Fraud Laws and Deficit Reduction Act Notice Policy

Policy Number: M111103166

Effective Date: 1/1/2007

Sponsoring Department: Compliance, SIU, Legal

Impacted Department(s): All Independent Health, and its affiliated organizations (Nova, Reliance Rx, PBD, WNY Collaborative Management Services LLC)

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☒ Corporate (All)
☐ State Products, if yes which plan(s): ☐MediSource; ☐MediSource Connect; ☐Child Health Plus; ☐Essential Plan
☐ Medicare, if yes, which plan(s): ☐MAPD; ☐PDP; ☐ISNP;☐CSNP
☐ Commercial, if yes, which type: ☐Large Group; ☐Small Group; ☐Individual
☐ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☒ No☐

Purpose and Applicability:

The purpose of this policy is to educate and explain the Federal and State laws about false and fraudulent claims and the penalties associated with such claims. The Federal Deficit Reduction Act of

2005 (“DRA”) requires Independent Health to provide information to its workforce regarding federal and state laws, dealing with health care fraud, waste, and abuse.

Policy:

Independent Health has a comprehensive **fraud, waste,** and **abuse** program which is led by its Special Investigations Unit (SIU) and is designed to detect, correct, prevent and report potentially illegal and fraudulent practices. One facet of Independent Health’s comprehensive fraud, waste, and abuse program provides **workforce members** and **contingent workers** and their employees with detailed, educational information about a few of the fraud, waste, and abuse laws we are required by law to follow. Collectively, these laws and rules create a framework for Federal and State Governments to detect and prevent fraud, waste and abuse in the health care system and to protect the individuals and entities who provide information to the Government about such fraud, waste and abuse. .

If you are a workforce member of Independent Health, information about these laws is provided during onboarding training and annually thereafter. Additional information can be obtained by contacting the Legal Department or Special Investigations Unit. Independent Health's fraud, waste and abuse related policies and business processes are posted on SharePoint Online InsideIH. Workforce members who believe they have encountered fraud, waste, abuse, or a violation of law or any questionable activity are required to report it to the Special Investigations Unit at 1-800-665-1182. See the Fraud Prevention and Reporting Policy (#A990901029).

If you are a **contingent worker** of Independent Health or an employee of a contingent worker of Independent Health, this information is provided to you to comply with Section 6032 of the United States Deficit Reduction Act of 2005, certain Medicare laws, rules, regulations and requirements under the Medicare Part D Program, as well as other Federal and State laws. If you believe you have encountered **fraud, waste, and abuse** related to your business dealings with Independent Health, we request you report the information to us by contacting Independent Health’s SIU at 1-800-665-1182. If you would like more information about the laws described in this document, please consult with your attorney.

REPORTING

Independent Health has contracted with a third party (Report It) to facilitate our compliance, ethics and fraud, waste, and abuse hotline. This service allows for any concerned party (workforce members, members, business partners, vendors, first tier related entities) to report actual or suspected issues or concerns of fraud, waste and abuse, noncompliance, misconduct, retaliation, intimidation, wrong-doing and ethical concerns confidentially and anonymously. The confidential and anonymous helpline may be accessed 24/7/365 by calling 1-877-229-4916 or via web access at http://reportit.net with the username IHA and password redshirt. See the Mechanisms for Reporting Noncompliance and Corrective Action Policy (#A990801007).

Federal Laws:

Federal False Claims Act:

Sets forth liability for any person who knowingly submits a false claim to the government or causes another to submit a false claim to the government or knowingly makes a false record or statement to get a false claim paid by the government.

