FreedomCare

COMPASSION • INDEPENDENCE • CHOICE

Freedom Care LLC (and all State affiliates)
FreedomCare Physician Practice, P.C.
FreedomCare Care Management LLC
FreedomCare MSO, LLC
Freedom Care IPA, LLC
EvergreenChoice, LLC

Compliance Plan

Effective October 2024

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A. Compliance Plan

Freedom Care LLC (and all State affiliates), FreedomCare Physician Practice, P.C., FreedomCare Care Management LLC, FreedomCare MSO, LLC, Freedom Care IPA, LLC and Evergreen Choice, LLC (collectively, "FreedomCare") takes pride in providing quality services to its clients. Freedom Care LLC is a fiscal intermediary in the Consumer Directed Personal Assistance Program ("CDPAP"). Acknowledging the unique aspects of CDPAP, we have established this plan (the "Compliance Plan") to comply with all CDPAP and Medicaid program requirements. There are no categories of people involved in the CDPAP program not covered by these policies. We have enacted a number of ongoing processes to monitor and evaluate our compliance with all CDPAP, Medicaid, and other applicable requirements. We have established procedures to make our internal systems more efficient and quickly identify and resolve problems. Our extraordinarily robust anti-fraud, monitoring, and evaluation procedures help us meet our goal of providing a high level of service to Consumers while minimizing the risk of fraud or mistake.

Unless otherwise specified, all policies herein apply to all employees and persons associated with FreedomCare, from the Chief Executive Officer to all other executives, officers, directors, coordinators, managers, owner(s), and Personal Assistants hired by Consumers (collectively, "Affected Individuals"). This Compliance Plan describes the procedures that will be followed for communicating, monitoring and enforcing these standards to ensure that FreedomCare stays in compliance with all applicable laws.

The Compliance Plan must be an integral part of an organization's mission and principles. To be considered effective, federal and state guidelines require that: (i) the Compliance Plan must establish written policies and procedures that describe compliance expectations as embodied in a Code of Conduct; (ii) the Compliance Plan must be administered by a designated Compliance Officer vested with responsibility for the day-to-day operation of the compliance program and having direct access to Senior Leadership; (iii) all Affected Individuals must receive periodic training and education on compliance issues and expectations; (iv) there must be communications lines to the compliance function that are accessible to Affected Individuals to allow compliance issues to be reported. (v) there must be disciplinary policies to encourage good faith participation in the compliance plan by Affected Individuals; (vi) there must be routine monitoring and regular auditing of the organization's business systems for identification of noncompliance and risk areas specific to FreedomCare's business; (vii) there must be a system to investigate and respond to compliance issues as they are raised through self-evaluation and auditing activities, including the development of corrective action plans to deal effectively with violations of compliance standards and, if needed, to ensure immediate action to protect the health and safety of anyone who may be impacted by the compliance issue raised; and (viii) there must be a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Plan. This Compliance Plan is designed to satisfy all of these requirements.

All Affected Individuals will be expected to read and understand this Compliance Plan and to review it as necessary in order to be alert to situations which could create a conflict of interest or otherwise be contrary to the established policies.

Modifications and Revisions to the Compliance Plan

The Compliance Officer will periodically review and analyze the effectiveness of the operation of the Compliance Plan. The Compliance Officer will recommend appropriate modifications of, or revisions to, the compliance procedures and this Compliance Plan, if any, in light of the results of such review. Previous copies of the Plan will be retained and each revised version will reflect the revision date.

Questions and Concerns

If after review of this Compliance Plan, you are unsure of what a proper course of conduct might be in a specific situation, or believe that the standards of conduct set forth in this Plan may have been violated, then you are urged to contact the Compliance Officer at gkaiser@freedomcare.com or the Assistant Manager of Compliance Operations at mlubin@freedomcare.com. Such correspondence will be held in strictest confidence and may be submitted anonymously. Reports may also be submitted via this web form: http://www.freedomcareny.com/report. This method of reporting may be used whether the reporter wants to remain anonymous or desires to leave his/her name and contact information. The identities of those reporting compliance issues or concerns will be kept strictly confidential to the extent possible. FreedomCare strictly prohibits intimidation or retaliation for reporting compliance concerns.

Statement of Policy

Our Compliance Plan represents our commitment to conduct all aspects of our operationsin full compliance with Federal and State law as well as the rules of theNew York State Department of Health (DOH), the Medicare Program, the New York Medicaid Program, and the rules of all other regulatory entities having jurisdiction over consumer-directed services and all other health-related services provided by FreedomCare. This includes compliance with all reimbursement rules of Medicare and Medicaid managed care plans. It also includes our continued compliance with all relevant federal and state laws, rules and regulations focused on preventing fraud and abuse, including prohibitions against improperly giving, receiving, offering or soliciting payments in return for referrals.

FreedomCare is committed to conducting its business with the highest standards of ethics, honesty, and integrity. This is essential for our long-term reputation for honesty and integrity in all of our dealings with others. This is also important because of the potential liability, civil or criminal, that FreedomCare may be exposed to for violating applicable legal standards. Our Compliance Plan aims to prevent violations before they occur and it is the responsibility of each FreedomCare employee to follow all applicable laws, rules, regulations and policies. It is the policy of FreedomCare to prevent and detect the occurrence of unethical or unlawful behavior, to halt such behavior as soon as is reasonable, to correct the behavior, discipline those who violate policies and to prevent the recurrence of such behavior.

These goals and ethical requirements of a Compliance Plan are required to effectively instill a culture of compliance within the organization to help prevent activities constituting fraud and abuse, whether intentionally or inadvertently. A Code of Conduct is included in the Compliance Plan which, together with the other elements of the Compliance Plan, clearly identifies the ethical and legal standards that all Affected Individuals, subcontractors and vendors are expected to follow and the consequences for failing to comply.

B. Compliance Officer

The Compliance Officer for FreedomCare is Geoffrey Kaiser, who is General Counsel and Director of Regulatory Affairs and Compliance for the organization. Mr. Kaiser is assisted in this role by Michelle Lubin, who is Compliance Supervisor. The Compliance Officer shall be responsible for the day-to-day operations of the Compliance Plan, as well as ongoing monitoring, implementation, evaluation, and enforcement of the Compliance Plan. He reports directly to the Chief Executive Officer, Yoel Gabay. The Compliance Officer will provide training and information to Senior Leadership and all Affected Individuals involved in CDPAP services regarding compliance issues, expectations and operation of the company's compliance program upon hiring and annually thereafter. The Compliance Officer is responsible for ensuring that FreedomCare is in compliance with all local, state and federal laws, rules, and regulations. It is the Compliance Officer's responsibility to determine whether each component of the Compliance Plan is fully operational, and to take remedial action, as necessary. In addition, the Compliance Officer is responsible for receiving and responding to all reports, complaints, and questions concerning compliance. All Affected Individuals can go to the Compliance Officer to express concerns about such matters.

On an ongoing basis, but no less than quarterly, the Compliance Officer shall report on and discuss regulatory concerns and issues, compliance initiatives and any new or revised federal, state or regulatory or contractual requirements that bear on the Company's compliance obligations to Senior Leadership.

C. Compliance Committee

FreedomCare has appointed a Compliance Committee with the responsibility of overseeing the Compliance Plan. The Compliance Committee will review FreedomCare's policies in order to protect the integrity and reputation of FreedomCare and to ensure compliance with local, state and federal laws, rules, and regulations. The Compliance Committee shall have responsibility for evaluating and taking action on matters which are brought to its attention. All Compliance Committee members must, upon receiving a copy of this Compliance Plan, sign and date the attached Acknowledgment of Receipt (Exhibit A) and return that Acknowledgment to the Compliance Officer. The Compliance Committee will support the Compliance Officer in fulfilling his responsibilities. The Compliance Officer shall serve as Chair of the Compliance Committee and the Compliance Committee shall meet monthly. Agendas and minutes for all meetings of the Compliance Committee shall be prepared and maintained by the Compliance Officer or his/her delegate. The Compliance Officer appointed the following individuals as original members of the Compliance Committee, subject to changes and substitutions as may be appropriate:

- Compliance Manager
- Intake Manager
- Engagement Manager
- LHCSA/PCA Director-Evergreen Choice
- QA & Process Improvement Lead
- VP of Technology
- Manager of Systems Operations & Security
- Manager, Financial Operations
- Team Lead, Payroll and Authorizations
- Quality and Service Excellence Manager

- Manager, Launch Operations
- Onboarding Supervisor
- Caregiver Wellness Director
- DPS/VP Clinical Operations

FreedomCare has entrusted the Compliance Committee with the following responsibilities:

- Overseeing and monitoring the implementation of the Compliance Plan, including the development of written standards and procedures;
- Assisting in analysis of risk areas and overseeing monitoring of internal and external audits and investigations.
- Establishing methods, such as periodic audits, to improve the practice's efficiency and quality of services, and to reduce the practice's vulnerability to fraud and abuse;
- Revising the compliance program as needed, in light of changes in the law and in the standards and procedures of government and private payer health plans;
- Developing, coordinating and participating in educational programs that focus on the components of the compliance program;
- Ensuring that there are no OIG and/or Medicaid excluded individuals and/or entities employed by the FreedomCare or contracted with FreedomCare;
- Investigating any report or allegation concerning possible unethical or improper business practices, and monitoring subsequent corrective action and/or compliance; and
- Developing communication methods to keep Affected Individuals regularly updated regarding compliance activities.

D. Compliance and Ethics Training

FreedomCare will ensure that all Affected Individuals receive compliance and ethics training in relation to matters relevant to FreedomCare's business operations, both upon hiring and annually thereafter. Compliance training is part of the orientation process for every employee and is not optional. All employees will be required to sign an acknowledgment of receipt indicating that they have read, understand and agree to comply with this Compliance Plan and Code of Conduct.

Training and education in compliance is mandatory and has two (2) components: (i) training and educating all Affected Individuals, including Senior Leadership, employees, physicians, and advanced practice professionals, about compliance expectations, compliance issues, and the compliance program operation; and (ii) motivating individuals to comply.

As part of initial orientation, all newly hired personnel receive training concerning the Compliance Plan's operation and the requirements of the Code of Conduct. In addition, all Affected Individuals at FreedomCare are required to complete annual compliance training.

The Compliance Officer or his/her delegate, in conjunction with the Compliance Committee, is responsible for the coordination, maintenance, and oversight of the training and educational program for all Affected Individuals. Additional training for certain personnel subcategories will focus on the legal requirements most relevant to their particular jobs, including a periodic review of departmental procedures.

At a minimum, the education curricula should include:

- Education on FreedomCare's commitment to developing, implementing and maintaining the Compliance Plan and the importance of the Compliance Plan and Code of Conduct;
- Providing relevant and timely educational opportunities to all Affected Individuals and persons associated with FreedomCare, including Senior Leadership, employees, physicians and advanced practice professionals;
- Reinforcing the importance of each individual's role in the success of the Compliance Plan;
- Providing awareness of the consequences of violating the standards and procedures set forth in the Compliance Plan; and
- Guidance regarding fraud and abuse.

At a minimum, billing education should include as appropriate:

- Correct Coding requirements;
- Proper documentation of services rendered;
- Proper billing standards and procedures for submission of accurate bills for services and supplies rendered;
- The personal obligation of each person involved in the claims submission process to ensure that such claims are accurate;
- The legal sanctions for submitting false or reckless billings; and

All Personnel involved with billing or coding will also be trained as to the applicable documentation, coding, and billing rules and regulations for Medicare, Medicaid, and other third-party payers. These training sessions will also focus on recent developments in federal or state billing rules, updates from Medicare bulletins, fraud alerts, problematic issues revealed during the course of compliance reviews, or any other subject matter that will help ensure that Personnel will perform their duties in compliance with all relevant rules, regulations, and laws.

FreedomCare is committed to complying with all provisions as provided under HIPAA and communicates such to all Affected Individuals. This commitment is evidenced through various mechanisms, including ongoing education related to a comprehensive policies and procedures implemented to ensure PHI is protected and secured throughout the organization, mandatory annual training, ongoing monitoring of compliance with policies and procedures, implementation of affirmative reporting duties required of Affected Individuals and contractors of potential breaches of that duty as well as enforcing the organization's privacy standards through well-publicized disciplinary actions resulting from non-compliance. FreedomCare provides Affected Individuals with training on requirements of HIPAA on an annual basis.

Taking appropriate remedial actions for failure to attend mandatory training, in person or online, is the responsibility of the Compliance Officer (in the case of Senior Leadership and other executives, directors and officers) and the Director of People Operations (in the case of other employees). Failure to comply with the requirements of this policy may result in disciplinary action, including termination. The Compliance Officer and the Director of People Operations will be responsible for maintaining records of all Affected Individuals who have undergone such training.

In the specific context of CDPAP, FreedomCare also provides information to Consumers and Personal Assistants regarding Medicaid compliance both orally upon initial contact, at enrollment, and in writing. In this regard, FreedomCare provides in-person training, written

materials, and a signed, written acknowledgement of the pertinent regulations relating to Personal Assistants, including the following:

a) FreedomCare inquires whether the designated Personal Assistant is under 18 years of age or whether such Personal Assistant is the Consumer's spouse or designated representative, and if so, inform the Consumer that the designated individual is ineligible.

b) FreedomCare will comply with New York State requirements for Medicaid exclusion list screenings for all Personal Assistants and Affected Individuals. FreedomCare will check monthly against the OMIG, GSA, NY DOH Office of Professional Medical Conduct, NYSED Office of Professions Professional Misconduct Enforcement, OIG, and SDN exclusion lists and the Social Security Administration's Death Master file.

c) FreedomCare will ensure that all required health assessment documentation is completed and on file in accordance with 10 NYCRR § 766.11(c) and (d) before the individual acts as a Personal Assistant, and annually thereafter. It will do so through automated reports checked by employees on a daily basis indicating which Personal Assistants have medical documentation expiring in the next 45 days, as well as automated text messages sent to such Personal Assistants. Members of the Client Success team work with Personal Assistants to obtain their annual medical documentation and that any Personal Assistant who does not obtain his or her annual health assessment before the expiration of the previous one is not authorized to work until we obtain proof that such annual medical documentation has been completed.

d) FreedomCare uses the Medflyt system to run a report to discover any instance of a Personal Assistant for whom we have billed who is billing for the same times at a different agency that is also using Medflyt services. In the event that there is a match, a Coordinator will be delegated to resolve the issue by either clarifying any misunderstanding and rebilling or terminating the offending Personal Assistant.

e) All Consumers and Personal Assistants will be trained to ensure that all timesheets/visit verifications are completed and attested by the Consumer or Consumer's Designated Representative and do not represent hours worked beyond those authorized.

f) Except for those Consumers approved for 24-hour live-in Consumer directed services, Consumers will be advised that no individual Personal Assistant may work more than sixteen hours in a day.

g) Affected Individuals are trained and agree to observe all relevant laws and regulations, including the prohibition against altering documentation or making any false/ misleading statements, and including Stark and anti-kickback laws, which prohibit, among other things, giving anything of cash or material value in exchange for referrals.

The Compliance Officer will ensure effective communication of the standards and procedures of the Compliance Plan, as well as pertinent education, to all new and current Affected Individuals, officers, directors and agents, Consumers and Designated Representatives, through training programs, orientations, and education programs.

Affected Individuals will be asked to sign a statement certifying that they have received, read and understand the Compliance Plan and its Code of Conduct. This signed statement will be retained in the employee personnel file and available for review by the Compliance Officer.

Affected Individuals will continue to be educated by the Compliance Officer on any new legal requirements as they relate to the provision, documentation, and delivery of FreedomCare services, including fiscal intermediary services in CDPAP.

E. Monitoring and Oversight Responsibilities

1. Monitoring of Compliance Program

FreedomCare will take steps to achieve compliance and assist in the reduction of identified problem areas through ongoing monitoring and auditing systems using the "Employee Handbook" (as it may be amended from time to time), as well as the standards set forth in the Compliance Plan and Code of Conduct. The Compliance Officer shall meet with Senior Leadership at least quarterly to discuss the ongoing implementation of the Compliance Plan and any outstanding compliance issues which require attention. The Compliance Officer will establish and utilize a reporting system which Affected Individuals or other agents, Consumers, Designated Representatives and Personal Assistants can use to make appropriate reports with factual details and resolutions of matters. Such reporting system will provide a method for anonymous and confidential reporting.

