

Attachment 3

**BETH ABRAHAM FAMILY OF HEALTH SERVICES
CORPORATE COMPLIANCE PROGRAM POLICY AND PROCEDURE****SUBJECT:** Detection and Prevention of Fraud, Waste and Abuse**Policy No.:****EFFECTIVE DATE:** January 1, 2007**PAGE:** 1 of 7**REVISION DATE:** August 23, 2007**Reference:** Federal Deficit Reduction Act of 2005 (DRA) sec. 6032 *et seq*; Office of the Medicaid Inspector General Provider Compliance guidance and BAFHS Corporate Compliance Program policies.

POLICY: Beth Abraham Family of Health Services (BAFHS) is committed to complying with the requirements of Section 6032 of the DRA and to detecting and preventing fraud, waste and abuse in the organization. To this end, BAFHS maintains a compliance program, the principal documents of which are updated from time to time to reflect current changes in the laws.**PURPOSE:** To protect against fraud, waste and abuse by informing members of the workforce and contractors of the new requirements under Federal and State false claims laws and to inform of the legal protections against retaliation for whistleblowing.**DISTRIBUTION:**

This policy will be distributed to the BAFHS workforce on hire and at the Annual Corporate Compliance training, as is applicable. Contractors will receive this information.

BAFHS POLICIES AND PROCEDURES:

BAFHS has adopted a corporate compliance program ("Program"). Every employee should be familiar with the Program. The principal documents which comprise the Program, and which apply to all BAFHS entities, are BAFHS' **Code of Conduct**, BAFHS' **Compliance Charter** and BAFHS' **Compliance Policies and Procedures**. These documents (the "Compliance Documents") are hereby incorporated, by reference, to this policy. The Compliance Documents are available on the MS Outlook Public Folders, within the Departments and with the Corporate Compliance Officer.

To assist BAFHS in meeting its legal and ethical obligations, any employee who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is

required to report such information to his/her supervisor, to the Corporate Compliance Officer or to any of the Compliance Officers in the respective BAFHS entities. Any employee of BAFHS who reports such information will have the right and the opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under BAFHS Program policies and Federal and State law (**Refer to the Program Policy on Non-retaliation**). BAFHS retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or of the organization's policies. The Program policies state that BAFHS commits itself to swiftly and thoroughly investigate any suspicions of fraud, waste and abuse and require all employees to assist in such investigations. If an employee believes that BAFHS is not responding to his or her report within a reasonable period of time, the employee should bring these concerns about BAFHS's inaction to the Compliance Officer. Every individual is expected to comply with the requirements set forth in the Compliance Documents. Most importantly, in the performance of his or her duties at BAFHS, every employee and contractor is required to comply fully with all applicable laws, regulations, ethical principals, and BAFHS policies. An employee's failure to do so will result in disciplinary action, including possible termination, and could subject both the employee and BAFHS to government penalties. A contractor's failure to comply could lead to termination of the contract and other appropriate action.

FEDERAL/STATE PROHIBITIONS AGAINST THE SUBMISSION OF FALSE CLAIMS:

One of the key purposes of the BAFHS Compliance Program is to ensure that all bills and other claims for payment to Medicare, Medicaid and other payors are complete and accurate in all respects. Federal and State law strictly prohibit the submission of false or fraudulent claims for payment. Anyone who is aware of any "false claims" activities at BAFHS is required by BAFHS policy to report such activity immediately. Under Federal law, employees and contractors may also report such matters to the government, and/or litigate such matters on behalf of the government, and employees and contractors may under certain circumstances be entitled to a portion of the government's recovery against BAFHS, as described below. As also described below, BAFHS is prohibited by law from retaliating against employees who file "whistleblower" actions. State law and BAFHS policy require employees and contractors to first report suspected wrongdoing internally.

Following is a summary of these laws – the Federal False Claims Act, the Program Fraud Civil Remedies Act and certain relevant State laws.

Federal False Claims Act

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, establishes liability for any person who engages in certain acts, including:

- knowingly presenting or causing to be presented a false or fraudulent claim to the Federal government for payment;
- knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal government; or
- conspiring to defraud the Federal government by getting a false or fraudulent claim allowed or paid.

