



**Always best
to comply!**

COMPLIANCE PROGRAM **CODE OF CONDUCT**

2022 VERSION



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Code of Conduct

At VNS Health, our Code of Conduct (“Code”) is a critical component of our Compliance Program. This Code applies to VNS Health, the corporate parent and its family of corporations. The VNS Health Enterprise is comprised of VNS Health Providers, VNS Health Health Plans, and VNS Health MSO.

VNS Health Providers include: VNS Health Home Care, VNS Health Hospice Care, VNS Health Personal Care, and Medical Care at Home, P.C.

VNS Health Health Plans is a managed care organization and offers multiple managed Medicare and Medicaid plans.

The VNS Health Providers are different types of service entities and operate under different licensure requirements. VNS Health Home Care is a Certified Home Health Agency (CHHA) that offers skilled professional services to patients on a part-time, intermittent basis based on a plan of care established in collaboration with the patient’s physician. VNS Health Hospice Care offers hospice and palliative care to patients with a certified terminal illness and provides services in the community. VNS Health Personal Care is a Licensed Home Care Services Agency (LHCSA) that contracts with other VNS Health Providers and VNS Health Health Plans to provide personal care services to patients and members; VNS Health Personal Care

also contracts with non-VNS Health entities and also contracts with non-VNS Health entities and individuals to provide nursing, personal care aides and other services.

Additionally, VNSNY Care Management IPA provides both care management and utilization management services. It contracts with other VNS Health Providers, VNS Health Health Plans, and non-VNS Health entities to provide these services.

All directors, officers, employees, contractors, volunteers, interns, agents and others associated with VNS Health, VNS Health Providers, VNS Health Health Plans, and VNS Health Health Plans’ First Tier, Downstream, and Related Entities (“FDRs”) (collectively, the “Personnel”) are required to comply with this Code.

VNS Health

Keep patient and member information confidential.

Shhhh!!

Remember to always protect patient health information — it's the law.

- Encrypt emails – In Outlook click “Options”, “Encrypt”, “Encrypt-Only” or type “ENCRYPTME” in the subject line
- Only access information necessary to perform your job
- Lock your computer when not in use (+L or Ctrl+Alt+Delete)
- Never leave protected health information out in the open (for example on your desk or a copy machine)
- Do not text protected health information (unless using VNS Health approved secure texting applications)
- Never post protected health information on social media
- Avoid conversations about protected health information in elevators and other open places

When in doubt, do not disclose!

VNS HEALTH'S HIPAA PRIVACY LEADERSHIP TEAM:

Annie Miyazaki-Grant Chief Compliance and Privacy Officer Annie.Miyazaki-Grant@vnshealth.org	Justin Bain Information Technology and Cyber Security Officer Justin.Bain@vnshealth.org
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OR CONTACT US AT:
HIPAAandPrivacyTeam@vnshealth.org

Anonymous reports can be made 24 hours a day, 7 days a week by calling the VNS Health Compliance Hotline at 888-634-1558, or by visiting www.vnshealth.ethicspoint.com.



VNS Health has adopted and implemented numerous compliance policies and procedures that further describe compliance expectations set forth in this Code. These policies and procedures are available on the intranet and address specific compliance risk areas and requirements in order to ensure that the Compliance Program is operating efficiently and effectively. However, this Code and related policies are not a detailed rule-book, nor are they all inclusive. Consequently, VNS Health relies on the good judgement and value of its Personnel to implement the intent of this Code when neither this Code nor VNS Health policies and procedures address a specific situation. If you have any questions or concerns about anything covered by the Code, or about any other matter relating to the Compliance Program, or if you wish to report a compliance concern or problem, please contact the appropriate individual or Compliance Hotline listed in Section IV.

The VNS Health Board of Directors (“VNS Health Board”) is responsible for overseeing the Compliance Program. The VNS Health Board has delegated the responsibility for overseeing the Compliance Program and adherence to the Code to the Audit Committee of the VNS Health Board. The Chief Compliance Officer reports directly to the Audit Committee. In addition, the VNS Health Provider Boards of Directors and the VNS Health Health Plans Board of Directors maintain responsibility for overseeing the compliance activities of VNS Health Providers and VNS Health Health Plans, respectively, and receiving reports of compliance activities, including substantiated reports of fraud, waste and abuse (“FWA”) from the Chief Compliance Officer.

