BRIGHTPOINT HEALTH

WELCOME TO WELLNESS

Corporate Compliance Plan

Corporate Compliance – April 2018

Letter of Commitment from President and CEO

Brightpoint Health's operations are subject to many different laws and regulations. Every employee is personally responsible for complying with these laws in everything they do, regardless of their position or location.

The principles set out in the Corporate Compliance Plan form the basis for acting in conformance with laws and rules, but do not cover every conceivable situation or describe every relevant policy or regulation. The Brightpoint Health's Corporate Compliance Principles are intended to provide employees with guidance in their daily work and help to prevent inappropriate behavior. Accordingly, they aim to highlight the issues most likely to be encountered in practice. Over and above that, all employees should familiarize themselves with the relevant policies and, if in doubt, should seek advice from their supervisor/manager, the Human Resources department or the Corporate Compliance Officer. Ignorance is not protection against the potential consequences of improper conduct. Please read the booklet carefully and in its entirety.

All employees must immediately report any breaches of the Corporate Compliance Principles to the Corporate Compliance Officer via the Corporate Compliance Hotline.

Every supervisor, manager and every employee must demonstrate personal integrity, thereby ensuring that corporate compliance is indispensably embedded in the corporate culture.

Paul Vitale
President & CEO

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Introduction

Statement of Policy

It is the intent of this Compliance Program to ensure that Brightpoint Health complies in all respects with all federal, state and local laws and regulations which govern their operations. Brightpoint Health is a federal and state tax-exempt entity, providing diagnostic and treatment, mental health, substance abuse, dental and other primary care services to the medically needy and underserved as designated a Federally Qualified Health Center. Brightpoint Health also operates a health home and an Adult Day Health Care (ADHC) program, and participates in other health homes and grant programs. Accordingly, Brightpoint Health is regulated by a myriad of federal and state laws and regulations and grant requirements.

To underscore and enhance its continued commitment to compliance and to assist its members of the Boards of Directors (each a "Director"), officers, employees, per diems, contractors, physicians contractors and vendors (collectively, referred to as "Affected Individuals") in complying, Brightpoint Health has adopted this comprehensive Compliance Program. The adoption and implementation of this Compliance Program will significantly advance the prevention of potential fraud, waste and abuse ("FWA") while, at the same time, ensuring the adherence to all governing laws and regulations, which will only further the fundamental mission of Brightpoint Health.

It is the responsibility of all Affected Individuals to proactively identify issues relating to potential non-compliance and FWA. All Affected Individuals are required to comply with the applicable provisions of Brightpoint Health's policies and procedures designed to minimize any exposure.

The Elements of the Program

The design of Brightpoint Health's Compliance Program is based on compliance guidance provided by the U.S. Department of Health and Human Services Office of Inspector General ("OIG") and the requirements imposed on health care providers under Section 363-d of the New York Social Services Law and Part 521 of Title 18 of the New York State Codes, Rules and Regulations and related guidance. The key elements of the Compliance Program that implement the operation of such program, and are discussed in greater detail in the sections referenced below, are as follows:

- A Code of Conduct (the "Code") that includes basic standards, and references more detailed written policies and procedures that guide Brightpoint Health's Affected Individuals' activities (Section I);
- The designation of an employee to oversee the Compliance Program, the Compliance Committee's responsibilities, and the Boards of Directors' responsibilities for the Compliance Program (Section II);
- Compliance training and education for Affected Individuals (Section III);
- Lines of communication to the Compliance Officer, including an confidential and anonymous reporting options (Section IV);

- Procedures for responding to reports of suspected compliance problems and cooperating in government investigations (Section V);
- A system for routine identification of compliance risk areas and detection of potential FWA or other improper activity (Section VI);
- Procedures for taking corrective action in response to identified compliance issues, including, where appropriate, refunding overpayments (Section VII);
- Disciplinary policies to encourage good faith reporting and require action against employees who engage in misconduct or fail to adhere to the terms of the Compliance Program (Section VIII); and
- Policy against intimidation and/or retaliation against any Affected Individual who reports a compliance issue in good faith (Section IV).

I. Code of Conduct

Scope of Code

This Code governs the conduct of Affected Individuals at Brightpoint Health.

Basic Principles

Brightpoint Health is committed to integrity, ethical behavior, and the highest professional conduct from all Affected Individuals. This Code reaffirms our commitment to always doing what is professionally and ethically right, and is intended to guide us in upholding this commitment. Each Affected Individual is expected to read, understand and abide by this Code. This will ensure that we continue to provide the highest levels of compassionate, quality health care while complying with all applicable laws, rules, and regulations.

The Code is designed to assist each Affected Individual in making the right choices when confronted with difficult situations. This Code requires every Affected Individual, when acting on behalf of Brightpoint Health, to act with a level of integrity that is higher than what the government requires. Each Affected Individual is responsible for ethical and compliant behavior when he/she makes decision for or on behalf of Brightpoint Health.

Here are the basic principles:

- Brightpoint Health and Affected Individuals abide by the letter and spirit of relevant laws and regulations that govern Brightpoint Health and their respective activities. Through full disclosure of even the smallest facts related to questionable activity, we demonstrate our commitment to integrity.
- Brightpoint Health and Affected Individuals will act with the highest level of ethics in our business activity. Our actions demonstrate our standing as strong ethical contributors within the community.
- Brightpoint Health and Affected Individuals will deal fairly and honestly with whom we interact and treat everyone as we would expect to be treated.

- Brightpoint Health and Affected Individuals will always avoid activities that we would not want publicized or would involve non-compliance.
- Brightpoint Health and its employees, contractors and Directors will promote relationships based on mutual trust and respect. We will create an environment where we can challenge questionable activity without fear of retaliation or harassment.
- Each of us will abide by Brightpoint Health's Conflict of Interest Policy. As required under that policy, each employee and Director will disclose and remove any potential conflict of interest.

Brightpoint Health's policy is to prevent unethical or unlawful behavior, to stop such behavior as soon as reasonably possible after its discovery, and to discipline people who violate the standards contained within this Code. This includes people who recklessly fail to detect any such activity. No Code can cover all circumstances or anticipate every situation. Consequently, Affected Individuals encountering situations not specifically mentioned in this Code should apply the overall philosophy and concepts of the Code to the particular situation, along with the highest ethical standards repeatedly discussed herein.

Any individual with questions about any part of this Code or Compliance Program or what to do in a specific situation should seek advice from his/her supervisor, the Compliance Officer, or the Compliance Hotline.

