

Masonic Care Community Resident Care Policy Statement

Title: Corporate Compliance Policy

Policy Statement:

A. Compliance Principles

1. It is the policy of the Masonic Care Community that all employees, contractors, and agents shall comply with all applicable federal, state and local laws and regulations, both civil and criminal. This includes but is not limited to, the Federal False Claims Act, all applicable regulations governing participation in the Medicare and Medicaid Program, the requirements necessary to maintain this facility's exception from federal, state and local taxes, the Stark Law, federal and state Anti-kickback laws, and all federal and state laws that relate to detection and prevention of fraud, waste, and abuse in federal health care programs.
2. At no time shall any employee have the authority to act contrary to any provision of the law, or to authorize, direct, or condone violations offered by another employee.
3. Any employee of the Masonic Care Community who has knowledge of facts regarding activities that he/she believes might violate the law is obligated to promptly report the matter to his/her immediate supervisor, to a member of the Compliance Committee, or to the Compliance Officer, or to the compliance hotline, (315) 798-4845. The compliance hotline is available 24 hours a day, 7 days a week. Calls to the compliance hotline may be made anonymously. Consistent with New York law, an employee who reports an illegal activity to a supervisor, the compliance hotline, a Compliance Committee member, or the Compliance Officer will be protected against discharge or other retaliatory personnel action. Detailed information concerning employee whistleblower protections is included in Appendix A.
4. The Masonic Care Community will communicate effectively its compliance standards and procedures to all employees through training sessions and by distributing materials that explain in a practical manner the applicable requirements.
5. Masonic Care Community will take steps to achieve and maintain compliance with standards by utilizing monitoring and auditing systems. A reporting system has been established whereby employees, contractors, and other agents are to report compliance concerns.
6. The Compliance Policy will be enforced through appropriate disciplinary mechanisms, in accordance with the Masonic Care Community's personnel policies and procedures. This includes, as appropriate, discipline of individuals responsible for the failure to detect an offense and those individuals who actually commit or conducted an offense. The form of discipline that will be appropriate will be case-specific.

1 Submitted by: Corporate Compliance Committee

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Additional Distribution: All Departments

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7. If an offense has been detected, the Masonic Care Community will implement steps to respond appropriately to the offense and to prevent further similar offenses. This may include modifications to the compliance program.

B. Compliance Commitments

The Masonic Care Community is committed to providing a holistic approach to the care of our residents to promote maximum functioning and independence in all aspects of their life. The Facility, its Board of Trustees, and its Employees are bound by the following commitments:

1. To the community, Masonic Care Community is committed to the promotion of health and well being of its residents. Its best effort will be taken to meet these needs while operating the facility in a fiscally responsible manner.
2. To its employees, the Masonic Care Community will implement and maintain employment standards that comply with all applicable federal and state laws.
3. To the residents of the Masonic Care Community, the facility is committed to providing an appropriate quality of care that is responsive to resident needs and complies with government laws.
4. To third-party payers, both private and public, the facility is committed to submitting bills for services in a timely and accurate fashion and reporting all reimbursable costs to the Medicare and Medicaid program and to any other third party in a legally appropriate manner.
5. To the Masonic Care Community suppliers, the facility stresses a sense of responsibility to be a good customer. When the facility feels that its best interest would be to utilize a competitive bidding then this process will be completed.
6. To all who do business with the Masonic Care Community, it is our policy to conduct ourselves in an appropriate manner consistent with tax-exempt status and all other applicable laws and regulations.

C. Federal and State tax-exempt Status

1. All employees, consultants, and other contractors or agents who contract with the Masonic Care Community must do so in a manner that is consistent with this facility's federal tax-exempt status.
2. At no time may any employee, contractor, or agent violate law or regulation that pertains to federal health care programs.
3. Any involvement and participation in a political campaign by employees must be on an individual basis, on their own time, and at their own expense. If any employee speaks on public issues, it must be made clear that comments or statements are those of the individual and not of the Masonic Care Community.

