Cayuga Health System

Regulatory Compliance Program Manual

Revisions as of 05/30/23
Reviewed and approved by Compliance Committee 06/07/23
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Part I Corporate Compliance Program

Cayuga Health System, Inc. (“CHS") has adopted a Regulatory Compliance Program (the “Program”) to demonstrate its commitment to comply with all federal and state laws and regulations, with particular emphasis on the standards established by the Department of Health and Human Services (HHS), the Office of the Inspector General of the Department of Health and Human Services (OIG), and the Office of the Medicaid Inspector General (OMIG). A summary of some of the applicable laws that inform this Program is set forth on Appendix A. The goal of the Program is to promote the highest ethical standards in CHS’ conduct of business.

The Program applies to all directors, officers, employees, contracted personnel, medical staff members, volunteers, students, contractors and agents (collectively referred to as “Affected Individuals”).

The Program includes policies and procedures that have been adopted and implemented to ensure that Affected Individuals have access to guidance and protocols that should be followed in performing their duties. **The policies and procedures set forth in this Program document are mandatory and must be followed** by all Affected Individuals at all times in the conduct of their duties for and on behalf of CHS.

The Program policies and procedures are intended to complement, not preempt, federal and state laws and regulations. The Program is not intended to be a comprehensive recitation of all laws and regulations to which CHS is subject. The purpose of the Program is to provide a framework that reduces the likelihood of non-compliance, and provide a process for effective mitigation and resolution of regulatory compliance risk. Program revisions will be made as appropriate to achieve this purpose.

The Program applies to all of CHS, with a particular emphasis on the following identified risk areas: billing, payment, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, and contractor/subcontractor/agent or independent contractor oversight.

To obtain further information or guidance about applicable CHS policies or applicable laws and regulations, you should contact the System Compliance Officer at 607-274-4494 or the Compliance Hotline at 607-274-4170.

Part II Code of Conduct

The CHS Code of Conduct (the “Code”) sets forth the principles that guide the actions of all Affected Individuals on a daily basis. The ultimate goal in adhering to the Code is to ensure that CHS meets its commitment to ethical standards and complies with applicable laws and regulations. The Code is a critical element of the Program. It is the responsibility of every Affected Individual to act in a manner that is consistent with policies set forth in the Code. The CHS Code of Conduct is attached to this Program Manual as Appendix B.

Part III Compliance Plan: Summary of Essential Elements

The essential elements of the Plan are designed to help prevent, detect, and correct violations of applicable law, regulations, third-party payer requirements, CHS’s policies/procedures, the Code and other applicable standards. These essential elements of the Plan incorporate all applicable state and federal regulations and guidance.

a. Written Policies and Procedures and Standards of Conduct

CHS’ obligations related to the Program are incorporated into the written policies, procedures, and standards of conduct (the “Compliance Policies”). The written Compliance Policies outline the operation of the Program and are reviewed at least annually and modified as necessary by the appropriate committee.

b. Compliance Officer and Compliance Committee

CHS has a designated compliance officer (the "Compliance Officer") who is vested with responsibility for the day-to-day activities of the Program. The Compliance Officer reports directly to the Vice President and General Counsel, as designee of the Chief Executive Officer, and has direct access to the Governing Board. CHS recognizes that there may be conflicts of interest and potential risks associated with the Compliance Officer reporting to the General Counsel, and therefore has adopted a written procedure for addressing any such conflicts of interest and potential risks. Periodically, but no less frequently than quarterly, the Chief Executive Officer, the Governing Board, directly or through the Audit Committee, and the Compliance Committee are provided a report from the Compliance Officer on the progress of adopting, implementing, and maintaining the Program.

It is the responsibility of the Compliance Officer to develop and coordinate the implementation of an annual compliance work plan. Individuals, other than the Compliance Officer, will be responsible for auditing and monitoring activities identified in the annual compliance work plan. CHS will periodically assess and monitor that it has allocated sufficient staff and resources to the Compliance Officer to perform the Compliance Officer's responsibilities for the day-to-day operation of the Program, which assessment will be completed during the annual Program effectiveness review.

