DePaul Corporate Compliance
False Claims Act and Whistleblower Protections Policy

Purpose:

DePaul (sometimes referred to as "Organization" or "the Organization") is committed to prompt, complete, and accurate billing of all services provided to service recipients. DePaul and its employees and contractors shall not make or submit any false or misleading entries on any claim forms. No employee or contractor shall engage in any arrangement or participate in such arrangement at the direction of another person, including any supervisor or manager, that results in the submission of a false or misleading entry on claims forms or documentation of services that result in the submission of a false claim.

This policy applies to all Board members, all employees including the president, senior leadership, and contractors.

For purpose of this Policy, a contractor is defined as:

- Any independent contractor, contractor, subcontractor, or other person who, on behalf of the Organization, furnishes or otherwise authorizes the furnishing of Medicare and/or Medicaid healthcare items or services, or performs billing or coding functions;
- Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are directly related to healthcare provision, and/or are included in or are a necessary component of providing items or services reimbursed by Medicare, Medicaid, or another federally funded healthcare program; or
- Any independent, contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by DePaul.

Policy:

It is the policy of DePaul to detect and prevent fraud, waste, and abuse in Federal and State healthcare programs. This Policy explains the Federal False Claims Act (31 U.S.C. §§ 3729 – 3733), the Administrative Remedies for False Claims (31 USC Chapter 38 §§3801-3812), the New York State False Claims Act (State Finance Law §§187-194), and other New York State laws concerning false statements or claims and employee protections against retaliation for reporting. This policy also sets forth the procedures that DePaul has put into place to prevent any violations of Federal or New York State laws regarding fraud, waste, or abuse in its healthcare programs. (Refer to the appendix entitled "Overview of Relevant Laws" for further information.)

Regulatory References:

Social Service Law 363-D
18 NYCRR Part 521
(Also refer to Overview of Relevant Laws, below)

Procedures:

1. DePaul will provide training and/or education in this policy and procedure to all Board members, all employees including the President and senior leadership, and contractors, as defined by this Policy.

2. Training and/or education in this Policy will be provided to all employees as part of the new employee orientation.

3. Training and/or education in this Policy will be provided to all Board members and to new Board members as part of Board orientation.

4. The Compliance Officer will ensure that all Board members, all employees including the President and senior leadership, and contractors receive training and/or education related to the contents of this Policy and the False Claims Act. The Compliance Officer will ensure records are maintained to document the receipt of training.

5. The Compliance Officer will ensure this Policy is attached to any contract with a contractor as defined by this Policy.

6. For the prevention of fraud, waste and abuse, DePaul requires compliance with the following requirements related to the provision of service(s) and claims for reimbursement:
    - All service documentation, records, and reports are prepared timely, accurately, and honestly;
    - All documentation supporting claims for service is complete and maintained in accordance with regulatory requirements and DePaul's policies;
    - All claims submitted to any government or private healthcare program are accurate and comply with all Federal and State laws and regulations and payer requirements;
    - Claims are only submitted for medically necessary services provided by eligible providers;
    - All claims are properly documented and accurately coded; and
    - Billing errors are promptly identified, and any payments received in error are promptly returned to the payer.

7. Any employee or contractor who has any reason to believe that anyone is engaging in false billing practices, false documentation of services, and other non-compliance related to service provision and billing is expected to report the practice to the Compliance Officer in accordance with the Reporting and Investigation of Compliance Concerns Policy.

8. Any form of retribution, intimidation, and/or retaliation against any party who reports, in good faith, a perceived problem or concern regarding the provision or billing of services is strictly prohibited.

9. Any employee or contractor who commits or condones any form of retribution, intimidation, or retaliation will be subject to discipline up to, and including, termination of employment or contract.

10. DePaul will perform billing activities in a manner consistent with the regulations and requirements of third-party payers, including Medicaid, Medicare, and other Federal healthcare programs.

11. DePaul will conduct regular auditing and monitoring procedures as part of its efforts to ensure compliance with applicable regulations.

12. DePaul will report and refund all overpayments to Medicaid and Medicare within 60 days of identification of the overpayment in accordance with the Billing Errors, Overpayments, and Self-Disclosure Policy.