1 CODE OF CONDUCT: Mission and Values

- VNS Health is proud of its long tradition of ethical and responsible conduct, embodied in VNS Health's three core values: integrity, empathy, and agility. We are committed to improving the health and well-being of people through high-quality, cost effective healthcare in the home and community. We provide these services pursuant to the highest ethical, business, and legal standards. These high standards apply to our interactions with everyone with whom we deal. This includes our patients and members, other health care providers, companies with which we do business, government entities to which we report, and the public and private entities from which reimbursement for services is sought and received. In this regard, all Personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. While the legal rules are very important, we must hold ourselves up to even higher ethical standards.
- In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with VNS Health. We expect and require all Personnel to be law-abiding, honest, trustworthy, ethical, and fair in all of their business dealings and to strive to avoid even the appearance of impropriety. To ensure that these expectations are met, the Compliance Program has become an integral part of our corporate mission, culture, and business operations.
- VNS Health has an open-door policy and encourages and supports open communication, feedback and discussion about any matters of importance or concern to Personnel. Our open-door policy means that Personnel are free to talk to their supervisor, the Compliance Department, the Human Resources Department, or Legal Department at any time.
- Except where specific elements of the Code state that they only apply to certain of the VNS Health subsidiaries, the Code applies to all VNS Health programs and Personnel.



2 **CODE OF CONDUCT:** Scope of Application

- All Personnel are responsible for creating and maintaining a work environment in which compliance concerns can be raised, reported, and addressed. VNS Health expects all Personnel to read and understand this Code, and to actively participate in the Compliance Program. It is up to all of us to ensure that an atmosphere of integrity and ethical conduct is engrained in our corporate culture.



3 **CODE OF CONDUCT:** Regulatory Agencies

- As a not-for-profit entity, VNS Health must comply with the New York Not-For-Profit Corporation Law, that is overseen, in part, by the New York Charities Bureau.
- VNS Health Providers are regulated by, and have relationships with, the New York State Department of Health (“DOH”) and the Centers for Medicare and Medicaid Services (“CMS”), among others. Certain of the VNS Health Providers which provide mental health services are also regulated by the New York State Department of Mental Hygiene, among others. If your job includes VNS Health Provider-related responsibilities, you must be familiar with and follow the policies adopted by that VNS Health Provider which are relevant to your responsibilities to ensure compliance with applicable laws, rules, and regulations.
- VNS Health Health Plans is regulated by, and has relationships with, the DOH, CMS, and the New York State Department of Financial Services (“DFS”), among others. If your job includes health plan-related responsibilities, you must be familiar with and follow the policies and procedures adopted by VNS Health Health Plans to ensure that we comply with all applicable health plan laws, rules and regulations.

4 Reporting Non-Compliance With the Code of Conduct

HOW TO REPORT COMPLIANCE CONCERNS:

- Contact an immediate supervisor or a member of the VNS Health Compliance Department.
- All Personnel may also report compliance issues or concerns anonymously to the Compliance Hotline.

The identity of the reporting Personnel will be kept confidential unless the matter is turned over to law enforcement and as is otherwise consistent with applicable law and the need to investigate the issue(s) raised.

ANONYMOUS HOTLINE & ONLINE REPORTING TOOL

Through our Hotline and online reporting tool, individuals can report a concern or seek guidance about compliance questions:

- 24 hours a day, 7 days a week
- Anonymously, if you choose

VNS Health Compliance Hotline:

(888) 634-1558

VNS Health Online Reporting Tool:

www.vnshealth.ethicspoint.com

COMPLIANCE LEADERSHIP

VNS Health Chief Compliance and Privacy Officer

Annie Miyazaki-Grant

SVP, Chief Compliance & Privacy Officer

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VP, Health Plans Compliance &

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There are so many ways to report compliance concerns. Which way do I choose?

You choose the way which is the most comfortable for you. You may always contact the Chief Compliance Officer directly. However, if you wish to remain anonymous, you must raise your compliance concern through the Compliance Hotline.

5 CODE OF CONDUCT: Standards

GENERAL STANDARDS

- Personnel must be honest and lawful in all of their business dealings and avoid any conduct that might create even the appearance of impropriety.
- Personnel must:
 - 1) Comply with the Code, all applicable laws, rules, contractual requirements, and VNS Health policies and procedures;
 - 2) Report any action(s) they think may be unlawful, inappropriate, or violate the Code, any applicable VNS Health compliance policy or procedure, or any law, rule or regulation;
 - 3) Fully cooperate with inquiries by the Compliance and Legal Departments; and
 - 4) Work to correct any improper or non-compliant practices that are identified.
- VNS Health does not tolerate any retaliation or intimidation for good faith participation in the Compliance Program. This protection extends to reports by Personnel of suspected violations of the Code, the Compliance Program or any law, rule or regulation, as well as Personnel participation in Compliance Program activities including, but not limited to:
 - 1) Reporting of potential issues;
 - 2) Investigations of compliance issues;
 - 3) Self-evaluations;
 - 4) Audits;

- 5) Remedial actions; and
- 6) Reports to appropriate officials as provided in N.Y. Labor Law §§ 740 and 741.

STANDARDS RELATING TO TREATMENT OF PERSONNEL

- VNS Health is committed to providing an environment where everyone treats everyone else with respect and dignity. VNS Health strongly believes that collaboration, communication and collegiality are essential for the provision of quality services and a joyful workplace.
- VNS Health treats, and expects its Personnel to treat, all Personnel without unlawful discrimination on the basis of race, color, national origin or ancestry, age, sex, sexual orientation, gender identity or expression, religion, disability, or any other protected category under applicable federal, state, and local laws. For additional information, please refer to the Equal Employment Opportunity Policy.
- VNS Health expects its environment to be free from slurs, epithets, threats, derogatory comments and unwelcome jokes, teasing, sexual advances, and other verbal or physical conduct of a lewd nature such as uninvited touching or sexually related comments. Please refer to the Human Resources Non-Harassment Policy.