Additional specific standards of our Code are set forth below:

Reporting Potential Non-Compliant or Fraudulent, Abusive or Wasteful Behavior

Each Affected Individual immediately must report any potentially non-compliant, illegal, or fraudulent, abusive or wasteful behavior by any Affected Individual, or any person with whom Brightpoint Health deals so that it can be investigated promptly. Reports can be made directly to one's supervisor, the Compliance Officer or to the Compliance Hotline by calling 1-866-691-1964. The Compliance Hotline is operated by a private outside vendor and is available 24 hours a day, 7 days a week, 365 days a year. Affected Individuals may report concerns confidentially and, if desired, anonymously via the Compliance Hotline.

Proper Financial Accounting and Reporting

Brightpoint Health's financial records and accounts must always be prepared accurately and reliably. It is a given manager's responsibility to control internal accounting methods to ensure the accuracy of all records related to his/her areas of oversight and pertinent Brightpoint Health assets. Managers are expected to follow established principles of accounting to assure an accurate record of all transactions. Before any submission is made to a government agency related to, or relying on financial records, Brightpoint Health shall ensure that all information in the submission is truthful and accurate.

Trade Practices/Antitrust

Antitrust laws are designed to preserve and foster fair and honest competition within the free enterprise system. To accomplish this goal, the language of these laws is deliberately broad,

prohibiting such activities as "unfair methods of competition" and agreements "in restraint of trade." Such language gives enforcement agencies the right to examine many different business activities to judge their effect on competition.

Brightpoint Health fully complies with all antitrust laws. In furtherance of this, employees, contractors and Directors must never discuss, in any form of communication, the make-up of patients, geographic areas, or services; the circumstances under which business will be conducted with suppliers, insurance companies, patients, or customers (including boycotts); or specific marketing efforts with any competitors. Further, discussions of future business plans of Brightpoint Health or any competitors should be avoided. Finally, employees, contractors and Directors should never discuss prices, reimbursement, or salary levels with any competitor.

Compliance with Anti-Kickback and Corrupt Influence Statutes

Both federal and state laws specifically prohibit any form of kickback, bribe or rebate made directly or indirectly, overtly or covertly, in cash or in kind to induce the purchase, recommendation to purchase, or referral of any kind of healthcare goods, services or items paid for by the Medicare, Medicaid, or other federal or state healthcare programs.

This means Brightpoint Health and Affected Individuals may not offer items or services for free or below fair market value to beneficiaries of federal and/or state health care programs to induce referrals, or provide services for free or below fair market to physicians, hospitals and other potential referral sources. Brightpoint Health and Affected Individuals may not accept anything of value in exchange for recommending a particular product or service. Brightpoint Health does not provide any remuneration to its providers for services either not rendered or in excess of fair market value for services rendered.

Billing for Patient Services

All Affected Individuals involved in coding and/or billing for health care services must ensure that they follow all applicable laws, rules, conditions of participation, and interpretive guidance relating to the billing process. Among other things, Affected Individuals must ensure that Brightpoint Health does not:

- Bill for patient services not actually provided;
- Bill for a service where an appropriately licensed or credentialed provider has not seen the patient;
- Bill twice for the same service;
- Bill for services not supported by the clinical documentation;
- Bill at the incorrect rate;
- Bill for services the employee knows are also being billed to the government by another health care provider; or

- Bill the Medicaid program as the primary payor when the /patient has other public or private health insurance coverage.

Brightpoint Health ensures that no Affected Individual intentionally falsifies a claim. Such conduct is a crime, is never in our best interest and would tarnish our name. Such actions would result in immediate, severe sanctions. Billing errors, either intentional or accidental, expose Brightpoint Health and the responsible party to civil and/or criminal liabilities under the Medicare and Medicaid programs. An incorrect bill could, in certain circumstances, be deemed to be a "false claim" (as discussed below).

We require all Affected Individuals involved in any aspect of billing to know, understand and abide by Medicare, Medicaid or other third-party insurer billing rules. Each Affected Individual must use his or her best efforts to prevent and report to his/her supervisor or the Compliance Officer errors, as well as billing practices or situations which seem suspicious.

If Brightpoint Health retains a vendor to submit bills on its behalf, Brightpoint Health may still be responsible for improper billing activity by the vendor. Accordingly, employees involved in delegating this function must provide clear direction to vendors on proper billing procedures and carefully monitor their performance.

Documentation Integrity

Brightpoint Health takes seriously its obligation to maintain complete, accurate, and timely documentation of the services it provides. Brightpoint Health requires staff to always document all services provided accurately and completely. Each medical record entry should be individualized to reflect the care rendered to that particular patient on that particular date of service. No Affected Individual should ever:

- Back date a document. All entries in the medical record shall clearly identify the date and time of the entry. The date and time shall identify when the entry is made, regardless of whether it relates to services provided on a prior date.
- Delete or remove a prior entry to correct a medical record. If you need to correct a prior entry, please speak to your supervisor or the Compliance Officer regarding how to create an addendum to the existing medical record entry.

Intentionally misrepresenting a service provided, the date the service was provided, or the provider of a service is fraud, will result in disciplinary action and can lead to criminal penalties. In addition, inaccurate medical record documentation can result in a patient receiving incorrect or inappropriate care.

Submitting Complete and Accurate Reports to Government Agencies

Under certain programs, reimbursement from the government may be based, in whole or in part, on Brightpoint Health's costs. In these programs, Brightpoint Health usually is required to submit regular cost reports, which are used by the government for rate-setting purposes. All Affected Individuals involved in the process of preparing and submitting cost reports must ensure that these reports are accurate and complete. Expenses reflected on cost reports

must have been actually incurred and properly allocated in accordance with program guidelines. The same standards of accuracy and completeness apply to any other reports or data regarding Brightpoint Health submitted to government agencies, private funding sources, or federal and state grant programs.

Taxes

Brightpoint Health is exempt from taxation by federal, state, and local governments. It is through this tax exempt status that we are able to continue to provide compassionate and cost-effective care to the communities we serve. We risk losing this tax-exempt status and face possible closure if we do not operate for the benefit of the community. Tax laws forbid us from operating for "private inurement" and "private benefit." Personal items should never be purchased through Brightpoint Health, even if Brightpoint Health is reimbursed by the purchaser.

Gifts and Entertainment

Brightpoint Health recognizes that it and Affected Individuals have ongoing business relationships that may occasionally involve an invitation for a meal or entertainment. Affected Individuals are prohibited from receiving gifts, favors, entertainment, special accommodations or other things of material value that may influence their decision-making or make them feel beholden to a third person or vendor. Similarly, Brightpoint and Affected Individuals are prohibited from providing gifts, favors, entertainment, special accommodations, or other things of material value to third persons or vendors that are intended or aimed at influencing decision-making or making the recipient feel beholden to Affected Individuals or Brightpoint Health, or that create the perception of such intent. Gifts of cash (including cash equivalents and gift certificates) are never acceptable.

