ALLEGANY COUNTY
CORPORATE COMPLIANCE PLAN

1. GENERAL STATEMENT

It is the duty of Allegany County hereinafter referred to as "the County", to comply with all applicable federal, state and local laws and regulations, both civil and criminal.

It is also the duty of the County to require staff to comply with the County Ethics Code, (Attachment #1), the Corporate Compliance Plan and any additional standard of conduct which may be adopted by the County Legislature.

This document summarizes the provisions of the County's Compliance Program and the requirements of the Federal Deficit Reduction Act of 2005, 42 USC s1396(a)(68), (Attachment #2), and provides information to Allegany County staff about important federal and state laws.

2. SCOPE

This plan applies to all employees, volunteers, contractors and students in those departments of the County providing billable items/services for which payments are received. The two departments providing these services are Community Services and the Department of Health, hereinafter referred to as "CS" and "DOH". This plan also applies to all contractors and agents who furnish or authorize the furnishing of billable services on behalf of the County, or perform billing or coding functions or are involved in monitoring the care provided by the County, hereinafter referred to as "agent."

The provisions, standards and requirements of the plan will be provided to new employees/agents upon hire and reviewed annually with said employees/agents.

3. ADMINISTRATION

This plan will be implemented and overseen by the Allegany County Board of Legislators, who will identify a Corporate Compliance Officer (CCO). The CCO will identify a Corporate Compliance Committee and may assign a CCO Designee. The Committee shall include the following:

a. County Administrator
b. Deputy County Administrator
c. County Attorney
d. Department of Health Director
e. Community Services Director
f. Assistant Director of Community Services
f. Department of Health Quality Assurance Coordinator
g. Department of Health Confidential Secretary – Secretary to Committee
h. Commissioner of Social Services
i. Corporate Compliance Coordinator - Corporate Compliance Officer (CCO)

CORPORATE COMPLIANCE COMMITTEE RESPONSIBILITIES:

- Manage all aspects of the corporate compliance plan
- Enforce the compliance of all state and federal rules and regulations
- The compliance officer or designee, will develop a process to, and investigate all complaints of potential violations of any state and federal rules and regulations and report findings to the Compliance Committee. (See Attachment #3) The Committee will determine if additional entities (New York State Department of Health (NYSDOH), New York State Health and Human Services Department (NYSHHSD) or New York State Office of the Medicaid Inspector General (NYSOMIG), etc.) require notification.
- Insure violations are corrected in a timely fashion and violators are reprimanded as outlined in the discipline section of this plan
- Oversee development and implementation of risk assessment/reduction plans for CS and DOH
- Review the corporate compliance plan at least annually and make appropriate amendments when required
- Review all findings from audits, as outlined in the auditing section of this plan
- Review all policies and procedures to ensure compliance with the plan during daily operations
- The Committee shall meet quarterly. Special meetings may be called more frequently if needed

CORPORATE COMPLIANCE OFFICER/DESIGNEE RESPONSIBILITIES:

- Active member of the Corporate Compliance Committee and reports all findings of potential violations, findings of investigations, and results of audits etc. to the Compliance Committee. The Committee will determine if additional entities (NYSDOH, NYSHHSD or NYSOMIG, etc.) require notification. If a conflict of interest exists, another committee member may be appointed by the CCO/Designee to conduct an investigation
- Insures documentation of education on the compliance plan annually and for all new employees/agents within CS and DOH
- Maintains documentation of any investigations, corrective action, occurrence screens and audits in regards to the compliance plan
- Promotes an atmosphere of compliance within the County
- Detection and investigation of any potential violations, such as through calls and/or reporting mechanisms
- Responds to complaints and problems in a way that promotes compliance
- The Compliance Officer/Designee will ensure all professional staff and agents are properly screened according to the schedule on page 6 of this document
- Insure reporting of meeting minutes, investigation results and discipline to the

4. BILLING PRACTICES

CS and DOH will invoice clients or third parties only for services provided and allowed by law, to the client and will assist clients to seek understanding of the cost relative to their care. Every attempt to resolve questions and objections, to satisfy the client, will be made. CS and DOH will:

