CP Rochester
Opening Doors. Enriching Lives.

happiness HOUSE
What happens here changes lives forever.

Rochester Rehabilitation
Work. Wellness. Independence.

Corporate Compliance Program

Approved by the Board of Directors on 7/26/17
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CORPORATE COMPLIANCE PROGRAM

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I. Introduction

Ability Partners, Inc. (API) was formed as a passive parent corporation, formally affiliating CP Rochester, Happiness House, and Rochester Rehabilitation Center as three subsidiaries of API; however, all three agencies continue to operate as separate corporations. They have common executive and operational leadership, and have aligned their Corporate Compliance Programs.

CP Rochester, Happiness House and Rochester Rehabilitation have established a Corporate Compliance Program and Code of Conduct to demonstrate our commitment to the highest standards of ethical behavior and practices in all areas of business connected with our agencies. The intent of this Program is to promote ethical behavior in the workplace and reduce the likelihood of abuse, fraud, unethical conduct, and health care violations. The program was implemented to emphasize the agencies' policy and commitment to those we serve and who are associated with the agencies, as well as to ensure compliance with Federal and New York State health care laws. The Corporate Compliance Program clearly defines the agencies' focus and expectations regarding quality service delivery, as demonstrated by the agencies' Mission, Vision, and Guiding Principles. This Program is established for the agencies' board members, employees, vendors, contractors, volunteers, student interns, physicians, independent contractors and other agents. The agencies' commitment to ethical and legal business practices is essential to the advancement of their Visions and Missions.

II. Mission & Vision Statements

CP Rochester

- **Mission**

  CP Rochester supports individuals of all ages and abilities to determine their own pathway in life. We partner with the individual, their family, and the community to fulfill the individual's right to live a productive and rewarding life. CP Rochester provides a wide range of quality health, educational, and support services in the greater Rochester area to assist individuals in achieving their goals.

- **Vision**
  We envision a community where people of all abilities lead rewarding lives. Meaningful partnerships are nurtured to ensure all doors are open and opportunities are available for everyone.

- **Guiding Principles**
  Our staff and volunteers will **RISE** to the high expectation of CP Rochester by following these Guiding Principles:
  - **R**espect the abilities, talents, and contributions of all people in our daily interactions.
  - **I**ntegrity is evident in everything we do.
  - **S**ervice through partnership with individuals, families, and the community to achieve goals and aspirations.
  - **E**xcellence is demonstrated through superior quality and fiscal responsibility.

Happiness House

- **Mission**
  Happiness House is an educational, residential, health and human service organization that excels in providing the highest quality, innovative and cost effective services to children and adults with and without disabilities through collaboration with families and partners throughout the Finger Lakes community. Our belief in the principles of equal opportunity, independence and realization of individual potential is the cornerstone of who we are and what we do. We believe "What Happens Here Changes Lives Forever."

- **Vision**
  We envision every community being ready to welcome and utilize the talents and abilities of all individuals. With the financial support of the Ability Partners Foundation, Happiness House will play a significant leadership role in making this a reality. We will lead by an unwavering commitment to our consumers and their families, as well as by our cumulative skill and wisdom as a premier provider of services. Our practice of quality leadership and service provision will be based upon:

- **Our Core Values**
  - **C**ommitment to the integration of community resources to create opportunities for lifelong learning and development
  - **R**espect for the dignity and self-worth of each individual
  - **E**ducational, recreational, residential and clinical services that are empowering, individualized and family centered
  - **E**xcellence in service provision
  - **D**evelopment and recognition of our consumers, employees and all others whose lives we touch

Rochester Rehabilitation

- **Mission**
  To maximize each person's ability to lead a full and active life by providing the highest quality services that foster physical and mental wellness, employment, and independence.

- **Values**
  - Deliver extraordinary customer service
  - Build open and honest relationships through communication
  - Create a collaborative and caring team environment
  - Hold ourselves and each other accountable for excellence
  - Strive for continuous improvement

III. Purpose

CP Rochester, Happiness House, and Rochester Rehabilitation have established this Corporate Compliance Program to ensure that the organizations maintain the highest level of honest, professional and ethical behavior in all aspects of their delivery of services and contacts with employees, individuals, third party payers, independent contractors and agents of the organization. The intent is to implement and enforce a Corporate Compliance Program that will detect, prevent and disclose misconduct. The Corporate Compliance Program is written in accordance with the recommendations of the New York State Office of the Medicaid Inspector General and is authorized by the Agency's Board of Directors. The agencies will continually strive to provide the highest level of care and service and will utilize the Corporate Compliance Program and related policies and procedures in achievement of these goals. The Corporate Compliance Officer and the Corporate Compliance Committee will make every effort to establish and implement systems which will assist each employee's ability to understand and adhere to this Compliance Program, and the complex laws and regulations that govern our business. The Program provides a process for resolution if a compliance issue does occur.

