

# **JAMAICA HOSPITAL MEDICAL CENTER**

## **COMMITMENT TO COMPLIANCE**

### **CODE OF CONDUCT AND COMPLIANCE PROGRAM SUMMARY**

SEPTEMBER 2009

## **COMMITMENT TO COMPLIANCE**

Jamaica Hospital Medical Center and all of its affiliated entities (collectively referred to as the "Organization") are committed not only to providing patients with high quality and caring medical services, but also to providing those services pursuant to the highest ethical, business, and legal standards. These high standards apply to our interactions with everyone with whom we deal. This includes our patients, the community, other healthcare providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. While the legal rules are very important, we must hold ourselves up to even higher ethical standards.

In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Organization. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Organization has prepared a comprehensive Code of Conduct and standards of conduct. The Code of Conduct and standards are designed to assist you in navigating the various compliance obligations of the highly regulated industry in which we do business. By adhering to the Code of Conduct and standards, you enable the Organization to continue to achieve its goal of providing excellent service to our patients in a legal and ethical fashion.

In addition, as part of the Organization's commitment to health care fraud and abuse and regulatory compliance, and in an effort to assist the Organization's personnel in meeting their compliance obligations, the Organization has established a Compliance Program for its affiliated entities. The Compliance Program is designed to implement the Code of Conduct and prevent violations of applicable laws and regulations and, where such violations occur, to promote their early and accurate detection and prompt resolution through education, monitoring, disciplinary action, and other appropriate remedial measures.

Because of the importance of the Compliance Program, we require that all personnel cooperate fully. All personnel will be given a copy of this Commitment to Compliance handbook (the "Handbook"). You will be required to review and become familiar with its contents. In addition to this Handbook, the Organization will provide you with formal training regarding the Code of Conduct and Compliance Program policies. The Compliance Program standards and policies applicable to each individual affiliated entity will be maintained by the Corporate Compliance Officer and available to all personnel upon request.

## I. CODE OF CONDUCT

The Organization has adopted the following Code of Conduct as a central part of our Compliance Program. Everyone should adhere both to the spirit and the language of the Code, maintain a high level of integrity in their conduct and avoid any actions that could reasonably be expected to adversely affect the integrity or reputation of the Organization. Compliance with the Code of Conduct is a condition of employment, and violation of the Standards (as defined below) will result in discipline being imposed, up to and including possible termination.

- **Honesty and Lawful Conduct.** Personnel associated with the Organization, including all physicians who see patients at any affiliated entity within the Organization, must avoid all illegal conduct, both in business and personal matters. No person should take any action that he or she believes violates any statute, rule, or regulation. In addition, personnel must comply with the Code and departmental compliance policies and procedures, strive to avoid the appearance of impropriety, and never act in a dishonest or misleading manner.
- **Cooperation with the Compliance Program.** We require everyone to cooperate fully with the Compliance Program because the Program is effective only if everyone works together to ensure its success and understands the requirements under the law and the Code. In particular, all departments, personnel and physicians must cooperate with all inquiries concerning improper business, documentation, coding or billing practices, respond to any reviews or inquiries, and actively work to correct any improper practices that are identified.
- **Questions and Concerns.** Neither this Handbook nor our overall Compliance Program can cover every situation that you might face. As a result, if you are unsure of what the proper course of conduct might be in a specific situation, or if you believe that the Code of Conduct, Code of Conduct Standards, or any compliance standards or policies (whether set forth in this Handbook or elsewhere) may have been violated, then you are expected to contact the Corporate Compliance Officer, who can be reached at:

One Brookdale Plaza  
Brooklyn, New York 11212  
(718) 206-7892  
**corporatecompliance@jhmc.org**

or by calling the

**Compliance “Helpline” at 718-206-7892**

You may contact the Corporate Compliance Officer at any time, either in person, by telephone or in writing, with any compliance-related question or concern you may have. Questions or concerns may be raised anonymously, if you wish. All reports will be held in the strictest confidence possible, consistent with the need to investigate the matter.

