MAIMONIDES HEALTH

CODE: COMPL-011 (Reissued)
DATE: July 21, 2026
ORIGINALLY ISSUED: April 26, 2007

SUBJECT: FALSE CLAIMS AND PAYMENT FRAUD PREVENTION

I. POLICY

Maimonides Health is committed to fully complying with all laws and regulations that apply to health care and to preventing and detecting any fraud, waste, or abuse related to Federal and State health care programs (Medicare, Medicaid and other governmental payor programs). This includes the knowing submission of a false claim for payment in relation to a federal or state-funded health care program. Such a submission violates the federal False Claims Act as well as various state laws, and may result in significant civil and/or criminal penalties.

Maimonides has established certain policies and provides employees, contractors and agents with information regarding: (1) Maimonides' policies and procedures for detecting and preventing fraud, waste and abuse ("FWA"); (2) the federal False Claims Act and similar New York State laws; and (3) an individual's rights to be protected from retaliation, harassment, discrimination or in the case of employees, adverse employment consequences when reporting in good faith any action or suspected action in violation with these laws or any applicable Maimonides policy as a whistleblower.

II. SCOPE

This policy applies to all employees, contractors, volunteers, students, trustees, medical staff members, and anyone who furnishes (on behalf of Maimonides) health care items or services, performs billing or coding functions, or who monitor the health care provided by Maimonides Health Resources, Inc. and its subsidiaries and affiliated entities, including, without limitation, Maimonides Medical Center, Maimonides Midwood Community Hospital, Community Care of Brooklyn IPA, Inc., Brooklyn Communities Collaborative, Inc., MMC Holding of Brooklyn, Inc., Maimonides Research and Development Foundation, and M2 Medical Community Practice, P.C. and its affiliated captive entities (collectively "Maimonides Health" or "Maimonides").

III. DEFINITIONS

Abuse: Payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representation or promises) any of the money or property owned by, or under the custody or control

of, any health care benefit program.
Waste: The overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs.

IV. POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FWA

A. Maimonides maintains a robust and active Corporate Compliance Program that:

1. Identifies, monitors, and manages, through a multitude of organizational policies and procedures and in compliance with federal and state laws, concerns of fraud, waste and abuse.
2. Includes a written Code of Conduct that establishes basic standards of workplace behavior, promotes adherence to all applicable laws, regulations and policies, and reflects Maimonides' commitment to the highest standards of integrity and ethical conduct.
3. Is dedicated to the training and education of its workforce members regarding applicable laws, regulations and policies related to preventing and detecting FWA. This includes the importance of submitting accurate claims and reports to the Federal and State governments as well as whistleblower protections afforded under such laws.
4. Makes available a confidential Compliance Hotline for employees and other individuals to report compliance concerns.
5. Includes written policies and procedures prohibiting retaliation or other harassment against individuals who, in good faith, participate in investigations or report alleged violations of applicable policies, rules, regulations or laws.

B. Pursuant to the Code of Conduct, employees are expected and encouraged to bring immediately to the attention of their supervisor, the Chief Compliance Officer ("CCO"), the Office of Corporate Compliance ("OCC") or the Office of Legal Affairs, information regarding suspected improper conduct. Employees may also call the **Compliance Hotline at (800) 585-7970** which is available 24/7 or by visiting http://maimo.ethicspointvp.com. Maimonides is committed to investigating any such allegation of fraud, waste, or abuse or other improper conduct swiftly and thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, Maimonides requires that all employees fully cooperate in the investigation.

C. Maimonides devotes substantial resources to investigate allegations of fraud and abuse and therefore, believes that all employees should bring their concerns to Maimonides first so it can redress and correct any fraudulent activity. Any employee of Maimonides who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under Maimonides' internal compliance policies and procedures and Federal and State law. As a Maimonides employee or affiliated individual, workforce members have an obligation to

report concerns using the internal methods listed above and to understand the options available should concerns not be resolved.

D. Maimonides retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or Maimonides' policy. Where appropriate, the CCO will report the issue to the Board of Trustees Compliance Committee. A record will be kept of all whistleblower interactions.

E. Although Maimonides requires that its employees bring their concerns to Maimonides, certain State and Federal laws discussed more fully below provide that any private citizen may bring their concerns of fraud and abuse directly to the government. Please note, however, that if an employee never reports concerns through the Maimonides' internal Compliance processes so that Maimonides can address these concerns, they will be in breach of Maimonides' policy.

F. Materials relating to Maimonides' policies for detecting and preventing fraud are listed on Maimonides' Intranet under the heading: "Departments", subheading: "Corporate Compliance" and on the "Corporate Compliance" page of Maimonides' website.

