10 St. Patrick's Place
Port Henry, NY 12974
518-546-3381
mountainlakeservices.org

Policy: False Claims Act

Category/Section: Compliance	Original Effective Date: 1/12/17
Department: Quality and Training/Compliance	**Current Version Effective Date: 8/21/25**
Policy Developed by: Tara Peters	Revision Dates: 4/26/23; 2/7/24; 6/26/25
CEO/ED Approval: 8/21/25	Board Approval: 8/21/25

PURPOSE

This policy and procedure describe the Mountain Lake Services' commitment to adhering to applicable False Claims Acts and the penalties that may be inflicted for violating the acts.

SCOPE

This policy and procedure are applicable and made available/accessible to all Affected Individuals unless a specific exemption is noted within this policy.

POLICY

Mountain Lake Services is committed to prompt, complete and accurate billing of all services provided to people supported. Affected Individuals of Mountain Lake Services shall not make or submit any false or misleading entries on any bills or claim forms, and no Affected Individual in such an arrangement at the direction of another person, including any supervisor or manager, which results in such prohibited acts.
Further, it is the policy of Mountain Lake Services to detect and prevent fraud, waste, and abuse. This Policy explains the Federal False Claims Act (31 U.S.C. §§ 3729 – 3733), the Federal Program Fraud Civil Remedies Act (31 USC §§3801-3812), the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119), the New York State False Claims Act (State Finance Law §§187-194) and other New York State laws concerning false statements or claims and employee protections against retaliation. This policy also sets forth the procedures Mountain Lake Services has put into place to prevent any violations of federal or New York State laws regarding fraud or abuse in its health care programs.

REGULATORY REFERENCES

Mountain Lake Services is governed by several federal, state, and local statutes, rules, and regulations; however, the focus of this policy is on those pertaining to the Federal False Claims Act (31 U.S.C. §§ 3729 – 3733) and the New York State False Claims Act State Finance Law §§187-194 along with other applicable laws supporting the state and federal False Claims Acts.

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APPLICABILITY

Among other things, the False Claims Act applies to claims submitted for payment by federal health care programs, including Medicare and Medicaid.

RESPONSIBILITIES

This policy and procedure are overseen by the Mountain Lake Services' Compliance Officer. The Compliance Officer (CO) and Compliance Committee (CC) are responsible for monitoring implementation of this policy and procedure, reviewing and revising as necessary; but no less frequent than annually.

DEFINITIONS

Affected Individuals: all persons who are affected by the required provider's risk areas including the required provider's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. (N.Y. Comp. Codes R. & Regs. tit. 18, § 521-1.2)

Fraud: defined as the wrongful or criminal deception intended to result in financial or personal gain. Fraud includes false representation of fact, making false statements, or by concealment of information. (oig.usaid.gov)

Waste: defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls. (oig.usaid.gov)

Abuse: defined as excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. Abuse can occur in financial or non-financial settings. (oig.usaid.gov)

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PROCEDURES

1. Overview of Relevant Laws

A. Deficit Reduction Act (DRA, 42 U.S.C § 1396-a(a)(68))

1. Overview. The Deficit Reduction Act (DRA) requires that any entity, as a condition of receiving Medicaid payments shall "(A) establish written policies for all affected individuals, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of the DRA); (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse."

B. Federal False Claims Act (31 U.S.C. §§ 3729 – 3733).

1. Overview. The False Claims Act is one of the laws the Government uses to prevent and detect fraud, waste, and abuse in federal health care programs. The False Claims Act establishes liability for any person who "knowingly" submits a false claim either (1) directly to the Government or (2) to a contractor or grantee of the Government, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest. A person may be liable for a civil penalty per false claim, plus up to three times the amount of the damages sustained by the Government due to the violation(s)[1]. The False Claims Act defines

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"knowingly" to mean that a person (1) has actual knowledge of the false claim; (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. Specifically, the False Claims Act may be violated by the following acts found at 31 U.S.C.A. § 3729:

a. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;

b. Knowingly making or using, or causing to be made or used, a false record or statement material to a false claim;

c. Conspiring to commit a violation of the False Claims Act; or

d. Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay money or transmit property to the Government**,** or knowingly concealing or avoiding or decreasing an obligation to pay money or transmit property to the Government.

2. Applicability. Among other things, the False Claims Act applies to claims submitted for payment by federal health care programs, including Medicare and Medicaid.

3. Examples. A few examples of actions that violate the False Claims Act include knowingly:

a. Billing for services that were not actually rendered;

b. Charging more than once for the same service;

c. Billing for medically unnecessary services; and

d. Falsifying time records used to bill Medicaid.

4. Methods of Enforcement. The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the False Claims Act. If a Relator brings an action under the False Claims Act, the Government has a period of time to investigate the allegations and decide whether to join the lawsuit. If the Government elects to join the lawsuit, the Relator is entitled to 15-25% of any recovery. If the Government elects not to join the

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lawsuit, the Relator may still proceed with the action and is entitled to 25-30% of any recovery.

5. Employee Protection. The False Claims Act prohibits discrimination by Mountain Lake Services against an employee, contractor, or agent for taking lawful actions in furtherance of an action under the False Claims Act. Under the False Claims Act, any employee, contractor, or agent who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee, contractor or agent whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorneys' fees.