- **No Retaliation.** It is absolutely forbidden for any personnel to punish or conduct reprisals against anyone who has reported a suspected violation of a law or regulation, the Code or Code of Conduct Standards, or any Organization policies. It is also forbidden for any personnel to punish or conduct reprisals against anyone who has participated or cooperated in an investigation of such matters. Retaliatory actions violate this Code and will not be tolerated.

## **II. CODE OF CONDUCT STANDARDS**

The Code of Conduct provides a high-level overview of the expectations that the Organization has for its personnel. Because personnel will be responsible for complying with this Code, the Organization has adopted the following standards of conduct (“Standards”) that all personnel are expected to follow. These Standards outline and summarize the basic concepts underlying the Organization’s Code of Conduct and its Compliance Program (which is described in more detail in Section III below). These Standards must be carefully reviewed and closely followed by all Organization personnel. Supplemental information relating to these Standards will be provided through periodic formal and informal training and educational programs. Additionally, many Standards are expanded in greater detail in each affiliated entity’s compliance standards and policies.

### **A. Compliance with the Law and High Ethical Business Standards**

The Organization operates in a heavily regulated industry and is subject to a large number of federal and state civil and criminal laws and regulations. Violation of these laws and regulations can result in harm to the public, severe financial penalties, exclusion from participation in government health care programs (such as Medicare and Medicaid) and – in some cases – criminal fines and/or imprisonment. The Organization’s Code of Conduct and Compliance Program are designed to prevent and detect such violations. Accordingly, it is critical that all personnel comply with all applicable federal and state laws and regulations and with all policies and procedures that comprise the Compliance Program.

While one of the objectives of the Organization’s Compliance Program is to educate all Organization personnel about the basic requirements of these laws and regulations, the Organization does not expect any of its personnel to become experts in these areas. For precisely this reason, where an individual is not sure whether a particular activity or practice violates the law (or any of the Compliance Program policies), the individual should not – under any circumstances – “guess” as to the correct answer. Instead, the individual should seek appropriate guidance from his or her supervisor or the Corporate Compliance Officer. Organization personnel will not be penalized for asking compliance-related questions. To the contrary, the Organization is intent on creating a culture in which every individual is comfortable asking the questions necessary to ensure that he or she understands and performs his or her tasks and obligations in full.

Personnel of the Organization shall adhere to the high standards of business ethics as set forth in the Compliance Program and in its Code of Conduct, and acknowledge that such compliance is a condition of employment and is a factor that will be considered in his or her performance evaluation.

### **B. Standards Relating to Quality of Care and Services**

The Organization is fully committed to providing the highest quality of patient care in accordance with all applicable laws, rules and regulations. As part of this commitment, the Organization will ensure that necessary quality assurance systems are in place and functioning effectively.

- ***Quality of Care Principles.*** In keeping with the Organization’s mission and values, the following quality of care and services principals have been incorporated into the Organization’s Compliance Program:
  - All patients will receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
  - All patients will receive information that is necessary to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

- All patients will receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- The Organization will protect and promote the rights of each patient, including, but not limited to, the patient's right to respect, privacy, a dignified existence, self-determination, and the right to participate in all decisions about their own care, treatment and discharge.
- The Organization will conduct background checks pursuant to federal and state law (which includes, but is not limited to, criminal convictions and/or exclusion from participation in any federal health care program) on all personnel involved in patient care, or who have access to patients' possessions.
- All individuals employed by the Organization will have the proper credentials, experience and expertise required to discharge their responsibilities.
- The Organization will continuously strive toward a culture of patient safety and providing quality medical care to its patients.
- **Credentialing.** The Organization complies with all applicable federal and state laws, rules and regulations governing the credentialing process. This is a key element to ensuring that the Organization provides the highest quality care and services to its patients. Each affiliated entity has processes in place for the on-going and continuous credentialing and competency reviews of clinical and non-clinical staff. Complying with credentialing and licensure requirements is a necessary component of the Organization's commitment to providing appropriate quality of care to its patients.
- **Mandatory Reporting.** As part of its commitment to providing the highest quality of patient care and services, the Organization complies with all applicable federal and state mandatory reporting laws, rules and regulations. To this end, the Organization will ensure that all incidents and events that are required to be reported by the affiliated entities are done so in timely manner, and will monitor compliance with such requirements.