STANDARDS RELATING TO QUALITY OF CARE

- VNS Health’s primary mission is to provide the highest quality of care in the most ethical and compassionate fashion to our patients, members and their families without regard to race, religion, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression, ethnic background, or ability to pay.
- VNS Health acknowledges and responds with sensitivity to the interruption of privacy that is necessitated by care at home and will enter no further into family life and affairs than is required to meet the goals set forth in the plan of care.
- VNS Health honors the dignity and privacy of each patient and member and will treat them with consideration, courtesy, and respect.
- VNS Health ensures that patient care conforms to all applicable clinical and safety standards.
- VNS Health Providers ensure that patients are properly evaluated and treated by qualified practitioners that are appropriately licensed, certified or registered.
- VNS Health Health Plans ensures that all providers in its network who provide services to its members are qualified and appropriately licensed, registered, or credentialed.
- VNS Health has a continuous quality and performance improvement program.

- VNS Health provides reasonable accommodations and modifications for patients and members with disabilities, as required by applicable laws, rules and regulations.

STANDARDS RELATING TO COLLECTION AND REPORTING OF DATA

The VNS Health Enterprise participates in the value-based payment model as both provider and as payor. Under this model, payment for home health services is shifting from volume-based to value-based.

For VNS Health Providers

- Under the value-based payment model, a portion of the VNS Health Provider’s payment is based on its performance as measured by identified metrics of quality, health outcomes, and efficiency. Each VNS Health Provider must develop and maintain systems and capacity to collect and track data in these identified performance metrics. Much of the data will be collected from clinical information entered into the patient record, such as OASIS items and visit notes, while other data may be collected from different types of sources such as the CAHPS survey.
- Data collection and reporting is a shared responsibility among various types of VNS Health Enterprise personnel, including but not limited to clinical, business and IT personnel. All VNS Health Provider personnel are individually responsible to collect, record, and report necessary data accurately and on a timely basis.

For VNS Health Health Plans

- VNS Health Health Plans is required to report certain types of data to New York State and other regulatory authorities. Data collection, validation and reporting is a shared responsibility among various types of VNS Health Enterprise personnel, including, but not limited to, clinical, operations, business intelligence, data analytics and IT personnel.
- Because these data (e.g., encounter data) can directly impact the compensation that VNS Health Health Plans receives from the Federal government or the State, it is critical that all such data be timely, accurate and truthful.
- All VNS Health Enterprise personnel are required to collect, record, validate and report data accurately and on a timely basis. In the event that any inaccuracies are identified in data that have been reported to the Federal government, the State or another party, VNS Health Health Plans shall promptly notify the other party that the data are potentially inaccurate and shall work cooperatively with the other party to take appropriate corrective action, which may include the resubmission of accurate data.
- Any non-routine data reported to the Federal government or the State or communications with the Federal government or the State regarding the inaccuracy of data previously reported must be approved in advance by either the Compliance Department, the Legal Department or a member of VNS Health Health Plans Senior Management who oversees the business area from which the data were derived.
- VNS Health Health Plans may participate in various value-based payment arrangements with its downstream providers.

- Under these payment models, all or a portion of the compensation payable for health services is based on performance as measured by identified metrics of quality, health outcomes and efficiency, rather than on the volume of services provided. These performance metrics are measured by data that are reported to VNS Health Health Plans by its downstream providers. To ensure the accuracy of these data, VNS Health Health Plans will monitor the downstream providers with whom it has value-based payment arrangements to ensure that such providers collect, record, validate and report data in an accurate and timely manner. In the event that any inaccuracies in such data are identified, VNS Health Health Plans shall notify downstream provider that the data are potentially inaccurate and, as appropriate, shall take corrective action in accordance with the contract between VNS Health Health Plans and the downstream provider.

For VNS Health MSO

VNS Health MSO may only use or disclose PHI as permitted by the applicable Business Associate Agreement, in accordance with applicable law.

STANDARDS RELATING TO CODING, BILLING, AND THE PROVISION OF SERVICES

- VNS Health ensures that coding, billing and reimbursement practices comply with all federal and state laws, regulations, guidelines, as well as contractual requirements and VNS Health policies and procedures. VNS Health has a zero-tolerance policy with respect to improper billing.

