GENESEE COUNTY EMPLOYEE FRAUD PREVENTION POLICY

WITH DEFICIT REDUCTION PROVISIONS

I. INTRODUCTION

Genesee County is committed to preventing health care fraud and abuse and complying with applicable state and federal fraud and abuse laws. To ensure compliance with such laws, the County has mechanisms in place to detect and prevent fraud, waste and abuse. It supports the efforts of federal and state authorities in identifying fraud, waste and abuse. The County prohibits the knowing submission of a false claim for payment in relation to a Federal or State Funded Health Care Program. Such submission violates the Federal False Claims Act, the New York False Claims Act as well as other federal and state laws and may result in significant civil and/or criminal penalties.

This policy provides information about the County's procedure to detect fraud, waste and abuse including; how to report concerns, an overview of applicable federal and state laws, and Whistleblower protections as required by the Deficit Reduction Act. This policy and procedure applies to all interns, volunteers and individuals providing Medicaid or Medicare health care items or services for which payments are made. All such personnel shall be required to sign a statement of certification that they have been informed of the County's policy and procedure.

Genesee County maintains an anonymous Fraud Hotline (585) 815-7830 to accept calls from anyone concerning suspected fraud, waste and/or abuse. The County has personnel dedicated to conducting periodic internal audits of its compliance with state and federal fraud and abuse laws.

If an employee believes in good faith that fraud, waste, abuse or other improper conduct has occurred in violation of laws, rules, regulations, policies, or standards, or the County's Compliance Plan, or Code of Conduct, the individual is required to report such information to the Compliance Officer (585)-344-2580 x2212, or their Department Head or Supervisor, or County Manager (585) 344-2580 x2204, or Assistant County Manager (585) 344-2580 x2200, or Legislative Liaison to the Compliance Committee (585) 344-2580 x2202, or in writing addressed to Genesee County Compliance Officer, 7 Main Street, Batavia, NY 14020. Individuals who report such conduct in good faith shall not be retaliated against or intimidated for making such a report.

The County shall maintain the confidentiality of persons reporting compliance issues, regardless of whether confidentiality or anonymity is requested, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the New York State Attorney General Medicaid Fraud Control Unit, the New York State Office of the Medicaid Inspector General, or law enforcement, or disclosure is required during a legal proceeding.

A copy of this policy shall be provided to new employees who provide Medicaid or Medicare health care items or services for which payments are made. All such employees shall be required to sign a statement of certification that they have been informed of the County's policy and procedure. Contractors and vendors shall be provided with this policy upon contract start and shall be available on the Genesee County Website. Contractors and vendors shall be required to sign a statement of certification.

II. FRAUD AND ABUSE LAWS

Federal Laws

False Claims Act (31 USC §§ 3729 – 3733; 18 USC § 287): Under the Federal Civil False Claims Act, any person who knowingly and/or willfully submits a false or fraudulent claim for payment to the Federal government may be subject to civil penalties, including monetary penalties, treble damages, exclusion from participation in the Medicare and Medicaid Programs, and fines of up to three times the government's loss plus up to $11,000 per claim filed (*i.e.*, each instance of an item or service billed to a government health care program). Examples of prohibited conduct include billing for services not rendered, upcoding claims, double billing, misrepresenting services that were rendered, falsely certifying that services were medically necessary, making false statements to the government, failing to comply with conditions of payment, and failing to refund overpayments made by a

Federal health care program. Notably, no specific intent to defraud the government is required, as "knowing" is defined to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. The civil False Claims Act also contains a whistleblower provision that permits private citizens ("relators") to file suits on behalf of the government ("*qui tam* suits") against those who have defrauded the government and the relator, if successful, may receive a portion of the government's recovery.

Federal law also establishes criminal liability against individuals or entities that knowingly submit, or cause to be submitted, a false or fraudulent claim for payment to the Federal government. Criminal False Claims Act liability can result in imprisonment of up to five years and/or substantial fines.

Administrative Remedies for False Claims (31 USC §§ 3801 – 3812): Federal law allows for administrative recoveries by Federal agencies related to false claims. The laws penalize any person who makes, presents, or submits (or causes to be made, presented, or submitted) a claim that the person knows or has reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that omits a material fact, is false, fictitious, or fraudulent as a result of such omission, and is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
- Is for payment for the provision of property or services which the person has not provided as claimed.

The Federal agency receiving the false claim may impose a penalty of up to $5,000 for each claim, as well as an assessment of up to twice the amount of the claim in violation of the False Claims Act. In these instances, the determination of whether a claim is false and the imposition of fines and penalties is made by the Federal administrative agency, rather than by a court. Moreover, in contrast to the False Claims Act, a violation of these laws occurs when a false claim is submitted, rather than when it is paid.