The agencies' Corporate Compliance Program is updated periodically to reflect the mandated elements set forth by the codes, rules and regulations of the State of New York, the Office of the Medicaid Inspector General (OMIG), and the Office of Inspector General (OIG). This program was developed by the following seven elements:

1. Establishment of policies and procedures that describe compliance expectations and promulgation of a Code of Business Conduct for employees and other agents of CP Rochester, Happiness House and Rochester Rehabilitation.
2. Designation of a Corporate Compliance Officer (CCO) vested with responsibility for the day-to-day operations of the compliance program, and a Corporate Compliance Committee, which is responsible for coordinating with the CCO to ensure the implementation and overall effectiveness of the Compliance Program.
3. Compliance training and education for all employees and agents of the organizations on compliance expectations and responsibilities.
4. Development and implementation of effective lines of communication for reporting potential violations of compliance standards, policies or procedures, and responding to inquiries. This includes a method for anonymous and confidential good faith reporting.
5. Establishment of disciplinary policies and standards to address potential violations and encourage good faith participation in the compliance program, including setting expectations for reporting compliance issues and the consequences of violations of the Code of Conduct.
6. Ongoing monitoring and auditing to identify potential violations and reduce compliance risk areas.
7. Establishment and implementation of a system for responding promptly to compliance issues as they are raised, and for investigating and correcting potential compliance problems.

To obtain further information or guidance about CP Rochester, Happiness House, or Rochester Rehabilitation's Corporate Compliance Program, please contact the Corporate Compliance Officer at (585) 334-6000.

IV. Element 1: Standards of Conduct and Written Policies and Procedures

A. Code of Conduct

Introduction

CP Rochester, Happiness House, and Rochester Rehabilitation's Code of Conduct describes the core values and beliefs of the agencies and provides the foundation for all business conduct. The Code of Conduct is designed as a commitment to uphold the highest standards of ethical behavior and practices in all areas of business connected with our agencies. All parties shall comply with all applicable laws and regulations that affect its various programs. All parties are obligated to observe and follow the Code of Conduct. Our agencies provide training related to the Code of Conduct and the Corporate Compliance Program to employees, Board members, contractors, and volunteers. Should their behavior conflict with this code, the agencies will undertake appropriate disciplinary measures.

This Code applies to employees, members of the Board of Directors, volunteers, contractors and other agents of the agencies.

The Board of Directors has appointed the Director of Compliance as the Corporate Compliance Officer for CP Rochester, Happiness House and Rochester Rehabilitation. If there are doubts about whether agency conduct is consistent with the agencies' high ethical standards, employees, volunteers, and other agents of the agencies may contact the Corporate Compliance Officer at (585) 334-6000 or the Corporate Compliance Hotline at (585) 334-6000 x2981.

All employees and agents have a duty to report any known or suspected violation of this Code, including any violation of laws, rules, regulations, practices or policies that apply to the agencies. Reporting a known or suspected violation of this Code will not be considered an act of disloyalty, but an action to safeguard the reputation and integrity of our agencies, the employees and the individuals we serve.

Please see Attachment A for the full Code of Conduct.

B. Policies and Procedures

Our agencies' policies and procedures identify the expectations of conducting business, at all times, in a manner that supports the integrity of its operations, and promotes the agencies' commitment to compliance. Policies and procedures provide guidance to employees and others on dealing with potential compliance issues, including identifying how to communicate potential compliance issues to appropriate personnel, and how potential compliance issues are investigated and resolved. All employees are able to access the Corporate Compliance Program, the Code of Conduct, and policies and procedures via each agency's shared network drive. The Corporate Compliance Program and the Code of Conduct are also available via each agency's website. Employees, Board members, and other agents of the agencies may request an electronic or paper copy of the Corporate Compliance Program, Code of Conduct, or policy at any time.

C. The False Claims Act

Our agencies take issues regarding false claims and abuse seriously. Our agencies encourage all members of the Board of Directors, employees, contractors or agents of the agencies to be aware of the laws regarding fraud and abuse and false claims and to identify, report and assist the agency in resolving any issues immediately. Issues are resolved quickly and most efficiently when given prompt attention at the program/department level.

The Federal False Claims Act imposes liability on any person or entity who:

- Knowingly files a false or fraudulent claim for payment or approval;
- Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim;
- Conspires to have a false or fraudulent claim paid by the federal government; or
- Knowingly uses or makes a false record or statement to an obligation to pay or transmit money or property to the government.

Under 31 USC §3729 (b) the term "knowingly" means that a person, with respect to information, 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. The government does not have to show proof of specific intent to defraud in order for a violation of the FCA to be found.

A person or entity found liable under the False Claims Act is, generally, subject to civil monetary penalties of between $11,000 and $22,000 per claim and three times the amount of damages that the government sustained because of the illegal act.

Under the False Claims Act individuals with knowledge of potential violations may file suit on behalf of the government in federal court. These individual, known as "qui tam relators," may be entitled to a percentage of the amount recovered by the government. The False Claims Act also provides protection from retaliation and discrimination for individuals that bring action in good faith under this law.

The New York False Claims Act is modeled after the Federal False Claims Act. This Act provides liability for knowingly presenting a false claim or record for payment from any state or local government. Violators of the Act can be subject to civil penalties of $6,000 to $12,000 per claim as well as three times the amount of damages that the government sustained because of the illegal act. As with the Federal False Claims Act, individuals with knowledge of false claims may bring action on behalf of the state or the local government. They are entitled to a percentage of the proceeds collected and are protected from retaliation and discrimination.