- VNS Health Providers only bill for services that are medically necessary, appropriately ordered, and that have been provided in a manner consistent with accepted standards of care. Billing and coding must always be based on appropriate and adequate documentation, which justifies the service provided. Submitted bills and all supporting documentation must be accurate, truthful, and in compliance with all applicable laws, rules and regulations.
- VNS Health monitors whether services were provided as documented and subsequently billed.
- VNS Health Personnel may never misrepresent charges or services to, or on behalf of, government agencies, or a patient, member or payor. False statements, intentional omissions, or deliberate and reckless misstatements to government agencies or any payors will expose Personnel involved to termination of employment and criminal prosecution.
- Personnel must comply with all applicable federal and state laws and regulations governing the submission of claims and related statements. A detailed description of: (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in Appendix A.
- If VNS Health receives payments to which it is not entitled from a governmental or

private payor, such payments will be reported and refunded in accordance with applicable laws, regulations, and guidance, and the VNS Health Policy on Self-Disclosure and Self-Reporting.

- VNS Health will ensure that patients and members meet the appropriate eligibility requirements for admission and services and/or enrollment into VNS Health and that eligibility is documented appropriately.

STANDARDS RELATING TO THE ELIGIBILITY FOR SERVICES FROM VNS HEALTH PROVIDERS

- VNS Health Providers ensure that patients meet the appropriate eligibility requirements for admission and ongoing services and that eligibility is documented appropriately.



I think I might have unintentionally submitted a false claim or report, what do I do?

You can contact your supervisor to determine how to fix it.

If your supervisor does not know, or you do not feel comfortable talking to your supervisor or you do not feel your supervisor gave an appropriate response, please contact the Compliance Department.

STANDARDS RELATING TO ENROLLMENT INTO VNS HEALTH HEALTH PLANS

VNS Health Health Plans ensures that each new member meets the necessary criteria for initial enrollment into a particular health plan and that such eligibility is documented appropriately.

VNS Health Health Plans also ensures that existing members meet the necessary criteria for continuing membership in a particular health plan.

STANDARDS RELATING TO APPEALS & GRIEVANCE FOR VNS HEALTH HEALTH PLANS MEMBERS

- VNS Health Health Plans is committed to promoting and maintaining quality health care for our members. Each member has the right to: (1) report all concerns of dissatisfaction with the Plan or medical care, and (2) access a complaint and grievance process for timely problem resolution. All grievances and appeals are handled fairly and in accordance with regulatory requirements and VNS Health Health Plans policies and procedures.

STANDARDS RELATING TO DOCUMENTATION

Documentation must be timely, accurate, truthful, complete, and legible. Records, including patient and member documentation and business records (such as employee time cards, reimbursement requests and invoices) must be prepared, maintained, and submitted in an accurate and reliable manner.

All reports submitted to governmental agencies, insurance carriers, and other entities will be prepared truthfully, timely, accurately, and in accordance with applicable laws, regulations, and contractual requirements, including without limitation:

- 1) VNS Health Providers' cost reports
- 2) VNS Health Home Care's OASIS Data
- 3) VNS Health Providers' claims for services
- 4) VNS Health Health Plans's bid submissions to CMS and DOH
- 5) VNS Health Health Plans' Medicaid Managed Care Operating Report (MMCOR)
- 6) VNS Health Health Plans' data submissions, including HEDIS/QARR

STANDARDS RELATING TO RECORD RETENTION

- VNS Health complies with all federal and state rules and regulations and applicable VNS Health record retention policies relating to the retention of billing, patient and member medical records and other business records.
- 1) VNS Health Providers maintain all medical and billing records in accordance with the VNS Health Corporate Policy on Record Retention.
 - 2) VNS Health Health Plans maintains its member records, enrollment documentation, and records that support its performance obligations under its federal and state contracts as required by law, regulation and contractual provisions.
 - 3) VNS Health MSO maintains its clients' records in accordance with the Business Associate and Confidentiality Agreements, and maintains its own business records in compliance with the VNS Health Corporate Policy on Record Retention.

STANDARDS RELATING TO CONFLICTS OF INTERESTS

- VNS Health expects Personnel to avoid situations that present an actual or potential conflict of interest and to avoid behavior that could otherwise compromise the integrity of VNS Health's work. Such situations occur when an individual's personal interests interfere or appear to interfere with his or her ability to make sound business decisions on behalf of VNS Health.
- In general, Personnel should refrain from making or continuing any business associations that might interfere with their ability to exercise independent judgment and to act in the best interests of VNS Health.
- Examples of potential conflicts include maintaining outside employment with, or holding an ownership or other interest in, a VNS Health competitor or a contractor of services to VNS Health.
- Accordingly, all VNS Health Board Members, all employees who hold a position as a director or above and other employees as specified in the Conflict of Interest Policy must annually submit a Conflict of Interest Disclosure Statement to the Chief Compli-

ance Officer, or designee. Personnel are encouraged to contact the Chief Compliance Officer, or designee, to discuss any potential conflict of interest that may arise. Personnel may also refer to the VNS Health Conflict of Interest Policy or contact their supervisor or the Legal Department.