CHS has a Compliance Committee (the "Compliance Committee") consisting of leadership level individuals, which Compliance Committee reports directly to the Chief Executive Officer and to the Governing Board. The Compliance Committee has adopted a committee charter that includes duties and responsibilities for coordinating with the Compliance Officer. The committee charter is reviewed annually and updated as necessary. The Compliance Committee coordinates with the Compliance Officer to ensure that all Affected Individuals complete compliance training and education during orientation and annually thereafter.

c. Compliance Program Training and Education

CHS has established and implemented an effective compliance training and education program for all Affected Individuals. All Affected Individuals are required to complete compliance training at least annually. Compliance training and education is documented in an annual training plan that is maintained by the Compliance Officer and outlines:

1. required subjects or topics,
2. timing and frequency of training,
3. which Affected Individuals are required to attend,
4. how attendance is tracked, and
5. how the effectiveness of the training is periodically evaluated.

Compliance training is provided in a manner that is understandable and accessible to all Affected Individuals.

All new employees receive compliance training and education as part of new employee orientation, which generally occurs within thirty (30) days of that employee's start date. Failure to undergo compliance education and training may result in discipline, up to and including termination.

Certain Affected Individuals may receive additional targeted compliance training depending upon the person's job-related obligations and responsibilities. Vendors and other contractors and agents are provided access to CHS's Program Manual and related policies and procedures on CHS's website at www.cayugahealth.org.

d. Lines of Communication

It is expected that any Affected Individual with knowledge of a suspected compliance issue will report that issue. CHS has established methods for the safe and anonymous reporting of actual or

suspected compliance issues. Reports of suspected compliance issued can be made in a number of ways as described below:

- Reporting orally or in writing to Affected Individual's supervisor, who in turn is obligated to report such suspected compliance issue to the Compliance Officer;
- by calling the Compliance Officer at 607-274-4494
- by calling the anonymous Compliance Hotline at 607-274-4170; and/or
- by completing and submitting the anonymous compliance reporting form found on the CHS Intranet page.

CHS, at the request of the reporting individual, will not disclose the identity of the reporting individual to the extent possible, consistent with its obligations to investigate the reporting individual's concerns and take necessary corrective action. Due to the nature of anonymous reports, CHS will be unable to provide feedback if anonymous reports are made. Concerns about the safety or quality of care provided at CHS should be reported using CHS' incident reporting system. Reported safety or quality of care concerns will be addressed in accordance with the processes established through the Quality and Patient Safety Department.

e. Disciplinary Standards

CHS' Human Resources department has established disciplinary standards and has implemented procedures for the enforcement of such standards to address potential violations of the Program and encourage good faith participation in the Program by all Affected Individuals. Any situations that require discipline of a CHS employee for Program violations will be referred by the Compliance Officer to Human Resources.

The disciplinary process will depend on the nature and severity of the offense and may result in any of the following disciplinary actions:

- verbal warning;
- written warning;
- suspension;
- disciplinary demotion; or
- discharge

f. Auditing and Monitoring

The Program is designed and implemented to prevent, detect, and correct non-compliance with applicable laws and regulations. Through the Program, CHS has established and implemented an effective system for routine identification and monitoring of compliance risks, which includes:

- Internal and external compliance audits focused on required risk areas.
- A process for identifying overpayments and ensuring they are reported, returned, and explained in accordance with applicable self-disclosure program requirements.
- Conducting annual reviews of the Program to determine its effectiveness, and whether any revision is required.
- Monthly exclusion checks of all Affected Individuals.

g. Responding to Compliance Issues

CHS promptly responds to all known or suspected compliance issues, including any issues identified in the course of an internal or external audit. CHS' response includes:

- Taking prompt action to investigate the conduct in question and determining if any corrective action is required.

- Correcting compliance problems promptly and thoroughly to reduce the potential for recurrence.
- Monitoring plans of correction to ensure compliance issues do not recur.
- Ensuring ongoing compliance with state and federal laws, rules, and regulations of government payment programs, including Medicare and Medicaid.
- Promptly reporting credible evidence that a state or federal law, rule, or regulation has been violated to the appropriate governmental entity.
- Reporting and returning overpayments in accordance with applicable self-disclosure program requirements.

h. Non-Retaliation for Good Faith Reporting of Compliance-Related Concerns

CHS is committed to maintaining a workplace where employees are free to raise good faith concerns regarding CHS's business practices and the care of its patients. It is the responsibility of every CHS employee to abide by applicable laws and regulations and support CHS's compliance efforts, including reporting their good faith belief of any violation of applicable local, state or federal law or CHS policies and procedures, including, without limitation, CHS's Corporate Compliance Program and Code of Conduct. To promote an open culture, CHS has adopted a strict non-retaliation policy.

