



Hackensack
Meridian Health

Origination Date: 12/2007
Effective: 02/2021
Last Approved: 02/2021
Last Revised: 02/2021
Next Review: 02/2024
Owner: *Daniel McManus: Compliance Officer North*
Policy Area: *Admin 1500 Legal Issues*
Applies To:
Applicability: *Hackensack Meridian Health Network*

Fraud, Waste and Abuse Prevention, Detection and Resolution – DRA Compliance

Policy

It is the policy of Hackensack Meridian *Health* to obey all federal and state laws, to implement and enforce procedures to detect, prevent and respond to fraud, waste and abuse regarding payments to Hackensack Meridian *Health* from federal or state healthcare programs, and to provide protections for those who report actual or suspected wrongdoing.

Hackensack Meridian *Health* policy "Fraud, Waste and Abuse Prevention, Detection and Resolution - DRA Compliance" supersedes and replaces:

Hackensack University Medical Center policy "Fraud, Waste, and Abuse Prevention, Detection and Resolution - DRA Compliance, 1521", Meridian policy "Compliance with False Claims Act - MH-COMPLY-001", Palisades Medical Center policy "Compliance with Applicable Federal and State False Claims Acts", The Harborage policy "Compliance with Federal and State False Claims Laws" and JFK Medical Center policy "False Claims Liability and Anti-Retaliation Protections".

Purpose

To satisfy the requirements of Section 6032 of the Deficit Reduction Act of 2005 by communicating certain federal and state laws relating to liability for false claims and statements; protections against reprisal or retaliation for those who report actual or suspected wrongdoing; and Hackensack Meridian *Health* policies and procedures to detect, prevent and respond to fraud, waste and abuse.

Scope

Unless otherwise noted in the policy, applicability is to all Hackensack Meridian *Health* affiliated facilities and providers (collectively "Hackensack Meridian *Health*" or "HMH"), including but not limited to, hospitals, ambulatory surgery centers, outpatient imaging centers, home health agencies, long term care facilities, physician practices, and all Corporate and affiliated Departments.

Administration

The Senior Vice President, Chief Compliance Officer will be responsible for the implementation and subsequent revisions to this policy.

Procedure

To assure that Hackensack Meridian *Health* meets its legal and ethical obligations, obeys all federal and state laws, implements and enforces procedures to detect, prevent and respond to fraud, waste and abuse, HMH has implemented a Corporate Compliance Program. Established in 1998, the program is designed to comply with OIG Compliance Program Guidance for Hospitals. The program operates under the Hackensack Meridian *Health* Compliance Plan and establishes priorities under an annual Work Plan. The Executive Leadership and Board of Trustees of Hackensack Meridian Health oversee the program through regular reports.

In order to effectively implement the Compliance Program, HMH requires that any team member who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste or abuse, take the following steps:

1. Report such information immediately to his/her supervisor by following the chain of command. Team members may also report such concerns directly to the Hackensack Meridian *Health* Compliance Officer at 848-888-4472 or through the organization's ComplyLine which is available either by phone at 1-877-888-8030 or through the web at www.hackensackmeridian.alertline.com.
 - Any team member of Hackensack Meridian *Health* who reports such information will have the right and opportunity to do so anonymously (see HMH Policy "ComplyLine Operations").
 - In addition, the team member will be protected against retaliation for coming forward with such information both under Hackensack Meridian *Health's* internal compliance policies and procedures and Federal and State law (see HMH Policy "Non-Retaliation/Retribution for Reporting; Conscientious Employee Protection Act (CEPA)").
 - However, Hackensack Meridian *Health* retains the right to take appropriate action against a team member who has participated in a violation of Federal or State law or any network or hospital policy (see HMH "Code of Conduct").
2. If a team member believes that Hackensack Meridian *Health* is not responding to his or her report within a reasonable period of time, the team member should bring these concerns about Hackensack Meridian *Health's* perceived inaction to the Senior Vice President, Chief Compliance Officer.
3. Team members should remember that failure to report and disclose or assist in an investigation of fraud, waste and abuse is a breach of the team member's obligations to Hackensack Meridian *Health* and may result in disciplinary action (see HMH "Code of Conduct").
4. Team members may also report concerns to the New Jersey Medicaid Fraud Division at 888-937-2835 or <https://www.nj.gov/comptroller/divisions/medicaid/complaint.html> or the New Jersey Insurance Fraud Prosecutor Hotline at 877-55-FRAUD or <https://njinsurancefraud2.org/#report>.

