

B. 27 PREVENTING FRAUD, WASTE, ABUSE, AND OTHER WRONGDOING
FRAUD, WASTE & ABUSE
Deficit Reduction Act, DRA, 2005
The Arc of Union County Compliance Policy

On February 8, 2006, the Deficit Reduction Act of 2005 was signed into law. The Deficit Reduction Act contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. Consistent with federal and state law, The Arc of Union County is committed to full compliance with federal and state laws, as listed within which may be subject to change, or any other law or regulation that may be enacted related to the administration of federal or state healthcare programs or any other regulation pertaining to false claims and the Deficit Reduction Act of 2005 ("DRA"). This policy enforces procedures to detect and prevent Fraud, Waste and abuse regarding payments from federal or state healthcare programs. The Arc of Union County provides protection for those who report in good faith actual or suspected wrongdoing.

The Arc of Union County does not tolerate making or submitting false or misleading claims or statements to any government agency or payor source. Employees shall be informed that it is illegal to knowingly submit an inappropriate bill to Medicaid or to cause a false claim to be sent to Medicaid.

Direction and timely reporting of misconduct will help maintain the integrity of The Arc of Union County and to preserve its status as a reliable, honest and trustworthy healthcare provider. Furthermore, penalties and sanctions can be reduced by voluntary disclosures of violations of civil, criminal, or administrative law in a timely manner.

SCOPE

This policy shall apply to the Arc of Union County, a.k.a. "the Agency." A New Jersey Nonprofit Corporation. This policy replaces all Agency policies regarding the subject matter contained herein.

PURPOSE

The purpose of this policy is to provide information to each employee, contractor and vendor about: the False Claims Act, Applicable State False Claims Regulations, Applicable protections for Whistleblowers including the Agency's non-retaliation policy, and the Agency's policies to detect and prevent fraud and abuse in Federal or State funded Healthcare Programs.

In accordance with Section 6032 of the Federal Deficit Reduction Act of 2005, we have created policies, procedures, and training materials to make sure everyone understands their roles and responsibilities in helping to prevent and detect Medicaid fraud, waste, and abuse.

Below is a summary of Section 6032, Contact Information for any employee, volunteer, Board Member, vendor or business associate to report any violations and summaries of the pertinent laws and regulations.

FALSE CLAIMS ACT POLICIES / DEFICIT REDUCTION ACT OF 2005, SECTION 6032

The Arc of Union County is a participant in federal health care programs and receives reimbursement from Medicaid agencies for services provided to Medicaid beneficiaries. As an entity that receives payments from Medicaid which meet the requirements under section 6032 of the Deficit Reduction Act of 2005, the Agency is required to comply with certain provisions of the Deficit Reduction Act.

Under the Deficit Reduction Act, the Agency is required by law to establish certain policies and provide all employees with information regarding:

- The federal False Claims Act and similar state laws;
- An employee's right to be protected as a whistleblower; and
- The Arc of Union County policies and procedures for detecting and preventing fraud, waste, and abuse in state and federal health care programs. Further, volunteers, Board Members, outside vendors and business associates are required to learn about and abide by the same provisions of the Deficit Reduction Act.

If an employee, volunteer, Board Member, vendor, or business associate suspects the existence of Medicaid fraud, waste, or abuse, he/she must reach out to one of the following internal or external contacts.

Within the Agency:

- Susan Luckman, Associate Executive Director of Quality, Compliance and Planning: Sluckman@arcunion.org; (973) 315-0070
- Carolyn Scott, Associate Executive Director, Chief of Staff
Cscott@arcunion.org; (973) 315-0008
- Vendors, Contractors and Community can contact the Arc of Union County Compliance Hotline: Dial: (973) 315-0046 or dial extension 2046 from an agency phone or *67 (973) 315-0046 from any phone other than an agency phone and or send an e-mail to: CorporateCompliance@arcunion.org

Retaliation or retribution for reporting issues in good faith is strictly prohibited and enforced at The Arc of Union County.

