



## **COMPLIANCE PROGRAM STRUCTURE AND GUIDELINES**

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**VNS HEALTH AND ITS SUBSIDIARY AND AFFILIATED ENTITIES  
STRUCTURE AND GUIDELINES OF THE COMPLIANCE PROGRAM**

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## **TABLE OF CONTENTS**

- I. OVERVIEW AND GOALS OF THE COMPLIANCE PROGRAM**
- II. STRUCTURE AND GUIDELINES OF THE COMPLIANCE PROGRAM**
  - A. Element 1: Written Policies, Procedures & Standards of Conduct**
  - B. Element 2: Designation of a Compliance Officer and Compliance Committee**
  - C. Element 3: Compliance Program Training and Education**
  - D. Element 4: Lines of Communication**
  - E. Element 5: Disciplinary Standards**
  - F. Element 6: Auditing & Monitoring**
  - G. Element 7: Responding to Compliance Issues**

## **I. OVERVIEW AND GOALS OF THE COMPLIANCE PROGRAM**

As a health care organization operating multiple programs and service lines, VNS Health (“VNS”) and its subsidiaries and affiliates (collectively, the “Enterprise”<sup>1</sup>) are proud of their long tradition of ethical and responsible conduct. The Enterprise is committed not only to providing our patients and members with the highest quality services but also to providing those services pursuant to the highest ethical, business, and legal standards. To that end, the Enterprise has implemented a comprehensive Compliance Program to ensure legal and ethical conduct is an integral part of VNS’ culture and operations.

The Enterprise’s Compliance Program is designed to be an effective and coordinated program that meets applicable federal, state, and local statutory and regulatory requirements. VNS’ goal as an organization is to ensure that our commitment to compliance is reflected throughout our systems, processes, and culture. The Enterprise updates and improves its Compliance Program to adapt to the complex and continually changing regulatory landscape on an ongoing basis. The expectations and standards of the Compliance Program are set forth in the Code of Conduct and numerous general and entity-specific compliance policies and procedures that address specific legal requirements and potential risk areas. These risk areas include billing, payments, governance, business relationships, mandatory reporting, credentialing, and other areas identified by the Enterprise. We have implemented risk assessment procedures, audit protocols, training requirements, reporting mechanisms, and investigative and corrective action processes, all of which have enhanced our ability to ensure ongoing compliance by preventing and detecting fraud, waste, and abuse.

This document, the “Compliance Program Structure and Guidelines,” describes the required elements of a Compliance Program and how each element is addressed and implemented by the Enterprise. The elements as described herein are consistent with guidance issued by: (i) the Centers for Medicare and Medicaid Services (“CMS”); (ii) the New York State Department of Health (“DOH”); (iii) the New York State Office of the Medicaid Inspector General (“OMIG”); (iv) the Office of Inspector General of the U.S. Department of Health and Human Services (“OIG”); and (v) the Federal Sentencing Guidelines.

The Enterprise’s Compliance Program is comprised of seven (7) basic elements. The following is a brief description of how each element is designed, structured, and implemented.

## **II. STRUCTURE AND GUIDELINES OF THE COMPLIANCE PROGRAM**

### **A. Element 1: Written Policies, Procedures & Standards of Conduct**

1. Code of Conduct. The Code of Conduct provides a high-level overview of the Enterprise’s Compliance Program for all directors, officers, employees, contractors, agents, volunteers, and others associated with the Enterprise, and the First Tier, Downstream and Related Entities (“FDRs”) associated with VNS Health Plans (collectively known as “Enterprise Personnel”). The Code of Conduct, attached as Addendum A, sets forth:
  - Standards for legal and ethical conduct;
  - Compliance expectations;

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<sup>1</sup> The Enterprise includes: (i) VNS Health; (ii) VNS Health Home Care, VNS Health Hospice Care, VNS Health Behavioral Health, VNS Health Personal Care, Medical Care at Home, P.C. and VNSNY Care Management IPA (collectively “VNS Health Providers”); (iii) VNS Health Health Plans (“VNS Health Plans”) (iv) VNS Health Management Services Organization, LLC (“MSO”) and (v) VNS Health Holdings, Inc. At the present time, the MSO is not operating and therefore not included in the compliance work plan.

- A high-level description of the Compliance Program;
  - Guidance for Enterprise Personnel and others on how to manage potential compliance issues;
  - Methods to communicate compliance issues to the Compliance Department; and
  - The process by which potential compliance problems are investigated and resolved.
2. Compliance Policies and Procedures. The Enterprise has adopted and implemented numerous compliance policies and procedures that details compliance expectations and requirements embodied in the Code of Conduct. These policies and procedures address specific compliance risk areas and requirements necessary to ensure the Compliance Program is effective and includes standards on Non-Intimidation and Non-Retaliation. The policies and procedures prescribed by VNS apply to all Enterprise programs and Enterprise Personnel. Policies and procedures pertaining to individual subsidiaries and affiliates may be specific to certain business units and address unique licensure or compliance mandates. The policies and procedures are reviewed annually, revised as needed, and updated to include an implementation and revision date.
  3. Location of Policies & Procedures. The Code of Conduct and all other Compliance policies are available on the VNS Health intranet and are provided to FDRs associated with VNS Health Plans as appropriate.

## **B. Element 2: Compliance Officer and Compliance Committee**

1. Chief Compliance and Privacy Officer. The VNS Health Chief Compliance and Privacy Officer (“CCO”) has overall responsibility for the Compliance Program of the Enterprise’s programs and services and acts as the lead compliance officer.
  - Responsibilities. The CCO is responsible for coordinating and overseeing the day-to-day compliance activities in collaboration with the Executive Vice President, Chief Legal and Risk Officer (“CLRO”), other appropriate members of Enterprise staff and senior management, the VNS Health Legal Department, outside compliance counsel and others. The CCO is responsible for the development of an annual compliance work plan, ensuring compliance issues are properly and consistently coordinated and addressed as they arise, and that appropriate compliance reviews, investigations, audits, and monitoring are conducted. In addition, the CCO is responsible for overseeing appropriate responses to all reports, complaints, and questions raised about compliance issues. In this regard, the CCO is the Compliance Program’s “point person” to whom all Enterprise Personnel may report concerns and raise questions about compliance. The CCO is also the Enterprise’s Privacy Officer and oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to VNS Health’s policies and procedures governing the privacy of, and access to, protected health information in compliance with federal and state laws, and VNS Health’s privacy practices.
  - Accountability. The CCO reports directly to the CLRO and the Audit Committee of the VNS Health Board of Directors (the “Audit Committee”). The CCO indirectly to the Executive Vice President & Chief of Provider Services and the Executive Vice President & Chief of Health Plans. The CCO also informs each Board of Directors of VNS Health and its subsidiaries and affiliates (collectively, the “Boards”) of compliance activities. In



addition, the CCO has direct access to the VNS Health President and Chief Executive Officer (“CEO”), and to committees of the Boards, as appropriate, to ensure compliance issues are appropriately and consistently addressed throughout the Enterprise.

- Meetings. The CCO attends and makes periodic compliance reports at Audit Committee meetings. The CCO may also attend meetings of the respective Boards. The CCO, or their designee, chairs the Compliance Committee Meetings for the VNS Health Providers and the VNS Health Plans. The CCO is also a member of and attends meetings related to VNS Health’s Enterprise Risk Management Program.
  - Outside Resources. The CCO has ongoing access to legal counsel, both from the VNS Health Legal Department and from external counsel, as appropriate.
  - Compliance Program Employees. The members of the Compliance Department are Enterprise employees who have compliance responsibilities and support the Compliance Program by performing day-to-day compliance activities, including, without limitation, reviewing and investigating compliance concerns, performing auditing and monitoring activities, and any other responsibilities directed by the CCO (“Compliance Employees”).
2. Special Provisions for VNS Health Plans. *VNS Health Plans operates several health plans. As such, it operates under the Enterprise Compliance Program and has developed, as required by applicable regulation and sub-regulatory guidance, its own supplemental compliance activities.*
- VNS Health Plans Medicare and Medicaid Compliance. The CCO officially oversees the activities and management of VNS Health Medicare and Medicaid compliance activities of VNS Health Plans, including the Special Investigation Unit and the Fraud, Waste, and Abuse (“FWA”) Program. In addition, the CCO is responsible for coordinating with VNS Health Plans Personnel to ensure there are appropriate responses to all reports, complaints, and questions about compliance issues that may arise for VNS Health Plans. The CCO is also responsible for providing compliance and FWA training for employees of the Health Plans on an annual basis and as part of orientation for new employees, as required by CMS. Similarly, the Health Plans’ delegated vendors, known as FDRs (first tier, downstream, and related entities), must attest that their employees and contractors complete compliance and FWA training within 90 days of initial hire and annually thereafter.
3. Compliance Committee. The compliance program is well-integrated into VNS Health’ operations and is supported by its senior management through their active participation in the compliance committee.
- The Compliance Committee is chaired by the CCO, or their designee. It is composed of Enterprise Personnel involved directly in compliance activities, including: the CCO, a representative of the VNS Health Legal Department, and representatives selected by the CCO from operational and shared services departments. Both the VNS Health Provider entities’ compliance committee and the Health Plans’ compliance committee meet at least on a quarterly basis, and more frequently if needed.
  - The Compliance Committee is responsible for collaborating with the CCO in the creation of an annual compliance work plan; reviewing the status and outcomes of compliance audits and monitoring; addressing compliance issues as they arise on a consistent, Enterprise-wide basis; and ensuring that all required personnel complete compliance training and education during orientation and annually thereafter, and reviewing

