



Detecting and Preventing Fraud, Waste, and Abuse

It is the obligation of the Mental Health Association of Nassau County, Inc. (MHANC) to prevent and detect any fraud, waste and abuse in its organization related to Federal and State Health Care Programs (Medicaid, Medicare, and other governmental payor programs). To this end, MHANC has developed and maintains a vigorous Compliance Program to educate its workforce regarding the importance of submitting accurate claims and reports to federal and state governments, as well as regarding the requirements, rights and remedies of federal and state laws governing the submission of false claims. This includes the rights of employees to be protected as whistleblowers under such laws. MHANC's Compliance Program has been developed to protect consumers from abuse and to prevent fraud within the Agency. MHANC will only conduct business in an ethically acceptable manner and will comply with regulations that have been identified by the local, state, and federal governments. Corporate Compliance is a systematic effort to prevent, detect, and report violations of law throughout the Agency. The purpose of Corporate Compliance is to ensure that employees, Business Associates, vendors, and consultants of MHANC conduct themselves in conformance with all applicable legal requirements.

MHANC's Corporate Compliance Plan consists of seven (7) core elements: (1) Code of Conduct/Code of Ethics, (2) Assignment of a Compliance Officer/Corporate Compliance Committee, (3) Education and Training for employees including education/training regarding false claims and acceptable Medicaid/Medicare documentation, (4) Communication with Corporate Compliance Officer, which includes anonymous and confidential reporting, (5) Discipline for failure to report suspected fraud, which permits noncompliant behavior, (6) Routine identification of compliance risk areas, including auditing and monitoring, and (7) System for responding to compliance issues as they are raised; how to correct such noncompliance, and reporting noncompliance to Medicaid/Medicare and any other necessary governmental agencies and refunding overpayments.

MHANC focuses on the prevention of fraud in federal and state health care plans by protecting against accidental or deliberate non-compliance. MHANC seeks to promote full compliance with all applicable legal duties, to foster and ensure ethical conduct, and to provide guidance and education to each employee of MHANC on his/her conduct. MHANC intends to detect non-compliance if it occurs, to discipline and/or provide re-training to those involved in such non-compliance, to remedy the effects of non-compliance and to prevent future non-compliance. All employees have been educated about compliance requirements in the health care industry as it relates to guidance provided by the Center for Medicare and Medicaid Services (CMS); United States Department of Health and Human Services Office of Inspector General (HHS-OIG); and the New York State Office of the Medicaid Inspector General (NYS OMIG).



Compliance Standards and Procedures

Numerous Federal and State laws and regulations define and establish obligations for the health care industry with which MHANC must comply. Any employee who violates these laws and/or regulations risks individual criminal prosecution and penalties, civil actions for damages and penalties, and subjects MHANC to these same risks and penalties. Any employee who violates these laws may be subject to immediate termination of his/her employment.

MHANC's assigned Corporate Compliance Officer is responsible for overseeing the Compliance Program, receives all compliance concerns and is responsible for responding to these concerns in a professional and timely manner. The Corporate Compliance Officer, in conjunction with the Compliance/Quality Improvement Department, and the Compliance Committee is responsible for assessing program risk areas, trending, assisting in the implementation of corrective action plans, investigating non-compliance and assisting with determining when overpayments may have occurred, communicate these concerns, and assist in the decision-making towards resolution of the issue.

Communication with Corporate Compliance Officer; Anonymous and Confidential Reporting

Communication is the key to effective compliance. Staff are responsible to report any individual who is suspected of violating compliance. Reports can be made to a staff member's direct Supervisor(s) or directly to the Corporate Compliance Officer.

In addition, MHANC provides all staff with an outside anonymous and confidential toll-free 24-hour supervised Compliance Hotline telephone number, which is operated by an external company:

Compliance Hotline Telephone Number: 1-(877) 813-8406

All staff have been provided training and education related to appropriately contacting the hotline.

Should a call be placed to the hotline by an MHANC staff member, an investigation will be conducted within 24 hours by the Compliance/Quality Improvement Department in conjunction with the Compliance Committee. Failure to report illegal, unethical, or activities of non-compliance will result in appropriate corrective and disciplinary action.

Monitoring and Auditing

MHANC has a robust Monitoring and Auditing Program. The OIG identifies internal monitoring and auditing among the fundamental components of an effective Compliance Program.

At a minimum, annual audits will be conducted to determine whether: (1) MHANC's policies and procedures are current and complete and (2) MHANC's claims submission practices comply with applicable requirements (that bills are accurately coded and accurately reflect the services



provided, documentation is being completed correctly, that services provided are reasonable and necessary, and if any incentives for unnecessary services exist). MHANC's finance policies and procedures will be audited on an annual basis, at a minimum, by appropriate outside financial auditors.

