Deficit Reduction Act Information

In accordance with the Deficit Reduction Act (DRA) of 2005, the Saint Regis Mohawk Tribe (SRMT) is mandated, as a condition of its participation in the Medical Assistance Program (Medicaid), to establish and disseminate written policies and procedures that inform its employees, contractors, agents and other persons about the following:

- SRMT's internal policies covering the prevention and detection of fraud, waste and abuse in its health care operations;
- the federal False Claims Act and any other similar law un the New York State (NYS) that govern false claims and statements; and
- whistleblower protections under federal and State laws, and SRMT policies.

In light of this mandate, the paragraphs that follow provide an overview of the SRMT's policies and procedures designed to prevent and detect fraud, waste and abuse in tis health care operations. Additionally, a summary of the federal False Claims Act and similar State laws, as well as federal, State laws, and SRMT policies on whistleblower protection are provided.

SRMT Corporate Compliance Plan Summary, Policies and Procedure for Detecting Health Care Fraud, Waste and Abuse

The Saint Regis Mohawk Tribe ("SRMT" or "Tribe") is committed to preventing and detecting fraud, waste and abuse. In support of this commitment, SRMT has established a Corporate Compliance Plan. The purpose of the Corporate Compliance Plan is to establish appropriate controls that will help ensure consistent compliance with the federal, tribal state laws which govern our activities, and to detect violations of the law by employees and others affiliated with the SRMT.

Elements of SRMT's Corporate Compliance Plan relating to Medicaid include:

- A Compliance Officer who is responsible for the day-to-day operations of the Corporate Compliance Plan.
- Written standards of conduct, policies and procedures that describe compliance expectations and promote SRMT's commitment to compliance for all employees, and for vendors, consultants, agents, independent contractors and employees of those entities who furnish or otherwise authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by SRMT.
- Regular, effective education and training programs for all employees whose job descriptions include activities that are subject to the Corporate Compliance Plan.
- Procedures to openly encourage employees to bring attention any situation that may be a violation of law or the Corporate Compliance Plan, and a system that allows for confidential and anonymous reporting of compliance issues or concerns.

- Policies to encourage good faith participation in the compliance program, including policies regarding reporting expectations, and disciplinary policies to address employees who have violated the Corporate Compliance policies.
- Compliance audits and/or other evaluation techniques to monitor compliance and assist in the reduction of potential problem areas.
- A system for responding to, investigating, correcting and reporting compliance issues.
- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program.

A goal of the SRMT Corporate Compliance Plan is to educate appropriate employees along with contractors, agents, and vendors and employees of those entities who furnish or otherwise authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by SRMT with respect to federal, tribal and state laws and regulations with which they must comply. In this regard, the federal Deficit Reduction Act ("DRA") requires SRMT to provide all employees with "detailed information" about:

- the federal False Claims Act
- the federal administrative remedies associated with the False Claims Act
- New York State laws pertaining to civil or criminal penalties for false claims and statements
- whistleblower protections provided under federal and State laws
- the role of federal and State laws in preventing and detecting fraud, waste and abuse

This letter provides you with the information required by the DRA. If you are receiving this letter and you are a contractor, vendor or agent of the SRMT please relay this information to your employees. Please advise them the SRMT's Compliance Plan—Medicaid Program Integrity and Compliance is available at **[insert web address]**. As a contractor, vendor or agent of the SRMT who handles Medicaid health care items or services or are involved in monitoring health care you must abide the Tribe's Medicaid Program Integrity and Compliance Program.

Federal and New York Statutes
Filing False Claims

Numerous federal and State laws prohibit health care providers from submitting "false" or "fraudulent" claims to Medicare and Medicaid and other federally-funded health care programs. Presented below is a listing and description of various federal and State statutes related to the filing of false Medicare and Medicaid claims.

Federal Laws

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

The federal False Claims Act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from Medicare, Medicaid, or other federal health programs. The penalty for filing a false claim is $11,181-$22,363 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claims filer may have to pay the government's legal fees.

The False Claims Act allows private individuals to file lawsuits in federal court, just as if they were federal prosecutors. 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, or 15-25% if the government did participate in the suit.

2. Administrative Remedies for False Claims, 31 U.S.C. 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 $11,181 for each claim. The agency may also recover twice the amount of the claim.

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.

New York State Laws

New York false claims laws fall into two categories: administrative and civil laws; and criminal laws. Many of the laws overlap. Some apply to recipient false claims, and some apply to provider false claims.

The New York False Claims Act allows private individuals to file lawsuits in State court. If the suit eventually concludes with payments back to the State, the person who started the case can recover a percentage of the proceeds based on whether the State did or did not participate in the suit.

2. Social Services Laws 145-c. 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 person's needs or the person's family's needs are not taken into account for six months if a first offense, 12 months if a second (once if benefits received are $1,000 - $3,900), 18 months if a third (or once if benefits received are over $3,900) and five years for four or more offenses.

3. 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

A. Administrative and Civil Laws

1. New York False Claims Act (State Finance Law 187-194). The New York False Claims Act is similar to the federal False Claims Act. It imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from Medicaid or other State or local health care programs. The potential penalty for knowingly filing a false claim is (1) $6,000 - $12,000 per claim, (2) payment of three times the State's damages, (3) payment of three times the damages sustained by any local government, and (4) payment of the State's legal fees.

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 five 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.

B. Criminal Laws

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. 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 any false or fraudulent claim for furnishing services, knowingly submits false information in order 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.

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. It has been applied to Medicaid fraud cases.

a. Fifth degree petit larceny involves property of any amount. It is a Class A misdemeanor.

b. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

c. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

d. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

e. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

4. Penal Law Article 175, False Written Statements. Four crimes in this Article relate to filing false information or claims that have been applied in Medicaid fraud prosecutions.

a. 175.05, Falsifying business records in the second degree 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 intent to defraud the State or a political subdivision. It is a Class E felony.

5. Penal Law Article 176, Insurance Fraud. Article 176 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.

6. Penal Law Article 177, Health Care Fraud. Article 177 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 the 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 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 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 aggregate. It is a Class B felony.

Whistleblower Protection

1. 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 (1) is in violation of a law that creates a substantial and specific danger to the public health and safety; or (2) has committed health care fraud (as defined in Penal Law Article 177). 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 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.

2. New York Labor Law 741. A health care 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 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. Federal False Claims Act (31 U.S.C. 3730(h)) and New York False Claims Act (State Finance Law 191). An employee who is "discharged, demoted, suspended, threatened, harassed or in any manner discriminated against" because of the employee's lawful acts under the federal or New York False Claims Act is entitled to reinstatement, double back pay with interest, special damages, litigation costs and reasonable attorneys' fees.

If you become aware of any compliance issues or have any questions regarding the information contained in this letter, please contact ~~Natalie Hemlock,~~ the SRMT Corporate Compliance Officer, at ~~natalie.hemlock@srmt-nsn.gov~~corporatecompliance@srmt-nsn.gov or 518-358-2272 ext 2231.