Masonic Care Community
Resident Care Policy Statement

Title: Corporate Compliance Program

Policy Statement:

This Compliance Program (the "**Program**") reflects commitment to quality of care on the part of Masonic Care Community. As used in this document, unless the context clearly requires otherwise, the name "**Masonic Care Community**" includes the Masonic Care Community of New York Health Pavilion, the Wiley Hall residential adult care facility, the Acacia Certified Home Care Company, and the Acacia Licensed Home Care Company. The term "**MCC Individuals**" refers to all volunteers, employees, managers, chief executives, the governing body members of Masonic Care Community facilities, and any individual who owns at least 5 percent interest in a Masonic Care Community facility. The term "**MCC Contractor"** refers to independent contractors, vendors, or others who provide services to Masonic Care Community or its facilities. MCC Individuals and MCC Contractors are collectively referred to as "**Affected Individuals**".

The Program is applicable to many critical areas and activities, including billing, payments, medical necessity and quality of care, governance, mandatory reporting, and credentialing. For example, implementation of the Program enhances quality of care by facilitating adherence to regulatory standards. Additional purposes of the Program include organizing Masonic Care Community resources to resolve compliance issues as quickly and efficiently as possible. In compliance with §6032 of the Deficit Reduction Act of 2005 ("DRA"), this Program also documents the Masonic Care Community's policies and procedures for detecting and preventing fraud, waste and abuse in federal health care programs.

Masonic Care Community is dedicated and committed to meeting high ethical standards and compliance with all applicable laws and in all activities regarding the operation of Masonic Care Community. This commitment and dedication is essential to Masonic Care Community meeting its mission and is critically important because a significant portion of Masonic Care Community's services are reimbursed through governmental and third-party payor programs which require that Masonic Care Community's business be conducted with complete integrity. To assure that Masonic Care Community's operations are being conducted in compliance with applicable law and highest ethical standards, Masonic Care Community has established the Program under the direction of the Chief Executive Officer and executed by the Compliance Officer. The Compliance Officer shall be charged with the responsibility and authority to oversee all activities of the Program, except as otherwise set forth in this Program. As is detailed within this Program, it is the duty of all Affected Individuals (including employees, officers/executives, members of the Masonic Care Community's governing body, and vendors/contractors) working in Medicaid-funded programs to comply with the codes of ethical conduct and health care compliance policies applicable to their individual areas of employment or service. This Program also advises all such Affected Individuals of the procedures to be used in educating staff regarding such standards and how violations are to be reported within the framework of a compliance protocol.

This Program, with Standards of Conduct at its core, encompasses the compliance program components mandated by NY Social Services Law § 363-d(2) as well as regulations promulgated by the New York State Office of the Medicaid Inspector General ("OMIG"), found in Part 521 of Title 18 of the New York Code of Rules and Regulations ("NYCRR"). In addition, the Program reflects compliance program recommendations issued by the United States Department of Health and Human Services, Office of Inspector General ("OIG") in its Compliance Program Guidance for Nursing Facilities, as published in 2000 and as supplemented in 2008. The Program also reflects consideration of authoritative guidance as to best practices and effectiveness review.

Although it is modeled in conformity with the New York State statute and regulations, OMIG publications, and OIG Guidance, this Program is specifically tailored to Masonic Care Community. It is designed to meet the internal needs and specific risks particular to Masonic Care Community, and it takes into account characteristics of Masonic Care Community such as culture, size, structure, clinical setting, and operational processes.

Many aspects of the Program, including portions of the Standards of Conduct, have been in effect since before the inception of a formal compliance program, and have been modified over time as operational and compliance requirements have evolved. Existing policies, procedures, and standards have been reviewed, revised, and brought under the umbrella of a coordinated compliance program.

The Program is an evolving document, reflecting an ongoing process of continuous quality improvement. Accordingly, the Program will be amended and supplemented from time to time to conform to changes in laws, regulations, guidance, and best practices.

Adherence to the Program is a condition of employment for all employees of Masonic Care Community.

A. ELEMENTS OF PROGRAM

The Program has seven core elements, which are structured according to the requirements set forth in NY Social Services Law § 363-d(2) and include:

1. Written policies, procedures, and standards of conduct that:
   1.1. articulate the organization's commitment to comply with all applicable federal and state standards;
   1.2. describe compliance expectations (as embodied in the Standards of Conduct);
   1.3. implement the operation of the compliance program;
   1.4. provide guidance to employees and others on dealing with potential compliance issues;
   1.5. identify how to communicate compliance issues to appropriate compliance personnel;
   1.6. describe how potential compliance issues are investigated and resolved by the organization;
   1.7. include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials; and
   1.8. identify and address all requirements listed under 42 U.S.C.1396-a(a)(68).

2. Designation of a Compliance Officer and a Compliance Committee who report directly and are accountable to the organization's chief executive or other senior management.
3. Establishment and implementation of effective training and education for the compliance officer and organization employees, the chief executive and other senior administrators, managers and governing body members (with training and education to occur at least once each year and is made a part of the orientation for all new employees, chief executives, managers, or governing body members).
4. Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the organization's employees, managers and governing body, and the organizations first tier, downstream, and related entities (with such lines of communication being accessible to all and allowing compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified).

5. Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals.
6. Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the organization's compliance with the medical assistance program requirements and the overall effectiveness of the compliance program.
7. Establishment and implementation of procedures and a system for:
   7.1. promptly responding to compliance issues as they are raised;
   7.2. investigating potential compliance problems as identified in the course of self-evaluations and audits;
   7.3. correcting such problems promptly and thoroughly to reduce the potential for recurrence; and
   7.4. ensuring ongoing compliance with the medical assistance programs requirements.

These elements and their related requirements are discussed in detail in the following pages.

Element 1: Written policies, procedures, and Standards of Conduct

1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards.

Masonic Care Community is committed to providing quality care in a manner that complies with all applicable federal and state standards. This commitment in each Masonic Care Community facility through the development of written policies and procedures.

Additionally, Masonic Care Community has developed written **Standards of Conduct** - the details of which are set forth more fully in Section 1.2, below – which also demonstrates the Masonic Care Community commitment to complying with federal and state standards and laws.

1.2. Written policies, procedures, and standards of conduct that describe compliance expectations (as embodied in the Standards of Conduct).

Masonic Care Community requires each Affected Individual to comply with all laws, regulations, policies, and procedures in providing care. In addition to the specific policies maintained by Masonic Care Community, as outlined in Section 1.1 above, Masonic Care Community has a written "Standards of Conduct". The Standards of Conduct sets forth the principles that all Affected Individuals are expected to follow as they perform their duties with regard to Masonic Care Community. Copies of the Standards of Conduct are: provided to the Affected Individual at the time of their initial orientation; posted in every Masonic Care Community building; discussed/reviewed in each annual training; and available from the Compliance Officer upon request by the Affected Individual.

Among other things, the Standards of Conduct is designed to explain Masonic Care Community's holistic approach to the care of its residents to promote maximum functioning and independence in all aspects of their life. By way of example, Masonic Care Community abides by, and requires all Affected Individuals to abide by the following:

CODE OF ETHICS AND STANDARDS OF CONDUCT

Masonic Care Community has always been strongly committed to a policy of compliance with the law and the maintenance of high ethical standards. By following this policy, Masonic Care Community has achieved a reputation for honesty and integrity. As Affected Individuals, all share in the continuing responsibility to maintain this reputation.

The purpose of the Code of Ethics and Standards of Conduct (the "**Code**") is to present some of the standards that Masonic Care Community expects its Affected Individuals to follow in their daily conduct on behalf of Masonic Care Community. Please read this document carefully and retain it for future reference. Please remember that the Code is applicable to all Affected Individual of Masonic Care Community.

