

**Department: Corporate Compliance**  
**Subject: Fraud, Waste, Abuse and Whistleblower Education**  
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**Formerly Policy Number: 10-2000-123**

**POLICY:**

All Cortland Regional Medical Center and its affiliated corporations which submit claims to Medicaid and/or receive reimbursement from Medicaid in excess of \$5 million per year, (hereinafter collectively “CRMC” or “Medical Center”) Board Members, employees, and DRA contractors and agents, and volunteers providing substantial services to CRMC (collectively referred to herein as “Staff”) are required to act in compliance with all federal and state laws that address fraud, waste and abuse in federal health care programs such as Medicare and Medicaid.

For purposes of this policy, “DRA contractors and agents” are any contractor, subcontractor, agent, or other person which or who, on behalf of CRMC, furnishes or otherwise authorizes the furnishing of Medicare or Medicaid health care items or services, performs billing or coding functions or is involved in monitoring of health care provided by CRMC.

The CRMC Corporate Compliance Officer is charged with overseeing this policy and will report to the CRMC Audit Committee on any issues that may arise hereunder.

**PURPOSE:**

The purpose of this policy is to inform CRMC Staff of those federal and state laws, such as the False Claims Act (“FCA”) and whistleblower protection laws, which address or are related to fraud, waste and abuse in federal health care programs and to provide general information regarding CRMC’s efforts to combat fraud, waste, and abuse.

This policy will be included in the presentation materials for initial orientation and training of all new employees, Medical Staff, Board Members, and volunteers.

**FEDERAL AND STATE FALSE CLAIMS ACT, ADMINISTRATIVE PENALTIES AND WHISTLEBLOWER PROTECTION LAWS:**

Attached hereto and incorporated herein as Appendix A is a summary of the Federal and State false claims acts, administrative remedies for false claims and statements and whistleblower protection laws.

Under Federal and New York Law, CRMC may not take any retaliatory actions (*i.e.*, discharge, suspension, demotion or other adverse action in terms or condition of employment) against an individual who discloses (or threatens to disclose) to a supervisor or to a public body an activity, policy or practice that is in violation

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of law, rule or regulation. This includes any violation that creates and presents a substantial and specific danger to the public health, patient safety or which constitutes the crime of health care fraud.

If you have any questions about these laws, please contact the Corporate Compliance Officer.

**CRMC'S PROCEDURE FOR DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE:**

Through its Corporate Compliance Plan, Code of Ethical Conduct and related policies and procedures CRMC has established standards and procedures to promote the highest ethical culture and discourage inappropriate conduct. It is the fundamental policy of CRMC to conduct its business in compliance with all applicable laws and regulations of the United States, the State of New York, all applicable local laws and ordinances, and the ethical standards/practices of the industry and the Medical Center.

The Medical Center is committed to ensuring that its coding, billing, and reimbursement procedures comply with all federal and state laws, regulations and guidelines. Accordingly, the Medical Center's policy prohibits billing or submitting a claim for services that were not provided as stated, not medically necessary, known not to be covered by the payor or are false, misleading, or inaccurate. If these types of inaccuracies are discovered in bills or claims already submitted to the payor, the individual who discovered the inaccuracies should report the issue immediately so that corrective action can be taken. Similarly, the Medical Center will check the excluded status of all Board Members, employees, new hires, Medical Staff members and DRA contractors and agents to ensure that none are excluded from participating in federal healthcare programs such as Medicare and/or Medicaid.

**NO RETALIATION:**

No Board Member, officer, employee or volunteer who reports any suspected non-compliance in good faith will suffer intimidation, harassment, discrimination or other retaliation of any kind.

As outlined in the Medical Center's Corporate Compliance Plan and handbook, employees must report known compliance issues or they will be subject to disciplinary action. Employees who report compliance issues in good faith will not be punished in any way for reporting the issue. In addition there will be no retaliation or intimidation for participating in investigations, audits and corrective actions related to compliance matters. An employee that attempts to retaliate against another employee for reporting a compliance issue in good faith will be subject to disciplinary action, including termination if appropriate. If an employee makes a false or misleading report related to a compliance issue, the employee will be subject to disciplinary action.

**REPORTING SUSPECTED NON-COMPLIANCE:**

Anyone may report an incident of suspected non-compliance. Reports may be made anonymously, in person, by phone, or in writing to any of the following resources:

1. Staff may report incidents of suspected non-compliance to their supervisor (unless the supervisor is involved in the matter of concern) or to any senior manager. Such supervisor or senior manager must promptly forward the report to the Compliance Officer or to a member of the Corporate

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Compliance Committee. Reports received by a member of the Corporate Compliance Committee must be immediately communicated to the Compliance Officer for documentation, investigation, and follow up.