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4. All employees must make a good-faith effort not to jeopardize the facility's exemption from state and local taxation.
- D. Compliance Officer
- The Masonic Care Community has designated a Corporate Compliance Officer. Employees have a duty to report any suspected violations of any standards, policies and laws to the Compliance Officer. The compliance office is located in the Health Pavilion at 798-4845. When a potential violation has been made known, the Executive Director and Committee will be notified and an investigation will begin. Any investigation of a suspected violation of these standards shall be done by the Compliance Officer in conjunction with the Committee and the facility's outside legal counsel.
- E. Federal and State Laws Concerning False Claims and False Statements in Federal Health Care Programs
- In compliance with §6032 of the Deficit Reduction Act of 2005, this Policy documents the Masonic Care Community's policies and procedures for detecting and preventing fraud, waste and abuse in federal health care programs.
- F. Appendix A of this Policy sets forth detailed information about federal and state laws relating to false claims, false statements, and whistleblower protections, as those laws pertain to preventing and detecting fraud, waste, and abuse in federal health care programs.
- The above policy is not intended to serve as an express or implied employment contract. Its objective is to communicate current policies. The Board of Trustees of the Masonic Care Community reserves the right to change, modify, or waive all provisions herein. Any questions or concerns should be forwarded to the Compliance Officer or any member of the Compliance Committee.

3 Submitted by: Corporate Compliance Committee

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**Summary of Federal and New York State Laws
on False Claims and False Statements
and Whistleblower Protections**

1. Federal Laws

1.1. Federal False Claims Act [31 U.S.C. §§ 3729 - 3733]

The following is the official description of the Federal False Claims Act provided to the Centers for Medicare and Medicaid Services by the United States Department of Justice (SMDL #07-003, March 22, 2007):

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

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease 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

(b) For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. 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).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government 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) is false and that indicate

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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 who obtains interim payments from Medicare 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 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.

The FCA 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 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.

1.2. Federal Administrative Remedies for False Claims and Statements [31 U.S.C. §§ 3801 - 3812]

In addition to a suit under the False Claims Act, the federal government (but *not* a private citizen) can seek administrative penalties against a person or entity for making false claims. An individual or entity may be subject to administrative penalties for making or submitting a claim that the person knows or has reason to know is:

- false or fraudulent;
- includes or is supported by a written statement that includes false information or omits certain material facts; or
- is for payment for property or services the person has not provided as claimed.

Any person making such a false claim may be required, after a hearing, to pay a maximum penalty of \$5,000 per claim and an assessment of up to double the amount of the claim.

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1.3. Prohibitions under the Social Security Act [42 U.S.C. §§ 1320a-7a – 1320a-7b]

The Social Security Act allows the government to impose civil penalties for various offenses. Examples of these offenses include improperly submitting claims for medical services (such as false claims or medically unnecessary claims), offering kickbacks, and making payments to induce the reduction or limitation of services.

The Social Security Act sets out criminal and civil penalties for making certain kinds of false statements in connection with federal health care programs, including Medicare. False statements made by a provider of items or services may constitute a felony punishable by a fine of up to \$25,000 and five years in jail, or both. A provider found to have made false statements can also be excluded from participation in the federal health care programs. When false statements are made by someone else, the penalty may be a fine of up to \$10,000 and one year in jail, or both.

Soliciting, receiving, offering or making illegal payments, including kickbacks, bribes or illegal rebates, is a felony punishable by a fine of up to \$25,000 and up to five years in jail, or both. Knowingly and willfully making false statements to qualify an institution for which certification is required is a felony punishable by a fine of up to \$25,000 or up to five years in jail, or both. Certain “illegal patient admittance and retention practices” are also punishable by a fine of up to \$25,00 or five years in prison, or both.