1. bill only for services rendered or provided
2. submit claims to Medicare Part B for clients who are eligible
3. submit claims for equipment, medical supplies and services that are medically necessary
4. not submit duplicate bills
5. identify and refund overpayments
6. not bill for knowingly inadequate or substandard care
7. not up-code the level of service provided
8. not provide misleading or inaccurate information
9. not alter documentation or fail to maintain sufficient documentation to support the diagnosis, treatment and outcomes
10. follow the third party reimbursement fee schedule
11. collect appropriate co-payments, deductibles, and/or co-insurance
12. use appropriate codes for treatments rendered
13. maintain documentation of submitted bills and payments received
14. provide clients with information regarding their financial obligation prior to treating
15. maintain documentation of communication during the collection process
16. make all reasonable effort to collect payment before determining the payment to be un-collectable

CS and DOH will not provide a blanket waiver of insurance co-payments, deductibles or co-insurance financial obligations, or financial or non-cash benefits to individuals in order to induce such individuals to request or receive services from CS or DOH.

Under appropriate circumstances, CS and DOH may provide appropriate financial accommodations (such as allowing a payment plan over time). CS and DOH may waive client's co- payment, deductible or co-insurance financial obligations based on an assessment of the individual client's financial condition and a determination that the payment of such financial obligation would cause a financial hardship for the client. These clients will be placed on a sliding fee scale to determine payment due.

Any employee who discovers an error or inaccuracy in any claim for billing that has been submitted for payment, will immediately notify their supervisor. The error will be logged on the monthly billing and coding log, along with the action taken to resolve the error. The monthly billing and coding log will be reviewed by the Quality Assurance Coordinator and reported to the ACDOH Billing and Corporate Compliance Committees.

5. RESPECT FOR THE CLIENT

CS and DOH will treat all clients with dignity, respect and courteousness. Our goal for our clients is to humanize and individualize their care by empowering them to be partners in maintaining and improving their health. The following will assist us in achieving our goal:

1. Clients will be involved in decisions regarding their care to the extent that such is practical and possible.
2. Staff/Agents will continuously seek to understand the client's goals in the care they seek.
3. Clients will be informed and educated on the plan of care, treatment goals and upon discharge, follow-up care.
4. In all circumstances, discriminatory practices, improper denial of access to care, verbal, mental or physical abuse, failure to provide privacy and failure to maintain confidentiality, will be prohibited.

6. CONFIDENTIALITY

The County recognizes the importance of maintaining confidentiality of client's medical, financial, billing and personal information relayed in the course of providing services. Confidential information will not be shared with unauthorized personnel. The County has established policies on confidentiality and is taking all appropriate steps to ensure they are adhered to.

7. MEDICAL NECESSITY

CS and DOH take all appropriate steps to ensure that only claims that they have reason to believe are medically necessary and that are ordered by a physician or other appropriate licensed practitioner, are submitted for payment. Documentation to support the medical necessity of the claim is provided in the medical record, as per policy.

8. ESTABLISHMENT AND RETENTION OF RECORDS

CS and DOH have developed and maintained policies and procedures for establishing, filing, protection of information, distribution of information, retention and preservation of the medical record, content, destroying of the medical record and the release of information. In addition, CS and DOH maintain the following documents:

1. All records and documents required for participation in Federal, State and Private health care programs
2. All records and documentation of audits
3. All records of financial activity for the organization
4. All documents that support the claim and payments received

9. QUALIFIED PERSONNEL

BACKGROUND CHECKS/CREDENTIALING OF LICENSED PROFESSIONALS:

CS and DOH will take the following steps to assure hiring practices that promote the hiring of qualified personnel who meet the standards of their individual profession and are not a threat to clients, employees or the standards set forth by the County:

- Reference checks on all employees prior to hire
- SCR checks in eligible programs, upon hire
- The following verification will be obtained monthly:

1. Discipline data from each state the professional is licensed in
2 Exclusion data-base from Medicare/Medicaid Programs

1. License verification from each state in which the professional is currently licensed will occur at hire, license renewal and annually

   The County will not hire any individual/agent who has been excluded from participating in a federal health care program. A current individual/agent will be immediately suspended from providing services upon exclusion and must provide written documentation of reinstatement as a qualified provider, before services will be authorized.