The Code is distributed to all management and supervisory personnel, as well as all employees and independent professionals and other Affected Individuals. It is the responsibility of supervisory staff to communicate the contents of the Code to all Affected Individuals and to impress upon them our commitment to these policies.

Legal and Ethical Standards

The policy of Masonic Care Community is one of strict observance of, and compliance with, all laws governing the conduct of Masonic Care Community's operations. The applicable laws affecting the operation of Center continue to grow in number and complexity. It is not expected that Affected Individuals will be fully versed in all laws of permissible activities involved in their work. Therefore, if an Affected

Individual has a question regarding the legality or propriety of a course of action, the Affected Individual should seek guidance from his or her supervisor or from the Compliance Officer before taking any action.

It is also Masonic Care Community's policy to comply with the highest standards of business ethics. This imposes upon each Affected Individual a standard of ethical conduct of a higher order than that required by mere compliance with the law. In all of our dealings with others we must exercise the highest degree of honesty and integrity.

Conflicts of Interest

No Affected Individual should place himself or herself, or allow himself or herself to be placed, in a situation where the Affected Individual's personal interests might conflict with the interests of Masonic Care Community. Masonic Care Community recognizes and respects an individual employee or independent professional's right to invest or participate in activities outside of his or her employment or contract provided that these activities in no way conflict with Masonic Care Community's interests or welfare and do not interfere with the employee or independent professional's responsibilities to Masonic Care Community or the effectiveness of his or her job performance.

Although it is difficult to set forth all possible situations which might be considered as conflicting with Masonic Care Community's interests, the following are examples of situations Affected Individuals, including their immediate family members, must avoid:

1. No individual should perform any outside employment or engage in any outside activities which interfere with the effective performance of his or her duties as an employee or independent professional of Masonic Care Community ;

2. No individual shall have a financial interest in a firm or entity which is doing, or seeking to do, business with Masonic Care Community or which is a competitor of Masonic Care Community. However, ownership of less than 1% of the securities of a publicly traded company shall not be considered significant or contrary to this policy;

3. No individual should render services in any capacity, such as a director, officer, employee or consultant to any person or firm that is competitive with Masonic Care Community, provides services to Masonic Care Community or is a third-party payor with regard to services provided at Masonic Care Community;

4. No individual should use his or her position at Masonic Care Community for personal gain such as by soliciting or accepting for personal benefit business opportunities that might otherwise accrue to the benefit of Masonic Care Community;

5. No individual should use his or her position at Masonic Care Community for his or her personal benefit, or disclose to unauthorized persons, any confidential or proprietary information about Masonic Care Community or its operation;

6. No individual should borrow money from individuals or firms (other than banks and/or lending institutions) doing, or seeking to do, business with Masonic Care Community;

7. No individual should compete with Masonic Care Community by selling or leasing or offering to sell or lease services or products similar to those services or products offered by Masonic Care Community;

8. No individual should purchase services or products for Masonic Care Community from their family members or from business organizations with which they or their family members are associated, without first obtaining written permission from the Compliance Officer;

9. No individual should accept unusual or significant gifts, discounts or other preferred personal treatment from any person associated with a present or prospective customer, competitor or supplier of Masonic Care Community. Affected Individuals must report all unusual gifts to their immediate supervisor;

10. No individual should have outside employment or business interests that place him or her in a position of appearing to represent Masonic Care Community; and

11. No individual may use Masonic Care Community's assets for personal benefit or personal business purposes.

Any personal or business activities by an Affected Individual that may raise such concerns must be reviewed in advance and in writing by the Compliance Officer.

Each Affected Individual shall disclose in writing to the Compliance Officer on at least an annual basis, any potential conflict of interest and, if applicable, how such conflict could be avoided or mitigated. Each Affected Individual will sign any forms requested by Masonic Care Community to comply with their conflict of interest disclosure requirements.

Restrictions on Confidential Information

Affected Individuals possess sensitive, privileged information about patients/clients and their care. Patients/clients accordingly expect that this information will be kept confidential. Masonic Care Community takes very seriously any violation of a patient/client's confidentiality. Discussing the medical condition of a patient/client or providing any information about a patient/client to anyone other than Masonic Care Community who need the information or other authorized persons will result in disciplinary action. Affected Individuals should not discuss patients/clients outside Masonic Care Community or with their families.

Masonic Care Community is required to maintain the confidentiality of the medical record of each patient/client. In this regard, medical records may not be released except with the consent of the patient/client or in other limited circumstances as required by law. Affected Individuals shall comply with all applicable standards for the confidentiality, security, and use of protected health information, including without limitation, Health Insurance Portability and Accountability Act ("**HIPAA**") and any related requirements under other applicable federal, state, and local laws, rules or regulations, including, without limitation, Article 33 of the New York Mental Hygiene Law, Public Health Law Section 2780 et seq. and 10 NYCRR part 63, or under Masonic Care Community's own policies and procedures. Special confidentiality requirements apply with regard to medical records relating to substance use, HIV infection and AIDS. Affected Individuals who have access to medical records must exercise their best efforts to preserve their confidentiality and integrity and no employee or independent professional is permitted access to the medical record of any patient/client without a legitimate reason for doing so. Medical records should not be physically removed from Masonic Care Community, altered or destroyed except as allowed under written computer use policies and/or record keeping policies.

Confidentiality obligations for Affected Individuals must also be maintained even after their employment or termination of contract with Masonic Care Community. It is expected that Affected Individuals will not disclose such confidential information unless required to do so by law. Issues concerning confidentiality of the medical record of a patient/client should be addressed initially to the Privacy Officer appointed by Masonic Care Community under HIPAA. If a question arises as to the permissibility of the release of the medical record of any patient/client or any information contained therein, the individual should seek guidance from his or her supervisor or the Compliance Officer.

Additionally, Affected Individuals are to treat, as confidential, Masonic Care Community's proprietary business assets including: valuable ideas, business plans, and other information about Masonic Care Community's business. Masonic Care Community's Affected Individuals should respect Masonic Care Community's assets as they would their own. No employee or independent professional shall divulge

to unauthorized persons, either during or after their employment or termination of contract, any information of a confidential nature connected with the business of Masonic Care Community. Examples of confidential business information include any and all information (whether written, oral, or contained on audio tapes, video tapes, or on computer drives) relating to the governance, business, operation, and financial condition of Masonic Care Community and/or any of its vendors or collaboration partners, as well as any other information determined to be confidential.

Privacy Officer

The Privacy Officer of Masonic Care Community is the Compliance Officer.

Accurate Reporting and Accounting Practices

Most employees and independent professionals report data of some kind in connection with their job. All reporting of information should be a fair presentation of the facts. Some forms of inaccurate reporting are illegal (e.g., listing a fictitious expense on an expense account or petty cash voucher or reporting overtime hours not actually worked).

It is of critical importance to Masonic Care Community that its Affected Individuals shall at all times comply with Masonic Care Community's accounting rules and internal control policies. These rules and policies include the following prohibitions:

1. No false or misleading entries shall be made in Masonic Care Community's books or records;

2. No payment on Masonic Care Community's behalf shall be made without adequate supporting documentation or for any purpose other than as described in the documentation;

3. No undisclosed or unrecorded personal account or fund shall be established for any purpose;

4. No resources of Masonic Care Community shall be used for any unlawful or improper purpose, whether or not disclosed; and

5. All clinical records shall accurately reflect the care, services and supplies provided to Masonic Care Community's patients/clients, as well as the medical necessity therefore, and shall be entered onto such records in accordance with standards established by Masonic Care Community. Any errors or necessary modifications to such records shall set forth the modification and correction along with the date and identity of the person making such change.

In general, all transactions should be conducted so as to be recorded and traceable in the normal course of business.