V. FEDERAL AND STATE FRAUD and ABUSE DETECTION, PREVENTION AND EMPLOYEE PROTECTION

A. Federal Laws:

1. False Claims Act (31 USC §3729; "FCA")

The FCA provides, in pertinent part, that**:**

Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; …or (7) knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $14,308and not more than $28,619, plus three times the amount of damages which the Government sustains because of the act of that person.

For purposes of this section, the terms "knowing" and "knowingly" 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
(iv) requires no proof of specific intent to defraud;

Although 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.

In sum, FCA imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds that the person knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services the physician knows they have 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 the contractor 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 they 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. These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement. The Act 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 lawsuit.

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 15- 25% 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 between 25- 30% of the proceeds recovered.

2. Administrative False Claims Act (formerly Program Fraud Civil Remedies Act ("PFCRA")), (31 USC §3801 et seq.)

This statute allows for administrative recoveries by federal agencies. If a person **submits** a claim or statement, the maximum penalty which may be assessed is the larger of:

(1) The amount for the previous calendar year; or

(2) An amount adjusted for inflation, calculated by multiplying the amount for the previous calendar year by the percentage by which the CPI-U for the month of October preceding the current calendar year exceeds the CPI-U for the month of October of the calendar year two years prior to

the current calendar year, adding that amount to the amount for the previous calendar year, and rounding the total to the nearest dollar.

A violation of PFCRA occurs when a false claim is **submitted** rather than when it is paid, as is the case under 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. The administrative agency may also recover twice the amount of the claim.

3. Disclosure and Return of Overpayments (42 USC §1320a-7k(d))

Section 6402(a) of the Patient Protection and Affordable Care Act ("PPACA") created a new requirement, effective as of March 23, 2010, related to reporting and returning "overpayments." PPACA defines an overpayment as "any funds that a person receives or retains under [Medicare and Medicaid] to which the person, after applicable reconciliation, is not entitled under such title." PPACA further provides that an overpayment must be reported and returned "by the later of--(A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable." Under current CMS regulation, a person has identified an overpayment when the person "knowingly receives or retains an overpayment."." PPACA also provides that an overpayment retained after the deadline for repayment is an "obligation" under the FCA.

4. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

The federal Anti-Kickback Statute (the "AKS") makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program such as Medicare or Medicaid. The AKS ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. The AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

Violation of the AKS constitutes a felony punishable by a maximum fine of $100,000 per violation, imprisonment up to ten years, or both. Conviction will also lead to automatic exclusion from federal health care programs, including Medicare and Medicaid. Where a party engages in conduct prohibited by the AKS, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party and/or initiate administrative proceedings to exclude such party from federal health care programs. Additionally, a claim for payment that includes items or services resulting from a violation of the AKS constitutes a false or fraudulent claim for purposes of the FCA.

B. New York State Laws

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

The New York State False Claims Act is similar to the federal FCA. 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. The New York False Claims Act, unlike the federal FCA, also extends liability to false or fraudulent claims, records, or statements made under state tax laws in certain circumstances.

The False Claims Act imposes civil penalties for submitting false claims, including penalties adjusted under applicable law, plus up to three times the amount of damages sustained by the government. Individuals and entities that violate the Act may also be responsible for applicable costs, including attorneys' fees, as permitted by law.

The 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 and 145-c - False Statements; Sanctions

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 statute imposes for recoveries up to three (3) times the amount incorrectly paid for more serious violations of Medicaid rules, billing for services not rendered, providing excess services, or failing to report and return a Medicaid overpayment. If repeat violations occur within five (5) years, a penalty of up to $7,500 per violation may be imposed. Separately, any person that makes a false or misleading statement in connection with an application for or receipt of public assistance, including Medicaid, is guilty of a misdemeanor and may be excluded from the public assistance program for periods of six months to a period of years depending on the number of offences.

3. Social Services Law, § 366-b- Penalties for Fraudulent Practices

Any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids and abets any person to obtain medical assistance to which he is not entitled, shall be guilty of a class A misdemeanor.

Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise, shall be guilty of a class A misdemeanor.

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

5. 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:

(i) §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.
(ii) §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.
(iii) §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.
(iv) §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.

6. Penal Law Article 176 - Insurance Fraud

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

(i) Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.
(ii) Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a class E felony.
(iii) Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a class D felony.
(iv) Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a class C felony.
(v) Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a

class B felony.
(vi) Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

7. Penal Law Article 177 - Health Care Fraud

This statute 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 five crimes:

(i) Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, the person 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.
(ii) 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.
(iii) 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.
(iv) 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.
(v) 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.

C. Whistleblower Protections

1. Federal False Claims Act (31 U.S.C. § 3730(h)) and New York State False Claims Act (State Finance Law §191)

Both the federal and New York States Acts provide 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 result of their furtherance of an action under either Act.