10. EDUCATION AND TRAINING

CORPORATE COMPLIANCE COMMITTEE: The Corporate Compliance Committee will begin training in the fall of 2009. Ongoing training will continue as necessary to keep informed of changes in regulations as they occur. CS and DOH will maintain documentation of staff training.

STAFF TRAINING: All staff will attend initial compliance training in the fall of 2009. Following the initial training, compliance training will be done for staff as follows:

- Upon hire during orientation for all staff
- Updated annually

- As needed when changes in the regulations occur

All members and employees will be required to read the plan and sign a statement reflecting such to place in the employee's personnel file. The Compliance Officer/Designee will provide accommodations in the event the employee is unable to read the plan.

The Compliance Plan will be easily accessible to staff by:

a) Being sent as an email to thumb tab for future reference
b) Being placed on the Shared Drive for anyone with a county computer to access

The Compliance Plan will be easily accessible to patients and the public by:

A) The Plan will be put on the Allegany County Department of Health Website.

11. AUDITING

The Compliance Officer/Designee shall review all audits done by the managers, directors, quality management or any other entity of the County. Auditing activities will include the following:

AUDIT	How Often Completed	Audit Tool	Responsible Person
1. Chart and/or Summary of Reviews	Quarterly	Yes	QA Coordinator
3. Business Associates Contract Review	Yearly	No	Program Mgr.
4. Contract Review	Yearly	No	Program Manager
5. License verification • State Discipline data-base • Exclusion data base	At hire, renewal and annually Monthly Monthly	No	QA Coordinator
6. Personnel Records Review	Yearly	No	QA Coordinator
7. Health Record Review	Yearly	No	QA Coordinator
8. Criminal Background checks	Upon hire, as required	No	Confidential Secretary
9. Billing & Coding errors	Monthly	Yes	QA Coordinator
10. Financial/IRS/Tax compliance	Yearly	Yes	County Administrator

Auditing activities will be reviewed, no less than annually, at CCC meetings.

12. COMMUNICATION/REPORTING

Open lines of communication play a key role in responding to employee concerns.

Employees, agents and patients may address their concerns in one of several ways:

- Voice concerns directly to the supervisor/director or Compliance Officer
- File a confidential occurrence screen with the supervisor or anonymously in the locked box affixed to the wall in the file room of DOH in Belmont, the bathroom at the Wellsville office, or the second floor bathroom at CS.
- Write a written complaint to the Corporate Compliance Committee members

Addressing concerns with the Compliance Officer/Designee may be done by:

- Calling the Compliance Officer/Designee directly at 585-268-9259
- Filing an occurrence screen

Posters outlining the above routes will be prominently displayed in the waiting rooms at the Belmont and Wellsville Clinic Sites and the CS office in Wellsville. See Attachment #4.

Matters reported through the above listed communication sources that suggest violations of the compliance plan, policies or regulations will be documented by the CCO/Designee, on an occurrence screen and investigated promptly to determine validity. Documentation of complaint, investigation and results will be reported to the Corporate Compliance Committee. The Committee will determine if additional entities (NYSDOH, NYSHHSD or NYSOMIG, etc.) require notification.

Confidentiality of an employee's identity will be maintained to the extent possible. The County will not permit retaliation against any employee who reports a compliance issue in good faith. Failure to report known violations, failure to detect violations due to negligence or reckless conduct and intentionally making false reports shall be grounds for disciplinary action, including termination.

13. ENFORCEMENT AND DISCIPLINE

Certain standards of conduct shall be adhered to, to maintain an environment that promotes respect, confidentiality, privacy and quality of care. The County has established policies and procedures that govern the conduct of our employees. Continued employment is dependent upon satisfactory job performance and compliance with policies and procedures of the County, as well as state and federal rules and regulations.

Disciplinary procedures for abuse/neglect of the organization's Corporate Compliance Plan will follow the procedure in accordance with NYS Civil Service Law, under the existing personnel policies of the County and bargaining unit language, and may result in immediate discharge. Discipline related to fraud/abuse and/or neglect or abuse of the Corporate Compliance Plan or encouragement or knowledge of fraud/abuse/neglect, shall be

administered by the Corporate Compliance Officer/Designee and reported to the Corporate Compliance Committee. The Committee will determine if additional entities (NYSDOH, NYSHHSD or NYSOMIG, etc.) require notification.