Brightpoint Health and Affected Individuals may never solicit gifts.
Gifts of nominal value offered or received without any attempt to influence the business activity or transaction may be appropriate. If you are unclear in certain situations where a gift is offered, please contact your supervisor, the Compliance Officer or the Compliance Hotline.

Labor and Employee Relations Matters

Brightpoint Health faces a number of labor issues every day. It is our policy to comply fully with all applicable wage and hour laws and other statutes regulating the employer-employee relationship and the workplace environment. If you have any questions about the myriad of laws governing labor and employee relations matters, please contact the Human Resources Department.

Environmental Health and Safety

Brightpoint Health takes its responsibility to the environment very seriously. We understand our financial and legal responsibility in the proper handling and disposal of hazardous materials and infectious wastes that are generated by our daily operation. It is essential that any Affected Individual who deals with hazardous materials and infectious waste comply with

environmental laws and regulations and understand and follow the environmental safety procedures explained in our programs and existing manuals.

Occupational Health and Safety

Every employee should work in a safe environment. The state and federal government has instituted laws regarding occupational safety and job related hazards. Strict attention should be given to those laws so that we may safely continue to provide the highest level of service to our patients.

Pharmaceuticals, Prescription Drugs, Controlled Substances

Many of our employees, contractors and vendors have responsibility for, and access to, prescription drugs, controlled substances, hypodermic needles, drug samples, and other regulated pharmaceuticals. Brightpoint Health is legally responsible for the proper distribution and handling of these pharmaceutical products. Federal, state, and local laws and regulations are intended to maintain the integrity of drug distribution and maintenance and ensure safety via properly labeled medications, prescription drugs and controlled substances.

These laws and regulations forbid distribution of any drug, including samples, in any amount, for any reason to an unauthorized individual or entity and govern adulterated, misbranded, mislabeled, expired, or diverted pharmaceuticals. Violation of these laws may result in severe criminal penalties.

It is Brightpoint Health's policy that every employee, contractor, and vendor be both diligent and vigilant in carrying out their obligations in regards to prescription drugs in accordance with all applicable laws, regulations, and internal policies. Any violation of law or internal policy involving prescription drugs, controlled substances, or other pharmaceuticals will constitute grounds for dismissal, termination and/or potential reporting to licensure boards or governmental authorities.

Loyalty and Conflicts of Interest

Every employee, contractor, and Director has a duty of loyalty to Brightpoint Health and must avoid even the appearance of a conflict of interest. Our business conduct must always put Brightpoint Health's interests ahead of personal interests. Individuals should never use their positions or confidential information obtained in the course of working at or on behalf of Brightpoint Health for personal gain. All employees, contractors, and Directors are expected to make prompt disclosure before taking action of any fact or circumstance that may involve, or appear to create, a conflict of interest, and all employees, contractors, and Board Members must follow Brightpoint Health's Conflict of Interest Policy.

Using Brightpoint Health Resources Exclusively for Brightpoint Health Business

Affected Individuals may use Brightpoint Health resources solely for the purpose of carrying out their job responsibilities. Brightpoint Health's facilities, equipment, staff and other assets may not be used by Affected Individuals for personal benefit or to engage in any outside business or volunteer activity with using Brightpoint Health resources without the prior approval of their supervisor. Affected Individuals may not use their affiliation with Brightpoint Health to promote any personal or other business, charity, or political cause. Affected Individuals shall seek reimbursement for expenses only to the extent such expenses have been incurred in the course of carrying out their job duties and in accordance with Brightpoint Health expense reimbursement policies.

Quality of Care and Patient Rights

Brightpoint Health is fully committed to providing the highest quality care and services necessary to attain or maintain each patient's highest practicable physical, mental, and psycho-social well-being. To this end, Brightpoint Health will institute mechanisms to assess each patient's needs as well as audit procedures to ensure that the care plan effectively meets the needs and improves the condition of each patient. Brightpoint Health will aim to maintain an adequate level of staff to ensure that patients receive medically necessary and timely care and services. Furthermore, Brightpoint Health will conduct and review surveys and perform quality improvement activities to identify specific areas of concern in order to ensure continuing superior quality of care for its constituents.

Brightpoint Health also recognizes the right of its patients to a dignified existence that promotes freedom of choice, self-determination and reasonable accommodation of individual needs. Patients are given the right to participate in care and treatment decisions. Moreover, Brightpoint Health is committed to providing access to care to all patients, regardless of their ability to pay.

Safeguarding the Privacy of Our Patients

Our business requires us to gather a great deal of personal information about our patients. Therefore, we must always protect our patients' rights to privacy, prevent the misuse of information identifiable to them, and limit access to that information. All patient records must be kept confidential in accordance with applicable privacy laws and regulations. Brightpoint Health is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which limits the use and disclosure of protected health information. Brightpoint Health must also comply with special confidentiality laws governing HIV-related information, mental health treatment and substance abuse. Actively safeguarding this information is everyone's responsibility. All Affected Persons are expected to comply with HIPAA and Brightpoint Health's HIPAA Policies and Procedures. The Privacy Officer should be contacted regarding any questions around using or disclosing any patient's information or any suspected violations of HIPAA or other patient confidentiality laws.

Confidentiality of Brightpoint Health Information

One of our most valuable assets is Brightpoint Health's confidential information. Computers make this information readily accessible to Affected Individuals. Failure to protect this information can lead to the loss of highly confidential information that may place all of us at great legal or other risk. Affected Individuals, either during their employment, contract or appointment and after, must never use any confidential information obtained during their employment, contract, or appointment for any reason, in any circumstance, without the written

consent of Senior Management.

Information Owned by Others

Other organizations and individuals have confidential information that they share with Brightpoint Health for particular business purposes. If you have access to another party's confidential information, you can prevent accusations that you misused their information by following certain guidelines. Never use, copy, or distribute their information, unless you are doing so in accordance with the terms of their agreement with our organization. Never, under any circumstances, may Affected Individuals bring in or install personal copies of software from your home or personal computer for use on any computer equipment owned or operated by Brightpoint Health.

This is especially true in acquiring software from others. Software is protected by copyright laws and may also be protected by patent, trade secret laws or as confidential information. Such software includes computer programs, databases and related documentation owned by the party you are dealing with or by a third party. The terms and conditions of software license agreements, such as provisions not to copy or distribute programs, must be strictly followed. Please contact Administration if you have questions about this standard.