Adherence to the Compliance Plan is a factor in evaluating the performance of all Affected Individuals. All calls are recorded to facilitate quality control and monitor Affected Individuals' adherence with the Compliance Program. All supervisors discuss with all supervised Affected Individuals the compliance policies and legal requirements pertinent to their function. They are informed that strict compliance with these policies and requirements is a condition of employment and they are made aware that Freedom Care will take disciplinary action, up to and including possible termination, for willful violation of these policies or requirements.

2. <u>Compliance Monitoring, Audits and Risk Assessments</u>

a. <u>Ongoing Monitoring & Auditing</u>

FreedomCare believes that ongoing monitoring and auditing as well as routine risk assessment are critical components to a successful Compliance Plan and supports the internal programs charged with detecting fraud, waste, and abuse.

Procedures for routine monitoring and auditing include both initial testing for compliance, then validation of correction and ongoing compliance performance. Compliance elements undergoing monitoring and audits are drawn from published regulations and guidance, contractual agreements, and all applicable state and federal laws and are documented in the FreedomCare internal policies and procedures. The Compliance Officer and the Compliance Committee will work together to administer continued monitoring of compliance with this Compliance Plan and all applicable laws, rules, and regulations.

The FreedomCare Compliance Committee, in conjunction with the Compliance Officer, develops an annual monitoring work plan that, at a minimum, addresses risk areas that will most likely affect patients as well as FreedomCare's compliance. They utilize this work plan to identify potential risk, to prioritize and develop monitoring plans, and to initiate and implement their reviews throughout the year. These monitoring reviews help ensure all departments which support and service CDPAP activities and patients generally are compliant with requirements of federal and state regulations, as well as FreedomCare policies and procedures.

The monitoring reviews also assist in the evaluation of the effectiveness of the Compliance Plan, including the review of training, the reporting mechanisms, investigations, record retention, and oversight activities. In addition to internal monitoring and auditing protocols, routine monitoring reviews are included as part of the FreedomCare Compliance Plan.

The results of any ongoing monitoring and auditing reviews are summarized and reported to the Compliance Committee as appropriate. Any deficiencies noted may require the operational or clinical business owner to define, and submit for compliance approval, a Corrective Action Plan (CAP) which provides how the deficiency will be addressed timely and brought to resolution. Ongoing monitoring of the progress of the CAP implementation is monitored by the Compliance Officer. Timely updates of progress made and/or challenges to bringing deficiencies to a resolution are provided to the Compliance Committee as needed.

Should an internal audit of medical records prepared by a physician or provider identify non-compliance in the manner in which the person documented, coded, or billed for any service, the physician or provider will be required, as necessary, to attend remedial training sessions and be subject to a follow-up focused audit.

If the follow-up focused audit demonstrated that the documentation, coding, or billing practices are still not in compliance with applicable laws, rules, and regulations, then the physician or provider may be required to undergo remedial training sessions and/or additional follow-up focused audits as deemed necessary. Furthermore, the physician's or provider's conduct will be considered as part of his or her performance appraisal and may directly affect compensation or promotion decisions.

If after additional follow up focused audits, a physician or provider has refused or is unable to correct identified documentation or coding errors; and these errors present the risk that improper claims will be submitted to governmental and other third-party payers, the matter will be referred directly to the Compliance Officer, who will determine the appropriate action in conjunction with Senior Leadership. Appropriate action may include termination from FreedomCare.

b. Tracking New Developments

Continually, the Compliance Officer or delegate will review and be knowledgeable concerning all new regulatory or legal requirements issued by the federal or state government. This includes, but is not limited to: reviewing all Medicare bulletins, Medicaid updates, annual updates to the Current Procedural Terminology (CPT), or other relevant announcements; and reviewing all new rules governing coding, documentation and billing of services provided by FreedomCare .

In light of new developments, the Compliance Officer will work with the Compliance Committee to review existing policies and procedures to ensure that FreedomCare is in compliance with all current federal and state laws, rules, and regulations. If corrective action is necessary, the

Compliance Officer and Compliance Committee will work together to update the necessary policies and procedures.

c. Monitoring Confidentiality of Protected Information

The FreedomCare Compliance Committee is responsible for ensuring periodic risk assessments occur to identify potential risks in the privacy and security compliance mandates of HIPAA, the HITECH Act, and other federal and state privacy and security laws, rules, and regulations.

The Compliance Officer, or designee, will use his/her professional judgment to list risks related to regulatory changes, internal investigations, complaints, and areas of high exposure to PHI to document such risks. The Compliance Officer, or his/her delegate, will use his/her various professional and specific areas of expertise to rank the priority of the risk and develop an action plan.

The Compliance Officer, or his/her delegate, will compile the individually identified risks into a master document to serve as the risk analysis and develop actionable steps and timelines surrounding the steps for creation of a work plan to effectuate the risk analysis. Work plans will be prioritized, implemented and evaluated on an ongoing basis. Risk assessment reports will be provided to the Compliance Committee, and escalated to Senior Leadership, as appropriate, on an ongoing basis.

d. Other Compliance Procedures Specific to CDPAP

- *Monitoring of Consumer Care*

To ensure Consumers are cared for as necessary for their self-directed care, our Coordinator team is empowered to handle Consumer or Personal Assistant calls regarding a number of issues, including (i) help with issues that arise when using the timesheet application; (ii) firing of current Personal Assistants or the hiring of new Personal Assistants; (iii) reporting injuries of the Consumer or her Personal Assistant; (iv) reporting Consumer hospitalization; or (v) making temporary or long-term changes in a Personal Assistant's schedule.

In addition, Coordinators reach out to most Consumers during the first month of care and, after that, on a quarterly basis to see how they are doing and determine whether there has been any change in their condition or whether their Personal Assistant(s) are able to take care of them properly. In addition, Coordinators are trained to advise Consumers to find an additional or backup Personal Assistant, particularly if they qualify for a large number of hours of care per week. If FreedomCare learns that a Consumer's health condition has changed or that a Consumer's Personal Assistant(s) are unable to properly care for him or her, it will help resolve the issue and/or, as appropriate under the circumstances, communicate this information to the Consumer's MLTC to ensure that alternative arrangements are made for the Consumer's care.

- *Verifying Personal Assistant Documentation and Eligibility*

FreedomCare includes a multi-tier process to ensure that it does not act as fiscal intermediary with respect to Consumers' employment of any Personal Assistants who are ineligible to work as Personal Assistants. It does this by causing each and every Personal Assistant it enrolls through

an electronic application system. The system is structured to prevent any Personal Assistant who does not agree to and acknowledge the Compliance Plan from completing his or her enrollment. In addition, the system prompts FreedomCare's Onboarding Specialists to indicate all relevant Medicaid compliance information such as date of health assessment and the results of the Personal Assistant's PPD test and Rubella and Rubeola (Measles) bloodwork. The system does not permit an Onboarding Specialist to finalize a Personal Assistant's application unless all required Medicaid and employment documentation (including, but not limited to, I-9 documentation) are attached to the application. Finally, even after the application and all required documentation is submitted, FreedomCare does not permit the Personal Assistant to work until the Onboarding supervisor or Compliance Officer have reviewed all documentation submitted by the Onboarding Specialist as its unbending internal policy and electronically as well – by establishing a system whereby a Personal Assistant account is electronically created in Medflyt only after both levels of review of each Personal Assistant's documentation.

- *Billing and Fraud Prevention Policies and Procedures*

In addition to the above, FreedomCare implements ongoing procedures to ensure that it meets the highest legal and ethical standards. Through the following processes, it strives to set an example for all entities subject to the rules of the DOH, the New York Medicaid Program, and the rules of all other regulatory entities having jurisdiction over Consumer-directed services:

- System does not permit billing for a Consumer unless Personal Assistant's paperwork (Health Assessment, bloodwork, authorization to work, etc.) is reviewed and approved by both an Onboarding Specialist and the Enrollment Manager or Compliance Officer. It does so because its system is designed not to create a Personal Assistant account in its billing system (currently Medflyt) until after both an Onboarding Specialist and the Onboarding supervisor or Compliance Officer have reviewed all of a Personal Assistant's documentation. In addition, the system does not permit a Personal Assistant to be scheduled if the Consumer lacks an authorization which has been approved by the Coordination department. Implements electronic and operational procedures to prevent billing Medicaid for work performed by a Personal Assistant without an up-to-date Health Assessment.

- Electronically checks every Personal Assistant's name against the GSA, OIG, and OMIG, exclusion lists upon hiring and every month thereafter.

- Implements electronic systems which do not permit Freedom Care to bill more hours for a Consumer than authorized under such Consumer's authorization. This system also disables any ability to bill for time following an authorization's expiration if there is no continuing authorization under which FreedomCare's finance department might bill.

- Using Medflyt system, which systemically does not permit FreedomCare to bill for care to a Consumer without electronic, or, if the Personal Assistant does not have a smartphone, IVR, or, if this is not possible for some reason, paper timesheet verification of time worked, FreedomCare ensures that the time it bills is consistent with time reported.

- Implements electronic timesheets for all Personal Assistants possessing Android or iPhone smartphones which accomplish the following:

  - ✓ Obtains signature of Personal Assistant following every shift on attestation that he/she actually worked the hours indicated in his/her timesheet and acknowledging that falsifying timesheets may be a crime.
  - ✓ Obtains signature of Consumer following every shift on attestation that Personal Assistant actually worked the hours indicated in the timesheet and acknowledging that falsifying timesheets may be a crime.
  - ✓ Once per week, obtains picture of Consumer captured on Personal Assistant's phone camera within five minutes of Consumer's signature. This makes it impossible for the Personal Assistant to finalize his/her timesheet if the Consumer is not physically present to review the timesheet and attest to the accuracy of the times submitted. Obtains picture of Personal Assistant captured on Personal Assistant's phone camera within five minutes of Personal Assistant's signature. This makes it impossible for the Consumer to finalize the Personal Assistant's timesheet in her absence if the Personal Assistant is not physically present to review the timesheet and attest to the accuracy of the times submitted.
  - ✓ Electronically obtains GPS verification of location of Personal Assistant upon clock-in and clock-out to determine whether Personal Assistant is within a set distance of the patient's home at that time. We have implemented procedures to flag Personal Assistants who are not verified to be within the proximity of the Consumer's home for spot-checks to identify potential and take appropriate action. If GPS reading is out of range, program will ask for face verification and perform facial recognition of Consumer. The program performs facial recognition of Personal Assistant upon login.
  - ✓

- Where Personal Assistant does not have an Android or iPhone, Consumer uses a call-in/call-out system to electronically confirm Personal Assistant's visits.

- Where Consumer is not able to use the call-in/call-out system to confirm his/her Personal Assistant's visits, she submits a paper timesheet which is only accepted if it contains (i) dates and start and end times worked; (ii) name of Consumer; (iii) name of Personal Assistant; (iv) Personal Assistant ID number; (v) signature of Consumer attesting to the accuracy of Personal Assistant's hours worked; (vi) signature of Personal Assistant attesting to Personal Assistant's hours worked; and (vii) dates for both signatures.

- To avoid instances where a Personal Assistant is servicing a Consumer while simultaneously servicing another Consumer through a different agency, either for PCA or CDPAP services, FreedomCare has contracted with Medflyt to provide conflict check services. Through this service, FreedomCare has the ability to run a report of any visits it has billed which conflict with a visit billed by the same Personal Assistant through a different agency that also uses Medflyt conflict check services. We have established the following conflict check procedures to eliminate any reported conflict:

- ✓ FreedomCare's in-house Claims Investigator performs a conflict check report each Monday for any conflicts through the end of the prior week. All of these conflicts are tracked in a spreadsheet on FreedomCare's server.
- ✓ The Claims Investigator contacts the agency with whom the conflict exists, as well as the relevant Personal Assistant and/or Consumer to determine, among other factors, and for both FreedomCare's Consumer and the other agency's Consumer: (i) the Personal Assistant's schedule; (ii) how the Personal Assistant clocks-in and -out (e.g., EVV, IVR, timesheets); (iii) whether the Personal Assistant's services to the other agency's Consumer are PCA or CDPAP; (iv) if CDPAP, the relationship between the Personal Assistant and the other agency's Consumer; (v) approximate location of the other agency's Consumer; and (vi) how the Consumer and Personal Assistant explain the conflict.
- ✓ Based on the results of the investigation, the Claims Investigator works with employees of the other agency to unbill and/or rebill, as appropriate either the other agency's billing or FreedomCare's. Any unbilling and/or rebilling to be done by FreedomCare is communicated to FreedomCare's finance department.
- ✓ The Claims Investigator reports to the Care Team manager.

➢ Performs spot-checks for most Consumers within the first month of service and, for all Consumers, quarterly thereafter, to ensure that Personal Assistants actually work hours billed by:

- ✓ Maintaining internal policy that Freedom Care does not bill Medicaid for any time worked by a Personal Assistant where Consumer did not schedule such Personal Assistant's hours in advance. This enables Freedom Care to know exactly when a Personal Assistant is or is not expected to be working, which, in turn, enables FreedomCare to perform spot-checks to ensure Personal Assistant are actually working billed hours.
- ✓ Calling most Consumers within the first month of service and quarterly thereafter during time Personal Assistant is scheduled to work for Consumer.
- ✓ If Personal Assistant is "out" during initial phone call, calling again within a few days thereafter.
- ✓ The process is repeated on a second call and if Personal Assistant is "out" again on the third call, escalating the matter to the Compliance Officer and Director of Coordination, who will arrange for either an in-person or additional by-phone spot checks, depending on the specific circumstances. Depending on the results of such subsequent actions, including in-person spot checks, the Compliance Officer reviews the facts and circumstances and takes appropriate action, including potentially notifying the Consumer and plan that Freedom Care will no longer provide Fiscal Intermediary services for such Consumer; notifying the plan of the relevant facts; and potentially notifying the Office of the Inspector General of suspected fraud.
- ✓ Whether a Personal Assistant is present on the second or third check, but is absent again on subsequent months' checks during initial spot checks, is taken into account when reviewing such subsequent months' thrice-failed spot-checks. The Director of Coordination and Compliance Officer will

consider, based on the specific facts of the case, whether such Consumer poses an elevated risk of Medicaid fraud, and what remedial measures, if any, may be appropriate, up to, and including, termination of Fiscal Intermediary services for such Consumer.

- ✓ In addition, all employees involved with the processing and submission of bills will be trained periodically to ensure that billing and reimbursement policies and procedures are understood and followed.

- *Records and Confidentiality*

All Consumer information will be kept confidential by all employees. No confidential Consumer information is to be relayed either verbally or in writing to anyone without a need to know, unless required by a court of law or any governmental authority. Any demand from any governmental authority or subpoena shall be reviewed by FreedomCare's General Counsel and Compliance Officer, before any disclosure is made. All Consumer-directed records required by applicable contract, rules, or regulations will be maintained securely either on or off-site for the period required by applicable regulations, or longer if required for backup, archival and/or purposes.

e. Compliance Reviews

Compliance monitoring and auditing may include, but is not limited to, the following types of reviews:

- *Billing and Coding Reviews*

The FreedomCare monitoring and audit program is designed to detect any billing practices which might violate local, state and federal laws, rules, and regulations and/or FreedomCare policies. The following proper coding initiatives will be monitored on an ongoing basis in order to prevent and detect violations of the laws:

- ➢ Levels of E&M services billed;
- ➢ Components of services performed;
- ➢ Reasonable and necessary services;
- ➢ Coding of services and items;
- ➢ Use of Modifiers;
- ➢ Billing of multiple procedures;
- ➢ Billing of supplies and implants;
- ➢ Billing to appropriate payer source;
- ➢ Sufficiency of documentation of billed services; and
- ➢ Documentation of medical necessity.