Disciplinary measures that are appropriate, fair and consistent across all county employees, shall be determined on a case-by-case basis and will involve the advice of legal counsel when necessary.

Disciplinary measures and procedures may involve consideration, direction or action from outside third parties, which may include fines, exclusion from insurance carrier, professional licensing board's disciplinary action, criminal prosecution and imprisonment.

14. CORRECTIVE ACTION

Investigating, Reporting, and Correcting Identified problems:

Upon notification of any potential violations, an investigation will be promptly undertaken to determine if violations of applicable law or the requirements of the compliance program has occurred and if so to take decisive actions to correct the problem. As appropriate, such steps may include a corrective action plan, the return of any overpayments, a report to the government, and/or a referral to criminal and/or civil law enforcement authorities.

15. RESPONDING TO A SUBPOENA

CS and DOH employees/agents will cooperate fully with any governmental interview or investigation. The following guidelines will be followed when a government representative appears personally with a search warrant or subpoena for documents and records:

- All employees are instructed to notify the County Attorney's Office and Corporate Compliance Officer/Designee
- The government representative should not be left alone and should be escorted to a secure area
- The Compliance Officer/Designee or Corporate Compliance Committee member will ask for ID and inform them the organization intends to cooperate fully. If the government representative is insistent that certain steps be undertaken immediately by consenting to the search, they will be told we must first have a representative of the County Attorney's Office present.
- The Attorney's Office representative will:
    - Review the subpoena
    - Assure warrant is issued by a magistrate, signed and dated
    - Check the time for execution to make sure it has not expired
    - Assure definitive description of subject matter of search (what specific records are to be seized)

- If the search begins before counsel arrives, gather information regarding the dates, times, areas searched, documents taken, employee questions and responses.
- Keep copies of all materials handed over
- Make a list of all questions asked

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ATTACHMENT #1 ALLEGANY COUNTY CODE OF ETHICS

RESOLUTION NUMBER 105-70
TITLE: A CODE OF ETHICS AND A BOARD OF ETHICS FOR THE COUNTY OF ALLEGANY

RESOLVED:

1. That proposed Local Law Intro. No. 1-70, Print No. 1 is hereby adopted without any changes in language, to wit:

BE IT ENACTED by the Board of Legislators of the County of Allegany as follows:

ARTICLE I
INTENT OF BOARD OF LEGISLATORS

Section 1. Statement of Legislative Intent. The Board of Legislators of the County of Allegany recognizes that there are state statutory provisions mandating counties to establish rules and standards of ethical conduct for public officers and employees which, if observed, can enhance public confidence in local government. In the light of the tendency today on the part of some people to downgrade our local governments and to discredit our public servants and our free institutions generally, it appears necessary that every effort be made to assure the highest caliber of public administration of this county as part of our state's important system of local government. It is the purpose of this local law to implement this objective through the establishment of standards of conduct, to provide for punishment of violation of such standards and to create a board of ethics to render advisory opinions to the county's officers and employees as provided for herein.

Section 2. The standards, prohibited acts and procedures established herein are in addition to any prohibited acts, conflicts of interest provisions or procedures prescribed by statute of the state of New York and also in addition to common law rules and judicial decisions relating to the conduct of county officers to the extent that the same are more severe in their application that this local law.

ARTICLE II
CODE OF ETHICS

Section 1. Definitions. As used in this local law, the term "county" shall mean any board, commission, district, council or other agency, department or unit of the government of the County of Allegany.
The term "county employee" shall mean any officer or employee of the County of Allegany whether paid or unpaid, whether serving in a full-time, part-time or advisory capacity.

Section 2. Rule with respect to conflicts of interest. No county employee shall have any interest, financial or otherwise, direct or indirect, or engage in any business or transaction or professional activity or incur any obligation of any nature, which is in substantial conflict with the proper discharge of his duties in the public interest.