**C. Standards Relating to Billing and Coding**

The Organization is committed to conducting the coding, billing and collection process with integrity. We, therefore, adhere to current coding principles and applicable billing laws, regulations and guidelines to facilitate the proper documentation, coding and billing of claims.

- **Billing Generally.** In conformity with the Organization's mission and values, bills will only be submitted based upon the patient's clinical condition, services actually rendered, and sufficient and adequate documentation of such services. All personnel responsible for billing will be trained in the appropriate rules governing billing and documentation and will follow all regulations governing billing procedures. Personnel will not knowingly engage in any form of up-coding of any service in violation of any law, rule, or regulation. The Organization takes all reasonable steps to ensure that our billing software reliably and accurately codes and bills all services according to the most recent federal and state laws and regulations.
- **Compliance with Federal and State Laws Regarding the Submission of Claims.** All personnel shall comply with all applicable federal and state laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in Appendix A

to this Handbook. Personnel will receive training on these laws as part of the Organization's Compliance Program and should consult with the Corporate Compliance Officer (who may confer with the Organization's legal counsel, as needed) if they have questions about the application of these laws to their job.

**D. Standards Relating to Business Practices**

The Organization will conduct its business affairs with integrity, honesty and fairness to avoid conflict between personal interests and the interest of our Organization. The Organization will forego any transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to induce the use of our services.

- ***Accuracy and Integrity of Books and Records.*** The Organization must keep accurate books, records, and accounts and must accurately reflect the nature of transactions and payments. This includes, but is not limited to, financial transactions, cost reports, and other documents used in the normal course of business. No false or artificial entries shall be made for any purpose. No payment or other remuneration shall be given or received, nor purchase price agreed to, with the intention or understanding that any part of such payment or remuneration is to be used for any purpose other than that described in the document supporting the payment or other remuneration.

To this end, the Organization maintains and monitors a system of internal accounting controls. The Organization records and reports facts accurately, honestly and objectively, and does not hide or fail to record any funds, assets, or transactions.

- ***Gifts and Benefits.*** Personnel are strictly prohibited from offering, giving, soliciting or receiving any gift or benefit for personal gain or inducement. This policy applies to our interactions with providers who refer patients to us or to which we make referrals, and to our interactions with our vendors (including, but not limited to, pharmaceutical companies with which we do business). This policy also applies to gifts or benefits received or offered by patients, their families, visitors, or others. The guiding principle is simple: personnel may not be involved with gifts or benefits that are undertaken: (i) in return for or to induce referrals, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of any of the foregoing) of any item or service.
- ***Conflicts of Interest.*** Personnel must exercise the utmost good faith in all transactions that touch upon his or her duties and responsibilities for, or on behalf of, the Organization. Even the appearance of illegality, impropriety, a conflict of interest or duality of interests can be detrimental to the Organization and must be avoided. All personnel who are in positions to influence any substantive business decision must complete an annual Conflict of Interest Disclosure Statement, disclosing all direct and familial interests which compete or do business with the Organization.
- ***Compliance with Medicare and Medicaid Anti-Referral Laws.*** Federal and state laws make it unlawful to pay or give anything of value to any individual on the basis of the value or volume of patient referrals. The Organization does not pay incentives to any person based upon the number of patients admitted, or the value of services provided, nor does the Organization pay physicians, or anyone else, either directly or indirectly, for patient referrals. All financial relationships with other providers who have referral relationships with the Organization are based on the fair market value of the services or items provided. All marketing and advertising of services are based solely on the merits of the services provided.

The policy detailing the anti-referral laws is set forth in Appendix B to this Handbook. Personnel will receive training on these laws as part of the Organization's Compliance Program and should

consult with the Corporate Compliance Officer (who may confer with the Organization's legal counsel, as needed) if they have questions about the application of these laws to their job.