Entertainment and Business Gifts

Improper or illegal remuneration of any kind to government officials, suppliers and others are strictly prohibited. Masonic Care Community recognizes that business dealings may include shared meals or other similar social occasions which may be proper business expenses and activities. More extensive entertainment, however, is not consistent with Masonic Care Community's policy and should be reviewed and approved in advance by the Compliance Officer before the individual may partake in or offer such entertainment.

Affected Individuals may not receive any gift from any person or entity under circumstances that could be construed as an improper attempt to influence Masonic Care Community's decisions or actions. Moreover, Affected Individuals may not receive any such gift(s) from any vendor who provides services to Masonic Care Community or is seeking to provide services to Masonic Care Community or from any actual or potential patient referral sources. If an Affected Individual receives a gift that violates this policy, the gift should immediately be returned to the donor and the event reported to the Compliance Officer. Gifts may be received by Affected Individuals when they are of such nominal value that they would not reasonably be

perceived by anyone as an attempt to affect the judgment of the recipient, for example, token promotional gratuities from suppliers, such as advertising novelties marked with the donor's name, are not prohibited under this policy.

No Affected Individual may make a cash gift or non-cash gift of more than nominal value to any officer, director or employee of a firm or entity or any individual that is an actual or prospective vendor of Masonic Care Community or an actual or potential source of referrals.

Under no circumstances may an Affected Individual of Masonic Care Community pay for the meals, refreshment, travel, lodging expenses or give anything of value to a government employee (state, federal or local) who in the course of his or her official conduct may investigate, survey or otherwise deal with Masonic Care Community.

Moreover, no Affected Individual may charge, solicit, accept or receive a gift, money, donation or other consideration from a patient/client or organization or person related to a patient/client as a pre-condition of admission or as a requirement for treatment at Masonic Care Community.

If an Affected Individual has any question as to whether the receipt of a gift or offering of a gift or the participation in an entertainment event or the offering to another the opportunity to participate in an entertainment event violates this policy, the individual is required to seek guidance from the Compliance Officer.

Political Contributions

Political contributions by Masonic Care Community are prohibited. The term "political contributions" means direct or indirect cash payments in support of political candidates, officeholders or political parties. In addition to cash payments, these include the use of personnel during paid working hours, the purchase of tickets to fund-raising events, or the payment for advertisements, printing or other campaign expenses.

Communication with News Media

With the exception of the Chief Executive Officer, no employee or independent professional should discuss any aspect of Masonic Care Community's business activities or internal operations with the news media without prior coordination with the Chief Executive Officer.

Subpoenas, Inquiries and Investigations

From time to time, government agencies may wish to subpoena business records and information from Masonic Care Community. It is Masonic Care Community's policy to cooperate with such requests through the Compliance Officer and legal counsel. In order to do so in a way that acknowledges the government's legitimate need for information, and Masonic Care Community's own rights and the rights of the organizations served by Masonic Care Community, all subpoenas, as well as other requests for information, must be referred in the first instance to the Compliance Officer. In addition to subpoenas, this includes requests for information, whether formal or informal (e.g., by telephone), from investigators or investigative agencies. By referring all requests to the Compliance Officer, Masonic Care Community will have the opportunity, where appropriate, to consult legal counsel to assure that the rights of all parties are respected and that appropriate and correct responses are submitted.

The same procedure must be followed with respect to any request for information from a third party that is not a routine part of the ordinary course of business.

Each Affected Individual is required, at the time of their initial orientation and as the Standards of Conduct are updated from time to time, to affirm in writing that they understand and agree to the Standards of Conduct and that they will abide by the Standards of Conduct throughout the duration of their affiliation with Masonic Care Community. Affected Individuals and Contractors are directed to contact the Compliance Officer in the event that the Affected Individual has, at any time, a question regarding what is required of the Affected Individual in order to abide by the Standards of Conduct. Affected Individuals who fail to comply with the Standards of Conduct are subject to disciplinary action in accordance with Masonic Care Community's disciplinary procedures.

1.3. Written policies, procedures, and standards of conduct that implement the operation of the compliance program.

Masonic Care Community's Program is maintained and operated by and through written policies and procedures:

These documents and the implementing policies, procedures, and standards of conduct are reviewed on a regular basis to ensure that the content is updated and effective in contributing to the compliance and operation of Masonic Care Community.

Additionally, the Standards of Conduct and its accompanying Acknowledgment Statement, detailed in Section 1.2 above, include requirements of all Affected Individuals to abide by and ensure the continued operation of the Program.

1.4. Written policies, procedures, and standards of conduct that provide guidance to employees and others on dealing with potential compliance issues.

Masonic Care Community strives to provide guidance to all Affected Individuals, including employees that enables Affected Individuals to prevent, identify, report, and/or resolve actual and potential compliance issues.

As noted in some of these policies and procedures, Affected Individuals who have questions or concerns related to compliance are encouraged and directed to contact the Compliance Officer at:

Maria Centolella

centolellam@mccny.org

315-798-4845 Compliance Help Line

1.5. Written policies, procedures, and standards of conduct that identify how to communicate compliance issues to appropriate compliance personnel.

The following policies, procedures identify how Affected Individuals may communicate with the Compliance Officer, Compliance Committee, or other personnel on potential compliance issues:

1.6. Written policies, procedures, and standards of conduct that describe how potential compliance issues are investigated and resolved by the organization.

It is anticipated that by Masonic Care Community and all Affected Individuals doing their best to comply with Masonic Care Community's policies and procedures that actual and potential compliance issues will be prevented, identified, reported, and/or resolved in a timely manner.

One method employed by Masonic Care Community to investigate and resolve potential compliance issues is through regular monitoring/auditing critical aspects of operations, including resident care and billing.

In addition to monitoring/auditing, Masonic Care Community has developed policies and procedures related to investigating reports of actual or suspected violations of this Program, including any Masonic Care Community policy or any state or federal law.

Education and training on investigation and resolution of compliance issues is provided to all Affected Individuals at the time of orientation and on at least an annual basis thereafter.

1.7. Written policies, procedures, and standards of conduct that include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

Masonic Care Community wants all Affected Individuals to report actual or suspected violations to the Compliance Officer, the appropriate government agency, or law enforcement. No Affected Individual who participates in good faith in the Program will be subject to any form of intimidation or retaliation by Masonic Care Community as a result of such participation. Protected activities include:

i. reporting and investigating potential compliance issues;

ii. participating in investigations of potential compliance issues;

iii. reporting instances of intimidation or retaliation;

iv. participating in self-evaluations, audits, and remedial actions; and

v. reporting health care fraud, waste, or abuse to government officials.

This policy does not mean that an Affected Individual who has violated a requirement or standard of the Program will not be subject to disciplinary action. Any Affected Individual who has a concern about potential intimidation or retaliation is encouraged to contact the Compliance Officer. All allegations of intimidation or retaliation will be promptly and fully investigated. An Affected Individual intimidates or retaliates against another, or who attempts to do so, shall be subject to disciplinary action.

DISCIPLINARY PROCEDURES

All Affected Individuals are required to comply with the Standards. Any Affected Individual who violates any of the foregoing Standards will be subject to disciplinary action, up to and including termination of employment or the contract.

Disciplinary action will be taken against an Affected Individual who:

1. Authorizes or participates directly in a violation of this Manual or the Code;

2. Deliberately fails to report a violation of this Manual or the Code;

3. Deliberately withholds relevant and material information concerning a violation of this Manual or the Code;

4. Deliberately fails to cooperate in an investigation of a suspected violation of this Manual or the Code;

5. Retaliates or seeks or causes retribution or intimidation against any Affected Individual who has either reported a suspected violation of this Manual or the Code or participated in an investigation of a suspected violation of this Manual or the Code;

6. Encourages, directs, facilitates, or permits either actively or passively non-compliant behavior; and

7. Fails to participate in required training programs.

Disciplinary action may also be taken against any supervisory personnel who direct or approve an individual's actions which result in a violation of this Manual or the Code, is aware that an individual's actions which violate this Manual or the Code, but fails to take appropriate corrective action, or who otherwise fails to exercise appropriate supervision.

