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MEMORANDUM

TO: All OneCity Health Workforce Members
All OneCity Health Business Partners

FROM: Wayne A. McNulty
Senior Assistant Vice President &
Chief Corporate Compliance Officer

DATE: September 29, 2017

RE: **THE DEFICIT REDUCTION ACT OF 2005**

Pursuant to the Deficit Reduction Act ("DRA") of 2005, NYC Health + Hospitals (hereinafter also referred to as the "System")[1] is required, as a condition of its participation in the Medical Assistance Program ("Medicaid"), to establish written policies and procedures that inform all NYC Health + Hospitals/OneCity Health ("OneCity Health") *Workforce Members* (*e.g.*, OneCity Health employees, personnel, students, trainees, volunteers, members of the governing body, agents, appointees, and individuals whose conduct is under the direct control of OneCity Health, whether or not they are paid directly by OneCity Health) and *Business Partners*[2] (*e.g.*, all performing providers (hereinafter also referred to as Partners) in the NYC Health +

[1] Throughout this document "NYC Health + Hospitals" and the "System" are used interchangeably. Both terms shall mean the New York City Health and Hospitals Corporation, a public benefit corporation created pursuant to the New York City Health and Hospitals Corporation Act (McKinney's Unconsolidated Laws of N.Y. § 7381 *et seq.* [L 1969, C. 1016, eff. May 26, 1969]).

[2] For purposes of § [I][A-G] of this memorandum, the term "Business Partner" includes any non-workforce member contractor, subcontractor, vendor or other third party who, acting on behalf of the System or otherwise being associated with the System: (i) engages in activities, functions or duties that contribute to the System's entitlement to receive payment from Federal healthcare programs; (ii) engages in activities, functions or duties that may place the System in a position to commit significant noncompliance with Federal healthcare program requirements or fraud, waste and abuse prohibitions; or (iii) delivers, furnishes, prescribes, directs, orders or otherwise provides Federal healthcare program items and services.

Hospitals-sponsored OneCity Health Performing Provider System ("PPS")), about the following:[3]

- The System's internal policies covering the prevention and detection of Federal healthcare program fraud, waste, and abuse;
- The Federal False Claims Act and any similar law under the State of New York (the "State") that governs false claims and statements;
- The Federal administrative remedies for false claims and statements;
- Any State law pertaining to civil or criminal penalties for false claims and statements; and
- Whistleblower protections under Federal and State laws.

Accordingly, the paragraphs that follow provide an overview of the System's policies and procedures designed to prevent and detect fraud, waste, and abuse. Additionally, annexed hereto as Appendix "A" is, among other things, a summary of the following: (i) the Federal False Claims Act and similar State laws; (ii) Federal administrative remedies for false claims and statements; and (iii) Federal and State whistleblower laws.

I. NYC HEALTH + HOSPITALS' POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE:

A. *NYC HEALTH + HOSPITALS CORPORATE COMPLIANCE PLAN*

The overall breadth of the System's Corporate Compliance Program (the "Program") is best reflected in its *Corporate Compliance Plan* (the "Plan"). Specifically, the Plan outlines and explains the structural and operational elements of the Program, highlighting the System's development and/or adoption of written policies and procedures covering compliance, including, without limitation, NYC Health + Hospitals' Operating Procedure 50-1 - *Corporate Compliance Program* ("OP 50-1"), which details the structure of the Program; NYC Health + Hospitals' *Principles of Professional Conduct* ("POPC"), which establishes the System's prohibition of fraudulent billing and other improper business practices; and *A Guide to Compliance at NYC Health + Hospitals* ("Guide to Compliance"), which provides a summary of important compliance issues, standards, and expectations at NYC Health + Hospitals. The Plan, OP 50-1, the POPC, and the Guide to Compliance may all be accessed through the System's Intranet under the Office of Corporate Compliance ("OCC") at: http://compliance.nychhc.org/, or by way of NYC Health + Hospitals' public website at: http://www.nychealthandhospitals.org/policies-procedures/. You may also contact your local Facility Compliance Officer or the OCC - by phone at (646) 458-7799 or by e-mail at COMPLIANCE@nychhc.org - to obtain copies of the same.

[3] *See* 42 U.S.C. § 1396a [a][68][A-C]; *see also* Office of the Medicaid Inspector General, *Section A- DRA Program FAQS*, § A-2 [What Are the DRA Requirements] ¶ (2), available at: https://omig.ny.gov/images/stories/provider_compliance/dra_faqs.pdf#page=2 (last accessed on 9/26/17).