Section 3. Standards. A)No county employee shall accept other employment which will impair his independence of judgment in the exercise of his official duties.
B) No county employee shall accept employment or engage in any business or professional activity which will require him to disclose confidential information which he has gained by reason of his official position or authority.
C) No county employee shall use or attempt to use his official position to secure unwarranted privileges or exemptions for himself or others.
D) No county employee shall engage in any transaction as representative or agent of the county with any business entity in which he has a direct or indirect financial interest that might reasonably tend to conflict with the proper discharge of his official duties.
E) A county employee shall not by his conduct give reasonable basis for the impression that any person can improperly influence him or unduly enjoy his favor in the performance of his official duties, or that her is affected by the kinship, rank, position or influence of any party or person.

F) Each county employee shall abstain from making personal investments in enterprises which he has reason to believe may be directly involved in decisions to be made by him or which will otherwise create substantial conflict between his duty in the public interest and his private interest.
G) Each county employee shall endeavor to pursue a course of conduct which will not raise suspicion among the public that he is likely to be engaged in acts that are in violation of his trust.
H) No county employee employed on a full-time basis nor any firm or association of which such employee is a member nor corporation a substantial portion of the stock of which is owned or controlled by directly or indirectly by such employee, shall sell goods or services to any person, firm, corporation or association which is licensed or whose rates are fixed by the county in which such employee serves or is employed.

Section 4. Violations. In addition to any penalty contained in any other provision of law, any such county employee who shall knowingly and intentionally violate any of the provisions of this local law may be fined, suspended or removed from office or employment in the manner provided by law.

ARTICLE III
BOARD OF ETHICS
Section 1. There is hereby established a Board of Ethics consisting of five members to be appointed by the Board of Legislators, all of whom reside in the County of Allegany and who shall serve without compensation and at the pleasure of the Board of Legislators of Allegany County. A majority of such members shall be persons other than county employees but shall include at least one member who is an elected or appointed county employee of the County of Allegany.

Section 2. The Board of Ethics established hereunder shall render advisory opinions to county employees on written request and upon request of the Board of Legislators make recommendations to such Board of Legislators as to any amendments of this local law. The opinions of the Board of Ethics shall be advisory and confidential and in no event shall the identity of the county employee be disclosed except to authorized persons or agencies. Such opinions shall be on the advice of counsel employed by the board of ethics, or if none, of the county attorney.

Section 3. Such board of ethics upon its formation shall promulgate its own rules and regulations as to its form and procedures and shall maintain appropriate records of its opinions and proceedings.

ARTICLE IV
ADMINISTRATION
Section 1. Upon the adoption of this local law, the Chairman of the Board of Legislators shall cause a copy thereof to be distributed to every county employee of this county. Failure to distribute any such copy or failure of any county employee to receive such copy shall have no effect on the duty of compliance with this code, nor the enforcement of provisions hereof. The Chairman of the Board of Legislators shall further cause a copy of this local law to be kept posted conspicuously in each public building under the jurisdiction of the county. Failure to so post this local law shall have no effect on the duty of compliance herewith, not the enforcement provisions hereof.

Section 2. Within thirty days of the adoption of this local law, the Clerk of the Board of Legislators shall file a copy thereof in the office of the state comptroller.

Section 3. The Board of Legislators may appropriate moneys from the general county funds for the maintenance of and for personnel services to the board of ethics established hereunder, but such board of ethics may not commit the expenditure of county moneys except within the appropriations provided herein.

ARTICLE V
SEVERABILITY CLAUSE
Section 1. If any clause, sentence, paragraph, section or part of this local law shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

ARTICLE VI
EFFECTIVE DATE
Section 1. This local law shall take effect immediately. Certification of true and correct copy and signature on July 13, 1970.

Note: The Health Department and Community Services Program has provided this information to their respective staff. A copy is hanging in the main entryway into the Health Department and at their off-site office in Alfred and the two off-site offices in Wellsville. Community Services has their copy hanging in their lobby.

ATTACHMENT #2 FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

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

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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 paid or approved by the Government;. . . 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 terms "knowing" and "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; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act 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. 31 U.S.C. 3729(b).

In sum, the False Claims Act 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 may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act 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) is 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 hospital 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.

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 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.

Administrative Remedies for False Claims (31 USC Chapter 38. §§ 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 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 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.

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 tracts 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 of 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 five 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.

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.

