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Owner	Shané Abercrombia: Director of Compliance
Area	Compliance
Applicability	VillageCare Corporate Services

Compliance with Deficit Reduction Act and Fraud, Waste, Abuse Regulations

PURPOSE:

VillageCare (VC) is committed to preventing and detecting fraud, waste, or abuse related to Federal and State health care programs. To this end, VC maintains a vigorous corporate compliance program and strives to educate its work-force on fraud and abuse laws, including the importance of submitting accurate claims and reports to Federal and State governments. In furtherance of this policy and to comply with Section 6032 of the Deficit Reduction Act of 2005, VC provides the following information about its policies and procedures and the role of certain Federal and State laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

DEFINITION:

"**AFFECTED INDIVIDUALS**" include all employees, appointees, executives, governing body members, and any person or affiliate who is involved in any way with VC such as the person or affiliate contributes to the required entitlement of VCs payment from the Medicaid program eg. Independent contractors, interns, students, volunteers, and vendors, and individuals who are at least 5 percent owner of VC.

POLICY:

VillageCare has adopted programs for detecting and preventing fraud, waste and abuse of Federal and State healthcare programs. The Corporate Compliance and Internal Audit department oversees these programs, and depending on the nature of an allegation or investigation, works collaboratively with General Counsel to conduct investigations in these areas.

As part of the commitment to ethical and legal conduct, employees are required to bring immediately to the attention of their supervisor or the Chief Compliance Officer, information regarding suspected improper conduct. Affected Individuals may also call the confidential VC Compliance Hotline and report anonymously at (844) 348-2664 to discuss concerns about possible violations of law or VC policy. VC is committed to investigating any allegation of fraud, waste, or abuse promptly and thoroughly, and will do so through its internal compliance program processes. To ensure that the allegations are fully and fairly investigated, VC requires that all employees fully cooperate in the investigation.

VC expects that all Affected Individuals should bring these concerns to the VC Chief Compliance Officer to investigate and correct any fraudulent activity. Any Affected Individual who reports such information will have the right and opportunity to do so anonymously, and will be protected against retaliation or intimidation for coming forward with such information both under VC's internal compliance policies and procedures, and Federal and State law. However, VC retains the right to take appropriate action against an Affected Individual who has participated in a violation of Federal or State law or policy.

While VC requires that its Affected Individuals bring their concerns to VC, certain State and Federal laws provide that any private citizen may bring their concerns of fraud, waste and abuse directly to the government. Please note, however, that if an employee never reports his/her concerns through VillageCare's internal compliance processes so that VC can address these concerns, they will be in breach of their duty to VC under the VC Code of Conduct.

If you would like more information on the Corporate Compliance Program and specific compliance policies, or how to report any concerns, please contact the Corporate Compliance department at (212) 337-5637 or go to the Compliance Program folder on the intranet.

RELATED POLICIES, PROCEDURES AND REGULATIONS

FEDERAL LAWS

Federal False Claims Act

The Federal False Claims Act ("FCA") imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally-funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

The FCA is not confined to health care claims but extends to any payment requested of the federal government. The FCA applies to billing and claims sent from the organization to any government payor program, including Medicare and Medicaid.

It is the policy of VC that Affected Individuals who knowingly and intentionally submit a false claim will be reported to the necessary authorities. Anyone, or any company, that submits a false claim or statement to the government may be fined under the FCA regardless of the size of the false claim, and the person or company could be required to pay an additional fine of three times the value of any charges.

Part of the FCA's purpose is to create an environment where employees and others feel safe reporting concerns about fraud. VC fully supports that goal. Any person who lawfully reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by VC for making such a report. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.

The FCA provisions are generally enforced by the U.S. Department of Justice. The FCA provides that a person may initiate a formal claim if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. If any funds are recovered, a portion of the funds may be paid to the person who initiated the formal claim, at the discretion of a federal court.

If a person wishes to file a claim regarding fraud or suspected fraud related to a health care payment directly with the government, he or she must first present a formal complaint, along with all material evidence relating to the alleged fraud, to the authorities at the U.S. Department of Justice. The authorities have 60 days to investigate, during which time the complaint is kept confidential. Upon completion of the investigation, the government will decide either to pursue the case on its own or decline to proceed with the case. If the federal government declines the case, the individual may still proceed with the case on his or her own, but without the government's assistance, and at his or her own expense.

A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government. (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances.)

Patient Protection and Affordable Care Act ("PPACA")

Under Section 6402, Enhanced Medicare and Medicaid Program Integrity Provisions, Part (d) reporting and returning of overpayments.