Reporting Methods outside the Agency:

- NJ Medicaid Fraud Division: 888-937-2835
<https://www.nj.gov/comptroller/divisions/medicaid/complaint.html>
- NJ Insurance Fraud Prosecutor Hotline: 877-55-FRAUD (877-553-7283)
<https://njinsurancefraud2.org#reports>
- Toll-free hotline established by the Federal Office of Inspector General in the U.S. Department of Health and Human Services to report any fraud, waste or abuse involving Medicare or other health care program involving only federal funds. That hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to <https://oig.hhs.gov/fraud/report-fraud/>

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1. Federal False Claims Act, 31 U.S.C.3729-3733

The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal Government (tax fraud excepted). In summary, the Act prohibits:

- a. Knowingly presenting, or causing to be presented to the Government a false claim for payment;
- b. Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the Government;
- c. Conspiring to defraud the Government by getting a false claim allowed or paid;
- d. Falsely certifying the type or amount of property to be used by the Government;
- e. Certifying receipt of property on a document without completely knowing that the information is true;
- f. Knowingly buying Government property from an unauthorized officer of the Government, and;
- g. Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

Any individual or entity engaging in any of the seven categories of prohibited actions listed in 31 U.S.C. 3729(a), including the submission of false claims to federally funded health programs, shall be liable for a civil penalty which currently is not less than \$14,308 and not more than \$28,619, plus three times the amount of damages (treble damages) sustained by the Federal Government. The amount of penalties is adjusted periodically for inflation in accordance with a federal formula.

The U.S. Attorney General may bring an action under this law. In addition, the law provides that any “whistleblower” may bring an action under this act on his own behalf and for the United States Government. These actions, which must be filed in U.S. District Court, are known as “qui tam” actions. The Government, after reviewing the complaint and supporting evidence, may decide either to take over the action, or decline to do so, in which case the whistleblower may conduct the action. If either the Government or the whistleblower is successful, the whistleblower is entitled to receive a percentage of the recovery. If prosecuted by the Federal Government, these qui tam actions are generally handled by the various U.S. Attorney’s Offices, or by the U.S. Justice Department.

Whistleblower Protections:

31 U.S.C. 3730(h) provides that any employee who is subject to retaliation or discrimination by an employer in the terms and conditions of employment because the employee lawfully sought to take action or assist in taking action under this act “shall be entitled to all relief necessary to make the employee whole.” This includes reinstatement with seniority restored to what it would have been without the retaliation or discrimination, double the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the employer’s actions, including litigation costs and reasonable attorney’s fees.

2. Federal Program Fraud Civil Remedies Act, 31 U.S.C. 3801-3812

Provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are \$14,308 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

3. New Jersey Medical Assistance and Health Services Act

Criminal Penalties, N.J.S. 30:4D-17(a)-(d)

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to the Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to \$10,000, imprisonment for up to three years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to \$10,000, imprisonment for up to three years, or both; (c) kickbacks, rebates and bribes: fine of up to \$10,000, imprisonment for up to three years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to \$3,000, or imprisonment for up to one year, or both. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a

In addition to the criminal sanctions discussed in Criminal Penalties of Section 3 above, violations of N.J.S. 30:4D-17(a)-(d) can also result in the following civil sanctions:

(a)unintentional violations: recovery of overpayments and interest; (b) intentional violation: recovery of overpayments, interest, up to triple damages, and, as indicated in section V.D.8 below, a penalty (From \$14,308 to \$28,619) for each false claim as a result of the NJ False Claims Act. Recovery Actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office and can be obtained against any individual or entity responsible for receiving the benefit or possession of the incorrect payments. In addition to recovery actions, violations can result in the exclusion of an individual or entity from all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

4. Health Care Claims Fraud Act N.J.S. 2C:21-4.2&4.3; N.J.S. 2C:51-5

Provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

- a. A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime in the second degree, and is subject to a fine of up to five times the monetary benefits obtained, or sought to be obtained and to permanent forfeiture of his license;
- b. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to one year;
- c. A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered, or certified by an appropriate State agency as a healthy care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits five or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least \$1,000. In addition to other criminal penalties allowed by law, such a person may be subject to a fine of up to five times the monetary benefit obtained or sought to be obtained;
- d. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to five times the monetary benefit obtained or sought to be obtained.

5. The Uniform Enforcement Act N.J.S. 45:1-21. b. and o.

Provides that a licensure board within the N.J. Division of Consumer Affairs “may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board” who has engaged in “dishonesty, fraud, deception, misrepresentation, false promise or false pretense” or has “advertised fraudulently in any manner.”

6. N.J. Consumer Fraud Act N.J.S. 56:8-2, 56:8-3.1, 56:8-13, 56:8-14 and 56:8-15

Makes unlawful the use of “any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact”, with the intent that others rely upon it, in connection with the sale, rental, or distribution of any items or services by a person, or with the subsequent performance of that person.