Record Retention/Destruction

Brightpoint Health complies with all federal and state laws and regulations and applicable Brightpoint Health record retention policies relating to the retention of billing, patient health, and other business records

Disposal or destruction of Brightpoint Health records and files is not discretionary with any Affected Individual, including the originator of such records. Certain laws and regulations dictate how long certain records must be maintained. In addition, when litigation or a government investigation or audit is pending or imminent, relevant records must not be destroyed until the matter is closed. To learn more about specific record retention requirements, Affected Individuals are directed to Brightpoint Health's Compliance Officer or the respective Department Head overseeing the relevant records.

Government Inquiries

Affected Individuals may speak voluntarily with government agents, and Brightpoint Health will not attempt to obstruct such communication. Employees, contractors and Directors, however, should contact Administration before speaking with any government agents or providing any documents for any non-routine requests by government agents. Brightpoint Health cooperates fully with government investigations.

If you become aware of an investigation or are contacted by a person representing themselves as an investigator who asks questions or requests documents about Brightpoint, or if you receive a subpoena or other written request for information related to a government investigation, you should promptly contact Administration for assistance. Brightpoint Health requires that all information provided to a government agency must be accurate and complete. Any action by any Affected Individual to destroy, alter, or change any Brightpoint

records in response to a request for such records is prohibited, and will subject the individual to immediate discharge and possible criminal prosecution.

Commitment to Fairness

Brightpoint Health recognizes that it greatest strengths lie in the talents and abilities of its employees. And though the tasks of our employees are different, we have established the following guidelines to ensure that each employee is treated with fairness and equality:

- Brightpoint Health provides equal opportunity for employment and advancement on the basis of ability and aptitude without regard to race, color, religion, sex, sexual orientation, gender identity or expression, age, national or ethnic origin, physical or mental disability, marital or veteran status, or any other classification protected by state or federal law.
- Brightpoint Health protects the health and safety of our employees in their work environment.
- Brightpoint Health will compensate employees according to their performance, and provide equitable benefits within the framework of prevailing practices.

Brightpoint Health is committed to a work environment in which all individuals are treated with respect and dignity. Each employee has a right to work without fear of sexual harassment. Discrimination or harassment, whether based on race, color, creed, age, sex or sexual orientation, disability, national origin, or any other classification protected by state or federal law, in or out of the workplace, is unacceptable and will not be tolerated.

Our employee handbook has been designed to educate every employee about matters of discrimination. Each employee is expected to know, understand and follow discrimination guidelines without exception.

Government Reporting and Overpayments

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

Discipline

Brightpoint Health will take disciplinary actions for, among other things:

- Authorization or encouragement of or participation in actions that violate the Code
- Directing, facilitating, or permitting non-compliant behavior

- Failure to report a violation of the Code or to cooperate in an investigation.
- Failure by a violator's supervisor(s) to detect and report a violation of the Code if such failure reflects inadequate supervision or lack of oversight.
- Retaliation and/or intimidation against an individual for reporting a violation or possible violation of the Code.

Affected Individuals who violate the Code, any applicable compliance policy or procedure, or any applicable law, rule, or regulation will be disciplined, based upon the severity of the violation, up to and including termination of their employment or other relationship with Brightpoint Health, and referred to licensing boards or to government authorities, when appropriate or required.

Credentialing and Exclusions

Brightpoint Health ensures that all employees and contractors are appropriately licensed and/or credentialed and performs required background checks or screenings.

It is the responsibility of the Human Resources Department or their contractor to ensure that employment applications are reviewed and that (i) the OIG List of Excluded Individuals/Entities, (ii) the U.S. General Services Administration Excluded Parties List System and (iii) the Office of the Medicaid Inspector General (the "OMIG") List of Restricted, Terminated or Excluded Individuals or Entities are utilized in screening employees. Those databases will be checked prior to hiring a new employee, and on a monthly basis thereafter.

A background check of all new vendors will take place, which includes, at a minimum, screening the three lists referenced above. Those databases will be checked prior to hiring a new vendor, and on a monthly basis thereafter.

Furthermore, in the event of any proposed debarment or exclusion of an individual or contractor from a governmental healthcare program, Brightpoint Health will remove said individual or contractor from direct responsibility for, or involvement in, any governmental healthcare program pending resolution of the debarment or exclusion action. If the resolution of the matter results in debarment or exclusion, Brightpoint Health will immediately terminate the employment arrangement with the individual or contractor.

Pending the resolution of criminal charges against an employee, Brightpoint Health will make an assessment, on a case-by-case basis, of whether such employee poses a risk to the health and safety of its patients, and whether such employee poses a risk of non-compliance with governing laws. Depending on the conclusion of such an assessment, the employee may be removed from responsibility for or involvement in, any activity involving the provision of healthcare services or relating to governmental healthcare programs, and may be subject to other discipline. In making this assessment, Brightpoint Health will consult with legal counsel as appropriate. If the resolution of the criminal charges results in a conviction of the employee, a similar assessment will be made.

Avoidance of Fraud, Waste and Abuse ("FWA")

FWA is a significant concern for all health care organizations. It is Brightpoint Health's duty to avoid FWA. To that end, all Affected Individuals have the responsibility to report any activity that they suspect of being FWA.

- Fraud is an intentional misrepresentation of a known fact made for the purpose of obtaining a benefit or financial gain.
- Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.
- Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards, and results in unnecessary cost or in reimbursement.

Individual Judgment

Affected Individuals are often faced with making critical judgments based on activities in the workplace. The following guidelines are intended to help employees evaluate situations and respond in a manner that would be appropriate.

Ask yourself the following questions:

- Is my action consistent with established Brightpoint Health policies and procedures?
- Could my action give the appearance of misconduct?
- Will the action bring discredit to any employee or to Brightpoint Health if publicized?
- Can I defend my action to my supervisor, to other employees, and to the general public?
- Does my action meet my own personal standards of integrity?
- Does my action conform to the spirit of the Compliance Program and Code?

Remember to always use good judgment and common sense. If anything within the Compliance Program or Code goes against your own good judgment, you are encouraged to discuss it with your supervisor or with the Compliance Officer.

Additional Responsibilities of Managerial Employees

Brightpoint Health employees in a managerial role must make sure that the employees they supervise and any vendor they oversee understand and comply with the high standards of ethical conduct set forth in the Code. Managers are responsible for ensuring that personnel attend programs in order to familiarize themselves with matters relating to the Code and the Compliance Program. The Compliance Program requires the promotion of, and adherence to, the applicable elements of the Compliance Program as a factor in evaluating the performance of managers and supervisors.