Disciplinary action may include oral or written warning, probation, suspension, demotion, termination from employment, or contract termination. Disciplinary action will be taken in accordance with the Center's personnel policies and procedures. Disciplinary action will be taken on a fair, equitable and consistent basis. Disciplinary action will be appropriate to the level of the Affected Individual's culpable conduct: that is, the more serious the level of culpable conduct (intentional conduct or reckless non-compliance) will result in more significant disciplinary action. Notwithstanding the foregoing, this statement is not a guaranty of progressive discipline and the Masonic Care Community reserves the right to terminate an employee at any time for any lawful reason.

Additionally, a summary of federal and New York State laws on false claims and whistleblower protections, as prepared and provided by the OMIG, is set out in **Appendix A**.

1.8. Written policies, procedures, and standards of conduct that identify and address all requirements listed under 42 U.S.C.1396-a(a)(68).

Masonic Care Community recognizes the for it and New York State to comply with certain federal requirements pertaining to medical assistance programs. Accordingly, pursuant to 42 U.S.C.1396-a(a)(68), and to the extent that Masonic Care Community receives or makes annual payments under New York State's medical assistance plan of at least $5,000,000, Masonic Care Community has:

i. established written policies for all Affected Individuals that provide detailed information about
   A. the False Claims Act established under sections 3729 through 3733 of title 31,
   B. administrative remedies for false claims and statements established under chapter 38 of title 31,
   C. any State laws pertaining to civil or criminal penalties for false claims and statements, and
   D. whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) Title 42);

ii. included as part of its written policies, detailed provisions regarding Masonic Care Communities policies and procedures for detecting and preventing fraud, waste, and abuse; and

iii. included in its employee handbook
   A. a specific discussion of the laws described in Section 1.8.i, above,

B. the rights of employees to be protected as whistleblowers, and
C. the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Additionally, a summary of federal and New York State laws on false claims and whistleblower protections, as prepared and provided by the OMIG and which is made available to all Affected Individuals is set forth in **Appendix A**.

The written policies referenced in and required by Section 1.8.ii, above, are identified in items 1.a through 1.g. of this Program policy.

Finally, pursuant to Section 1.8.iii above, a specific discussion of these laws, the rights of employees to be protected, and Masonic Care Community's applicable policies are included in the employee handbook.

Element 2: Compliance Committee and Compliance Officer

Masonic Care Community has designated a Compliance Officer and a Compliance Committee who report directly and are accountable to Masonic Care Community's chief executive or other senior management.

The Board of Trustees has the ultimate responsibility for oversight of the Program. The Board considers compliance-related matters on a periodic basis and whenever warranted by circumstances. The Compliance Committee, appointed by the Board and chaired by the Compliance Officer, includes representation from various Masonic Care Community departments, as determined by the Board. The compliance officer shall report directly and be accountable to Masonic Care Community's chief executive and another senior manager whom the chief executive may designate for reporting purposes provided, however, such designation does not hinder the compliance officer in carrying out their duties and having access to their chief executive and governing body.

The Compliance Officer is chosen by the Executive Director.The Compliance Officer may designate other individuals to perform compliance-related tasks or to assist in the evaluation or resolution of specific issues from time to time. The responsibilities of the Compliance Officer include, but are not limited to:

- Overseeing and monitoring the adoption, implementation, and maintenance of the compliance program and evaluating its effectiveness;
- Drafting, implementing, and updating no less than annually or, as otherwise necessary to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance work plan which shall outline the required provider's proposed strategy for meeting the requirements of this section for the coming year;
- Revising the compliance program and the written policies and procedures and standards of conduct, to incorporate changes based on the required provider's organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards;
- Establishing methods, such as periodic audits and ongoing monitoring, to reduce Masonic Care Community's vulnerability to fraud and abuse;
- Developing, coordinating and participating in training programs;

- Maintaining records of Compliance Program activities;
- Ensuring that the OIG's and the OMIG's lists of excluded individuals and entities and the General Services Administration's list of parties debarred from federal programs, have been checked with respect to all employees and contractors;
- Coordinating the investigation of any report or allegation concerning possible violations of the Program, and monitoring subsequent corrective action and/or compliance in accordance with Masonic Care Community policy;
- Reporting directly, on a regular basis, but no less frequently than quarterly, to the required provider's governing body, chief executive, and compliance committee on the progress of adopting, implementing, and maintaining the compliance program;
- Assisting the required provider in establishing methods to improve the required provider's efficiency, quality of services, and reducing the required provider's vulnerability to fraud, waste and abuse;
- Investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and the State; and
- Coordinating the implementation of the fraud, waste, and abuse prevention program with the director and lead investigator of the MMCO's special investigation unit pursuant to 18 NYCRR 521-2, if applicable.

The Compliance Officer may be assigned other duties, provided that such other duties do not hinder the compliance officer in carrying out their primary responsibilities under 18 NYCRR 521-1.4(b).

The Compliance Committee shall be responsible for coordinating with the compliance officer to ensure that Masonic Care Community is conducting its business in an ethical and responsible manner, consistent with its compliance program. Masonic Care Community shall outline the duties and responsibilities, membership, designation of a chair and frequency of meetings in a compliance committee charter.

The Compliance Officer is chosen by the Executive Director. The Compliance Officer may designate other individuals to perform compliance-related tasks or to assist in the evaluation or resolution of specific issues from time to time. The responsibilities of the Compliance Officer include, but are not limited to:

- Receiving regular reports from the Compliance Officer and providing guidance regarding the operation of the Program; Coordinating with the compliance officer to ensure that the written policies and procedures, and standards of conduct are current, accurate and complete, and that the training topics are timely completed;
- Coordinating with the compliance officer to ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other function or activity required by 18 NYCRR 521-1.4(c).
- Approving the internal auditing plan carried out under the Program; Approving the compliance training program provided to all staff, contractors, and Board members;
- Advocating for the allocation of sufficient funding, resources and staff for compliance officer to fully perform their responsibilities;

- Ensuring that Masonic Care Community has 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;
- Advocating for adoption and implementation of required modifications to the compliance program
- Reviewing and confirming the adequacy of all investigations of suspected non-compliance and any corrective action taken as a result of such investigations;
- Reviewing policies and procedures related to compliance; and
- Recommending and approving any changes to the Program.

Membership in the committee shall, at a minimum, be comprised of senior managers. The compliance committee shall meet no less frequently than quarterly and shall, no less frequently than annually, review and update the compliance committee charter.

The Compliance Officer and Compliance Committee each will report directly to the Chief Executive Officer or another senior administrator designated by the Chief Executive Officer, and shall also each periodically report directly to the Board of Trustees on the activities governed by the Program.

Element 3: Effective Training and Education

Education is essential to maintaining compliance. Educational programs are tailored to the needs of Masonic Care Community and the duties or obligations of Affected Individuals on an ongoing basis. For instance, Masonic Care Community provides focused training and education based on whether the Affected Individual is an employee, a vendor, or a member of the governing body.

To ensure that all Affected Individuals are familiar with their responsibilities under the Program, the Center will implement an ongoing educational and training program. All current and new employees will be required to participate in initial and annual training sessions. Additionally, periodic training sessions will be required for new employees and, as determined by the Compliance Officer, for employees of certain departments with responsibilities for purchasing, billing and coding or any other responsibilities that the Compliance Officer determines appropriate for periodic training. All other Affected Individuals shall have training on at least an annual basis. In addition, the training will include the mandated Deficit Reduction Act training regarding Federal and State statutes and regulations addressing fraud, abuse, and waste, false claim acts and employee/whistleblower protections under federal and state laws.