Other Audit Areas

The Compliance/Quality Improvement Department will conduct a review of MHANC's Compliance Program on an annual basis, at a minimum, to evaluate its effectiveness, and to identify problems or weaknesses in its design and/or implementation. The review will include an examination of whether the Compliance Program's various elements have been satisfied. In addition, self-assessments of the Compliance Program are conducted on an annual basis as well as the creation of an annual Compliance Work Plan.

Consumer Records and Documentation

Monitoring of consumer documentation assists the programs in verifying that billing requirements have been met (as applicable) and ensures that the Agency's largest risk areas are assessed. Monitoring also assists in safeguarding the Agency by confirming that all services documented were actually rendered, that services provided are medically necessary, and that documentation is sufficient in evidencing that services were performed by qualified and licensed staff (if applicable).

Excluded Individuals

MHANC will not willingly employ any individual that has been excluded from Medicaid. The Human Resources Department shall conduct exclusion checks for all newly hired employees as well as conduct monthly checks thereafter of all current employees to determine if the employee has been excluded from Medicaid. Each new employee will be asked to indicate any Medicaid-related fraud, arrests, sanctions, or convictions that he/she has been involved with and/or has received. Employment will be determined based upon this information. In addition, the Human Resources Department will conduct exclusion checks for all Business Associates on a monthly basis.

Whistleblower Protections

An internal whistleblower is an employee, former employee, or member of MHANC, who reports misconduct, in this case, health insurance fraud, to those that have the power to take corrective action (MHANC's Administration).

An external whistleblower is any private party outside of MHANC that may report fraud to outside persons or entities on behalf of the United States Government.

Any person may bring a qui tam action (a person who brings a suit on behalf of the Government). The False Claims Act provides protection to any person who brings a qui tam



action on behalf of the Government and who may be, as a result, terminated, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of whistleblowing. Remedies include reinstatement of one's employment with comparable seniority, two (2) times the amount of any back-pay, interest on back-pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

State and Federal Fraud and Abuse Detection, Prevention and Employee Protection

Discussion of Applicable Legal Standards

Below are some major Federal and State statutes specifically applicable to health care providers, which are not all inclusive. They are designed to effectively combat all Federal Health Care Program fraud. Any employee who is uncertain about applicable laws should always consult with the Agency's Compliance Officer.

Federal Laws

The False Claims Act (31 U.S.C. § 3729)

- (a) Any person who:
- (1) Knowingly presents, or causes to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval;
 - (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
 - (3) Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
 - (4) Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
 - (5) 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;
 - (6) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, who lawfully may not sell or pledge the property; or
 - (7) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,



is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.

- (b) For purposes of this section, the term “knowingly” mean that a person, with respect to information: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; (3) acts in reckless disregard of the truth or falsity of the information; and no proof of specific intent to defraud is required.

In sum, 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. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. Lastly, the FCA imposes liability on an individual who obtains money from the federal government to which he or she may not be entitled and uses the false statements or records in order to retain the money.

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% but not more than 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, section 3730 (d) (2) provides that the relator shall receive an amount that the court decides is reasonable and shall not be less than 25% and not more than 30%.

Administrative Remedies for False Claims (31 U.S.C. §§ 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 admits 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 it 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 are made by the administrative agency, not by prosecution in the federal court system.

New York State Laws



Civil and Administrative Laws

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

The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes 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 two (2) times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 15% - 30% of the proceeds, depending upon whether the government participated in the suit. The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

Social Service 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 up to three (3) times the amount of the incorrectly paid claim. In the case of non-monetary false statements, the local Social Service district or State 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 five (5) years, a penalty up to \$7,500 may be imposed if they involve more serious violations of the Medicaid rules, billing for services not rendered, or providing excessive services.

Social Service 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



and the person's family needs are not taken into account for a period of six (6) months to five (5) years, depending upon the number of offenses.

Criminal Laws

Social Service 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 Service Law § 366-b, Penalties for Fraudulent Practices

Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which he/she is legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor. 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.

Social Service 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 and the person's family needs are not taken into account for a period of six (6) months to five (5) years, depending upon the number of offenses.

Penal Law Article 175, Written False Statements

There are four (4) crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information, altering an agency's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent, a person may be guilty of a Class A misdemeanor or a Class E felony.

Penal Law Article 176, Insurance Fraud

This Article applies to claims for insurance payment, including Medicaid or other health insurance. The six (6) crimes in this Article involve intentionally filing a false insurance



claim. Under this article, a person may be guilty of a felony for false claims in excess of \$1,000.

Penal Law Article 177, Health Care Fraud

This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), he/she knowingly provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which he/she is not entitled. Health care fraud is punished with fines and jail time based on the amount of payment inappropriately received due to the commission of the crime.

Whistleblower Protection

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 (2) 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 False Claims Act (State Finance Law §191)

The New York False Claims 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 Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two (2) 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 consumer 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.