Corporate Compliance

Fraud, Waste and Abuse Prevention and Education Policy

The Compliance Program at the Cortland Regional Medical Center (CRMC) demonstrates our commitment to uphold all federal and state laws and regulations, and to inhibit fraud, waste and abuse in the hospital and its affiliated corporations.

If after you review this policy you have questions, please contact our Corporate Compliance Officer at (607) 428 – 5150.

Policy

All Cortland Regional Medical Center and its affiliated corporations which submit claims to Medicaid and/or receive reimbursement from Medicaid in excess of $5 million per year, (hereinafter collectively "CRMC" or "Medical Center") Board Members, employees, and DRA contractors and agents are required to act in compliance with all federal and state laws that address fraud, waste and abuse in federal health care programs such as Medicare and Medicaid. DRA contractors and agents are any contractor, subcontractor, agent, or other person which or who, on behalf of CRMC, 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 CRMC.

Purpose

The purpose of this policy is to inform CRMC Board Members, employees, DRA contractors and agents of those federal and state laws, such as the False Claims Act ("FCA") and whistleblower protection laws, which address or are related to fraud, waste and abuse in federal health care programs and to provide general information regarding CRMC's efforts to combat fraud, waste, and abuse.

FEDERAL AND STATE FALSE CLAIMS ACT, ADMINISTRATIVE PENALTIES AND WHISTLEBLOWER PROTECTION LAWS

Attached hereto and incorporated herein as Appendix A is a summary of the Federal and State false claims acts, administrative remedies for false claims and statements and whistleblower protection laws.

Under Federal and New York Law, employers are prevented from taking any retaliatory actions (i.e., discharge, suspension, demotion or other adverse action in terms of condition of employment) against an employee who 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 which violation creates and presents a substantial and specific danger to the public health or which constitutes the crime of health care fraud.

If you have any questions about these laws, please contact the Corporate Compliance Officer.

CRMC'S PROCEDURE FOR DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE

Through its Corporate Compliance Plan, Code of Conduct and related policies and procedures CRMC has established standards and procedures to promote the highest ethical culture and discourage inappropriate conduct. It is the fundamental policy of CRMC to conduct its business in compliance with all applicable laws and regulations of the United States, the State of New York, all applicable local laws and ordinances, and the ethical standards/practices of the industry and the Medical Center.

The Medical Center is committed to ensuring that its coding, billing, and reimbursement procedures comply with all federal and state laws, regulations and guidelines. Accordingly, the Medical Center's policy prohibits billing or submitting a claim for services that were not provided as stated, not medically necessary, known not to be covered by the payor or are false, misleading, or inaccurate. If these types of inaccuracies are discovered in bills or claims already submitted to the payor, the employee who discovered the inaccuracies should report the issue immediately so that corrective action can be taken. Similarly, the Medical Center will check the excluded status of all Board members, employees, new hires, medical staff members and contractors to ensure that none are excluded from participating in federal healthcare programs such as Medicare and/or Medicaid.

NO RETALIATION

As outlined in the Medical Center's Corporate Compliance Plan and handbook, employees must report known compliance issues or they will be subject to disciplinary action. Employees who report compliance issues in good faith will not be punished in any way for reporting the issue. In addition there will be no retaliation or intimidation for participating in investigations, audits and corrective actions related to compliance matters. An employee that attempts to retaliate against another employee for reporting a compliance issue in good faith will be subject to disciplinary action, including termination if appropriate. If an employee makes a false or misleading report related to a compliance issue, the employee will be subject to disciplinary action.

REPORTING SUSPECTED NON-COMPLIANCE

Anyone may report an incident of suspected non-compliance. Reports may be made anonymously, in person, by phone, or in writing to any of the following resources:

1. Employees may report incidents of suspected non-compliance to their supervisor (unless the supervisor is involved in the matter of concern) or to any senior manager. Such supervisor or senior manager must promptly forward the report to the Compliance Officer or to a member of the Corporate Compliance Committee. Reports received by a member of the Corporate Compliance Committee must be immediately communicated to the Compliance Officer for documentation, investigation, and follow up.

2. Corporate Compliance Officer 607-428-5150

3. HIPAA Privacy Officer 607-756-3687

4. Compliance Hotline 607-428-5151

5. Compliance FAX 607-428-5069

Written communications may include e-mail, memorandum, and letter or incident report. The reporter may identify him/herself or remain anonymous. Every attempt will be made to keep the reporter's identity confidential unless he/she gives permission or requests that his/her identity be revealed through the process or investigation. However, there may be situations where the direction of the investigation may lead to identification of the reporter.

The failure to report compliance issues and assist in the resolution may result in disciplinary action up to and including termination and such discipline will be fairly and uniformly imposed. Disciplinary action may be taken for failure to report suspected problems; participation in non-compliant activity; or encouraging, directing, facilitating or permitting non-compliant conduct. Employees are also expected to participate in audits, investigations and corrective action plans related to compliance issues and the failure to do so may result in disciplinary action up to and including termination.

The CRMC Corporate Compliance Plan, compliance policies and this policy set forth the processes CRMC utilizes to detect and prevent fraud, waste and abuse including, without limitation, a code of conduct; a designated corporate compliance officer with access to the Board of Trustees; compliance education and training for employees and Board Members; processes for reporting compliance issues; auditing and monitoring of CRMC practices to detect and investigate potential compliance issues; disciplinary actions that may be taken against employees who fail to comply with applicable laws and/or CRMC policies; the corrective action CRMC will take including self-disclosure and/or repayment of overpayments in response to compliance related issues and the prohibition on retaliation against people who make good faith reports of suspected non-compliance.

The Corporate Compliance Plan, Appendix A and other applicable CRMC policies and procedures are available on the Medical Center's intranet.

Please address any questions regarding this policy to the Corporate Compliance Officer.

APPENDIX A

OMIG SUMMARY

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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;. . . or (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,

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

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of

liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from 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 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not Intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

<u>Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)</u>

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, 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 False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of tines and penalties is made by the administrative agency, not by prosecution in the federal court system.

NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

CIVIL AND ADMINISTRATIVE LAWS

<u>NY False Claims Act (State Finance Law, §§187-194)</u>

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and 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 and three times

the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and live years for 4 or more offenses.

CRIMINAL LAWS

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices.

a. 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.

b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny.

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

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

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

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

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements.

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud,

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

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

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

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

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

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

Penal Law Article 177, Health Care Fraud,

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health cam fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

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

The FCA 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 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 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.

NY False Claim Act (State Finance Law §191)

The False Claim 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 the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York 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.