Such reviews will include, but not be limited to, examination of the following: the presence of a signed note in the medical record; an appropriate diagnosis code; proper use of modifiers and site of service designation; proper completion of charge documents; that the services billed correspond to the services rendered; and that, for diagnostic tests, a proper, signed order is in the file.

FreedomCare has a policy of ensuring that all patient and payer overpayments are identified and refunded in a timely manner. Requests from payers for refunds are researched and processed immediately. Medicare and Medicaid overpayments are processed according to the respective program's requirements.

Periodic reviews will also be performed of denials from Medicare, Medicaid, and other third-party payers in order to determine any patterns of improper billing. Additionally, billing complaints received from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues.

If there are any changes in the rules regarding how services or tests are coded and billed, it is the responsibility of the Compliance Officer or his/her delegate to ensure that all Affected Individuals know and incorporate these changes into FreedomCare's billing practices.

- *Chart Reviews*

The Compliance Officer will work with designated personnel to conduct chart reviews. The review will consist of an examination of a sample of medical records, and the corresponding billing documents, to test the adequacy of documentation and coding of services and tests being billed. The medical record and the relevant billing documents will be examined, and both the adequacy of the documentation and the appropriateness of the billing code selected will be checked.

If any documentation or coding issues are identified, the physician or provider will receive education and a follow-up chart review will be scheduled to confirm that the issue(s) identified are corrected. If a pattern of deficient or problematic documentation or coding is identified, the Compliance Officer will take further corrective action, as set forth above which may include, but not be limited to, repayment of an overpayment received.

- *Utilization Monitoring* Reviews

From time to time, FreedomCare may compare individual physician Relative Value Units ("RVUs") to American Medical Group Association ("AMGA"") standards for the respective specialty, and individual provider billing volumes to FreedomCare averages. In addition, FreedomCare may compare individual E & M coding distribution to Medical Management Group Association ("MGMA") standards for the respective specialty. The Compliance Officer reviews the issues identified as a result of the utilization reviews. If it is determined by the Compliance Officer that corrective action is necessary, appropriate corrective action, as described above, will be implemented.

- *Third Party Audit Reviews*

Following resolution of audits by third-party payers, the results of the audit will be reviewed to determine if those results reflect any systemic deficiency or problem in FreedomCare's compliance with state or federal laws, rules, and regulations. If such a problem is identified, appropriate corrective action, as outlined above, will be taken.

- *Compliance Issue* Reviews

Periodically, the Compliance Officer will review reports received of suspected violations of the Compliance Plan to determine if there are any patterns of violations that might indicate broader

compliance issues. The Compliance Officer and/or his delegate may also periodically spot check FreedomCare's business practices to insure compliance with applicable laws, rules and regulations. Such checks might include a review of FreedomCare's Medicare, Medicaid and other credit balances, any potential practice of aiving co-payments or providing professional courtesy, and claim denials received from payers.

- *CDPAP-Specific Internal Reviews*

Because CDPAP fiscal intermediaries are at risk of not maintaining proper Personal Assistant documentation, records of Personal Assistant time worked, and updated annual medical/work authorization documentation for Personal Assistants, among other issues, FreedomCare will review a sampling of Consumer files at least once per quarter to ensure compliance with the Compliance Plan and to identify areas of potential concern such as:

  - Monitoring of business arrangements (anti-kickback concerns)
  - Improper solicitation of Consumers and high-pressure marketing
  - Billing for services provided by ineligible Personal Assistants
  - Documentation to support reimbursement (Health Assessment for paper timesheets: incomplete timesheets, timesheets with white outs, timesheets reflecting dates or hours worked that are known to be inaccurate, missing signatures, different signatures)
  - Billing for services in excess of those authorized (more hours than authorized in the Consumer's plan of care)
  - Routine and documented Personal Assistant attendance checks to compare with timesheets
  - Routine and documented contact with Consumers to ensure their continued eligibility for CDPAP services
  - Failure to return overpayments and to seek reimbursement from the Consumer when appropriate
  - Monthly audits reviewing a sampling of timesheets to verify whether (i) FreedomCare has accurately completed timesheets supporting all time billed for a given quarter; (ii) Personal Assistant and Consumer pictures in Android/iPhone timesheets match pictures we have on file; and (iii) Personal Assistant and Consumer signatures match signatures we have on file.

If and when any issues are discovered in the course of these internal audits, the Compliance Officer will ensure that proper corrective action is taken not only with respect to the particular issues discovered in the audit, but will also determine what circumstances, policies, procedures, practices, systems, or lack of any of the foregoing led to the issue and will implement new/corrected policies, procedures, practices, or systems to ensure that such issues to not re- occur.

- *Follow-Up Compliance Reviews*

If any of these reviews indicate that possible compliance issues might exist, the Compliance Officer will work with the Compliance Committee to ensure that an appropriate inquiry and corrective action is instituted, as provided above.

F. Reporting, Review, and Corrective Action

1. Internal Reporting

All Affected Individuals are obligated to be good faith participants in the Compliance Plan and to raise any compliance questions regarding improper, unethical, or illegal conduct with the Compliance Officer no matter how general.

An open line of communication between the Compliance Officer and FreedomCare employees is important to the successful implementation of the FreedomCare compliance program and the reduction of any potential for fraud, waste and abuse. All employees are required to communicate and report potential unethical or illegal conduct. This includes, but is not limited to:

- Breaches of confidentiality
- Unethical relationships (e.g., ineligible Personal Assistant such as, parent, designated representative)
- Fraudulent or false actions (e.g., forged or false timesheets)
- Improper billing practices
- Unethical behavior
- Unethical/inappropriate care (e.g., unauthorized hours or services)
- Bribes or kickbacks or other improper inducements

Reports of actual or suspected non-compliance may be made anonymously and confidentially. Reports of suspected misconduct or non-compliance may be reported by any Employee or outside party to the Compliance Officer orally, in person, by calling 718-260-6305 or 516-319-0256, by email at mlubin@freedomcare.com or gkaiser@freedomcareny.com, or in writing by mailing a letter to Compliance Officer, Freedom Care, LLC, 1979 Marcus Ave., Suite C115, New Hyde Park, NY 11042. Reports may also be submitted confidentially and anonymously via this web form: http://www.freedomcareny.com/report.)

This reporting system serves as a mechanism to receive, record, and respond to compliance questions and concerns, reports of improper conduct, reports of suspected non-compliance, and allegations of fraud waste and abuse.

Sufficient detail should be provided so that the Compliance Officer may initiate an investigation. Affected Individuals who have a good faith belief that the Compliance Officer has violated the Compliance Plan may instead make a report to the Chief Executive Officer.

Failure to report actual or suspected non-compliance, participating in non-compliant behavior, or encouraging, directing, facilitating or permitting non-compliant behavior will result in disciplinary action.

2. General Complaints and Grievances

Any Affected Individual may make a complaint or file a grievance about any matter with Michelle Lubin, 1979 Marcus Ave., Suite C115, New Hyde Park, NY 11042, Phone: 718-260-6305, Fax: 347-990-3988, mlubin@freedomcare.com or Geoffrey Kaiser, 1979 Marcus Ave.,

Suite C115, New Hyde Park, NY 11042, Phone: 516-319-0256, gkaiser@freedomcare.com
Grievances may be made in person or by mail, fax or email.

Within CDPAP, FreedomCare informs every patient and Personal Assistant at their initial orientation with an Onboarding Specialist of their right to make a complaint or file a grievance. In addition, FreedomCare makes it easier for Consumers and Personal Assistants to avail themselves of this right by calling the Consumer's coordinator. FreedomCare has also placed "Call Coordinator" and "Email Coordinator" buttons on FreedomCare's time-submission app. Coordinators may submit Consumers' and Personal Assistants' complaints and grievances to the Compliance Officer, or connect such individuals to communicate with the Compliance Officer directly.

Grievances, both verbal and written, from all Affected Individuals as well as the public, may contain complaints or allegations of possible misconduct, compliance issues, fraud, waste or abuse. Procedures have been developed that require any complaint which identifies potential compliance, fraud, waste, and/or abuse concerns to be provided immediately to the Compliance Officer. The Compliance Officer is responsible for ensuring appropriate investigation protocols are followed and any potential issues identified and resolved. Issues which may be identified through the investigative process are presented, as appropriate, to the Compliance Committee on a monthly basis.

3. Confidentiality and Anonymity

FreedomCare strives to create a workplace where all Affected Individuals are willing to report violations of its compliance policies and procedures, including but not limited to violations of this Compliance Plan and Code of Conduct, violations of applicable law and regulations and/or unethical behavior. Any compliance concern may be raised anonymously and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. To the extent possible, the Compliance Officer will not reveal the identity of anyone who reports suspected violations or who takes part in an investigation.

4. Non-Intimidation and Non-Retaliation

FreedomCare strictly prohibits intimidation or retaliation for good faith reporting of compliance-related concerns and participating in the compliance program including, but not limited to: reporting and investigating potential issues, conducting of self-evaluations, audits and remedial actions, and reporting to appropriate officials. To this end, supervisors, managers and employees are not permitted to engage in discouragement, intimidation, retaliation, retribution or any form of harassment directed against an employee who reports a compliance concern. Anyone involved in any act of retaliation or retribution will be subject to disciplinary action, up to and including termination.

As provided in New York State Labor Law §§ 740 and 741 and other relevant laws and regulations, intimidation and retaliation will not be permitted against individuals who, in good faith, participate in FreedomCare's Compliance Plan, including but not limited to: reporting potential issues, investigating issues, and participating in self-evaluations, audits and remedial actions. FreedomCare will immediately investigate and take appropriate action with respect to all suspected acts of retaliation and intimidation. Employees who are found to have engaged

in such behavior will be subject to discipline, including possible termination of employment. Acts of retaliation and intimidation should be immediately reported to the Compliance Officer and will be disciplined appropriately.

5. Investigation and Corrective Action

Investigation

The Compliance Officer will report to the Compliance Committee a report of unethical, improper or illegal conduct, or a pattern of possible improper documentation, coding or billing, or a possible violation of the Compliance Plan, as appropriate. All reports of suspected non-compliance will be taken seriously and will be investigated and documented by the Compliance Officer, who shall report the status and results of such investigation to the Chief Executive Officer and/or Senior Leadership, as appropriate, and make a determination as to the appropriate corrective action, including how to reduce the potential for recurrence of identified problems.

The Compliance Officer will initiate the investigation and assign, as appropriate, the complaint to the proper department in order to ensure that all such communications are logged, documented, maintained, and undergo an appropriate investigation to resolve the matter. The Compliance Officer will conduct an inquiry and take all necessary and appropriate actions. All Affected Individuals are expected to fully cooperate in such investigations. The process, following a report, may provide the complainant with information and progress reports, as appropriate, on a confidential basis. The objective of such investigation will be to determine whether a compliance issue exists and if so, to determine its cause and the appropriate and effective corrective action to be instituted. All investigations follow established procedures for responding to compliance inquiries, complaints, and allegations of fraud, waste, or abuse.

Documentation will include, but will not be limited to: the suspected violation reported, individual/individuals involved, investigational findings, disciplinary actions and corrective actions taken. The Compliance Committee, as well as legal counsel, may be consulted in determining the seriousness of the violation.

Additionally, if the investigation involves improper billing or related issues, the investigation may include the selection of a small, random sampling of bills, along with supporting requisitions or other relevant documentation to audit. Only bills that are still being processed within the institution will be selected. If the review warrants, the sample will be expanded as necessary to determine the extent of any problems more accurately. During the review, any bills that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding the documentation have been resolved.

In conducting investigations, the Compliance Committee shall respect the confidentiality of privileged records and information and shall comply with applicable confidentiality laws and professional ethical standards.

All files of compliance-related investigations shall be marked "Confidential" and shall be maintained by the Compliance Officer, in a confidential manner. The information shall not be disclosed, except to: (1) members of the Compliance Committee; (2) members of Senior Leadership; (3) FreedomCare's representatives having a need to know; or (4) as may be required by law or order of a court of competent jurisdiction.

Corrective Action

All Affected Individuals will be held accountable for failing to comply with this Compliance Plan, Code of Conduct, and/or applicable laws and regulations. Violation of the Compliance Plan or the Company's policies and procedures will result in corrective disciplinary action, up to and including termination. The discipline taken will be determined on a case-by-case basis.

Moreover, as all Affected Individuals are required to be good faith participants in the Compliance Plan by reporting compliance issues to the Compliance Officer and assisting in their resolution, disciplinary action will result, not only for those instances where Affected Individuals violate this Plan and/or the Code, but also where any Affected Individual knowingly fails to report actual or suspected non-compliance or encourages, directs, facilitates or permits non-compliant behavior.

Additionally, under certain circumstances, disciplinary action may result for failure to detect non-compliance when routine observation or due diligence provided or should have provided adequate clues or put one on notice to non-compliance.

An individual's self-reporting by admitting wrongdoing to FreedomCare for compliance violations is not a guarantee of protection from disciplinary action. The Compliance Officer, however, will take the individual's self-reporting into consideration when determining what, if any, disciplinary action is warranted.

In the event that the violation is by a Consumer or a Personal Assistant within CDPAP, Freedom Care will address the violation with the Consumer or Personal Assistant as appropriate, and will make a determination whether a report must be made to the appropriate Managed Care Organization, Social Services District, or governmental agency, including but not limited to the Office of Medicaid Inspector General ("OMIG").

If, after a thorough investigation, the Compliance Officer concludes that there has been a violation, then appropriate discipline will be imposed. Every violation will be considered by the Compliance Officer on a case-by-case basis to determine the recommended appropriate disciplinary sanction. When disciplinary action is warranted, such action may include immediate suspension and/or immediate termination of employment. Responsibility for ensuring that recommended disciplinary action for violations of the Compliance Plan, as determined by the Compliance Officer, is imposed rests with Senior Leadership.
Any corrective action and response implemented must be designed to ensure that the violation or problem does not re-occur (or to reduce the likelihood of reoccurrence) and be based on an analysis of the root cause of the problem. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented. Corrective actions may include, but are not limited to, the following:

- Informing about and discussing with the offending employee both the violation and how it should be avoided in the future;
- Providing remedial education (formal or informal) to ensure that they understand the applicable rules and regulations;
- Conducting a follow-up review to ensure that the problem is not recurring;
- Having the offending employee go through a cycle or cycles of remedial education and focused audits;
- Refunding any overpayments that resulted from improper billing or payroll expenses;

- Imposing appropriate discipline, up to and including termination; and
- Voluntary disclosure to an appropriate governmental agency.

The following factors will be taken into account in determining the appropriate disciplinary actions imposed:

- The nature of the violation and its ramifications to FreedomCare ;
- The disciplinary action imposed for similar violations;
- The history of past violations, by the individual/individuals.
- Whether the violation was willful or unintentional;
- Whether the individual was directly or indirectly involved in the violation;
- Whether the violation is an isolated occurrence or a pattern of conduct;
- Whether the violation was a result of lack of due diligence.
- Whether the violation was retaliation against another individual for reporting a violation and/or cooperating with the investigation.
- Whether the individual in question reported the violation through self-disclosure.
- The degree to which the individual cooperated with the investigation.

If it is determined at the conclusion of the investigation that any bills were submitted in error to the government and overpayments were received, the source of payment will be contacted within 60 days of identifying and quantifying the overpayment in order to arrange refunding of such payments.

In consultation with legal counsel, a decision will be made concerning whether any confirmed incident of noncompliance warrants further reporting to the Office of Inspector General, U.S. Department of Health and Human Services ("OIG"), OMIG, the Medicaid Fraud Control Unit of the NYS Attorney General's Office ("MFCU") or another agency.

G. Fraud, Waste and Abuse

It is the obligation of FreedomCare to prevent and detect any fraud, waste, and abuse in its organization related to federal and state health care programs (Medicare, Medicaid and other governmental payer programs). To this end, FreedomCare maintains a vigorous compliance program and strives to educate our work force regarding the importance of submitting accurate claims and reports to Federal and State governments, as well as regarding the requirements, rights and remedies of federal and state laws governing the submission of false claims, including the rights of employees to be protected as whistleblowers under such laws.