**E. Standards Relating to Confidentiality**

The Organization safeguards confidential information regarding its patients, such as individually identifiable health information, and confidential and proprietary information regarding the business of the Organization, such as patient lists, development plans, marketing strategy, financial data, proprietary research, and information about pending or contemplated business deals. Inappropriate disclosure of the Organization's confidential business information, whether intentional or accidental, may adversely affect the Organization.

Due to this risk of harm to the Organization, personnel who learn confidential business information about the Organization or its patients, shall not disclose that information to third parties, including family or friends. In addition, personnel may not disclose such confidential information to any third party after leaving employment except with the prior written consent of the Organization, or as required by applicable law.

**III. COMPLIANCE PROGRAM: DESCRIPTION AND SUMMARY**

**A. The Compliance Program**

The Organization's Compliance Program consists of the following core components:

1. The Organization and its affiliated entities have developed and implemented (and will continue to develop and implement) written policies and procedures addressing the Organization's commitment to compliance and specific policies and procedures addressing areas of potential fraud and abuse applicable to the affiliated entities.
2. The Organization has appointed a Compliance Officer who will be responsible for maintaining the Code of Conduct, Standards and Compliance Program policies. Designated individuals will assist the Compliance Officer in carrying out the Compliance Program at each affiliated facility. The Organization's Compliance Officer will chair a Compliance Committee that is responsible for developing, maintaining, and monitoring the Compliance Program.
3. The Organization will provide its personnel, including Board members and senior management, with compliance education and training with respect to the Compliance Program, both through formal, periodic training seminars and by maintaining an open line of communication between the Organization's personnel and the Compliance Officer.
4. The Organization has established procedures for receiving reports concerning possible violations of relevant laws and regulations, the Code of Conduct, or any entity-specific compliance standards and policies, and for protecting the anonymity of the reporting party so as to open the lines of communication between the Organization and its personnel.
5. The Organization has established procedures to encourage good faith participation in the Compliance Program and set forth the Organization's expectation that personnel will raise questions and report concerns relating to the Organization's Code of Conduct, Standards, entity-specific compliance standards and policies, and violations of federal and state laws, rules and regulations. Personnel that violate the above, participate in non-compliant behavior, encourage or allow non-compliant behavior, or fail to report suspected compliance problems will be firmly and fairly disciplined up to, and including, possible termination.

6. The Organization has a system for routine identification and assessment of compliance risk areas specific to the various types of entities within the Organization through the use of periodic reviews, audits, and other practices. As part of that assessment, and in an effort to detect and prevent fraud, waste and abuse, the Organization's Compliance Officer, or a designee, will periodically monitor and/or conduct specific reviews of the following risk areas at each affiliated entity: business, coding and billing practices; departmental reviews of high risk departments; issues relating to quality of care and services; the credentialing processes; compliance with mandatory reporting requirements; and other potential compliance risk areas that may arise from complaints, Helpline calls, risk assessments, and as identified by departmental compliance protocols and elsewhere.
7. The Organization has a system for responding to and investigating potential compliance issues as they are raised by personnel or identified in the course of self-evaluations and audits. Corrective action is promptly implemented with periodic reviews to verify successful correction.
8. The Organization strictly prohibits retaliation in any form against an individual who reports an issue in good faith.

**B. Compliance Responsibilities**

- ***Responsibility of the Board.*** Each affiliated entity's Board of Trustees is responsible for overseeing the operation of the Compliance Program at its respective entity and ensuring that processes are in place so that the entity can operate in compliance with all federal and state laws, rules and regulations. To this end, each Board has adopted a Compliance Charter which details how issues are to be communicated, reviewed, and responded to by the respective Board. Each Board will maintain a direct reporting relationship with the Compliance Officer and receive appropriate reports from the Compliance Officer and senior management as to the operation of the Compliance Program, identification of potential issues, and the formulation of annual work plans based on appropriate risk assessments. All Board members will receive periodic training, either on an informal or formal basis, as to basic compliance principles (including a review of the fraud and abuse laws and regulations), the Board's responsibilities and the specific risk areas that need to be addressed by the Compliance Program.
- ***Responsibility of All Employees.*** All employees are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job within the Organization. All employees are also expected to comply with this Code of Conduct, the Code of Conduct standards set forth herein, and any applicable compliance standards and policies adopted by the affiliated entity for which the employee works. Employees must, upon new hire and annual orientation by the Organization, sign and date an acknowledgement that they received a copy of the Code of Conduct and Compliance Program Summary and training on the Compliance Program and false claims acts.
- ***Responsibilities of Department Heads, Supervisors and Managers.*** All department heads, supervisors and managers at each affiliated entity have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the personnel they supervise understand the importance of the Code of Conduct, Standards, and the entity's specific compliance standards and policies; that personnel are aware of the procedures for reporting suspected wrongdoing; and that all personnel are protected from retaliation if they come forward with information about such suspected wrongdoing.