#### Corporate Compliance Policies.

- The annual compliance work plan is informed by the Enterprise-wide risk assessment, which is compiled and maintained by the Enterprise Risk Management Program. See, Element 6, below.
  - Each Compliance Committee is governed by a charter that outlines the duties and responsibilities of committee members, the names of the membership, the designation of a chair, and the frequency of meetings.
4. Enterprise Risk Management Program. The VNS Health Risk Department operates an Enterprise Risk Management (“ERM”) program, which is a structured, organization-wide approach to identifying, assessing, managing, and monitoring risks that could affect a VNS Health organizational objective. Unlike traditional risk management, which often focuses on isolated risks within specific departments (e.g., finance or operations), ERM takes a holistic view of all risks—strategic, financial, operational, legal, reputational, and emerging—and integrates risk considerations into decision-making across the enterprise. VNS Health’s Director of Risk and Legal Operations conducts annual assessments of strategic, regulatory, and fraud risk for the Enterprise. These assessments form the basis of compliance workplans for the VNS Health Provider entities and VNS Health Plans. As a key contributor to the organization’s ERM program, the CCO ensures regulatory compliance while helping to identify, assess, and manage broader strategic, financial, operational, and reputational risks.
5. Oversight by the Audit Committee and VNSNY Board of Directors. The Audit Committee has primary responsibility for overseeing the VNS Health Compliance Program and the ERM Program. The Audit Committee meets at least quarterly, reviews the ERM risk assessments annually, and receives reports from the VNSNY General Counsel & CLRO, and the CCO, on compliance issues, identified risk areas and issues, risk, and compliance management activities, and external and internal audits and investigations. The Chairperson of the Audit Committee, the CEO, the CLRO, and/or the CCO report periodically to the full VNS Health Board of Directors on risk and compliance matters. Finally, the Boards each exercise oversight, as appropriate, and receive their own reports on compliance matters at their quarterly Board meetings from the CCO and, as necessary, either the Executive Vice President of VNS Health Provider Services or the Executive Vice President of VNS Health Plans.

#### C. Element 3: Compliance Program Training and Education

1. General. VNS Health has established and implemented an effective compliance training and education program for all Enterprise Personnel. The training and education are mandatory and tracked automatically in the Workday System’s Learning Management System (“LMS”) or manually for those who are not in the Workday System (such as vendors and certain volunteers). Failure to comply with education and training requirements may result in disciplinary action consistent with the severity of such non-compliance. The content of the training and education includes all core requirements, is customized for different Enterprise Personnel, and is reviewed and updated on an annual basis.
2. Timing and Frequency of Training. Training and educational programs are conducted as follows:
  - New Employee Orientation Training. As part of their orientation, newly hired Enterprise Personnel receive in-person compliance orientation training and other training mandated by law and regulation including, without limitation, training on HIPAA and other patient and member confidentiality laws. Enterprise Personnel receive a VNS

Health Corporate Compliance Handbook that includes, among other things, a copy of the Code of Conduct, all Corporate Compliance policies, and a copy of the training deck that was presented at orientation. Enterprise Personnel are required to sign a form to acknowledge their receipt of the Corporate Compliance Handbook, and the form is maintained in everyone's personnel file.<sup>2</sup>

- Annual Training. As part of the Enterprise's annual in-service program, which is administered in the LMS and the Care Connect application for VNS Health Personal Care Home Health aides, all Enterprise Personnel receive compliance, Code of Conduct and HIPAA training. Enterprise Personnel are provided with a link to the Code of Conduct and all policies that are posted on the intranet. Successful completion of a knowledge check by Enterprise Personnel is a mandatory part of annual training.<sup>3</sup>
- Periodic Specialized Training and Ongoing Education. To the extent that an issue arises through an audit, investigation or issuance of new laws, rules regulations or, otherwise, Compliance staff will work with management on developing and disseminating appropriate training points and educational materials. Training may be delivered in person, digital or on the LMS.
- Board Training. All members of the Boards receive training on the Code of Conduct, and their responsibilities to exercise effective oversight over the VNS Health Compliance Program on an annual basis. Board members receive a digital copy of the training via email and must complete an attestation of completion.

#### **D. Element 4: Lines of Communication**

1. Communication Methods. The CCO maintains open lines of communication with Enterprise Personnel to facilitate communication and reporting of compliance issues. Confidential reports may be made by mail, email, phone call or face-to-face interaction. VNS Health also maintains a Compliance Hotline for the anonymous and confidential reporting of compliance issues, as discussed below. The Enterprise has established procedures to encourage good faith participation in the Compliance Program. This procedure details the expectation that Enterprise Personnel will raise questions and report concerns relating to the Code of Conduct; compliance policies and procedures; suspected or actual violations of federal and state laws, rules and regulations; and FWA.
2. How to Report. Enterprise Personnel are required to report concerns and raise questions they may have about compliance issues either verbally or in writing to a supervisor, the CCO, and/or the VNS Health Legal Department. All reports of suspected or actual non-compliance should contain as much detail as possible, including names, dates, times, locations and the specific conduct the individual suspects may violate a rule, regulation, law or VNS Health's policies and procedures.
  - Compliance Hotline. In addition to reporting concerns and raising questions, Enterprise

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<sup>2</sup> FDRs who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers are deemed to have met the training and educational requirements for FWA and are otherwise exempt from the VNS Health New Hire training.

<sup>3</sup> Enterprise Personnel, who do not have access to the LMS receive the training in digital form and are required to sign an attestation of completion. Additionally, vendors that supply proof of their own compliance, HIPAA & FWA training, are exempt from VNS Health annual training.

Personnel may call the Hotline to report possible violations, ask questions, or raise compliance concerns. The Hotline is a dedicated confidential telephone line maintained by an outside vendor, Navex Global, and using the Ethics Point platform. Hotline calls are automatically logged by the Ethics Point system, including the date and time of the call, the reporter's name and contact information (unless the caller wishes to remain anonymous) and the nature of the allegation or inquiry. The CCO or designee monitors the Hotline and assigns the allegations and inquiries received to Compliance Employees to investigate and resolve any compliance concern. Non-compliance concerns are referred to the appropriate department in the Enterprise. The Compliance Hotline is also available for VNS Health FDRs and Health Plan members to make reports or inquiries.

- Confidentiality. All information, reports and questions provided or raised by any individual will be held in the strictest confidence permitted by applicable law. Also, the Enterprise will not disclose the identity of anyone who reports a suspected violation of law or who participates in an investigation, unless the matter is turned over to law enforcement and as otherwise consistent with applicable law. Enterprise Personnel should be aware, however, the CCO and compliance counsel are obligated to act in the best interests of VNS Health and do not act as any person's representative or lawyer. Accordingly, confidentiality may not be guaranteed if the disclosure is necessary for an investigation or is required by law.
- The Right to Report Anonymously. If Enterprise Personnel wishes to remain anonymous, they may call the Hotlines or send a written, typed or computerized report to the CCO, or designee. However, we encourage Enterprise Personnel to identify themselves when making reports so that an investigation can be conducted with a full factual background and without undue delay.
- Investigation and Reporting Back. The CCO, or designee, will investigate all complaints and, if appropriate, advise the individual or entity reporting the complaint about the process of, and outcome of the investigation.

#### **E. Element 5: Disciplinary Standards**

Enterprise Personnel are required to adhere to the Code of Conduct, and all applicable compliance policies and procedures, laws, and regulations. As detailed in the Enterprise's disciplinary policies and procedures, appropriate discipline will be imposed if after an appropriate investigation, it is concluded that any individual has not adhered to the Code of Conduct, compliance policies and procedures, or has violated applicable laws and regulations. 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 Code of Conduct, and all applicable compliance policies and procedures, laws and regulations), condoning or not reporting unlawful actions by others, retaliation or intimidation against those who report suspected wrongdoing, or other violations. Discipline may include giving an employee a verbal or written warning, probation for a specified period, suspension, or termination of employment.