This law permits the N.J. Attorney General, in addition to any other penalty provided by law, to assess a penalty of not more than \$10,000 for the first offense, and not more than \$20,000 for the second and each subsequent offense. Restitution to the victim also can be ordered.

7. Conscientious Employee Protection Act “Whistleblower Act”, N.J.S.A. 34:19-4

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

- a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
- b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of the law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
- c. Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
- d. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:

- (i) is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
- (ii) is fraudulent or criminal; or
- (iii) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

N.J.S.A. 34:19-3.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergent in nature.

8. New Jersey False Claims Act N.J.S.A. 2A:32C-1 et seq

The New Jersey False Claims Act (NJFCA) was enacted in January 2008 and became effective in March 2008. It has similar provisions to the Federal False Claims Act. For example, the Attorney General may bring an action against an individual or entity that makes a false claim. In addition, the NJFCA also allows for individuals to bring a private right of action in the name of the State against wrongdoers and be able to collect a penalty from those wrongdoers. Under the NJFCA, the civil penalties are currently \$14,308 to \$28,619 per false or fraudulent claim.

The NJFCA provides that a person will be liable for the same penalties as under the Federal False Claims Act but to the State of NJ if that person:

- a. Knowingly presents or causes to be presented to an employee, officer, or agent of the State, or to any contractor, grantee, or other recipient of the State funds, a false or fraudulent claim for payment or approval;
- b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;
- c. Conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the State;
- d. Has possession, custody, or control of public property or money used or to be used by the State and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
- e. Is authorized to make or deliver a document certifying receipt of property used or to be used by the State and, intending to defraud the entity, makes or delivers a receipt without completely knowing that the information on the receipt is true;
- f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property; or

- g. 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.

In addition to the above, the NJ False Claims Act has whistleblower protections similar to the ones under the Federal False Claims Act.

9. New Jersey Insurance Fraud Prevention Act (NJIFPA) N.J.S.A. 17:33A-1 et seq

The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.

The NJIFPA makes it unlawful to:

- 1-Present or cause to be presented (including the assisting, conspiring, or urging of another to present) any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing the statement contains false or misleading information concerning any fact or thing material to the claim,
- 2-Conceal or knowingly fail to disclose the occurrence of an event which effects any person's initial or continued right or entitlement to any insurance benefit or payment or the amount of any benefit or payment to which the person is entitled. A violation of this law can subject a person or entity to civil damages equal to three times the amount of damages, tiered money penalties based upon the number of offenses, and a State surcharge. In addition, the law authorizes the State Attorney General to pursue additional criminal penalties.

10. Federal Anti-Kickback Statute (42 U.S.C. 1320a-7b)

The Federal Anti-Kickback Statute (AKS) is a federal law that makes it illegal for anyone to knowingly and willfully offer, pay, solicit, or receive kickbacks, remuneration, or anything of value, directly or indirectly, to influence the referral of federal health care program business, including Medicare and Medicaid. In some industries, it is acceptable to reward those who refer business to you. However, in Federal Healthcare Programs, paying for referrals is a crime. Remuneration includes anything of value, and can take many forms besides cash, such as free rent, expensive hotel stays and meals, tickets to sporting events/concerts/entertainment, computers and supplies, gift certificates, office cleaning, billing, and collection services, etc. A violation of the Anti-Kickback Statute constitutes a "false or fraudulent" claim under the False Claims Act.

Civil penalties: False Claims Act Liability, recoupments, triple damages, civil monetary penalties, exclusion from Federal Healthcare program (such as Medicare/Medicaid).

Criminal Penalties: Fines of up to nearly \$75,000 per violation, and up to five years of federal incarceration per violation

Safe Harbors: There are certain practices and payments that may appear to violate the AKS but are protected under “safe harbor” regulations. A few examples are: payments made for lease of equipment or office space; referrals made as part of a legitimate employment or professional services arrangement; specific payments for health practitioner recruitment. Because there are so many gray areas, it is typically recommended to retain legal counsel before assuming that an arrangement will meet the “safe harbor” provision.