Anti-Kickback Statute (42 USC § 1320a-7b(b)): The Federal Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service that is payable by a Federal health care program. Remuneration includes kickbacks, bribes, and rebates paid director or indirectly, overtly or covertly, in cash or in kind (*i.e.*, anything of value), and items or services includes drugs, supplies, or health care services provided to Medicare or Medicaid patients. The Statute covers both the payers and recipients of kickbacks. No intent to violate the Statute is required, and the Statute 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.

An individual or entity that is found to have violated the Anti-Kickback Statute may be subject to criminal penalties and administrative sanctions including fines, imprisonment, and exclusion from participation in Federal health care programs, including the Medicaid and Medicare Programs. Safe harbors protect certain payment and business practices from criminal and civil prosecution that could otherwise implicate the Anti-Kickback Statute. To be protected by a safe harbor, the arrangement must fit squarely within the safe harbor and must satisfy all of its requirements.

Physician Self-Referral Law (42 USC § 1395nn): The Federal Physician Self-Referral Law, commonly referred to as the "Stark Law," prohibits physicians—including medical doctors, doctors of osteopathy, psychologists, oral surgeons, dentists, podiatrists, optometrists, and chiropractors—from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family

member has a financial relationship, unless the ownership or compensation arrangement is structured to fit within a regulatory exception.

Financial relationships include both ownership/investment interests and compensation arrangements, and "designated health services" are any of the following services, other than those provided as emergency physician services furnished outside of the United States, that are payable in whole or in part by the Medicare Program:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Radiology and certain other imaging services;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The Stark Law is a strict liability statute, and therefore, proof of specific intent to violate the law is not required. The Law also prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark Law include fines, civil penalties, repayment of Medicare and/or Medicaid reimbursement, and exclusion from participation in the Federal health care programs.

Exclusion Statute (42 USC § 1320a-7): The Federal Exclusion Statute requires the U.S. Department of Health and Human Services Office of Inspector General to exclude individuals and entities convicted of certain types of criminal offenses from participation in all Federal health care programs (including the Medicare and Medicaid Programs), and gives the Office the discretion to exclude individuals and entities on several other grounds. The following types of criminal offenses require exclusion:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
- Patient abuse or neglect;
- Felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Physicians who are excluded from participation in Federal health care programs are barred from receiving payment from programs such as Medicaid and Medicare for items or services furnished, ordered, or prescribed. Additionally, individuals and entities providing health care services may not employ or contract with excluded individuals or entities in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. Employing or contracting with an excluded individual or entity may result in civil monetary penalties and an obligation to repay any amounts paid by a Federal health care program attributable to the excluded individual or entity's services.

Civil Monetary Penalties Law (42 USC § 1320a-7a): The Federal Civil Monetary Penalties Law authorizes the U.S. Department of Health and Human Services Office of Inspector General to seek civil monetary and other penalties against individuals and entities for a wide variety of conduct, including presenting a claim that a person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, presenting a claim that the person knows or should know is for an item or service that is not payable, or making false statements or misrepresentations on applications or contracts to participate in Federal health care programs, among others. Violations of the False Claims Act, Anti-Kickback Statute, and Stark Law implicate the Civil Monetary Penalties Law and can lead to civil monetary and other penalties.

The amount of the penalties and assessments that the U.S. Department of Health and Human Services Office of Inspector General is authorized to seek under the Civil Monetary Penalties Law differs depending on the type of

violation at issue. Specifically, the Civil Monetary Penalties Law authorizes penalties in the amount of $100,000 for each act in violation of the Anti-Kickback Statute, in addition to any other penalty that may be prescribed by law. Regulations also permit the U.S. Department of Health and Human Services Office of Inspector General to impose a penalty up to $50,000 for each offer, payment, solicitation or receipt of remuneration, and violations of the Anti-Kickback Statute can result in assessments of up to three times the total amount of the remuneration offered, paid, solicited, or received. Remuneration under the Civil Monetary Penalties Law includes waivers of coinsurance and deductible amounts (including partial waivers), and transfers of items or services for free or for amounts other than fair market value. In addition to civil monetary penalties, persons or entities may also be excluded from participation in Federal health care programs, fines, treble damages, denial of payment, and repayment of amounts improperly paid.

New York State Laws

New York State False Claims Act (N.Y. State Finance Law §§ 187 – 194): The New York State False Claims Act closely tracks the Federal False Claims Act, and 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 the Medicaid Program. Specifically, the Act penalizes any person or entity who, among other conduct:

- Knowingly presents, or causes to be presented, to any employee, officer, or agent of the State or a local government a false or fraudulent claim for payment or approval, or conspires to do the same;
- Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim, or conspires to do the same;
- Conspires to defraud the State or a local government by getting a false or fraudulent claim allowed or paid; or
- 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 State or a local government.