C. Federal Program Fraud Civil Remedies Act (31 USC §§3801-3812). The Program Fraud Civil Remedies Act of 1986 is a federal law that provides for administrative recoveries by federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information or omits material information. Violations of this law are investigated by the Department of Health and Human Services and monetary sanctions may be imposed in an administrative hearing setting. Monetary sanctions may include penalties[2] and damages of twice the amount of the original claim.

D. Patient Protection and Affordable Care Act "PPACA" (Pub. L. No. 111-148, 124 Stat. 119). The Patient Protection and Affordable Care Act of 2010 is a federal healthcare law that through amendments expanded provisions of the Federal False Claims Act. Most significantly, PPACA expanded FCA liability for possession of overpayments (42 U.S.C.§ 1320a-7k). The law clarified that an overpayment must be reported and returned by 60 days after the date on which the overpayment was identified. Overpayments

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retained after the deadline are considered an obligation as defined in the FCA imposing FCA liability.

E. New York State False Claims Laws

1. New York State False Claims Act (State Finance Law §§187-194). The New York State False Claims Act was modeled after the Federal False Claims Act and its provisions are very similar. This Act provides that anyone who "knowingly" submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment including consequential damages, which the state or local government sustains because of the act of that person, plus mandatory penalties between $6,000 and $12,000 for each false claim submitted. The False Claims Act defines "knowingly" to mean that a person (1) has actual knowledge of the false claim; (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. The Act requires no proof of specific intent to defraud, provided, however that acts occurring by mistake or as a result of mere negligence are not covered by the Act. The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. In addition, the New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

2. Social Service Law §145-b. Under this section 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. In the

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event of 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 of the incorrectly paid claim. 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. In addition, the Department of Health may impose a monetary penalty of up to $10,000 per violation unless a penalty under the section has been imposed within the previous five years, in which case the penalty may be up to $30,000.

3. Social Services Law § 145-c. Under this section, if any person individually or as a member of a family applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, then the needs of that person shall not be taken into account for determining the needs of that person or those of his or her family: (i) for a period of 6 months if a first offense; (ii) for a period of 12 months if a second offense, or upon an offense which resulted in the wrongful receipt of benefits in an amount of between $1,000 and $3,900; and (iii) for a period of 18 months if a third offense or upon an offense which resulted in the wrongful receipt of benefits in excess of $3,900, and 5 years for any subsequent occasion of any such offense.

4. Social Services law §145. Under this section, any person who submits false statements or deliberately conceals material information to receive public assistance, including Medicaid, is guilty of a misdemeanor. This crime is punishable by fines and by imprisonment up to one year.

5. Social Service Law § 366-b. Under this section any person who, with intent to defraud, presents for payment any false or fraudulent claim for services or merchandise, or knowingly submits false information for the purpose of obtaining compensation greater than

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that to which he/she is legally entitled to shall be guilty of a class A misdemeanor.

6. Penal Law Article 155. Under this Article, 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 similar behavior. This Article has been applied to Medicaid fraud cases. This crime is punishable by fines and imprisonment up to twenty-five years.

7. Penal Law Article 175. Under this Article, four crimes relating to falsifying business records or filing a false instrument have been applied in Medicaid fraud prosecutions. These crimes are punishable by fines and imprisonment up to four years.

8. Penal Law Article 176. This Article establishes the crime of insurance fraud. A person commits such a crime when he/she intentionally files a health insurance claim, including Medicaid, knowing that it is false. This crime is punishable by fines and imprisonment up to twenty-five years.

9. Penal Law Article 177. This Article 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), he/she 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 he/she 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.

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10. Labor Law §740. In addition to provisions contained in the Federal and New York State False Claim Acts, this section offers protection to employees who may notice and report inappropriate activities. Under New York State Labor Law §740, an employer may 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 that 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 investigating, 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 reasonably believe the alleged violation poses a substantial and specific danger to the public health or safety. 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, the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof, the reinstatement of full fringe benefits and seniority rights, the compensation for lost wages, benefits and other remuneration, the payment by the employer of reasonable costs, disbursements, and attorney's fees, a civil penalty of an amount not to exceed ten thousand dollars, and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton. A court, in its discretion, may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the

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court determines that an action brought by an employee under this section was without basis in law or in fact.

11. Labor Law §741. Under this section, an employer may not take any retaliatory personnel 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 gives 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. 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, backpay and compensation of reasonable costs.

II. Procedure

A. General Principles.

1. Mountain Lake Services provides training to all its Affected Individuals regarding this Policy.

2. Billing activities are performed in a manner consistent with Medicare, Medicaid and other payor regulations and requirements and in accordance with Mountain Lake Services' *Documentation of Service Recipient Services* policy.

3. To assist in its efforts to detect and prevent fraud, waste and abuse, Mountain Lake Services conducts regular audit and

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monitoring procedures as described in *Auditing and Monitoring* policy.

B. Reporting Non-Compliance.

If an Affected Individual has any reason to believe that anyone is engaging in false billing practices, that person immediately reports the practice in accordance with Mountain Lake Services'[reporting potential compliance concerns policy]. The Mountain Lake Services Compliance Hotline telephone number is 518-546-7487. The dedicated Compliance email is compliance@mountainlakeservices.org.

C. Non-Retaliation.

Mountain Lake Services does not retaliate against any Affected Individual for taking any lawful action under the False Claims Act. Moreover, Mountain Lake Services does not retaliate against any affected individual for reporting any potential compliance concern, as described in Mountain Lake Services' *Anti-retaliation* policy.

POLICY REVIEWS WITH NO REVISIONS:

Date/Name/Title	Date/Name/Title	Date/Name/Title