I. Policy

Schoharie Arc is committed to prompt, complete and accurate billing of all services provided to consumers. Schoharie Arc and its employees, persons associated with the provider, executives and governing body members shall not make or submit any false or misleading entries on any bills or claim forms, and no employee, persons associated with the provider, executives and governing body members or agent shall engage in any arrangement or participate in such an arrangement at the direction of another person, including any supervisor or manager, that results in such prohibited acts.

Further, it is the policy of Schoharie Arc to detect and prevent fraud, waste and abuse in federal healthcare programs. This Policy explains the Federal False Claims Act (31 U.S.C. §§ 3729 – 3733), the Federal Program Fraud Civil Remedies Act (31 USC §§3801-3812), the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119), the New York State False Claims Act (State Finance Law §§187-194) and other New York State laws concerning false statements or claims and employee protections against retaliation. This policy also sets forth the procedures Schoharie Arc has put into place to prevent any violations of federal or New York State laws regarding fraud or abuse in its health care programs.

II. Scope

This Policy applies to all employees, persons associated with the provider, executives and governing body members

Overview of Relevant Laws

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

1. Overview. The False Claims Act is one of the laws the Government uses to prevent and detect fraud, waste and abuse in federal health care programs. The False Claims Act establishes liability for any person who "knowingly" submits a false claim either (1) directly to the Government or (2) to a contractor or grantee of the Government, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest. A violation of the False Claims Act can result in a civil penalty between $10,781 and $21,563 for each false claim submitted, plus up to three times the amount of the damages sustained by the Government due to the violation(s). The False Claims Act defines "knowingly" to mean that a person (1) has actual knowledge of the false claim; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Specifically, the False Claims Act may be violated by the following acts:

    a. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;

b. Knowingly making or using, or causing to be made or used, a false record or statement material to a false claim;

c. Conspiring to commit a violation of the False Claims Act; or

d. Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay money or transmit property to the Government, or knowingly concealing or avoiding or decreasing an obligation to pay money or transmit property to the Government.

2. Applicability. Among other things, the False Claims Act applies to claims submitted for payment by federal health care programs, including Medicare and Medicaid.

3. Examples. A few examples of actions that violate the False Claims Act include knowingly:

a. Billing for services that were not actually rendered;

b. Charging more than once for the same service;

c. Billing for medically unnecessary services; and

d. Falsifying time records used to bill Medicaid.

4. Methods of Enforcement. The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the False Claims Act. If a Relator brings an action under the False Claims Act, the Government has a period of time to investigate the allegations and decide whether to join the lawsuit. If the Government elects to join the lawsuit, the Relator is entitled to 15-25% of any recovery. If the Government elects not to join the lawsuit, the Relator may still proceed with the action and is entitled to 25-30% of any recovery.

5. Employee Protection. The False Claims Act prohibits discrimination by Schoharie Arc against any employees, persons associated with the provider, executives and governing body members for taking lawful actions in furtherance of an action under the False Claims Act. Under the False Claims Act, any employees, persons associated with the provider, executives and governing body members who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employees, persons associated with the provider, executives and governing body members whole. Such relief may include reinstatement, double back pay, and

compensation for any special damages, including litigation costs and reasonable attorneys' fees.

B. Federal Program Fraud Civil Remedies Act (31 USC §§3801-3812).

The Program Fraud Civil Remedies Act of 1986 is a federal law that provides for administrative recoveries by federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information or omits material information. Violations of this law are investigated by the Department of Health and Human Services and monetary sanctions may be imposed in an administrative hearing setting. Monetary sanctions may include penalties of up to $10,781 per claim and damages of twice the amount of the original claim.

C. **Patient Protection and Affordable Care Act "PPACA" (Pub. L. No. 111-148, 124 Stat. 119).**

The Patient Protection and Affordable Care Act of 2010 is a federal healthcare law that through amendments expanded provisions of the Federal False Claims Act. Most significantly, PPACA expanded FCA liability for possession of overpayments (42 U.S.C.§ 1320a-7k). The law clarified that an overpayment must be reported and returned by 60 days after the date on which the overpayment was identified. Overpayments retained after the deadline are considered an obligation as defined in the FCA imposing FCA liability.