After a team member report has been filed, Hackensack Meridian *Health* will take action investigate the team member's report based on the information provided. Hackensack Meridian *Health* may request additional information from the team member in order to complete its investigation. Once the investigation is complete Hackensack Meridian *Health* will take all necessary action in order to correct, mitigate and/or report the false claim or report or any other identified fraud, waste, or abuse.

Explanation of Laws: Set forth below are summaries of certain statutes that provide liability for false claims and statements. These summaries are not intended to identify all applicable laws, but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005.

Federal Laws

The Role of Federal and State Laws in Preventing Fraud, Waste, and Abuse: The Centers for Medicare and Medicaid Services (CMS) defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as incidents or practices of providers that are inconsistent with sound medical practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are medically unnecessary. "Waste" is defined as any healthcare spending or practice that can be eliminated without reducing the quality of care and includes incurring unnecessary costs because of inefficient or ineffective practices, systems or controls.

The Federal Government and the State of New Jersey have enacted criminal and civil laws pertaining to the submission of false or fraudulent claims for payment or approval to the federal and state governments and to private payors. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and also provide anti-retaliation provisions for individuals who make good faith reports of fraud, waste and abuse.

A. Federal Civil False Claims Act

The **Civil False Claims Act** (31 USC §3729 *et seq.*) is a statute that imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- conspires to defraud the government by getting a false or fraudulent claim allowed or paid,
- uses a false record or statement to avoid or decrease an obligation to pay the Government,
- and other fraudulent acts enumerated in the statute.

The term "**knowingly**" as defined in the Civil False Claims Act ("FCA") includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and eleven thousand per claim, treble damages, and the costs of any civil action brought to recovery such penalties or damages.

The **Attorney General of the United States** is required to diligently investigate violations of the FCA, and may bring a civil action against a person. Before filing suit the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for **Actions by Private Persons** (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume

primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit has the right to conduct the action.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five percent of the proceeds of the action or settlement. If the *qui tam* plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty percent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

Whistleblower Protection and Anti-Discrimination

The Civil False Claims Act also provides for protection for team members from retaliation. A team member who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, back pay plus penalties and interest, and other enumerated costs, damages, and fees.

Hackensack Meridian *Health's* Corporate Compliance Program and Code of Conduct place an affirmative duty on its team members to report actions or behaviors that violate policy and procedure or may violate law in some manner. Team members are encouraged to use chain of command in reporting their concerns, however team members may also report directly to the Corporate Compliance Department or to the Compliance ComplyLine. HMH has embraced a policy of non-retaliation or retribution for reporting of issues.

B. Federal Program Fraud Civil Remedies Act of 1986

The **Program Fraud Civil Remedies Act of 1986** ("Administrative Remedies for False Claims and Statements" at 31 USC §3801 *et seq.*) is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services). These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act. Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when paid.

The term "**knows or has reason to know**" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The authority, i.e., federal department, may investigate and with the Attorney General's approval commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the submission of the claim. The Act allows for **civil monetary sanctions** to

be imposed in administrative hearings, including penalties of five thousand five hundred dollars per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

State Laws

New Jersey

A. The New Jersey False Claims Act

The NJ False Claims Act amends the New Jersey Medicaid Statute, NJSA 2A:32C-1 et seq. and amending 30:4D-17(e), and authorizes the NJ Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections. The act also provides that violations of the NJ False Claims Act give rise to liability under NJSA 30:4D-17(e) and also amends the NJ Medicaid statute to increase the false claim civil penalties under NJSA 30:4D-17(e)(3) to the same level provided for under the Federal False Claims Act, currently between \$11,463 and \$23,331 per false claim.