If you suspect that any activity may be considered a violation of the federal or state law, you should report it immediately to your immediate supervisor (Manager/Director/VP) as appropriate. If the supervisor (Manager/Director/VP) is not deemed to be the appropriate contact or if the supervisor (Manager/Director/VP) fails to respond quickly and appropriately to the concern then the reporting individual should report the concern to the Corporate Compliance Officer at 585-334-6000 or through the Corporate Compliance Hot Line (585) 334-6000 ext. 2981 for CP Rochester, (315) 781-1932 ext. 7171 for Happiness House, and (585) 286-9221 for Rochester Rehabilitation.

Please see Appendix B for additional information on the False Claims Act and New York State Labor Law, Section 740 and New York State Labor Law, Section 741.

Whistleblower Policy Statement

The Agencies want to prevent all fraud and abuse associated with billing claims. To ensure an environment where employees feel secure to disclose concerns with the agencies' practices, said employees will be offered whistleblower protection as defined by the Federal and New York State False Claims Acts.

The Federal False Claims Act provides protection to qui tam relators or whistleblowers (individuals who commence a False Claims action). Federal law prohibits employers from retaliating against employees who file suits on behalf of the government under this act. New York law also provides protection to qui tam relators. This law prohibits employers from retaliating against an employee for disclosing or threatening to disclose 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.

CP Rochester, Happiness House, and Rochester Rehabilitation are committed to encouraging all Agency employees, Board members, contractors, volunteers and all other agents of the agencies to report in good faith actual or potential violations of the law, Agency policies and/or the Agency's Code of Conduct. The organizations are devoted to safeguarding reporters from intimidation or retaliation of any kind for active, good faith participation in the compliance program. Reports may be made by an employee, contractor, Board member, volunteer or any other agent confidentially and anonymously in writing, by telephone, in person, or via the Hotline without fear of retaliation. Any employee who commits or condones any form of intimidation or retaliation will be subject to disciplinary action, up to and including termination.

The Agencies encourage individuals to report concerns to their immediate supervisor (Manager/Director/VP) as appropriate. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the reporting individual should report the concern to any Director, Vice President, the Corporate Compliance Officer, or through the Corporate Compliance Hot Line.

V. Element 2: Designation of a Corporate Compliance Officer vested with responsibility for the day to day operation of the compliance program, and designation of a Compliance Committee

A. Role of the Board of Directors

The Board of Directors has adopted a resolution authorizing the implementation of a Corporate Compliance Program and the appointment of a Compliance Officer. The Board of Directors appoints a representative to participate in the activities of the Corporate Compliance Committee. This representative shall report the actions of the Corporate Compliance Committee to the Board following each attended meeting. The Board will also respond to reports of potential or actual non-compliance received from the Compliance Officer, President, or Corporate Compliance Committee.

The Agencies have a diverse Board of Directors whose combined knowledge and talents support the agencies in achieving their mission and vision. A Conflict of Interest Disclosure Statement will be completed by Directors and Officers prior to their appointment and annually thereafter. The Agencies

prohibit any attempt by Directors who have a conflict to influence the deliberations or voting on the matter where the conflict exists. In accordance with the Revitalization Act, when a Director (board member) or administrator (officer and key employee) has a conflict of interest or commitment, they will recuse themselves from the board room/meeting room for the entirety of the conversation and actions associated with the topic.

B. Role of the Corporate Compliance Officer

The Corporate Compliance Officer is primarily responsible for the oversight of agency-wide regulatory compliance and ensuring that employees adhere to the Compliance Program and to the Code. The Compliance Officer maintains current regulatory resources, oversees the day to day operations of the Compliance Program and the activities of the Corporate Compliance Committee, and assures decisive action on issues of potential and actual non-compliance.

The Corporate Compliance Officer shall:

1. Oversee and monitor the adoption, implementation and maintenance of the Agency compliance program.
2. Ensure that the Corporate Compliance Program is reinforced through ongoing communications and that all employees have access to the Corporate Compliance Program.
3. Collaborate with the Training Department and Directors to ensure that all employees receive training as it relates to corporate compliance, billing requirements (documentation and service delivery), the Code of Conduct policy and False Claims Act.
4. Oversee compliance monitoring, internal auditing and risk assessments of programs.
5. Respond to alleged violations of rules/regulations/policies related to corporate compliance activities by performing an investigation of the situation.
6. Monitor the Compliance Hotline.
7. Review and revise the compliance program, the policies and procedures and standards of conduct, to incorporate changes to federal, state laws, rules, regulations policies, and standards.
8. Report directly, no less than quarterly, to the Board of Directors, CEO, and Corporate Compliance Committee (CCC) on the progress of adopting, implementing, and maintaining the compliance program.

