) or online by visiting https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx or by reporting directly to the Medicare plan sponsor.

XIII. WHISTLEBLOWER PROTECTION:

A. **Retaliation Prohibited:** NYC Health + Hospitals and HIPAA regulations[84] strictly prohibit retaliation, as defined in Subdivision "B" of this Section, *infra*, or intimidation in any form, against any individual ("Reporter" or "Whistleblower") who makes a report, complaint or inquiry in good faith concerning a violation of this OP, as well as any individual who participates in or cooperates with an investigation of any violation of this OP.

B. **Retaliation Defined:** Retaliation means the discharge, suspension, demotion, engagement of threatening or coercive conduct, penalization, discrimination or other adverse employment, contractual, business-related or patient care-related action imposed against any individual or entity as a consequence of making a good faith report of any violation of this Policy or the laws and regulations stated herein.[85]

XIV. QUESTIONS: Any questions regarding the application or interpretation of this OP may be addressed to the CCO by phone, e-mail, facsimile, confidential compliance helpline or mail as provided above in Subdivision "B" of § XII, *supra*.

XV. ONGOING REVIEW OF POLICY: The CCO shall be responsible for the periodic review and, where necessary, the amendment, updating, and supplementation of this Policy to ensure that the purposes and procedures outlined herein remain consistent with applicable law and compliance program best practices.

XVI. EFFECTIVE DATE: This OP shall become effective as of the date first written above and shall remain in effect until modified in writing.

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[84] *See* 45 CFR § 164.530(g); *see also* 65 Fed. Reg. 82461, 82563 (Dec. 28, 2000).
[85] *See* Labor Law §§ 740 (1)(e), 741(1)(f).