Episcopal Health Services

DEFICIT REDUCTION ACT NOTICE

It is the policy of EHS to comply with all federal, state, and local laws to implement and enforce procedures to detect and prevent fraud, waste, and abuse related to federal and state-funded healthcare programs. EHS team members, including employees, contractors, and agents, should be aware of requirements governing our operations, as well as the policies in place for preventing, detecting, and deterring fraud, waste, and abuse.

Section 6032 of the Federal Deficit Reduction Act of 2005 requires EHS to provide information on the following:

- Federal and New York State laws related to filing false claims;
- Whistleblower protections for employees under federal and state laws; and
- EHS' Policies and Procedures for detecting and preventing fraud, waste, and abuse.

FEDERAL STATUTES RELATED TO FILING FALSE CLAIMS AND WHISTLEBLOWER PROTECTIONS

Numerous federal and state laws prohibit healthcare providers from submitting false or fraudulent claims to Medicare, Medicaid, and other government-funded healthcare programs. EHS team members should be aware of the following federal and New York State statutes related to the filing of false claims to government healthcare programs.

FEDERAL FALSE CLAIMS ACT (31 U.S.C. §§ 3729–3733)

The federal False Claims Act ("FCA") imposes penalties and fines on persons and entities who knowingly file false or fraudulent claims for payment from Medicare, Medicaid, or other federal health programs. The government can recover damages up to three (3) times the value of the falsely received amount. A person violates the FCA when knowingly:

- Concealing or avoiding a requirement to pay the government;
- Making or using a false document or statement leading to a false claim; and
- Presenting a false claim to the government for payment and/or conspiring to violate the FCA.

The FCA allows a private individual to file a "qui tam" lawsuit in federal court. A "qui tam" lawsuit is a lawsuit by a citizen to help recover wrongful payments on behalf of the government. The FCA also provides protection for "whistleblowers" or reporters.

If a qui tam suit eventually concludes with government re-payments, the person who started the case can recover a percentage of the proceeds that is determined by whether the government participated in the suit.

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ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS (31 U.S.C. §§ 3801 – 3812)

If a person submits a claim that the person knows is false, contains false information, or omits material information, then the agency receiving the claim may impose a penalty for each claim. The agency may also recover up to twice the amount of the claim.
Unlike the FCA, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties, is made by the administrative agency, not by prosecution in the federal court system.

NEW YORK CIVIL AND ADMINISTRATIVE LAWS

NEW YORK FALSE CLAIMS ACT (State Finance Law §§ 187-194)

The New York State False Claims Act ("NYS FCA") mirrors the federal FCA and imposes penalties and fines on persons and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs, such as Medicaid. New York State may recover damages up to three (3) times the value of the falsely received amount. In addition, the false claim filer may have to pay the government's legal fees.

The NYS FCA 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 re-payments to New York State, the person who started the case can recover a percentage of the proceeds that is determined by whether New York State did or did not participate in the suit.

SOCIAL SERVICES LAW §145-B, FALSE STATEMENTS

It is a violation to obtain knowingly or attempt to obtain payment from public funds, including from the Medicaid program, by use of a false statement, deliberate concealment, or other fraudulent scheme or device. New York State or the local social services district may recover up to three (3) times the incorrectly paid amount. The Department of Health may also impose a civil penalty for each violation.

SOCIAL SERVICES LAW §145-C, SANCTIONS

If any person applies for or receives public assistance, like Medicaid, by intentionally making a false or misleading statement or misrepresenting, concealing, or withholding facts, then the person's needs will not be taken into account in determining the qualification for or amount of public assistance for which the person and/or the person's family may be eligible.

Episcopal Health Services

NEW YORK CRIMINAL LAWS

SOCIAL SERVICES LAW §145, PENALTIES

This law states that any person whom submits false statements or deliberately conceals material information to receive public assistance, including Medicaid, is guilty of a misdemeanor.

SOCIAL SERVICES LAW § 366-B, PENALTIES FOR FRAUDULENT PRACTICES

This law states that any person whom 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 any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

PENAL LAW ARTICLE 155, LARCENY

A person commits larceny when, with intent to deprive another of his property, obtains, takes, or withholds the property by means of trick, embezzlement, false pretense, or false promise, including a scheme to defraud, or other similar behavior. Larceny generally ranges from petit larceny (a Class A misdemeanor) to first degree grand larceny involving property valued at over $1 million (a Class B felony).