C. Role of the Corporate Compliance Committee

The Agencies have established oversight authority for the Corporate Compliance Program through the Corporate Compliance Committee. This committee is committed to supporting all agency staff and agents in meeting the standards set forth in the Corporate Compliance Program.

i. Duties

The role of the Corporate Compliance Committee is to advise and assist the Corporate Compliance Officer with the implementation and the overall effectiveness of the Agencies' compliance plan. This includes coordinating with the CCO to ensure written policies and procedures and standards of conduct are current and accurate; training topics required are completed; and coordinating with the CCO to ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or any other function/activity required. The Committee will also assist with ensuring that the Agencies have effective systems and processes in place to identify compliance program risks, overpayments and

other issues, and effective policies and procedures for correcting and reporting such issues. The Committee will also support adoption and implementation of required changes to the compliance program.

The Compliance Committee will meet at least once every two months to review the status and effectiveness of the Corporate Compliance Program, present and discuss potential compliance concerns and issues, and recommend changes and/or improvement opportunities to the respective service areas. Representatives of the Board of Directors shall participate as members of the Agencies' Corporate Compliance Committee and shall report corporate compliance activity back to the full Board of Directors at the next scheduled Board meeting.

Principle Responsibilities:

1. Reviews policies and procedures and recommends them to the Board of Directors for adoption.
2. Reviews revisions to existing policies and procedures and recommends them for adoption.
3. Reviews any corporate compliance investigations and Plans of Correction.
4. Reviews Annual Risk Assessments
5. Monitors Risk Reduction Plans.
6. Reviews the results and findings of all internal and external audits and investigations, including recommended Plans of Correction.
7. Monitors Plans of Correction until their completion.
8. Reviews annual survey results.
9. Monitors Plans of Quality Improvement.
10. Makes additional recommendations to Plans of Correction, Risk Reduction Plans, Plans of Quality Improvement, the Annual Quality Assurance Work Plan, and the Corporate Compliance Program to ensure effective and ethical business practices at the agency.
11. Promotes a culture of ethics and integrity for all employees and service partners.
12. The Board Liaison to the Committee reports back to the Board of Directors.

ii. Members

The Committee is comprised of personnel from each of the following departments: Administration, Human Resources, Clinic, Finance and Program Services.
Membership:
Members of the Board of Directors
Vice President/COO
VP of Finance/Billing Manager
Corporate Compliance Officer (CCO)
Vice President of Human Resources
Director of Clinical Services

The Corporate Compliance Plan is structured to provide a direct reporting line to the President of the Agencies. Any concerns about the Corporate Compliance Committee members, the Committee's actions/determinations or about the senior administration are brought directly to the Agency President.

iii. Role of Outside Legal Counsel

The role of outside legal counsel secured by the Agencies is to assist the Board of Directors, President, the Executive Management Team, the Corporate Compliance Officer and the Corporate Compliance Committee as needed to identify and interpret applicable federal and state laws and regulations, to assist in the maintenance of the Compliance Program, and to

provide legal advice to the Agencies with respect to any aspect of the Corporate Compliance Program.

Outside legal counsel may be notified at the discretion of the President or Compliance Officer of occurrences that have the potential of confirmed non-compliance. Following the complete investigation of the occurrence by the Corporate Compliance Officer, the results of the investigation will be reviewed by legal counsel to provide legal advice to the Agencies.

VI. Element 3: Training and Education Agency Employees and Service Partners.

The Agencies are committed to providing education and training to all employees, independent contractors, the Board of Directors and other agents, as determined by the President/designee, on the organizations' policies and procedures to detect and prevent fraud, waste and abuse. Corporate Compliance training will be designed to optimize each employee's knowledge, understanding and ability to implement all parts of the Corporate Compliance Program. Each employee and Board member will be trained annually. The education provided will include, but is not limited to:

- The Agency's risk areas and organizational experience
- Compliance Policies and Procedures including the Code of Conduct and expectations
- Reporting responsibilities and options, including protection for intimidation and retaliation for good faith participation in the compliance program
- Whistleblower protections and the false claims act
- The investigation process, including response to compliance issues and implementation of corrective action plans
- Disciplinary standards, specifically standards related to the required provider's compliance program and prevention of fraud, waste and abuse
- Requirements specific to the Medicaid program and the agency's categories of service
- The role of the Corporate Compliance Officer (CCO) and Compliance Committee

The Board of Director's training will also include information regarding their responsibilities for oversight.

All employees will receive training on how to perform their job tasks in compliance with the standards of the agency and all applicable regulations. All employees will understand their role in the operation of the Agency Compliance Program, including reporting responsibilities and options, and that those employees who violate the standards and procedures may be subject to disciplinary measures up to and including termination.

Initial employee training will be a standard component of the agency's monthly new-employee orientation training process, and a quiz will be taken at the conclusion of each training session to ensure that all new employees are fully aware of the components of the Compliance Program. Current employees will receive ongoing/annual training to ensure knowledge and comprehension of current laws, regulations and policies. Training will also occur upon any changes in the program or at the request of a supervisory staff. All employees will be required to acknowledge in writing that they agree to comply with the Code of Conduct and expectations. Contractors will also complete compliance training no less than annually.

The Compliance Program will be made available to all employees and agents of CP Rochester, Happiness House, and Rochester Rehabilitation.

