Circare

Policy on the Deficit Reduction Act of 2005

Purpose

Circare is committed to the highest levels of quality and ethical standards and to ensuring that all its business is conducted in compliance with applicable laws, rules, regulations, and standards, and with honesty, fairness, and integrity. This policy describes our compliance with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

1. Introduction

Circare is committed to complying with Section 6032 of the Federal Deficit Reduction Act of 2005 as well as other laws, rules, and regulations and ensuring that its delivery of services is documented honestly and correctly and that billing is done accurately and for the exact and medically necessary services that were actually provided.

2. Deficit Reduction Act

The Deficit Reduction Act of 2005 (DRA) mandates notification about certain compliance laws for organizations that receive $5 million or more annually in Medicaid payments. The DRA is intended to reduce fraud, waste, and abuse in federal and state healthcare programs through employee and contractor education about: (a) federal and state laws that prohibit false claims; (b) civil and criminal penalties; and (c) protections from retaliation for employees who report wrongdoing, misconduct, or violations of laws and regulations in good faith. Circare is fully committed to compliance with the DRA.

3. Federal and State Regulations

The federal False Claims Act and New York State laws prohibit the knowing submission of false claims or statements to the government for payment. Although they differ in detail, these laws define false claims as "knowingly submitting false or fraudulent claims for payment to the federal or state government or making or using a false record or statement in connection with the submission of a claim for payment to the government." Violations can subject Circare and those involved in the violation to significant fines as well as criminal penalties.

<u>Examples of False Claims Under Medicare and Medicaid</u>

- Billing for medical services that were not provided;
- Billing for undocumented or medically unnecessary services;
- Duplicate billing;
- Knowingly making false statements or relying on false data or information to support a claim for reimbursement or payment; and
- Participating in kickbacks (payments or other types of compensation) made in order to influence referrals for services paid for by Medicare or Medicaid

Detailed information about the provisions of the federal False Claims Act and New York's civil and criminal state laws pertaining to false claims and statements is available to all members of the Circare workforce — agency, state, contract, and temporary employees, Board of Directors, interns, volunteers, vendors, contractors, and consultants. A list of relevant federal and state regulations and more information on the Deficit Reduction Act is available from the Compliance Officer.

4. Circare Compliance Program & Code of Conduct

Circare has implemented a Compliance Program to ensure that our business is conducted with the highest standards of ethics and integrity. At the heart of this program is Circare's Code of Conduct, which sets forth the values and standards of conduct that govern the behavior of the Circare workforce. The Compliance Officer is responsible for the Compliance Program and reports directly to the Executive Director and the Board of Directors. The Compliance Plan outlines how Circare will structure, administer, enforce, and otherwise effectively implement its Compliance Program. Copies of Circare Compliance Program documents, including the Code of Conduct, Compliance Plan, and Compliance Policies and Procedures are available at www.cir.care.

4.1 Circare Policies on Prevention and Detection of Fraud and Abuse

All members of the Circare workforce should be aware of Circare policies regarding detection and prevention of healthcare fraud and abuse. These policies can be accessed by contacting the Compliance Officer.

4.2 What Are Fraud and Abuse?

Fraud means intentionally misrepresenting facts, knowing that the deception could result in some unauthorized benefit — usually payment from a healthcare program such as Medicare, Medicaid, or a private insurer.

Abuse involves actions that are inconsistent with accepted sound medical, business, or fiscal practices. Abuse directly or indirectly results in unnecessary costs or improper payments.

Both fraud and abuse carry significant penalties. A healthcare provider can be found guilty of fraud or abuse if they knew *or should have known* something was wrong.

4.3 Detecting and Preventing Fraud and Abuse

Circare expects that its workforce will do everything they can to prevent and detect false claims and potentially fraudulent behavior. The following are examples of measures that Circare takes to accomplish this:

- providing training to its direct workforce
- investigating reports of compliance issues, concerns, or violations
- providing reporting mechanisms including an anonymous and confidential Compliance Hotline
- performing internal risk assessments
- internally monitoring high risk areas
- performing audits
- protecting members of the workforce who report compliance issues, concerns, or violations
- performing exclusion screenings and background checks on new members of the direct workforce

4.4 Reporting Compliance Violations

Federal and state laws also impose an affirmative obligation on Circare and its workforce to know and understand the rules and regulations regarding the submission of claims. Circare requires all members of the its workforce to report, without hesitation, in good faith, and through an appropriate channel of communication, compliance issues, concerns, or violations of which they become aware, even if they only suspect that a problem exists or has occurred. Failure to report is itself a violation of the Compliance Program. Circare supports its workforce in fulfilling this obligation through its policies prohibiting intimidation of and retaliation against others who report compliance problems in good faith and by providing a hotline that allows its workforce to report issues confidentially and anonymously.