Training and education objectives will be established no less frequently than annually by the Compliance Officer and are based in part on auditing and monitoring results as well as the Compliance Officer's assessment of risk areas. The Compliance Officer will determine:

- Individual training and education needs; and
- The types of training and/or education that best suit the needs of Masonic Care Community, and that accomplish objectives effectively and efficiently.

Training and education will be provided as part of an Affected Individual's orientation and on an as-needed basis to respond to identified risk areas, but at least annually, and in compliance with any changes in Medicare or Medicaid coding or billing procedures. A record of training and educational activities related to compliance will be maintained, under the direction of the Compliance Officer.

Training and education shall be provided in a form and format accessible and understandable to Affected Individuals, consistent with Federal and State language and other access laws, rules or policies.

Masonic Care Community shall develop and maintain a training plan. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing, frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated.

Some of the key topics including in Masonic Care Community's education and training are outlined in Items 3.1 through 3.3, below.

3.1. Compliance Training

MCC Individuals, including the Compliance Committee members, will undergo compliance-related training pertinent to their responsibilities, as part of their orientation to those roles and responsibilities. Board members will receive training as to the role of the Board in oversight of the Program and as to governance issues identified by OMIG.

Topics included in this compliance training include, for example:

- Masonic Care Community's risk areas and organizational experience;
- Masonic Care Community's written policies and procedures;
- The role of the compliance officer and the compliance committee;
- How Affected Individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the compliance program;
- Disciplinary standards; with an emphasis on those standards related to the Masonic Care Community's compliance program and prevention of fraud, waste, and abuse;
- How Masonic Care Community responds to compliance issues and implements corrective action plans;
- Requirements specific to the MA program and Masonic Care Community's category or categories of service;
- Coding and billing requirements and best practices, if applicable;
- Claim development and the submission process, if applicable;
- The operation and importance of the Program;
- The Program as a condition of continued employment;
- The consequences of violating compliance standards and procedures, including disciplinary measures; and
- The role of each Affected Individual in the operation of the Program.

Training may be intramural or extramural, as appropriate. When considering outside training sources, the Compliance Officer will consider: offerings of professional organizations; programs offered by carriers; third-party billing company seminars; the services of an outside consultant; and other resources as

available and appropriate. Topics for training may be drawn from publications such as OMIG publications; DOH Medicaid Updates; the OIG's Special Fraud Alerts; OIG Advisory Opinions; and Medicare Part B News.

To underscore our commitment to compliance training for employees, the Masonic Care Community's employee handbook includes a specific discussion of this Policy. The employee handbook also includes a specific discussion of state and federal laws on false claims and the rights of employees to be protected as whistleblowers. A summary of those laws is set out in this Policy as **Appendix A**.

3.2. Coding and Billing Training

It is the responsibility of each practitioner to properly document his or her services and to accurately code his or her services for billing purposes. Any newly employed or affiliated practitioner who is responsible for coding of his or her own services will be trained as part of orientation, which shall occur as soon as possible upon the practitioner assuming his or her duties.

Masonic Care Community recognizes that non-clinical personnel who are directly involved with billing, coding or other aspects of the federal health care programs may also require coding and billing education and training specific to that individual's responsibilities. The Compliance Officer shall identify all individuals who may require such education and training and ensure that education and training is provided. Examples of topics that may be pertinent to such an individual's responsibilities include:

- Coding requirements and methodology, including proper use of Masonic Care Community's medical record documentation forms;
- General understanding of the claim development and submission processes;
- Proper billing standards and procedures and submission of accurate bills to payors and patients; and
- Legal sanctions for submitting deliberately or recklessly false billings.

3.3. Dissemination of Compliance Information to Certain Contractors

Under the DRA, the Masonic Care Community is required to disseminate information on Corporate Compliance to all contractors and agents who, on behalf of the Masonic Care Community, furnish or authorize the furnishing of Medicaid health care items or services; perform billing or coding functions; or are involved in the monitoring of health care provided by the Masonic Care Community. The DRA requires that all such contractors and agents adopt and abide this Policy in relation to all work performed for the Masonic Care Community; train their employees who are involved in performing work for the Masonic Care Community to comply with applicable laws; and make this Policy available to those employees.

To facilitate our contractors' and agents' compliance training and education, this Policy is posted on the Masonic Care Community's website.

Under 18 NYCRR 521-1.3(c), contractors, agents, subcontractors, and independent contractors (together "Contractors") are subject to Masonic Care Community's compliance program, to the extent such Contractors are affected by the Masonic Care Community's risk areas and only within the scope of the contracted authority and affected risk areas. Masonic Care Community acknowledges it is ultimately responsible for the adoption, implementation, maintenance, enforcement, and effectiveness of tis compliance programs.

Element 4: Effective Lines of Communication

4.1. Generally.

All Affected individuals, including Board members and MCC Contractors, are encouraged to discuss any billing or compliance concern of any nature with the Compliance Officer, either formally or informally. Formal and informal communication channels are intended to implement an "open door" policy.

Adherence to the Program, including the obligation to report potential non-compliance, is expected and required of all Affected Individuals. **Although Affected Individuals are encouraged to contact the Compliance Officer directly to report concerns, concerns may also be reported confidentially by submitting a written report to the Compliance Officer on an anonymous basis, or by calling the compliance hotline, accessible 24 hours per day, at (315) 798-4845**.

Further, an employee, intern, or volunteer or other MCC Individual who does not wish to report a compliance concern directly to the Compliance Officer may report the concern through his or her supervisor or to a member of the Compliance Committee, who will then become responsible for ensuring making a report to the Compliance Officer or another member of the Compliance Committee

The lines of communication shall be accessible to all Affected Individuals and allow for questions regarding compliance issues to be asked and for compliance issues to be reported.

Masonic Care Community shall publicize the lines of communication to the compliance officer and such lines of communication must be made available to all Affected Individuals and all MA recipients of service from Masonic Care Community.

Masonic Care Community shall have a method for anonymous reporting of potential fraud, waste and abuse, and compliance issues directly to the compliance officer.

Masonic Care Community must ensure that the confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under Masonic Care Community's policy for non-intimidation and non-retaliation.

Masonic Care Community shall make available on its website, information concerning its compliance program, including its standards of conduct, where applicable.

4.2. Communication between Compliance Officer, Compliance Committee, Affected Individuals, and related entities.

In addition to the general lines of communication identified above in Section 4.1, Masonic Care Community has also established and implemented effective and confidential lines of communication, between the compliance officer, members of the Compliance Committee, the organization's employees, managers and governing body, and the organizations first tier, downstream, and related entities. These lines of communication are accessible to all and are designed to allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified

Element 5: Publication and Implementation of Disciplinary Standards

When non-compliant conduct at any level of the Masonic Care Community has been identified, corrective actions will be undertaken as appropriate. Non-compliant conduct on the part of an employee of

Masonic Care Community will be documented in the employee's personnel or credentialing file. Violations of Masonic Care Community's compliance policies, including failure to report potential violations, participating in non-compliant conduct, or actively or passively encouraging, directing, facilitating, or permitting non-compliant conduct, will result in disciplinary action, in proportion to the seriousness of the violation, in accordance with Human Resources policies and procedures. Sanctions may include oral warnings; written reprimands; demotion; suspension; or termination. The written policies and procedures establishing Masonic Care Community's disciplinary standards and the procedures for taking such actions shall be published and disseminated to all Affected Individuals and shall be incorporated into the required provider's training plan. The required provider shall enforce its disciplinary standards fairly consistently, and the same disciplinary action should apply to all levels of personnel.