Under the Federal False Claims Act, a person acts “knowingly” if s/he:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

There is no requirement that the person specifically intended to defraud the government through his or her actions.

Under the Federal False Claims Act, a “claim” is any request or demand for money or property if the Federal government provides any portion of the money or property in question. This includes requests or demands submitted to a contractor of the Government and includes Medicaid and Medicare claims.

A violation of the Federal False Claims Act results in a civil penalty between \$5,500 and \$11,000 for each false claim submitted, plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in Federal health care programs.

The False Claims Act allows a private person to file a *qui tam* lawsuit on behalf of the Federal government. This person, also called a relator or whistleblower, must file his or her lawsuit under seal in a federal district court. The government may decide to intervene with the lawsuit, in which case the United States Department of Justice will direct the prosecution. If the government does not decide to intervene, the relator may still continue the lawsuit independently.

If a *qui tam* lawsuit is successful, the relator may receive between 10 to 30% of the recovery, depending on the level of the government’s participation and other factors, as well as reasonable attorney’s fees and costs. In addition, there can be no retaliation against the relator for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant’s attorney’s fees and costs.

Federal Program Fraud Civil Remedies Act of 1986

The Federal Program Fraud Civil Remedies Act of 1986, 31 USC §§3801, *et seq.*, is similar to the False Claims Act, establishing an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent to certain Federal agencies, including HHS, and again, includes Medicaid and Medicare claims.

Similar to the False Claims Act, a person who “knows or has reason to know” is defined as one who:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

Once again, there is no necessary proof of specific intent to defraud the government.

A violation of the Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to \$5,500 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing after investigation by HHS and approval by the United States Attorney General.

New York State Laws

In addition to the federal prohibition against the submission of false claims, in April 2007 New York State enacted a new Article 13 to the New York State Finance Law, §§187-194, which creates a State False Claims Act ("SFCA"). This State statute largely mirrors the federal False Claims Act and establishes liability for any person who engages in certain acts, including:

- knowingly submitting (or causing to be submitted) a false claim to the State or a local government for payment or approval;
- knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved by the government;
- conspiring to get a false claim allowed or paid by the government;
- knowingly making or using a false record to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

A violation of the SFCA results in a civil penalty \$6,000 to \$12,000 for each false claim, plus up to three times the amount of damages that the Government sustains because of the violations. In addition the Government could find for the costs of a civil suit for recovery penalties or damages.

The SFCA gives a private person or *qui tam* plaintiff, who becomes aware of a false claim, the right to file a civil suit for him or herself and for the government. The suit must be filed in the name of the government. If a *qui tam* plaintiff alleges a false claims violation, the complaint must be served on the government. Once the action is filed, no person other than the State (and, if applicable, local) government is allowed to intervene or file a lawsuit based on the same facts.

If the State or a local government decides to file a civil suit, it assumes responsibility for prosecuting the action and is not bound by the acts of the *qui tam* plaintiff. However, the *qui tam* plaintiff has the right to continue as a party to the action, subject to certain limitations. If the government decides not to file a civil suit, the *qui tam* plaintiff still has the right to proceed with a lawsuit. The government can intervene later upon a showing of good cause.

If a *qui tam* lawsuit is successful, the *qui tam* plaintiff may receive between 15 and 30% of the recovery, depending on the level of the government's participation and other factors, as well as reasonable attorney's fees and costs. In addition, the whistleblower protections of the SFCA protects an employee participating in a lawsuit in good faith from retaliation for certain protected false claims activities that include investigation for, initiation of, testimony for, or assistance in a false claims action that has been or will be filed. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

Under New York Social Services Law §145-b, it is unlawful to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other

fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. For a violation of this law, the local Social services district or the State has a right to recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Service district or State may recover three times the damages (or \$5,000, whichever is greater) sustained by the government due to the violation.