VNS Health will ensure disciplinary standards are enforced in a timely, consistent, and effective manner. Enterprise Personnel will be subject to such disciplinary action, regardless of their level or position, for failure to comply with the Code of Conduct, and applicable compliance policies and procedures, laws, and regulations. Investigation and disciplinary records will be maintained for ten (10) years for disciplinary actions imposed for compliance violations.

As further described in Element 7 below, VNS Health's reporting policies and procedures detail when compliance issues must be reported, how compliance issues will be investigated and resolved, as well as the potential sanctions for (i) not reporting suspected compliance issues; (ii) not participating in the Compliance investigations as required; and (iii) encouraging, directing, facilitating, or permitting non-compliance behavior.

## **F. Element 6: Auditing and Monitoring**

### **1. Routine Identification of Compliance Risk Areas.**

- Annual Compliance Risk Assessment. On an annual basis, the Risk Department, in collaboration with the Enterprise's individual business units and departments, performs a risk assessment of the entire organization and its subsidiaries and affiliates, identifies the top compliance risks, and prepares a risk a (the "Compliance Risk Inventory"). Once the Compliance Risk Inventory is completed, specific risk owners, including business unit senior managers and risk leads, are responsible for addressing the identified risks through internal activities, reviews, or audits and then report back to the CCO during the year. The Compliance Risk Inventory is based upon numerous sources, including, but not limited to:
  - (i) the OIG and OMIG work plans, as reviewed by the CCO and the VNS Health' Legal Department;
  - (ii) interviews with senior management and business unit risk leads;
  - (iii) issues identified as a result of audits or reviews;
  - (iv) changes in laws or regulations;
  - (v) issues identified by regulatory bodies pursuant to audits, pronouncements, or otherwise;
  - (vi) issues identified by the VNS Health Compliance Committees;
  - (vii) departmental risk assessments and inventories; and
  - (viii) risks identified by staff members raised throughout the organization and reported to their supervisors, the CLRO, the CCO, and/or the Legal Department.
- Compliance Committees & Work Plan. Based on the Compliance Risk Inventory, the various departments' and operating units' inventories, and its own review of potential risks areas, each Compliance Committee assists in the creation and monitoring of an annual Work Plan and the operation of the Compliance Program.

### **2. Ongoing Compliance Auditing and Monitoring.** Extensive compliance auditing and monitoring occurs throughout the organization, based on the risk assessments described above, and the results are monitored by the Compliance Department, each Compliance Committee and the relevant operational or shared services department. These ongoing activities are just some of the activities conducted by subunits of VNS Health.

- Internal Audit. The Internal Audit Department maintains a separate workplan and reports its findings to the Audit Committee and works with business units on corrective actions with respect to audit findings.
- Compliance Auditors. Compliance Employees and other various specialists and

compliance auditors throughout the organization (collectively, the “Compliance Auditors”) may be deployed to perform periodic reviews and focused audits of Enterprise programs and will report, as appropriate, to the CCO. The Compliance Auditors ensure that VNS Health vigilantly monitors all its programs, providers, and functions from a compliance and quality of care perspective.

- VNS Health Compliance Employees. Compliance Employees review the OMIG and OIG work plans, as well as other compliance sources, and develop an audit and review schedule based on identified risk areas that could impact VNS Health Providers. The review and audit schedule is updated during the year to the extent that the CCO identifies new risk areas. If appropriate, the results of these reviews and audits are reported to the President of Provider Services, the Audit Committee, and/or the VNS Health Provider Boards of Directors. In addition, relevant findings are also reported to the ERC. Compliance Employees also assist in the prevention and detection of issues related to regulatory non-compliance, fraud, and abuse for all VNS Health Plans business lines. Responsibilities include, but are not limited to, reviewing, auditing, and analyzing the accuracy and effectiveness of VNS Health Plans operational systems, including those delegated to subcontractors; preparing audit reports, recommending corrective action, and following up to ensure that appropriate corrective actions are implemented; and facilitating external audits and regulatory survey visits. Results of such reviews and audits are reported to the CCO and, if appropriate, to the President of VNS Health Plans, the Audit Committee, and/or the VNS Health Plans Board.
- Special Investigation Unit (“SIU”). The SIU is staffed by Compliance Employee(s) and contracted staff whose function is to detect and investigate allegations of fraudulent and abusive billing practices, and engages a vendor, as appropriate. The SIU is chiefly responsible for accepting referrals related to alleged fraudulent and/or abusive practices from outside and within VNS Health Plans and for performing targeted audits related to detecting fraudulent and/or abusive practices. Results of investigations and audits are reported to the CCO and the VNS Health Plans Compliance Committee.
- Quality Care Management Departments. VNS Health Provider and VNS Health Plans each perform quality management activities and develops quality measures and provides support in the achievement of such targets. These measures are created based on, among other things, known areas of needed improvement, agency strategic objectives or industry initiatives, areas of risk identified by the ERM program, chart reviews, analysis of trends in complaints and incidents, etc. In addition, the quality management program ensures ongoing clinical and operational training and education is provided to the appropriate VNS Health Personnel. Pertinent findings are reported to the relevant Boards. To the extent that a compliance issue arises through an audit or issuance of new laws, regulations, or otherwise, the CCO works with the Quality Management programs and departments to ensure an appropriate response.
- Contract Administration. On an annual basis, the Contract Administration Department performs audits of all VNS Health Provider contracted licensed home care services agencies to confirm they follow appropriate VNS Health and VNS Health Provider policies and procedures and applicable federal and state laws and regulations. The contracted licensed home care service agencies are contractually required to implement corrective action to remediate deficiencies identified in such audits. Additionally, Contract Administration monitors conflict reporting activities for all VNS Health Providers’ and Plans’ contracted licensed home care services agencies.

- VNS Health Plans Delegated Vendor Oversight Program. This program is responsible for the monitoring and oversight of FDRs that perform administrative and health care service functions on behalf of VNS Health Plans and/or those entities that are under a Management Services Agreement per NYS DOH regulatory requirements. VNS Health Plans must demonstrate accountability for their delegated functions and ensure adherence to regulatory requirements. On an annual basis, the Delegated Vendor Oversight (DVO) Department will develop a work plan and present the work plan to the VNS Health Plans Delegation Oversight Committee and the VNS Health Plans Compliance Committee. In addition, the Plan has established a Credentialing Subcommittee, which meets monthly, to evaluate providers for credentialing and recredentialing as part of the VNS Health's provider network. When an issue with a delegated function warrants remediation, a Corrective Action Plan (CAP) is developed in close collaboration with the delegated entity then the CAP is then tracked by Compliance and overseen through completion.
3. Coordination of Activities. The CLRO and the CCO collaborate to ensure that internal auditing and monitoring activity is both effective and is not duplicated throughout the organization and arrange for appropriate coordination of both internal and external auditing and monitoring activities. Reports of pertinent findings are reported to the Compliance Committee, the ERC and, as appropriate, the Audit Committee, the CEO, and the Boards. Corrective actions are implemented and monitored as set forth in Element 7 below.
  4. Tracking New Developments. On a continuing basis, the CCO, the VNS Health Legal Department, the VNS Health Government Affairs Department, and other Compliance Personnel will ensure that new regulatory or legal requirements issued by federal and state governments are reviewed by the appropriate personnel. This includes, but is not limited to:
    - Reviewing new rules governing the provision and billing of services;
    - Receiving and reviewing applicable Medicare bulletins, Medicaid updates, and other relevant announcements;
    - Receiving and reviewing the CMS Quarterly Medicare Provider Compliance Newsletter for guidance to address billing or other issues;
    - Receiving and reviewing Health Plan Management System memos and guidance;
    - Communicating with the appropriate professional societies as to recent initiatives or developments that might affect the Enterprise;
    - Reviewing newly issued OIG Special Fraud Alerts and Advisory Opinions;
    - Reviewing OMIG's compliance alerts and related issuances; and
    - Reviewing Model Compliance Guidelines and OMIG and OIG Work Plans.

Based on any relevant new developments, the CCO, in conjunction with the appropriate members of senior management and the VNS Health Legal Department, will review existing policies, procedures, and practices to ensure that the Enterprise follows the requirements of federal and state law.