- **Types of False Claims:**
  - **Direct False Claims:** A civil lawsuit can be brought by the United States Government against any person who knowingly makes a false claim to obtain money or property, any part of which is provided to the Government directly or indirectly to a person, agent or contractor of the Government, a grantee of the Government or a recipient of any money or property from the Government.
  - **False Records:** A civil lawsuit can be brought by the United States Government against any person who knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim. The word "material" means having a natural tendency to influence, or be capable of influencing the payment or receipt of money or property. In order to make its case, the Government does not have to demonstrate a direct connection between the false record or statement and the Government's payment of a claim. In addition, a person or entity can be held responsible for damages in the amount of $50,000 for each false record or statement.
  - **Underpayments:** A civil lawsuit can be brought by the United States Government against any person who knowingly makes underpayments to the Government.
  - **Certifications:** A civil lawsuit can be brought by the United States Government against any person who, with intention to defraud the Government, certifies receipt of Government money or property without completely knowing that the receipt is true and correct.
  - **Improper Property Transfers:** A civil lawsuit can be brought by the United States Government against any person who knowingly buys or receives as a pledge of an obligation or debt, public property from an officer or employee of the United States Government, who lawfully may not sell or pledge property.
  - **Overpayments:** An overpayment means a health plan receives funds under the Medicare or Medicaid program and, after appropriate reconciliation; it retains them even though it is not entitled to do that. Under the Federal False Claims Act, Independent Health is obligated to report and return Overpayments to the Secretary of the United States Department of Health and Human Services, New York State, a Government intermediary, carrier or contractor within 60 days of the date the overpayment was identified or the date any corresponding cost report is due, if any. When Independent Health returns an overpayment, it is obligated to include a written statement indicating the reason why the overpayment is being returned. A civil lawsuit can be brought by the Government against any person who knowingly retains an Overpayment when there was an obligation to repay the Government. This part of the False Claims Act is often referred to as a "reverse false claim." See Reporting and Returning Overpayment Policy # A20150512027 for additional information.
  - **Anti-Kickback Law Claims:** The Anti-Kickback Law is discussed in more detail later in this policy under the heading entitled "Federal Health Care Program Anti-Kickback Law." There are

times when a violation of the Anti-Kickback Law will also be considered a violation of the Federal False Claims Act. Penalties will be assessed under both Federal laws.

- **Stark Law**: The Stark Law prevents the practice of a physician referring a patient to a medical facility (e.g., hospital, lab, etc.) in which the physician or the physician's immediate family member may have a financial interest, be it ownership, investment, or a structured compensation arrangement. This type of arrangement may encourage over-utilization of services which in turn drives up health care costs.
- **Conspiracy:** A lawsuit can also be brought against any person who conspires with another person or entity to commit any of the acts just described in this section.

- **Important Definitions in the Federal False Claims Act:**
  - A "claim" means any request or demand, whether under a contract or otherwise, for money or property and regardless of whether the Government has title to the property that is presented to the Government or to a Government contractor, grantee or other recipient if the money or property is going to be spent on the Government's behalf or in a way that advances any Government program or interest. This is an extremely broad definition.
  - Knowingly" means the person:
    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 for the truth or falsity of the information.
  - To make a case against an individual or entity, the Government only has to prove that the **fraud** against the Government occurred. The Government does not have to prove the person or entity had a specific mental state or intention to defraud the Government.

- **Damages under the Federal False Claims Act*:***
  An individual can be held responsible for damages for: up to three times the amount of the damage the Government sustains plus mandatory penalties ranging from $5,000 to $10,000 (these penalty ranges can be adjusted for inflation) plus the costs of any civil lawsuit brought against him or her by the Government.

- **Some examples of potentially problematic activities under the Federal False Claims Act*:***
  - Knowingly falsifying records that are then used to get a false claim paid (please note, the potential penalty for this type of violation is $50,000 for each false record or statement).
  - Double billing.
  - Submitting bills for services that were never performed.
  - Retention of an overpayment where there is an obligation to repay.
  - Inaccurately reporting or certifying data in bids and rate proposals.
  - Using inaccurate data to support reported claims experience and loss ratios.
  - Failing to correctly report rating or discounts for similarly sized subscriber groups under

Federal Employee Health Benefits (FEHB).

- Falsely certifying compliance with Medicaid Managed Care marketing or other program requirements.
- Manipulating provider or **vendor** dealings to distort reported claims experience in our government programs.
- Making any false statement, omission or misrepresentation in any application, bid or contract to participate in Medicare Advantage, Medicare Part D plan or Medicaid Managed Care (please note, the potential penalty for this type of violation is $50,000 for each false statement or misrepresentation and not more than three times the total amount claimed for each item or service for which payments were received and was based on the application which contained the false statement).