Revisions and Amendments:

The agency shall annually review and consider whether and or how this policy should be revised or amended to better meet its objectives and report substantive finds and recommendations to the agency Board. Questions regarding the interpretation of this policy should be addressed to:

[Arc Human Resources](#) or Cscott@arcunion.org

The Arc of Union County Federal Deficit Reduction Act (FDRA) Statement of Compliance

On February 8, 2006, the Deficit Reduction Act of 2005 was signed into law. The Deficit Reduction Act contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. Consistent with federal and state law, The Arc of Union County is committed to full compliance with federal and state laws, as listed within which may be subject to change, or any other law or regulation that may be enacted related to the administration of federal or state healthcare programs or any other regulation pertaining to false claims and the Deficit Reduction Act of 2005 ("DRA"). This policy enforces procedures to detect and prevent Fraud, Waste and abuse regarding payments from federal or state healthcare programs. The Arc of Union County provides protection for those who report in good faith actual or suspected wrongdoing.

The Deficit Reduction Act applies to employees, associates, vendors, providers and other business partner, vendor, contractor, client, and the community of The Arc of Union County. The Arc of Union County, Inc. is committed to complying with the requirements of the Federal Deficit Reduction Act (DRA) of 2005 and to prevent and detect fraud, waste, and abuse. The DRA requires The Arc of Union County to establish written policies regarding compliance with the federal False Claims Act and certain other laws, which include whistleblower protections and procedures for detecting and protecting against fraud, waste and abuse, as a condition of receiving reimbursement from federal and state health care programs.

False Claims Act (FCA)

As a recipient of Medicaid federal health care program funds, The Arc of Union County is required by law to include in its policies and provide to all employees, associates, agents and contractors, detailed information regarding the federal False Claims Act. This includes applicable state civil and criminal laws intended to prevent and detect fraud, waste, and abuse in federal health care programs.

As an employee, associate, vendor, provider and any other business associate of The Arc of Union County, you are required to adhere to The Arc of Union County's Fraud, Waste and Abuse and the Federal False Claims Act Policy. Please ensure that all applicable personnel within your organization understand and agree to follow The Arc of Union County's Fraud Waste and Abuse Policy when engaging in activities related to their work with The Arc of Union County. Under the False Claims Act, it is a violation to knowingly submit a false claim to the federal government.

Examples of health care fraud that could lead to the submission of false claims to the government are:

- Falsifying billing or medical coding
- Billing for goods or services not medically necessary
- Duplicate billing for items or services
- Submitting bills for services never performed or items never furnished.
- Failing to return overpayments.

The Arc of Union County's Code of Conduct and Ethical Behavior places emphasis on honesty and integrity. All members of The Arc of Union County's community, including vendors, associates and business partners, must comply with federal, state, and local laws and must exercise their duty to prevent fraud, waste and abuse at The Arc of Union County. Such duties include, but are not limited to, reporting all concerns and suspicions regarding instances of fraud, waste, abuse, or suspected false claims act violations to appropriate parties or authorities. The Arc of Union County maintains a corporate compliance program and strives to educate all members of the Arc of Union County's community on fraud and abuse laws, including the importance of submitting accurate claims and reports to federal and state government authorities. Anyone with knowledge of potential fraud, waste, or abuse must report such through any of the following methods:

Vendors, Contractors and the Community can contact the Arc of Union Compliance Hotline: Dial: (973) 315-0046 or internal staff can dial- extension 2046 from an agency phone or *67 (973) 315-0046 from any phone other than their agency phones And or send an e-mail to: CorporateCompliance@arcunion.org

Send electronic mail to: The Arc of Union County's compliance staff, Susan Luckman, Associate Executive Director, Quality, Compliance and Planning at SLuckman@arcunion.org; (973) 315.0070 or Human Resources, Carolyn Scott, Associate Executive Director, Chief of Staff, CScott@arcunion.org; (973) 315.0008.

Call the toll-free NJ Fraud and Abuse Hotline at 1-888-9FRAUD5 (1-888-937- 2835) and report any information about fraud, waste or abuse in Medicaid or NJ Family Care. Callers can either speak to the hotline operator or leave a message if the operator does not answer. Callers do not have to give their name and may receive a reward if their call leads to a recovery. Also, contact the NJ Insurance Fraud Prosecutor Hotline: 877-55-FRAUD

Call the toll-free hotline established by the Federal Office of Inspector General in the U.S. Department of Health and Human Services to report any fraud, waste or abuse involving Medicare or any other health care program involving only federal funds. That hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to <https://oig.hhs.gov/fraud/report-fraud/>

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