Licensing and Credentialing
All employees who are in positions requiring professional licenses must provide the Human Resources Department with proof of a current license at the time of application or contract negotiations and a renewed license prior to the expiration date. Human Resources will maintain all verifications of employee licenses.

The Board of Directors appoints the Medical Director. The Medical Director will review all applications and credentials for medical staff and will provide them privileges. The Director of Outpatient Clinical Services will ensure that credentials are obtained and are filed for review. Medical staff are re-credentialed every two years.

Medicaid Exclusion Verification Process
The Agencies will perform an exclusion check prior to: hire, entering into a contract, purchasing, filling an order for service, extending an invitation to be on the Board of Directors or beginning volunteer service. Monthly exclusion checks will be completed thereafter. All current employees, volunteers, potential and existing board members, contractors, physicians and ordering practitioners, and vendors will be subject to the exclusion checks.

The following sites will be utilized by all parties when conducting the monthly exclusion checks:

- https://omig.ny.gov/search-exclusions
- https://exclusions.oig.hhs.gov/
- General Services Administration's (GSA) System for Award Management (SAM): Excluded Parties

If a potential employee is determined to be an ineligible individual, the individual will no longer be eligible for hire. If a current employee, vendor or contractor is determined to be ineligible, all services provided by and payments to the vendor/contractor will immediately cease. If a practitioner has been excluded from federal or state healthcare programs, the services or goods will not be billed to Medicare or Medicaid. If a Board member is determined to be ineligible they will immediately step down from their position on the Board of Directors.

VII. Element 4: Communication Lines to the Compliance Officer to allow compliance issues to be reported.

The Agencies are committed to ensuring that all corporate compliance issues are reported and are promptly investigated in as confidential a manner as possible. All Agency employees, volunteers, contractors, members of the Board of Directors and any other concerned person who believes that there is a violation of the Code of Conduct, Compliance Guidelines, operational policies or any law or regulation that pertains to business practices or billing are responsible for reporting the violation, in good faith, to the Corporate Compliance Officer. The Agencies are committed to promoting honest and ethical behavior in all work-related activities; therefore, all individuals involved with the complaint and/or investigation are reminded that confidentiality during an investigation is paramount in ensuring the investigator has access to untainted information.

The agency is devoted to safeguarding reporters from intimidation, retaliation or retribution of any kind for good faith reporting and active participation in the Compliance Program. This includes reporting of potential compliance concerns and reporting instances of intimidation or retaliation. Confidentiality of persons reporting compliance issues or concerns will be maintained, to the greatest extent possible, unless the matter is subject to a disciplinary proceeding, has been referred to, or is under investigation by MFCU, OMIG, or law enforcement, or disclosure is required during a legal proceeding, during the investigation and follow up of any suspected violation, as allowable by law.

The Agencies provide concerned persons with multiple options for reporting concerns:

1. Compliance Hotline: allows concerned persons to leave a voice mail message for the Compliance Officer. The caller should provide the nature of the concern as well as any evidence. The caller may choose to identify themselves or leave the message anonymously.
   CP Rochester: Call the Corporate Compliance Hotline at (585) 334-6000 ext. 2981
   Happiness House: Call the Corporate Compliance Hotline at (315) 789-6828 ext. 7124
   Rochester Rehabilitation: Call the Corporate Compliance Hotline at (585) 286-9221

2. Written Notice to the Compliance Officer: The Corporate Compliance Issue Report is provided to employees at the time of initial training and annually thereafter. The form is also available on the agency drive in the forms folder. Although use of the form is encouraged for written reports the form is not mandatory and any notice to the CCO will be handled appropriately. Employees using written notification are encouraged to provide the following information: the nature of the concern, the individual(s) involved, and any evidence regarding the concern. The employee may sign this form or submit it anonymously.

3. Direct contact to the CCO via e-mail, phone, and/or face to face visit.

4. Notification to the President/CEO, Chief Operating Officer (COO), Chief Financial Officer (CFO), Program Vice President, or to the Vice President of Human Resources are options when the employee has attempted to reach the CCO but they are not readily available or the employee is uncomfortable contacting the CCO.

5. If an employee is concerned about reporting to executive management and the CCO, they may contact the Board of Directors.

VIII. Element 5: Enforcement of the Corporate Compliance Program, including encouraging good faith participation and disciplinary standards for non-compliant behavior.

The Agencies are committed to the highest level of ethical and legal behavior as it relates to interactions with individuals, families, employees, physicians, third party payors, independent contractors and all other individuals or entities connected to the agencies. The Agencies intend, through the continued implementation of the Corporate Compliance Program, to detect, report, resolve and prevent all violations of the standards and procedures set forth in the Compliance Program. All employees, contractors, and Board members will be held accountable for the understanding and implementation of the Corporate Compliance Program. They will be trained on the Compliance Program, and the policies and procedures that will ensure proper reporting, investigation and follow up for any identified concern. All employees, independent contractors and agents of the Agencies are expected to adhere to the Code of Conduct, policies and procedures, as well as all applicable laws and regulations that affect their various programs.

