

Policy Number: **CC 16-10**

Original Date: January, 2007

Revised: 10/23/09; 12/7/10¹, 5/27/14, 5/8/18, 10/1/18,
2/19/21

Reviewed: May 23, 2008

Subject/Title: Health Care Waste, Fraud and Abuse Policy

Policy:

Oneida Health Hospital (OHH) and its affiliates take health care fraud and abuse very seriously. It is OHH policy that all Affected Persons (defined below) comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse.

Purpose:

The purpose of this Policy is to inform all Affected Persons about those federal and state laws which address or are related to fraud, waste and abuse in federal and state health care programs and to provide general information regarding OHH's efforts to combat fraud, waste and abuse, including the following:

- The Federal False Claims Act;
- The New York State False Claims Act;
- Remedies available under these Acts;
- Other applicable state, civil or criminal laws;
- How employees, contractors and agents can use these regulations;
- Federal and New York whistleblower protections available to employees, contractors and agents;
- Procedures that OHH has in place to detect health care waste, fraud and abuse.

Attached as Exhibit A to this Policy and incorporated by reference is a summary of applicable Fraud and Abuse and Whistleblower Protection Laws.

Scope:

This policy applies to all Board members, officers, managers, and other workforce members including, employees, trainees, volunteers, providers, consultants, independent contractors, students and temporary workers ("Affected Persons") of OHH, including the hospital and all of its departments and health centers, the Extended Care Facility, OHH's affiliated physician practices (Oneida Medical Services, PLLC, Oneida Medical Practice, P.C. and Genesee Physician Practice, PLLC), and any other department or entity which is part of OHH, as appropriate.

¹ This policy was revised to ensure it met the regulatory requirements of Section 6032 of the Deficit Reduction Act of 2005 and Fraud Enforcement and Recovery Act of 2009 (FERA).
{H4277526.3}

Procedure:

I. Detecting and Preventing Fraud and Abuse:

There are numerous elements to OHH's Corporate Compliance Program that are in place to help all Affected Persons to **detect and prevent fraud and abuse**.

A. The following elements are in place to help **prevent health care fraud** at OHH:

- A reporting and response system is in place (see OHH Compliance Policies CC 16-1 - *Compliance Reporting System* and CC 16-2 - *Internal Investigations and Response*).
- Compliance work plans are utilized to schedule proactive compliance audits in areas that the federal and state government have deemed as medium to high risk, or in area(s) that members of management may determine as high risk to OHH.
- Compliance-related training and education is initially provided to all employees and Board members at a general orientation session or in one-on-one training with the CCD, and annually thereafter which includes the methods available to them and others to prevent health care fraud, including receipt of OHH's Corporate Compliance Plan and up-to-date compliance-related policies.
- OHH performs monthly federal (OIG) and state (OMIG) exclusion checks for all Affected Persons to ensure that OHH is not employing or contracting with an individual who has had a prior wrongdoing (such as health care fraud) that has caused him/her to be excluded from the Medicare or Medicaid program.
- OHH *Billing and Claims Submission Policy* (CC 16-9) describes the responsibilities for accurate billing, the various risks of claims submissions, and how to decrease such risks.

B. The following elements are in place to **help detect health care fraud** at OHH:

- A developed corporate compliance program structure that includes a CCD who is charge of the day-to-day operations at OHH, a related Corporate Compliance Plan for OMP, OMS and Genesee Physician Practice, PLLC (GPP), including designation of Corporate Compliance Liaisons responsible for the day-to-day operations of those entities, and a Corporate Compliance Committee to assist the CCD and Liaisons with their respective service lines.
- A policy for the return of identified overpayments to the appropriate party (parties may include Medicare, Medicaid, insurance company or self-pay patients) (see Compliance Policy CC 16-23 – *Response to Overpayments*).
- A policy of non-retaliation and non-intimidation of any individual who reports a compliance concern in good faith in raising a question or concern (see Compliance Policy CC 16-33 – *Whistleblower Protection Policy*).
- Policies that guide the disciplinary action to be taken by OHH (see *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy for Compliance Program CC 16-30*) in the event health care fraud is found, whether intentional or accidental.
- A reactive compliance audit may be conducted in order to investigate a potential compliance issue, which may then subsequently be written into the annual work plan. Conducting reactive audits takes precedence over scheduled proactive audits.