Part IV Other Focus Areas of Compliance

a. Health Care Fraud and Abuse Prevention

One of the primary goals of CHS's Corporate Compliance Program is to prevent and detect fraud and abuse. Health care decision-making must be based upon the patient's medical needs, and must not be based upon financial benefits to CHS, employees (including medical staff), or that of any other entity or individual.

CHS and its Employees may not give, receive, offer or ask for anything of value in exchange for referring patients, products, or services ("Anti-Kickback"). This includes accepting anything of value for purchasing, leasing, ordering, arranging for, or recommending a particular product or service.

CHS shall ensure that its relationships with Physicians satisfy the rules concerning the prohibition against physician self-referral (both the Federal Stark law and applicable state law).

b. Coding and Reimbursement

CHS promotes full compliance with all relevant billing and claims reimbursement requirements.

All persons who are involved in any aspect of CHS's coding, billing and claims submission processes must be appropriately trained, credentialed if required, and prepared for their responsibilities, including without limitation appropriate training with respect to the requirements of the Medicare and Medicaid programs.

c. Record Retention and Destruction

All employees must protect the integrity of CHS's documents and records to ensure that records are maintained in accordance with regulatory and legal requirements, and for the required length of time. All records, both medical and business, shall be retained in accordance with the law and CHS's specific record retention policies. Records and documents, which include both written and computer-based information, such as e-mail or computer files on disk or tape, shall be retained and destroyed in accordance with CHS policy and procedures.

d. Confidentiality

Employees should become familiar with their department's specific policies and procedures in addition to CHS-wide policies, such as the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Generally, an employee should only access and use the information necessary to perform the employee's work-related responsibilities and should only disclose information as authorized to

others having an official need to know. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, employees should seek guidance from their supervisor. Supervisors in turn should seek guidance from an appropriate CHS administrator, the Privacy Officer, or the Compliance Officer.

CHS will maintain the confidentiality of Protected Health Information, or PHI, including information such as: names, addresses, medical diagnoses, social security numbers, etc.

HIPAA also requires adherence to the minimum necessary standard for use and disclosure of patient information. Below are some examples of inappropriate disclosure:

- access another employees medical record unless it is for treatment, payment or operations
- discussing patient information in public areas (e.g., elevator, cafeteria) where it can be overheard by others not involved in their care
- sharing information about a patient with your family members or friends
- reviewing your own medical records without following the proper procedure

e. Conflict of Interest

A conflict of interest may occur if an employee's outside activities or personal financial interests influence or appear to influence the employee's ability to make objective decisions in the course of the employee carrying out his/her CHS responsibilities and obligations. Employees should always avoid such conflicts of interest.

CHS requires certain employees to disclose financial interest that the employee (or the employee's immediate family member) may have that would interfere or affect the employee's responsibilities for on behalf of CHS. Employees should refer to CHS's Conflict of Interest Policy for more details concerning conflicts.

f. Provider/CHS Business Relationships and Referrals

Any business relationship or arrangement between CHS and a physician, physician entity or other healthcare provider must be structured to ensure compliance with all legal requirements, including, but not limited to, the fraud and abuse laws and regulations, and to avoid jeopardizing CHS's tax-exempt status as a not-for-profit entity. Such relationships and arrangements must be documented in writing, signed by the parties and subject to review and approval by CHS's legal counsel.

g. Social Media

Protecting the privacy and confidentiality of patient, employee and confidential business information is fundamental to our mission as a healthcare provider. Posting any patient or proprietary information on social media/networking sites such as Facebook, Twitter, or YouTube is prohibited. Authorized personnel at CHS (i.e., Marketing and Communications) may use social media in the course of their duties for approved, business-related purposes. Employees should refer to CHS's Social Communication policy for more information.

h. Agents and Independent Contractors

CHS is committed that all organizations acting as agents on its behalf, such as contractors, subcontractors, consultants and independent contractors, will comply with the Program. All consultants, agents, and independent contractors are responsible for accessing and reviewing the CHS Compliance Plan, and agree to abide by it, as made available on the cayugahealth.org website.

CHS will not conduct business with consultants and independent contractors that have been excluded from participation in the Medicare and Medicaid programs.