The penalty for filing a false claim is $6,000 to $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the person or entity that filed the false claim may have to pay the government's legal fees, including the costs of a civil action brought to recover any penalties or damages and attorneys' fees. The New York State False Claims Act also allows private individuals ("relators") to bring an action on behalf of the State or local government ("*qui tam* suits"). If the lawsuit results in a recovery or settlement, the relator may share in a percentage of the proceeds.

New York Social Services Law § 145: Under Section 145 of the New York Social Services Law, any person who makes false statements or representations, deliberately conceals any material fact, impersonates another, or through another fraudulent device obtains, or attempts to obtain, or aids or abets any person to obtain, public assistance or care to which the person is not entitled, including Medicaid Program benefits, is guilty of a misdemeanor. However, if the act constitutes a violation of a provision of the New York Penal Law, the person will be punished in accordance with the penalties fixed by the applicable law.

New York Social Service Law § 145-b: Section 145-b of the New York Social Services Law makes it unlawful to knowingly make a false statement or representation, to deliberately conceal any material fact, or to engage in any other fraudulent scheme or device to obtain or attempt to obtain public funds, including Medicaid Program funds. In instances where a violation of this law occurs, the local Social Services District or the State may recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Services District or State may recover three times the damages sustained by the government due to the violation or $5,000, whichever is greater. The Department of Health may also impose a civil penalty of up to $2,000 per violation, and if repeat violations occur within five years, a penalty of up to $7,500 per violation may be imposed if the conduct involves more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

New York Social Services Law § 145-c: Under Section 145-c of the New York Social Services Law, any person who 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 person or their family are not taken into account for various

periods of time based on the offense committed. Specifically, the person's or their family's needs will not be taken into account for six months on the first offense, 12 months on the second offense or a single offense that resulting in the wrongful receipt of benefits in an amount of between $1,000 and $3,900, 18 months on the third offense or upon an offense that results in the wrongful receipt of benefits in an amount in excess of $3,900, and five years for any subsequent occasion of any such offense. These sanctions are in addition to any sanctions which may be provided for by law with respect to the offenses involved.

New York Social Services Law § 366-b: Under Section 366-b of the Social Services Law, any person who obtains or attempts to obtain, for themselves 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. Additionally, any person who, with intent to defraud, presents for payment a 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. Finally, if an act also constitutes a violation of a provision under the New York Penal Law, the person committing the act will be punished in accordance with the penalties fixed by such law.

New York Penal Law Article 155: Article 155 of the New York Penal Law establishes the crime of Larceny, which occurs when a person, with intent to deprive another of their property, obtains, takes, or withholds the property by means of trick, embezzlement, false pretense, false promise, a scheme to defraud, or other similar behavior. The four crimes of Larceny have been applied to Medicaid fraud cases. These crimes include:

- Penal Law § 155.30, Grand Larceny in the Fourth Degree, which involves property valued over $1,000, and is a Class E felony;
- Penal Law § 155.35, Grand Larceny in the Third Degree, which involves property valued over $3,000, and is a Class D felony;
- Penal Law § 155.40, Grand Larceny in the Second Degree, which involves property valued over $50,000, and is a Class C felony; and
- Penal Law § 155.42, Grand Larceny in the First Degree, which involves property valued over $1 million, and is a Class B felony.

New York Penal Law Article 175: The four crimes in Article 175 of the New York Penal Law, Offenses Involving False Written Statements, relate to filing false information or claims and have been applied in Medicaid fraud prosecutions. These crimes include:

- Penal Law § 175.05, Falsifying Business Records, which involves entering false information, omitting material information, or altering an enterprise's business records with the intent to defraud, and is a Class A misdemeanor;
- Penal Law § 175.10, Falsifying Business Records in the First Degree, which includes the elements of Penal Law § 175.05 and the intent to commit another crime or conceal its commission, and is a Class E felony;
- Penal Law § 175.30, Offering a False Instrument for Filings in the Second Degree, involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information, and is a Class A misdemeanor; and
- Penal Law § 175.35, Offering a False Instrument for Filing in the First Degree, which includes the elements of Penal Law § 175.30 and an intent to defraud the State or a political subdivision, and is a Class E Felony.

