Mental Health Association of Rockland County
Connecting people. Educating families. Rebuilding lives.

Fraud Waste and Abuse Prevention Plan

The Mental Health Association of Rockland County, Inc. (MHAR) is committed to the highest possible standards of trustworthy conduct while ensuring a workplace environment that promotes openness, fairness, productivity, and teamwork. It is the policy of the MHA to consistently and fully comply with all laws and regulations pertaining to the billing for services under Medicaid, Medicare, and other New York State (NYS) and federal government programs. This policy: 1) ensures compliance with the Federal False Claims Act and relevant NYS laws regarding false claims and statements and 2) provides assurance that the employee will be protected from retaliation, reprisals, or victimization for conveying such information appropriately and in good faith.

This plan is intended to supplement, not replace, Human Resources policies or routine operational procedures. MHA requires that all staff comply with applicable federal and state laws and regulations. Staff shall receive training on these laws, which are summarized below, and should consult with the Director of Corporate Compliance (who may confer with legal counsel, as needed) if they have questions about the application of these laws to their job.

Federal False Claims Act 31 USC §§3729-3733

The Federal False Claims Act provides for penalties and damages for anyone who knowingly submits or causes the submission of false or fraudulent claims to the United States for government funds. The Act defines knowingly to 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. Examples include:

a. Knowingly presenting a false or fraudulent claim for payment or approval;
b. Knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved;
c. Conspiring with another to get a false or fraudulent claim paid or allowed;
d. Knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

Regarding Medicaid, specific examples of false claims include:

a. Submitting claims to Medicaid for services not actually rendered;
b. Submitting inaccurate or incomplete cost reports to Medicaid;
c. Double billing for services;
d. Documenting for services not rendered.

There is no requirement that there be intent to defraud.

New York False Claims Act (state Finance Law, § 187-194) (2013)

The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes penalties on parties that file false and fraudulent claims for payment from any state or local government, including Medicaid. Penalties are $6,000 – $12,000 per claim and the recoverable damages are three times the value of the amount falsely received including consequential damages sustained by state or local government.

The law also allows for qui tam lawsuits by individuals.

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 $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

There are additional civil, administrative, and criminal laws that apply to the submission of a false claim. Additional information on these laws is available by contacting the Corporate Compliance Officer.

Plan of Action

All claims submitted for payment to Medicaid, Medicare, third party or clients are to be accurate and appropriate to services provided. The Finance Department will maintain Procedure Manuals for each entity program. These manuals also include information relating to federal and state regulatory requirements. MHA will strive to ensure truth, accuracy, and conformity to all pertinent Federal and State Laws and Regulations. MHA prohibits any employee from presenting or causing to be presented claims for payment or approval which are false, fictitious, or fraudulent whether knowingly or recklessly. It is the policy of the MHA to:

- Use diagnosis-related information listed on the billing form that accurately reflects the client's condition.
- Bill only for services provided, as documented in the client's case record or other supporting documentation.
- Use billing codes that accurately reflect the level and type of service provided; Seek payment for only those services that are medically necessary; and conform to generally accepted methods of practice.
- Prepare and maintain all claims according to generally accepted accounting principles and regulations established by Medicaid, Medicare, and other payers.

Finance staff are oriented and trained as needed in proper billing and coding procedures. Clinical staff are oriented and trained in clinical medical record keeping duties as per the Policy and Procedures manual for each respective program.