- Personnel are expected to make prompt disclosure, before taking any action, of any fact or circumstance that may involve, or appear to create, a conflict of interest.
- The Code is not intended to, and shall not be construed to, infringe upon non-supervisory employees' right to engage in protected and/or concerted activity under the National Labor Relations Act (for example: participating in union activities; discussing wages, working conditions, or other terms and conditions of employment, etc.). Similarly, this policy does not require non-supervisory employees to give notice to or obtain approval from VNS Health in connection with such activities. VNS Health will not interpret or apply the Code of Conduct in a manner that improperly interferes with or limits employees' rights under the National Labor Relations Act.



STANDARDS RELATING TO BUSINESS PRACTICES

- VNS Health maintains the utmost integrity in all of its business practices and relationships and will forego any business transaction or opportunity that can be obtained only by improper or illegal means.
- Personnel will not engage, either directly or indirectly, in any corrupt business practice intended to influence the manner in which VNS Health provides services, accepts referrals, or otherwise engages in its business practices.



STANDARDS RELATING TO REFERRALS, BRIBES AND KICKBACKS

In accordance with federal and state law, VNS Health does not solicit, offer, pay or receive any payment from physicians, providers or anyone else, whether directly or indirectly, for or to induce patient or member referrals, or any other referrals of items or services reimbursable by the Medicare or Medicaid programs or any other payor. All decisions to accept a patient for services or a member for enrollment must

be made based solely on whether the patient or member meets the VNS Health criteria for admission or enrollment, respectively.

- VNS Health does not: offer items or services for free or below fair market value to beneficiaries of federal and/or state health care programs to induce referrals; or provide services for free or below fair market to physicians, hospitals and other potential referral sources. VNS Health does not provide any remuneration to referring physicians for services either not rendered or in excess of fair market value for services rendered.
- Under federal and state anti-kickback laws, it is a crime to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business for which payment may be made under federal or state healthcare programs such as Medicare and Medicaid. Personnel may not offer, pay, solicit, or accept money, a gift, or other benefit in exchange for patient or member referrals, purchase, leases, or orders for services.
- Special considerations apply to contact with government employees. Government employees are prohibited by law from accepting payment for meals, refreshments, travel or lodging expenses or any type of gratuity, and strict compliance is required. Nothing of value should be given to a government employee even if there is no intent to influence an official action or decision. Personnel should not entertain a public official without authorization from the Legal Department. You may contact the Legal or Government Affairs Departments with any questions.

STANDARDS RELATING TO CLASSIFIED INFORMATION

- All information and data, regardless of medium, is subject to the VNS Health Data Classification Policy, which describes the recognized levels of classification.
- VNS Health patients and members have a right to confidentiality that is assured by state and federal laws, such as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Health Information Technology for Economic and Clinical Health Act (“HITECH”) and their implementing regulations, and by VNS Health policies and procedures, and additional federal and state rules regarding HIV confidentiality, mental health, and alcohol and substance abuse disorders.
- Actively safeguarding these rights is the responsibility of everyone. Patient and member information should be accessed only when needed to provide care or conduct VNS Health business. Sometimes it can be difficult to know when it is acceptable to access, use or share patient or member information. The Privacy Officer is available to answer privacy and confidentiality questions, provide resources, and respond to concerns and complaints. There are also laws that may require us to inform patients and members or the government of an activity that may be a violation of privacy policy. If you know of an activity that may be inappropriate, you must report it to the Privacy Officer. See VNS Health HIPAA Policies and Procedures.
- VNS Health employees have a right to confidentiality that is assured by Section 203-D of New York State Labor Law, and other state laws, as it relates to an employee’s personally identifying information.
- Confidential information acquired by VNS Health Personnel about the business of VNS Health, including, without limitation, computer software programs, forms, marketing and sales plans, strategic plans, financial information, fee or pricing information, business contract information, employee information, personnel compensation and related information, and other confidential matters or trade secrets must also be held in confidence and not used for personal gain, either directly or indirectly. Upon commencing work for or with VNS Health, VNS Health Personnel are required to agree to protect, to the best of their capabilities, such information from unauthorized disclosure. This commitment continues even after an employee or contractor leaves VNS Health. Likewise, VNS Health Personnel must protect against the disclosure of all confidential information of third parties who, for various business or other reasons, have disclosed such information to VNS Health.



- All information or data, including protected health information, whether stored in paper or electronic form is subject to the Data Handling Guidelines, and must be handled carefully during work hours, must be properly secured at the end of the business day. When such information is no longer needed and has been retained beyond our Record Retention Requirements as defined in the Record Retention Policy, it must be disposed of in an approved, secure manner to avoid improper disclosure.

STANDARDS RELATING TO FINANCIAL CALCULATIONS AND REPORTING

- All financial books, records, and accounts must correctly reflect transactions and events, and conform to generally accepted accounting principles, applicable laws, rules, regulations, and to VNS Health's system of internal controls.
- VNS Health Providers maintain integrity in financial reporting related to its cost report submissions.
- VNS Health Health Plans maintains integrity in its financial reporting and reconciliation

process related to the MMCOR, Medical Loss Ratio calculations, and CMS bid submissions, among other financial reports submitted to government agencies.