- **Administrative Remedies for False Claims and Statements:**
  Another false claims provision that works together with the Federal False Claims Act is the **Program Fraud and Civil Remedies Act**. This provision expands the damages listed above so that a person who knowingly submits a false claim is liable for a civil penalty of up to $5,000 for each false claim submitted and may also be subject to an "assessment" of up to twice the amount of each false claim submitted. The United States Attorney General's Office is responsible for investigating the allegations, filing the action, holding hearings, issuing subpoenas and collecting the penalties assessed.

- **Federal False Claims Act Qui Tam Lawsuits:**
  The Federal False Claims Act allows "qui tam" actions. These lawsuits are brought on behalf of the Government by a workforce member, a contingent worker or one of Independent Health's agents who knows about the fraud. The individual sues as an individual and on behalf of the Government. The individual who brings the lawsuit is called a "whistleblower" or a "qui tam relator."

  - **How this works:** The individual files a lawsuit on behalf of the Government in a federal district court "under seal." "Under seal" means the lawsuit will be confidential when the Government investigates it and decides whether to join in the lawsuit. If the Government joins in the lawsuit, the lawsuit will be directed by the United States Department of Justice. If the Government does not join the lawsuit, the individual will continue to lead the lawsuit.
  - **When:** Qui tam lawsuits must be filed by the individual within six years of the alleged violation or no more than three years after the date the Government knows or reasonably should know about the alleged violation, but in no event more than 10 years after the violation was committed.
  - **Awards:** If the Government joins in the lawsuit and the lawsuit is successful, the individual may receive between 15% and 25% of the proceeds of the lawsuit. If the Government does not join in the lawsuit and the lawsuit is successful, the individual may receive between 25% and 30% of the proceeds.

- **Special Protections:** In addition to the financial awards provided to the individual, the Federal False Claims Act strives to make the individual whole and provide them with all relief necessary, such as reinstatement with the same seniority status, two times the amount of back pay (plus interest) and other special compensation due to the employer's retaliatory conduct (or the business partner's retaliatory conduct) against the individual for filing the qui tam lawsuit, such as litigation costs and reasonable attorney's fees.

Anti-Kickback Statute and Safe Harbors:

The Anti-Kickback Statute is a criminal law that prohibits the knowing and willful offer, payment or solicittion of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Both the recipient of the remuneration and the individual or entity who offers the remuneration is subject to the Anti-Kickback Statute.

- **Remuneration:** Remuneration means any kickback, bribe, discount, rebate made in cash or in kind, regardless of whether it was paid directly, indirectly, overtly or covertly. The Government defines the word remuneration very broadly. Remuneration that is intended to induce referrals is banned and so is remuneration that is intended to induce the purchasing, leasing, ordering or arranging for any good, facility, service or item paid for by a Federal health care program. Besides the Anti-Kickback Statute, the beneficiary inducement statute also imposes civil monetary penalties on insurers who offer renumeration to Medicare and Medicaid beneficiaries to influence them to enroll.

- **Exceptions:** Because of the broad reach of the statue the Government has issued regulations that create a list of practices that do not violate the Anti-Kickback Statute, these practices are commonly referred to as "safe harbors." Safe harbors are narrow exceptions to the Anti-Kickback Statute's prohibited practices which specify various payment and business practices are not subject to sanctions under the statue. If you would like more information about the Anti-Kickback Statute's safe harbors, please contact an attorney in the Legal Department. If you are a **contractor/vendor** of Independent Health, please consult with your attorney. For additional information on safe harbors, see "OIG's Safe Harbor Regulations." The safe harbors cover a small number of payment practices such as:

  - The waiver of coinsurance and deductible amounts under certain specific conditions.
  - Giving incentives to individuals to promote the delivery of preventive care.
  - Remuneration which promotes access to care and which poses a low risk of harm to patients and Federal health care programs.
  - Offering or transferring coupons and rebates or other retailer rewards for free or less than fair market value if certain conditions are met,
  - Offering or transferring items or services for free or less than market value if: (a) they are not offered through an advertisement, (b) they are not tied to an item or service that is reimbursable under a federal or state health care program, (c) there is a reasonable

connection between the items or services offered and the individual's medical care, (d) the individual receiving the item or service is in financial need,

- As of January 1, 2011, the waiver of any copayment for the first prescription fill of a generic drug that is covered by Medicare Part D.

