

MAIMONIDES MEDICAL CENTER

CODE: COMPL-011 (Revised)

DATE: October 24, 2019

ORIGINALLY ISSUED: April 26, 2007

FALSE CLAIMS AND PAYMENT FRAUD PREVENTION

I. POLICY

Maimonides Medical Center (the “Medical Center”) is committed to fully complying with all laws and regulations that apply to health care and to preventing and detecting any fraud, waste, or abuse related to Federal and State health care programs.

The Medical Center is required by law to establish certain policies and provide employees, contractors and agents with information regarding: (1) Medical Center’s policies and procedures for detecting and preventing fraud, waste and abuse (“FWA”); (2) the federal False Claims Act and similar New York State laws; and (3) an employee’s rights to be protected from retaliation as a whistleblower. In furtherance of its policy and to comply with Section 6032 of the Deficit Reduction Act of 2005 (the “DRA”), the Medical Center provides the following information about its policies and procedures and the role of certain federal and state laws in preventing and detecting FWA in federal and state health care programs.

II. SCOPE

For purposes of this policy, the term “Medical Center” shall also include Maimonides Research and Development Foundation (“MRDF”), MMC Holding of Brooklyn, Inc. (“MMCH”), Maimonides Health Resources, Inc., and its subsidiaries and any other affiliated companies in which the Medical Center or they have a controlling interest.

This policy is applicable to the Medical Center’s employees, volunteers, residents and fellows, physicians and ancillary medical staff appointed to the Medical Center’s medical staff, vendors or consultants, who furnish (on behalf of the Medical Center) health care items or services, perform billing or coding functions, or who monitor the health care provided by the Medical Center (“Workforce Members”).

III. DEFINITIONS

Abuse: Means payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

Fraud: Generally means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent

pretenses, representation or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 USC §1347)

Waste: Means the overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

IV. POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FWA

- A. The Medical Center maintains a robust and active Corporate Compliance Program that:
1. Identifies, monitors, and manages, through a multitude of organizational policies and procedures and in compliance with federal and state laws, concerns of fraud, waste and abuse.
 2. Includes a written Code of Conduct that establishes basic standards of workplace behavior, promotes adherence to all applicable laws, regulations and policies, and reflects the Medical Center's commitment to the highest standards of integrity and ethical conduct.
 3. Is dedicated to the training and education of its Workforce Members regarding applicable laws, regulations and policies related to preventing and detecting FWA. This includes the importance of submitting accurate claims and reports to the Federal and State governments as well as whistleblower protections afforded under such laws.
 4. Makes available a confidential Compliance Hotline for employees and other individuals to report compliance concerns.
 5. Includes written policies and procedures prohibiting retaliation against individuals who, in good faith, participate in investigations or report alleged violations of applicable policies, rules, regulations or laws.
- B. Pursuant to the Code of Conduct, employees are required to bring immediately to the attention of their supervisor, the Chief Compliance Officer, the Corporate Compliance or the Legal departments, information regarding suspected improper conduct. Employees may also call the **Compliance Hotline at (800) 585-7970** to report concerns about possible violations of the law or Medical Center policies. The Medical Center is committed to investigating any such allegation of fraud, waste, or abuse or other improper conduct swiftly and thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, the Medical Center requires that all employees fully cooperate in the investigation.

- C. The Medical Center devotes substantial resources to investigate allegations of fraud and abuse and therefore, believes that all employees should bring their concerns to the Medical Center first so it can redress and correct any fraudulent activity. Any employee of the Medical Center who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under the Medical Center’s internal compliance policies and procedures and Federal and State law. However, the Medical Center retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or Medical Center policy.
- D. While the Medical Center requires that its employees bring their concerns to the Medical Center, certain State and Federal laws discussed more fully below provide that any private citizen may bring their concerns of fraud and abuse directly to the government. Please note, however, that if an employee never reports his/her concerns through the Medical Center’s internal compliance processes so that the Medical Center can address these concerns, they will be in breach of Medical Center policy.
- E. Materials relating to the Medical Center’s policies for detecting and preventing fraud are listed on the Medical Center Intranet under Corporate Compliance and on the Internet under “About Us –Corporate Compliance.”

V. SUMMARY OF FEDERAL AND STATE LAWS

The following is a summary of the federal False Claims Act and the Program Fraud Civil Remedies Act, and the relevant New York State statutes.

A. Federal Laws:

1. False Claims Act (31 USC §3729; “FCA”) provides, in pertinent part, as follows:

(a) Liability for certain acts.

- (1) In general.--Subject to paragraph (2), any person who—
 - (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
 - (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
 - (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
 - (D) has possession, custody, or control of property or money used, or to be used,

by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is 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;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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 \$10,781 and not more than \$21,563, subject to annual adjustment for inflation, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.— A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) **Definitions.** For purposes of this section—

(1) the terms “knowing” and “knowingly” –

(i) mean that a person, with respect to information—

- (ii) has actual knowledge of the information;
- (iii) acts in deliberate ignorance of the truth or falsity of the information; or
- (iv) acts in reckless disregard of the truth or falsity of the information; and
- (v) requires no proof of specific intent to defraud;

(2) the term “claim”—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

- (i) is presented to an officer, employee, or agent of the United States; or
- (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
 - (I) provides or has provided any portion of the money or property requested or demanded; or
 - (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

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 USC §3729(b)(1).