II. **Reporting Potential Fraud and Abuse Issues:**

Affected Persons of OHH have an obligation to report suspected fraud, waste or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, or provider. When an Affected Person suspects fraud, waste or abuse:

- Report it to the CCD, Renee Olmsted, directly at extension 2117 or 315-361-2117. You may also call the OHH Compliance Hotline at extension 2116 or 315-361-2116 and report it anonymously.
- You are not required to report a possible False Claim Act violation to OHH first. You may report possible False Claim Act violations directly to the U.S. Department of Health & Human Services, Office of the Inspector General (OIG). However, Affected Persons are encouraged to contact the CCD so OHH can investigate and correct any issues as quickly as possible.
- OHH will not retaliate against you if you inform OHH or the federal government of a possible False Claims Act violation.

III. False Claims Act Training:

- OHH trains all Affected Persons regarding the federal and state False Claims Acts and also provides periodic updates through the dissemination of this policy. All members of our workforce are required to participate in training about the federal and state False Claims Acts. All contractors and agents are required to accept educational information offered by OHH or to participate in scheduled training, as determined by the organization.
- Specifically, Medical Staff and other providers will receive this policy as part of the new credentialing provider packet. Temporary hires will receive the policy as part of the information packet provided on their first date of hire. This policy is also a part of the employee handbook. All Affected Persons receive this policy during the general orientation process.

If you have any questions about the information contained in this Policy, please call:

- Renee Olmsted, RHIA, Corporate Compliance Director, 315-361-2117
- Ofrona Reid, MD, VP Medical Staff, Corporate Compliance Officer, 315-361-2409
- Jessica Gurdo, RN, ENT, Ortho, Neuro, Vascular, Podiatry OMP Corporate Compliance Liaison, 315-363-5421
- Kathi Austin, GI, Pulmonology OMP Corporate Compliance Liaison 315-361-2353
- Maureen Mosack, RN, Article 28 Health Centers, Tri Valley Family Practice, Corporate Compliance Liaison, 315-361-2114
- Lisa Abbe, WHA and Maternal Health Center Corporate Compliance Liaison, 315-363-9380
- Renee Frawley, PA, VP Practice Management, Cardiology 315-361-2031
- Wayne Kegley, Oneida Health Roswell Park Oncology 315-361-2383

You may also reach out to any member of the Corporate Compliance Committee, who will seek guidance from the CCD, if you have any questions or need further information related to this Policy. (SSL 363-d.2(d))

Other related Policies/Procedures: All Compliance policies are online on the intranet.
See also references below.

Previous Policy #: NA

References:

{H4277526.3}

1. OMIG document: “Employee Education Requirement Regarding False Claims Recoveries.”
2. OMIG document: “The Fraud Enforcement and Recovery Act of 2009 and its Significance to Medicaid Providers.”
3. Public Law Document: Official Summary 5/20/09, Public Law, Fraud Enforcement and Recovery Act of 2009 or FERA.
4. Reed Smith Health Industry Alert: May 2009 FERA, Significant Changes to FCA Liability Provisions.
5. DHHS, CMS: SMDL #06-024: Guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005.
6. DRA 6032: Employee Education about False Claims Recovery-Frequently Asked Questions
7. OHH Policies:
 - Compliance Policies: 9, 23, 30
 - CC 16-1 Compliance Reporting System
 - CC 16-2 Internal Investigations and Response
 - CC 16-4 Compliance Hotline
 - CC 16-33 Whistleblower Protection Policy
 - Human Resources Policy HR-68 Code of Conduct and Disruptive Behavior and HR 11 Discipline Policy
 - OHH and OMP, OMS and GPP Corporate Compliance Plans

Standards: NA

Forms: NA

Approved By: Corporate Compliance 6/14, 10/18, 3/21

EXHIBIT A
SUMMARY OF FRAUD AND ABUSE
AND WHISTLEBLOWER PROTECTION LAWS

I. FEDERAL LAWS

- 1) Federal False Claims Act (31 USC §§3729-3733)
- 2) Medicare and Medicaid program integrity provision (42 USC §§1320a-7k(d))

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

- 1) New York False Claims Act (State Finance Law §§187-194)
- 2) Social Services Law, Section 145-b - False Statements
- 3) Social Services Law, Section 145-c - Sanctions

B. CRIMINAL LAWS

- 1) Social Services Law, Section 145 - Penalties
- 2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
- 3) Social Services Law, Section 145-c - Sanctions
- 4) Penal Law Article 175 - False Written Statements
- 5) Penal Law Article 176 - Insurance Fraud
- 6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

- 1) Federal False Claims Act (31 U.S.C. §3730(h))
- 2) New York State False Claim Act (State Finance Law §191)
- 3) New York State Labor Law, Section 740
- 4) New York State Labor Law, Section 741
- 5) New York Not-For-Profit Corporation Law

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:

§ 3729. False claims

(a) Liability for certain acts.—

(1) In general.--Subject to paragraph (2), any person who—

- (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
- (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
- (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly 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 between \$11,665 and \$23,331 per false claim², as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.—If the court finds that-

- (A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims 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

² Amounts applicable to civil penalties assessed after June 19, 2020; penalty amounts are subject to adjustment annually.
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(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

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

(b) Definitions.—For purposes of this section—

(1) The terms “knowing” and “knowingly”—

(A) mean that a person, with respect to information—

- (i) has actual knowledge of the information;
- (ii) acts in deliberate ignorance of the truth or falsity of the information; or
- (iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) The term “claim”—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

- (i) is presented to an officer, employee, or agent of the United States; or
- (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government-

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual’s use of the money or property.