Element 6: Effective System for Routine Monitoring and Identification of Compliance Risks

Masonic Care Community has established a system of routine auditing and monitoring. The objective of the auditing and monitoring component of the Program is to ensure that Affected Individuals are properly carrying out their responsibilities and that claims are being submitted appropriately. Masonic Care Community will utilize audit tools as a means of ascertaining what, if any, problems exist and focus on the risk areas that are associated with those problems. Auditing and monitoring will include, but will not be limited to, Medicare and Medicaid claims, and will be comprised of both internal and external audits and monitoring as appropriate. This system is revised from time to time to ensure effective monitoring, but generally includes the procedures/protocols set forth in items 6.1 through 6.3 below.

Ongoing audits are performed by internal or external auditors who have expertise in Medicaid program requirements or the subject area of the audit. Audits or investigations conducted by state or federal governmental entities are not considered external audits.

Audits shall meet the following requirements:

- Internal and external compliance audits shall focus on risk areas identified in 18 NYCRR 521-1.3;
- The results of all internal or external audits, or audits, or audits conducted by the State or Federal government of Masonic Care Community, shall be reviewed for risk areas that can be included in updates to Masonic Care Community's compliance program and compliance work plan;
- The design, implementation, and results of any internal or external audits shall be documented, and the results shared with the compliance committee and the governing body; and
- Any MA program overpayments identified shall be reported, returned and explained in accordance with 18 NYCRR 521-3, and Masonic Care Community shall promptly take corrective action to prevent recurrence.

6.1. Standards and Procedures Review

The Compliance Officer or designee will periodically, but no less than annually, monitor and review Masonic Care Community's current standards, policies and procedures (for example, those related to mandatory reporting, governance and quality of care) to determine if they are current and complete, in accordance with currently applicable standards, regulations, and other authoritative guidance.

The reviews may be carried out by the compliance officer, compliance committee, external auditors, or other staff designated by the required provider, provided however, that such other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and are independent from the functions being reviewed.

The reviews should include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method Masonic Care Community deems appropriate, provided that such method does not compromise the independence or integrity of the review.

Masonic Care Community shall document the design, implementation and results of its effectiveness review, and any corrective action implemented.

The results of annual compliance program reviews shall be shared with the chief executive, senior management, compliance committee and the governing body.

Among the standards and materials the Compliance Officer will utilize are the Medicaid Provider Manuals, the current Medicare Manuals, relevant Medicare news bulletins, and DOH Medicaid Updates. All authoritative guidance issued or updated by local, state, or federal authorities will, as appropriate and/or applicable, be distributed to Affected Individuals and incorporated into training and education as necessary. The Compliance Officer or designee will alert staff members to pertinent changes on an as-needed basis.

As required by the circumstances, Masonic Care Community will seek the advice of consultants for assistance in coding questions, and will consult with legal counsel for assistance in interpreting federal and state regulations and guidance as needed.

Masonic Care Community shall confirm the identity and determine the exclusion status of Affected Individuals. Masonic Care Community shall require contractors to comply with this requirement. The results of such exclusion check shall be shared with the compliance officer and appropriate compliance personnel. In determining the exclusion status of a person Masonic Care Community shall review the following State and Federal databases at least every thirty (30) days:

- New York State Office of the Medicaid Inspector General Exclusion List; and
- Health and Human Services office of Inspector General's List of Excluded Individuals and Entities.

6.2. Claims Submission Audit

The Compliance Officer will be responsible for the processes for reviewing bills and medical records for compliance with applicable coding, billing, and documentation requirements. A representative sampling of claims will be periodically reviewed prior to submission, and any identified defects will be corrected.

Self-audits will be used to review such matters as:

- Whether bills are properly coded and accurately reflect the services provided and documented in the medical record;
- Whether documentation is completed correctly;
- Whether the services or items provided were medically reasonable and necessary;
- Whether the services were provided by appropriately credentialed individuals; and
- Whether there were any incentives for unnecessary services.

Internal audits will involve routine review of appropriate samplings of charts on a regularly scheduled basis. In addition, focused audits will be performed to verify implementation of any recommended corrective actions.

Risk areas identified by internal or outside audits will be examined in subsequent internal audits as warranted. Where an audit reveals the need for additional education of employees and clinical staff, the Compliance Officer will determine the means by which additional training and education will be implemented.

In addition to internal monitoring and auditing, the Compliance Officer will be responsible for procedures to review denied, rejected, and down-coded claims. Any rejection or down-coding patterns that are identified will be promptly addressed, with additional training and education as needed.

6.3. Identification of Risk Areas

As necessary, Masonic Care Community will develop written policies and procedures that address identified risk areas. These written policies and procedures will be communicated to staff members as necessary and pertinent. Risk areas, including risk areas that are identified in the course of quality improvement and credentialing processes, will be addressed as appropriate in periodic and special audits.

Risk areas identified from time to time by OIG, OMIG or other authorities will be addressed in Masonic Care Community's auditing activities as appropriate.

The OIG Guidance has identified the following as areas of potential risk:

- Coding;
- Medical necessity;
- Non-covered services;
- Documentation, including legibility;
- Billing for services of physician extenders; and
- Improper inducements, kickbacks and self-referrals.

Risk areas identified by OMIG include:

- Billings;
- Payments;
- Medical necessity and quality of care;
- Governance;
- Mandatory reporting;
- Credentialing;
- Ordered services;
- Contractor, subcontractor, agent, or independent contract oversight;
- Reserved bed day billings;
- Base year cost calculations;
- Review of ancillary services included in the Medicaid rate;

- Medicaid rate Part B carve outs;
- Property/capital cost allocations;
- Temporary staffing costs;
- Review of resource utilization group (RUG-II) categorizations; and
- Net available monthly income (NAMI) calculations.

Element 7: System of Identifying, Responding to, Investigating, and Correcting Compliance Issues

It is important to the integrity of Masonic Care Community that all suspected violations of the Code of Ethics and Standards of Conduct be thoroughly reviewed and investigated so that appropriate action can be taken as necessary. Concerns identified by the Compliance Officer, Affected Individuals, or other sources will be reviewed by the Compliance Officer. Under the direction of the Compliance Officer, such concerns will be prioritized, investigations will be undertaken as warranted, and appropriate corrective action programs will be implemented. Investigations may be conducted internally by the Compliance Officer or externally by either accountants or lawyers engaged by Masonic Care Community, Affected Individuals are required to cooperate with the individual or individuals conducting an investigation of a suspected violation. Such cooperation may involve being interviewed by the individual or individuals conducting the investigation or supplying such individual or individuals with requested documentation. Response may include coordination with quality improvement processes and programs, where pertinent and appropriate. Failure to cooperate in an investigation of a suspected violation may result in disciplinary action being taken.

Depending upon the nature of the concern, the Compliance Officer may consult with legal counsel to determine whether a significant and or reportable violation of applicable law may have occurred, and, if so, the appropriate measures to take.

Additional information and policies related to Masonic Care Community's system of identifying, preventing, responding to, and resolving actual and potential compliance issues are found in additional elements/items of this Program (as included above).

7.1. Responding to Compliance issues as they are raised.

Masonic Care Community has established and implemented procedures and a system for promptly responding to compliance issues as they are raised. This system begins at the time that an Affected Individual discloses the concern to the Compliance Officer, a member of the Compliance Committee, or the Affected Individual's direct supervisor(s). In the event that a member of the Compliance Committee or a supervisor is notified of the concern, said supervisor or Compliance Committee member is required to convey the concern to the Compliance Officer (except in the event that the Compliance Officer is the subject of the compliance concern, in which case . . .). All Affected Individuals (including supervisors and Compliance Officers are required to report their concerns promptly, ideally within 24 hours of either the date that the compliance concern raised or, if applicable, the date on which the supervisor or Compliance Committee member was notified of the concern. Delays in reporting compliance concerns may, depending on the specific scenario, serve as the basis for disciplinary action.