## **G. Element 7: Responding to Compliance Issues**

1. Responding to and Investigating Compliance Issues. VNS Health has a robust system for responding to: (i) compliance issues identified during VNS Health's ongoing monitoring and auditing, as described in Element 6 above; and (ii) compliance inquiries received by the CCO, the CLRO, and any other Enterprise Personnel who receive reports of compliance issues. When an issue of possible improper conduct is identified, including without limitation, improper billing, documentation, marketing, contracting, governance, credentialing, reporting or other practices, the CCO, as appropriate, promptly investigates the matter, and as appropriate, inform senior management, the VNS Health Human Resources Department, the VNS Health Legal Department, and/or outside compliance counsel. The CCO or designees, as appropriate, shall conduct a full investigation of the report, including determining whether a compliance issue exists or whether there has been a violation of the Code of Conduct or any applicable compliance policies and procedures, laws and/or regulations. If an issue or violation does exist, the investigation will attempt to determine its cause so that appropriate and effective corrective action may be instituted. The CCO will take necessary and appropriate follow-up actions. Enterprise Personnel are expected to cooperate in such inquiries and investigations.
2. Reporting of Improper Conduct. Substantiated reports of improper conduct are reported to the Compliance Committee, senior management, the VNS Health Legal Department, the appropriate Board(s), and Human Resources, as appropriate.
3. Corrective Action and Responses to Suspected Violations. When a compliance problem is substantiated, the CCO will ensure that appropriate, timely and effective corrective action is implemented. The CCO will work in conjunction with other Compliance Employees, the VNS Health Legal Department, senior management, the Compliance Committee and/or outside counsel, as appropriate, in discharging this responsibility.

Any corrective action or response implemented must be based on a root cause analysis and designed to ensure the violation or problem does not reoccur or reduces the likelihood that it will reoccur again in the future. In addition, the corrective action plan must include, whenever possible, a follow-up review of the effectiveness of the corrective action following its implementation. If a follow-up review establishes that the corrective action plan has not been effective, then additional or new corrective actions may be implemented. Corrective actions are always documented and may include, but are not limited to, the following:

- Creating new compliance, business or billing procedures, or modifying and improving existing procedures, to ensure that similar errors will not reoccur;
- Informing and discussing with the offending personnel about the violation and how it should be avoided in the future;
- Providing remedial education to ensure that personnel understand the applicable rules and regulations, existing procedures and policies, and any new or modified policies and procedures that may have been instituted;
- Conducting a follow-up review to ensure that any corrective action instituted has been effective and that the problem is not reoccurring;
- Refunding to the proper payor all overpayments that have been identified;
- Disciplining the offending personnel, as appropriate; and



- Making a voluntary disclosure to an appropriate governmental agency, as appropriate.

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**ADDENDUM A**  
**CODE OF CONDUCT**





**ABC:  
Always Best  
to Comply!**

# COMPLIANCE PROGRAM **CODE OF CONDUCT**

**2025 VERSION**

Reviewed: 8/2025

Approved:







# Table of Contents

Message from Dan Savitt . . . . .	4	Standards Relating to Documentation . . . . .	15
Message from David Rosales and John Burke . . . . .	5	Standards Relating to Record Retention . . . . .	16
<b>CODE OF CONDUCT . . . . .</b>	<b>6</b>	Standards Relating to Conflicts of Interests . . . . .	16
<b>1 CODE OF CONDUCT: MISSION AND VALUES . . . . .</b>	<b>8</b>	Standards Relating to Business Practices . . . . .	17
<b>2 CODE OF CONDUCT: SCOPE OF APPLICATION . . . . .</b>	<b>9</b>	Standards Relating to Referrals, Bribes and Kickbacks . . . . .	17
<b>3 CODE OF CONDUCT: REGULATORY AGENCIES . . . . .</b>	<b>9</b>	Standards Relating to Classified Information . . . . .	18
<b>4 REPORTING NON-COMPLIANCE WITH THE CODE OF CONDUCT . . . . .</b>	<b>10</b>	Standards Relating to Financial Calculations and Reporting . . . . .	19
Anonymous Hotline & Online Reporting Tool . . . . .	10	Standards Relating to Returning Overpayments. . . . .	19
Compliance Leadership . . . . .	10	Standards Relating to Marketing . . . . .	20
<b>5 CODE OF CONDUCT: STANDARDS . . . . .</b>	<b>11</b>	Standards Relating to Mandatory Reporting. . . . .	20
General Standards . . . . .	11	Standards Relating to Discipline. . . . .	20
Standards Relating to Treatment of Personnel . . . . .	11	Standards Relating to Credentialing and Exclusions . . . . .	21
Standards Relating to Quality of Care . . . . .	12	Standards Relating to Meals, Gifts, and Other Business Courtesies . . . . .	21
Standards Relating to Collection and Reporting of Data . . . . .	12	Standards Relating to Training . . . . .	22
Standards Relating to Coding, Billing, and the Provision of Services . . . . .	13	Standards Relating to Government Inquiries. . . . .	22
Standards Relating to the Eligibility for Services from VNS Health Providers . . . . .	15	Standards Relating to VNS Health Health Plans and First Tier, Downstream, and Related Entities . . . . .	23
Standards Relating to Enrollment into VNS Health Health Plans . . . . .	15	Standards for Political Contributions and Lobbying . . . . .	23
Standards Relating to Appeals & Grievance for VNS Health Health Plans Members . . . . .	15	Standards for Combating Fraud, Waste and Abuse (FWA) . . . . .	23
		<b>APPENDIX A . . . . .</b>	<b>25</b>



Dan Savitt

**VNS Health President  
and Chief Executive Officer**

I'm pleased to introduce the 2025 version of the **VNS Health Code of Conduct** developed by our VNS Health Corporate Compliance team.

Our Code of Conduct provides all of us with a framework for how we must operate as an organization and how we must behave as individual employees in order to remain compliant and behave ethically. The Code is in alignment with both our VNS Health Mission and Core Values to follow the highest ethical, business and legal standards. Unlawful or unethical behavior, including fraud, waste and abuse, is not tolerated.

The VNS Health Compliance team leads our organization's comprehensive Compliance Program. However, ensuring we're compliant as an organization rests with each of you. By adhering closely to the VNS Health Code of Conduct, whatever your role is or wherever you may be working from, you're protecting our entire organization from potential missteps and contributing directly to VNS Health's ongoing success in providing an excellent quality of care and consumer experience to our patients, members and clients.

I know how dedicated each of you is to VNS Health and our Mission—and it's important to remember that our Code of Conduct is an essential part of that Mission. I ask that you please take the time to carefully review this Code of Conduct, and that we all continue to focus as an organization on our shared responsibility to implement these guidelines in every aspect of our daily work.

Thank you for your help and support!



David Rosales  
**VNS Health Executive Vice President  
and Chief of Provider Services**



John Burke  
**VNS Health Executive Vice President  
and Chief of Health Plans**

Welcome to our **VNS Health Code of Conduct**. While many of you are already familiar with the Code, we encourage everyone to read through this latest update.

We want to take this opportunity to reaffirm our personal commitment to upholding our Code of Conduct—a commitment that we know all of you share. In adhering to its guidelines, you are helping to ensure that VNS Health team members maintain the highest standards of integrity, honesty, and ethical practices in the way we provide care to our patients, members and clients. In setting out these standards, this Code is in direct alignment with VNS Health’s Mission, Vision, and Core Values—it reflects who we are, and what our organization represents.

We also want to emphasize that adherence to this Code is not only essential but mandatory, and that compliance to the Code is an integral part of annual employee performance evaluations. Developed by our VNS Health Corporate Compliance team, the policies and procedures it embodies are based on Federal and State laws and regulations that apply to all VNS Health employees, regardless of position, department and status. Our Code is designed to prevent any and all fraud, waste, abuse, and other misconduct, and to promote and support a welcoming workplace culture that is free from discrimination and harassment. This includes a strict policy against retaliation should any team member report or raise a concern related to compliance with the Code.

VNS Health has an “open door policy” regarding our Code of Conduct. Team members can contact senior management, their direct supervisor, or anyone in the Compliance Department at any time, should you have questions about the Code or concerns about possible violations. Team members can also submit concerns about compliance issues anonymously via our Compliance Hotline at **888-634-1558** or our Online Reporting Tool at **[www.vnshealth.ethicspoint.com](http://www.vnshealth.ethicspoint.com)**.

Thank you for your attention to this critically important matter, and for all you do to support VNS Health and the patients, members and clients we serve.



# Code of Conduct

At VNS Health, our Code of Conduct (“Code”) is a critical component of our Compliance Program. This Code applies to VNS Health, the corporate parent and its family of corporations. The VNS Health Enterprise is comprised of the VNS Health Providers, VNS Health Health Plans, and VNS Health MSO.


VNS Health Providers include VNS Health Home Care, VNS Health Hospice Care, VNS Health Personal Care, VNS Health Behavioral Health, Inc., and Medical Care at Home, P.C.

VNS Health Health Plans is a managed care organization and offers multiple managed Medicare and Medicaid plans.