Part V Appendixes

Appendix A: Description of Fraud and Abuse/Non-Retaliation Laws

*All fines noted below are as of the publication of this document, amendments to fines may have been made post-publication and may not be reflected.

I. Federal and New York State Health Care Fraud and Abuse Laws.

Both the federal and New York state governments fund health care programs that provide medical and mental health care benefits to qualified patients. Examples of such government health care programs include, but are not limited to, Medicare and Medicaid. To avoid waste, fraud and abuse in Medicare, Medicaid and other programs, there are Federal and State laws designed to deter fraud and abuse, some of which are described below.

a. Federal False Claims Act, 31 USC §§ 3729 -3733.

The federal False Claims Act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from Medicare, Medicaid or other federal health programs. The penalty for filing a false claim is $12,537 to $25,076 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The FCA provided that any person who knowingly submitted false claims to the government was liable for double the government's damages plus a penalty of $2,000 for each false claim. The FCA has been amended several times and now provides that violators are liable for treble damages plus a penalty that is linked to inflation. . In addition, such violations can subject a person to exclusion from participation in federally funded health care programs, such as Medicare and Medicaid.

The False Claims Act allows private individuals to file lawsuits in federal court, just as if they were federal prosecutors. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25 - 30% of the proceeds if the government did not participate in the suit or 15 - 25% if the government did participate in the suit.

This law applies to any person (or entity) who:

- knowingly presents, or causes to be presented, to the United States Government, a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
- 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;
- 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 the property; or
- knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
- any person who engages in any of the above conduct may have violated the False Claims Act and may be liable for monetary penalties and damages, depending on the

circumstances surrounding the false claim(s).

b. **Program Fraud Civil Remedies Act, 31 USC §§ 3801-3812 (PFCRA).** This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $13,508 for each claim. The agency may also recover twice the amount of the claim.

   Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not 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.

c. **New York State False Claims Act, State Finance Law §§187-194.** The New York State false claims act is very similar to the Federal False Claims Act.

   Section 189 of the New York State Finance Law makes it unlawful in the State of New York for a person or entity to commit any of the fraudulent acts set forth in the federal False Claims Act. Both the federal and New York False Claims Acts impose civil liability on any person who commits fraudulent acts including, without limitation, one who: (i) knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval; (ii) conspires to defraud the government by getting a false or fraudulent claim allowed or paid; or (iii) knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay the government. The New York False Claims Act (the "Act") also makes it unlawful for a person or entity to: (i) have property or money of the State or local government and, with the intent to defraud or willfully conceal the property or money, deliver less property or money than the amount stated in the receipt; (ii) make or deliver a document certifying receipt of property without completely knowing that the information on the receipt is true; or (iii) knowingly buy or accept unlawfully sold public property from a State or local government employee or officer.

   The term "knowingly" is defined in Section 188 of the Act with language identical to that of the federal False Claims Act. Proof of specific intent to defraud is not required, provided, however that acts occurring by mistake or as a result of mere negligence do not subject a person to liability.

   For the commission of any single fraudulent act, the actor shall be liable to the State for a civil penalty of between $13,508 and $27,018, and to both the State and local government for three times the amount of damages each sustained as a result of the fraudulent act. Section 190 of the Act allows for civil enforcement actions to be commenced by either the Attorney General of the State of New York, by any local government, or by any private person who brings an action on behalf of the state or any local government.

   It prohibits the filing of a false claim which means that a person:

   - knowingly presents, or causes to be presented, to any employee, office or agent of the state or a local government, a false or fraudulent claim for payment or approval;
   - knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;
   - conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid;
   - has possession, custody, or control of property or money used, or to be used, by the State or a local government and, intending to defraud the state or a local government or willfully to conceal the property or money, delivers, or causes to be delivered, less property or money than the amount for which the person receives a certificate or receipt;
   - is authorized to make or deliver a document certifying receipt of property used or to be used by the state or a local government and, intending to defraud the state or a local government,

makes or delivers the receipt without completely knowing that the information on the receipt is true;

- knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee lawfully may not sell or pledge the property; or
- knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a local government.
- a person who does any of the above acts will be liable for a civil penalty of between $13,508.00 and $27,018.00 plus three times the amount of damages sustained by the state or local government. The amount of damages may be reduced if the violator self discloses the violation.