Remedies include an injunction to restrain continued discrimination, reinstatement with comparable seniority as the person would have had but for the discrimination, two times the

amount of any back pay, interest on any back pay, reinstatement of full fringe benefits and seniority rights, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

2. New York State Labor Law, § 740

An employer may not take any retaliatory action against an employee, former employee, or independent contractor if the individual discloses or threatens to disclose 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 an employee, former employee or independent contractor reasonably believes (i) violates a law, rule or regulation; or (ii) imposes a substantial and specific danger to the public health and safety.

The law requires that before disclosing such information, the employee, former employee, or independent contractor must first make a good-faith effort to raise the matter with a supervisor and give the employer a reasonable opportunity to correct the alleged violation. Employees, former employees or independent contractors are not required to take those steps if they reasonably believe: (i) there is imminent and serious danger to public health or safety, (ii) the supervisor is already aware of and will not correct the unlawful activities: (iii) the activity would endanger the welfare of a minor; (iv) physical harm will result to the individual or another person; or (v) the reporting of such would lead to the destruction of evidence or other concealment of the activity.

3. New York State Labor Law, § 741

A health care employer may not take any retaliatory action against an employee, former employee, or independent contractor if the individual discloses or threatens to disclose certain information about the employer's policies, practices or activities to a supervisor, regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that are asserted by the employee, former employee, or independent contractor in good faith and with reasonable belief that the policy, practice or activity constitutes improper quality of patient care and/or improper quality of workplace safety.

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 activity, policy or practice, unless the danger is imminent to the public health or safety to the health of a specific patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action.

4. New York Not-for-Profit Corporation Law, § 715-b

This law also prohibits intimidation, harassment, discrimination, or other retaliation and adverse employment consequences where an employee makes a good-faith report of suspected improper conduct.

D. PROTECTION AGAINST RETALIATION

Maimonides' policy strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith, concerning suspected fraud, waste and abuse or other suspected violation of law or Maimonides' policy. Retaliation is subject to discipline, up to and including dismissal from employment or termination of the business relationship with Maimonides (See COMPL-010 Protection Against Retaliation Policy).

E. RESPONSIBILITIES

1. Human Resources is responsible for providing copies of the information required by the Deficit Reduction Act as described in this policy to all new employees during orientation and obtaining an acknowledgement of receipt which will be maintained in the employee's personnel file.

2. Management (at all levels) is responsible for encouraging a culture of compliance by reiterating the importance of compliance, developing procedures specific to their area that assist in the prevention of fraud, waste and abuse and responding to staff who come forward with suspicions of fraud, waste or abuse.

3. The OCC will ensure that a copy of this policy is posted on the OCC's intranet page and Maimonides' website.

4. The Credentialing Department will provide a copy of this policy and the information required by the DRA to all medical staff members at the time of initial appointment and will obtain an acknowledgment of receipt which will be kept in the credential files.

5. The OCC is responsible for implementing and maintaining the Corporate Compliance Program, which includes but is not limited to: a) providing training that aids staff in their ability to prevent and detect fraud, waste and abuse, including the federal and state False Claims Acts; b) responding to reports of fraud, waste and abuse in a timely fashion; c) developing and implementing new policies that assist Maimonides in preventing and detecting fraud, waste and abuse, and; d) reporting suspected fraud, waste or abuse or criminal acts of Maimonides employees and covered entities including but not limited to, the appropriate CMS Medicare Integrity Contractor/Medicare Advantage Plan Sponsor, as applicable, and in accordance with contract agreements with outside parties.

VI. CONTROLS

The OCC will be responsible for monitoring compliance with this policy.

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REFERENCE : Deficit Reduction Act of 2005, S. 1932 Sec. 6032;
Social Security Act, 42 U.S.C. § 1396a(a)(68);
False Claims Act 31 U.S.C. §§ 3729-3733;
28 C.F.R Part 85 Civil Monetary Penalties Inflation Adjustment;
Federal Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812;
Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10104(j)(2),
124 Stat. 119, 901-02 (2010);
42 C.F.R. 401.305(a)(2);
Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, § 4, 123 Stat. 1617, 1621-25;
NYS False Claims Act, NY Finance Law Sec. 187-194;
Medicaid False Claims Act, NY Social Services Law §§ 145-b, 145-c and 366-b;
NY Penal Law §§ 155 and 175-177;
Retaliatory Action by Employers, NY Labor Law Article 20-C;
L. 2013, ch. 56, Sec. 8 (State Finance Law § 189(1)(h))
COMPL-010 Protection Against Retaliation & Intimidation

INDEX: Fraud, Waste, Abuse
DEPARTMENT RESPONSIBLE: Corporate Compliance

ATTACHMENTS: None