The VNS Health Providers are different types of service entities and operate under different licensure requirements. VNS Health Home Care is a Certified Home Health Agency (CHHA) that offers skilled professional services to patients on a part-time, intermittent basis based on a plan of care established in collaboration with the patient’s physician. VNS Health Hospice Care offers hospice and palliative care to patients with a certified terminal illness and provides services in the community. VNS Health Behavioral Health offers clinic-based and home-based behavioral health services to clients in the community. Personal Care is a Licensed Home Care Services Agency (LHCSA) that contracts with other VNS Health Providers and VNS Health Health Plans to provide personal care services to patients and members; VNS Health Personal Care also contracts with non-VNS Health entities and individuals to provide nursing, personal care aides and other services.

Additionally, VNSNY Care Management IPA provides both care management and utilization management services. It contracts with other VNS Health Providers, VNS Health Health Plans, and non-VNS Health entities to provide these services.

All directors, officers, employees, contractors, volunteers, interns, agents and others associated with VNS Health, VNS Health Providers, VNS Health Health Plans, and VNS Health Health Plans’ First Tier, Downstream, and Related Entities (“FDRs”) (collectively, the “Personnel”) are required to comply with this Code.



**VNS Health**

**Keep patient and member information confidential.**

**Shhhh!!**

**Remember to always protect patient health information — it's the law.**

- Only access PHI needed to perform your job
- Never leave PHI out in the open (e.g., on your desk)
- Dispose of PHI in confidential shredding bins – not in the trash
- Protect PHI by locking your computer when not in use
- Encrypt emails containing PHI
- Only use VNS Health approved apps to text PHI
- Never post PHI on social media
- Do not talk about PHI in elevators and other public places

**When in doubt, do not disclose!**

**VNS HEALTH'S HIPAA PRIVACY LEADERSHIP TEAM:**

<b>Leah Griggs Pauly</b> Interim SVP, Chief Compliance and Privacy Officer <a href="mailto:Leah.GriggsPauly@vnshealth.org">Leah.GriggsPauly@vnshealth.org</a>	<b>Justin Bain</b> VP, Information Security Officer <a href="mailto:Justin.Bain@vnshealth.org">Justin.Bain@vnshealth.org</a>
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**OR CONTACT US AT:** [HIPAA@vnshealth.org](mailto:HIPAA@vnshealth.org)

Anonymous reports can be made 24 hours a day, 7 days a week by calling the VNS Health Compliance Hotline at 888-634-1558, or by visiting [www.vnshealth.ethicspoint.com](http://www.vnshealth.ethicspoint.com).



VNS Health has adopted and implemented numerous compliance policies and procedures that further describe compliance expectations set forth in this Code. These policies and procedures are available on the intranet and address specific compliance risk areas and requirements in order to ensure that the Compliance Program is operating efficiently and effectively. However, this Code and related policies are not a detailed rule book, nor are they all inclusive. Consequently, VNS Health relies on the good judgement and value of its Personnel to implement the intent of this Code when neither this Code nor VNS Health policies and procedures address a specific situation. If you have any questions or concerns about anything covered by the Code, or about any other matter relating to the Compliance Program, or if you wish to report a compliance concern or problem, please contact the appropriate individual or Compliance Hotline listed in Section IV.

The VNS Health Board of Directors (“VNS Health Board”) is responsible for overseeing the Compliance Program. The VNS Health Board has delegated the responsibility for overseeing the Compliance Program and adherence to the Code to the Audit Committee of the VNS Health Board. The Chief Compliance Officer reports directly to the Audit Committee. In addition, the VNS Health Provider Boards of Directors and the VNS Health Health Plans Board of Directors maintain responsibility for overseeing the compliance activities of VNS Health Providers and VNS Health Health Plans, respectively, and receiving reports of compliance activities, including substantiated reports of fraud, waste and abuse (“FWA”) from the Chief Compliance Officer.

# 1 CODE OF CONDUCT: Mission and Values

- VNS Health is proud of its long tradition of ethical and responsible conduct, embodied in VNS Health's three core values: integrity, empathy, and agility. We are committed to improving the health and well-being of people through high-quality, cost-effective health care in the home and community. We provide these services pursuant to the highest ethical, business, and legal standards. These high standards apply to our interactions with everyone with whom we deal. This includes our patients and members, other health care providers, companies with which we do business, government entities to which we report, and the public and private entities from which reimbursement for services is sought and received. In this regard, all Personnel must not only act in compliance with all applicable legal rules, regulations and contractual requirements, but also strive to avoid even the appearance of impropriety.
- In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with VNS Health. We expect and require all Personnel to be law-abiding, honest, trustworthy, ethical, and fair in all of their business dealings and to strive to avoid even the appearance of impropriety. To ensure that these expectations are met, the Compliance Program has become an integral part of our corporate mission, culture, and business operations.
- VNS Health has an open-door policy and encourages and supports open communication, feedback and discussion about any matters of importance or concern to Personnel. Our open-door policy means that Personnel are free to talk to their supervisor, the Compliance Department, the Human Resources Department, or Legal Department at any time.
- Except where specific elements of the Code state that they only apply to certain of the VNS Health subsidiaries, the Code applies to all VNS Health programs and Personnel.





## 2 **CODE OF CONDUCT:** Scope of Application

All Personnel are responsible for creating and maintaining a work environment in which compliance concerns can be raised, reported, and addressed. VNS Health expects all Personnel to read and understand this Code, and to actively participate in the Compliance Program. It is up to all of us to ensure that an atmosphere of integrity and ethical conduct is engrained in our corporate culture.



## 3 **CODE OF CONDUCT:** Regulatory Agencies

- As a not-for-profit entity, VNS Health must comply with the New York Not-For-Profit Corporation Law, that is overseen, in part, by the New York Charities Bureau.
- VNS Health Providers are regulated by, and have relationships with, the New York State Department of Health (“DOH”), the New York State Office of Mental Hygiene (OMH), and the Centers for Medicare and Medicaid Services (“CMS”), among others. If your job includes VNS Health Provider-related responsibilities, you must be familiar with and follow the policies adopted by that

VNS Health Provider which are relevant to your responsibilities to ensure compliance with applicable laws, rules, and regulations.

- VNS Health Health Plans is regulated by, and has relationships with, the DOH, CMS, and the New York State Department of Financial Services (“DFS”), among others. If your job includes health plan-related responsibilities, you must be familiar with and follow the policies and procedures adopted by VNS Health Health Plans to ensure that we comply with all applicable health plan laws, rules, regulations and contractual requirements.

# 4 Reporting Non-Compliance With the Code of Conduct

## HOW TO REPORT COMPLIANCE CONCERNS:

- Contact an immediate supervisor or a member of the VNS Health Compliance Department.
- All Personnel may also report compliance issues or concerns anonymously to the Compliance Hotline.

The identity of the reporting Personnel will be kept confidential unless the matter is turned over to law enforcement and as is otherwise consistent with applicable law and the need to investigate the issue(s) raised.

## ANONYMOUS HOTLINE & ONLINE REPORTING TOOL

Individuals can report a concern or seek guidance about compliance questions by using our Hotline and online reporting tool:

- 24 hours a day, 7 days a week
- Anonymously, if you choose

**VNS Health Compliance Hotline:**  
**(888) 634-1558**

**VNS Health Online Reporting Tool:**  
**[www.vnshealth.ethicspoint.com](http://www.vnshealth.ethicspoint.com)**

## COMPLIANCE LEADERSHIP

### Leah Griggs Pauly

Interim SVP, Chief Compliance  
and Privacy Officer

[Leah.GriggsPauly@vnshealth.org](mailto:Leah.GriggsPauly@vnshealth.org)



***There are so many ways to report compliance concerns. Which way do I choose?***

You choose the way which is the most comfortable for you. You may always contact the Chief Compliance Officer directly. However, if you wish to remain anonymous, you must raise your compliance concern through the Compliance Hotline.

# 5 CODE OF CONDUCT: Standards

## GENERAL STANDARDS

- Personnel must be honest and lawful in all of their business dealings and avoid any conduct that might create even the appearance of impropriety.
- Personnel must:
  - 1) comply with the Code, all applicable laws, rules, contractual requirements, and VNS Health policies and procedures;
  - 2) report any action(s) they think may be unlawful, inappropriate or violate the Code, or any applicable VNS Health compliance policy or procedure, or any law, rule, regulation or contractual requirement;
  - 3) fully cooperate with inquiries by the Compliance and Legal Departments; and
  - 4) work to correct any improper or non-compliant practices that are identified.
- VNS Health does not tolerate any retaliation or intimidation for good faith participation in the Compliance Program. This protection extends to reports by Personnel of suspected violations of the Code, the Compliance Program or any law, rule, regulation or contractual requirement, as well as Personnel participation in Compliance Program activities including but not limited to:
  - 1) reporting of potential issues;
  - 2) investigations of compliance issues;
  - 3) self-evaluations;
  - 4) audits;
  - 5) remedial actions; and

- 6) reports to appropriate officials as provided in N.Y. Labor Law §§ 740 and 741.