FreedomCare strictly prohibits the knowing submission of a false claim for payment in relation to a federal or state-funded health care program. Such a submission violates the Federal False Claims Act as well as various state laws and may result in significant civil and/or criminal penalties. False or misleading documentation must not be made in any FreedomCare records or documents, nor should preexisting documents be improperly altered in any way. No claims for payment are to be prepared or submitted with the intention or understanding, that any part of the claim is false or improper.

CMS defines "fraud" as the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s). Examples of fraud include:

- Knowingly submitting, or causing to be submitted, false claims or making

misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist.

- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by Federal health care programs.
- Knowingly making prohibited referrals for certain designated health services.
- Knowingly signing certificates of medical necessity (CMN) on behalf of a physician when Medicare/Medicaid requires the physician him or herself to sign the CMN;
- Knowingly collecting from Medicare/Medicaid patients more than the permitted amounts or repeatedly violating a participation or assignment agreement;
- Knowingly waiving or failing to collect deductibles and/or copayment obligations;
- Knowingly billing for services or supplies not provided;
- Knowingly disguising or describing non-covered services, supplies, or equipment as covered or chargeable;
- Knowingly arranging to get paid twice for the same service (e.g. duplicate billing to Medicare/Medicaid and the patient and/or another insurer);
- Knowingly misrepresenting services performed, the fee for services, the date of services, or the identity of the patient;
- Knowingly falsifying records to appear to meet conditions of participation and/or coverage;
- Knowingly altering or manipulating claims to increase payments (e.g. up coding); and
- Knowingly billing services or supplies over a period of days when all occurred in one day.

"Abuse" describes practices that may directly or indirectly result in unnecessary costs to health care programs, including Medicaid and Medicare. Abuse involves paying for items or services when there is no legal entitlement to that payment, but when the provider has not knowingly or intentionally misrepresented facts to obtain payment. Examples of abuse may include:

- Billing for unnecessary medical services.
- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

The difference between "fraud" and "abuse" depends on specific facts, circumstances, intent, and knowledge. Abusive practices may, under certain circumstances, escalate to fraud violations. Both fraud and abuse can expose providers to liability, whether criminal, civil or administrative. Fraud and abuse have similar impacts, as they both cause financial losses to Medicare/Medicaid and other health insurance programs. The examples of "Fraud and Abuse" listed above are not exhaustive. Please see attached Exhibit B for a summary of "Federal and New York State Statutes Relating to Fraud and Abuse."

"Waste" includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

It is the policy of FreedomCare to prevent fraud, waste and abuse in all situations and involving all state, federal, and/or other payers. Responsibility for avoiding fraud, waste and abuse rests with all Affected Individuals. Any Affected Individual who knowingly engages in such conduct may be subject to administrative, civil or criminal penalties, in addition to being subject to disciplinary action, up to and including possible termination from employment at FreedomCare.

H. Compliance with Law

It is the policy of FreedomCare to comply with all local, state and federal laws, rules and regulations, regarding all its operations, including the billing of health care-related services and supplies. All Affected Individuals are strictly prohibited from engaging in any activity which is fraudulent, wasteful or abusive. All Affected Individuals are required to report any suspected violation of local, state and federal laws, rules and regulations and/or FreedomCare's policies and this Compliance Plan to the Compliance Officer or to any Compliance Committee member and to assist as may be appropriate in the resolution of such report.

I. Compliance Plan Certification

If Freedom Care is required to have a Compliance Plan pursuant to 18 NYCRR § 521.2(b) (Medicaid revenues are or are expected to be $500,000 or greater in a twelve-month period), the Compliance Officer shall make a determination of the effectiveness of this plan, and on behalf of Freedom Care shall annually complete and submit the certifications required by the Office of the Medicaid Inspector General.

J. Code of Conduct

The FreedomCare Code of Conduct (also referred to as "the Code") is an integral part of this Compliance Plan and sets forth the expectations of conduct for all Affected Individuals as well as subcontractors and vendors of FreedomCare. Everyone should adhere both to the spirit and the language of the Code's standards of conduct set forth below (the "Standards"), maintain a high level of integrity in their conduct, and avoid any conduct that could reasonably be expected to reflect negatively upon the integrity or reputation of FreedomCare. All Affected Individuals, subcontractors and vendors are required to maintain the following Code of Conduct:

1. <u>Standards Relating To Personal Behavior</u>

a. Each individual is expected to act honestly.

b. Each individual is expected to act with respect towards Consumers, Personal Assistants and co-workers.

c. Each individual is expected to adhere to all of Freedom Care's policies and procedures.

d. Each individual is expected to adhere to all federal, state and local laws, rules and regulations governing FreedomCare activities and operations, including CDPAP.

e. Each individual is prohibited from engaging in any of the following actions: (a) commission of fraud including any misstatement or omission to state any material fact for the purpose of persuading somebody to give something of value, while knowing that person will rely on the misstatement; (b) submission of fraudulent claims, inaccurate timesheets or other documentation in connection with billing and reimbursement; (c) bribery or kickbacks; (d) abuse or exploitation; or (e) unlawful discrimination.

f. No employee may use their position at Freedom Care for personal gain.

g. Consumer privacy and the privacy of Personal Assistants and Affected Individuals of Freedom Care must be respected. Information regarding such individuals should not be shared or discussed except in accordance with law and on a need-to-know-basis. To the extent that information is Protected Health Information and covered by HIPAA/HITECH Act, Affected Individuals are expected to comply with Freedom Care's HIPAA/HITECH Act policies.

h. All FreedomCare managers and supervisors have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible for ensuring all employees understand the importance of the Compliance Plan and Code that these employees are aware of its provisions and of the procedures for reporting suspected unlawful activity as set forth herein; and that all employees are protected from retaliation and intimidation if they are forthcoming with information about suspected violations.

i. All individuals are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job within FreedomCare, as appropriate. All individuals are also expected to comply with the standards set forth in this Plan, the Code, and with any applicable compliance protocols and policies. Strict compliance with these legal and compliance standards is a condition of employment, and violation of any of these standards of conduct may result in discipline being imposed, including termination.

j. If any individual believes that these standards or any applicable legal rules were or may have been violated — or has a question about a compliance issue — they should raise their concern with their supervisor or with the Compliance Officer.

k. To the extent practical, all persons and entities with which FreedomCare contracts will be asked to cooperate with FreedomCare's Compliance Plan and Code of Conduct. This includes vendors, contractors, and other healthcare providers.

2. Standards Relating To Billing, Coding and Providing Services

It is the policy of FreedomCare that all healthcare services and supplies rendered by FreedomCare be provided and documented in accordance with local, state and federal laws, rules, and regulations. The following standards apply to all FreedomCare personnel who provide billing, coding, and/or related management services.

a. General Standards

FreedomCare billing services must be delivered in a manner that complies with all applicable rules and regulations governing correct coding and billing. In this regard, all federal and state regulations governing billing procedures will be strictly followed.

FreedomCare policy prohibits the submission of any bill or claim by or on behalf of any provider that fails to satisfy applicable requirements for payment by government and private payers. The ultimate responsibility for coding rests with the physicians and other billing providers. It is the responsibility of each billing physician and advanced practice professional to ensure that services are billed accurately and documented appropriately.

b. Truthful Billing

FreedomCare only bills for the actual patient care services or tests rendered, and the billing for such services and tests must comply with all applicable rules and regulations governing correct documentation, coding, and billing. All billing must be accurate and truthful; and no employee should ever misrepresent charges to, or on behalf of, a patient, a physician or provider, or third-party payer. False statements or intentional omissions of relevant information by any employee to a government agency or other payer will not be tolerated. Purposeful misstatements to government agencies or other payers will expose the employee involved to termination and criminal penalties. All employees must also avoid reckless misstatements. It is illegal to supply false information with a deliberate ignorance or reckless disregard of its falsity or truth. Therefore, if employees have any question as to the truth or accuracy of the documentation for billing purposes, or if there is relevant information that is missing, the bill for the services in question must be held until the questionable issues are resolved. Anything less can result in over-billing and is strictly prohibited

All relevant FreedomCare personnel will be trained in the rules applicable to billing, coding, and/or documentation. In claims processing and billing, such personnel will correctly enter data provided and ensure that the coding and billing process accurately reflects that data without distortion or additions. Once data is entered, the claim will then be processed and billed in compliance with all applicable rules and regulations.

FreedomCare will not engage in, nor tolerate any of its personnel engaging in, any improper billing practice, including but not limited to practices such as: improperly unbundling a service with a global or aggregate billing code into separate billing codes for the components of the service; inappropriate balance billing of insureds for the difference between the total client charges and the allowable payment where such billing is prohibited; duplicate billing for the same service; and improper use of coding modifiers, site of service designations, or other descriptions of the service rendered to enhance reimbursement inappropriately.

The following practices are strictly prohibited:

- Billing for items or services not rendered or not provided as claimed;
- Billing for services, supplies, etc. that are not reasonable and necessary;
- Double billing, resulting in duplicate payment;
- Billing for non-covered services as if they were covered services;
- Misusing provider identification numbers;
- Unbundling of claims (billing for each component of a service instead of billing or using an all-inclusive code);
- Improper use of coding modifiers;
- Improper coding of Evaluation and Management ("E&M") services; and
- Retaining overpayments.

c. Proper Documentation Practices

Billing must always be based on adequate documentation of the medical justification for the service provided and for the bill submitted, and this medical documentation must comport with all applicable regulations. A bill may not be submitted to a payer if the documentation of the nature or scope of the service is unclear. Billing on the basis of unclear documentation can result in over-billing and it is thus strictly prohibited.

d. Code Based on Information Provided by Provider of Service

Billing staff will rely on coding information supplied by the rendering provider in entering coding information regarding a claim. The billing staff will contact any provider who does not supply the actual diagnostic code, such as CPT, or ICD-10-CM, to request a numeric code for the services rendered based on the medical record documentation. It is the responsibility of the provider to ensure that, prior to submitting that charge document for billing, the documentation for the service is clear and in conformity with all applicable rules and regulations. All billing staff will be assisted and monitored by appropriately trained supervisors. A certified coder may change a code based upon the documentation provided in the medical record. Codes should never be selected on the basis of whether the given code guarantees or enhances payment; rather, only those codes that correspond to the service rendered and documented should be selected.

e. Obtaining Clarification from Providers

If the information supplied by the provider of service is insufficient to accurately assign the appropriate diagnostic codes or if the billing staff is uncertain for any reason as to the code, a request for clarification or additional information will be sent to the provider of service. As a general matter, it is FreedomCare's policy to maintain open communication with all our physicians and providers. All FreedomCare's billing personnel are thus instructed to contact the physician or provider if there are any questions regarding the nature of the service rendered and to be billed, the diagnosis, or the codes to be selected. Personnel are strictly prohibited from influencing or attempting to influence a physician or other provider to submit false or misleading information to improperly justify any claim.

f. "Assumption" and "Default" Coding Prohibited

Billing personnel cannot create coding or diagnostic information based on their own interaction with the patient, from information provided from an earlier date of service, or based on what they might conclude is the probable or most likely diagnosis. No personnel shall knowingly engage in any form of upcoding of any services in violation of any law, rule, or regulation. Nor may personnel improperly select codes, such as CPT or ICD-10-CM diagnosis codes, for the sole purpose of ensuring reimbursement. Code assignments must be based on information supplied by the provider of service and supported in the medical record documentation.

FreedomCare does not provide financial incentives to physicians, employees, or outsider vendor/contractors to upcode claims. If a claim is denied or if a payer requests additional information about a claim, any changes made to the codes that have been submitted will have documentation in the record to support the change. FreedomCare personnel will never change a code to bypass a payer's edit.

g. Charge Tickets/Encounter Forms

FreedomCare will assist providers in using properly designed electronic charge capture templates, encounter forms, charge tickets, superbills, or other charge capture documents. These documents will be designed to encourage the provider to accurately document and code for the service rendered, to reduce the likelihood of inadvertent up-coding, and to ensure that FreedomCare will be provided appropriate and accurate information needed for billing the service rendered. FreedomCare will work with providers to review the accuracy and appropriateness of the services and codes set forth on the charge capture devices and/or documents to ensure accuracy periodically. The superbill or charge ticket prepared for billing purposes must accurately reflect the service provided and assign the appropriate billing code.

h. Correct Use of Provider Identification Numbers

Every insurer to whom claims for payment is submitted requires the use of identifying numbers on the claims form (e.g., UPIN numbers, carrier assigned Provider Identification Numbers, group provider numbers for Medicare). The rules for obtaining and using identifying numbers vary from insurer to insurer. However, inclusion of the appropriate identifying numbers on any claims form is essential to allow for timely processing of the claims.

Moreover, the physician or provider who actually provided the service must be accurately and correctly reflected on the claims form. In this regard, use of another's name or identification number, in lieu of one's own when the other provider was not involved in the delivery of the service, may be considered fraudulent billing. The correct use of identifying numbers on claims forms has recently been the subject of increased government scrutiny, focusing on, in particular, whether the actual provider of services is identified on the claims form. If personnel have any questions regarding the correct use of identifying numbers in connection with claims for payment, they should contact their supervisor or Compliance Officer.

i. Waiver of Coinsurance

Routine waiver of deductibles or co-payments for beneficiaries of Federal health care programs by providers, practitioners, or suppliers is unlawful and may result in a violation of the Anti-Kickback Statute and False Claims Act. A waiver is appropriate for Federal health care beneficiaries only if the financial hardship exception is met when a patient's financial situation meets stipulated criteria. The improper granting of a financial hardship exception is considered an improper waiver. Routine waivers of copayments for patients other than Federal health care program beneficiaries may raise other regulatory issues.

j. Waivers from Patients

If a FreedomCare physician deems it clinically appropriate to order a test or perform a service that Medicare may find to be medically unnecessary and thus not reimbursable, the patient should complete and sign a Medicare "Advance Beneficiary Notice." This notice informs that patient that the service or test may not be covered by Medicare and that he or she thus may be liable for paying for the test. In cases in which clinically appropriate but non-reimbursable tests are performed for a Medicare patient, the patient may not be billed for the service without such a Notice having been completed.

k. Collecting Insurance Information

Medicare requires that all providers must bill other primary payers before billing Medicare and must maintain a system that is reasonably designed to identify payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Medicaid is always the secondary payer to all other payers. FreedomCare has instituted such procedures for all payers, including Medicare and Medicaid, and will make a good faith effort as to all patients to determine the primary or secondary payers and to bill accordingly.

l. Submitting Claims for the Purpose of Receiving a Denial

Denials may sometimes be required in order for a patient to seek reimbursement from a secondary insurer. When a claim is being submitted or this purpose, the personnel submitting the document must indicate on the claim that it is being submitted for the purpose of receiving a denial in order to bill a secondary insurer, and use appropriate modifiers in accordance with regulations. If a carrier pays such a claim even though the service is non-covered and FreedomCare did not intend for payment to be made, the amount paid must be immediately refunded with an explanation that the service is not covered.

m. Credentialing: Licensure and Competency Requirements

All FreedomCare physicians and other providers employed by or associated with FreedomCare will comply with FreedomCare's standard credentialing process. All physicians and other providers will be properly licensed pursuant to applicable state requirements, and FreedomCare will take steps on a regular basis to ensure each individual's compliance with state requirements and basic competency through credentialing. This includes a National Practitioner Data Bank review, Office of the Inspector General of the Federal Department of Health and Human Services ("OIG") and Medicaid exclusions check, providing copies of all necessary documents, including, but not limited to, a CV, license, DEA, board certificate, and certificate of insurance.