d. New York State Finance Law § Section 191. Any current or former employee, contractor, or agent of any private or public employer who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment, or otherwise harmed or penalized by an employer, or a prospective employer, because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action brought under this article or other efforts to stop one or more violations of this article, shall be entitled to all relief necessary to make the employee, contractor or agent whole. Such relief shall include but not be limited to:

- an injunction to restrain continued discrimination;
- hiring, contracting or reinstatement to the position such person would have had but for the discrimination or to an equivalent position;
- reinstatement of full fringe benefits and seniority rights;
- payment of two times back pay, plus interest; and
- compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

For purposes of this section, a “lawful act” shall include, but not be limited to, obtaining or transmitting to the state, a local government, a qui tam plaintiff, or private counsel solely employed to investigate, potentially file, or file a cause of action under this article, documents, data, correspondence, electronic mail, or any other information, even though such act may violate a contract, employment term, or duty owed to the employer or contractor, so long as the possession and transmission of such documents are for the sole purpose of furthering efforts to stop one or more violations of this article. Nothing in this subdivision shall be interpreted to prevent any law enforcement authority from bringing a civil or criminal action against any person for violating any provision of law. An employee, contractor or agent described above in subdivision one of this section may bring an action in the appropriate Supreme Court for the relief provided in this section.

e. Qui Tam Lawsuits. The Federal False Claims Act and the New York State False Claims Act also provide for *qui tam* lawsuits through which any person (the “qui tam relator”) may bring a civil action for himself or herself and on behalf of the US Government for any violation of the False Claims Act. If the qui tam relator ultimately wins the lawsuit or if there is a settlement of the lawsuit, he or she may share in a portion of any money recovered with the government and receive reimbursement for reasonable expenses, reasonable attorneys’ fees and costs. Please note recovery by the qui tam relator is uncertain and dependent upon the facts and circumstances of the case.

f. Federal Anti-Kickback Statute (“Anti-Kickback Statute”), 42 U.S.C. § 1320a-7b(b)

- The federal Anti-Kickback Statute is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business (Medicare or Medicaid).

- Criminal penalties include fines up to $100,000 per violation, 10 years in prison or both. Civil penalties include False Claims Act liability, Civil Monetary Penalties up to $50,000 per violation, civil assessment of up to three times amount of kickback and program exclusion. Safe harbors protect certain payment and business practices that could otherwise implicate the Anti- Kickback Statute from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to bona fide employees.

g. Physician Self-Referral Law ("Stark Law"), 42 U.S.C. § 1395nn

- The Physician Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive designated health services (DHS) payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. It also prohibits entities from presenting or causing to be presented claims to Medicare or Medicaid for those referred services.

- Civil penalties include overpayment/refund obligation, False Claims Act liability, Civil Monetary Penalties (CMP) and program exclusion for knowing violations, potential $15,000 CMP for each service and civil assessment of up to three times the amount claimed.

h. Non-Retaliation Policy.

- The False Claims Act forbids retaliation by an employer against an employee who cooperates with investigators regarding potential False Claims Act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program CHS fully complies with all applicable "whistle-blower" protections.
- The False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. The New York State False Claims Act has similar non-retaliation protections.

i. New York State Social Services Law § 145-b: False Statements.

- Under New York Social Services Law § 145-b, it is unlawful for any person, firm or corporation to knowingly by means of a false statement or representation (defined below), or by deliberate concealment of any material fact, or other fraudulent scheme or device, on behalf of himself/herself or others, to attempt to obtain or to obtain payment from public funds for services or supplies furnished or purportedly furnished under the Social Services Law, including Medicaid.
- "Statement or representation" includes, but is not limited to: a claim for payment made to the state, a political subdivision of the state, or an entity performing services under contract to the state or a political subdivision of the state; an acknowledgment, certification, claim, ratification or report of data which serves as the basis for a claim or a rate of payment, financial information whether in a cost report or otherwise, health care services available or rendered, and the qualifications of a person that is or has rendered health care services.
- For the violations described in section i above, the government may recover civil damages (plus interest) equal to three times the amount of the false claim or in the case of non-

monetary false statements, three times the amount of actual damages or five thousand dollars, whichever is greater.

j. DOH Penalties

The Department of Health may require the payment of a monetary penalty by any person who fails to comply with the standards of Medicaid or of generally accepted medical practice in a substantial number of cases or grossly and flagrantly violated such standards and receives, or causes to be received by another person, Medicaid payment when such person knew, or had reason to know, that:

- The payment involved the providing or ordering of care, services or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
- The care, services or supplies were not provided as claimed;
- The person who ordered or prescribed care, services or supplies which was medically improper, unnecessary or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from Medicaid at the time the care, services or supplies were furnished; or
- The services or supplies for which payment was received were not, in fact, provided.

k. New York State Social Services Law § 145-c: Sanctions. It is a violation of the law for any person to apply for or receive public assistance, including Medicaid, by intentionally making (or intending to make) a false or misleading statement. Social Services Law §145-c sets forth certain sanctions which may be imposed against a person for such illegal actions.

l. Social Services Law § 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.

m. New York Social Services Law § 366-b. Any person who obtains or attempts to obtain, for himself or others, Medicaid benefits by false means is guilty of a Class A misdemeanor. In addition, any person who, with the intent to defraud, presents for payment any false or fraudulent claim, knowingly gives false information to obtain more money than he is legally entitled to, or knowingly gives false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

n. New York Penal Law Article 155, Larceny. A person steals property and commits larceny when, with the intent to deprive another of his property, wrongfully takes, obtains, or withholds such property by means of trick, embezzlement, false pretense or fraud. There are four levels of offenses, depending on the value of the property involved. It has been applied to Medicaid fraud cases.

- Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
- Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
- Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
- First degree grand larceny involves property valued over $1 million. It is a Class B felony.

o. New York Penal Law Article 175, False Written Statements. The crimes under Article 175, involve false written statements, including for example, filing false information, the falsification of business records and tampering with public records. It has been applied in Medicaid fraud prosecutions:

- §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.

- §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.

- §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.

- §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.

p. Insurance Fraud Under Article 176 of the New York Penal Law. Under Penal Law § 176.05, a fraudulent health care insurance act is committed by any person who, knowingly and with intent to defraud, presents (or causes to be presented) to an insurer, including Medicaid, a claim for health benefits which such person knows to contain materially false or misleading information. There are six levels of offenses, generally depending on the value of the false claim. A person is guilty of aggravated insurance fraud when he commits a fraudulent insurance act, and has been previously convicted within the preceding five years of any offense also involving a fraudulent insurance act.

- Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

- Insurance fraud in the 4th degree is filing a false insurance claim for over $1000. It is a Class E felony.

- Insurance fraud in the 3rd degree is filing a false insurance claim for over $3000. It is a Class D felony.

- Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

- Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

- Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

q. Health Care Fraud Under Article 177 of the New York Penal Law

Penal Law Article 177 also involves offenses of health care fraud. Under Article 177, a person is guilty of health care fraud when, with the intent to defraud a health plan (including Medicaid), he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for items or services and, as a result of such information or omission, payment is received for which he/she or another person is not entitled. There are five levels of offenses, depending on the value of the fraudulent claims.

- Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A

Misdemeanor.

- Health care fraud in the 4th degree is filing false claims and annually receiving over $3000 in aggregate. It is a Class E felony.

- Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

- Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

- Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

- It is a defense for crimes under Article 177 that the defendant was a clerk, bookkeeper or other employee (other than an employee charged with active management and control, in an executive capacity, of the affairs of the corporation) who, without personal benefit, merely executed the orders of his or her employer/supervisor.

r. Insurance Frauds Prevention. Section 403 of the New York Insurance Law prohibits an individual, firm, association or corporation from committing a fraudulent insurance act as defined in Penal Law § 176.05. Violators may be subject to both criminal liability and money penalties.

s. 31 U.S. Code § 3730 (h). Relief from Retaliatory Actions. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section (31 U.S. Code § 3730) or other efforts to stop 1 or more violations of this subchapter (Subchapter III. CLAIMS AGAINST THE UNITED STATES GOVERNMENT).

Relief shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection. A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

II. Employee Whistleblower Protection Rights/Non-Retaliation.

a. **CHS's Non-Retaliation Policy**. As set forth in greater detail below, the False Claims Act forbids retaliation by an employer against an employee who cooperates with investigators regarding potential False Claims Act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program, CHS fully complies with all applicable "whistle-blower" protections.

b. **Specific False Claims Act Protection**. The False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys'

fees.

c. **New York Labor Laws Prohibiting Retaliatory Personnel Actions.** Two Laws prohibiting employer retaliation against employees are addressed below. The first is Labor Law § 740 and applies to employers in general. The second is Labor Law § 741, and is specific to health care providers.

