NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

False Claims Recoveries – Medicaid Fraud and Abuse

This Information is Provided for Contractors, Agents and Family Care Providers

DEFICIT REDUCTION ACT OF 2005 § 6032

The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities receiving or making $5 million or more in Medicaid payments during a federal fiscal year to establish written policies and procedures informing their employees, contractors and agents about federal and state false claim acts and whistleblower protections. The policies must be available to the entity's employees as well as employees of its agents and contractors. For purposes of Section 6032 compliance, Centers for Medicare and Medicaid Services' (CMS) guidance is as follows:

> *CMS defines the term, "Contractors and Agents," as any contractor, subcontractor, agent, or other person that, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity*.
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> *Contractors furnishing Medicaid health care items or services include, but are not limited to, all contract therapists, physicians (including, but not limited to, house staff, hospitalists, and independent contractors), and pharmacies*. *Contractors not associated with the provision of Medicaid health care items or services, such as copy or shredding services, grounds maintenance, or hospital cafeteria or gift shop services, are excluded from the definition of "contractor."*

The New York State Office for People With Developmental Disabilities' (OPWDD) contractors meeting the criteria in the above definition are required to participate in the review and audits described in OPWDD's policies, and to abide by these policies with respect to funding for OPWDD services. Such contractors are also required to make this information available to all their employees and contractors involved in performing work under their contracts with OPWDD.

OPWDD DEFICIT REDUCTION ACT §6032 POLICY

It is the policy of OPWDD to assist in ensuring the integrity of the Medicaid program by safeguarding against Medicaid abuse and the submission of false or fraudulent Medicaid claims. OPWDD acts under the direction of the New York State Office of the Medicaid Inspector General (OMIG) to maintain Medicaid program integrity. The OMIG has been established by statute as an independent entity within the New York State Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. In carrying out its mission, the OMIG conducts and supervises all prevention, detection, audit and investigation efforts with OPWDD and other State agencies.

OPWDD performs various internal reviews and monitoring of its Medicaid claims. Based on these reviews, inappropriate claims are voided or adjusted and disclosed to the OMIG when appropriate.

For OPWDD State Operated services:

- OPWDD Office of Audit Services (OAS), Bureau of Internal Audit conducts reviews of

documentation supporting Medicaid claims prepared by its State Operations.

- Medicaid Compliance Liaisons, staff of OPWDD's Developmental Disabilities Service Offices, regularly monitor the documentation supporting Medicaid claims for quality and adherence to billing requirements.
- OPWDD Central Operations utilizes several separate review procedures to screen Medicaid claims for inappropriate or fraudulent billing.

For Medicaid claims prepared by OPWDD certified voluntary agencies, the OMIG is responsible for the field audit function. In consultation with OPWDD, the OMIG develops audit protocols which it uses to conduct detailed field audits. When an audit reveals that claims have been improperly reimbursed to the voluntary agency, funds will be recovered. The OMIG also investigates alleged improper Medicaid practices, including the employment of unqualified providers of Medicaid eligible services by voluntary agencies, and takes further legal steps necessary to properly address the underlying conditions. In response to allegations of Medicaid irregularities made by staff and the public, OPWDD auditors will make referrals to the OMIG as warranted.

OPWDD Medicaid Compliance Program (State Operations)

To comply with the requirements of New York Social Services Law § 363-d, NYCRR Title 18 Part 521, and the Deficit Reduction Act (DRA) obligations in 42 USC § 1396a(a)(68), OPWDD has implemented a Medicaid Compliance Program applicable to its State Operations, i.e. where OPWDD acts as a provider of Medicaid services. The purpose of the program is to assist in enhancing the integrity of the Medicaid program, including efforts to detect and prevent fraudulent, abusive, and wasteful practices within OPWDD and to correct improper Medicaid billings or payment mistakes. OPWDD seeks to provide uniform guidance for its State Operations Offices for billing and accounting activities, as well as program integrity areas including quality of care, governance, credentialing and other risk areas that may be identified.