FreedomCare will not submit any bill to a third-party payer for services provided by a physician or other provider who is not properly licensed.

n. OIG and Medicaid Excluded Individuals

FreedomCare has implemented policies to ensure that all physicians, advanced practice professionals, and employees are compared with the database of OIG/Medicaid excluded individuals on a monthly basis. Exceptions will be reviewed by the Compliance Officer. All physicians, advanced practice professionals, and employees are required to notify the Compliance Officer if they have been excluded from participation in Federal or New York State health care benefit programs.

o. Retention of Records

FreedomCare has instituted a comprehensive medical record and document retention policy, adhering to federal and state laws and regulations. This policy must be followed by all FreedomCare personnel. Destruction of medical records and other documents must be performed in accordance with the established written policy. The Compliance Committee is responsible for establishing procedures designed to safeguard medical records and preserve the integrity of documentation. Each manager or department head is responsible for monitoring compliance with this policy within his/her area of responsibility.

p. Credit Balances

Periodically, FreedomCare will generate reports of the status of any credit balances or refunds owed to Medicare, Medicaid and other third party payers. FreedomCare will then work to ensure that appropriate refunds are then made in a timely and reasonable manner.

q. Computer System

FreedomCare will periodically review, internally or externally, its computer billing systems, software edits, and related programs to ensure that they are fully consistent and up-to-date with all applicable federal, state, and private payer requirements. The review will also ensure that billing personnel are encouraged to enter only accurate and appropriate information supplied by our physicians and providers and are not encouraged to enter data in fields indicating that services were rendered, although not actually performed or documented.

r. Billing for Physician Extenders

Federal and state laws allow, in certain limited circumstances, for the billing of services rendered by physician extenders ("PEs"), such as physical therapists, physician assistants, and nurse practitioners. The rules governing how and when a provider can bill for services by PEs can be complex, and can vary based on who employs the PE, where the service is rendered, and what kind of supervision is provided by the physician. Billing for PE services, whether incident-to or direct, will be done in strict compliance with the applicable rules and regulations, and should occur only after an appropriate review has determined how those rules and regulations apply to the specific services being rendered.

s. Assignment of Benefits

An assignment of benefits is an authorization in which a patient requests that his/her health benefit payments be made directly to a designated person or facility (e.g., physician). It is advisable that the patient sign this authorization to allow insurance payments to come directly from the carrier to the physician or advanced practice professional.

t. Billing for Clinical Lab and Other Diagnostic Testing

In ordering and billing for laboratory or other diagnostic tests, all relevant federal and state laws, rules, and regulations will be followed.

i. Bill Only for Tests Actually Ordered and Conducted

Personnel will only bill for the actual tests performed and interpreted by physicians and other providers, and the billing for such tests must comply with all applicable rules and regulations governing correct documentation, coding and billing. Tests should be performed only when there is a clear order from the patient's provider. If a test is ordered, but is not performed for any reason, no bill for the test may be submitted to any third-party payer.

ii. Additional or "Add-on" Tests

If physicians deem it clinically necessary to perform additional tests for a patient other than the specified test ordered by the patient's physician, the original referring physician should be contacted for clarification to perform the additional tests. In some cases, additional tests may automatically be performed if initial testing indicates that follow up testing is required.

iii. Unclear or Verbal Orders

Tests should be performed only when there is a clear order from the patient's physician or another provider. If a patient arrives for a test without a test order, with only a verbal order, or with an ambiguous order, Personnel should call the ordering practitioner to request a clarification of the order provided. If possible, verbal orders should be accepted only infrequently. All verbal orders should be documented appropriately, and all test orders must be retained as required by state regulations.

iv. Diagnostic Codes

An appropriate ICD-10-CM diagnosis code or narrative must accompany all orders for diagnostic tests. These codes assigned must be accurate and as specific as possible, based on the information available to the physician ordering the test, based on the patient's actual condition, and based on information that is otherwise in the patient's chart.

Only diagnostic information obtained from the physician who ordered or interpreted the test should be placed on any claim/billing form. If the diagnosis is unclear or has not been provided, the billing Personnel must contact the ordering physician or provider to obtain the necessary information. When diagnostic information is obtained, billing Personnel involved will appropriately document the receipt of that information.

For tests with inadequate diagnostic information, FreedomCare will either not perform the test or make sure that a bill for the test is not submitted until the appropriate information has been obtained.

v. Standing Orders

In situations in which a patient is receiving an extended course of treatment, it may be necessary to create a standing order with a laboratory to have the same test conducted on a periodic basis. While such orders are not prohibited as a matter of law, the OIG notes that such orders have "too often in the past" led to "fraudulent and abusive practices." 62 Fed. Reg. at 9438. Like any other order for tests that will be reimbursed by Medicare or Medicaid, each test must be based on an individualized determination of medically necessity. As a result, once it is no longer necessary to conduct a test specified in a standing order as to a particular patient, the order must be terminated.

3. Standards Relating To Business Practices

a. Business Transactions

FreedomCare will forego any business transaction or opportunity that can only be obtained by improper or illegal means, and will not make any unethical or illegal payments to anyone to induce the use of our services. Business transactions and joint ventures with other health care providers will be based on the bona fide financial value of the investment and its positive impact on FreedomCare's ability to deliver services. Such investments will not be based on intent to induce or reward referrals to or from another provider. In all dealings, FreedomCare personnel must never make any misrepresentations, dishonest statements, or statements intended to mislead or misinform. If it appears that anything you have said has been misunderstood, correct it promptly.

b. Business Records

All business records must be accurate and truthful, with no material omissions; the assets and liabilities of FreedomCare must be accounted for properly in compliance with all tax and financial reporting requirements; and no false records can ever be created. Similarly, all reports submitted to governmental agencies, insurance carriers, or other entities will be accurately and honestly made.

c. Non-Discrimination

FreedomCare complies with all applicable federal, state and local civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender or sexual orientation. FreedomCare will not tolerate any practice that would reasonably be expected to have the effect of denying or discouraging the provision of medically necessary services to eligible individuals. FreedomCare provides free aids and services to people with disabilities to communicate effectively with FreedomCare, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, and other formats) as well as free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If an individual is in need of these services, he or she may contact FreedomCare's Section 1557 Coordinator, Geoffrey Kaiser, General Counsel and Director, Regulatory Affairs and Compliance, phone: 516-319-0256, email: gkaiser@freedomcare.com).

If an individual believes that FreedomCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with FreedomCare's 's Section 1557 Coordinator. An individual may also file a grievance in person or by mail, fax, or email. If an individual needs help filing a grievance, FreedomCare's Section 1557 Coordinator is available to help. An individual can also file a civil rights complaint with HSS, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. FreedomCare will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator, in conjunction with FreedomCare's staff, will be responsible for making such arrangements.

d. Referrals

FreedomCare complies with all Federal and State anti-referral and anti-kickback Laws. The Federal and State Anti-Kickback statutes make it a crime to give or receive any remuneration (which is broadly defined to include money, goods, and services) in exchange for a referral or as an inducement to provide health care items or services paid for by Federal health care programs, including Medicare or Medicaid. The physician self-referral laws (the "Stark" laws) in general, a physician cannot refer patients to entities furnishing "designated health services," which are payable under Medicare or Medicaid, if the physician or his or her immediate family member has a prohibited financial interest in that entity. A prohibited financial relationship may include both an ownership or investment interest and a compensation arrangement.

FreedomCare does not pay physicians or providers or patients, or anyone else, either directly or indirectly, for referrals. Decisions concerning patient referrals are based on the physician's independent clinical decision and medical need. Federal and state laws make it unlawful to pay any individual on the basis of the value or volume of referrals of services or tests reimbursed by a federally funded program (such as Medicare and Medicaid). This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral.

e. Relationships with Other Healthcare Providers

All contracts, leases, and other financial relationships with other healthcare medical providers who have a referral relationship with FreedomCare will be in compliance with these laws and will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

Any practice that violates the anti-referral laws or tends to create an appearance of illegality or impropriety is strictly prohibited. Examples of such prohibited activity include: accepting office space for free or below fair market value to see private patients from a facility; accepting interest-free loans from a hospital; renting diagnostic equipment from another professional corporation for less than market value; or accepting free equipment, supplies, or services from a clinical laboratory that are not directly related to the delivery of the laboratory's services.

f. Review of All New Contracts and New Arrangements

All new contracts, leases, and other financial relationship with providers with whom FreedomCare has a referral relationship must be reviewed by the Compliance Officer to ensure compliance with the Federal and State Anti-Kickback and Stark Laws, and compliance with any applicable Safe Harbor or Exception under those laws.

g. Marketing Activities and Patient Referrals

All marketing activities and advertising by personnel must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. No personnel should disparage the service or business of a competitor through the use of false or misleading representations. All marketing activities and advertising by personnel must be based on the merits of the services provided and not on any promise, express or implied, of remuneration for referrals.

h. Purchasing and Competitive Bidding Policy

All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for FreedomCare at the most reasonable price. No purchasing decision may be made based on any consideration that any employee or officer- or any family member or friend of any of them- will benefit by the transaction. Rather, the sole criteria behind all purchasing decisions must be only in the best interest of FreedomCare . Nor can any service or item be purchased in return for a referral of patients from another or with a view towards inducing another to refer patients.

i. Conflict of Interest Rules

The relationship between FreedomCare and all of our personnel is one which carries with it a duty of honesty, loyalty, and commitment. All personnel must exercise utmost good faith in all transactions which touch upon their duties and responsibilities for or on behalf of FreedomCare. Even the appearance of illegality, of impropriety, or of a conflict of interest or duality of interest can be detrimental to FreedomCare, and therefore must be avoided.

A conflict of interest occurs when an individual's private interest makes it difficult to act objectively in the best interest of FreedomCare. Although it is not intended to be a complete list, some examples of conflicts of interest may include situations when an individual (or an individual's relative):

- Causes FreedomCare to engage in business relationships with relatives or friends. Except after full disclosure and with the approval of Senior Leadership, no employee, his or her spouse, dependents, or member of his or her household may be employed by or have, directly or indirectly, a financial interest in any business enterprise with which

FreedomCare has business dealings, or with any business that is owned or controlled by any company or principal of any company with which the FreedomCare does business.

- Competes with FreedomCare. No employee, his or her spouse, dependents, or member of his or her household may have, directly or indirectly, a personal or financial interest in any transaction which is, or may be, adverse to the FreedomCare.
- Solicits or accepts gifts, favors, or entertainment from business partners when such item or service exceeds nominal value or ordinary social hospitality. Employees are not permitted to realize personal gain from employment with FreedomCare other than salary and benefits paid by FreedomCare. Furthermore, except after full disclosure and with the approval of Senior Leadership, FreedomCare employees are prohibited from soliciting or accepting money, gifts of merchandise, personal services, gratuities, or entertainment from suppliers , subcontractors, agents or others with whom FreedomCare does business, has done business, or seeks to do business. Any Affected Individual, subcontractor or vendor who is uncertain over whether a particular transaction is permissible under this provision should inquire with the Compliance Officer;
- Seeks a loan, or guarantee for borrowed money, from FreedomCare (unless the loan or guarantee have been authorized by FreedomCare.; or

Uses FreedomCare's property, information or position for personal gain. Unless properly authorized, employees shall not give or release, outside FreedomCare, any data or information of a confidential nature concerning FreedomCare or its operations.Any questions concerning interpretation of conflicts of interest should be directed to the Compliance Officer.

All persons who have a potential conflict of interest as outlined above, must disclose their interest in writing to the Compliance Officer; take no part in the consideration or determination of the matter on the part of FreedomCare; and to the extent reasonable given the circumstances, should take no part in, and should have no financial participation in, the transaction between the enterprise and FreedomCare. If FreedomCare is considering engaging in a transaction with an enterprise in which a person has an interest, that interest must first be brought to the attention of the Compliance Officer, who will then review the matter. A recommendation will then be made about the propriety of the transaction.

j. Professional Courtesy

Providing professional courtesy discounts to physicians, family members of physicians or to office staff is not prohibited if they are provided only as a true "courtesy," without regard to the physician's referral of patients to the provider. Professional courtesy may only be provided in accordance with a written professional courtesy policy adopted by FreedomCare. No individual who is a Federal health care program beneficiary may receive professional courtesy unless there is a good faith showing of financial need. If any individual believes that a physician or provider is offering discounts to others in violation of these principles, the individual should contact the Compliance Officer who will review the matter and raise the issue, as appropriate, with the physician or other provider.

4. Standards Relating to Confidentiality and Regulatory Inquiries

a. Confidential Patient Information

All individuals must keep patient information in the strictest of confidence in accordance with all local, state and federal HIPAA regulations and in accordance with FreedomCare's HIPAA policies, as may be amended from time to time. Such information will not be disclosed to anyone unless authorized by the patient or otherwise permitted by law. Thus, in receiving, storing, processing or otherwise dealing with any patient information or records, those staff members are fully bound by the applicable provisions of the following: 1) privacy and security regulations under the Federal Health Insurance Portability and Accountability Act of 1996 and amendments; and 2) any other federal or state laws and related regulations governing the confidentiality of patient information, including but not limited to HIV-related information.

b. Confidential Business Information

Confidential information acquired about the business of FreedomCare must also be held in confidence and may not be used as a basis for personal gain by employees, their families, or others. Such information includes, but is not limited to: patient lists, development plans, marketing strategy, financial data, proprietary research, and information about pending or contemplated business deals. The governing principle is that if any material confidential information pertaining to FreedomCare is received by an employee, they must not use such information for their own or their family's benefit, nor should they disclose it to others for their personal use.

c. Regulatory Inquiries

It is the policy of FreedomCare that all of its employees will cooperate with the Centers for Medicare and Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Comptroller General, the Federal Government, the New York State Department of Health, the New York State Office of the Medicaid Inspector General ("OMIG"), and other governmental agencies. These organizations have a right to audit, inspect, investigate and evaluate FreedomCare's books, contracts, records, and documents.

d. Speaking with Government Agents

FreedomCare will not attempt to obstruct any government inquiry or prevent any employee from speaking with government agents. Employees may speak voluntarily with government agents, should they desire to do so. However, it is recommended to all employees, that, before speaking with government agents, they contact their supervisor and/or the Compliance Officer. Employees should first establish the identity of the government representative(s). They should request to see the photo identification, business card(s) or other credentials of the investigator(s) and make copies of the identification provided. All employees should be polite and let the government investigator know that the appropriate administrative personnel will arrive shortly to respond to their inquiry. If asked, staff should also politely advise the government investigators that the staff does not have the authority to disclose documents or consent to a search. Following this procedure will enable FreedomCare to cooperate with governmental agencies while also preserving its rights and protecting FreedomCare's staff and its patients' confidential records and proprietary information.

If the government investigator(s) have properly identified themselves, presented written

authorization, and assert that their audit must be immediate, employees should not attempt to block them. The government representative(s) must comply with applicable laws and regulations (e.g., HIPAA) unless an exception applies. If the employee is unclear whether an exception applies, he or she should politely ask the government representative(s) to produce evidence of an exception to applicable law. The employee may inform the government representative(s) that FreedomCare wishes to cooperate with the investigation, but also has a legal obligation to protect patient protected health information (PHI) and must comply with other applicable laws and regulations.

If possible, employees should document exactly what the investigator(s) review, request copies of, or take with them. They may follow the investigator(s) through FreedomCare's property as they execute the audit. FreedomCare is entitled to a written receipt for any property taken by the investigator(s) when they leave the premises. Employees should keep a record of all interactions between the government representative(s) and staff, and all documents exchanged. This includes patient records or claims information that government representative(s) may view, even if they do not take the documents or copies with them. It is particularly critical that FreedomCare obtain a copy of the legal authority authorizing the release to the investigator(s) of patient PHI and that FreedomCare maintain a record of all PHI that may be used or disclosed.