B. The New Jersey Health Care Claims Fraud Act

Health Care Claims Fraud Act (NJSA 2C:21-4.2 and 4.3; NJS 2C:51-5), provides for automatic permanent forfeiture of health care licenses for those convicted of health care claims fraud in the second degree, and a one-year suspension for those convicted of health care claims fraud in the third degree. The Act also provides for imprisonment of up to 10 years for fraudulent claims submitted for professional services and payment of fines up to \$150,000 or up to 5 times the amount of the fraudulent claim.

C. The New Jersey Medical Assistance and Health Services Act

The criminal provisions of the **NJ Medical Assistance and Health Services Act** (NJSA 30:4D-17 (a) – (d)) provides for the imposition of penalties not more than \$10,000 or imprisonment of not more than 3 years or both, for a conviction of willfully receiving, in the case of recipients, or payments in the case of providers, to which a person is not entitled.

The civil provisions of the **NJ Medical Assistance and Health Services Act** (NJSA 30:4D-7 (h) and NJSA 30:4D-17(e) – (i)) allows for the repayment with interest on any amounts received as a result of unintentional violations and are liable to pay up to triple damages between \$11,463 and \$23,331 per false claim when violations of the Medicaid statute are intentional, or when there is a violation of the New Jersey False Claims Act. Participants engaging in civil violations may be excluded from participation in Medicaid and other health care programs under NJSA 30:4D-17.1(a).

Check amounts 10,957/21,916

D. The Uniform Enforcement Act

The Uniform Enforcement Act (NJS. 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 as engaged in "dishonesty, fraud, deception, misrepresentation, false promise or false pretense:, or has "advertised fraudulently in any manner."

E. New Jersey Consumer Fraud Act

The NJ Consumer Fraud Act (NJS. 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.

F. The New Jersey Insurance Fraud Prevention Act

The New Jersey Insurance Fraud Prevention Act (NJSA 17:33A-1 et seq.) 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; or (2) conceal or knowingly fail to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to any insurance benefit of payment or the amount of any benefit or payment to which the person is entitled. A violation of the New Jersey Insurance Fraud Prevention Act can subject a person or entity to civil damages equal to three times the amount of damages; penalties of \$5,000 for the first offense, \$10,000 for the second offense and \$15,000 for each subsequent offense; and a surcharge paid to the state of \$1,000 or five percent (5%) of an out-of-court settlement. In addition, the New Jersey Insurance Fraud Prevention Act authorizes the Attorney General to pursue additional criminal penalties.

G. False Claim for Payment of a Government Contract

Another New Jersey state statute (NJSA 2C:21-34a) makes it a crime to: i) knowingly submit to the government any claim for payment for performance of a government contract knowing that the claim is false, fictitious or fraudulent; and ii) knowingly make a material representation that is false in connection with the negotiation, award or performance of a government contract. The criminal penalties for violations of this statute vary from a crime in the fourth degree to a crime in the second degree depending on the amount of the claim.

New York

In accordance with New York State Office of the Medicaid Inspector General Compliance program requirements, some Hackensack Meridian *Health* providers/entities may also be under the jurisdiction of New York State specific laws. The following list is not meant to be all inclusive.

Civil and Administrative Laws

A. New York False Claims Act

The New York False Claims Act (State Finance Law § 191) is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs. The NY FCA also has similar provisions to the Federal FCA in regards to reverse false claims, actions by private individuals and whistleblower protections.

B. Social Services Law

1. Section 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 ten thousand dollars per violation. If repeat violations occur within five years, a

penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

2. Section 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 his 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 one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

Criminal Laws

A. Social Services Law

1. Section 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. Section 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 a 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.