Any person who, with intent to defraud, presents for payment and 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.

Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
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:

§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.
§ 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.
§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.
§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.
Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
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 *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 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 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.

09/30/09

Attachment #3

Process for Investigation of Complaints or Reports of potential fraud/abuse/neglect

COMPLAINTS/REPORTS MADE DIRECTLY TO THE CORPORATE COMPLIANCE OFFICER/DESIGNEE

1. Upon directly receiving either a confidential or anonymous report/occurrence screen, the CCO/Designee will assess the complaint/report to determine involvement of other staff in the investigation (County Attorney, Department Head where complaint/report originated, etc.).
2. The CCO/Designee will interview the claimant if known to gather all evidence and statements.
3. Once all evidence and statements are gathered, if the CCO/Designee and other appropriate staff deem it to be a valid complaint/report, the staff member the complaint has been made against, will be interviewed and allowed time to gather contradicting evidence, if there is any.
4. After all interviews/statements and evidence has been collected, the CCO/Designee will present the findings to the Corporate Compliance Committee within one week of completion of investigation. Special meetings of the Corporate Compliance Committee can be called at any time.
5. The CCC will determine course of action up to and including discipline or dismissal of the violator(s) and whether reporting to the NYS Office of Medicaid Inspector General, NYS Health and Human Services Department and/or NYS Department of Health or law enforcement is warranted.
6. The Committee will insure that all findings and results are reported to the Allegany County Board of Health, Human Services Committee of the Allegany County Legislature and to the Allegany County Department of Health Quality Assurance Committee for DOH cases and to the CS Board of Directors and Human Services Committee of the Allegany County Legislature for CS cases.
7. The Committee will define plans of correction, if applicable and insure implementation and follow-up of the plan of correction to insure no further violations occur.

COMPLAINTS/REPORTS FOUND IN SUGGESTION BOX OR MADE TO SUPERVISOR/QUALITY ASSURANCE COORDINATOR/DIRECTOR

1. Staff person receiving the complaint/report, will immediately notify the Corporate Compliance Officer/Designee.
2. If already in written form, it will immediately be hand delivered to the CCO/Designee to commence their investigation.
3. If the complaint/report is verbal, the person making the complaint/report will be asked to complete an occurrence screen, insuring all contact information for the person making the report is on the screen and complete for further communication during the investigation. The occurrence screen will then follow Step 2 above.

Attachment #4 Poster to Alert Patients to Avenues to File a Complaint/Report

DO YOU SUSPECT BILLING FRAUD, ABUSE, NEGLIGENCE OR WASTE?

You may file a confidential or anonymous complaint, or ask questions in the following ways:

Confidential

Ask to speak to a supervisor and they will guide you through filling out an occurrence screen.

There are locked boxes in the bathrooms at the Wellsville WIC and Community Services bathrooms. There is a locked box in Room 19 in the Health Department in Belmont. You can go in there and fill out an occurrence screen and put it in the box. The County Administrator or Corporate Compliance Officer will contact you for an interview and fact-finding.

Call the County Administrator (Tim Boyde) at (585)268-9217, or the County Corporate Compliance Officer (Penny Chudy) at (585)268-9259 to make an appointment.

You can mail a written report/complaint, with your contact information enclosed, to:

Mr. Tim Boyde, County Administrator
County Office Complex Room 207
Belmont, NY 14813

or

Penny Chudy, Corporate Compliance Officer
County Office Complex, Room 30
Belmont, NY 14813

Anonymous

There are locked boxes in the bathrooms at the WIC and Community Services bathrooms. There is a locked box in Room 19 in the Health Department in Belmont. You can go in there and fill out an occurrence screen and put it anonymously in the box.

You can file your complaint/report over the phone to the Corporate Compliance Officer/Designee.

You can mail a written, unsigned report/complaint to:

Mr. Tim Boyde, County Administrator
County Office Complex Room 207
Belmont, NY 14813

or

Penny Chudy, Corporate Compliance Officer
County Office Complex, Room 30
Belmont, NY 14813

Please be sure to be as detailed as you can, since no one will be able to contact you for further information.

Please do not hesitate to speak to someone if you have an issue. There will be **no** retaliation for a complaint/report made in good faith.