- **Labor Law § 740.** This law prohibits retaliatory personnel action by an employer against an employee who discloses or who threatens to disclose, to a supervisor or to a public body, an activity, policy or practice of the employer that the employee believes in good faith to be in violation of law, rule or regulation which creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud.

  a. The protection against retaliatory personnel action provided above pertaining to disclosure to a public body only applies where the employee has first brought the activity, policy or practice believed to be in violation of law, rule or regulation to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice.

  b. Labor Law § 740 also prohibits an employer from taking retaliatory personnel action against an employee who provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into a violation of law, rule or regulation by such employer. In addition, an employer may not take retaliatory personnel action against an employee who objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

  c. For purposes of Labor Law §740, "retaliatory personnel action" means the discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

  d. An employee who has been the subject of a retaliatory personnel action in violation of Labor Law § 740 may commence a civil court action within one year after the alleged retaliatory personnel action was taken. The employee may seek the following relief:

  - an injunction to restrain the employer's continued violation;
  - the reinstatement of the employee to the same position held before the retaliatory personnel action, or to an equivalent position;
  - the reinstatement of full fringe benefits and seniority rights;
  - compensation for lost wages and benefits; and
  - payment by the employer of reasonable costs, disbursements, and attorney's fees.

  e. Labor Law § 740 does not diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract. However, an action brought under § 740 is deemed a waiver of the rights and remedies otherwise available to the employee under any other contract, collective bargaining agreement, law, rule or regulation or under the common law.

- **Labor Law § 741.** This law prohibits retaliatory action by *certain health care* employers against a health care employee who discloses or who threatens to disclose, to a supervisor or to a public body, an activity, policy or practice of the employer or employer's agent that the employee, in good faith reasonably believes constitutes improper quality of patient care. Labor Law § 741 also prohibits retaliatory action by such employer if the employee objects to, or refuses to participate in any activity, policy or practice of the employer that the employee, in good faith, reasonably believes constitutes improper quality of patient care.

  a. Protection against retaliatory action does not apply unless the employee has first notified the employer of the improper quality of patient care and has afforded the employer a reasonable opportunity to correct such activity, policy or practice. However, such notice is

not required if there is an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

b. For purposes of Labor Law § 741, "retaliatory action" means the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

c. Under Labor Law § 741, an employee has two years from the date of the alleged retaliatory action to commence a lawsuit. In addition to the remedies that may be available to the employee a court may assess a fine up to $10,000 against the employer if the court finds that the employer acted in bad faith. These fines are not paid to the employee, but will be deposited into a state-wide fund to improve patient care.

Appendix B: Code of Conduct

Purpose

The Cayuga Health System (CHS) Code of Organizational Ethics and Business Conduct (the "Code") provides the virtues and principles that guide our actions on a daily basis in serving our mission. CHS is committed to the principles of dignity, respect, integrity and courtesy in our conduct:

- for our patients and customers, we are committed to providing quality health care, delivered timely and at a reasonable cost;
- for our employees, we are committed to fairness, just management, and providing a safe and healthy work environment;
- for the communities where we live and work, we are committed to acting as concerned and responsible neighbors, reflecting all aspects of good citizenship; and
- for our suppliers, we are committed to fair competition and the sense of responsibility required of a good customer.

The ultimate goal in adhering to the Code is to ensure that we meet our commitment to ethical standards and comply with applicable laws and regulations. The Code is a critical element of CHS' Regulatory Compliance Program. It is the responsibility of every governing body member, officer, employee, physician, volunteer, student and other agent to act in a manner that is consistent with policies set forth in the Code.

Policy

- We will fairly and accurately represent our organization's capabilities and ourselves to our patients and the public.

- We will provide services that are designed to meet the identified needs of our patients and the residents of our service area while at the same time avoiding the provision of services which may be unnecessary. Admission, clinical, transfer and discharge decisions are based on the identified health care needs of the patient and the services available at the CHS, not on payment determinations or financial incentives.

- We will adhere to uniform standards of care and provide health care services within the scope of our license and medical ability. In the various settings where patient services are provided, they will be well designed, based on the needs of patients, and provided without regard to a patient's cultural background, marital status, sexual or religious orientation, ethnic background, age, disability, or ability to pay.

- We will treat all patients in a manner that considers and respects their decisions, or those of their legally designated proxy or guardian in matters regarding the care they receive.