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In sum, FCA imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds 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 FCA 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) are 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 which obtains interim payments from Medicare or Medicaid 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 or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. (31 USC §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 15- 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 be between 25- 30% of the proceeds recovered. This award may be reduced or negated, however, if the court finds that the person filing the case planned and initiated the fraud. The Act also provides that persons who prosecute clearly frivolous cases can be held liable to the company for its attorneys’ fees and costs.

2. Program Fraud Civil Remedies Act (“PFCRA”) (31 USC §3801 et seq.):

This statute allows for administrative recoveries by federal agencies. If a person **submits** a claim or statement on or after January 1, 2017, the maximum penalty which may be assessed is the larger of:

- (1) The amount for the previous calendar year; or
- (2) An amount adjusted for inflation, calculated by multiplying the amount for the previous calendar year by the percentage by which the CPI-U for the month of October preceding the current calendar year exceeds the CPI-U for the month of October of the calendar year two years prior to the current calendar year, adding that amount to the amount for the previous calendar year, and rounding the total to the nearest dollar.

Notice of the maximum penalty which may be assessed for calendar years after 2016 will be published in the Federal Register on an annual basis on or before January 15 of each calendar year. For 2019, the maximum civil penalty under PRCRA for each false, fictitious or fraudulent

statement or claim is \$11,462.

A violation of PFCRA occurs when a false claim is **submitted** rather than when it is paid, as is the case under the False Claims Act. Additionally, 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. The administrative agency may also recover twice the amount of the claim.

3. Disclosure and Return of Overpayments (42 USC §1320a-7k(d)):

Section 6402(a) of the Patient Protection and Affordable Care Act (“PPACA”) created a new requirement, effective as of March 23, 2010, related to reporting and returning “overpayments.” PPACA defines an overpayment as “any funds that a person receives or retains under [Medicare and Medicaid] to which the person, after applicable reconciliation, is not entitled under such title.” (42 USC §1320a-7k(d)(4)(B)). PPACA further provides that an overpayment must be reported and returned “by the later of--(A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable.” (42 USC §1320a-7k(d)(2)). Pursuant to a CMS regulation, a person has identified an overpayment when the person “has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.” (42 CFR §401.305(a)(2)). PPACA also provides that an overpayment retained after the deadline for repayment is an “obligation” under the FCA.

4. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

The Anti-Kickback Statute (the “AKS”) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program such as Medicare or Medicaid. The AKS ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. The AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

Violation of the AKS constitutes a felony punishable by a maximum fine of \$100,000, imprisonment up to ten years, or both. Conviction will also lead to automatic exclusion from federal health care programs, including Medicare and Medicaid. Where a party engages in conduct prohibited by the AKS, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party and/or initiate administrative proceedings to exclude such party from federal health care programs.

Additionally, a claim for payment that includes items or services resulting from a violation of the AKS constitutes a false or fraudulent claim for purposes of the FCA.

B. New York State Laws

New York State False Claim Laws fall under the jurisdiction of both New York’s civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Some of the “common law” crimes may also apply to areas of interaction with the government and so are applicable to health care fraud.

- **Civil and Administrative Laws**

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

The New York False Claims Act is similar to the federal FCA. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then either (i) knowingly uses false statements or records in order to retain the money; or (ii) knowingly conceals or knowingly and improperly avoids or decreases an obligation to return the money. (State Finance Law § 189(1)). The New York False Claims Act, unlike the federal FCA, also extends liability to false or fraudulent claims, records, or statements made under state tax laws in certain circumstances. (State Finance Law §189(4)(a)).

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person, plus consequential damages. (State Finance Law §189(1)). In addition, a person who violates this act is liable for costs, including attorneys’ fees, of a civil action brought to recover any such penalty. (State Finance Law §189(3)).

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the New York State Attorney General or a local government. 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, or 15-25% if the government did participate in the suit. (State Finance Law §190(6)).

2. Social Services Law, Section 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 (3) times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$12,000 per violation. If repeat violations occur within five (5) years, a penalty of up to \$30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

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

• **Criminal Laws**

1. Social Services Law, Section 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, Section 366-b - Penalties for Fraudulent Practices.

(1) Any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids and abets any person to obtain medical assistance to which he is not entitled, shall be guilty of a class A misdemeanor, unless such act constitutes a violation of a provision of the penal law or the state of New York, in which case he shall be punished in accordance with the penalties fixed by such law.

- (2) Any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under this title, shall be guilty of a class A misdemeanor, unless such act constitutes a violation of a provision of the penal law of the state of New York, in which case he shall be punished in accordance with penalties fixed by such law.

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. This statute 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.

4. 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:

- (i) §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.
- (ii) §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.
- (iii) §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.
- (iv) §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.

5. Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and, as applicable to health insurance, contains six crimes:

- (i) Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.
- (ii) Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000. It is a class E felony.
- (iii) Insurance fraud in the 3rd degree is filing a false insurance claim for over \$3,000. It is a class D felony.
- (iv) Insurance fraud in the 2nd degree is filing a false insurance claim for over \$50,000. It is a class C felony.
- (v) Insurance fraud in the 1st degree is filing a false insurance claim for over \$1 million. It is a class B felony.
- (vi) Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6. Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes:

- (i) Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a

health plan. This is a class A misdemeanor.

(ii) Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

(iii) Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.

(iv) Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.

(v) Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

B. Whistleblower Protections

1. 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 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.

2. New York State False Claims Act (State Finance Law §191)

The New York State False Claims Act also provides protection to current, former, and prospective employees, agents, and contractors who are discharged, demoted, suspended, threatened, harassed, discriminated against in the terms and conditions of their employment, or otherwise harmed or penalized as a result of their lawful acts in furtherance of an action under the Act or other efforts to stop a violation of the Act. Remedies include an injunction to restrain continued discrimination, reinstatement with comparable seniority as the person would have had but for the discrimination, two

times the amount of any back pay, interest on any back pay, reinstatement of full fringe benefits and seniority rights, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

“Lawful acts” in furtherance of an action under the Act include, without limitation, “obtaining or transmitting to the state, a local government, a qui tam plaintiff, or private counsel solely employed to investigate, potentially file, or file a cause of action under this article, documents, data, correspondence, electronic mail, or any other information, even though such act may violate a contract, employment term, or duty owed to the employer or contractor, so long as the possession and transmission of such documents are for the sole purpose of furthering efforts to stop one or more violations of this article.” The protection afforded to transmitting documents or data in furtherance of an action under the Act, however, does not prevent law enforcement authorities from taking action against a person for violating the law through such activity.

3. New York State Labor Law, Section 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 not to exceed \$10,000 on the employer. The law also provides that employees who bring an action without basis in law or fact may be held liable to the employer for its attorneys' fees and costs.

4. New York State Labor Law, Section 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.

IV. PROTECTION AGAINST RETALIATION

Medical Center policy strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith, concerning suspected fraud, waste and abuse or other suspected violation of law or Medical Center policy. Retaliation is subject to discipline, up to and including dismissal from employment or termination of the business relationship with Maimonides Medical Center (See Compl- 010 "Protection Against Retaliation").

V. RESPONSIBILITIES

- A. Human Resources is responsible for providing copies of the information required by the Deficit Reduction Act as described in this policy to all new employees during orientation and obtaining an acknowledgement of receipt which will be maintained in the employee's personnel file.
- B. Management (at all levels) are responsible for encouraging a culture of compliance by reiterating the importance of compliance, developing procedures specific to their area that assist in the prevention of fraud, waste and abuse and responding to staff who come forward with suspicions of fraud, waste or abuse.
- C. The Compliance Department will ensure that a copy of this policy is posted on the Intranet Corporate Compliance section and the Internet.
- D. The Credentials Department will provide a copy of this policy and the information required by the DRA to all medical staff members at the time of initial appointment

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and will obtain an acknowledgment of receipt which will be kept in the Credentials file.

- E. The Corporate Compliance Department is responsible for implementing and maintaining the Corporate Compliance Program, which includes but is not limited to: a) providing training that aids staff in their ability to prevent and detect fraud, waste and abuse, including a new section on the federal and state False Claims Acts; b) responding to reports of fraud, waste and abuse in a timely fashion; c) developing and implementing new policies that assist the Medical Center in preventing and detecting fraud, waste and abuse, and; d) reporting suspected fraud, waste or abuse or criminal acts of the Medical Center's employees and covered entities including by not limited to, the appropriate CMS Medicare Integrity Contractor/Medicare Advantage Plan Sponsor, as applicable, and in accordance with contract agreements with outside parties.

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VI. **CONTROLS**

The Chief Compliance Officer and the Executive Vice President for Legal Affairs and General Counsel will be responsible for monitoring compliance with this policy.



Kenneth Gibbs
President & CEO

REFERENCE:

Deficit Reduction Act of 2005, S. 1932 Sec. 6032; and Social Security Act, 42 U.S.C. § 1396a(a)(68); False Claims Act 31 U.S.C. §§ 3729-3733; 28 C.F.R Part 85 Civil Monetary Penalties Inflation Adjustment; Federal Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10104(j)(2), 124 Stat. 119, 901-02 (2010); 42 C.F.R. 401.305(a)(2); Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, § 4, 123 Stat. 1617, 1621-25; NYS False Claims Act, NY Finance Law Sec. 187-194; Medicaid False Claims Act, NY Social Services Law §§ 145-b, 145-c and 366-b; NY Penal Law §§ 155 and 175-177; Retaliatory Action by Employers, NY Labor Law Article 20-C; L. 2013, ch. 56, Sec. 8 (State Finance Law § 189(1)(h) and COMPL.-10 Protection Against Retaliation

ORIGINATING
DEPARTMENT:

Corporate Compliance/Legal Department