The Plan also underscores NYC Health + Hospitals' commitment to routinely identify potential areas of corporate risks and vulnerabilities, and to perform self-evaluations and audits of its operations and practices, which are required under New York's mandatory compliance program regulations.[4]

B. *NYC HEALTH + HOSPITALS OPERATING PROCEDURE ("OP") 50-1- CORPORATE COMPLIANCE PROGRAM*

As evidenced by its internal operating procedures[5], the System has implemented a Program that satisfies the mandatory provider compliance program regulations promulgated by the New York State Department of Social Services.[6] Additionally, the Program also adopts the principles set forth in the 2015 United States Sentencing Commission Guidelines Manual pertaining to effective compliance and ethics programs. The Program is responsible for, among other things, aggressively identifying, directing, and addressing corporate-wide and local compliance activities and concerns. The following are some key highlights of the Program:

- The appointment of a Corporate Compliance Officer ("CCO") charged with the oversight and implementation of the Program;
- The creation of an annual Corporate Compliance Work Plan ("Work Plan") designed to proactively address compliance vulnerabilities;
- The institution of a confidential process and toll-free hotline (1-866-HELP-HHC) to receive complaints;
- The implementation of corporate-wide training and education regarding compliance issues;
- The requirement that the CCO report, at least quarterly, NYC Health + Hospitals' compliance activities to the Chairperson of the Board of Directors ("BOD"), the Chairperson of the Audit Committee of the BOD, and NYC Health + Hospitals' President and Chief Executive;
- The requirement that all NYC Health + Hospitals Workforce Members and Business Partners report violations of OP 50-1, as well as of all applicable laws, rules, codes and regulations (collectively "Laws"), to the CCO;
- The investigation of allegations regarding: (i) violations of applicable laws and NYC Health + Hospitals OP 50-1; and (ii) intimidation and retaliation for reports of such violations; and
- The prohibition of intimidation and retaliation against any person who, acting in good faith, engages in the Program.

[4] *See* 18 N.Y.C.R.R. § 521.3[c][6]; *see also* NYC Health + Hospitals' Corporate Compliance Plan (Updated 11/09/11), p.35.
[5] *See* NYC Health + Hospitals' Operating Procedure 50-1 - Corporate Compliance Program.
[6] *See* 18 N.Y.C.R.R. Part 521.

C. *NYC HEALTH + HOSPITALS PRINCIPLES OF PROFESSIONAL CONDUCT ("POPC")*

The POPC is a guide that sets forth the System's compliance expectations and commitment to comply with all applicable Federal and State laws. It describes the System's standards of professional conduct and efforts to prevent fraud, waste and abuse. All Workforce Members and Business Partners, as described in the POPC, are expected to carry out their duties and functions in a lawful and ethical manner. Some examples of violations of professional conduct are:

- Submitting false and/or fraudulent claims;
- Improper billing practices, including, without limitation, billing for items or services that are not medically necessary and upcoding;
- Inappropriate patient referrals;
- Failure to promptly report and refund, as required by law, any overpayment;
- Breaches of patient confidentiality;
- Accepting gifts from a vendor;
- Failure to adhere to the System's policies concerning the delivery of patient care;
- Engaging in conduct that: (i) is discriminatory; (ii) amounts to sexual or other harassment; or (iii) involves threats of violence; and
- Failure to comply with laws and policies governing workplace safety.

D. *A GUIDE TO COMPLIANCE AT NYC HEALTH + HOSPITALS*

The Guide to Compliance defines the terms *compliance*, *fraud*, *waste*, and *abuse*. The Guide to Compliance also describes the goals of NYC Health + Hospitals' Program, the consequences of non-compliance with applicable Laws and internal policies, and the responsibilities of each workforce member with regard to compliance. In addition to the foregoing, the Guide to Compliance provides information regarding the following compliance subjects:

- Federal and State False Claims Acts;
- The System's policy on retaliation; and
- Instructions on how to report a compliance issue.