Circare expects its vendors, contractors, and consultants to support its efforts to prevent and detect practices that could potentially violate laws, regulations, professional standards, or Circare's policies. Any employee of a vendor, contractor, or consultant who has a concern about the work she or he does for Circare or work done by Circare must report that concern. Concerns may be reported through the Compliance Hotline, an anonymous and confidential method of reporting.

Circare is committed to making every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports a compliance issue, concern, or violation in good faith. The identities of reporters who request confidentiality and those who report via the Compliance Hotline will be kept confidential within the compliance reporting structure. At times the agency may be required to disclose a reporter's identity when a matter is turned over to law enforcement.

5. Whistleblower Provisions and Protections

A person may become a whistleblower and notify the government of known or suspected fraudulent activity at Circare. Under both federal and state law, as well as its own internal policy, Circare, and its workforce, is prohibited from retaliating against individuals who notify the government of potential violations. Also, under these statutes, the person who reported the fraudulent behavior may receive a portion of monies recovered or penalties paid in the recovery of false or fraudulent claims.

6. Enforcement

Members of the Circare workforce acting in violation of this policy are subject to disciplinary action, up to and including termination from the workforce.

7. Distribution

Circare will distribute a copy of this policy to all members of its workforce.

The federal False Claims Act, New York State's False Claims Act and certain other New York State laws can subject individuals and organizations to significant fines and penalties if they commit fraud against either the federal or the state government. Under the federal False Claims Act, false claims may include "knowingly submitting false or fraudulent claims to the government for payment or making or using a false record or statement in connection with the submission of such claims." In addition to willful and intentional acts of fraud, individuals and organizations can be penalized for submitting or causing the submission of claims in deliberate ignorance or reckless disregard for the truth.

Examples of false claims include:

- billing for services with knowledge that such services are not medically necessary or performed;
- billing twice or multiple times for the same items or services;
- falsifying internal records that are used to support claims;
- failing to report known over payments and credit balances to a government payor; and
- upcoding claims in order to obtain reimbursement in excess of the proper amount due.

Circare requires all members of the its workforce to report, without hesitation, in good faith, and through an appropriate channel of communication, compliance issues, concerns, or violations of which they become aware, even if they only suspect that a problem exists or has occurred. Failure to report is itself a violation of the Compliance Program. Circare supports its workforce in fulfilling this obligation through its policies prohibiting intimidation and retaliation against others who report in good faith and by providing a hotline that allows its workforce to report issues confidentially and anonymously. Any person may, under certain conditions, become a whistleblower and notify the government of known or suspected fraudulent activity at Circare. As a matter of statute as well as its own internal policy, Circare is prohibited from taking any adverse action against persons who notify the federal government of potential violations. Both the federal and state False Claims Act and Circare's internal policies protect persons who in good faith notify the government under the federal False Claims Act from retaliation or discrimination.

1. Federal Laws

1.1 False Claims Act (31 USC §§ 3729-3733)

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

(a) Any person who (1) knowingly presents, or causes to be presented, 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 material to a false or fraudulent claim; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or (7) knowingly makes, uses, or causes to be made or used, a false record or statement 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 $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required (31 U.S.C. § 3729).

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act (31 U.S.C. 3729(b)).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this

may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States (31 U.S.C. 3730 (b)). These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

1.2 Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 - 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

2. New York State Laws

Several New York statutes also impose civil and criminal penalties for false claims and statements. New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

2.1 Civil and Administrative Laws

2.1.1 NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare 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 uses false statements or records in order to retain the money.

The penalty for filing a false claim is $6,000 -$12,000 per claim plus three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

2.1.2 Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

2.1.3 Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of the individual's family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of $3,900), and five years for any subsequent occasion of any such offense.

2.2 Criminal Laws

2.2.1 Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2.2.2 Social Services Law § 366-b, Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

2.2.3 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.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

2.2.4 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:

a. §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.
b. § 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.
c. §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.
d. §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.

2.2.4 Penal Law Article 176, Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

2.2.5 Penal Law Article 177, Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
b. Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.
c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.
d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.
e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

3. Whistleblower Protection

3.1 Federal False Claims Act (31 U.S.C. §3730(h)

The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

3.2 NY False Claim Act (State Finance Law §191)

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

3.3 New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes healthcare fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

3.4 New York Labor Law §741

A healthcare 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.