Furthermore, all managers and supervisors involved in the coding, claims and cost report development process should:

- Discuss with all supervised persons and vendors the compliance policies and legal requirements applicable to their function;
- Inform all supervised persons that strict compliance with these policies, procedures, and requirements is a condition of employment or contract; and
- Disclose to all supervised persons that Brightpoint Health will take disciplinary action, up to and including termination of employment or contract, for violations of these policies and requirements.

It is the policy of Brightpoint Health that managers and supervisors will be sanctioned for failure to adequately instruct their subordinates with respect to governing requirements and the Compliance Program. Managers and supervisors will be sanctioned for failing to detect non-compliance with applicable policies and requirements where reasonable diligence, on the part of the manager or supervisor, would have led to the discovery of potential problems or violations and given Brightpoint Health the opportunity to correct them at an earlier time.

II. Designated Compliance Oversight

Although it is the responsibility of all Brightpoint Health employees, contractors and Directors to comply with the Compliance Program, the Compliance Officer has primary responsibility for the day-to-day administration and oversight of the Compliance Program. The Compliance Officer reports to the President & CEO, the Chief Administrative Officer, and the Boards of Directors. The Boards of Directors has ultimate authority for the governance of Brightpoint Health, including oversight of Brightpoint Health's Compliance Program.

Compliance Officer's Responsibilities

The Compliance Officer has ultimate responsibility for the administration of the Compliance Program. In this capacity, the Compliance Officer must be accessible to all Affected Individuals, patients, and any other person associated with Brightpoint and maintain frequent and direct communication with employees, contractors, Senior Management, and the Board of Directors.

The Compliance Officer's primary responsibilities include:

- Overseeing and monitoring the implementation of the Compliance Program;
- Reviewing and revising, as appropriate, the Code, the Compliance Program guidelines, and compliance policies;
- Developing, approving and ensuring the implementation of educational and training materials and programs related to the Compliance Program, and ensuring that all Affected Individuals receive required training and that any other person associated with Brightpoint Health receive appropriate educational materials about the Compliance Program and their responsibilities;

- Working with the Compliance Committee to coordinate Compliance Program activities;
- Performing an annual risk assessment, and creating, re-evaluating, and implementing Brightpoint Health's annual monitoring and auditing work plan;
- Partnering and coordinating with Human Resources Department on employee issues and confirming that the appropriate sources are utilized in screening employees, contractors, Directors, and vendors;
- Directing the investigation and resolution, with the advice of legal counsel if necessary, of reported or suspected concerns related to compliance and FWA and determining any appropriate corrective and/or disciplinary actions, if any;
- Ensuring that all Affected Individuals have the ability to report compliance concerns confidentially and anonymously without fear of retaliation or harassment;
- Ensuring that the disciplinary measures stipulated within the Compliance Program are appropriately enforced in all instances of non-compliance or non-compliant behavior;
- Reporting to Senior Management and the Board of Directors on Compliance Program activities, including status and resolutions of compliance investigations.

The Compliance Officer will collaborate with other Brightpoint Health departments to ensure an overall understanding of, and adherence to the Compliance Program, as well as to oversee and evaluate the applicable auditing, monitoring, and training activities related thereto.

The Compliance Officer will have the authority to review all documents and other information that are relevant to compliance activities, including, but not limited to, patient records, billing files, and contractual arrangements with employees, independent contractors, suppliers, agents, physicians, etc. Access to these records will enable the Compliance Officer to better assess Brightpoint Health's level of compliance, identify any potential weaknesses or exposures with regard to compliance, and readily investigate any reported instances of suspected non-compliance.

Compliance Committee Responsibilities

The Compliance Committee is primarily responsible for advising and assisting the Compliance Officer in the fulfillment of his or her responsibilities and coordinating the implementation and ongoing operation of the Compliance Program. The Compliance Committee will be comprised of individuals whose backgrounds, experiences, and areas of expertise are relevant to our Compliance Program. In addition to being representative of the affected functional disciplines within Brightpoint Health, the Compliance Committee's membership should (if possible) include a physician representative, as well as representation from selected departments.

The Compliance Committee is not responsible for Brightpoint Health's actual compliance with applicable laws, rules, and regulations, but strives to ensure that a continually effective Compliance Program exists and that the requisite policies, procedures, and practices are

most appropriate for Brightpoint Health and are properly communicated, monitored, and enforced on an ongoing basis.

Boards of Directors' Responsibilities

Each of the Boards of Directors of Brightpoint Health has ultimate authority for the governance of the specific Brightpoint Health entity, including oversight of Brightpoint Health's compliance with applicable law. This responsibility includes overseeing the activities of the Compliance Officer and Compliance Committee, as well as the general operation of the Compliance Program.

The Boards of Directors of each of Brightpoint Health's entities receives reports on the operation of the Compliance Program directly from the Compliance Officer at least once every quarter. The Compliance Officer has the right to bring matters directly to the Board's attention at any time. Annually, the Board of Directors will evaluate the effectiveness of the Compliance Program.

III. Compliance Training

All employees, contractors, and Directors, as well as certain vendors, are to receive a copy of our Code of Conduct and are trained regarding the operation of the Compliance Program, the Code, Brightpoint Health compliance policies and procedures, program-specific supplemental policies and procedures, and applicable laws, rules, and regulations affecting compliance and the prevention and detection of FWA. Individuals and vendors may also be updated through ongoing educational efforts, including topic-specific presentations, emails, and other communications. In addition, Brightpoint Health disseminates educational materials to other persons who may visit Brightpoint Health or its website to advise them of the existence of the Compliance Program.

As part of their orientation, all newly hired or contracted individuals receive compliance orientation training and all other training mandated by law and regulation, including without limitation, training on HIPAA and other patient confidentiality laws. As part of such training, such personnel receive a copy of the Code and are required to sign an acknowledgment form, which is maintained in each individual's personnel file.

Vendors and contractors receive on-boarding appropriate to the services they are rendering to Brightpoint Health and receive a copy of, or access to the Brightpoint Health Compliance Program, Code, and how to report FWA.

Soon after appointment, and annually thereafter, all Directors receive training on the Code, the Compliance Program, and their responsibilities to exercise effective oversight of the Compliance Program.

As part of Brightpoint Health's annual training program, all Affected Individuals receive compliance, Code, and HIPAA training appropriate to their role with the organization. Clinicians also receive training in clinical policies and procedures on an annual basis.

To the extent that an issue arises through an audit or issuance of new laws, rules regulations or otherwise, the Compliance Officer will work with management on developing and disseminating appropriate training points and educational materials.