STANDARDS RELATING TO RETURNING OVERPAYMENTS

- VNS Health identifies, investigates and addresses all potential violations of law and compliance issues, and discloses relevant findings to appropriate governmental agencies, consistent with its obligations under applicable laws, regulations, guidelines and contractual requirements.
- VNS Health reports timely to appropriate governmental agencies any overpayments, and makes necessary refunds. Under federal law, all identified overpayments must be refunded to the government payer within 60 days of identification. Failure to do so can result in fines and other penalties. Therefore, employees must promptly report knowledge of any overpayment to the Compliance Department. See Self-Disclosure and Self-Reporting Policy.

STANDARDS RELATING TO MARKETING

- VNS Health markets its services in a fair, truthful and ethical manner.
- All marketing activities and advertising by VNS Health and its Personnel must be based on the scope of and merits of the services provided by VNS Health. All marketing information that is distributed outside of VNS Health must fairly and accurately depict VNS Health and its products and services, and must otherwise comply with all applicable laws, regulations and required approval procedures.
- VNS Health prohibits discriminatory marketing and admission and enrollment practices that are based on a patient or a member's degree of risk for costly or prolonged treatment.



Can I be retaliated against for participating in an investigation?

No. VNS Health does not permit retaliation against anyone for good-faith and honest participation in an internal or external investigation. Everyone employed by or affiliated with VNS Health is expected to cooperate with all investigations.

- All VNS Health Health Plans marketing activities comply with all legal, regulatory and sub-regulatory requirements.

STANDARDS RELATING TO MANDATORY REPORTING

- VNS Health ensures that all incidents and events that are required to be reported under federal and state mandatory reporting laws, rules, and regulations are reported properly.

STANDARDS RELATING TO DISCIPLINE

- Disciplinary actions may be taken for, among other things:
 - 1) Authorization of or participation in actions that violate the Code;
 - 2) Failure to report a violation of the Code or to cooperate in an investigation;
 - 3) Failure by a violator's supervisor(s) to detect and report a violation of the Code if such failure reflects inadequate supervision or lack of oversight; or
 - 4) Retaliation and/or intimidation against an individual for reporting a violation or possible violation of the Code.
- Personnel who violate the Code, any applicable compliance policy or procedure, or any applicable law, rule or regulation, will be:
 - 1) Disciplined, based upon the severity of the violation, up to and including termination of their employment or other relationship with VNS Health; and
 - 2) Referred to licensing boards or to governmental authorities, when appropriate or required.



STANDARDS RELATING TO CREDENTIALING AND EXCLUSIONS

- VNS Health ensures compliance with all federal, state, and local laws, rules, and regulations regarding licensure and credentialing of Personnel on an ongoing basis.
- VNS Health Health Plans ensures that all providers and suppliers in their networks have been appropriately credentialed at all times in accordance with applicable laws, regulations, policies and procedures.
- VNS Health does not knowingly employ, appoint, contract with, or bill for an individual or entity that has been debarred, excluded, or is otherwise ineligible for participation in Federal or state health care programs. See VNS Health Policy on Sanction Checks.
- Any payment made to a sanctioned or excluded provider or supplier will be recovered and/or refunded to the payor.

STANDARDS RELATING TO MEALS, GIFTS, AND OTHER BUSINESS COURTESIES

- VNS Health recognizes that it and its Personnel have ongoing business relationships that may occasionally involve invitations for a meal or entertainment.
- Personnel are prohibited from receiving gifts, favors, entertainment, special accommodations or other things of material value that may influence their decision-making or make them feel beholden to a third person or vendor. Similarly, VNS Health Personnel are prohibited from providing gifts, favors, entertainment, special accommodations or other things of material value to third persons or vendors that are intended or aimed at influencing decision-making or making the recipient feel obligated to Personnel or VNS Health, or that create the perception of such intent. VNS Health ensures that such courtesies are always appropriate and in conformity with our standards and applicable law and regulations.
- Gifts of cash (including cash equivalents and gift certificates) are never acceptable.
- Personnel may never solicit gifts or business courtesies.
- All Personnel are encouraged to consult with their supervisors, the Compliance Department or the Legal Department with respect to issues arising under this standard and accompanying policies.
- VNS Health maintains a separate charitable gift acceptance policy for the solicitation and acceptance of gifts to help the organization further fulfill its mission and to benefit VNS Health's operations, programs, and services.

STANDARDS RELATING TO TRAINING

- The laws and regulations that govern VNS Health are complex and constantly changing. Keeping current on and refreshing our understanding of external expectations and internal policies is a necessity in our business. For this reason, VNS Health offers general compliance education, including education on FWA, the Code, the Compliance Program, and HIPAA, for all Personnel, as well as targeted training that is specific to particular jobs and on focused topics.
 - 1) General compliance education is provided at hire for new staff, at the time of contracting for certain contractors, and at appointment for Board members and annually thereafter. The education and training methods may include group presentations, online courses, and other formats.
 - 2) When an issue arises through an audit, compliance investigation, reported compliance concern, or as the result of the issuance of new laws, rules, regulations or other guidance, appropriate specialized training and education is provided to applicable Personnel.
- VNS Health expects all Personnel to participate in all required compliance training and education. Failure to do so may result in disciplinary action.