It is a crime to destroy or alter documents, falsely deny knowledge of requested information, or attempt to influence the testimony of staff. All employees must respond to questions about the location of documents, but they are not required to answer other questions without the benefit of legal counsel.

e. Responding to Subpoenas and Requests for Documents

As a general matter, any employee who receives a governmental request for information, a subpoena, or any other inquiry or legal document regarding FreedomCare's business should notify FreedomCare's General Counsel before attempting to make a reply. An employee may not respond to a request to disclose documents that are the property of FreedomCare without following the aforementioned procedure.

f. Accurate and Complete Responses

FreedomCare is committed to comply with the law and to cooperate with reasonable demands made during the course of a legitimate governmental investigation or inquiry. If a response is given to a request for information from government regulatory agencies, the response must be accurate and complete.

g. No Destruction of Records or Evidence

All employees must preserve documents and not destroy or alter documents that are the subject of a government investigation. Such action will subject the employee to immediate discharge and possible criminal prosecution. FreedomCare will take affirmative steps, if necessary, to ensure the preservation of documents (including electronic data) that are the subject of any government inquiry. FreedomCare will also immediately halt any planned, routine destruction of relevant information. Under certain circumstances, CMS may determine there is a special need to retain a particular record or group of records for a longer period and would notify FreedomCare before the normal disposition date.

h. Communication of Investigation

Employees may not communicate to anyone any matter related to a government investigation without the express permission of FreedomCare. Inquiries from the media should be directed to FreedomCare's General Counsel. Employees should not provide any comments to the press. During the course of the government investigation, all correspondence related to the investigation should be directed through FreedomCare's General Counsel.

K. Other Compliance Protocols and Procedures

In addition to the compliance procedures set forth in this Compliance Plan and Code of Conduct, FreedomCare has also promulgated other, more specific compliance policies and procedures. These additional policies and procedures are an integral part of FreedomCare's compliance program and are designed to complement the procedures and standards set forth in this Plan.

L. Disclaimer

FreedomCare has prepared this Compliance Plan and Code of Conduct to the best of its ability to provide guidance to all Affected Individuals. Subject to the approval of Senior Leadership, the Compliance Officer reserves the right to amend and update components of the Compliance Plan and Code of Conduct at any time to make changes based on regulatory guidance, enhancements to the program to improve effectiveness, or for any other reason as the Compliance Officer deems appropriate. Should anyone have any questions or concerns regarding the Compliance Plan or Code of Conduct, they should contact the Compliance Officer for additional guidance by emailing gkaiser@freedomcare.com or calling 516-319-0256.

Approved:

Exhibit A

COMPLIANCE PLAN ACKNOWLEDGEMENT

I, _____, am a/an: ❑ Employee ❑ Contractor of FreedomCare. By my signature below, I certify that:

1. I have received, read, and understand the FreedomCare Compliance Plan and Code of Conduct, together with their related policies and procedures.

2. I pledge to act in compliance with and abide by the Compliance Plan and Code of Conduct during the entire term of my employment and/or contract.

3. I acknowledge that I have a duty to report to the Compliance Officer any alleged or suspected violation of the Compliance Plan and Code of Conduct, or applicable laws and regulations.

4. I will seek advice from my supervisor or the Compliance Officer concerning appropriate actions that I may need to take in order to comply with Compliance Plan and Code of Conduct.

5. I understand that failure to comply with this certification or failure to report any alleged or suspected violation of the Compliance Plan or Code of Conduct may result in disciplinary action up to and including termination of employment or contract.

6. I agree to participate in any future compliance trainings as required and acknowledge my attendance at such trainings as a condition of my continued employment/contract.

7. I agree to disclose the existence and nature of any actual or potential conflict of interest to the Compliance Officer. Further, I certify that I am not aware of any conflicts of interest.

_____ _____

Signature Date

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Acknowledgment of Contractual Provider Compliance Program:

❑ I certify that as a contractual provider I have elected to not participate in the FreedomCare Compliance Plan and hereby certify that I have an independently developed and implemented Compliance Plan in which to ensure compliance with all applicable laws and regulations and ensure ethical behavior consistent with the FreedomCare Compliance Plan and Code. A copy of said Compliance Plan is attached.

_____ _____

Contractual Provider Signature Date

Exhibit B

Federal and New York State Statutes Relating to Health Care Fraud and Abuse

A. Federal Laws

Federal Civil False Claims Act

The civil False Claims Act ("FCA") protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. If a claim results from a kickback or is made in violation of the Stark Self-Referral law, that also may render it false or fraudulent, creating liability under the civil FCA as well as the Anti-Kickback Statute or Stark law.

The FCA (31 U.S.C. §3729 *et seq.)* is a statute that imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim,
- conspires to commit any act prohibited by the statute.,
- uses a false record or statement to avoid or decrease an obligation to pay the Government, and
- other fraudulent acts enumerated in the statute.

The term **"knowingly"** as defined in the Civil False Claims Act ("FCA") includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term **"claim"** includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA includes civil monetary penalties and treble damages. Currently, the civil monetary penalties (which are indexed annually to inflation), for violations occurring after May 9, 2022, range from $12,537 to $25,076 for each false claim.

The **Attorney General of the United States** is required to diligently investigate violations of the FCA, and may bring a civil action under the law. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for **Actions by Private Persons** *(qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is

filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit generally has the right to conduct the action, although the statute also permits the Government to seek dismissal of the lawsuit.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. If the *qui tam* plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty per cent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, “clearly vexatious”, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

Whistleblower Protection. The Civil False Claims Act also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. The Office of Inspector Genera, Department of Health and Human Services may also impose administrative civil monetary penalties for false or fraudulent claims, pursuant to the Civil Monetary Penalties Law (discussed below).

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. **In some industries, it is acceptable to reward those who refer business to you. However, when dealing with Federal health care programs, paying for referrals is a crime.** The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration. Each party's intent is a key element of their liability under the AKS.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the Civil Monetary Penalties Law, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS 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.

For additional information on safe harbors, see "OIG's Safe Harbor Regulations."

Kickbacks in health care can lead to:

- Overutilization
- Increased program costs
- Corruption of medical decision making
- Patient steering
- Unfair competition

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail. It is also legal to provide free or discounted services to uninsured people.

Besides the AKS, the beneficiary inducement statute (42 U.S.C. § 1320a-7a(a)(5)) also imposes civil monetary penalties on physicians who offer remuneration to Medicare and Medicaid beneficiaries to influence them to use their services.

The Government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS. An individuals can be guilty of violating the AKS even if the service was actually rendered and medically necessary. Taking money or gifts from a drug or device company or a durable medical equipment (DME) supplier is not justified by the argument that you would have prescribed that drug or ordered that wheelchair even without a kickback.

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;

- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

For more information, see CMS's Stark law Web site

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Exclusion Statute [42 U.S.C. § 1320a-7]

OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. **Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.** In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.

For more information, see Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs

Individuals are responsible for ensuring that they do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against OIG's List of Excluded Individuals and Entities. This online database can be accessed from OIG's Exclusion Web site. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil

monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

For more information, see OIG's exclusion Web site.

Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a]

OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation. Some examples of CMPL violations include:

- presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- presenting a claim that the person knows or should know is for an item or service for which payment may not be made;
- violating the AKS;
- violating Medicare assignment provisions;
- violating the Medicare physician agreement;
- providing false or misleading information expected to influence a decision to discharge;
- failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor; and

making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 *et seq.)*

This statute establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

The term **"knows or has reason to know"** is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term **"claim"** includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The authority (i.e., federal department), may investigate and with the Attorney General's approval commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the submission of the claim. The Act allows for **civil monetary sanctions** to be imposed in administrative hearings, including penalties of up to ten thousand seven hundred eighty-one dollars per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

Health Care Fraud (18 U.S.C. § 1347)

The Federal Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services. Health Care Fraud is punishable by up to 10 years imprisonment and a fine. If the violation results in serious bodily injury, it is punishable by up to 20 years imprisonment and fine. If the violation results in death, it is punishable by up to life imprisonment and a fine.

False Statements Relating to Health Care (18 U.S.C. § 1035)

It is a crime for any person, in any matter involving a health care benefit program, to knowingly and willfully falsify, conceal, or cover up by any trick, scheme, or device a material fact; or make any materially false, fictitious, or fraudulent statements or representations, or make or use any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services. A violation is punishable by up to 5 years imprisonment and a fine.

B. State Laws

The New York False Claims Act (State Finance Law, Art. 13, §§187-194)

The New York False Claims Act permits the New York Attorney General and local governments to bring lawsuits against any person or entity that knowingly presents a false or fraudulent claim for payment to the State or a local government. This statute also allows individuals to bring suits on behalf of the State for violations of the Act. In certain circumstances where the suit is successful, individuals may receive a portion of the funds recovered by the State.

Like the FCA, the New York False Claims Act prohibits all forms of retaliation by an employer against any employee who brings a lawsuit concerning false or fraudulent claims or who otherwise assists in the prosecution of a suit. Any employee who is retaliated against may be entitled to reinstatement, back pay and other compensation.

New York Stark Law

There is a New York State analog to the Federal Stark Self-Referral Law contained in NY Public Health Law 238-a. The New York law bars certain practitioners from referring patients to health care providers of specified services when the practitioner, or the practitioner's immediate family member, has a financial relationship with such health care provider. The law applies to practitioners who order clinical laboratory, pharmacy, radiation therapy or physical therapy or x-ray or imaging services. There are a number of exceptions to this prohibition which may make such referrals acceptable.

New York Labor Law §§ 740 and 741

NY Labor Law §§ 740 and 741 also prohibit retaliation against employees who disclose information to regulatory, law enforcement or other similar agencies or public officials about employer policies, practices or activities that violate the law and create substantial and specific danger to the public health, that constitute healthcare fraud under Penal Law § 177 or that constitute improper patient care. The employee's disclosure is protected only if it is asserted in good faith and if the information disclosed constitutes a violation of law or improper patient care. Labor Law § 740 also requires that the employee first raise the matter with a manager and give the employer a reasonable opportunity to correct the alleged violation.

Other New York Statues provide for fines and criminal penalties for making false statements for the purpose of obtaining services provided under programs such as Medicaid and Medicare.

Professional Misconduct Rules Applicable to Medical and Nursing Licensees

It is professional misconduct for licensed professionals to engage in certain activities and such violations could implicate other laws, including the federal or state False Claims Acts. Among these prohibited activities are (a) directly or indirectly giving or receiving (or agreeing to give or receive) anything for the referral of a patient or in connection with performing services and (b) permitting anyone to share in the fees for professional services, other than a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant or legally authorized trainee.

Medicaid Anti-Kickback Statute

There is a New York State analog to the Federal Anti-Kickback Statute specifically for the Medicaid Program, contained in NY Social Services Law 366-d. The law bars Medicaid providers from accepting or giving (or agreeing to accept or give) anything in exchange for the referral of Medicaid services or to purchase, lease or order any Medicaid good, facility, service or item. A violation is punishable by imprisonment and a fine.

New York Penal Law

Health Care Fraud (Article 177)

Health Care Fraud in the first through fifth degrees is included in the New York State Penal Law for filing false health care claims.

Insurance Fraud (Article 176)

Insurance Fraud in the first through degrees is included in the New York State Penal Law for filing false claims for insurance payments.

ADDENDIX 1 (MISSOURI)

The Missouri Health Care Payment Fraud and Abuse Act ("MHCPFA") makes it both a felony offense and a civil false claims violation for a health care provider to knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment, including but not limited to: (1) knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the health care for which the health care payment is claimed was medically necessary, if in fact it was not; (2) knowingly concealing the occurrence of any event affecting an initial or continued right under a medical assistance program to have a health care payment made by a health care payer for providing health care; (3) knowingly concealing or failing to disclose any information with the intent to obtain a health care payment to which the health care provider or any other health care provider is not entitled; (3) knowingly presenting a claim to a health care payer that falsely indicates that any particular health care was provided to a person or persons, if in fact health care of a lesser value than that described in the claim was provided. The Act also makes it a felony offense and civil false claims violation to pay or receive kickbacks in exchange for medical referrals reimbursed by Medicaid. See Mo. Rev. Stat. § 191.905. The Act separately makes it a crime to knowingly abuse a person receiving health care. The Act also makes it a felony to willfully prevent, obstruct, mislead or delay the communication or information relating to a violation of the Act or to attempt any of those things.

Civil penalties for violations of the **MHCPFA** include, but are not limited to, civil penalties of not less than $5,000 and not more than $10,000 for each violation, three times the amount of damages, restitution, and imprisonment. Certain liabilities may be reduced if the violator furnishes the State with all known information within thirty (30) days of receiving such information, provided that the violator did not know of any investigation at the time of disclosure, and cooperates with the investigation. See Mo. Rev. Stat. § 191.905. The Missouri Attorney General shall have the power to investigate suspected violations and bring action against a person who violated the MHCPFA. While the statute does not contain a qui tam provision, a person who is the original source of the information used by the Attorney General to bring an action shall receive a percentage of any recovery by the Attorney General. See Mo. Rev. Stat. § 191.907, 191.910. Whistleblower Protection

The **MHCPFA** contains an employee protection provision that provides that an employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding under the **MHCPFA**. See Mo. Rev. Stat. § 191.908. Such relief under the employee protection provision includes reinstatement to the employee's position without loss of seniority, two times the amount of lost back pay, and interest on the back pay at the rate of one percent over the prime rate. See Mo. Rev. Stat. § 191.908.

ADDENDIX 2 (NORTH CAROLINA)

The **North Carolina False Claims Act ("NCFCA")** makes it unlawful for any person to: (a) knowingly present, or cause to be presented a false or fraudulent claim for payment or approval to the State; (b) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim to the State; (c) have possession, custody, or control of property or money used, or to be used, by the State and, knowingly deliver, or cause to be delivered, less property than the amount for which the person receives a certificate or receipt; (d) knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State, or knowingly conceal or knowingly and improperly avoid or decreases an obligation to pay or transmit money or property to the State; (e) conspire to commit a violation of the NCFCA. See N.C. Gen. Stat. § 1-607. Violators will be liable to the State for three times the amount of damages that the State sustains because of the act of the violator, plus a civil penalty of not less than $5,500 and not more than $11,000 per claim. Penalties may be lowered in certain circumstances based on self-disclosure and cooperation.

An individual may also bring a private civil action on behalf of the individual and the State. In the event the qui tam action is successful, the individual bringing the civil action may be awarded a percentage of the funds recovered. See N.C. Gen. Stat. §§ 1-609, 1-610, 1-614. The statute contains an anti-retaliation provision which indicates any employee, contractor, or agent who experiences retaliatory action because of lawful acts done by the individual in furtherance of an action under the North Carolina False Claims Act or other efforts to stop violation(s) of the North Carolina False Claims Act shall be entitled to all relief necessary to make the individual whole, including reinstatement, two times the amount of back pay, interest on back pay, and compensation for any special damages incurred as a result, including litigation costs and attorney fees. See N.C. Gen. Stat. § 1-613.

Medical Assistance Provider False Claims Act ("MAPFCA") similarly prohibits any provider of medical assistance under the Medical Assistance Program from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved. Liability for each violation is between $5,000 and $10,000, plus treble damages for each false claim, costs of the civil action, interest on damages, and costs of the investigation. See N.C. Gen. Stat. §§ 108A-70.10-70.16. Whistleblower Protections. As with the NCFCA, the MAPFCA contains similar whistleblower protections. See N.C. Gen. Stat. § 108A-70.15.

North Carolina Criminal Code (GS 58-2-161 and 108A-63) criminalizes insurance fraud and medical assistance provider fraud and makes both felonies. There is also a North Carolina analog to the Federal Anti-Kickback Statute contained in GS 108A-63 which bars any person from accepting or giving (or agreeing to accept or give) anything in exchange for the referral of Medicaid services or to purchase, lease, order or arrange, or recommend same for, any Medicaid good, facility, service or item. A violation is a felony under North Carolina law.