Attendance and participation in training and educational programs are mandatory for all employees, contractors and Directors. Failure to comply with education and training requirements may result in disciplinary action consistent with the gravity of such non-compliance or removal from the Board of Directors.

The Compliance Officer maintains evidence of all compliance and FWA training and annually reviews all training and educational materials and makes updates or revisions, as necessary.

IV. Lines of Communication to the Compliance Officer

Procedures That Ensure Open and Effective Lines of Communication

An open line of communication between the Compliance Officer and all Affected Individuals and access to the Compliance Officer by patients, vendors, and others associated with Brightpoint Health is imperative to the successful implementation and maintenance of our Compliance Program. Furthermore, active communication will reduce the potential for FWA. All information reported to the Compliance Officer regarding compliance concerns or potential FWA will be kept confidential unless the matter is turned over to law enforcement. No Affected Individual will be subject to retaliation or harassment for raising compliance concerns in good faith, as described below.

Reporting Mechanisms

All Affected Individuals are required to report any non-compliance or suspected non-compliance or FWA by anyone. Brightpoint Health takes all reports of non-compliance seriously.

Reports may be made in the following manner:

- To a supervisor, and that supervisor must report the matter to the Compliance Officer.
- Directly to the Compliance Officer in person, writing to compliance@brightpointhealth.org or contacting the Compliance Officer directly through the mechanisms set forth at the end of the Corporate Compliance Plan.
- Anonymously by calling the toll-free Compliance Hotline (1.866.691.1964) or writing to Brightpoint Health, Attn: Corporate Compliance, 71 West 23rd Street, 8th Floor, New York, NY 10010.

The Hotline is a dedicated confidential telephone line maintained by an outside vendor. All Hotline calls are automatically logged by the vendor's system, including the date and time of the call, the reporter's name and contact information (unless the caller wants to remain anonymous), and the nature of the allegation or inquiry. All reports, regardless of source, will be logged and assigned an identification code at the time of the call or date of contact that can be used when referring any new/additional information on the same matter. The Compliance Officer monitors the Hotlines and receives allegations and inquiries made through

the Hotline. In the event that a report relates to the Compliance Officer, the report may be made to the Chief Administrative Officer or the Chief Executive Officer.

An individual reporting known or suspected improper conduct is not required to identify themselves. Anonymous reports will be investigated and acted upon in the same manner as reports where the reporter reveals their identity. No effort will be made to determine the identity of an individual making an anonymous report unless the individual admits to engaging in improper conduct. The reporter is encouraged to provide as much information as possible to assist with the evaluation of the issue.

It is the responsibility of the Compliance Officer to ensure that each report of potential non-compliance or FWA, in whatever format, is documented, investigated, and brought to a satisfactory conclusion. The Compliance Officer will present on any reported issues and the status of ongoing investigations the Compliance Committee, the CEO, and Chief Administrative Officer and the Boards of Directors on a periodic basis.

V. Procedures for Responding to Suspected Compliance Concerns and Cooerating in Governmental Investigations

Internal Investigations

All reports of fraudulent, abusive, or other improper conduct, whether made through the Compliance Hotline or otherwise, are promptly reviewed by the Compliance Officer. The Compliance Officer determines, in consultation with Senior Management or external counsel as necessary, whether the report warrants an internal investigation. If so, the Compliance Officer coordinates or performs the investigation, as appropriate, issues a written report of his/her findings, and proposes any corrective action that may be appropriate.

The Compliance Officer will be required to ensure that an objective and informed version of the facts has been uncovered during the investigation. The resulting report may contain:

- The circumstances that led to the investigation;
- The investigative steps that were taken;
- The facts disclosed during the investigation;
- The applicable laws or regulations at issue;
- The internal policies, procedures, or practices that led to the violation; and
- Recommended remedial actions.

The Compliance Officer may seek support from legal counsel as needed.

Cooperation

Affected Individuals are required to cooperate in the investigation of any alleged violations and will be disciplined for not cooperating in any such investigation.

VI. Procedure for Taking Corrective Action in Response to Identified Compliance Issues

Responding to Detected Offenses and Developing Corrective Action Initiatives

Violations of the Compliance Program, failure to comply with applicable federal or state law, and other types of misconduct threaten Brightpoint Health's status as reliable, honest, and trustworthy providers capable of participating in federal healthcare programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of Brightpoint Health. Consequently, upon reports, reasonable indications of suspected non-compliance, or results of monitoring and auditing activities, the Compliance Officer and other designated members of Senior Management will initiate prompt steps to investigate the conduct in question. A determination as to whether a material violation of applicable law or the requirements of the Compliance Program occurred will be undertaken so that the appropriate measures, if necessary, can be commenced to correct the problem. Such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the government, and/or the refunding of any overpayments, if applicable.

Instances of non-compliance will be determined on a case-by-case basis, and the existence, or amount, of a monetary loss to a healthcare program is not solely determinative of whether or not the conduct should be investigated and reported to governmental authorities. There may be instances where there is no loss at all, but corrective action and possible reporting are still necessary to protect the integrity of the specific program and its beneficiaries. The advice of legal counsel may be sought to plan the appropriate course of action.

If an alleged violation is discovered and an investigation is initiated, the Compliance Officer may remove the subjects of the investigation from their current work activites in order to protect the integrity of the investigation. This will be done in consultation with the Human Resource Department. If a violation is ongoing, immediate steps will be taken to halt the behavior in question.

Brightpoint Health will take whatever steps are necessary to correct past problems, if any, and prevent them from recurring. As determined necessary by the Compliance Officer, Compliance Committee and/or Senior Management, subsequent reviews and/or studies may be undertaken to ensure that the recommended corrective action has been successfully implemented. Brightpoint Health will document its efforts to comply with applicable statutes, regulations and federal healthcare program requirements.

Investigations and corrective action may involve contractors or vendors to Brightpoint Health. The Compliance Officer, in coordination with the department(s) served by the contractor or vendor, shall determine the scope of any investigation and corrective action, including any remedial actions the contractor or vendor will be required to implement, the monitoring and auditing that will be conducted to confirm implementation, and report(s) that the contractor or vendor and the Brightpoint Health department(s) will be required to submit to the Compliance Officer to confirm the effectiveness of the corrective action. A contractor or vendor may be terminated, after a consultation with and agreement by Administration and/or legal counsel, as a result of a substantiated issue and/or failure to implement required corrective action.