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- **Damages:** Kickbacks in health care can lead to Overutilization, increased program costs, corruption of medical decision making, patient steering, and unfair competition, to name a few. The Government does not need to prove harm or financial loss to the programs to show a violation of the AKS occurred. Violating the Anti-Kickback Statute (AKS) is a felony that can result in hefty fines (up to $50,000 per kickback plus three times the amount of the remuneration), prison time, and Program Exclusion. A person or entity can be held criminally and/or civilly liable for violating the Anti-Kickback Statute. The criminal penalty is a fine of up to $25,000 and/or imprisonment of up to five years. On the civil side, a person or entity can be required to pay the Government up to three times the amount of the total remuneration offered, paid, solicited or received plus a $50,000 fine for each violation of the Anti-Kickback Statute.

Medicare Overpayment Provisions:
See the Reporting and Returning Overpayment Policy #A20150512027.

Self-Reporting Violations:
As a contractor of the United States Department of Health and Human Services ("HHS") Centers for Medicare and Medicaid Services ("CMS") for various Medicare products, Independent Health is obligated to report to the HHS Office of the Inspector General in writing and send a carbon copy to the CMS official in charge of Independent Health's contract with CMS when it has credible evidence that one of its workforce members or Medicare-related subcontractors has violated:

- Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations in Title 18 of the United States Code; or
- The Federal False Claims Act.

When making such reports to the Government, Independent Health shall mark each page of its written report as "Confidential."

Federal Audits:
Federal law permits the HHS to audit Independent Health for potential violations of a variety of Federal fraud laws, regulations, and rules. If Independent Health does not grant the Government timely access to our facilities, records, and systems so they can perform their audits, investigations and evaluations, Independent Health can be subject to a penalty in the amount of $15,000 per day.

New York State Law

New York False Claims Act

- A civil lawsuit can be brought by the New York State Attorney General and or any local Government against any person who does any of the following activities:

- Knowingly presenting a false claim to the State or a local Government or a Medicaid Managed Care plan.
- Knowingly making use of a false record to receive payment from the State or a local Government or a Medicaid Managed Care plan.
- Conspiring to defraud the State or a local Government by getting a claim paid.
- Delivering, or causing to be delivered, to the State or a local Government less property or money than the amount for which a person receives a Certificate of Receipt, with an intent to defraud or willfully to conceal the property or money.
- Making or delivering, with intent to defraud, a certifying receipt to the State or local Government without completely knowing that the information on the receipt is true.
- Knowingly buying or receiving as a pledge of an obligation or debt, public property from a State officer or employee knowing that the property may not be lawfully sold or pledged.
- Knowingly making, using, or causing to be used a false record or statement to conceal, avoid or decrease an obligation of money or property to the State or a local Government.

- **Damages:** The person can be held responsible for damages for: (1) a civil penalty of $6,000 to $12,000 paid to the State, (2) three times the amount of damages the State suffers ("treble damages"), (3) three times the amount of damages any local Government suffers; and (4) the cost of any civil lawsuits and attorney's fees brought to recover any such penalties and damages. A court may reduce treble damages to double damages if: (1) the violator furnishes all information to the officials who are investigating the violation within 30 days of the violator obtaining that information; (2) the violator fully cooperates with the Government's investigation; and (3) at the time the violator provides the information, no criminal, civil or administrative action had begun and the violator did not have actual knowledge of any investigation.