APPENDIX 3 (NEVADA)

The **Nevada False Claims Act ("NFCA")** makes it unlawful when any person: (a) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval; (b) knowingly makes or uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim; (c) has possession, custody or control of public property or money used or to be used by the State or a political subdivision and knowingly delivers or causes to be delivered to the State or a political subdivision less money or property than the amount of which the person has possession, custody or control; (d) is authorized to prepare or deliver a document that certifies receipt of money or property used or to be used by the State or a political subdivision and knowingly prepares or delivers such a document without knowing that the information on the document is true; (e) knowingly buys, or receives as a pledge or security for an obligation or debt, public property from a person who is not authorized to sell or pledge the property; (f) knowingly makes or uses, or causes to be made or used, a false record or statement that is material to an obligation to pay or transmit money or property to the State or a political subdivision; (g) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to theState or a political subdivision; (h) is a beneficiary of an inadvertent submission ofa false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the State or political subdivision within a reasonable time; or (i) conspires to commit any of the acts set forth in this subsection. Violators will be liable to the State for three times the amount of damages that the State sustains because of the act of the violator, plus a civil penalty of not less than $5,500 and not more than $11,000 per claim, except as may be adjusted under federal law pursuant to the Civil Penalties Inflation Adjustment Act of 1990. Penalties may be lowered in certain circumstances based on self-disclosure and cooperation. **Nev. Rev. Stat. § 357.040.**

An individual may also bring a private civil action on behalf of the individual and the State. In the event the qui tam action is successful, the individual bringing the civil action may be awarded a percentage of the funds recovered. **Nev. Rev. Stat. § 357.210**.

Whistleblower Protection. The NFCA also contains an anti-retaliation provision which states that any employee, contractor, or agent who experiences retaliatory action because of lawful acts done by the individual in furtherance of an action under the NFCA or other efforts to stop violation(s) of the NFCA shall be entitled to all relief necessary to make the individual whole, including reinstatement, two times the amount of back pay, interest on back pay, and compensation for any special damages incurred as a result, including litigation costs and attorney fees. **Nev. Rev. Stat. § 357.250.**

Fraud Against Medicaid. Nevada law criminalizes fraud against Medicaid. Nev. Rev. Stat. Ann. § 422.540**.** A person, with the intent to defraud, commits a violation if the person: (1) makes a claim or causes it to be made, knowing the claim to be false; (2) makes or causes to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false; (3) makes or causes to be made a statement or representation for use by another in obtaining goods or services pursuant to the plan; or (4) makes or causes to be made a statement or representation for use in qualifying as a provider; knowing the statement or representation to be false in whole or in part by commission or omission. If the claim is greater than or equal to $650, a violation is a Class D felony.

APPENDIX 4 (ARIZONA)

Insurance Fraud. Arizona law criminalizes insurance fraud.

Ariz. Rev. Stat. Ann. § 44-1220. A person who presents a false or fraudulent claim or proof in support of such claim, upon a contract of insurance for payment of any loss, or who prepares, makes or subscribes to an account, certificate of survey, affidavit or proof of loss, or other book, paper or writing, with intent to present or use it or allow it to be presented or used in support of such claim, is guilty of a felony.

Ariz. Rev. Stat. Ann. § 20-463. It is a felony to, with intent to injure, defraud or deceive an insurer, present, cause to be presented or prepare with the knowledge or belief that it will be presented an oral or written statement, including computer generated documents, to or by an insurer, reinsurer, purported insurer or reinsurer, insurance producer or agent of a reinsurer that contains untrue statements of material fact or that fails to state any material fact in relation to insurance applications, policies and payments.

Fraud Against State Agency. Arizona law criminalizes fraud against State agencies. Ariz. Rev. Stat. Ann. § 13-2311. It is a felony for any person, in any matter related to the business conducted by any department or agency of Arizona or any political subdivision thereof, pursuant to a scheme or artifice to defraud or deceive, knowingly falsifies, conceals or covers up a material fact by any trick, scheme or device or makes or uses any false writing or document knowing such writing or document contains any false, fictitious or fraudulent statement or entry.

Fraud Against Medicaid. Civil penalties may be imposed for false claims submitted to Medicaid for medical items and services. Ariz. Rev. Stat. Ann. § 36-2918(A).

Whistleblower Protection. Arizona law also protects whistleblowers.

Ariz. Rev. Stat. Ann. § 23-1501(A)(3)(c)(i)-(ii). Arizona law allows an employee to sue an employer if the employee is retaliated against based on a disclosure by the employee in a reasonable manner of information or a reasonable belief that the employer, or an employee of the employer, has violated, is violating or will violate the Constitution of Arizona or the statutes of the State to either the employer or a representative of the employer who the employee reasonably believes is in a managerial or supervisory position and has the authority to investigate the information provided by the employee and to take action to prevent further violations, to or an employee of an Arizona public body or political subdivision, or to any agency of either.

Ariz. Rev. Stat. Ann. § 36-450.02(A) and (E). Arizona law requires health care institutions to adopt non-retaliation policies protecting health professionals who make good faith reports based on a reasonable belief that an activity, policy or practice violates professional standards or the law.

ADDENDIX 5 (PENNSYLVANIA)

Pennsylvania Fraud and Abuse Control Act ("PFAC"). The PFAC protects the Pennsylvania Medicaid program against fraud and abuse by prohibiting, among other things, false claims, kickbacks and services not provided. 62 Pa. Stat. and Cons. Stat. § 1401 *et. seq.* A violation of the PFAC carries both criminal and civil penalties. Any person who violates the PFAC is guilty of a felony of the third degree for each such violation with a maximum penalty of $15,000 and seven years of imprisonment. 62 Pa. Stat. and Cons. Stat. Ann. § 1407(b)(1). Whenever any person has been previously convicted in any state or federal court of conduct that would constitute a violation of the PFAC, a subsequent allegation, indictment, or information under the PFAC shall be classified as a felony of the second degree with a maximum penalty of $25,000 and ten years of imprisonment. *Id*. In addition, the trial court shall order any person convicted under the PFAC to: (i) repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth and (ii) pay an amount not to exceed threefold the amount of excess benefits or payments. 62 Pa. Stat. and Cons. Stat. Ann. § 1407(b)(2). Further, any person convicted under the PFAC shall be ineligible to participate in Medicaid for a period of five years from the date of conviction. 62 Pa. Stat. and Cons. Stat. Ann. § 1407(b)(3). If a violation occurs, the state has the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider for twice the amount of excess benefits or payments plus legal interest from the date the violation occurred. 62 Pa. Stat. and Cons. Stat. Ann. § 1407(c)(1). Providers who are terminated from participation in Medicaid are prohibited from ordering any service for Medicaid recipients during the period of termination.

Pennsylvania Whistleblower Law ("PWL") (43 Pa. Stat. and Cons. Stat. §§ 1421 to 1428). The PWL provides protection from discrimination and retaliation to any person employed by a public body and who makes or is about to make a good faith report of the wrongdoing or waste to the employer or an appropriate authority or is requested by an appropriate authority to participate in an investigation, hearing, or inquiry held by an appropriate authority or in a court action. 43 Pa. Stat. and Cons. Stat. Ann. §§ 1423(a)-(b). Further, after making a report to the appropriate authorities, the authority is prohibited from disclosing the identity of the whistleblower without his/her consent, except in specified circumstances. 43 Pa. Stat. and Cons. Stat. § 1423(c). A person who alleges a violation of the PWL may bring a civil action for injunctive relief or damages or both within 180 and Cons. Stat. Ann. § 1424. A court may order relief, as it considers appropriate, reinstatement of the employee, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages or any combination of these remedies, as well as the costs of litigation. 43 Pa. Stat. and Cons. Stat. Ann. § 1425. Pennsylvania does not have a whistleblower protection law that applies to private-sector employment. Furthermore, if retaliatory actions arising out of a PFAC violation in turn violate the PWL, additional civil penalties, including a fine of not more than $10,000. 43 Pa. Stat. and Cons. Stat. Ann. § 1426.

ADDENDIX 6 (COLORADO)

Colorado Medicaid False Claims Act ("CMFCA") is a civil statute which is designed to eliminate waste, fraud, and abuse in the State's Stat. Ann. §§ 25.5-4-303.5 to 25.5-4-310. The CMFCA became effective on May 26, 2010. Violations of CMFCA include: (1) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval of a Medicaid claim; (2) knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent Medicaid claim; (3) having possession, custody, or control of property or money used, or to be used, by the state in connection with the Colorado Medical Assistance Act and knowingly delivering, or causing to be delivered, less than all of the money or property; (4) authorizing the making or delivery of a document certifying receipt of property used, or to be used, by the state in connection with the Colorado Medical Assistance Act and, intending to defraud the state, making or delivering the receipt without completely knowing that the information on the receipt is true; (5) knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the state in connection with the Colorado Medical Assistance Act who lawfully may not sell or pledge the property; (6) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the Colorado Medical Assistance Act, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state in connection with the Colorado Medical Assistance Act; and (7) conspiring to commit a violation of any of the acts labeled (1) to (6) above. Colo. Rev. Stat. Ann. §§ 25.5-4-305. Like federal law, the CMFCA includes a civil investigative demand provision. Colo. Rev. Stat. Ann. §§ 25.5-4-309.

The CMFCA also grants the Colorado Attorney General a broad investigative power to subpoena documents and testimony prior to the filing of a lawsuit. *Id.* Additionally, claims resulting from a violation of the Colorado Medical Assistance Act and the federal Anti-Kickback Statute constitute false claims under the CMFCA. Colo. Rev. Stat. Ann. § 24-31-810(2). The statute includes qui tam provisions that allow individuals to file a lawsuit to enforce the CMFCA on behalf of the state and receive between 15% and 30% of the proceeds recovered by the State from a successful resolution of the claim.

The CMFCA protects employees who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in terms and conditions of their employment because they took lawful steps to disclose information with regard to a CMFCA suit or to stop a violation. Such employees are entitled to reinstatement with the same seniority status the employee would have had but for the discrimination, twice the amount of back pay, and interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees. Colo. Rev. Stat. Ann. § 25.5-4-306(7).

The CMFCA establishes per claim monetary penalties of $5,500 to $11,00, as adjusted by Federal law consistent with the Federal False Claims Act plus three times the amount of damages that the state sustains because of the violation. Colo. Rev. Stat. Ann. § 25.5-4-305(1). In addition, persons found to have violated the CMFCA are liable to the state or to the *qui tam* plaintiff for the costs of the action. Colo. Rev. Stat. Ann. § 25.5-4-306(4)(a)(III).

Colorado's Medicaid Fraud Control Statute (Colo. Rev. Stat. Ann. § 24-31-801 *et seq*.) also prohibits knowingly and willfully, with intent to defraud: (1) making a claim or causing a claim to be made, knowing the claim contains material that is false, in whole or in part, by omission or

commission; (2) making a statement or representation, or causing a statement or representation to be made knowing the statement or representation contains material information that is false, in whole or in part, by commission or omission: (a) for use in obtaining or seeking to obtain authorization to provide a good or service, (b) for use by another in obtaining a good or service under the Medicaid program, (c) for use in qualifying as a provider of a good or service under the Medicaid program; and (3) signing or submitting, or causing to be signed or submitted, an application to participate as a provider in the Medicaid program, an income or expense report upon which rates of payment are or may be based, an invoice for payment of a good or service provided to a beneficiary containing a statement that all matters stated therein are true and accurate, which is signed by an individual authorized by the provider, with knowledge that the statement contains material information that is false, in whole or in part, by commission or omission; (4) charging Medicaid beneficiaries in excess of Medicaid program rates; (5) falsifying or concealing any records that are required to fully disclose the nature of all goods or services for which the claim was submitted or reimbursement was received, including destroying or removing the records or failing to maintain them as required by law for a period of at least six years after the date on which payment was received; (6) altering, falsifying, or concealing any records that are required to disclose fully all income and expenditures upon which rates of reimbursement were based, or destroying or removing the records with the intent to prevent their review by the state; and (7) except as authorized by law, and without the consent of the beneficiary, recovering or attempting to recover payment from a beneficiary or his family or failing to credit the state for payments received from other sources. Colo. Rev. Stat. Ann. § 24-31-808.

Colorado's criminal code prohibits presenting or causing to be presented: (a) an insurance claim containing false material information or withholding material information with the intent to defraud and (b) any material or statement as part of, in support of or in opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing the material or statement contains or withholds material information. Colo. Rev. Stat. Ann. § 18-5-211(1)(b) and (e). This is a Class 5 felony under Colorado law.

ADDENDIX 7 (GEORGIA)

Georgia False Medicaid Claims Act ("GFMCA") (Ga. Code Ann. § 49-4-168 *et seq.*) became effective on May 24, 2007. Violations of the GFMCA include actions by natural persons or legal entities capable of being sued that (1) knowingly present or cause to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval; (2) knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim; (3) having possession, custody, or control of property or money used or to be used by the Georgia Medicaid program and knowingly delivering or causing to be delivered less than all of such property or money; (4) being authorized to make or deliver a document certifying receipt of property used (or to be used) by the Georgia Medicaid program and, intending to defraud the Georgia Medicaid program, making or delivering the receipt without completely knowing that the information on the receipt is true; (5) knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the Georgia Medicaid program who lawfully may not sell or pledge the property; or (6) knowingly making, using, or causing to be made or used a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit property or money to the Georgia Medicaid program; and (7) conspiring to commit any of these violations. Ga. Code Ann. § 49-4-168.1(a).

The statute includes qui tam provisions that allow individuals to file a lawsuit to enforce the GFMCA on behalf of the state and receive between 15% and 30% of the proceeds recovered by the State from a successful resolution of the claim. Ga. Code Ann. § 49-4-168.2(i).

The GFMCA protects employees who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in terms and conditions of their employment because they took lawful steps to disclose information with regard to a CMFCA suit or to stop a violation. Such employees are entitled to reinstatement with the same seniority status the employee would have had but for the discrimination, twice the amount of back pay, and interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees. Ga. Code Ann. 49-4-168.4(b).

GMFCA imposes penalties consistent with the civil penalties provision of the FCA plus three times the amount of dam ges which the Georgia Medicaid program sustains because of the violator's actions. Ga. Code Ann. § 49-4-168.1(a). Additionally, violators are liable to the state for all costs of any civil action brought to recover the damages and penalties.

Georgia Medical Assistance Act of 1977 ("GMAA") (Ga. Code Ann. § 49-4-140 *et seq.*) became effective on July 1, 1997. Violations of the GMAA include: (1) obtaining, attempting to obtain, or retaining for oneself or any other person any medical assistance or other benefits under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by: (A) knowingly and willfully making a false statement or false representation, (B) deliberate concealment of any material fact; or (C) any fraudulent scheme or device; and (2) knowingly and willfully accepting medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled or knowingly and willfully falsifying any report or document required under the GMAA. Ga. Code Ann. § 49-4-146.1(b).

Violators of the GMAA are guilty of a felony and will be subject to imprisonment for one to ten years and/or a fine of not more than $10,000 per offense. Ga. Code Ann. § 49-4-146.1(c). Where the defendant is convicted of abuse (when a provider knowingly obtains or attempts to obtain medical assistance or other benefits or payments to which the provider knows he or she is not entitled when the assistance, benefits, or payments are greater than what would have been paid according to the department's policies and procedure manuals and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program), penalties of two times the amount of any excess benefit or payment are imposed. Ga. Code Ann. § 49-4-146.1(c.1)(1-1). Additionally, each person guilty of a violation shall be liable the greater of (1) three times the amount of the excess benefit or payment or (2) $1,000 for each excessive claim for assistance, benefit, or payment.

Georgia Code Ann. § 16-10-20 and § 16-10-21 contain criminal provisions for making false claims. These sections penalize knowingly and willfully, in any matter within the jurisdiction of state government: (1) falsifying, concealing, or covering up by any trick, scheme, or device a material fact; (2) making a false, fictitious, or fraudulent statement or representation; or (3) making or using any false writing or document, knowing it to contain any false, fictitious, or fraudulent statement or entry and conspiring to defraud the state or a political subdivision, respectively. Conspiracy to defraud the state or a political subdivision is defined as conspiring or agreeing with another to commit theft of property of the state or political subdivision or any agency thereof or which is under the control or possession of a state officer or employee of the political subdivision in his official capacity. The crime is complete when the conspiracy or agreement is effected and an overt act in furtherance thereof has been committed, regardless of whether the theft is consummated. Ga. Stat. Ann. § 16-10-21.