D. New York State False Claims Laws

1. New York State False Claims Act (State Finance Law §§187-194). The New York State False Claims Act was modeled after the Federal False Claims Act and its provisions are very similar. This Act provides that anyone who "knowingly" submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties between $6,000 and $12,000 for each false claim submitted. The False Claims Act defines "knowingly" to mean that a person (1) has actual knowledge of the false claim; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

   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. In addition, 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.

2. Social Service Law §145-b. Under this section it is unlawful to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. In the event of a violation of this law, the local Social services district or the State has a right to recover civil damages equal to three 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 damages (or $5,000, whichever is greater) sustained by the government due to the violation. In addition, the Department of Health may impose a monetary penalty of up to $10,000 per violation unless a penalty under the section has been imposed within the previous five years, in which case the penalty may be up to $30,000.

3. Social Services Law § 145-c. Under this section, if any person individually or as a member of a family applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, then the needs of that person shall not be taken into account for determining the needs of that person or those of his or her family: (i) for a period of 6 months if a first offense; (ii) for a period of 12 months if a second offense, or upon an offense which resulted in the wrongful receipt of benefits in an amount of between $1,000 and $3,900; and (iii) for a period of 18 months if a third offense or upon an offense which resulted in the wrongful receipt of benefits in excess of $3,900, and 5 years for any subsequent occasion of any such offense.

4. Social Services law §145. Under this section, any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor. This crime is punishable by fines and by imprisonment up to one year.

5. Social Service Law § 366-b. Under this section any person who, with intent to defraud, presents for payment any false or fraudulent claim for services or merchandise, or knowingly submits false information for the purpose of obtaining compensation greater than that to which he/she is legally entitled to shall be guilty of a class A misdemeanor.

6. Penal Law Article 155. Under this Article, 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 similar behavior. This Article has

been applied to Medicaid fraud cases. This crime is punishable by fines and imprisonment up to twenty-five years.

7. Penal Law Article 175. Under this Article, four crimes relating to falsifying business records or filing a false instrument have been applied in Medicaid fraud prosecutions. These crimes are punishable by fines and imprisonment up to four years.

8. Penal Law Article 176. This Article establishes the crime of insurance fraud. A person commits such a crime when he/she intentionally files a health insurance claim, including Medicaid, knowing that it is false. This crime is punishable by fines and imprisonment up to twenty-five years.

9. Penal Law Article 177. 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 and willfully 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.

10. Labor Law §740. In addition to provisions contained in the Federal and New York State False Claim Acts, this section offers protections to employees who may notice and report inappropriate activities. Under New York State Labor Law §740, an employer may not take any retaliatory personnel action against an employee because the employee:

- discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation that presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;
- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or

- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

To bring an action under this provision, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back-pay and compensation of reasonable costs. The law also provides that employees who bring an action without basis in law or fact may be held liable to the employer for its attorney's fees and costs.

11. Labor Law §741. Under this section, an employer may not take any retaliatory personnel 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 gives 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. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back-pay and compensation of reasonable costs.

III. Procedure

A. General Principles.

Schoharie Arc provides training to all its employees, persons associated with the provider, executives and governing body members regarding this Policy.

Billing activities are performed in a manner consistent with Medicare, Medicaid and other payor regulations and requirements and in accordance with Schoharie Arc's documentation/billing policies.

To assist in its efforts to detect and prevent fraud, waste and abuse, Schoharie Arc conducts regular audit and monitoring procedures as described in the auditing and monitoring policy.

B. Reporting Non-Compliance.

If a Schoharie Arc employees, persons associated with the provider, executives and governing body members has any reason to believe that anyone is engaging in false billing

practices, that person immediately reports the practice in accordance with Schoharie Arc's reporting compliance concerns and anti-retaliation policy. The Schoharie Arc Compliance Hotline telephone number is 518-295-8125.

C. Non-Retaliation.

Schoharie Arc does not retaliate against any employee taking any lawful action under the False Claims Act. Moreover, Schoharie Arc does not retaliate against any employees, persons associated with the provider, executives and governing body members for reporting any potential compliance concern, as described in Schoharie Arc's reporting compliance concerns and anti-retaliation policy.

D. Employee Handbooks and Contractor Agreements.

This Policy is summarized in all employee handbooks and attached to any contracts with outside contractors or agents, and included on Schoharie Arc's website.