Understanding False Medicaid Claims

A "false claim" occurs when someone submits a bill to Medicaid for services that they know were not provided, knowingly causes another person to submit a false claim to the government, or knowingly makes a false record or statement to get a false claim paid by the government.

Federal and State laws impose liabilities on an individual who knowingly submits a false record in order to obtain payment from the government.

Reporting Medicaid Misconduct

Contractors, agents and employees who have knowledge of violations of law, OPWDD policy or operating procedures, or conduct which could be characterized as Medicaid fraud, waste or abuse have a duty to report what they know, as soon as possible. Contractors, agents and employees should understand that they may be subject to disciplinary or other corrective administrative actions or sanctions if they commit acts of non-compliance, misconduct, fraud, waste and abuse.

OPWDD evaluates, and investigates or refers to appropriate parties for further action, all complaints of Medicaid misconduct, fraud, waste, and abuse.

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If someone suspects or sees Medicaid wrongdoing, OPWDD needs to know. This includes:

- Giving or receiving bribes or kickbacks;
- Using unacceptable medical and/or billing practices;
- Misusing or abusing Medicaid services; or
- Falsifying records or giving false information.

As much information as possible on the issue should be reported, which includes:

- what wrongdoing occurred;
- who is involved;
- when it occurred;
- whether there are witnesses to the misconduct; and
- how the issue was discovered or any other relevant information or detail to support how Medicaid Fraud is being committed.

Several communication lines are available for reporting Medicaid allegations.

OPWDD's Toll-free Information Line:
Phone - Voice: 1-866-946-9733 (1-866-94NYSDD)
Phone - TTY: 1-866-933-4889 (1-86 NYDD4TTY)
The OPWDD Information Line manages all complaints. All calls are logged and forwarded to the appropriate personnel. Callers may report **anonymously** via the online form:
OPWDD InfoLine On-Line Reporting Form.

OPWDD Medicaid Compliance Officer**:**
Write: Jill A. Pettinger, Psy.D.
44 Holland Avenue, 4th floor
Albany, NY 12229
Medicaid.Compliance@opwdd.ny.gov

New York State Office of the Medicaid Inspector General:
Phone: 1-877-87 FRAUD (1-877-873-7283)
Online: www.omig.ny.gov
Write: NYS OMIG Bureau of Fraud Allegations
800 North Pearl Street
Albany, NY 12204

Office of the Inspector General:
Phone: 1-800-DO-RIGHT (1-800-367-4448)
Online: https://ig.ny.gov
Write: Office of the State Inspector General (OIG)
Empire State Plaza, Agency Bldg. 2, 16th Floor
Albany, NY 12223

New York State Office of the Attorney General's Medicaid Fraud Control Unit:

Phone: 1-800-771-7755
Online: https://ag.ny.gov/comments-mfcu
Write: Office of the Attorney General
The Capitol
Albany, NY 12224-0341

FEDERAL AND NEW YORK STATE STATUTES RELATING TO FILING FALSE CLAIMS

FEDERAL STATUTES

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

The False Claims Act (FCA) imposes liability on:

- Any person who submits a claim to the federal government that he or she knows (or should know) is false. An example of a false claim would be a physician who submits a bill to Medicare for medical services she knows she has not provided.
- An individual who may knowingly submit a false record to obtain payment from the government. An example of a false record would be a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
- Those instances in which someone receives money from the federal government to which he or she is not entitled, and then uses false statements or records or knowingly and wrongfully conceals, avoids or decreases the obligation to pay to keep the money. An example of this so-called "reverse false claim" would be a hospital that gets interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year to avoid giving money back to the Medicare program or Medicaid program.

While the False Claims Act imposes liability only when someone 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.

The FCA also 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 fifteen percent (15%) but not more than twenty-five percent (25%) 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, FCA section 3730(d)(2) provides that the *qui tam* relator shall receive an amount that the court decides is reasonable and shall be not less than twenty-five percent (25%) nor more than thirty percent (30%).

False Claims Recoveries – Medicaid Fraud and Abuse

Background
The FCA dates to the Civil War. Congress enacted the FCA in response to wartime scandals in which defense contractors defrauded the Union government.