1.4. Health Care Fraud [18 U.S.C. § 1347]

It is illegal to knowingly and willfully execute or attempt to execute a scheme to either defraud a health care benefit program or to obtain money or property from a health care benefit program by means of false pretenses or representations. The penalty for such actions in connection with the delivery of or payment for health care items or services may be a fine or up to ten years imprisonment, or both. If the violation results in serious bodily injury, the penalty may be a fine or imprisonment of up to 20 years, or both; if the violation results in death, the person may be fined or imprisoned for any terms of years or for life.

1.5. False Statements Relating to Health Care Matters [18 U.S.C. § 1035]

In a matter involving a health care benefit program, it is illegal for any person to knowingly and willfully falsify, conceal or cover up by a trick, scheme or device a material fact; make any materially false, fictitious or fraudulent statement or representation; or make or use a materially false document knowing that it contains materially false statements. The penalty may be a fine or imprisonment for up to five years, or both.

1.6. Theft or Embezzlement in Connection with Health Care [18 U.S.C. § 669]

It is illegal to knowingly and willfully embezzle, steal, convert or intentionally misapply money or assets of a health care program. The penalty may be a fine or up to ten years imprisonment, or both.

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1.7. Other Federal Laws Relating to False Claims and False Statements

1.7.1. Mail and Wire Fraud [18 U.S.C. § 1341]

It is illegal to engage in a scheme to defraud or to obtain money or property by means of false or fraudulent pretenses, representations or promises by using the U.S. mail or a commercial interstate carrier. Penalties may be fines or imprisonment for up to 20 years, or both.

1.7.2. Laundering of Monetary Instruments [18 U.S.C. § 1956]

The federal money-laundering statute prohibits the laundering or transportation of funds from certain illegal activities. The penalties for violation are fines and imprisonment or both.

1.7.3. Racketeer Influenced and Corrupt Organizations (“RICO”) [18 U.S.C. §§ 1961 - 1968]

The RICO law prohibits certain “racketeering activity,” including mail fraud. It is illegal to invest the profits from a pattern of racketeering activity or collection of an unlawful debt in any business which affects interstate or foreign commerce. The penalty is a fine or up to 20 years in prison (or life imprisonment, if that penalty applies to the underlying crime) or both. The defendant may also be ordered to forfeit property to the government. Any person whose business or property is injured by the violation of RICO can seek to recover in court three times the amount of damages he or she sustained, plus reasonable attorneys’ fees and expenses.

2. New York State Laws Regarding False Claims or Statements

2.1. New York False Claims Act [State Finance Law §§ 187 - 194]

The New York False Claims Act (“NYFCA”) establishes penalties of \$6,000 to \$12,000 per claim for knowingly submitting false or fraudulent claims to the state or a local government, or to a contractor or other recipient if the state or a local government provides any portion of the money that is requested or reimbursed. A false claim is a claim that is, in whole or in part, false or fraudulent.

A person is deemed to act “knowingly” with respect to a claim or claim information if that person has actual knowledge with respect to the claim or information, or if that person acts in deliberate ignorance or in reckless disregard of the truth or falsity of the claim or information. Proof of specific intent to defraud is not required, but acts occurring by mistake or as a result of mere negligence are not subject to the NYFCA.

The Attorney General has authority to investigate and prosecute state false claims. The NYFCA also includes qui tam provisions that allow private parties to bring false claim whistleblower actions. A qui tam plaintiff may be entitled to receive up to 30% of the proceeds recovered in a false claim action.

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Protections for employees who lawfully participate in the initiation, investigation or prosecution of actions under the NYFCA are described below, in the description of New York laws prohibiting retaliation.

2.2. False Statements Relating to the Medicaid Program [Social Services Law § 145-b]

Under New York state law, it is illegal for a person, firm, or corporation to knowingly obtain or attempt to obtain payment from public funds for social services, including medical services, by:

- making a false statement or representation;
- deliberately concealing a material fact; or
- a fraudulent scheme.

Any person or entity that obtains or attempts to obtain such payment may be ordered to pay damages of three times the amount that was overstated. If the false statement was non-monetary, the damages may be three times the amount of loss that the state or other governmental entity incurred. In addition, if a provider of medical services is required to refund a payment received from the state or local government, the repayment must be made with interest.