E. *MEMORANDUM FROM THE SYSTEM'S CHIEF CORPORATE COMPLIANCE OFFICER REGARDING MEDICARE PARTS C AND D TRAINING*

In furtherance of the System's compliance efforts and to meet CMS requirements and the System's contractual obligations with Medicare Advantage Organizations ("MAO"), each System Workforce Member and Business Partner was provided with the December 29, 2016 Memorandum authored by the System's Chief Corporate Compliance Officer, which outlined the System's Medicare Parts C and D compliance

training requirements.[7] The Memorandum also included *CMS Medicare Parts C and D General Compliance Training* slides ("Parts C and D Training") for review by the System's Workforce Members and Business Partners. Note that, the main learning objectives of the Parts C and D Training are to ensure all Workforce Members and Business Partners recognize how: (i) a compliance program operates; and (ii) compliance program violations should be reported.

Although the subject Memorandum is primarily focused on providing and disseminating the Parts C and D Training to the System's Workforce Members and Business Partners, it also outlines, in policy form, the following important elements of the Program:

- The goals of the System's Program, which include the prevention of fraud waste and abuse, the promotion of ethical conduct, and the establishment of internal controls to prevent compliance violations;
- The compliance expectations of Workforce Members and Business Partners (*e.g*., the adherence to the System's Principles of Professional Conduct);
- Instructions on how Workforce Members and Business Partners can report a System compliance issue; and
- An overview of the System's non-retaliation/whistleblower protection policy.

F. ***NYC HEALTH + HOSPITALS/ONECITY HEALTH ("ONE CITY HEALTH") DSRIP COMPLIANCE TRAINING AND EDUCATION POWERPOINT PRESENTATION***

To assist OneCity Health Partners meet their Delivery System Reform Incentive Payment ("DSRIP") program compliance training and education requirements, on December 30, 2016, the OCC provided each Partner with a memorandum, which included as an attachment a *Delivery System Incentive Payment Program Compliance Training and Education* PowerPoint presentation (the "PowerPoint") prepared by NYC Health + Hospitals/OneCity Health for DSRIP compliance training and education purposes. Kindly note that, the PowerPoint can be accessed at the OneCity Health public website at: http://www.onecityhealth.org/wp-content/uploads/DSRIP-Compliance-Training-Materials-Final.pdf.

The Memorandum and PowerPoint included, without limitation, the following:

- Information about the System's written policies and procedures implemented to address fraud, waste and abuse;
- Information about Federal and State laws that govern false claims and statements and fraud, waste and abuse;
- Information about Federal and State whistleblower protection laws;

[7] The Parts C and D Training is available on the System's public website at:

- Information about where DSRIP Partners can obtain more information regarding the System's DRA-related policies and procedures;
- Information about the System's Program and how the System has addressed the special considerations for DSRIP compliance; and
- Instructions on how OneCity Health Partners can report a DSRIP-related compliance issue or concern.

G. *DSRIP COMPLIANCE ATTESTATION OF ONE CITY HEALTH PARTNERS*

On February 2, 2017, OneCity Health disseminated to each Partner a memorandum and Compliance Attestation, which was primarily designed to assess the compliance program integrity of the Partners.[8] Notwithstanding the fact that the Attestation was developed for the purpose of gathering Partner compliance-related information, the memorandum and Compliance Attestation also covered the following DRA-related topics:

- Information about the criteria that determines if a Partner is required to file compliance certifications with OMIG under New York Social Services Law § 363-d and/or the Deficit Reduction Act of 2005;
- Information about the NYC Health + Hospitals Principles of Professional Conduct ("POPC"), which, as previously indicated, describes the System's standards of professional conduct and as well as efforts to prevent fraud, waste and abuse; and
- Information about the periodic screening of Partner workforce members to ensure that none are excluded from participating in Federal health care programs (*e.g.* Medicare and Medicaid), which included the provision of links to the following government exclusion lists: (i) U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities; (ii) NYS Office of Medicaid Inspector General List of Excluded or Restricted Individuals or Entities; and (iii) U.S. General Services Administration System for Award Management Excluded Individual or Entity Database.

Partners may access the memorandum and Compliance Attestation on the OneCity Health public website at: http://www.onecityhealth.org/wp-content/uploads/DSRIP-Partner-Compliance-Memo-w-Attachments-2-2-17.pdf.

Attachment

cc:
Stanley Brezenoff

[8] The Memorandum included a link to the *Delivery System Reform Incentive Payment Compliance Training and PowerPoint Presentation* referred to §I.F above.