- **New York False Claims Act Qui Tam Lawsuits:**
  Similar to the Federal False Claims Act, the State False Claims also allows "qui tam" actions. These lawsuits are brought by an individual who knows about the fraud. This individual is called a "whistleblower" or a "qui tam relator." The Government works with the individual and decides whether to get involved in the lawsuit.
  - **How this works:** The individual files a lawsuit in New York State Supreme Court, a trial level court of law. The individual's complaint is "sealed" and kept confidential for at least 60 days. During that period of time, the Government will investigate the complaint and decide whether to get involved in the case. The Government may either: (1) take over the case completely and re-file the lawsuit in the name of the State of New York; (2) join in the lawsuit and help the individual who filed the lawsuit; or (3) decide not to participate at all. If the Government joins in the case, the Government will try the case to its completion or settle the case. The court will determine if a settlement is fair before it is finalized.
  - **When:** Qui tam lawsuits must be filed by the individual within six years of the violation or three years after the date facts that are material to the case are known or reasonably should have been known to the Government official charged with the responsibility to act in the

circumstances, whichever occurs last. In no event may the lawsuit be brought later than 10 years after the violation was committed.

- **Awards:** If the Government gets involved in the lawsuit and the lawsuit is successful, the individual is entitled to 15%-25% of the total recovery or the settlement. If the Government does not get involved in the lawsuit and the lawsuit is successful, the individual is entitled to 25%–30% of the total recovery or the settlement. The court may also award reasonable costs and expenses, including attorney's fees. An individual's recovery may be reduced to 10% of the proceeds of the lawsuit or a settlement if the court finds that the lawsuit was based mainly on disclosures from someone other than the individual who started the lawsuit which are connected to allegations in a criminal, civil or administrative hearing or in a legislative or administrative report, hearing audit, or investigation or from the news media.
- **Anti-retaliation Protections:** If an employer discharges, demotes, suspends, threatens, harasses or is otherwise discriminated against one of its employees for filing a State False Claims Act lawsuit, the employee is entitled to all relief necessary to put the person in the position he or she was in before the discrimination. For example, the employee may be entitled to reinstatement to a position he or she would have had if the discrimination did not occur or two times the amount of back-pay. An employee may file another lawsuit to get the relief needed to make him or her whole. See the Non-retaliation and Non-intimidation Whistleblower Protection Policy (#A030414073) for additional information.

Unacceptable Practices Under Medicaid:

New York State law makes knowingly submitting a false statement and claim a Class A misdemeanor under the New York State criminal law. New York law also lists certain prohibited practices for companies and individuals involved in providing benefits or services to Medicaid recipients. The unacceptable practices include, but are not limited to:

- Making false claims for medical care or services
- Making false statements relating to claims for payment for medical services or supplies
- Failing to disclose information about the right to payment
- Taking a medical assistance payment and using it for something other than medical assistance
- Taking bribes and kickbacks and inappropriate referrals
- Unacceptable recordkeeping practices
- Submitting claims or accepting payments for medical care, services or supplies offered by a person who is not qualified to participate in the Medicaid program
- Receiving additional payments for services or supplies for which a Medicaid claim has been made
- Deceiving a Medicaid recipient in any way
- Furnishing excessive medical care, services or supplies to a Medicaid recipient
- Any conspiracy to do any the activities listed above; and

- Unlawful discrimination against a Medicaid recipient.

Medicaid Overpayment Provisions:
See the Reporting and Returning Overpayment Policy #A20150512027.

Fraud Against a Health Plan:
New York State criminal law contains specific provisions about fraud against health plans. To be guilty of healthcare fraud against a health plan, a person must do the following:

- Act with intent to defraud a health plan
- Knowingly and willfully provide materially false information or omit information to request payments from a health plan for a healthcare item or service; and
- Actually receive a payment he or she or another person is not entitled to receive.

NON-RETALIATION AND NON-INTIMIDATION

Independent Health will not retaliate or engage in intimidation tactics against any workforce members who reasonably believe and in good faith make reports of known or suspected wrong-doing, non-compliance, violations of any corporate policy or any illegal or fraudulent action or participates in/with an organizational investigation pertaining to alleged wrong-doing or non-compliance, or who assists appropriate authorities in investigating possible wrong-doing or non-compliance, will not suffer intimidation, harassment, discrimination or other retaliation, including any adverse employment consequences. All workforce members are provided a copy of this information within 90 days of hire and annually thereafter. See the Non-retaliation and Non-intimidation Whistleblower Protection Policy (#A030414073) for additional information.