## STANDARDS RELATING TO TREATMENT OF PERSONNEL

- VNS Health is committed to providing an environment where everyone treats each other with respect and dignity. VNS Health strongly believes that collaboration, communication and collegiality are essential for the provision of quality services and a joyful workplace.
- VNS Health treats, and expects its Personnel to treat, all Personnel without unlawful discrimination on the basis of race, color, national origin or ancestry, age, sex, sexual orientation, gender identity or expression, religion, disability, or any other protected category under applicable federal, state, and local laws. For additional information, please refer to the Equal Employment Opportunity Policy.
- VNS Health expects its environment to be free from slurs, epithets, threats, derogatory comments and unwelcome jokes, teasing, sexual advances, and other verbal or physical conduct of a lewd nature such as uninvited touching or sexually related comments. Please refer to the Human Resources Harassment Prevention Policy.

## STANDARDS RELATING TO QUALITY OF CARE

- VNS Health's primary mission is to provide the highest quality of care in the most ethical and compassionate fashion to our patients, members and their families without regard to race, religion, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression, ethnic background, or ability to pay.
- VNS Health acknowledges and responds with sensitivity to the interruption of privacy that is necessitated by care at home and will enter no further into family life and affairs than is required to meet the goals set forth in the plan of care.
- VNS Health honors the dignity and privacy of each patient and member and will treat them with consideration, courtesy, and respect.
- VNS Health ensures that patient care conforms to all applicable clinical and safety standards.
- VNS Health Providers ensure that patients are properly evaluated and treated by qualified practitioners that are appropriately licensed, certified or registered.
- VNS Health Health Plans ensures that all providers in its network who provide services to its members are qualified and appropriately licensed, registered, or credentialed.
- VNS Health has a continuous quality and performance improvement program.

- VNS Health provides reasonable accommodations and modifications for patients and members with disabilities, as required by applicable laws, rules and regulations.

## STANDARDS RELATING TO COLLECTION AND REPORTING OF DATA

The VNS Health Enterprise participates in the value-based payment model as both provider and as payor. Under this model, payment for home health services is shifting from volume-based to value-based.

### For VNS Health Providers

- Under the value-based payment model, a portion of the VNS Health Provider's payment is based on its performance as measured by identified metrics of quality, health outcomes, and efficiency. Each VNS Health Provider must develop and maintain systems and capacity to collect and track data in these identified performance metrics. Much of the data will be collected from clinical information entered into the patient record, such as OASIS items and visit notes, while other data may be collected from different types of sources such as the CAHPS survey.
- Data collection and reporting is a shared responsibility among various types of VNS Health Enterprise personnel, including but not limited to clinical, business and IT personnel. All VNS Health Provider personnel are individually responsible to collect, record, and report necessary data accurately and on a timely basis.

### **For VNS Health Health Plans**

- VNS Health Health Plans is required to report certain types of data to New York State and other regulatory authorities. Data collection, validation and reporting is a shared responsibility among various types of VNS Health Enterprise personnel, including, but not limited to, clinical, operations, business intelligence, data analytics and IT personnel.
- Because these data (e.g., encounter data) can directly impact the compensation that VNS Health Health Plans receives from the Federal government or the State, it is critical that all such data be timely, accurate and truthful.
- All VNS Health Enterprise personnel are required to collect, record, validate and report data accurately and on a timely basis. In the event that any inaccuracies are identified in data that have been reported to the Federal government, the State or another party, VNS Health Health Plans shall promptly notify the other party that the data are potentially inaccurate and shall work cooperatively with the other party to take appropriate corrective action, which may include the resubmission of accurate data.
- Any non-routine data reported to the Federal government or the State or communications with the Federal government or the State regarding the inaccuracy of data previously reported must be approved in advance by either the Compliance Department, the Legal Department or a member of VNS Health Health Plans Senior Management who oversees the business area from which the data were derived.
- VNS Health Health Plans may participate in various value-based payment arrangements with its downstream providers.

- Under these payment models, all or a portion of the compensation payable for health services is based on performance as measured by identified metrics of quality, health outcomes and efficiency, rather than on the volume of services provided. These performance metrics are measured by data that are reported to VNS Health Health Plans by its downstream providers. To ensure the accuracy of these data, VNS Health Health Plans will monitor the downstream providers with whom it has value-based payment arrangements to ensure that such providers collect, record, validate and report data in an accurate and timely manner. In the event that any inaccuracies in such data are identified, VNS Health Health Plans shall notify downstream provider that the data are potentially inaccurate and, as appropriate, shall take corrective action in accordance with the contract between VNS Health Health Plans and the downstream provider.

### **For VNS Health MSO**

VNS Health MSO may only use or disclose PHI as permitted by the applicable Business Associate Agreement, in accordance with applicable law.

### **STANDARDS RELATING TO CODING, BILLING, AND THE PROVISION OF SERVICES**

- VNS Health ensures that coding, billing and reimbursement practices comply with all federal and state laws, regulations, guidelines, as well as contractual requirements and VNS Health policies and procedures. VNS Health has a zero-tolerance policy with respect to improper billing.



- VNS Health Providers only bill for services that are medically necessary, appropriately ordered, and that have been provided in a manner consistent with accepted standards of care. Billing and coding must always be based on appropriate and adequate documentation, which justifies the service provided. Submitted bills and all supporting documentation must be accurate, truthful, and in compliance with all applicable laws, rules and regulations.
- VNS Health monitors whether services were provided as documented and subsequently billed, which may include reviews of statistically valid samples of claims or other verification processes that evaluate the delivery of services being billed.
- VNS Health Personnel may never misrepresent charges or services to, or on behalf of, government agencies, or a patient, member or payor. False statements, intentional omissions, or deliberate and reckless misstatements to government agencies or any payors will expose Personnel involved to termination of employment and criminal prosecution.
- Personnel must comply with all applicable federal and state laws and regulations governing the submission of claims and related statements. A detailed description of: (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in Appendix A.
- VNS Health will comply with all applicable laws, rules, regulations and contractual requirements regarding the completion of timely payment and claims processing for contracted providers.
- If VNS Health receives payments to which it is not entitled from a governmental or private payor, such payments will be reported and refunded in accordance with applicable laws, regulations, and guidance, and the VNS Health Policy on Self-Disclosure and Self-Reporting.
- VNS Health will ensure that patients and members meet the appropriate eligibility requirements for admission and services and/or enrollment into VNS Health and that eligibility is documented appropriately.
- VNS Health Health Plans ensures that it maintains, and can demonstrate, a sufficient and adequate network for the delivery of all covered services either directly or through a network of contracted providers.
- VNS Health Health Plans ensures that its members receive all medically necessary services. VNS Health Health Plans, its delegated contractors, and all providers in its network may never use incentive payment or value-based payment arrangements that reward the restriction of medically necessary care to its members (also known as, underutilization or stinting).



***I think I might have unintentionally submitted a false claim or report, what do I do?***

**You can contact your supervisor to determine how to fix it.** If your supervisor does not know, or you do not feel comfortable talking to your supervisor or you do not feel your supervisor gave an appropriate response, please contact the Compliance Department.

## **STANDARDS RELATING TO THE ELIGIBILITY FOR SERVICES FROM VNS HEALTH PROVIDERS**

- VNS Health Providers ensure that patients meet the appropriate eligibility requirements for admission and ongoing services and that eligibility is documented appropriately.

## **STANDARDS RELATING TO ENROLLMENT INTO VNS HEALTH HEALTH PLANS**

- VNS Health Health Plans ensures that each new member meets the necessary criteria for initial enrollment into a particular health plan and that such eligibility is documented appropriately.
- VNS Health Health Plans enrolls eligible individuals regardless of their health status or potential resource use and does not seek to involuntarily disenroll members because of their health status or resource use.
- VNS Health MLTC enrolls members only after initial assessment is completed by a NYS Independent Assessor. After enrollment, the MLTC evaluates new enrollees to develop a plan of care. Subsequent re-assessments are performed as required by law to determine a member's ongoing medical necessity and Medicaid eligibility. Any member found to be no longer eligible for the MLTC program will be disenrolled.

## **STANDARDS RELATING TO APPEALS & GRIEVANCE FOR VNS HEALTH HEALTH PLANS MEMBERS**

- VNS Health Health Plans is committed to promoting and maintaining quality health care for our members. Each member has the right to: (1) report all concerns of dissatisfaction with the Plan or medical

care, and (2) access a complaint and grievance process for timely problem resolution.

All grievances and appeals are handled fairly and in accordance with regulatory requirements and VNS Health Health Plans policies and procedures.