APPENDIX "A"[9]

DEFICIT REDUCTION ACT OF 2005 – FALSE CLAIMS ACT REQUIREMENTS TITLE 42 UNITED STATES CODE SECTION 1396a(a)(68)[10]

FEDERAL AND NEW YORK STATUTES RELATING TO THE FILING OF FALSE CLAIMS

I. FEDERAL LAWS

A. Federal False Claims Obligation (42 USC §1396a (a)(68))
(*See* https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXIX-sec1396a.pdf)

B. Federal False Claims Act (31 USC §§ 3729-3733)
(*See* https://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3729.pdf)

C. Administrative Remedies for False Claims (31 USC Chapter 38, Sections 3801-3812)
(*See*: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title31/pdf/USCODE-2010-title31-subtitleIII-chap38.pdf)

II. NEW YORK STATE LAWS

New York State Laws link: http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO
Select "Laws of New York" under the "Laws" tab.

A. CIVIL AND ADMINISTRATIVE LAWS

1) **New York False Claims Act (State Finance Law §§ 187-194)**
2) **Social Services Law, Section 145-b - False Statements**
3) **Social Services Law, Section 145-c - Sanctions**

B. CRIMINAL LAWS

1) **Social Services Law, Section 145 - Penalties**

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[9] Sections I, II and III on the first and second pages of Appendix "A", are, in pertinent part, duplicated from the website of the New York State Office of the Medicaid Inspector General ("OMIG"), Compliance, Compliance Library, Federal Deficit Reduction Act - References, available at: **https://www.omig.ny.gov/images/stories/provider_compliance/dra_2005_references.pdf** (last accessed 9/26/17). Section 1 (A) on the second page of Appendix "A" is duplicated from 42 USC 1396a (a)(68). Section 1(B) and the remainder of the sections in the Appendix "A" are duplicated from the website of OMIG, Compliance, Certification, Federal Deficit Reduction Act, Relevant Statutes, available at: **http://www.omig.ny.gov/images/stories/relevant_fca_statutes_122209.pdf** (last accessed 9/26/17).

[10] The information provided in this Appendix, as well as any links contained therein, are intended solely as guidance, do not represent an all-inclusive list of relevant laws on this topic, may not reflect recent changes to law, and are not a substitute for legal counsel. Recipients of this memorandum should contact the OCC if they have any questions regarding the content contained herein as it relates to the Program.

2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
3) Penal Law Article 155 - Larceny
4) Penal Law Article 175 - False Written Statements
5) Penal Law Article 176 - Insurance Fraud
6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. §3730(h))
2) New York State False Claim Act (State Finance Law §191)
3) New York State Labor Law, Section 740
4) New York State Labor Law, Section 741

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I. FEDERAL LAWS

A. Federal False Claims Obligation (42 USC §1396a(a)(68))

A State plan for medical assistance must—

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, 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 1320a–7b(f) of this title);
(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

B. Federal False Claims Act (31 USC §§3729-3733)

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

§ 3729. False claims

(a) Liability for certain acts.—

(1) In general.--Subject to paragraph (2), any person who--

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant obtained the information;
(B) such person fully cooperated with any Government investigation of such violation; and
(C) at the time such person furnished the United States with the information about theviolation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section—

(1) the terms “knowing” and “knowingly” –

(A) mean that a person, with respect to information--
(i) has actual knowledge of the information;
(ii) acts in deliberate ignorance of the truth or falsity of the information; or
(iii) acts in reckless disregard of the truth or falsity of the information; and
(B) require no proof of specific intent to defraud;

(2) the term “claim”--

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--

(i) is presented to an officer, employee, or agent of the United States; or
(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-
(I) provides or has provided any portion of the money or property requested or
demanded; or
(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

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, or submits a claim to entities administering government funds 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 which obtains interim payments from Medicare or Medicaid 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 or Medicaid 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.

C. Administrative Remedies for False Claims (31 USC Chapter 38, §§ 3801 – 3812)

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, 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 rather than when it is paid. Also unlike the False Claims Act, 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.

II. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§ 187-194)

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 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 ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3) Social Services Law, Section 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 needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

1) Social Services Law, Section 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.

2) Social Services Law, Section 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 a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3) Penal Law Article 155 - Larceny

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

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.

4) 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.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, 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.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

a. Health care fraud in the 5th degree – a person is guilty of this crime 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. This is a class A

misdemeanor.

b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

III. WHISTLEBLOWER PROTECTION

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

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their 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.

2) New York State False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their 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.

3) New York State Labor Law, Section 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.

4) New York State Labor Law, Section 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.