All employees will understand that whoever violates any part of the agency's compliance program standards and procedures may be subject to disciplinary measures which could include termination from employment. It is the expectation that questions concerning interpretation of any portion of the Compliance Program shall be directed to the Corporate Compliance Officer (CCO), the President/CEO, Chief Operating Officer (COO), Chief Financial Officer (CFO), or Program Administrators.

It is the responsibility of all employees, contractors and agents thereof to understand and comply with any and all aspects of the Corporate Compliance Program.

All confirmed occurrences of non-compliance will be addressed through a well-defined plan of corrective action. It is the responsibility of all Vice Presidents/Directors to implement and monitor all corrective plans of action in their service area or department.

Disciplinary Policy

Employees and independent contractors must adhere to all applicable local, state and federal laws. An employee who violates the Code of Conduct, agency policies, the law, or knowingly permits others to do so, will be subject to disciplinary action, up to and including termination. Contracts will include termination provisions for failure to adhere to the agency's compliance program requirements.

Failure to report compliance concerns and/or cooperate with an investigation or the resolution of compliance concerns, or retaliation against an individual for reporting a potential violation, will result in disciplinary action up to and including termination. Confidentiality during an investigation is paramount in ensuring the investigator has access to untainted information.

The Agencies strive to provide consistency in disciplinary action regardless of the position of the individual involved in the event. The Vice President of Human Resources and the Corporate Compliance Officer are utilized as a resource in the agency's response to events. If a situation arose where the Compliance Officer felt they needed to contact the Board of Directors, this contact would be made through the Chairman of the Board or the Board's Representative to the Corporate Compliance Committee.

If the issue is not resolved through use of counseling or if the situation requires additional disciplinary action, the supervisor will generally impose discipline according to a progressive system, including verbal and/or written warnings, corrective action plans, demotions, administrative leave with or without pay, and termination. The agency does not, however, guarantee that any specific type of discipline will precede any other type of discipline. The agency at all times reserves the right, in its sole discretion, to determine the nature and severity of discipline that is imposed depending on the circumstances. That means that the agency may terminate employment at any time based on the seriousness of the conduct for which an employee is being disciplined.

IX. Element 6: Systems for Routine Identification of Compliance Risk Areas and Routine Auditing and Monitoring

The Agencies are committed to ensuring compliance with standards and with encouraging any reports of substandard conduct. Audits of program areas are completed to monitor and assess the overall quality of programs, to monitor compliance with regulations, identify risk areas, and to evaluate potential or actual

non-compliance. The Corporate Compliance Program for internal audits will assess the appropriateness of services, implement procedures for overseeing the effectiveness of programs, and make recommendations to the program if trends/deficiencies are detected. Our agencies will conduct ongoing auditing and monitoring of identified risk areas related to compliance including but not limited to billing and service provision.

All reports will require follow up and/or a written plan of correction addressing the identified issues and recommendations. In addition, the Corporate Compliance Committee will review the results of these audits. Should any audits identify possible instances of non-compliance with the Agencies' corporate compliance standards, the Corporate Compliance Officer will report the concern to the Agency President.

On an annual basis, the Corporate Compliance Officer will revise the Agency's Quality Assurance Work Plan and determine an audit/assessment schedule based on the identified highest risk areas and/or programs, regulatory requirements, and timing of external audits. This plan is approved by the Corporate Compliance Committee and the Board of Directors.

In addition to a review of billing records to assess compliance, the Corporate Compliance Committee and the Corporate Compliance Officer may direct an assessment of compliance within other areas of the agency. These reviews could include, but are not limited to: a review of past surveys to determine patterns of deficiencies or to verify that corrective action has been implemented; unannounced surveys; and on-site visits.

Risk assessment
An annual risk assessment will be completed by each program area and these will be collated into an agency wide risk assessment. The risk assessment is reviewed by Executive Leadership and a Risk Reduction Plan is then developed. The Board of Directors adopts this plan, and quarterly updates are then provided to the Corporate Compliance Committee.

X. Element 7: System for responding to compliance issues as they are raised, and for investigating potential compliance concerns

To ensure that our business practices remain appropriate, corporate compliance concerns are investigated. Compliance concerns can be reported at any time by an employee, an individual receiving services, or any other concerned person. Compliance concerns may also be identified during the course of an internal audit, external audits, or during the investigation of a secondary issue.

The Corporate Compliance Officer/designee will promptly and thoroughly investigate any suspected violation in a confidential manner so that corrective action can be taken. Investigations will be timely; the length of the investigation is determined by the complexity and volume of the concern. It is the responsibility of the Corporate Compliance Officer and President to determine the need for legal consultation, and such need would then be communicated to the Corporate Compliance Committee. If a violation is proven to have occurred, the Corporate Compliance Officer will recommend decisive steps to agency administration in response to the problem. As appropriate, such steps will involve a written plan of correction from the involved VP/Director, which will detail the return of any overpayments, possible voids for services billed in error, a referral to law enforcement authorities, discipline, retraining, or other corrective action taken, steps to prevent recurrence, future monitoring requirements, and/or a revision to policies and procedures. The Corporate Compliance Committee

reviews investigative reports, Plans of Correction, and regular updates on corrections until the issue has been fully addressed.