Definitions

Abuse is any incident or practice of a provider, physician or supplier which, although not usually considered fraudulent, is inconsistent with accepted and sound medical, business or fiscal practices and directly or indirectly results in services that fail to meet professionally-recognized standards of care or, in some cases, may be medically unnecessary.

Contingent workers: are external resources, not employed by Independent Health Association, its subsidiaries or affiliated organizations which include: Temporaries (including interns), Consultants, independent Contractors, Vendors and Board Members.

Fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity, or to some other party.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system.

Workforce Member means Independent Health's employees, officers, directors, board members, contingent workers, and volunteers who provide substantial services, who perform services on behalf of Independent Health and its subsidiaries and affiliates.

References

Related Policies, Processes and Other Documents

- Fraud Prevention and Reporting Policy # A99090129
- Fraud Prevention Plan
- Non-Retaliation and Non-Intimidation Whistleblower Protection Policy # A030414073
- Reporting and Returning Overpayment Policy # A20150512027
- Mechanisms for Reporting Noncompliance and Corrective Action Policy #A990801007
- Corporate Code of Conduct and Ethics
- Corporate Compliance Plan
- Independent Health Associate Handbook

Regulatory References

- Deficit Reduction Act of 2005, Pub. L. No. 109-171, §6032, 120 Stat. 4 (2006) (codified as 42 U.S.C. §1396a(a)(68)(2006))
- Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, § 4, 123 Stat. 1617 (2009) (codified as 31 U.S.C. §§ 3729, 3730(h), 3732(c), 3733 (2009))
- Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§§6402, 6408, and 10606, 124 Stat. 119 (2010) (codified as 42 U.S.C.§1320a-7K(d), 42 U.S.C. §1320a-7(b)(16) (g) and (h), 42 U.S.C. §1320a-7a(a)(8) and (9), (i)(6)(F)-(I), 18 U.S.C. §1347(b)).
- Section 14 of the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93
- 28 C.F.R. § 85.3
- 31 U.S.C. § 3729, et. seq.
- 31 U.S.C. § 3730, et. seq.
- 31 U.S.C. § 3801, et. seq.
- 42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7a(a)(5), 1320a-7a(a)(7), 1320a-7b(b), 1320a-7b(f)
- 42 U.S.C. §§1395 nn
- 42 C.F.R. §411.350 - §411.389
- 42 C.F.R. § 422.326 and 423.360
- 42 C.F.R. § 422.503(b)(4)(vi)
- 42 C.F.R. § 423.504(b)(4)(vi)
- 42 C.F.R. § 1001.952, et. seq.
- 48 C.F.R. §52.203-13(b)(3)

- N.Y. State Fin. Law § 187-194
- N.Y. Soc. Serv. Law § 366-b and 145-b(4)
- 18 NYCRR § 515.2
- N.Y. Penal Law §§ 177.00 – 177.30
- N.Y. Lab. Law § 740
- NPCL § 715-b

Version Control

Sponsored By:
Name sponsor: John Mineo
Title of sponsor: Executive Vice President, General Counsel
Signature of sponsor: Click here to enter text.

Revision Date	Owner	Notes
12/16/2008	Compliance	N/A
1/1/2012	Compliance	N/A
1/1/2012	Compliance	N/A
8/13/2013	D. Odrzywolski	Reviewed, no changes
3/3/2015	D. Odrzywolski	Updated per NPCL 715-b and ACA Overpayment Provisions
3/1/2016	D. Odrzywolski	Revised, minor changes
11/17/2016	D. Odrzywolski	Revised, added anonymous hotline
1/1/2017	D. Odrzywolski	Reviewed, minor changes
1/1/2018	D. Odrzywolski	TBD
1/1/2019	N. Britton	Reviewed, formatting changes
1/1/2020	N. Britton	Reviewed, no changes
1/1/2021	N. Britton	Reviewed, notation of impacted departments
1/1/2022	N. Britton	Reviewed, updated impacted departments
1/1/2023	N. Britton / S. Caulfield	Reviewed, updated references, consolidated non-retaliation and overpayment content, updated AKS section and safe harbor reference