In addition to requiring repayment of improperly claimed funds, the Department of Health may impose a penalty of up \$2,000 per item or service; if the provider has been subject to another penalty within the prior five years, the maximum penalty is \$7,500 per item or service. These penalties may be imposed for:

- failing to comply with the standards of the medical assistance program;
- failing to comply with generally accepted medical practices in a substantial number of cases; or
- gross and flagrant violation of generally accepted medical standards; *if that person also* receives payment for claims when the provide knew, or had reason to know, that:
 - the care, services or supplies ordered or provided were medically improper, unnecessary or in excess of the medical needs of the patient;
 - the care, services or supplies were not provided as claimed;
 - the person who ordered or prescribed the care which was medically improper, unnecessary or in excess of the medical needs of the patient was suspended or excluded from the medical assistance program; or
 - the services or supplies were never provided to the patient.

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2.3. Unacceptable Practices in the Medicaid Program [18 NYCRR §§ 515.2 - 515.3]

Under Medicaid provider regulations, false claims and false statements are unacceptable practices. Sanctions that the Department of Health may impose on a provider for unacceptable practices include censure, repayment, and exclusion from participation in the Medicaid program.

Making a false claim means submitting, or inducing or seeking to induce another person to submit, a claim for:

- care, services or supplies that have not been furnished;
- care, services or supplies provided at a frequency or in an amount that is not medically necessary;
- an amount that exceeds established Medicaid rates; or
- amounts substantially in excess of the customary charges or costs to the general public.

Making a false statement means making, or inducing or seeking to induce another person to make, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment or for use in determining the right to payment.

Concealing or failing to disclose an event that affects the right to payment, with the intention that a payment be made when unauthorized or in an amount greater than the amount due, is also an unacceptable practice in the Medicaid program.

2.4. Criminal Prohibitions under New York Law

In certain circumstances, a person who makes false statements may be charged criminally under New York law. Each of the following crimes may be a misdemeanor or a felony, depending on the intent of the perpetrator. Penalties include fines or imprisonment, or both.

2.4.1. Health Care Fraud [New York Penal Law §§ 177.00- 177.30]

A person may be found guilty of health care fraud if he or she, with the intent to defraud a health plan, knowingly and willfully provides materially false information (or omits material information) to obtain payment from a health plan and thereby receives a payment in an amount the person is not entitled to. A health plan is defined, for purposes of this law, as any publicly or privately funded health insurance or managed care plan or contract, including Medicaid. It is a defense to the charge of health care fraud that the defendant was a clerk, bookkeeper or other employee who, without personal benefit, merely executed orders.

2.4.2. Insurance Fraud [New York Penal Law §§ 176.00 – 176.35]

A person may be found guilty of committing a fraudulent health care insurance act if he or she knowingly, with an intent to defraud, presents or prepares a false statement to support the

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issuance of a health insurance policy or to obtain payment under a health insurance policy or a government-sponsored plan for health care coverage, when the statement contains materially false information or conceals material information.

2.4.3. Falsifying Business Records [New York Penal Law § 175.00 - 175.15]

Business records are defined as any writings, including computer data, that are kept or maintained by an enterprise to evidence its condition or activity. A person may be found guilty of falsifying business records if, with the intent to defraud, he or she:

- makes or causes a false entry in the business records;
- alters, erases, obliterates, deletes, removes or destroys a true entry in the business records;
- omits to make a true entry in business records when required to do so by law or his or her position; or
- prevents the making of a true entry or causes the omission of a true entry in business records.

It is a defense to a charge of falsifying business records if the person was merely an employee who, without any personal benefit, executed the orders of a supervisor.

2.4.4. Tampering with Public Records [New York Penal Law §§ 175.20 - 175.25]

A person may be found guilty of tampering with public records if he or she knowingly removes, mutilates, destroys, conceals, makes a false entry in or falsely alters any record or other written instrument filed with, deposited in, or otherwise constituting a record of a public office or public servant, when he or she knows he or she does not have the authority to do so.