There may be times when performance concerns, incidents and a corporate compliance concern overlap. It will be the CCO's responsibility to determine the nature of the complaint and to ensure that it is investigated by the appropriate individual.

XI.

CALL

Your concern is our concern!

Our Agencies are committed to the highest ethical standards and integrity in our business practices.

If you have a concern about the implementation of an agency policy, a potential case of fraud, or know of a situation that may be a violation of the Agency's Corporate Compliance Program, please call the number below to report:

Corporate Compliance Officer: (585) 334-6000 x 1849

Corporate Compliance Hot Line:

- **CP Rochester - (585) 334-6000 x 2981**
- **Happiness House – (315) 781-1932 x 7171**
- **Rochester Rehabilitation (585) 271-2520 x 1234**

All calls are confidential and will be addressed promptly. Anonymous reports are accepted.

XII. Appendix

A. Code of Conduct

Introduction

The Code of Conduct describes the core values and beliefs of the agency and provides the foundation for all business conduct. The Code of Conduct (also known as Standards of Conduct) is designed as a commitment to uphold the highest standards of ethical behavior and practices in all areas of business connected with our agencies. All parties shall comply with all applicable laws and regulations that affect its various programs. All parties are obligated to observe and follow the Code of Conduct. Should their behavior conflict with this code, the agency will undertake appropriate disciplinary measures.

This Code applies to employees, members of the Board of Directors, volunteers, contractors and other agents of the agencies.

The Board of Directors has appointed the Director of Compliance as the Corporate Compliance Officer for CP Rochester, Happiness House, and Rochester Rehabilitation. If you have doubts about whether agency conduct is consistent with our agencies' high ethical standards you may contact the Corporate Compliance Officer at (585) 334-6000 or the Corporate Compliance Hotline at (585) 334-6000 x2981.

All agency employees and agents have a duty to report any known or suspected violation of this Code, including any violation of laws, rules, regulations, practices or policies that apply to our agencies. Reporting a known or suspected violation of this Code will not be considered an act of disloyalty, but an action to safeguard the reputation and integrity of our agencies, the employees and the individuals we serve.

All parties shall:

1. Show proper respect and consideration for each other, individuals, individual's families, and all those whose lives we touch.
2. Respect and protect the rights of individuals.
3. Be honest in performing their jobs.
4. Present themselves in a positive, ethical and professional manner when interacting with those we serve, their families, peers and/or any community members during the performance of their job.
5. Comply with all applicable laws; regulations, standards and other requirements imposed by any level of government.
6. Comply with all requirements of the Medicare and Medicaid programs.
7. Report any abusive treatment they witness immediately. Failure to make such a report will be treated as a serious disciplinary offense.
8. Promptly report all suspected violations of the Code of Conduct, Compliance Guidelines/Plan, operational policies, laws or regulations to the Compliance Officer.
9. Report any unsafe working condition to a Director/Vice President immediately so the situation can be corrected.
10. Only employ or work with persons with proper credentials, experience and expertise to perform their job functions.
11. Observe safe work practices.
12. Maintain the agencies' integrity and reputation.
13. Deliver quality services through the use of qualified, competent employees.
14. Ensure compliance with required/mandatory training.

15. Provide services as defined by the individuals service plans.
16. Respect and protect the confidentiality of individual's records and other personal information. The standards for confidentiality are clearly set in the HIPAA (Health Insurance Portability and Accountability Act) Policies. Any party that obtains information regarding the HIV status of other parties or individuals shall hold that information with the confidentiality defined in the HIV Policy. HIV related information will not be examined, removed, copied, disclosed or discussed with any party unless such party is authorized to access such information pursuant to Public Health Law. An intentional breach of confidentiality concerning any individual(s) may be grounds for dismissal.
17. Ensure confidential information obtained is held in confidence during their tenure and upon leaving the agency.
18. Report any observed misuse of the agencies property to a Director.
19. Only bill for services actually rendered and which are documented in the person's record. If the service must be coded, then only billing codes that accurately describe the services provided will be used.
20. Maintain complete and thorough clinical and billing records. Each employee is expected to check documentation prior to submission to ensure its accuracy.
21. Ensure reports and other information required to be provided to any federal, state, or local government agency is accurate, complete, and filed on time.
22. Take every reasonable precaution to ensure that their work is accurate, timely, and in compliance with federal and state laws and regulations and agency policies.
23. Ensure that no deficiency or error is ignored or covered up. Problems should be brought to the attention of those who can properly assess and resolve the problem.
24. Act promptly to investigate and correct the problem if errors in claims that have been submitted are discovered.