## **STANDARDS RELATING TO DOCUMENTATION**

All documentation created and maintained by VNS Health must be timely, accurate, truthful, complete, and legible. Examples include, but are not limited to:

- Clinical records pertaining to patients and members must be prepared, maintained, and submitted in an accurate and reliable manner.
- Business records (such as employee timecards, reimbursement requests and invoices) must be prepared, maintained, and submitted in an accurate and reliable manner.
- VNS Health Health Plans Medicare procurement and bid documentation must be prepared, maintained, and submitted in an accurate and reliable manner.

All reports submitted to governmental agencies, insurance carriers, and other entities will be prepared truthfully, timely, accurately, and in accordance with applicable laws, regulations, and contractual requirements, including without limitation:

- 1) VNS Health Providers' cost reports
- 2) VNS Health Home Care's OASIS Data
- 3) VNS Health Providers' claims for services
- 4) VNS Health Health Plans' bid submissions to CMS and DOH
- 5) VNS Health Health Plans' Medicaid Managed Care Operating Report (MMCOR)
- 6) VNS Health Health Plans' data submissions, including HEDIS/QARR

## STANDARDS RELATING TO RECORD RETENTION

- VNS Health complies with all federal and state rules and regulations and applicable VNS Health record retention policies relating to the retention of billing, patient and member medical records and other business records.
- 1) VNS Health Providers maintain all medical and billing records in accordance with the VNS Health Corporate Policy on Record Retention.
  - 2) VNS Health Health Plans maintains its member records, enrollment documentation, and records that support its performance obligations under its federal and state contracts as required by law, regulation and contractual provisions.
  - 3) VNS Health MSO maintains its clients' records in accordance with the Business Associate and Confidentiality Agreements, and maintains its own business records in compliance with the VNS Health Corporate Policy on Record Retention.

## STANDARDS RELATING TO CONFLICTS OF INTERESTS

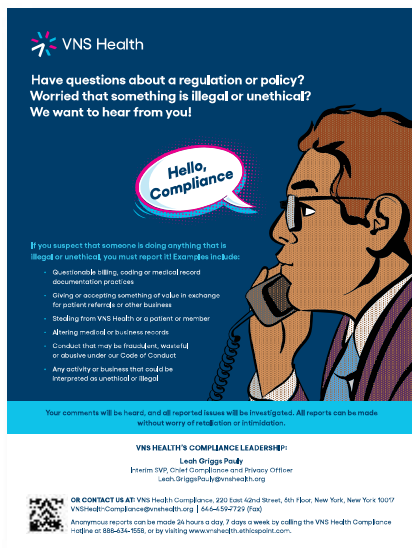
- VNS Health expects Personnel to avoid situations that present an actual or potential conflict of interest and to avoid behavior that could otherwise compromise the integrity of VNS Health's work. Such situations occur when an individual's personal interests interfere or appear to interfere with his or her ability to make sound business decisions on behalf of VNS Health.
- In general, Personnel should refrain from making or continuing any business associations that might interfere with their

ability to exercise independent judgment and to act in the best interests of VNS Health.

- Examples of potential conflicts include maintaining outside employment with, or holding an ownership or other interest in a VNS Health competitor or a contractor of services to VNS Health.
- Accordingly, all VNS Health Board Members, all employees who hold a position as a director or above and other employees as specified in the Conflict of Interest Policy must annually submit a Conflict of Interest Disclosure Statement to the Chief Compliance Officer, or designee. Personnel are encouraged to contact the Chief Compliance Officer, or designee, to discuss any potential conflict of interest that may arise. Personnel may also refer to the VNS Health Conflict of Interest Policy or contact their supervisor or the Legal Department.
- Personnel are expected to make prompt disclosure, before taking any action, of any fact or circumstance that may involve, or appear to create, a conflict of interest.
- The Code is not intended to, and shall not be construed to, infringe upon non-supervisory employees' right to engage in protected and/or concerted activity under the National Labor Relations Act (for example: participating in union activities; discussing wages, working conditions, or other terms and conditions of employment, etc.). Similarly, this policy does not require non-supervisory employees to give notice to or obtain approval from VNS Health in connection with such activities. VNS Health will not interpret or apply the Code of Conduct in a manner that improperly interferes with or limits employees' rights under the National Labor Relations Act.

## STANDARDS RELATING TO BUSINESS PRACTICES

- VNS Health maintains the utmost integrity in all of its business practices and relationships and will forego any business transaction or opportunity that can be obtained only by improper or illegal means.
- Personnel will not engage, either directly or indirectly, in any corrupt business practice intended to influence the manner in which VNS Health provides services, accepts referrals, or otherwise engages in its business practices.



## STANDARDS RELATING TO REFERRALS, BRIBES AND KICKBACKS

In accordance with federal and state law, VNS Health does not solicit, offer, pay or receive any payment from physicians, providers or anyone else, whether directly or indirectly, for or to induce patient or member referrals, or any other referrals of items or services reimbursable by the Medicare or Medicaid programs or any

other payor. All decisions to accept a patient for services or a member for enrollment must be made based solely on whether the patient or member meets the VNS Health criteria for admission or enrollment, respectively.

- VNS Health does 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 value to physicians, hospitals and other potential referral sources. VNS Health does not provide any remuneration to referring physicians for services either not rendered or in excess of fair market value for services rendered.
- Under federal and state anti-kickback laws, it is a crime to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business for which payment may be made under federal or state healthcare programs such as Medicare and Medicaid. Personnel may not offer, pay, solicit, or accept money, a gift, or other benefit in exchange for patient or member referrals, purchase, leases, or orders for services.
- Special considerations apply to contact with government employees. Government employees are prohibited by law from accepting payment for meals, refreshments, travel or lodging expenses or any type of gratuity, and strict compliance is required. Nothing of value should be given to a government employee even if there is no intent to influence an official action or decision. Personnel should not entertain a public official without authorization from the Legal Department. You may contact the Legal or Government Affairs Departments with any questions.

## STANDARDS RELATING TO CLASSIFIED INFORMATION

- All information and data, regardless of medium, is subject to the VNS Health Data Classification Policy, which describes the recognized levels of classification.
- VNS Health patients and members have a right to confidentiality that is assured by state and federal laws, such as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Health Information Technology for Economic and Clinical Health Act (“HITECH”) and their implementing regulations, and by VNS Health policies and procedures, and additional federal and state rules regarding HIV confidentiality, mental health, and alcohol and substance use disorders.
- Actively safeguarding patient and member information is the responsibility of everyone. Patient and member information should be accessed only when needed to provide care or conduct VNS Health business. Sometimes it can be difficult to know when it is acceptable to access, use or share patient or member information. The Privacy Officer is available to answer privacy and confidentiality questions, provide resources, and respond to concerns and complaints. There are also laws that require us to notify patients and members and government agencies of certain privacy violations. If you know of an activity that may be inappropriate, you must report it to the Privacy Officer. See VNS Health HIPAA Policies and Procedures.
- VNS Health employees have a right to confidentiality that is assured by Section 203-D of New York State Labor Law, and other state laws, as it relates to an employee’s personally identifying information.
- Confidential information acquired by VNS Health Personnel about the business of VNS Health, including, without limitation, computer software programs, forms, marketing and sales plans, strategic plans, financial information, fee or pricing information, business contract information, employee information, personnel compensation and related information, and other confidential matters or trade secrets must also be held in confidence and not used for personal gain, either directly or indirectly. Upon commencing work for or with VNS Health, VNS Health Personnel are required to agree to protect, to the best of their capabilities, such information from any unauthorized disclosure. This commitment continues even after an employee or contractor leaves VNS Health. Likewise, VNS Health Personnel must protect against the disclosure of all confidential information of third parties who, for various business or other reasons, have disclosed such information to VNS Health.







- All information or data, including protected health information, whether stored in paper or electronic form is subject to the Data Handling Guidelines, and must be handled carefully during work hours, must be properly secured at the end of the business day. When such information is no longer needed and has been retained beyond our Record Retention Requirements as defined in the Record Retention Policy, it must be disposed of in an approved, secure manner to avoid improper disclosure.

## **STANDARDS RELATING TO FINANCIAL CALCULATIONS AND REPORTING**

- All financial books, records, and accounts must correctly reflect transactions and events, and conform to generally accepted accounting principles, applicable laws, rules, regulations, and to VNS Health's system of internal controls.
- VNS Health Providers maintain integrity in financial reporting related to its cost report submissions.
- VNS Health Health Plans maintains integrity in its financial reporting and reconciliation process related to the MMCOR, Medical Loss

Ratio calculations, and CMS bid submissions, among other financial reports submitted to government agencies.