2. Corporate Compliance Officer 607-428-5150
3. HIPAA Privacy Officer 607-428-5150
4. HIPAA Security Officer 607-756-3579
5. Compliance Hotline 607-428-5151
6. Compliance Fax 607-428-5069
7. [Compliance.Office@cortlandregional.org](mailto:Compliance.Office@cortlandregional.org)

Written communications may include e-mail, memorandum, and letter or incident report. The reporter may identify him/herself or remain anonymous. Every attempt will be made to keep the reporter's identity confidential unless he/she gives permission or requests that his/her identity be revealed through the process or investigation. However, there may be situations where the direction of the investigation may lead to identification of the reporter.

The failure to report compliance issues and assist in the resolution may result in disciplinary action up to and including termination and such discipline will be fairly and uniformly imposed. Disciplinary action may be taken for failure to report suspected problems; participation in non-compliant activity; or encouraging, directing, facilitating or permitting non-compliant conduct. Staff is also expected to participate in audits, investigations and corrective action plans related to compliance issues and the failure to do so may result in disciplinary action up to and including termination.

The CRMC Corporate Compliance Plan, compliance policies and this policy set forth the processes CRMC utilizes to detect and prevent fraud, waste and abuse including, without limitation, a Code of Ethical Conduct; a designated corporate compliance officer with access to the Board of Trustees; compliance education and training for employees, Medical Staff and Board Members; processes for reporting compliance issues; auditing and monitoring of CRMC practices to detect and investigate potential compliance issues; disciplinary actions that may be taken against employees who fail to comply with applicable laws and/or CRMC policies; the corrective action CRMC will take including self-disclosure and/or repayment of overpayments in response to compliance related issues and the prohibition on retaliation against people who make good faith reports of suspected non-compliance.

The Corporate Compliance Plan, Appendix A and other applicable CRMC policies and procedures are available on the Medical Center's intranet and website [www.cortlandregional.org](http://www.cortlandregional.org).

Please address any questions regarding this policy to the Corporate Compliance Officer.

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**APPENDIX A**  
**SUMMARY OF FRAUD AND ABUSE**  
**AND WHISTLEBLOWER PROTECTION LAWS**

**FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS**

**I. FEDERAL LAWS**

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

**II. NEW YORK STATE LAWS**

**A. CIVIL AND ADMINISTRATIVE LAWS**

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

**B. CRIMINAL LAWS**

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

**III. WHISTLEBLOWER PROTECTION**

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

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**I. FEDERAL LAWS**

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

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

§ 3729. False claims

(a) Liability for certain acts.—

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

- (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
- (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
- (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.

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

- (A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims 30 days after the date on which the defendant first obtained the information;
- (B) such person fully cooperated with any Government investigation of such violation; and
- (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.

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- (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.

**Definitions.—For purposes of this section—**

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

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

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

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

**(2) The term “claim”—**

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

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

provides or has provided any portion of the money or property requested or demanded; or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

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

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

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

(C) exemption from disclosure.—Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

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

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

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

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

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

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### **3) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)**

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim. Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

### **4) Reporting and Returning of Overpayments**

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The Accountable Care Act enacted a provision requiring that overpayments be reported and refunded within the specific parameters. More specifically, Section 1320a – 7k (d) requires a person who has received an overpayment of Medicare or Medicaid funds to report the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment. The statute requires that such an overpayment be reported and returned by the later of - - (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. The statute specifies that an overpayment retained by a person after the deadline for reporting and returning an overpayment is an “obligation” (as defined in 31 U.S.C. 3729(b)(3) for purposes of the False Claims Act, 31 U.S.C. 3729. The term “overpayment” means any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is not entitled under the program. Finally, the Act defines the term “person” as a provider of services, supplier, Medicaid managed care organization (MCO) or the Medicare Advantage organization (MAO) or PDP sponsor but does not include a beneficiary.

## **II. NEW YORK STATE LAWS**

### **1) CIVIL AND ADMINISTRATIVE LAWS**

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

### **B. CRIMINAL LAWS**

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

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

### **(A) CIVIL AND ADMINISTRATIVE LAWS**

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

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding

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

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

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

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

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

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**B. CRIMINAL LAWS**

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

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

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

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- 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 a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

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

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

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

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

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

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

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**5) Penal Law Article 176 - Insurance Fraud**

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

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

**6) Penal Law Article 177 - Health Care Fraud**

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

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

- a. Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.
- b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
- c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.

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

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**III. WHISTLEBLOWER PROTECTION**

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

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

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

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

**3) New York State Labor Law, Section 740**

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

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**4) New York State Labor Law, Section 741**

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

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

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

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