Who is Liable?
The FCA makes anyone who submits (or causes someone else to submit) a false or misleading claim liable for penalties and fines.

What is a claim?
A claim is a demand for money or property, where the federal government provides any portion of the money or property requested. Because the federal government funds a portion of New York's Medicaid program, the FCA covers claims or bills to Medicaid in New York, including claims or bills for Medicaid-funded services or goods provided by OPWDD or provided by OPWDD-funded agencies or persons.

How Does This Work?
If a Medicaid claim or bill is untrue (or "false"), it will bring liability upon the person who said it was true. The penalties and fines under the FCA will vary for each claim and can include the government's costs in pursuing a lawsuit against the person. Some of the acts included in the FCA are falsifying billing records, billing for services not rendered, billing for goods not provided, billing for a more expensive service than the one provided (often called "upcoding") and duplicating billing to obtain double payment. No proof of specific intent to defraud the government is required to be held liable under the FCA. All that is required is that the person either has actual knowledge or has acted with deliberate ignorance or reckless disregard of the truth or falsity of his or her claim. Attempting to use the defense of "I didn't know it was illegal" does not work.

The FCA also includes incentives for employees to come forward and report misconduct. Generally, a person who knows about the false claims (the whistleblower) may sue on behalf of the government for a violation of the FCA. After the whistleblower files a lawsuit, the government can pursue the suit on its own, or decline and allow the whistleblower to continue. The government may elect to move forward with the lawsuit as is, change it to a criminal or administrative case, settle it, or request a dismissal. The whistleblower can participate in the lawsuit along with the government, but the judge can limit who the whistleblower calls as witnesses, how long they testify and how much the whistleblower can cross examine witnesses (i.e., if the whistleblower is merely harassing the defendant or is interfering with or duplicating the government's case).

Depending on the outcome of the case and the whistleblower's involvement, the whistleblower can receive a percentage of the proceeds of the action or settlement. The whistleblower only gets this money if the government recovers money from the defendant because of the FCA lawsuit. The whistleblower's award may be reduced if the judge decides that the whistleblower planned and initiated the violation. A whistleblower who files a frivolous lawsuit can be forced to reimburse the defendant for all the costs of defending the lawsuit, including attorneys' fees.

Is there a Statute of Limitations?
Yes. A lawsuit to enforce the FCA must be brought within six (6) years of the violation, or, if the government brings the lawsuit, within three (3) years of when the government knew or should have known the facts about the violation. However a lawsuit cannot be brought later than ten (10) years after the date the violation was committed.

B. Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)

The Administrative Remedies for False Claims and Statements is a federal statute that 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 and additional amounts for the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties, is made by the administrative agency, not by prosecution in the federal court system.

NEW YORK STATE STATUTES

The New York False Claims Act and other state laws address false claims. These laws fall into two categories: 1) civil and administrative laws; and 2) 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 "common law" crimes are also applicable.

A. Civil and Administrative Laws

New York False Claims Act (New York State Finance Law Article XIII, §§ 187-194)

The NY False Claims Act closely resembles 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. It also has a provision regarding reverse false claims similar to the federal FCA. 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 or she is not entitled, and then uses false statements or records in order to keep the money. There are penalties of at least $6,000 but not more than $12,000 per claim and damages of not more than two times the loss the government sustains because of the false claim. 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, subject to some limitations imposed by the State Attorney General or a local government. If the lawsuit eventually concludes with payments back to the government, the person who started the case can recover, in addition to reasonable attorneys' fees and other related expenses, a percentage of the proceeds, amounts of which are dependent upon whether the government did or did not participate in the lawsuit and the extent the person contributed to the prosecution (25% - 30% if the government did not participate in the lawsuit, 15% - 25% if the government did participate in the lawsuit and 10% or less if the court finds most of the relevant information in the case was provided by a source other than the person who filed the lawsuit).

New York Social Services Law §145-b; False Statements; Actions for Treble Damages

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 (3) times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If the offender engages in repeat violations within a five-year period, a penalty of up to $30,000 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.