Upon the detection of potential compliance risks and compliance issues, whether through reports received or as a result of the auditing and monitoring practices outlined above, Masonic Care Community shall take prompt action to investigate the conduct in question and determine what, if any, corrective action is required, and likewise promptly implement such corrective action.

7.2. Investigating potential compliance problems identified in self-evaluations and audits

In addition to the systems for responding to concerns (as identified in Section 7.3) and investigating compliance concerns generally (as identified in Items 1.f., 1.g, and 2), Masonic Care Community has a system in place to investigate potential compliance problems as identified in the course of self-evaluations and audits.

Masonic Care Community shall document its investigation of the compliance issue which shall include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that Masonic Care Community completed a thorough investigation of the issue. Where appropriate Masonic Care Community may retain outside experts, auditors, or counsel to assist with the investigation.

7.3. Correcting Potential or Actual Compliance Programs.

Masonic Care Community has procedures and a system in place for correcting compliance concerns and problems, including those concerns raised as referenced by Section 7.2 and those problems identified through self-audits or evaluations (as reference in Section 7.3).

As appropriate, corrective actions may include one or more of the following:

- Discipline of an employee up to and including termination;
- Retraining;
- Reporting and return of overpayments within 60 days of identification;
- Self-disclosure to the carrier intermediary or the OIG or OMIG;
- Revision of a Masonic Care Community policy;
- Implementation of procedures, policies, or systems to reduce the potential for recurrence; or
- Modification of a relationship with an outside party, such as a billing company.

Where the concern or problem relates to the acts or omissions by an Affected Individual, the Compliance Officer or, as appropriate, the Compliance Committee member, will address the issue with the individual and use reasonable efforts (including investigation as necessary) to identify the root cause of the individual's failure to act in a manner required by law or this Program. The Affected Individual may also be subject to corrective or disciplinary action, which is determined based on the severity of the act and in accordance with Masonic Care Community's policies and procedures. Masonic Care Community shall document any disciplinary action taken or the corrective action implemented.

In the event that the concern or problem relates to the feasibility or efficacy of a policy or procedure, (for example, if a policy under the Program failed to anticipate, detect, or prevent a problem) the Compliance Officer will review such policies and procedures to determine what changes, if any, should be modified to reduce the likelihood of recurrence. If such a Program failure or deficiency is identified, the Program will be revised, if practicable, in a manner that minimizes the risk of future failures.

7.4. Ensuring Ongoing Compliance with the Medical Assistance Program Requirements.

From time to time, but no less than annually, the Compliance Officer shall review relevant law and guidance to ensure the ongoing and compliance with the medical assistance program and related requirements. The Compliance Officer's review includes reviewing and monitoring applicable state and federal regulations (for example, those found in the Social Services Law and 18 NYCRR 521) and keeping

current with all guidance or directives issued by state or federal agencies (including, for example, DOH, CMS, OMIG, and the OIG).

In the event the Compliance Officer identifies an area that is no longer in compliance or is no longer effective, the Compliance Officer will take action pursuant to Section 7.4 to modify the practice or policy that is to be revised.

If Masonic Care Community identifies credible evidence or credibly believes that a State or Federal law, rule or regulation has been violated, the required provider shall promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The compliance officer shall receive copies of any reports submitted to governmental entities.

This Program will be revised and updated from time to time to reflect ongoing Program assessment, current compliance guidance, the requirements of regulatory agencies, and considerations of best practices.

This document is not intended to serve as an express or implied employment contract, nor shall it be construed to confer any right upon any individual. Its objective is to communicate current policies relating to the compliance efforts of Masonic Care Community. The Board of Trustees of the Masonic Care Community reserves the right to change, modify, or waive all provisions herein. Any questions or concerns should be forwarded to the Compliance Officer or any member of the Compliance Committee.

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)
2) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801— 3812)
3) Additional Federal Civil and Criminal Penalties and Sanctions For False Claims

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.--

(1) 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 $5,000 and not more than $10,000, 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,

[then] 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;

(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.

1.a) 31 U.S.C. §3730 (Civil Actions Under the Act – Qui Tam):

Enforcement of the Act is the responsibility of the United States Attorney General. However, private individuals have the ability to bring a civil action for a violation of §3729 of the Act. These private actions are known as "Qui Tam" actions.

Qui Tam actions are brought by private individuals in the name of the Government. When the complaint in an action brought by a private individual is filed with the Court, it remains under seal for a period of sixty days and cannot to be served upon the defendants named therein until ordered by the Court. Under seal means that the action remains confidential and is not subject to disclosure. The private individual must serve a copy of the complaint and written disclosures of substantially all material evidence and information the individual possesses on the Government. Within sixty days of the Government's receipt of the complaint and written disclosures, the Government shall either intervene and proceed with the action, in which case, the action shall be conducted by the Government, or notify the Court that it declines to take over the action, in which case, the private individual bringing the action shall have the right to proceed with the action.

If the Government elects to proceed with the action brought by a private individual, the private individual shall receive at least 15% but not more than 25% of the proceeds of the action or settlement of the claim, depending upon the extent to which the private individual contributed to the prosecution of the action. If the Government does not proceed with the action, and the private individual is successful in the action or settles the action, the private individual is entitled to an amount not less than 25% and not more than 30% of the proceeds of the action or settlement which shall be paid out of the proceeds of the action or settlement. In addition, the private individual is entitled to receive an amount for reasonable expenses necessarily incurred in the action plus reasonable attorneys' fees and costs. On the other hand, if the private individual is unsuccessful in prosecuting the action, the Court, upon a finding that the action was clearly frivolous, clearly vexatious or brought primarily for purposes of harassment, may award the defendant in the action its reasonable attorneys' fees and expenses. If the private individual in the action is a person who planned or initiated the violation of the Act, the Court, where appropriate, may reduce the amount of the award to the private individual. Moreover, if such private individual is convicted of a crime arising from his or her role in the violation, the person will not receive any share of the proceeds of the action.

A civil action under the Act may not be brought:

1. More than six years after the date on which the violation of the Act is committed; or
2. More than three years after the date when facts material to the right of action are known or reasonably should have been known by an official of the Government charged with responsibility to act in the circumstances but in no event more than 10 years after the date on which the violation is committed,

whichever occurs last.

---

2) <u>Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801— 3812)</u>31 U.S.C.

§3801 et. seq.

Section 3801 imposes additional civil penalties for the filing of false claims or statements with the federal government which are conducted through an administrative process. The term "Claim" is defined as:

> Any request, demand or submission - -
>
> (A) made to [the Government] for property, services or money (including money representing grants, loans, insurance or benefits);
>
> (B) made to a recipient of property, services or money from [the Government] or to a party to a contract with [the Government] - -
>
> (i) for property or services if the United States - -
>
> (I) provided such property or services;
> (II) provided any portion of the funds for the purchase of such property or services; or
> (III) will reimburse such recipient or party for the purchase of such property or services; or
>
> (ii) for the payment of money (including money representing grants, loans, insurance or benefits), if the United States –
>
> (I) provided any portion of the money requested or demanded; or
> (II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or
>
> (C) made to [the Government] which has the effect of decreasing an obligation to pay or account for property, services or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1986.

The term "Statement" is defined as:

> Any representation, certification, affirmation, document, record or accounting or bookkeeping entry made - -
>
> (A) with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(B) with respect to (including relating to eligibility for - -

(i) A contract with, or a bid or proposal for a contract with; or
(ii) A grant, loan or benefit from,

an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan or benefit, or if the Government will reimburse such State, political subdivision or party for any portion of the money or property under such contract or for such grant, loan or benefit,

except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1986.