Sanction Statement:

Non-compliance with this policy may result in disciplinary action, up to and including termination.

Compliance Statement:

As part of its ongoing auditing and monitoring process in its Compliance Program, DePaul will review this policy based on changes in the law or regulations, as DePaul's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with DePaul's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all Affected Individuals, who will also be notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

Record Retention Statement:

DePaul will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

Overview of Relevant Laws

The False Claims Act (31 USC Chapter 37, §§ 3729-3733)

The False Claims Act is a Federal law designed to prevent and detect fraud, waste, and abuse in Federal healthcare programs, including Medicaid and Medicare. Under the False Claims Act, anyone who "knowingly" submits false claims to the Federal Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of approximately $12,000 to $25,000[1] for each false claim submitted.

The law was revised in 1986 to expand the definition of "knowingly" to include a person who:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in the claim; and
- Acts in reckless disregard of the truth or falsity of the information in a claim.

False Claims suits can be brought against individuals and entities. The False Claims Act does not require proof of a specific intent to defraud the Government. Providers can be prosecuted for a wide variety of conduct that leads to the submission of a false claim.

Examples include, but are not limited to, the following:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- Upcoding;
- Using false records or statements to avoid paying the Government;
- Falsifying time records used to bill Medicaid; or
- Otherwise causing a false claim to be submitted.

I. ***Whistleblower or "Qui Tam" Protections***

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a "Qui Tam" or whistleblower protection

The United States Government, or an individual citizen acting on behalf of the United States Government, can bring actions under the False Claims Act. An individual citizen, referred to as a whistleblower or "Relator," who has actual knowledge of allegedly false claims may file a lawsuit on behalf of the United States Government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an award ranging from 15% - 30% of the amount recovered.

More information can be found at 31 USC 3730: Civil actions for false claims (house.gov)

II. ***Employee Protections***

[1] The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

The False Claims Act prohibits discrimination by **ORGANIZATION** against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees.

More information can be found at 31 USC 3729: False claims (house.gov)

III. ***Administrative Remedies for False Claims (31 USC Chapter 38, §§3801-3812)***
The Federal False Claims Act allows for administrative recoveries by Federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information, or omits material information. The Federal agency receiving the claim may impose a monetary penalty of up to $5,500 per claim and damages of twice the amount of the original claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid.

More information can be found at 31 USC Chapter 38 - Administrative Remedies for False Claims and Statements.

New York State Laws

1. Civil and Administrative Laws

I. ***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 healthcare programs such as Medicaid. The penalty for filing a false claim is $6,000 - $12,000[2] 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 be responsible for the government's legal fees.

The New York State 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 False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of

[2] The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

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.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under FIS/Financial Services Law.

II. ***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 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 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.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under SOS/Social Services.

III. ***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 months to five years, depending upon the number of offenses.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under SOS/Social Services.

2. Criminal Laws

I. ***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.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under SOS/Social Services.

II. ***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 they are 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.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under SOS/Social Services.

III. ***Penal Law Article 155, Larceny***

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

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under PEN/Penal.

IV. ***Penal Law Article 175, Written False Statements***

There are four 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 organization'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 E felony.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under PEN/Penal.

V. ***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), they knowingly provide false information or omits material information for the purpose of requesting payment for a healthcare item or service and, as a result of the false information or omission, receives such a payment in an amount to which they are not entitled. Prosecution under Health Care Fraud is determined by the amount of payment inappropriately received.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under PEN/Penal.

VI. ***New York Labor Law §740***

An employer may not take any retaliatory personnel 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.

This law offers protection to an employee who:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety;
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or
- Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, with certain exceptions. The law allows employees who are the subject of a retaliatory action to bring a suit in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under LAB/Labor.

VII. ***New York Labor Law §741***

Under this law, a healthcare 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 or improper quality of workplace safety.

This law offers protection to an employee who:

- Discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or
- Objects to, or refuses to participate in any activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected under this law only of 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. Certain exceptions apply. If the 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 healthcare 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.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: under LAB/Labor.