



To: SRMT Tribal Council

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Cc: Tsiorasa Barreiro, Executive Director *TB*

Re: Corporate Compliance Policy Addendum

Date: December 30, 2019

The following listing and description of various Federal and State statutes related to the filing of false claims, including Medicare and Medicaid, was approved for inclusion in the 2013 Corporate Compliance Policy.

### **False Claims Act and Whistleblower Provisions**

#### **Purpose:**

The Saint Regis Mohawk Tribe (SRMT) is committed to prompt, complete, and accurate billing of all services provided to individuals. The SRMT and its employees, contractors, and agents shall not make or submit any false or misleading entries on any claim forms. No employee, contractor, or agent 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.

It is the policy of the SRMT to detect and prevent fraud, waste, and abuse in tribal 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) as it may pertain to certain tribal programs, and other applicable laws concerning false statements or claims and employee protections against retaliation. This policy also sets forth the procedures that the SRMT has put in place to prevent any violations of Federal or other applicable laws regarding fraud or abuse in its healthcare programs.

This policy applies to all employees, including management, contractors, and agents, and the employees of those contractors, vendors, and agents.

For purpose of this policy, a contractor, vendor or agent is defined as:

- Any contractor, subcontractor, agent, or other person who, on behalf of the SRMT, furnishes or otherwise authorizes the furnishing of Medicare and/or Medicaid healthcare items or services, or performs billing or coding functions; or
- Any contractor, subcontractor, agent, 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 of Medicare- and/or Medicaid-funded programs; or
- Any contractor, subcontractor, agent, or other person who is involved in the monitoring of healthcare provided by the SRMT.

### **Overview of Relevant Laws:**

Presented below is a listing and description of various Federal and State statutes related to the filing of false claims including Medicare and Medicaid.

#### Federal Laws

##### **1. False Claims Act (31 U.S.C. §§ 3729-3733)**

The False Claims Act is a Federal law designed to prevent and detect fraud, waste, and abuse in Federal programs, including healthcare, Medicaid and Medicare. Under the False Claims Act, anyone who “knowingly” submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus civil penalties of \$10,781.40 to \$21,562.80<sup>1</sup> for each false claim submitted.

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<sup>1</sup> The penalties are updated regularly; please refer to the Federal False Claims Act for current amounts.

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. Individuals and entities can be prosecuted civilly or criminally for a wide variety of conduct that leads to the submission of a false claim.

Some examples include:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- 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.

## 2. Administrative Remedies for False Claims (31 U.S.C. 3801-3812).

This statute allows for administrative recoveries by federal agencies.

### **State Laws**

State false claims laws fall into two categories: administrative and civil laws; and criminal laws. Many of the laws overlap. Some apply to recipient false claims, and some apply to provider false claims.

## **A. Administrative and Civil Laws**

1. State False Claims Act (State Finance Law 187-194). The State False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from any state program including Medicaid, other State, tribal or local health care programs.

2. Social Services Laws 145-c. 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 needs or the person's family's needs are not taken into account for six months if a first offense, 12 months if a second (once if benefits received are \$1,000 - \$3,900), 18 months if a third (or once if benefits received are over \$3,900) and five years for four or more offenses.

3. 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 \$10,000 per violation. If repeat violations occur within five years, a penalty up to \$30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

## **B. Criminal Laws**

1. 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.

2. 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 in order to obtain greater Medicaid compensation or knowingly submits false information in

order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

3. Penal Law Article 155, Larceny. The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

a. Fifth degree petit larceny involves property of any amount. It is a Class A misdemeanor.

b. Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.

c. Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.

d. Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.

e. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

4. Penal Law Article 175, False Written Statements. Four crimes in this Article relate to filing false information or claims that 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. 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 intent to defraud the State or a political subdivision. It is a Class E felony.

5. Penal Law Article 176, Insurance Fraud. Article 176 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.

6. Penal Law Article 177, Health Care Fraud. Article 177 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 the 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 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 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 aggregate. It is a Class B felony.

## **Whistleblower Protection**

1. State 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 (1) is in violation of a law that creates a substantial and specific danger to the public health and safety; or (2) has committed health care fraud (as defined in Penal Law Article 177). 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 a court of competent jurisdiction.

2. State 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 a court of competent jurisdiction.

3. Federal False Claims Act (31 U.S.C. 3730(h)) and State False Claims Act (State Finance Law 191). An employee who is "discharged, demoted, suspended, threatened, harassed or in any manner discriminated against" because of the employee's lawful acts under the federal or State False Claims Act may be entitled to reinstatement, double back pay with interest, special damages, litigation costs and reasonable attorneys' fees.

## **Policy:**

1. The SRMT will provide training/education in this policy and procedure to all its employees, contractors, and agents. This training will be provided to all new employees as part of the new employee orientation.

2. The SRMT will perform billing activities in a manner consistent with the regulations and requirements of third party payors, including Medicaid and Medicare.
3. The SRMT will conduct regular auditing and monitoring procedures as part of its efforts to assure compliance with applicable regulations.
4. Any employee, contractor, or agent who has any reason to believe that anyone is engaging in false billing practices or false documentation of services is expected to report the practice according to the SRMT's Reporting of Compliance Concerns and Non-Retaliation Policy and Procedure.
5. Any form of intimidation and/or retaliation against any employee who reports a perceived problem or concern in good faith is strictly prohibited.
6. Any employee who commits or condones any form of intimidation and/or retaliation will be subject to discipline up to, and including, termination.

**Procedures:**

1. The Compliance Officer will ensure that all employees will receive training/education and agents, contractors and vendors will receive notice related to the contents of this Policy and the False Claims Act. The Compliance Officer will ensure that records are maintained to document the receipt of training.
2. In appropriate circumstances, the Compliance Officer will ensure that this Policy and its procedures is incorporated in any contract with contractors, vendors or agents (as defined in this Policy) and this Policy is binding on them and their employees.
3. The Compliance Officer will ensure that a copy of the letter sent to vendors, contractors, and agents is maintained. Furthermore, vendors, contractors and agents are notified of the link to the SRMT's Corporate Compliance False Claims and Whistleblower provisions.

**Nothing in this policy including addendums or any provisions therein shall be construed as a waiver of tribal sovereign immunity.**