All Parties Shall Not:

1. Participate in unethical or illegal conduct.
2. Accept or provide any gift, favor or entertainment if it will obligate or appear to obligate the person who receives it. Receiving or giving gifts of cash, cash equivalents, or gift cards is never allowed.
3. Abuse, mistreat, or neglect any individual. Should an allegation of abuse, mistreatment, or neglect be made against a party, the agency will take all necessary steps to protect the individual, while completing an investigation.
4. Display discriminatory treatment, harassment, abuse, or intimidation of others.
5. Distribute, sell, possess, purchase, or consume illegal substances or alcohol while working.
6. Come to work, or work if their ability to perform their job is impaired due the use of alcohol, a controlled substance, an illegal substance, a prescribed medication, or over the counter medication.
7. Use the agencies' or *an* individuals' resources for personal or improper purposes, or permit others to do so. Any improper financial gain to the employee through misconduct involving misuse of the agencies or individuals' property is prohibited, including the outright theft of property or embezzlement of money.
8. Reveal or use any confidential information concerning the agencies, for personal gain.
9. Carry firearms or other weapons on the grounds of the facility or while in the capacity of providing services to an individual.

10. Participate in any financial interaction with an individual or their family, which may be construed as exploitation of that individual or result in a greater benefit to the employee or volunteer than the individual.
11. Form inappropriate social relationships with individuals or engage in any form of sexual activity with an individual. Employees are not to supply pornographic or other sexually explicit materials to individuals. In those cases where an individual's treatment plan authorizes presentation of such materials to the individual, employees shall not infringe on the individual's rights to obtain said materials.
12. Borrow or take property from individuals for personal use.
13. Require an individual to carry out the duties of an employee unless such tasks are described in their service plan for the purpose of improving their skills.
14. Pursue any business opportunity that requires engaging in unethical or illegal activity.
15. Submit claims for payment or reimbursement of any kind that is false, fraudulent, inaccurate or fictitious.
16. Falsify any record to include, but not limited to, medical records and recorded time, that are used as the basis of submitting claims. Falsification of records will not be tolerated.
17. Permit any action of retaliation or reprisal to be taken against an employee who reports a violation of law, regulation, standard, procedure, or policy.
18. Solicit or accept personal gratuities, favors or anything of significant monetary value from any third parties when engaging in the award and administration of contracts or other financial awards.

** Violations of any point in the Code of Conduct may result in discipline up to and including termination.

The agency will contribute to an employee's competence by making available continuing job-related education and training within the limits of its resources.

B.
FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§187-194)
2) Social Services Law, Section 145-b - False Statements
3) Social Services Law, Section 145-c – Sanctions

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties
2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
3) Social Services Law, Section 145-c - Sanctions
4) Penal Law Article 175 - False Written Statements
5) Penal Law Article 176 - Insurance Fraud
6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. §3730(h))
2) New York State False Claim Act (State Finance Law §191)
3) New York State Labor Law, Section 740
4) New York State Labor Law, Section 741

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:
§ 3729. False claims
(a) Liability for certain acts.--

2) In general.--Subject to paragraph (2), any person who--

(A) knowingly presents, or causes to be presented, 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 material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the 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 an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000,[1] as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section—

(1) the terms "knowing" and "knowingly" –

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

[1] *The penalties are updated regularly; refer to the Federal False Claims Act for current amounts.*

(ii) acts in deliberate ignorance of the truth or falsity of the information; or
(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or
(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds, that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with

certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

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3) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 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, the agency receiving the claim may impose a penalty of up to $5,500 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also 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.

II. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE 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 upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars[2] per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, 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.

3) Social Services Law, 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.

B. CRIMINAL LAWS

1) Social Services Law, 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) Social Services Law, 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.

[2] *The penalties are updated regularly; refer to the NYS False Claims Act for current amounts.*

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.

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. 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.

4) Penal Law 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.

5) Penal Law 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.

6) <u>Penal Law Article 177 - Health Care Fraud</u>

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 six 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.

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. § 3730(h))

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

2) New York State False Claim Act (State Finance Law § 191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses, or threatens to disclose, 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 or Social Services Law § 145-b. The employee's disclosure is protected only if the employee first raised the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. Employees are also protected from retaliatory action if the employee objects to, or refuses to participate in, any activity that 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 or Social Services Law § 145-b.

If an employer takes retaliatory action against the employee, the employee may sue in State court for reinstatement to the same, or an equivalent position, any back wages and benefits, and attorneys' fees. If the employer is a health care provider and the court finds that the employer's retaliatory action was in bad faith, the court may impose a civil penalty of $10,000 on the employer.

4) New York State Labor Law, Section 741

A health care employer may not take any retaliatory action against an employee if the employee discloses, or threatens to disclose, certain information about the employer's policies, practices, or

activities to a regulatory, law enforcement, or other similar agency or public official, to a news media outlet, or to a social media forum available to the public at large.

Protected disclosures are those that the employee, in good faith, believes constitute improper quality of patient care or improper quality of workplace safety. The employee's disclosure is protected only if the employee first raised 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 a patient, and the employee has a good faith belief that reporting to a supervisor would not result in corrective action. Employees are also protected from retaliatory action if the employee objects to, or refuses to participate in, any activity, policy, or practice of the employer that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

If an employer takes retaliatory action against the employee, the employee may sue in State court for reinstatement to the same, or an equivalent position, any back wages and benefits, and attorneys' fees. If the employer is a health care provider and the court finds that the employer's retaliatory action was in bad faith, the court may impose a civil penalty of $10,000 on the employer.