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

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

- (c) exemption from disclosure.—Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.
- (d) exclusion.—This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person, who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b). Proof of specific intent to defraud is not required for liability.

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

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

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

3) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 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, 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 False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

4) Reporting and Returning of Overpayments

The Accountable Care Act enacted a provision requiring that overpayments be reported and refunded within the specific parameters. More specifically, Section 1320a – 7k (d) requires a person who has received an overpayment of Medicare or Medicaid funds to report the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the {H4277526.3}

overpayment. The statute requires that such an overpayment be reported and returned by the later of - - (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. The statute specifies that an overpayment retained by a person after the deadline for reporting and returning an overpayment is an “obligation” (as defined in 31 U.S.C. 3729(b)(3) for purposes of the False Claims Act, 31 U.S.C. 3729. The term “overpayment” means any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is not entitled under the program. Finally, the Act defines the term “person” as a provider of services, supplier, Medicaid managed care organization (MCO) or the Medicare Advantage organization (MAO) or PDP sponsor but does not include a beneficiary.

II. NEW YORK STATE LAWS

1) CIVIL AND ADMINISTRATIVE LAWS

- 1) New York False Claims Act (State Finance Law §§187-194)**
- 2) Social Services Law, Section 145-b - False Statements**
- 3) Social Services Law, Section 145-c - Sanctions**

B. CRIMINAL LAWS

- 1) Social Services Law, Section 145 - Penalties**
- 2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.**
- 3) Social Services Law, Section 145-c - Sanctions**
- 4) Penal Law Article 175 - False Written Statements**
- 5) Penal Law Article 176 - Insurance Fraud**
- 6) Penal Law Article 177 - Health Care Fraud**

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

(A) CIVIL AND ADMINISTRATIVE LAWS

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

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money. The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty. The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3) **Social Services Law, Section 145-c - Sanctions**

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. **CRIMINAL LAWS**

1) **Social Services Law, Section 145 – Penalties**

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

2) **Social Services Law, Section 366-b - Penalties for Fraudulent Practices.**

- a. Any person who obtains or attempts to obtain, for him or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.
- b. Any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3) **Penal Law Article 155 – Larceny**

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

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

4) **Penal Law Article 175 - False Written Statements**

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

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

- b. §175.10 - Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.
- c. §175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.
- d. §175.35 - Offering a false instrument for filing in the first degree includes the elements of the second-degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes:

- a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.
- b. Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000. It is a class E felony.
- c. Insurance fraud in the 3rd degree is filing a false insurance claim for over \$3,000. It is a class D felony.
- d. Insurance fraud in the 2nd degree is filing a false insurance claim for over \$50,000. It is a class C felony.
- e. Insurance fraud in the 1st degree is filing a false insurance claim for over \$1 million. It is a class B felony.
- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6) Penal Law Article 177 - Health Care Fraud

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

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

- a. Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.
- b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

- c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
- d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
- e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

III. WHISTLEBLOWER PROTECTION

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

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

2) New York State False Claim Act (State Finance Law §191)

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

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action 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.

4) New York State Labor Law, Section 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.

5) Not-For-Profit Corporation Law – Whistleblower Policy Requirements

Not-For-Profit Corporation Law § 715-B requires all not-for-profit corporations in New York with 20 or more employees and annual revenues exceeding \$1,000,000 to adopt a Whistleblower Policy that contains the following elements:

1. Provides that there will be no intimidation, harassment, discrimination or an adverse employment consequence for any trustee, officer, employee or volunteer who in good faith reports any action or suspected action within the corporation that is illegal, fraudulent or in violation of any adopted policy;
2. Contains procedures for reporting violations or suspected violations of law or corporate policies, including procedures for preserving the confidentiality of reported information;
3. Requires that an employee, officer, or trustee of the corporation be designated to administer the whistleblower policy and report to a committee of independent trustees of the Board of Trustees; and,
4. Requires that a copy of the whistleblower policy be distributed to all trustees, officers, employees and to volunteers who provide substantial services to the corporation.