PENAL LAW ARTICLE 175, FALSE WRITTEN STATEMENTS

Four crimes for filing false information or claims have been applied in Medicaid fraud prosecutions:

1. § 175.05. Falsifying business records in the second degree 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;

2. § 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;

3. § 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;

4. § 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

This law applies to claims for insurance payment, including Medicaid or other health insurance, and ranges from insurance fraud in the fifth degree for the intentional filing of a health insurance claim knowing that it is false (a Class A misdemeanor) to insurance fraud in the first degree for filing a false insurance claim for over $1 million (a Class B felony).

Aggravated insurance fraud is the commission of insurance fraud after having been previously convicted within the preceding 5 years of any offense, the essential element of which is the commission of a fraudulent insurance act. It is a Class D felony.

PENAL LAW ARTICLE 177, HEALTH CARE FRAUD

This law applies to claims for health insurance payment, including Medicaid claims, and ranges from healthcare fraud in the fifth degree for knowingly filing, with the intent to defraud, a claim for payment that intentionally has false information or omissions (a Class A misdemeanor) to healthcare fraud in the first degree for filing false claims and annually receiving over $1 million in the aggregate (a Class B felony).

WHISTLEBLOWER PROTECTIONS

The following federal and New York State laws provide protections for EHS team members to report issues of fraud, waste, and abuse without facing any adverse employment action.

FEDERAL FALSE CLAIMS ACT (31 U.S.C. § 3730(h))

The FCA provides protection to "whistleblowers" who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in their job because they did something to try to stop a violation of the FCA. Remedies include reinstatement with comparable seniority as the whistleblower would have had but for the discrimination, two (2) times the amount of any back pay, interest on any back pay, compensation for any special damages sustained as a result of the discrimination, and reimbursement of litigation costs and reasonable attorneys' fees.

NEW YORK FALSE CLAIMS ACT (State Finance Law § 191)

The NYS FCA provides many of the same protections as the federal FCA that are explained above, but applies to whistleblowers under both the federal and NYS FCAs.

NEW YORK LABOR LAW § 740 AND § 741

This state law prohibits an employer from taking 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: (1) is in violation of a law that creates a substantial and specific danger to the public health and safety; (2) has committed healthcare fraud under Penal Law § 177; or (3) has provided an 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. 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 on the employer.

EHS' POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE

EHS' Compliance and Privacy Department ("Compliance & Privacy") works in conjunction with other lines of business at EHS, such as Revenue Cycle, Finance, Risk Management, People Operations, and Quality, as well as with outside regulatory entities, such as the New York State Office of the Medicaid Inspector General, New York State Department of Health, U.S. Department of Health and Human Services Office of Inspector General, Office for Civil Rights, and Centers for Medicare and Medicaid Services.

Compliance & Privacy is responsible for administering the organization's *Compliance Plan* and its policy and procedures for *Fraud, Waste, and Abuse Prevention & Self-Disclosures*. These documents are available on EHS' public website and internal intranet.

- **Fraud** means deliberate deception by an individual or individuals (or an organization), either internal or external to government, which could result in a benefit to themselves, others, or the government or could cause detriment to others or the government.
- **Waste** is the intentional or unintentional, thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources to the detriment or potential detriment of EHS or the federal or state government. This can include overusing services or practices that result in unnecessary costs to a federal healthcare program. It is often not considered to be criminal.
- **Abuse** means using one's position or any resource of EHS in a manner contrary to applicable laws, policies, or generally accepted practices. This includes intentional destruction, diversion, manipulation, misapplication, or misuse of assets, information, systems, relationships, or other resources.

Examples include:

- Billing for services or supplies not actually provided;
- Changing procedure billing codes to ones that are reimbursed at higher amounts;
- Brand name billing for generic drugs;
- Falsifying any type of records including payroll or time records, medical records, or research records for the purposes of committing fraud;
- Unlawful patient financial inducements (free gifts or services to patients); and
- Writing excessive prescriptions for the same condition.

PREVENTING FRAUD, WASTE AND ABUSE

Internal Controls

Creating effective internal controls is one way to prevent fraud, waste, and abuse. Internal controls are processes carried out by EHS' management and other personnel designed to provide reasonable assurance that EHS' assets are safeguarded, operations are effective and efficient, financial reports are reliable, and laws, regulations, and policies are followed by employees, contractors, and agents.