1. In general, if a person has received an overpayment, the person shall
    a. report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
    b. notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
2. DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS – An overpayment must be reported and returned under paragraph (1) 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.
3. ENFORCEMENT - Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.
4. DEFINITIONS – In this subsection:

a. KNOWING AND KNOWINGLY – The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

b. OVERPAYMENT – The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

c. PERSON – (i) IN GENERAL – The term 'person' means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

Federal Program Fraud Civil Remedies Act

Persons or companies that commit fraud on the federal government, by false claim or statement, can be assessed money penalties in addition to the penalties of the False Claims Act because of a law called the Program Fraud Civil Remedies Act (referenced in this policy as "PFCRA"). Specifically, there are penalties per false claim or statement that apply if a person or company submits a claim to the federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements containing false, fictitious, or fraudulent information; includes or is supported by written statements that omit a material fact, which causes the statements to be false, fictitious, or fraudulent, and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed.

The penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

NEW YORK STATE LAWS

The New York False Claims Act (NYFCA) provides, in pertinent part, that:

Any person who:

1. 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;
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 State or a local government; conspires to defraud the State or a local government by getting a false or fraudulent claim allowed or paid; or
3. 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; is liable (a) to the State of New York for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages that the State sustains because of the act of that person; and (b) to any local government for three times the amount of damages sustained by such local government because of the act of that person.

For purposes of this section, the terms "knowing" and knowingly" mean that with respect to a claim, or information relating to a claim, a person:

1. Has actual knowledge of such claim or information;
2. Acts in deliberate ignorance of the truth or falsity of such claim or information; or
3. Acts in reckless disregard of the truth or falsity of such a claim or information.

Proof of specific intent to defraud is not required, but acts occurring by mistake or due to mere negligence are not covered by this law.

Under the NYFCA, "claim" means any request or demand for money or property that is made to any employee, officer, or agent of the State or a local government. This includes request or demands submitted to a contractor of the government and includes Medicaid claims, among other items.

The NYFCA also provides that private parties may bring an action on behalf of the State or a local government. These private parties, known as "qui tam relators" may share in a percentage of the proceeds from a NYFCA action or settlement.

The NYFCA 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 his or her employer because of lawful acts taken by the employee in furtherance of an action under the NYFCA. Remedies for such discrimination include reinstatement, two times back pay, and compensation for any special damages sustained as a result of the discrimination.

Certain relevant portions of other New York State Codes are summarized below.

New York Social Services Law §145-b, it is unlawful to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. For a violation of this law, the local Social Services district or the State has a right to 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 Service district or State may recover three times the damages (or $5,000, whichever is greater) sustained by the government due to the violation.

The law also empowers the New York State Department of Health to impose a monetary penalty on any person who, among other actions, causes Medicaid payments to be made if the person knew or had reason to know that:

the payment involved care, services, or supplies that were medically improper, unnecessary, or excessive; the care, services or supplies were not provided as claimed;

the person who ordered or prescribed the improper, unnecessary, or excessive care, services, or supplies was suspended or excluded from the Medicaid program at the time the care, services, or supplies were furnished; or the services or supplies were not in fact provided.

The monetary penalty shall not exceed $2,000 for each item or service in question, unless a penalty under the section has been imposed within the previous five years, in which case the penalty shall not exceed $7,500 per item or service.

New York Social Services Law §366-b (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 compensation greater than that to which s/he is legally entitled for furnishing services or merchandise shall be guilty of a Class A misdemeanor. If such an act constitutes a violation of a provision of the penal law of the state of New York, the person committing the act shall be punished in accordance with the penalties fixed by such law.

New York Penal Law §177 establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), s/he knowingly and willfully provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which s/he is not entitled. Health Care Fraud is punished with fines and jail-time based on the amount of payment inappropriately received due to the commission of the crime; the higher the payments in a one-year period, the more severe the punishments, which currently range up to 25 years if more than $1 million in improper payments are involved.

New York law also affords protections to employees who may notice and report inappropriate activities. Under New York Labor Law §740, an employer shall not take any retaliatory personnel action against an employee because the employee:

discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud; provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

To bring an action under this provision, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back-pay and compensation of reasonable costs. 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.

REFERENCES:

Section 6032 of the Deficit Reduction Act of 2005

1902(a)(68)(A) Social Security Act

31 U.S.C. §§ 3729-3733

31 U.S.C. §§ 3801-3812

NYS Social Services Law § 363-d

NYS Social Services Law § 366-b (2)

NYS Social Services Law§ 145-b

NYS Penal Law § 177

NYS Labor Law § 740

NYSDOH Approval Required: Yes
Approval: June 17, 2021

Approval Signatures

Step Description	Approver	Date
Final Approval	Emma Devito: President & CEO	6/27/2023
Compliance Officer	Dara Quinn: Chief Compliance Officer	6/27/2023
	Shané Abercrombia: Director of Compliance	6/27/2023