The penalties for concealment of false claims under Ga. Code Ann. § 16-10-20 is a fine of not more than $1,000 and/or imprisonment for one to five years. Under Ga. Code Ann. § 16-10-21, a person convicted of the offense of conspiracy to defraud the state shall be punished by imprisonment for a sentence of one to five years.

Georgia Insurance Code ("GIC") (Ga. Code Ann. § 33-1-9) prohibits knowingly or willfully making or aiding in the making of any false or fraudulent statement or representation of any material fact or thing in any written statement or certificate and in the filing of a claim for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer. Ga. Code Ann. § 33-1-9(a). The code additionally prohibits a natural person knowingly and willfully with the intent to defraud subscribing, making, or concurring in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false. Ga. Code Ann. § 33-1-9(c). The code specifically states that a person commits a "fraudulent insurance act" if he: (1) knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, which he knows to contain materially false information concerning any fact material or if he conceals, for the purpose of misleading another, information concerning any fact material thereto; or (2) knowingly and willfully transacts any contract, agreement, or instrument which violates the Georgia Insurance Code. Ga. Code Ann. § 33-1-16(a). Violators of the Georgia Insurance Code will be convicted of a felony and punished by imprisonment for two to ten years, or by a fine of not more than $10,000, or both. Ga. Code Ann. § 33-1-9(e).

ADDENDIX 8 (INDIANA)

The Indiana False Claims and Whistleblower Protection statute ("IFCWP") (Ind. Code Ann. § 5-11-5.5-1, et seq.), effective May 11, 2005, penalizes the submission of false claims to the state of Indiana. **The Indiana Medicaid False Claims and Whistleblower Statute** ("IMFCWS") (Ind. Code Ann. § 5–11–5.7–1, et seq.), effective July 1, 2013, penalizes the submission of false claims to the Indiana Medicaid program. Additionally, the Indiana insurance code prohibits fraudulent insurance acts.

Violations of the IFCWP include knowingly or intentionally: (1) presenting a false claim to the state for payment or approval; (2) making or using a false record or statement to obtain payment or approval of a false claim from the state; (3) with intent to defraud the state, delivering less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state; (4) with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) receiving public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property; (6) making or using a false record or statement to avoid an obligation to pay or transmit property to the state; (7) conspiring with another person to perform an act described in (1) through (6) above; or (8) causing or inducing another person to perform an act described in (1) through (6) above. Ind. Code Ann. § 5-11-5.5-2(b).

Violations of the IMFCWS include, for claims submitted in relation to the Indiana Medicaid program: (1) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval; (2) knowingly making, using, or causing to be made or used, a false record or statement that is material to a false or fraudulent claim; (3) having possession, custody, or control of property or money used, or to be used, by the state, and knowingly delivering, or causing to be delivered, less than all of the money or property; (4) while being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) knowingly buying or receiving, as a pledge of an obligation or debt, public property from an employee who is not lawfully authorized to sell or pledge the property; (6) knowingly: (A) making, using, or causing to be made or used, a false record or statement concerning an obligation to pay or transmit money or property to the state; or (B) concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state; (7) conspiring with another person to perform an act described in (1) through (6) above; or (8) causing or inducing another person to perform an act described in (1) through (6) above. Ind. Code Ann. § 5-11-5.7-2(a).

An individual may bring a civil action for violation of the IFCWP or IMFCWS on behalf of the state. See Ind. Code Ann. § 5-11-5.5- 4(a); Ind. Code Ann. § 5-11-5.7-4(a). If the Indiana Attorney General and Indiana Inspector General intervene in the action, the person filing the complaint is entitled to receive between 15% and 25% of the proceeds of the action or settlement, plus reasonable attorneys' fees and an amount to cover the expenses and costs of bringing the action. Ind. Code Ann. § 5-11- 5.5-6(a)(1). Ind. Code Ann. § 5-11-5.7-4(a).

Under both statutes, an employee is entitled to relief if they have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by the employee's employer because the employee: (1) objected to an act or omission under the statute; or (2) initiated, testified, assisted, or participated in an investigation, an action, or a hearing under the statute. Ind. Code Ann. § 5-11-5.5-8(a), 5-11-5.7-8(a). Such relief includes (1) reinstatement with the same seniority status the employee would have had but for the act of

retaliation; (2) two times the amount of back pay owed the employee; (3) interest on the back pay owed the employee; and (4) compensation for any special damages sustained as a result of the act of retaliation, including costs and expenses of litigation and reasonable attorney's fees. Ind. Code Ann. § 5-11-5.5-8(b), § 5-11-5.7-8(b).

Violations of the IFCWP are punishable by a civil penalty of at least five thousand dollars ($5,000) and for up to three (3) times the amount of damages sustained by the state. Violations of the IMFCWS are punishable by a civil penalty between $5,500 and $11,000, as adjusted for inflation, and for up to three (3) times the amount of damages sustained by the state. Ind. Code Ann. § 5-11-5.7-2(a).

Indiana Insurance Code. Under Indiana's insurance code, a fraudulent insurance act includes: (1) the preparation or presentation of a written statement as part of, or in support of, a fraudulent claim under a policy of commercial or personal insurance; (2) the concealment, for the purpose of misleading, of information concerning any fact material to a claim under a policy of commercial or personal insurance; (3) the act or omission of a person who, knowingly and with the intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer or its agent, an oral or written statement that the person knows to contain materially false information as part of, in support of, or concerning any fact that is material to a claim for payment or benefit under an insurance policy or payments made in accordance with the terms of an insurance policy; and (4) concealing any information regarding the same. Ind. Code. Ann. § 27-1-3-22(a)(1)(B); Ind. Code. Ann. § 27-1-3-22(b)(1)(C) and (E).

ADDENDIX 9 (OREGON)

The Oregon False Claims Act ("OFCA") is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. Or. Rev. Stat. Ann. §§ 180.750 to 180.785. The OFCA became effective on January 10, 2010. Oregon also has a **False Claims for Health Care Payments Act ("OFCHCP")** (Or. Rev. Stat. Ann. §§ 165.690 to 165.698) which works to fight false claims for health care payments. The OFCHCP became effective in 1995. Additionally, Oregon has statutes regarding investigations and recovery of public assistance and medical assistance. Or. Rev. Stat. Ann. § 411.670 et seq.

Violations of the OFCA include: (1) presenting or causing to be presented for payment or approval a claim that the person knows is false; (2) in the course of presenting a claim for payment or approval, making or using a false record or statement that the person knows to contain, or to be based on, false or fraudulent information; (3) agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim; (4) delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt; (5) making or delivering a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information; (6) 38 21882771.40 buying property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property; (7) receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property; (8) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or (9) failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval. Or. Rev. Stat. Ann. § 180.755(1).

Violations of the OFCHCP occur when a person, defined as an individual, corporation, partnership, or association providing health care services or any other form of legal or business entity providing health care services, does the following: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled. Or. Rev. Stat. Ann. § 165.692.

Oregon's statute regarding investigations and recovery of public assistance and medical assistance prohibits obtaining or attempting to obtain, for personal benefit or the benefit of another person, a payment for furnishing any need to or for the benefit of a medical assistance recipient by knowingly submitting or causing to be submitted to the Department of Human Services or the Oregon Health Authority: (1) a false claim for payment; (2) a claim for payment that has already been submitted for payment unless the claim is clearly labeled as a duplicate; (3) a claim that already has been paid by any source unless clearly labeled as already paid. This section also prohibits accepting a payment from the department or authority for the costs of items or services

that have not been provided to or for the benefit of a medical assistance recipient. Or. Rev. Stat. Ann. § 411.675.

The OFCA does not contain qui tam provisions allowing individuals to file a lawsuit on behalf of the state. Actions may be brought by the Oregon Attorney General on behalf of the state. Or. Rev. Stat. Ann. §§ 180.760(1). All damages assessed for violations of the OFCA are awarded to the state. Similarly, violations of the OFCHCP may be prosecuted only by the district attorney or the Attorney General. Or. Rev. Stat. Ann. § 165.696.

A claim for violating the OFCA must be brought within three years after the date that the officer or employee of the public agency charged with responsibility for the claim discovers the violation, but in no event, more than 10 years after the date on which the violation is committed. Or. Rev. Stat. Ann. § 180.765. Penalties for violating the OFCA include damages payable to the state, plus the greater of (1) an amount not less than $10,000 and not greater than $50,000 for each violation and (2) an amount equal to twice the amount of damages incurred for each violation. Or. Rev. Stat. Ann. § 180.760(4). Courts may also award attorney's fees and costs of investigation, preparation, and litigation to the state if the state prevails. Or. Rev. Stat. Ann. § 180.760(8). Although the OFCHCP does not have its own set of penalties, the statute requires that the prosecuting attorney must notify the Oregon Health Authority and any appropriate licensing boards of a person convicted under the OFCHCP. Or. Rev. Stat. Ann. § 165.698. Violators of Oregon's statute regarding investigations and recovery of public assistance and medical assistance are liable for treble damages. Or. Rev. Stat. Ann. § 411.690(2).

Oregon prohibits retaliation against whistleblowing generally and also has a statute specific to whistleblowers who are employed at a licensed health care facility. It is an unlawful employment practice in Oregon for an employer to discharge, demote, suspend, or in any manner discriminate or retaliate against an employee with regard to promotion, compensation, or other terms, conditions, or privileges of employment for the reason that the employee has, in good faith: (1) reported information that the employee believes is evidence of a violation of a state or federal law, rule, or regulation (Or. Rev. Stat. Ann. § 659A.199(1)) and (2) caused a complainant's information or complaint to be filed against any person, cooperated with any law enforcement agency conducting a criminal investigation, brought a civil proceeding against an employer, or has testified at a civil proceeding or criminal trial (Or. Rev. Stat. Ann. § 659A.230(1)). These remedies are in addition to any other remedy that may be available to an employee for the conduct constituting a violation under this section. Or. Rev. Stat. Ann. § 659A.199(2) and Or. Rev. Stat. Ann. § 659A.230(3).

Oregon's health care facilities licensing statute states that health care facilities or a person acting in the interest of the facility may not take disciplinary or other adverse action against any employee who, in good faith, brings evidence of inappropriate care or any other violation of law or rules to the attention of the proper authority, solely because of the employee's reporting action. Or. Rev. Stat. Ann. § 441.044(2). Employees are protected by these provisions as soon as they report the alleged violation to the health care facility's administration or to a state agency. Or. Rev. Stat. Ann. § 441.044(4). Any person suffering loss or damage due to a violation of this protection has a right of action for damages and other appropriate remedies. Or. Rev. Stat. Ann. § 441.044(5).

ADDENDIX 10 (CONNECTICUT)

The Connecticut False Claims Act (the "CFCA") makes it unlawful for any person to: (a) knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a stateadministered health or human services program; (b) knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim under a state-administered health or human services program; (c) be authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to a state-administered health or human services program and intending to defraud the State, make or deliver such document without completely knowing that the information on the document is true; (d) knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state under a state-administered health or human services program; (e) knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the State under a state-administered health or human services program. See Conn. Gen. Stat. § 4-275(a). Violations of the CFCA are civil offenses and can result in significant monetary penalties of not less than $5,000 and not more than $11,000, plus three times the amount of damages that the State sustains because of a violation of the CFCA. In addition, certain liabilities may be reduced if the violator furnishes the State with all information known to the violator within thirty (30) days or receiving such information, provided that the violator does not have knowledge of an investigation at the time the violator furnishes such information. See Conn. Gen. Stat §§ 4-275(b)-(c).

The CFCA contains an employee protection provision that provides any employee, contractor, or agent with all relief necessary to make the employee, contractor, or agent whole, if the employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the employer or by any other person because of lawful acts done by the employee, contractor, or agent or associated others in furtherance of an effort to stop any violations of the CFCA. The relief provided under the CFCA includes reinstatement with the same seniority status that the employee, contractor, or agent would have had but for the discrimination, two 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. See Conn. Gen. Stat. § 4-284.

False claims to the Connecticut Medicaid program may be prosecuted criminally under vendor fraud and larceny statutes. *See* CGS §§ 53a-290-296, 53a-121 to 125.

The law prohibits retaliation against whistleblowers. Generally, officers, employees, or appointing authorities with state or quasi-public agencies or large state contractors may not take or threaten to take any personnel action against an employee in retaliation for the employee's (1) testimony to, or assistance with, a whistleblower investigation or (2) whistleblower disclosure (CGS § 4-61dd(e)(1)).

Con. Gen. Stat. § 33-1336 protects whistleblowers for employees of certain Connecticut corporations by barring any officer, employee, contractor, subcontractor or agent of any such corporation from discharging, demoting, suspending, threatening, harassing or discriminating against any employee who performs any portion of such employee's employment duties within Connecticut because of any lawful act done by the employee (1) to provide information, cause information to be provided, or otherwise assist in an investigation regarding any conduct that the employee reasonably believes constitutes a violation of 18 USC Section 1341, 1343, 1344 or 1348,

any rule or regulation of the Securities and Exchange Commission, or any provision of federal or state law relating to fraud against shareholders, when the information or assistance is provided to or the investigation is conducted by (A) a federal or state regulatory or law enforcement agency, (B) a member or committee of Congress or the General Assembly, or (C) a person with supervisory authority over the employee, or such other person working for the employer who has the authority to investigate, discover or terminate misconduct, or (2) to file or cause to be filed a proceeding, or to testify, participate or otherwise assist in a proceeding filed or about to be filed, with any knowledge of the employer, relating to an alleged violation of 18 USC Section 1341, 1343, 1344 or 1348, any rule or regulation of the Securities and Exchange Commission, or any provision of federal or state law relating to fraud against shareholders.

ADDENDIX 11 (MASSACHUSETTS)

Violations of the **Massachusetts False Claims Act** include, but are not limited to, knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim, or conspiring to commit an aforementioned violation. See Mass. Gen. Laws. ch. 12, §5B. A violator will be liable to the Commonwealth for a civil penalty not less than $5,500 and not more than $11,000 per violation, plus three times the amount of damages, including consequential damages that the Commonwealth or a political subdivision thereof sustains because of the violations, as well as attorney's fees and the cost of the investigation. Certain liabilities may be reduced if the violator furnishes the office of the attorney general with all known information within 30 days after the date on which the person first obtained the information, before any legal action had commenced, and the person fully cooperated with any commonwealth investigation. See Mass. Gen. Laws ch. 12, §5B.

The Massachusetts Attorney General shall investigate violations under the false claims statutes and may bring a civil action against a person who has violated the statute. An individual may also bring a private action on behalf the Commonwealth. In the event the qui tam action is successful, the individual bringing the civil action may be awarded a percentage of the funds recovered. See Mass. Gen. Laws ch. 12, §5C and 5F. Whistleblower Protection Massachusetts false claims laws contain an employee protection provision that entitles an employee, contractor or agent to any relief necessary to make them whole if the employee, contractor or agent is discharged, demoted, suspended, 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 a person associated with the employee, contractor or agent in furtherance of an action under the false claims statute. See Mass. Gen. Laws ch. 12, §5J.

The Massachusetts criminal code includes a provision prohibiting false claims, including, but not limited to, making or presenting to the State any claim upon or against any department, agency, or public instrumentality of State or any political subdivision thereof, knowing such claim to be false, fictitious, or fraudulent. Violators will be punished by a fine of not more than $10,000 or by imprisonment for not more than five years. See Mass. Gen. Laws ch. 266, § 67B.

Massachusetts whistleblower laws are designed to protect people who report information about suspected illegal, wasteful or unethical activity. When you report suspicions regarding illegal activity by an individual or organization to our public fraud, waste and abuse hotline or public transportation fraud, waste and abuse hotline, you and your identity may be protected under state law (M.G.L. c. 12A, § 14(b)). State law also specifically protects you from retaliation by your employer for submitting a complaint or disclosing information to the OIG (M.G.L. c. 12A, § 14(c)). Other state laws, including the **Massachusetts Whistleblower Act (M.G.L. c. 149, § 185)**, may provide further protections. State law also criminalizes the intimidation of whistleblowers. (M.G.L. c. 268, § 13B).