Reporting Misconduct and All Other Compliance-Related Concerns to Governmental Authorities
If the Compliance Officer discovers credible evidence of misconduct or other compliance-related issue, and after reasonable inquiry, including consultation with legal counsel, the Compliance Officer determines there isreason to believe that the misconduct may violate criminal, civil, or administrative law, then Brightpoint Health will report the existence of such misconduct or other compliance-related issue to the appropriate governmental authority within the time period required by law and refund any overpayments. All Brightpoint Health employees and contractors should be aware that the reporting of credible evidence of misconduct or other compliance-related issue to the government may be considered a mitigating factor by the government in determining sanctions (e.g., penalties, fines, assessments, and exclusion) if Brightpoint Health or a Brightpoint Health employee or affiliate becomes the target of an investigation.

VII. A System for Routine Identification of Compliance Risk Areas and Detection of Potential FWA or Other Improper Activity

Auditing and monitoring procedures will enable Brightpoint Health to continually assess the Compliance Program's effectiveness while ensuring compliance with applicable laws, regulations, policies, and procedures and preventing FWA.

Brightpoint Health will engage each year in a risk assessment process to identify and evaluate the compliance and FWA risks facing the organization. Brightpoint Health will review, at a minimum, the OIG and the OMIG annual work plans, DOH (Department of Health)- or CMS (Center for Medicare and Medicaid Services)-issued bulletins, updates, and interviews with employees involved in management, operations, coding, claim development and submission, patient care, business development, and other related departments and activities. Based on this risk assessment, Brightpoint Health will create a monitoring and auditing workplan to assist with identifying and/or mitigating identified high risks, which will consider how to monitor: billing, payments, quality of care, medical necessity, documentation, governance, business relationships, mandatory reporting, and credentialing. The monitoring and auditing plan may include engagement of internal or external auditors who have expertise in federal and state healthcare statutes, regulations and requirements relevant to perform certain monitoring and auditing activities.

If the monitoring and auditing reveals a compliance issue, Brightpoint Health will take corrective actions to ensure that the violation or problem does not reoccur, or reduce the likelihood that it will reoccur, and be based on a root cause analysis. Any potential overpayments discovered as a result of deviations will be promptly refunded to the affected payor in a manner determined to be appropriate, and if necessary, upon consultation with legal counsel.

VIII. Disciplinary Policies to Encourage Good-Faith Reporting and Compliance with the Code and Compliance Program

Common sense, integrity, and appropriate personal behavior is expected of each Affected Individual. The imposition of discipline may be based on, among other things, the person's unlawful or unethical actions, negligent or reckless conduct, deliberate ignorance of the rules that govern the job (including the applicable Code, compliance policies and procedures,

and applicable laws, rules and regulations), encouraging, directing, facilitating, or permitting non-compliant behavior, condoning or not reporting unlawful actions by others, or retaliation or intimidation against those who report suspected wrongdoing, or other violations. Such sanctions will range from oral warnings to suspension, privilege revocation (subject to applicable peer review procedures), or termination or financial penalties, as appropriate, and may require reporting to federal and/or state oversight bodies. Disciplinary action will be taken where an employee's or contractor's failure to detect a violation is attributable to his or her negligence or reckless or intentional misconduct. Disciplinary action will be taken on a fair and equitable basis. Managers and supervisors should be aware that they have a responsibility to discipline employees in an appropriate and consistent manner. Violations will be handled through Brightpoint Health's normal disciplinary procedures where applicable.

In determining what disciplinary action may be taken against an employee, Brightpoint Health will take into account an employee's own admission of wrongdoing; provided, however, that the employee's conduct was not previously known to Brightpoint Health or its discovery was not imminent, and that the admission was complete and truthful. In addition to disciplining employees who violate the Code and/or Compliance Program, Brightpoint Health will also discipline employees who ignore conduct that is potentially volatile.

It is the policy of Brightpoint Health that no employee shall be disciplined on the basis that he or she reported, in good faith, what was believed to be an act of wrongdoing or a violation of the Compliance Program or Code. However, an employee whose report of potential misconduct contains admissions of personal wrongdoing will not be guaranteed protection from potential disciplinary action. The fact of an admission, however, as opposed to deliberate non-reporting, will be taken into consideration in connection with making a disciplinary decision, and depending on all of the relevant circumstances, may result in a lesser disciplinary action than would result in the event of non-reporting. Please note that Affected Individuals will be subject to disciplinary action, including potentially termination of employment or contract, if Brightpoint Health reasonably concludes that the report of wrongdoing was knowingly fabricated, distorted, exaggerated, or minimized to either injure someone else or to protect others.

IX. Non-Retaliation/Non-Intimidation

Every employee, contractor, supervisor, and Director has an affirmative duty to report issues or concerns that come to their attention. Failure to do so can result in disciplinary action up to and including termination of employment. As such, a key element of the Compliance Program is the ability of employees, contractors, and Directors to express problems, concerns, or opinions, and participate in and corporate in a compliance investigation, without fear of retaliation or intimidation, in full compliance with, among other laws and regulation, New York State Labor Law Sections 740 and 741 (a copy of which is attached to this Code). Brightpoint Health will not tolerate any retaliation or intimidation against any employee, contractor, or Director for complying with any aspect of the Compliance Program and/or who in good faith raises a compliance concern, otherwise participates in the Compliance Program, including, but not limited to, reporting and/or in-

vestigating compliance issues, engaging in self-evaluations, audits, or remedial actions, or for reporting to appropriate officials as defined in New York State Labor Law Sections 740 and 741.

Retaliation or intimidation in any form taken against an individual for raising a compliance concern or FWA concern by any individual associated with Brightpoint Health is strictly prohibited and is itself a serious violation of the Code.

Managers have the responsibility to maintain an environment whereby employees and contractors feel comfortable raising issues or asking questions. Managers should also take appropriate steps to address concerns that are raised and communicate the results of corrective action whenever possible or appropriate. If anyone feels that he or she is being intimidated or retaliated against, that individual should contact the Compliance Officer or Human Resource Department immediately. Any employee or contractor who commits or condones any form of retaliation will be subject to discipline, up to and including termination.

Conclusion

Brightpoint Health expects that the Compliance Program will ensure that Affected Individuals will be better able to fulfill their commitment to ethical behavior, as well as meet the dynamic changes and challenges being imposed upon Brightpoint Health by Congress, the OIG, the OMIG, other regulatory bodies, and private insurers. Ultimately, it is the desire of Brightpoint Health that this Compliance Program will enable them to meet their goals, continually improve the quality of patient and care, and substantially reduce potential fraud, waste, abuse, and other non-compliance. In closing, through the appropriate implementation and continued maintenance of this Compliance Program, Brightpoint Health will be able to further their fundamental mission.