To create effective internal controls:

(1) Review operational processes of the billing procedures or other areas under consideration;

(2) Evaluate the potential risk of fraud, waste, or abuse inherent in each process;

(3) Make a list of actions included in the process or potential actions that could be included for the purpose of decreasing the inherent risk;

(4) Assess whether there are internal controls that need to be improved or added to the process under consideration;

(5) Implement controls or improvements to existing controls that are deemed the most efficient and effective way to decrease the risk of fraud, waste, and abuse; and

(6) Develop an oversight and monitoring process to ensure the effectiveness and continuing evaluation of the control system.

Examples of internal controls, include: (1) separation of responsibilities between team members; (2) physical safeguards over assets; (3) documentation of transactions; (4) independent review of transactions; and (5) proper supervision over team members and processes.

Ethical Work Environment

Another way to prevent fraud, waste, and abuse is by developing a culture of honesty and high ethics. To create such an environment, management should behave ethically and communicate to others that they are expected to behave ethically. To promote and support an ethical environment, the following actions may be taken: (1) reward/recognize appropriate behavior; (2) clearly assign job responsibilities; (3) set reasonable goals; and (4) provide education and training.

Internal Monitoring

Through the internal monitoring process, EHS can assess the adequacy and effectiveness of the internal controls that are developed and implemented by management and others, and make recommendations for improvements.

As part of internal monitoring, EHS can conduct audits designed to detect fraud, waste, or abuse. However, the primary responsibility for prompt detection and prevention rests with management and management should not rely solely on internal monitoring as a means for preventing or detecting fraud, waste, or abuse.

EHS internal monitoring can also assist management with the identification of risks and the implementation of controls.

Professional Licensure and Credentialing

No licensed professional will be permitted to provide professional medical and health services for which EHS bills unless it has been demonstrated that the individual possesses the education and licensure required by law. All licensed professionals shall be properly credentialed and EHS will maintain a file on each licensed professional that contains documentation of these credentials.

EHS personnel and licensed professionals involved in the credentialing process shall comply with all applicable laws, regulations, and standards. If you become aware of any information or documentation indicating that any EHS team member or licensed professional has not adhered to the requirement for credentialing or licensure, you should bring it to the attention of Compliance & Privacy immediately.

DETECTING AND REPORTING FRAUD, WASTE, AND ABUSE

If fraud, waste, or abuse is known or suspected, it should be reported to either your supervisor or Compliance & Privacy. It is the obligation of each EHS team member to report conduct that the team member knows or reasonably believes to constitute fraud, waste, or abuse.

Concerns or reports should be brought to the attention of Compliance & Privacy, either directly and immediately upon learning of the potential problem, or upon determining through their dealings

with their team members or supervisors that their concerns have not been addressed satisfactorily and completely.

A team member does not need to be absolutely certain that a violation has occurred before making a report; reasonable belief that a violation may have occurred is sufficient. Reporting enables EHS to investigate potential problems quickly and to take prompt action to resolve them.

These reports may be made in person or as follows:

- By phone at 718-869-5711
- By email at compliance@ehs.org
- By 24/7 Confidential & Anonymous Compliance Hotline at 1-844-973-0162
- Online at www.ehs.ethicspoint.com
- By mail addressed to:

  Episcopal Health Services Inc.
  327 Beach 19th Street
  Far Rockaway, NY 11691
  Attn: Compliance & Privacy

If you suspect fraud involving Medicare or other federally-funded healthcare programs, you may also call the U.S. Department of Health and Human Services Office of Inspector General at 1-800-HHS-TIPS.

If you suspect fraud involving the New York State Medicaid program, you may also call the New York State Office of the Medicaid Inspector General at 1-877-873-7283.

WHISTLEBLOWER AND NON-RETALIATION/INTIMIDATION PROTECTIONS

Compliance & Privacy is responsible for administering the organization's *Code of Conduct* and its policy and procedures for *Whistleblower and Non-Retaliation/Intimidation* protections. These documents are available on EHS' public website and internal intranet.

EHS strictly prohibits intimidation, harassment, or retaliation, in any form, against any individual who in good faith participates in the Compliance Program by reporting or participating in an investigation of suspected fraud, waste, or abuse.

"Participation in good faith" means that EHS will not discipline a team member solely on the basis that the team member reported conduct that the team member either knew or reasonably believed to be fraud, waste, or abuse. However, a team member is subject to discipline if EHS concludes that the team member participated in the non-compliant behavior or incident, has knowingly been untruthful or omitted relevant information, or fabricated a report of wrongdoing for self-protection purposes, protection of another person, or to injure another person.