## **STANDARDS RELATING TO RETURNING OVERPAYMENTS**

- VNS 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.
- VNS Health timely reports any overpayments and makes any necessary refunds to appropriate government agencies. 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, employees must promptly report knowledge of any overpayment to the Compliance Department. See Self-Disclosure and Self-Reporting Policy.

## STANDARDS RELATING TO MARKETING

- VNS Health markets its services in a fair, truthful and ethical manner.
- All marketing activities and advertising by VNS Health and its Personnel must be based on the scope of and merits of the services provided by VNS Health. All marketing information that is distributed outside of VNS Health must fairly and accurately depict VNS Health and its products and services, and must otherwise comply with all applicable laws, state and federal regulations and required approval procedures.
- VNS Health prohibits discriminatory marketing and admission and enrollment practices that are based on a patient or a member's degree of risk for costly or prolonged treatment.

### Q&A

#### ***Can I be retaliated against for participating in an investigation?***

**No.** VNS Health does not permit retaliation against anyone for good-faith and honest participation in an internal or external investigation. Everyone employed by or affiliated with VNS Health is expected to cooperate with all investigations.

All VNS Health Health Plans marketing activities comply with all state and federal regulatory and sub-regulatory requirements. For example, these requirements prescribe:

- the format or setting in which information must (or may not) be presented;
- the compensation that may be offered to marketing representatives; and
- the manner or setting which member enrollments may (or may not) be conducted, including whether gifts of nominal value may be offered to encourage attendance by prospective members.

## STANDARDS RELATING TO MANDATORY REPORTING

- VNS Health ensures that all incidents and events that are required to be reported under federal and state mandatory reporting laws, rules, and regulations are reported properly.

## STANDARDS RELATING TO DISCIPLINE

- Disciplinary actions may be taken for, among other things:
  - 1) Authorization of or participation in actions that violate the Code;
  - 2) Failure to report a violation of the Code or to cooperate in an investigation;
  - 3) 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; or
  - 4) Retaliation and/or intimidation against an individual for reporting a violation or possible violation of the Code.

Personnel who violate the Code, any applicable compliance policy or procedure, or any applicable law, rule or regulation, will be:

- 1) Disciplined, based upon the severity of the violation, up to and including termination of their employment or other relationship with VNS Health; and
- 2) Referred to licensing boards or to governmental authorities, when appropriate or required.

## **STANDARDS RELATING TO CREDENTIALING AND EXCLUSIONS**

- VNS Health ensures compliance with all federal, state, and local laws, rules, and regulations regarding licensure and credentialing of Personnel on an ongoing basis.
- VNS Health Health Plans ensures that all providers and suppliers in their networks have been appropriately credentialed at all times in accordance with applicable laws, regulations, policies and procedures.
- VNS Health does not knowingly employ, appoint, contract with, or bill for an individual or entity that has been debarred, excluded, or is otherwise ineligible for participation in Federal or state health care programs. See VNS Health Policy on Sanction Checks.
- Any payment made to a sanctioned or excluded provider or supplier will be recovered and/or refunded to the payor.

## **STANDARDS RELATING TO MEALS, GIFTS, AND OTHER BUSINESS COURTESIES**

- VNS Health recognizes that it and its Personnel have ongoing business relationships that may occasionally involve invitations for a meal or entertainment.
- Personnel 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, VNS Health Personnel 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 obligated to Personnel or VNS Health, or that create the perception of such intent. VNS Health ensures that such courtesies are always appropriate and in conformity with our standards and applicable law and regulations.
- Gifts of cash (including cash equivalents and gift certificates) are never acceptable.
- Personnel may never solicit gifts or business courtesies.
- All Personnel are encouraged to consult with their supervisors, the Compliance Department or the Legal Department with respect to issues arising under this standard and accompanying policies.
- VNS Health maintains a separate charitable gift acceptance policy for the solicitation and acceptance of gifts to help the organization further fulfill its mission and to benefit VNS Health's operations, programs, and services.



## STANDARDS RELATING TO TRAINING

- The laws and regulations that govern VNS Health are complex and constantly changing. Keeping current on and refreshing our understanding of external expectations and internal policies is a necessity in our business. For this reason, VNS Health offers general compliance education, including education on FWA, this Code, the Compliance Program, and HIPAA for all Personnel, as well as targeted training that is specific to particular jobs and on focused topics.

- 1) General compliance education is provided at hire for new staff, at the time of contracting for certain contractors, and at appointment for Board members and annually thereafter. The education and training methods may include group presentations, online courses, and other formats.
- 2) When an issue arises through an audit, compliance investigation, reported compliance concern, or as the result of the issuance of new laws, rules, regulations or other guidance, appropriate specialized training and education is provided to applicable Personnel.

- VNS Health expects all Personnel to participate in all required compliance training and education. Failure to do so may result in disciplinary action.



## STANDARDS RELATING TO GOVERNMENT INQUIRIES

- VNS Health Personnel may speak voluntarily with government agents, and VNS Health will not attempt to obstruct such communication. VNS Health requires that all information provided to a government agency in any form must be accurate and complete. Personnel should contact the Legal Department before speaking with any government agents or providing any documents for any non-routine requests by government agents.
- VNS Health cooperates fully with government investigations. If you become aware of an investigation or are contacted by a person representing him or herself as an investigator who asks questions or requests documents about VNS Health, or if you receive a subpoena or other written request for information related to a government investigation, you should promptly contact the Legal Department for assistance.
- Any action by VNS Health Personnel to destroy, alter, or change any VNS Health records in response to a request for such records is prohibited, and will subject the individual to immediate discharge and possible criminal prosecution.

## STANDARDS RELATING TO VNS HEALTH HEALTH PLANS AND FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

- FDRs of VNS Health Health Plans are also required to act in a legal, ethical and appropriate manner and to comply with this Code and other applicable compliance policies and procedures designed to promote and ensure FDR compliance with Medicare Parts C and D delegated responsibilities.
- All FWA issues related to FDRs must be reported to the VNS Health Compliance Department and will be thoroughly investigated. VNS Health Health Plans has a Special Investigations Unit (“SIU”) to detect and investigate allegations of FWA.

## STANDARDS FOR POLITICAL CONTRIBUTIONS AND LOBBYING

- VNS Health’s assets will not be used for political campaign contributions. This does not prohibit or restrict any individual from making contributions on his or her own behalf or from participating in a political organization. However, Personnel are prohibited from soliciting political contributions from colleagues.
- Contributions are distinct from “lobbying” activities, and VNS Health plays a role on the federal and state levels by advocating for laws and regulations which enable VNS Health to provide services to its patients and members. Lobbying, subject to certain limitations, is permitted, and all VNS Health lobbying efforts are coordinated by the Government Affairs

Department. To ensure that lobbying laws and policies are fully complied with, it is expected that no employee will engage in lobbying on behalf of VNS Health without prior authorization from the Legal Department.



## STANDARDS FOR COMBATING FRAUD, WASTE AND ABUSE (FWA)

- FWA is a significant concern for all health care organizations. It is VNS Health’s duty to avoid FWA. To that end, all Personnel have the responsibility to report any activity that we suspect of being FWA. Not only is it expected by our members and patients in order to keep health care affordable, it is required by our contracts with the federal and state government.
  - 1) Criminal Fraud is knowingly and willfully defrauding or attempting to defraud any health care benefit program; or obtaining, by false or fraudulent means, any of the money owned by, or under the control of, any health care benefit program.

- 2) 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.
  - 3) Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.
- The Compliance Department helps ensure that VNS Health is regularly monitoring potential FWA and is proactively detecting and preventing FWA. All Personnel have a responsibility to report any activity that they suspect may constitute FWA.
  - For questions or concerns about FWA, you should contact the Compliance Department or, if it is specific to VNS Health Health Plans, you may contact the SIU or the Hotline or online reporting tool directly.

All VNS Health employees will receive a copy of this Code upon hire and will be required to sign and return the Acknowledgment of Receipt. When modifications are made to this Code of Conduct, a revised version will be made available on the VNS Health intranet and upon request from any of the Compliance Officers.

**THIS VERSION Reviewed & Revised: August 2025**

**Approved:\_\_\_\_\_ 2025**





# 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.

### FALSE CLAIMS STATUTES

#### I. 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, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of x 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 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) requires 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.

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, subject to inflation. 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.

## **II. 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, subject to inflation, to maintain compliance with the Federal Deficit Reduction Act, 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 materially 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.

### **III. 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.

## IV. ANTI-KICKBACK LAWS AND CIVIL MONETARY PENALTIES LAW

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

Under the federal Anti-Kickback Law:

(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.

(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 wilfully 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. 10 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.” 10 NYCRR §29.1(b)(3). Any professional in violation of this regulation shall be subject to the penalties that includes censure and reprimand, monetary fines, suspensions and/or probationary terms.

### V. 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 wilfully 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 civil monetary penalties 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).