2.4.5. Offering a False Instrument for Filing [New York Penal Law §§ 175.30 - 175.35]

A person may be found guilty of offering a false statement for filing if he or she, knowing that a written instrument contains false information, offers or presents it to a public office with the knowledge or belief that it will be filed with, registered or recorded in or otherwise become a part of the records of such public office.

2.5. New York Laws Prohibiting Retaliation

2.5.1. Protections under New York False Claims Act [State Finance Law §191]

Any employee of a public or private employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms of conditions of employment because of the employee's lawful acts in furtherance of an action under the New

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York False Claims Act may be entitled to an injunction, reinstatement, double back pay with interest, litigation costs, and other relief necessary to make the employee whole.

2.5.2. Other Prohibitions on Employers [New York Labor Law §§ 740]

Under New York law, an employer cannot take any retaliatory personnel action (discharge, suspension, demotion, or other adverse employment action) against an employee because the employee:

- disclosed or threatened to disclose to a supervisor or to a public body an activity of the employer that is illegal and that presents a substantial and specific danger to public health or safety;
- provides information to or testifies before a public body that is conducting an investigation or hearing into the employer's violation of law; or
- objects to or refuses to participate in the illegal activity of the employer.

A "public body" includes the U.S. Congress, the state legislature, any elected local governmental body, any federal, state or local judiciary, a grand jury or petit jury, any federal, state or local regulatory, administrative or public agency or authority, any law enforcement agency, a prosecutorial office or a police officer.

For an employee to be protected against retaliatory action for disclosing to a public body an activity of the employer that is illegal and that presents a substantial and specific danger to public health or safety, the employee must first report the violation to his or her supervisor and give the employer a reasonable opportunity to correct the activity.

If the employee is subjected to retaliation, he or she has one year from the retaliatory personnel action to bring a civil action in court. If the employee prevails in that suit, he or she may be reinstated and may receive lost wages and reasonable costs and attorney's fees. If, however, the court finds that the employee brought the suit without a basis in law or fact, the court may award the employer its costs and reasonable attorney's fees.

In any court action brought under this law, it is a defense for the employer if the personnel action was based on grounds other than the employee's exercise of protected rights.

2.5.3. Health Care Facilities [New York Labor Law § 741]

Employees who perform health care services for certain health care facilities have additional protections against retaliatory personnel actions. Health care facilities include, among others: hospitals, nursing homes, and other facilities licensed under Article 28 of the Public Health Law; home care services agencies and certified home health agencies; and facilities that provide health care services under the Mental Hygiene Law. A health care facility employee covered by this statute has two years to bring suit if he or she is subject to a retaliatory personnel action for:

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- disclosing to a supervisor or public body that he or she reasonably believes, in good faith, that the employer is providing “improper quality of patient care,” as defined below; or
- objecting to or refusing to participate in any practice of providing “improper quality of patient care.”

“Improper quality of patient care” means a practice or action, or a failure to act, that violates a law or regulation if the violation relates to matters that may present a substantial and specific danger to public health or safety or a significant threat to the health of a specific patient. In order to be protected against retaliation, the employee must first bring the matter to the attention of his or her supervisor and give the employer a reasonable opportunity to correct the problem, unless there is an immediate threat to health or safety and the employee reasonably believes in good faith that reporting to the supervisor will not result in corrective action.

The court may award a covered employee back pay, costs and attorneys fees and may order that he or she be reinstated. If the court finds that the employer acted in bad faith, it may assess a civil penalty of up to \$10,000, to be paid into a fund for improving quality of patient care.

In any court action brought under this law, it is a defense for the employer if the personnel action was based on grounds other than the employee's exercise of protected rights.

2.5.4. Public Employers [Civil Service Law § 75-b]

Different protections are available to employees in the public sector, such as employees of state agencies and other governmental entities.

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