Specifically, civil monetary penalties under 31 U.S.C. §3801 et. seq. will be imposed against:

1. Any person (individual or entity) who makes, presents, or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know:

(A) is false, fictitious or fraudulent;
(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;
(C) includes or is supported by any written statement that:

(i) omits a material fact;
(ii) is false, fictitious or fraudulent as a result of such omission; and
(iii) is a statement in which the person making, presenting or submitting such statement has a duty to include such material facts; or

(D) Is for payment for the provision of property or services which the person has not provided as claimed; or

2. Any person who makes, presents or submits, or causes to be made, presented or submitted, a written statement that:

(A) The person knows or has reason to know:

(i) asserts a material fact which is false, fictitious or fraudulent; or
(ii) is false, fictitious or fraudulent as a result of such omission;

(B) in the case of a statement described in clause (ii) of subparagraph (A) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and
(C) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement.

The term "knows or has reason to know" means that:

A person, with respect to a claim or statement - -

(A) has actual knowledge that the claim or statement is false, fictitious or fraudulent; or
(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or
(C) acts in reckless disregard of the truth or falsity of the claim or statement,

and no proof of specific intent to defraud is required.

Civil monetary penalties under 31 U.S.C. §3801 et. seq. are not more than $5,000 for each false claim or statement (31 U.S.C. §3802). Also, in lieu of damages sustained by the federal government, an assessment of not more than twice the amount of such claim(s) may be imposed. An individual or entity against whom civil monetary penalties are sought under 31 U.S.C. §3801 et. seq. is entitled to notice, an opportunity for a hearing and judicial review (31 U.S.C §§ 3803-3812).

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.

3) Additional Federal Civil and Criminal Penalties and Sanctions For False Claims

- **42 U.S.C. §1320a-7a (Civil):**

In addition to the False Claim Act and 31 U.S.C. §3801 et. seq., the federal government may, pursuant to, impose civil monetary penalties (CMP) for improperly filed claims. Such claims include those knowingly presented that were:

1) for item or service that person knew or should have known were not provided as claimed, including up coding.
2) false or fraudulent
3) for service that person knew or should have known were by unqualified physician

4) provided by provider excluded from federal health care program reimbursement
5) for service or item that person knew or should have known were unnecessary
6) in violation of assignment, agreement on limited charge, or provider agreement

§1320a-7a also provides for penalties for the following additional acts:

1) knowingly providing false or misleading information leading to a hospital discharge
2) being excluded and owning or being an officer of an entity submitting claims
3) providing remuneration to influence beneficiaries
4) contracting with excluded individual or entity for which reimbursement is made
5) participating in kickback or improper or rebate referral remuneration
6) knowingly making or using a material false record or statement for a claim
7) failing to timely permit access to OIG for audit
8) ordering or prescribing by provider when he/she knew or should have known she was excluded from federal health care program reimbursement
9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program
10) knows of and fails to report and return overpayment

The CMP for the above violations may be assessed in addition to any other penalty prescribed by law. The penalties may be up to $10,000 for each item or service with some exceptions2. In addition, a violator shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. The Secretary may also make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a–7b (f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program. Additional CMPs for hospitals and physicians is also provided under the statute.

- **42 U.S.C. §1320a-7:**

In addition to civil monetary penalties, the federal government may, pursuant to 42 U.S.C. §1320a-7, exclude an individual or entity from participation in federal and state health care programs (including Medicare and Medicaid) for certain false claims or actions. Generally, exclusion is mandatory in cases where the individual is convicted of a felony relating to health care fraud, otherwise, exclusion is permissive, that is, subject to the discretion of the Government.

- **42 U.S.C. §1320a-7k(d)(2):**

Pursuant to 42 U.S.C. §1320a-7k(d)(2) (enacted as §6402 of the Patient Protection and Affordable Care Act), providers are obligated to report, explain and repay overpayments within calendar 60 days of identification. Those that fail to properly disclose, explain and repay the overpayment in a timely manner may be subject to liability under the New York and Federal False Claims Act.

- **42 U.S.C. §1320a-7b (Criminal):**

Pursuant to, criminal sanctions may be imposed against an individual or entity for making or causing to be made false statements or representations. Specifically, criminal sanctions will be imposed against an individual or entity who:

1. Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program;
2. At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefits or payments;
3. Having knowledge of the occurrence of any event affecting (1) his/her initial or continued right to any such benefit, or (2) the initial or continued right to any such benefit or payment of any other individual in whose behalf he/she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;
4. Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;
5. Presents or causes to be presented a claim for a physician's service for which payment may be made under a federal health care program and knows that the individual who furnishes the services was not licensed as a physician; or
6. knowingly and willfully, for a fee, counsels or assistants an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under [Medicaid] if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

In addition, criminal sanctions will be imposed against any individual or entity who knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution, facility or entity in order that such institution, facility or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled facility, facility, intermediate care facility for the mentally retarded, home health agency, or other entity for which certification is required under Medicare or a state health care program or with respect to information required to be provided under 42 U.S.C. §1320a-3a (disclosure requirements for other providers under Medicare Part B).

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 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 (Qui Tam), 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.

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) Penal Law Article 177 - Health Care Fraud

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

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes 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 (meaning an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under this section, including (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment including but not limited to discharge, suspension, or demotion; (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member, as defined in subdivision two of section four hundred fifty-nine-a of the social services law, to a federal, state, or local agency) against an employee if the employee:

(a) discloses, or threatens to disclose to a supervisor or to a public body an activity,

policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety, or which constitutes health care fraud;

(b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or

(c) objects to, or refuses to participate in any such activity, policy or practice.

The employee's disclosure is protected only if the employee first made a good faith effort to notify his or her employer by bringing the activity, policy or practice to the attention of a supervisor and gave the employer a reasonable opportunity to correct the activity, policy or practice. Such employer notification shall not be required where: (a) there is an imminent and serious danger to the public health or safety; (b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice; (c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor; (d) the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or (e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice. If an employer takes a retaliatory action against the employee, the employee may sue in state court for an injunction to restrained continued violation of Section 740, reinstatement to the same position held before the retaliatory action, or an equivalent position, or front pay in lieu thereof, reinstatement of full fringe benefits and seniority rights, any lost back wages and payment by the employer of reasonable costs, disbursements and attorneys' fees. If the Court determines that a civil action under Section 740 was without basis in law or fact, the Court, in its discretion, may award reasonable attorneys' fees and court costs and disbursements to the employer.

4) New York State Labor Law, Section 741

A health care employer may not take any retaliatory action (meaning a discharge, suspension, demotion, penalization, discrimination or other adverse employment action taken against an employee in the terms and conditions of employment) against an employee if the employee does any of the following:

(a) discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care ("improper quality of patient care" means any practice, procedure, action or failure to act of an employer which violates any law, rule, regulation or declaratory ruling adopted pursuant to law, where such violation relates to matters which may present a substantial and specific danger to public health or safety or a significant threat to the health of a specific patient) or improper quality of workplace safety ("improper quality of workplace safety" means any practice, procedure, action or failure to act of an employer which violates any law, rule, regulation, or declaratory ruling adopted pursuant to law where such violation relates to matters which may present an unsafe workplace environment or risk of employee safety or a significant threat to the health of a specific employee); or

(b) objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct such improper quality of patient care or improper quality of workplace safety, unless it: (1) presents an imminent threat to public health or safety or to the health of a specific patient or employee; and (2) the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. The court may also impose a civil penalty not to exceed $10,000 on the employer which is to be paid to the Improving Quality of Patient Care Fund established under the State Finance Law.

Submitted by: Corporate Compliance Committee

Reference to:

Original: January 2000
Revised: 9/07, 10/09, 5/12,3/16

Procedure Development: Compliance Committee

Additional Distribution: All Departments