- **Responsibilities of Contractors and Other Providers.** All persons and entities with which the Organization contracts will receive a copy of this Handbook and will be asked to cooperate with the Organization's Compliance Program. This includes individual physicians, physician groups, vendors, contractors, and other healthcare providers.

**C. Violations, Anonymity, and Non-Retaliation**

All personnel are required as a condition of employment to report suspected misconduct. Reports of suspected misconduct may be made to any one or more of the following people:

- A manager or supervisor;
- Another member of senior management;
- Human Resources Vice President or designee;
- The Compliance Officer; or
- The Compliance Helpline.

Anyone who receives such a compliance report must advise the Corporate Compliance Officer as soon as possible. The Corporate Compliance Officer may be reached by one of the following methods:

- **E-Mail** – Personnel, agents and contractors may leave e-mail messages for the Corporate Compliance Officer with questions, issues and concerns relating to the Organization's Compliance Program at [corporatecompliance@jhmc.org](mailto:corporatecompliance@jhmc.org).
- **In-Person Meeting** – Personnel, agents or contractors may request a confidential meeting with the Compliance Officer for the purpose of communicating questions, issues and concerns relating to the Organization's Compliance Program by calling the Corporate Compliance Officer directly through the **Compliance Helpline** at **(718) 206-7892** to schedule an appointment.

In all instances when requested, the Organization will strive to maintain the anonymity of any reporting personnel. It must be understood, however, that there may come a point in time where a reporting individual's identity may become known or may have to be revealed (e.g., if government authorities become involved in the investigation). Finally, whether or not the identity of any reporting personnel becomes known or is revealed, under no circumstances will the Organization take adverse action against personnel who report actual or potential misconduct in good faith and who were not involved in the misconduct in question. Simply put, there shall be no retaliation for good faith reporting of actual or possible violations of the Code, Compliance Program policies or federal and/or state laws and regulations. Personnel who intentionally file false reports, however, will be subject to appropriate disciplinary action.

**D. Investigations**

All reported violations of the Code, Standards, entity-specific compliance standards and policies, and federal and/or state laws and regulations will be promptly reviewed and investigated, as appropriate, by the Corporate Compliance Officer or an appropriate designee, and will be treated confidentially to the extent possible and consistent with the Organization's legal obligations.

Investigations by the Organization of reported wrongdoing involving compliance issues will be directed and coordinated by the Corporate Compliance Officer or in some cases by the Organization's legal counsel, as appropriate. Personnel are expected to cooperate in such investigations. If the result of the investigation indicates

that corrective action is required, the Organization will decide what steps it should take to rectify the problem and avoid the likelihood of its recurrence.

**E. Disciplinary and Remedial Action**

Personnel will be subject to disciplinary action, ranging from verbal warnings to termination of employment, regardless of their level or position, if they fail to comply with any applicable laws or regulations, the Organization's Code of Conduct, Standards or the affiliated entity's Compliance Program standards or policies. Disciplinary action shall be taken fairly and firmly enforced as appropriate for:

- Authorization or participation in actions that violate federal and/or state laws and regulations, the Code of Conduct, Standards, or the affiliated entity's Compliance Program standards and policies;
- Failure to report a violation, or suspected violation, of federal and/or state laws and regulations, the Code of Conduct, Standards, or the affiliated entity's Compliance Program standards and policies;
- Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
- Failure by a violator's supervisor(s) to detect and report a compliance violation, if such failure reflects inadequate supervision or lack of oversight;
- Refusal to cooperate in the investigation of a potential violation; and
- Retaliation against an individual for reporting a compliance violation.