New York Penal Law Article 176: Article 176 of the New York Penal Law, Insurance Fraud, applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes. The crimes include:

- Penal Law § 176.10, Insurance Fraud in the Fifth Degree, which involves intentionally filing a health insurance claim knowing that it is false, and is a Class A misdemeanor;
- Penal Law § 176.15, Insurance fraud in the Fourth Degree, which involves filing a false insurance claim for over $1,000, and is a Class E felony;

- Penal Law § 176.20, Insurance Fraud in the Third Degree, which involves filing a false insurance claim for over $3,000, and is a Class D felony;
- Penal Law § 176.25, Insurance Fraud in the Second Degree, which involves filing a false insurance claim for over $50,000, and is a Class C felony; and
- Penal Law § 176.30, Insurance Fraud in the First Degree, which involves filing a false insurance claim for over $1 million, and is a Class B felony;
- Penal Law § 176.35, Aggravated Insurance Fraud, which involves committing insurance fraud more than once, and is a Class D felony.

New York Penal Law Article 177: Article 177 of the New York Penal Law establishes the crime of Health Care Fraud, and applies to claims for health insurance payment, including claims submitted to the Medicaid Program and other health plans, including non-government plans, and contains five crimes. The crimes include:

- Penal Law § 177.05, Health Care Fraud in the Fifth Degree, involves knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions, and is a Class A misdemeanor;
- Penal Law § 177.10, Health Care Fraud in the Fourth Degree, involves filing false claims and annually receiving over $3,000 in the aggregate, and is a Class E felony;
- Penal Law § 177.15, Health Care Fraud in the Third Degree, involves filing false claims and annually receiving over $10,000 in the aggregate, and is a Class D felony;
- Penal Law § 177.20, Health Care Fraud in the Second Degree, involves filing false claims and annually receiving over $50,000 in the aggregate, and is a Class C felony; and
- Penal Law § 177.25, Health Care Fraud in the First Degree, involves filing false claims and annually receiving over $1 million in the aggregate, and is a Class B felony.

Whistleblower Protections

Federal False Claims Act (31 USC §§ 3730(h)): The civil False Claims Act provides protection to 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 False Claims Act. Remedies include reinstatement with comparable seniority as the 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. However, if the *qui tam* action has no merit or is for the purpose of harassing the person or entity, the individual may have to pay the person or entity for its legal fees and costs in defending the suit.

New York State False Claims Act (N.Y. State Finance Law § 191): The New York State False Claims Act provides protection to an employee of any private or public employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by their employer because of lawful acts taken by the employee in furtherance of an action under the New York State False Claims Act. Remedies can include reinstatement to the same position or an equivalent position, two times back pay, reinstatement of full fringe benefits and seniority rights, and compensation for any special damages sustained, including litigation costs and reasonable attorneys' fees.

New York Labor Law § 740: An employer may not take any retaliatory action against an employee (including former employees) if the employee discloses, or threatens to disclose, information about the employer's policies, practices, or activities to a regulatory, law enforcement, or another similar agency or public official. Protected disclosures include disclosures of an activity, policy, or practice of the employer that the employee reasonably believes are in violation of law, rule, or regulation, or that the employee reasonably believes pose a substantial and specific danger to the public health or safety. The employee's disclosure is protected only if the employee first raised the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. However, employer notification is not required where:

- There is an imminent and serious danger to the public health or safety;

- The employee reasonably believes that reporting to the supervisor would result in destruction of evidence or other concealment of the activity, policy, or practice;
- The activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
- The employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
- The employee reasonably believes that the supervisor is already aware of the activity, policy, or practice and will not correct it.

Employees are also protected from retaliatory action if the employee objects to, or refuses to participate in, any activity that is in violation of law, rule, or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety. Additionally, employees are protected when the employee provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into an employer's activity, policy, or practice. If an employer takes retaliatory action against the employee, the employee may sue in State court for reinstatement to the same position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the employer's violation was willful, malicious, or wanton, punitive damages may be imposed.

New York State Labor Law § 741: A health care employer may not take any retaliatory action against a health care employee if the health care employee discloses, or threatens to disclose, certain information about the health care employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official, to a news media outlet, or to a social media forum available to the public at large. Under the law, a "health care employee" is any person who performs health care services for, and under the control and director of, any public or private employer that provides health care services for wages or other remuneration.

Protected disclosures include disclosures of an activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitute improper quality of patient care or improper quality of workplace safety. Health care employees are also protected from retaliatory action if the health care employee objects to, or refuses to participate in, any activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The health care employee's disclosure is protected only if the health care employee first raised the matter with a supervisor and gave the health care employer a reasonable opportunity to correct the activity, policy, or practice. However, employer notification is not required where the improper quality of patient care or workplace safety presents an imminent threat to public health or safety, to the health of a specific patient, or to the health of a specific health care employee and the health care employee reasonably believes, in good faith, that reporting to a supervisor would not result in corrective action.

If a health care employer takes retaliatory action against the health care employee, the health care employee may sue in State court for reinstatement to the same position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the health care employer's violation was willful, malicious, or wanton, punitive damages may be imposed.