STANDARDS RELATING TO GOVERNMENT INQUIRIES

- VNS Health Personnel may speak voluntarily with government agents, and VNS Health will not attempt to obstruct such communication. VNS Health requires that all information provided to a government agency in any form must be accurate and complete. Personnel should contact the Legal Department before speaking with any government agents or providing any documents for any non-routine requests by government agents.
- VNS Health cooperates fully with government investigations. If you become aware of an investigation or are contacted by a person representing him or herself as an investigator who asks questions or requests documents about VNS Health, or if you receive a subpoena or other written request for information related to a government investigation, you should promptly contact the Legal Department for assistance.
- Any action by VNS Health Personnel or providers to destroy, alter, or change any VNS Health records in response to a request for such records is prohibited, and will subject the individual to immediate discharge and possible criminal prosecution.

STANDARDS RELATING TO VNS HEALTH HEALTH PLANS AND FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

- FDRs of VNS Health Health Plans are also required to act in a legal, ethical and appropriate manner and to comply with this Code and other applicable compliance policies and procedures designed to promote and ensure FDR compliance with Medicare Parts C and D delegated responsibilities.
- All FWA issues related to FDRs must be reported to the VNS Health Health Plans Compliance Department and will be thoroughly investigated. VNS Health Health Plans has established a Special Investigations Unit (“SIU”) to detect and investigate allegations of FWA.

STANDARDS FOR POLITICAL CONTRIBUTIONS AND LOBBYING

- VNS Health’s assets will not be used for political campaign contributions. This does not prohibit or restrict any individual from making contributions on his or her own behalf or from participating in a political organization. However, Personnel are prohibited from soliciting political contributions from colleagues.
- Contributions are distinct from “lobbying” activities, and VNS Health plays a role on the federal and state levels by advocating for laws and regulations which enable VNS Health to provide services to its patients and members. Lobbying, subject to certain limitations, is permitted, and all VNS Health lobbying efforts are coordinated by the Government Affairs Department. To ensure

that lobbying laws and policies are fully complied with, it is expected that no employee will engage in lobbying on behalf of VNS Health without prior authorization from the Legal Department.



STANDARDS FOR COMBATING FRAUD, WASTE AND ABUSE (FWA)

- FWA is a significant concern for all health care organizations. It is VNS Health’s duty to avoid FWA. To that end, all Personnel have the responsibility to report any activity that we suspect of being FWA. Not only is it expected by our members and patients in order to keep health care affordable, it is required by our contracts with the federal and state government.
 - 1) Criminal Fraud is knowingly and willfully defrauding or attempting to defraud any health care benefit program; or obtaining, by false or fraudulent means, any of the money owned by, or under the control of, any health care benefit program.

- 2) Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.
 - 3) Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.
- The Compliance Department helps ensure that VNS Health is regularly monitoring potential FWA and is proactively detecting and preventing FWA. All Personnel have a responsibility to report any activity that they suspect may constitute FWA.
 - For questions or concerns about FWA, you should contact the Compliance Department or, if it is specific to VNS Health Health Plans, you may contact the SIU or the Hotline or online reporting tool directly.

All VNS Health employees will receive a copy of this Code upon hire, and will be required to sign and return the Acknowledgment of Receipt. When modifications are made to this Code of Conduct, a revised version will be made available on the VNS Health intranet and upon request from any of the Compliance Officers.

THIS VERSION Reviewed: July 2022 Revised & Approved: August 2022



APPENDIX A

Federal & New York state statutes relating to false claims; anti-kickback prohibitions and civil monetary penalties

Following is a brief summary of federal and New York State laws regarding false claims and whistleblower protections, as well as the Anti-Kickback laws and regulations and Civil Monetary Penalties law.

FALSE CLAIMS STATUTES

I. FEDERAL LAWS

A. The Federal False Claims Act (31 U.S.C §§ 3729-3733)

The federal False Claims Act (“FCA”) provides, in pertinent part, that:

(1) (a) 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 subparagraphs (A), (B), (D), 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;... 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, plus 3 times the amount of damages which the Government sustains because of the act of x that person.

(2) Reduced Damages.

If the court finds that –

(a) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information; (B) such person fully cooperated with any Government investigation of such violation; and (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.

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

(b) Definitions

For purposes of this section:

(1) the terms “knowing” and “knowingly” (A) mean that a person, with respect to information - (i) has actual knowledge of the information; (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) requires 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;

(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.

(d) Exclusion.

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

While the FCA 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 FCA 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 medi-

cal services she knows she has not provided. The FCA 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 health care facility that 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) of the FCA 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.

B. Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then

the agency receiving the claim may impose a penalty of up to \$5,000 for each claim, subject to inflation. The agency may also recover twice the amount of the claim.