B. Penal Law

1. 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. 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.

3. Article 176 - Insurance Fraud

This law applies to claims for insurance payments, 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.

4. Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute. This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes five crimes.

- a. Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.
- b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
- c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
- d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.

- e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

Other Whistleblower Protections

A. Enhancement of Contractor Employee Whistleblower Protections

The Enhancement of contractor protection from reprisal for disclosure of certain information (41 USC §4712) applies to all employees of a contractor, subcontractor, grantee, or subgrantee or personal services contractor of Federal contracts and grants. It states that employees may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant to one of the following:

- A Member of Congress or a representative of a committee of Congress.
- An Inspector General
- The Government Accountability Office.
- A Federal employee responsible for contract or grant oversight or management at the relevant agency.
- An authorized official of the Department of Justice or other law enforcement agency.
- A court or grand jury.
- A management official or other employee of the contractor, subcontractor, or grantee who has the responsibility to investigate, discover, or address misconduct.

Any team member who believes he or she has been subjected to retaliation or reprisal as stated above may submit a claim to the Inspector General of the governmental agency involved. The team member will have all rights and remedies afforded by Federal Law.

B. Conscientious Employee Protection Act "Whistleblower Act"

The NJ Conscientious Employee Protection Act (NJSA 34:19-1 et seq.) affords protection to whistleblowers by prohibiting an employer from taking any retaliatory action against a team member who:

- 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;
- Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of 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
- 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.
- 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.

- Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
 - 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;
 - is fraudulent or criminal; or
 - is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. NJSA 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.

C. 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 health care 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.

D. 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 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.

References:

Deficit Reduction Act of 2005, S. 1932 (February 8, 2006)
Enhancement of Contractor Protection From Reprisal For Disclosure of Certain Information (41 USC §4712)
Federal False Claims Act, 31 U.S.C. §3729 – 3733
Federal Program Fraud Civil Remedies Act, 31 U.S.C. § 3801 – 3812
New Jersey Medical Assistance and Health Services Act – Criminal Penalties, NJSA 30:4D-17(a) – (d)
New Jersey Medical Assistance and Health Services Act – Civil Remedies, NJSA 30:4D-7.h.; NJS 30:4D-17(e) – (i); NJS 30:4D-17.1.a.
Health Care Claims Fraud Act, NJSA. 2C:21-4.2 and 4.3; NJS 2C:51-5.
Conscientious Employee Protection Act, NJSA 34:19-1 et seq.
New Jersey False Claims Act, P.L.. 2007, C. 265
Uniform Enforcement Act, NJS 45:1-21 b and NJS 45:1-21 o
New Jersey Consumer Fraud Act, NJS 56:8-2, NJS 56:8-13; NJS 56:8-14, NJS 56:8-15
False Claims for Payments of a Government Contract, NJ Rev Stat §2C:21-34
New Jersey Insurance Fraud Prevention Act, NJSA 17:33A-1 et seq.
New York Labor Law, Sections 740 and 741
New York False Claims Act (State Finance Law §§ 187-194)
New York Social Services Law, Sections 145-b, 145-c, 145, 366-b
New York Penal Law, Articles 155, 175, 176, 177

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Thomas Flynn: SVP Chief Compliance Officer	02/2021
	Daniel McManus: Compliance Officer North	02/2021

Applicability

Bayshore Medical Center, Carrier Clinic, HMH Nursing & Rehabilitation, Hackensack Meridian Health Inc., Hackensack University Medical Center, Home Health and Hospice, JFK Medical Center, JFK Medical Center EMS, Jersey Shore University Medical Center, Legacy Meridian Health, Ocean University Medical Center, Old Bridge Medical Center, Palisades Medical Center, Physician Services Division, Raritan Bay Medical Center, Riverview Medical Center, Southern Ocean Medical Center, System Search Engine (All Sites)