The law also empowers the New York State Department of Health to impose a monetary penalty on any person who, among other actions, causes Medicaid payments to be made if the person knew or had reason to know that:

- the payment involved care, services, or supplies that were medically improper, unnecessary, or excessive;
- the care, services or supplies were not provided as claimed;
- the person who ordered or prescribed the improper, unnecessary, or excessive care, services, or supplies was suspended or excluded from the Medicaid program at the time the care, services, or supplies were furnished; or
- the services or supplies were not in fact provided.

The monetary penalty shall not exceed \$2,000 for each item or service in question, unless a penalty under the section has been imposed within the previous five years, in which case the penalty shall not exceed \$7500 per item or service.

Under New York Social Services Law §366-b (2), any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining compensation greater than that to which s/he is legally entitled for furnishing services or merchandise shall be guilty of a class A misdemeanor. If such an act constitutes a violation of a provision of the penal law of the state of New York, the person committing the act shall be punished in accordance with the penalties fixed by such law.

In addition, New York Penal Law §§ 155, 175-177 establishes crimes to persons with intent to defraud.

Under §155 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.

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

Under §175 four crimes in this article relate to false written statements and apply to a person filing false information or claims as follows:

- 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.
- 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.
- 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.
- 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.

Under §176 the section on insurance fraud contains six crimes as follows:

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

Under §177 which applies to claims of health insurance, including Medicaid, a person commits Health Care Fraud when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), s/he knowingly and willfully provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which s/he is not entitled. Health Care Fraud is punished with fines and jail time based on the amount of payment inappropriately received due to the commission of the crime; the higher the payments in a one year period, the more severe the punishments, which currently range up to 25 years if more than \$1 million in improper payments are involved.

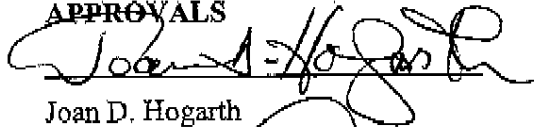
New York law also affords protections to employees who may notice and report inappropriate activities. Under New York Labor Law §§740-741, an employer shall not take any retaliatory personnel action against an employee because the employee:

- discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;

- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or
- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

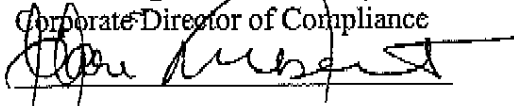
To bring an action under this provision, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back pay and compensation of reasonable costs. The law also provides that employees who bring an action without basis in law or fact may be held liable to the employer for its attorney's fees and costs.

APPROVALS



Joan D. Hogarth
Corporate Director of Compliance

8/31/07
Date



Clari Gilbert
Senior VP of Operations

8/24/07
Date

Attachment 4**BETHCO SYSTEM
COMPREHENSIVE CARE MANAGEMENT CORPORATION****CODE OF CONDUCT**

This Code of Conduct governs the conduct of employees and those independent contractors and others affiliated with the Bethco system that the Compliance Officer has designated as covered by the Compliance Program.

- We will comply with applicable laws and regulations and with the Compliance Program, and will strive to act in a manner that will reflect positively on the Bethco system and its component entities.
- We will furnish the highest practical level of care to patients and residents.
- We will treat patients and residents, and their families, with dignity and respect.
- We will respect resident rights.
- We will ensure that patient or resident health care information is held in strict confidence, except as otherwise mandated by law.
- We will timely, accurately, and completely document all care that we give.
- We will bill Medicare, Medicaid and other payers only for care that we actually provide and that has been properly documented.
- We will not accept or pay kickbacks, or offer or accept any payment for referrals.
- We will not use our position to improperly benefit us, our relatives, friends or a business in which we have an interest, and we will promptly report potential conflicts of interest.
- We will treat all our partners fairly and with respect – unions, vendors, supporters.
- We will show respect for the environment and our community.
- We will treat our co-workers with respect.
- We will work with our colleagues and supervisors to correct problems as they occur and we will promptly report suspected wrongdoings to our supervisor or to the compliance officer. There will be no retaliation for making a good-faith report of possible improper behavior.
- Important telephone numbers for reporting compliance issues are listed below:

Compliance Officer**Lori Lahn****347-640-6090****Compliance Hotline****718-519-4057**