Compliance Officer Contact Information:

Should you have any questions about the Code of Conduct, or need further guidance, contact:

Gail Rosen, Corporate Compliance Officer
71 West 23rd Street, 8th Floor
New York, New York 10010
718.681.8700 x4458

Additionally, the Corporate Compliance Officer has provided the following alternative ways to report violations of the Code of Conduct:

- You can **CALL** the Compliance Hotline at 1.866.691.1964
- You can send an **EMAIL** to: compliance@brightpointhealth.org
- You can send a **LETTER** to: Gail Rosen, Corporate Compliance Officer, 71 West 23rd Street, 8th Floor, New York, NY 10010

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Appendix A

FEDERAL & NEW YORK STATE STATUTES RELATING TO FALSE CLAIMS; ANTI-KICKBACK PROHIBITIONS AND CIVIL MONETARY PENALTIES

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

I. FALSE CLAIMS STATUTES

II. FEDERAL LAWS

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

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

(1) (a) In general. Subject to Paragraph (2), any person who -

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraphs (A), (B), (D), ... or (G); (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;...or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

* * *

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced Damages.

If the court finds that - (A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information; (B) such person fully cooperated with any Government investigation of such violation; and (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investi-

gation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

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

(b) Definitions.
For purposes of this section:

(1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information - (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud;

(2) the term "claim" (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that - (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded;

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

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

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

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

31 U.S.C. § 3729(b).
In sum, the FCA imposes liability on

any person who submits a claim to the federal government, or submits a claim to entities administering government funds that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a health care facility that obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

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

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

B. Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)
This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the federal FCA, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the federal FCA, the determination of whether a claim is false, and the imposition of fines and penalties,

is made by the administrative agency, not by prosecution in the federal court system.

C. New York False Claims Laws

III. NEW YORK STATE LAWS

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

A. New York Civil and Administrative Laws

1. New York False Claims Act (State Finance Law §§ 187-194)

The New York False Claims Act is similar to the federal FCA. It imposes penalties and fines on individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding "reverse false claims" similar to the federal FCA, such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which the person may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim under the New York False Claims Act is $6,000-$12,000 per claim, plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

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

2. Social Services Law § 145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the New York State Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within

5 years, a penalty up to $30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3. Social Services Law § 145-c - Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least $1,000 and no more than $3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of $3,900), and five years for any subsequent occasion of any such offense.

B. Criminal Laws

1. Social Services Law § 145 - Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law § 366-b - Penalties for Fraudulent Practices

(a) Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.

(b) Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3. Penal Law Article 155 - Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

(a) Fourth degree grand larceny involves property valued over $1,000. It is a class E felony.

(b) Third degree grand larceny involves property valued over $3,000. It is a class D felony.

(c) Second degree grand larceny involves property valued over $50,000. It is a class C felony.

(d) First degree grand larceny involves property valued over $1 million. It is a class B felony.

4. Penal Law Article 175 – False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

(a) § 175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor,

(b) § 175.10 - Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.

(c) § 175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a class A misdemeanor.

(d) § 175.35 - Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5. Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance and it includes six crimes.

(a) Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.

(b) Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a class E felony.

(c) Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a class D felony.

(d) Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a class C felony.

(e) Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a class B felony.

(f) Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6. Penal Law Article 177 - Health Care Fraud

This statute primarily applies to claims for health insurance payments, including Medicaid, and contains five crimes:

(a) Health care fraud in the 5th degree - a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides material false information or omits material information for the purpose of requesting payment from a health plan. It is a class A misdemeanor.

(b) Health care fraud in the 4th degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving more than $3,000. It is a class E felony.

(c) Health care fraud in the 3rd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over $10,000. It is a class D felony.

(d) Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over $50,000. It is a class C felony.

(e) Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over $1 million. It is a class B felony.

IV. WHISTLEBLOWER PROTECTIONS

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

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

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

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

C. New York Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific

danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

D. New York Labor Law § 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

V. ANTI-KICKBACK LAWS AND CIVIL MONETARY PENALTIES LAW

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

Under the federal Anti-Kickback Statute:

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

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

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

Q: I know of a situation that may violate our Code. Should I report it even if I am not completely sure there is a problem?

A: Yes. You are responsible for reporting possible violations immediately. Report it to your supervisor, the Compliance Department, or via the Hotlines. Your report will be taken seriously and investigated. It is better to report a suspicion that turns out not to be an issue than to ignore a possible violation.

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

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

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

42 U.S.C. § 1320a-7b(b).

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

B. New York State Anti-Kickback Laws and Regulations

1. Social Services Law § 366-d.

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

While the statute does not enumerate any "safe harbors," subsection 2(d) specifically states that the prohibition "shall not apply to any activity specifically exempt by federal statute or federal regulations promulgated thereunder." A violation of the statute is either a misdemeanor or felony depending upon whether the defendant obtains money and/or property in violation of the statute and, if so, the amount obtained.

2. Social Services Law § 366-f.

The statute provides that no person acting in concert with a Medicaid provider may solicit, receive, accept or agree to receive or accept or offer, agree to give or give any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (a) for the referral of services for which Medicaid payment is made; or (b) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program. The statute specifically exempts from the prohibition any activity exempt by federal statute or regulation. A violation of the statute is a misdemeanor punishable by imprisonment or a fine of $10,000 or double the amount of gain attributable to the violation. If the violation results in the individual obtaining money or funds in excess of $7,500, such violation is a class E felony.

3. 18 N.Y.C.R.R. § 515.2

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

4. 8 N.Y.C.R.R. §29.1(3)

Section 29.1 of Title 10 of the NYCRR defines professional misconduct of professionals under the New York

State Education Law. Included in the specific listing of practices or activities constituting misconduct is the direct or indirect "offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services." 8 NYCRR §29.1(3). Any professional in violation of this regulation shall be subject to the penalties that includes censure and reprimand, fines (up to $10,000 for each violation), suspensions and/or probationary terms.

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

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to: (a) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (b) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (c) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (d) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (e) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or (f) using a payment intended for a federal health care program beneficiary for another use. The Office of Inspector General is authorized to seek different amounts of CMPs and assessments based on the type of violation at issue. See 42 CFR § 1003.103. For example, in a case of false or fraudulent claims, the OIG may seek a penalty of up to $10,000 for each item or service improperly claimed, and an assessment of up to three times the amount improperly claimed. 42 U.S.C. § 1320a-7a(a). In a kickback case, the OIG may seek a penalty of up to $50,000 for each improper act and damages of up to three times the amount of remuneration at issue (regardless of whether some of the remuneration was for a lawful purpose). 42 U.S.C. § 1320a-7a(a).

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