New York Social Services Law § 145-c: Sanctions

If a 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 or her family shall not be taken into account for the purpose of determining his or her needs or that of his or her family for six (6) months after a first offense, for twelve (12) months after a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen (18) months after a third offense (or if benefits wrongfully received are in excess of $3,900), and for five (5) years for any subsequent offense.

B. Criminal Laws

New York 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.

New York Social Services Law § 366-b: Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain Medicaid, for himself or others, 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.

New York 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. § 155.30 Fourth degree grand larceny involves property valued over $1,000. This is a Class E felony.

b. § 155.35 Third degree grand larceny involves property valued over $3,000. This is a Class D felony.

c. § 155.40 Second degree grand larceny involves property valued over $50,000. This is a Class C felony.

d. § 155.42 First degree grand larceny involves property valued over $1,000,000. This is a Class B felony.

New York Penal Law Article 175: False Written Statements

Several sections in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions.

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

b. § 175.10 Falsifying business records in the first degree includes the elements of § 175.05 plus

the additional element of the intent to commit another crime or conceal its commission. This 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. This is a Class A misdemeanor.

d. § 175.35 Offering a false instrument for filing in the first degree includes the elements of § 175.30 plus the additional element of the intent to defraud the state or one of its political subdivisions. This is a Class E felony.

New York Penal Law Article 176; Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six (6) crimes involving filing false insurance claims and committing insurance fraud.

a. § 176.10 Insurance Fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. This is a Class A misdemeanor.

b. § 176.15 Insurance fraud in the fourth degree is filing a false insurance claim in an amount over $1,000. This is a Class E felony.

c. § 176.20 Insurance fraud in the third degree is filing a false insurance claim in an amount over $3,000. This is a Class D felony.

d. § 176.25 Insurance fraud in the second degree is filing a false insurance claim in an amount over $50,000. This is a Class C felony.

e. § 176.30 Insurance fraud in the first degree is filing a false insurance claim in an amount over $1,000,000. This is a Class B felony.

f. § 176.35 Aggravated insurance fraud is committing insurance fraud on more than one occasion. This is a Class D felony.

New York 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 five (5) crimes.

a. § 177.05 Health care fraud in the fifth degree – with intent to defraud a health plan, a person 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. § 177.10 Health care fraud in the fourth degree – a person files such false claims on more than one occasion and annually wrongfully receives more than $3,000. This is a Class E felony.

c. § 177.15 Health care fraud in the third degree – a person files such false claims on more than one occasion and annually wrongfully receives over $10,000. This is a Class D felony.

d. § 177.20 Health care fraud in the second degree - a person files such false claims on more than one occasion and annually wrongfully receives over $50,000. This is a Class C felony.

e. § 177.25 Health care fraud in the first degree - a person files such false claims on more than one occasion and annually wrongfully receives over $1,000,000. This is a Class B felony.

WHISTLEBLOWER PROTECTIONS

A. Federal False Claims Act (31 U.S.C. § 3730(h))
The Federal False Claims Act (FCA) 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 because of their furtherance of an action under the FCA. 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 because of the discrimination, including litigation costs and reasonable attorneys' fees.

B. New York False Claims Act (New York State Finance Law § 191)
The New York State False Claims 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 because 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.

C. New York Labor Law § 740; Retaliatory Personnel Action by Employers; Prohibition
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 New York 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;
    - or, any individual within an employer's organization who has the authority to direct and control the work performance of the affected employee;
    - or who has managerial authority to take corrective action regarding the violation of the law, rule or regulation;
- **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 up to $10,000 on the employer.

D. New York Labor Law § 741; Prohibition; Health Care Employer Who Penalizes Employees Because of Complaints of Employer Violations
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 the employee asserts, in good faith, constitute improper quality of patient care.

The employee's disclosure is protected only if:

- the employee first brought up the matter with a supervisor;
  - or someone who has the authority to direct and control the work performance of an employee;
  - or who has the authority to take corrective action regarding the violation of a law, rule or regulation;
- **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 up to $10,000 on the employer.