The severity of the disciplinary action, which will be determined by members of senior management (in consultation with the Corporate Compliance Officer and the individual's supervisor), will depend on a variety of factors, including, but not limited to (1) the severity of the violation, (2) whether the violation was committed intentionally, recklessly, negligently or accidentally, (3) whether the individual has committed any other violations in the past, (4) whether the individual self-reported his or her misconduct, and (5) whether (and the extent to which) the individual cooperated with the Organization in connection with its investigation of the misconduct.

In addition to taking disciplinary action, the Organization will implement other remedial measures, as appropriate, in the event of a violation of any applicable laws or regulations, the Organization's Code of Conduct, Standards or the affiliated entity's Compliance Program standards or policies.

## Appendix A

### **COMPLIANCE WITH APPLICABLE FEDERAL AND STATE FALSE CLAIMS LAWS**

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Jamaica Hospital Medical Center and all of its affiliated entities (collectively referred to as the "Organization") is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, and preventing and detecting any fraud, waste, or abuse in the Organization. To this end, the Organization maintains a compliance program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the federal and state governments. The Organization has instituted various procedures, which are set forth in the our Compliance Manual, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in federal health care programs. In furtherance of this policy and to comply with the Deficit Reduction Act, the Organization disseminates this policy to all employees (including management, contractors and other agents) to ensure that such persons are aware of certain relevant federal and state laws, and that submission of a false claim can result in significant administrative and civil penalties under the federal False Claims Act and other New York State laws.

#### **POLICY**

To assist the Organization in meeting its legal and ethical obligations, any employee who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a federally or state funded health care program is required to report such information to his/her supervisor and the Corporate Compliance Officer. Any employee who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under our internal compliance policies and procedures and federal and state law. However, the Organization retains the right to take appropriate action against an employee who has participated in a violation of federal or state law or Organization policy or intentionally and maliciously reports a false claim.

The Organization commits itself to investigate any suspicions of fraud, waste, or abuse swiftly and thoroughly and requires all employees to assist in such investigations. If an employee believes that the Organization is not responding to his or her report within a reasonable period of time, the employee shall bring these concerns about the Organization's perceived inaction to the Corporate Compliance Officer. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the employee's obligations to the Organization and may result in disciplinary action, up to, and including termination.

#### **FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS**

##### **I. FEDERAL LAWS**

###### **The Federal False Claims Act**

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

- (1) 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 [the above violations]; . . . 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,

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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,<sup>1</sup> plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

(b) 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; and

(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

(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.

*31 U.S.C. § 3729.*

While the FCA 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.

In sum, the FCA imposes liability on any person who submits a claim to the federal government or a contractor of 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 FCA 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 healthcare facility that 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.

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<sup>1</sup> Although the statutory provisions of the FCA authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation and increased by regulation to not less than \$5,500 and not more than \$11,000. *28 CFR §85.3(a)(9)*.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 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.

### **The Program Fraud Civil Remedies Act (“PFCRA”)**

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 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.

## **II. 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.

### **A. CIVIL AND ADMINISTRATIVE LAWS**

#### **NY False Claims Act (State Finance Law, §§187-194)**

The NY False Claims Act closely tracks 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 or 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 5 years for 4 or more offenses.

## **B. 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 any 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 care 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 any employee, contractor, or agent who is 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 lawful acts in furtherance of other efforts to stop violations of the FCA. Remedies include reinstatement with comparable seniority as the employee, contractor, or agent 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.