- We recognize that from time to time, conflicts will arise among those who participate in hospital and patient care decisions. Whether this conflict exists between employees, medical staff, management, board members or between patient caregivers and the patient, CHS will endeavor to resolve all conflicts fairly, objectively and expeditiously. In those situations where a satisfactory resolution has not occurred, the President/CEO or their designee will be involved as per policy.

- We recognize the need to maintain patient and other information in a confidential manner. As such, patient information will not be shared in an unauthorized manner and sensitive information concerning human resource and management issues will be maintained in strictest confidence, accessed only by those individuals authorized by policy or law.

- We recognize that patients have the right to be informed of the existence of business relationships between the CHS and educational institutions, other health care providers, payers, or networks that may influence the patient's treatment and care.

- We shall have a written agreement defining the respective roles and responsibilities of the CHS and any educational program or institution which utilizes the clinical facilities of the CHS for the education of students. These agreements shall recognize the responsibility of the CHS for activities of the educational program and students that affect the care of patients.

- As a charitable organization, we will conduct business in compliance with all IRS regulations governing tax-exempt organizations and refrain from any private inurement or benefit issues.

- Patient care must be necessary, appropriate and well documented. We must ensure the medical necessity of the care provided and verify patient eligibility. In addition, we will accurately record all services provided, documenting physician authorization when necessary. Improper coding of services and care provided (i.e., upcoding, fragmentation, use of obsolete or inappropriate coding) will not be tolerated and will result in immediate disciplinary actions.

- For all proposals, bid preparations or contracting negotiations, we will make certain that all statements, communications and representations to prospective partners or suppliers are accurate and truthful. In buying goods or services, we will treat all suppliers uniformly and fairly. In deciding among competing suppliers, we will objectively and impartially weigh all facts and avoid even the appearance of favoritism. Established policies and procedures will be followed in the procurement of all goods and services.

- We recognize the potential for conflicts of interest exist for board members, employees and physicians. Generally, any relationship, influence or activity that might impair ones ability to make objective and fair decisions when performing their duties should be avoided. Potential conflicts of interest include: employee outside employment, accepting gifts, related party transactions, arrangements, contracts or compensation plans.

- We will generate billing and claims accurately reflecting that services rendered are supported by relevant documentation and are submitted in compliance with applicable laws, regulations and government program requirements (such as Medicare, Medicaid, TRICARE, etc.). We will never submit improper, false, fictitious or fraudulent claims to any government or private health care program. We will assist our patients in understanding the cost of their care and attempt to resolve billing questions and conflicts to the satisfaction of the patient.

- Business integrity is a key principle for the selection and retention of those who represent the CHS. Physicians, consultants or agents must express their willingness to comply with our policies and procedures and will never be retained to circumvent our ethical values and virtues. Accepting or paying bribes or kickbacks, obtaining the proprietary data of a third party, or gaining inside information or influence are just a few examples of what could give us an unfair competitive advantage and result in violations of law.

- We will comply with all regulations governing the management and distribution of controlled substances. Specifically, no employee or physician affiliated with the CHS will illegally distribute any controlled

substances, including prescription drugs. In addition, expired, adulterated or misbranded pharmaceutical drugs may not be distributed or diverted. Medical and infectious waste will be properly handled and disposed of in accordance with the appropriate regulations.

- We will provide all employees a work environment in which they feel respected, satisfied and appreciated. Employees will be hired, promoted and compensated according to their qualifications and performance. Harassment or discrimination of any kind, especially involving race, color, disability, age, ethnic or cultural background, sexual orientation and veteran or marital status is unacceptable and will not be tolerated.

- We will comply with Medicare and Medicaid anti-kickback stipulations that no employee or physician knowingly and willfully offer, pay, solicit or receive compensation (i.e., in cash or “in kind” consideration) in connection with the referral of patients or acquisition of items for services.

- We will comply with federal and state antitrust laws. These laws address agreements and practices resulting in the restraint of competition including boycotting suppliers, discussing pricing or patients with competitors, implementing unfair or deceptive business practices, and misrepresenting services.

- We will comply with all environmental, health and safety laws and regulations. Providing a drug-free, safe and healthy environment is of the utmost importance. Observe posted warnings and regulations. Any accident or injury sustained on the job, or any environment or safety concern should be reported immediately to the appropriate management.