Unlike the federal FCA, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the federal FCA, the determination of whether a claim is false, and the imposition of fines and penalties, is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York State False Claim laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to health care 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.

A. New York 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 FCA. It imposes penalties and fines on 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 the person may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim under the New York False Claims Act is \$6,000-\$12,000 per claim, subject to inflation, to maintain compliance with the Federal Deficit Reduction Act, 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 New York False Claims Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. 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.

2. Social Services Law § 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 New York State Department of Health may impose a civil penalty of up to \$10,000 per violation. If repeat violations occur within 5 years, a penalty up to \$30,000 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 § 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 six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least \$1,000 and no more than \$3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of \$3,900), and five years for any subsequent occasion of any such offense.

B. Criminal Laws

1. 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.

2. Social Services Law § 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 any 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. It 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 it includes 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 primarily applies to claims for health insurance payments, including Medicaid, and contains five crimes:

(a) Health care fraud in the 5th degree - a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. It 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 receiving more than \$3,000. It 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 \$10,000. It 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 \$50,000. It 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 \$1 million. It is a class B felony.

III. WHISTLEBLOWER PROTECTIONS

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

The federal FCA 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.

B. New York False Claims Act (State Finance Law § 191)

The New York State False Claims Act also provides protection to qui tam relators 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.

C. New York Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

D. New York Labor Law § 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official.

Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost

back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

IV. ANTI-KICKBACK LAWS AND CIVIL MONETARY PENALTIES LAW

A. Federal Anti-Kickback Law (42 U.S.C. § 1320a-7b(b))

Under the federal Anti-Kickback Law:

(b) (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal

health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b).

In sum, the federal Anti-Kickback Law imposes criminal penalties on any person that knowingly and wilfully solicits, receives, offers, or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to any person, in return for or to induce such person to do either of the following: refer an individual to a person for the furnishing or arranging for the furnishing of an item or service for which payment may be made in whole or in part under a federal health care program, or purchase, lease, order, or arrange for or recommend the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program. Not all interactions encompassed by the broad scope of the statute, however, violate the statute. There are statutory exceptions to the prohibition for certain types of activities.

B. New York State Anti-Kickback Laws and Regulations

1. Social Services Law § 366-d.

The statute applies to all providers in the New York Medicaid program and prohibits such providers from soliciting, receiving, accepting or agreeing to receive or accept or offer, agree to give or give any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (a) for the referral of services for which Medicaid payment is made; or (b) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program.

While the statute does not enumerate any “safe harbors,” subsection 2(d) specifically states that the prohibition “shall not apply to any activity specifically exempt by federal statute or federal regulations promulgated thereunder.”

A violation of the statute is either a misdemeanor or felony depending upon whether the defendant obtains money and/or property in violation of the statute and, if so, the amount obtained.

2. Social Services Law § 366-f.

The statute provides that no person acting in concert with a Medicaid provider may solicit, receive, accept or agree to receive or accept or offer, agree to give or give any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (a) for the referral of services for which Medicaid payment is made; or (b) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program.

The statute specifically exempts from the prohibition any activity exempt by federal statute or regulation. A violation of the statute is a misdemeanor punishable by imprisonment or a fine of \$10,000 or double the amount of gain attributable to the violation. If the violation results in the individual obtaining money or funds in excess of \$7,500, such violation is a class E felony.

3. 18 N.Y.C.R.R. § 515.2

This regulation lists unacceptable practices under the Medicaid program, including: (a) directly or indirectly soliciting or receiving any payment, or offering or paying any payment, in cash or in kind, in return for referring a client for medical care, services or supplies for which payment is claimed under the medical assistance program, and (b) purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the medical assistance program.

4. 10 N.Y.C.R.R. §29.1(3)

Section 29.1 of Title 10 of the NYCRR defines professional misconduct of professionals under the New York State Education Law. Included in the specific listing of practices or activities constituting misconduct is the direct or indirect

“offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services.” 10 NYCRR §29.1(b)(3). Any professional in violation of this regulation shall be subject to the penalties that includes censure and reprimand, monetary fines, suspensions and/or probationary terms.

V. FEDERAL CIVIL MONETARY PENALTY LAW (42 U.S.C. § 1320a-7a)

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to:

(a) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way;

(a) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; **(c)** offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; **(d)** arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; **(e)** knowingly or wilfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or **(f)** using a payment intended for a federal health care program beneficiary for another use. The Office of Inspector General is authorized to seek different amounts of civil monetary penalties and assessments based on the type of violation at issue. See 42 CFR § 1003.103. For example, in a case of false or fraudulent claims, the OIG may seek a penalty

of up to \$10,000 for each item or service improperly claimed, and an assessment of up to three times the amount improperly claimed. 42 U.S.C. § 1320a-7a(a). In a kickback case, the OIG may seek a penalty of up to \$50,000 for each improper act and damages of up to three times the amount of remuneration at issue (regardless of whether some of the remuneration was for a lawful purpose). 42 U.S.C. § 1320a-7a(a).