## Appendix B

### ANTI-REFERRAL LAWS AND RELATIONSHIPS WITH OTHER HEALTH CARE PROVIDERS

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#### I. Overview of the Anti-Referral Laws

##### A. **Anti-Kickback Statutes**

Federal and state laws make it unlawful to pay any individual on the basis of the value or volume of referral of residents. The federal and state Anti-Kickback Statutes prohibit giving or receiving any remuneration (which includes, without limitation, money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid for by Medicare or Medicaid. The federal law contains certain statutory exceptions. Regulations describing additional exceptions for certain business arrangements and payment practices – known as “safe harbors” – also exist. Each exception/safe harbor has a number of specific requirements. Compliance with each requirement of all applicable safe harbors/statutory exceptions removes the risk of criminal, civil or administrative action pursuant to the Anti-Kickback Statute. Failure to fall squarely within a safe harbor or exception, however, does not necessarily render an arrangement illegal per se or otherwise actionable. Instead, in such cases, the arrangement will be analyzed in light of the governing law and regulations and, in particular, the intent of the parties.

##### B. **Physician Self-Referral Laws**

The physician self-referral laws (the “Stark” laws) forbid referrals between physicians and health care entities that have certain prohibited financial relationships. Under the Stark laws, a physician cannot refer patients to entities furnishing “designated health services” (“DHS”) which are payable under Medicare or Medicaid if the physician or his or her immediate family members have a financial interest in that entity. A prohibited financial relationship includes an ownership or investment interest and any compensation arrangement. Like the Anti-Kickback exceptions/safe harbors, the “Stark” exceptions are often very complex and very detailed. If the Stark law is implicated, all relevant exceptions must be squarely met, or the law will have been violated (i.e., Stark, unlike the Anti-Kickback Statute, is a “strict liability” law. In other words, under Stark, the intent of the parties is irrelevant).

#### II. Policy

In compliance with these laws, the Organization does not pay incentives to any person based upon the number of patients admitted or the value of services provided, nor does the Organization pay physicians, or anyone else, either directly or indirectly, for patient referrals. The decision to refer patients is a separate and independent clinical decision made by the health care provider. Moreover, the Organization does not accept any form of remuneration in return for referring its patients to other health care providers. The Organization discharges, transfers or refers patients to other providers based on patients’ documented medical needs for the referred services and the ability of the referred provider to meet those needs. The Organization at all times respects and honors a patient’s freedom to choose a health care provider.

#### III. **Relationships with Other Health Care Providers**

All contracts, leases, and other financial relationships with other providers who have a referral relationship with the Organization will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

We will not engage in any practice that violates the anti-referral laws or tends to create an appearance of illegality or impropriety, including, but not limited to:

- Free Services. We will not provide free services or items to, or accept free services or items from, another provider with whom a referral relationship exists.
- Fair Market Value. We will not pay or charge excessive amounts above fair market value for providing equipment, space or personnel services, to or from, another provider. We will not pay or charge amounts below fair market value for providing equipment, space or personnel services, to or from, another provider.
- Joint Ventures. We will not enter into joint ventures with other providers when applicable safe harbors or exceptions under the anti-referral laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.
- Discounts. Any discount that the Organization receives for items or services purchased will be in accordance with the discount safe harbor to the Anti-Kickback Statute. Among other things, that means that discounts will be in the form of a price reduction based on an arm's length transaction and will be properly disclosed and accurately reflected on the institutional cost report.

All contracts, leases, and other financial relationships with providers with whom the Organization has a referral relationship will be reviewed to ensure compliance with the anti-referral laws, and compliance with any applicable safe harbor or exception under those laws. Thus, for instance, for any such agreement that the Organization may enter into for the provision of DHS services, the Organization will ensure that it obtains and maintains signed agreements covering all time periods for which an arrangement is in place. Moreover, the Organization will engage in a process for making and documenting reasonable, consistent and objective determinations of fair-market value and for ensuring that needed items and services are furnished or rendered. In further compliance with the Stark law, the Organization has in place a process for tracking non-monetary compensation provided annually to referring physicians.

#### **IV. Marketing Activities**

All marketing activities and advertising must be based on the merits of the services provided and not on any promise, expressed or implied, of any remuneration for referrals. In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. The Organization's best advertisements pertain to the quality of its services. Personnel should not disparage the service or business of a competitor through false or misleading representation.