TO: **All Woods Services, Inc. Personnel, Providers, and Contractors**
FROM: **Compliance/Human Resources Departments**
RE: **Supplement to Code of Conduct and Compliance Plan**

Section 6032 of the Federal Deficit Reduction Act of 2005 requires certain health care organizations, including Woods Services, Inc. ("Woods") to assist in preventing, detecting and addressing fraud, waste and abuse in federal health care programs by taking certain actions, including having in place a policy to describe provisions of certain federal and state anti-fraud and false claim laws. As part of our obligations under Section 6032, we are distributing a summary of applicable legal requirements including a general description of laws which are specified in the Code of Conduct and Compliance Plan. The goal of the Compliance Program is to ensure that each of us performs our duties ethically, legally and responsibly. It applies to all Personnel, including employees, officers, board members, volunteers, vendors, contractors, and agents of Woods involved, directly or indirectly, in the provision or monitoring of, or coding or billing for, health care services billed to or payable by any government or private third party payer.

FEDERAL, NEW JERSEY STATE & PENNSYLVANIA STATE ANTI-FRAUD AND FALSE CLAIMS LAWS

1. Federal Anti-Fraud And False Claims Laws:

a. The Federal False Claims Act ("FCA"), 31 U.S.C. § 3729 et seq.

The FCA is a law that prohibits a person or entity, such as Woods Services and its staff members, agents and contractors, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the federal government. The FCA also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid and knowingly or improperly retaining an overpayment. These prohibitions extend to claims submitted to federal and federally-funded health care programs, such as Medicare and Medicaid.

The FCA establishes liability when any person or entity improperly receives from or avoids payment to the Federal government--tax fraud excepted. In summary, the Act prohibits:

- Knowingly presenting, or causing to be presented to the Government a false claim for payment;
- Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the Government by getting a false claim allowed or paid;
- Falsely certifying the type or amount of property to be used by the Government;
- Certifying receipt of property on a document without completely knowing that the information is true;
- Knowingly buying Government property from an unauthorized officer of the Government, and;
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

Any individual or entity found guilty of violating this law shall be liable for civil money penalties. The Federal False Claims Act (FCA), codified at 31 U.S.C. §§ 3729-3733, as amended in 1986, provided for penalties of between $5,500 and $11,000 per false claim, and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims to the United States for government funds or property. The FCA allows for inflationary adjustments, however, so these penalties have increased over the years. In 2025 penalties ranged from $14,308 to $28,619 per claim plus triple damages. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

The FCA broadly defines "knowing" and "knowingly." Knowledge will have been proven under the FCA if the

person or entity: (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. The law specifically provides that a specific intent to defraud is not required to prove a violation.

Under the Affordable Care Act, the law was amended to, among other things, extend liability for "reverse false claims," or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the federal government. Thus, overpayments from federally-funded health care programs not returned within required timeframes may create FCA liability. In addition, violating the FCA can provide the basis to subject a person or entity to exclusion from participation in Medicare, Medicaid and other federal health care programs.

Private persons are permitted to bring civil actions for violations of the FCA on behalf of the United States (also known as "qui tam" actions) and are entitled to receive a percentage of monies collected. Persons bringing these claims (known as "relators" or "whistleblowers") are granted protection under the law. Any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the FCA will be entitled under the law to remedies, including reinstatement with seniority, double pay back, interest, special damages sustained as a result of discriminatory treatment, and attorney fees and costs.

b. <u>The Administrative False Claims Act of 2023 ("AFCA")(formerly the Program Fraud Civil Remedies Act, PFCRA), 31 U.S.C. § 3801 et seq.</u>

In October 1986, Congress enacted the Program Fraud Civil Remedies Act, Public Law 99-509 (codified at 31 U.S.C. 3801-3812). The statute was modernized and renamed the Administrative False Claims Act of 2023 through the National Defense Authorization Act for Fiscal Year 2025. The law establishes an administrative remedy against any person who makes, or causes to be made, a false claim or written statement to certain Federal agencies. In brief, it requires the affected Federal agencies to follow certain procedures in recovering penalties and assessments against individuals who file false claims or statements for which the liability is $1,000,000 (as adjusted for inflation) or less. The AFCA makes it illegal for a person or entity to make, present or submit (or cause to be made, presented or submitted) a "claim" (i.e., a request, demand or submission) for property, services, or money to an "authority" (i.e., an executive department of the federal government, such as the U.S. Department of Health and Human Services) when the person or entity "knows or has reason to know" that the claim: (i) is false, fictitious or fraudulent, or (ii) includes or is supported by any written statement which asserts a material fact that is false, fictitious or fraudulent, or (iii) includes or is supported by any written statement that omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact, or (iv) is for the provision of items or services which the person or entity has not provided as claimed.

In addition, it is illegal to make, present or submit (or cause to be made, presented or submitted) a written "statement" (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity "knows or has reason to know" such statement (i) asserts a material fact that is false, fictitious or fraudulent, or (ii) omits a material fact making the statement false, fictitious or fraudulent because of the omission.

Similar to the FCA, the AFCA broadly defines the terms "knows or has reason to know" as (i) having actual knowledge that the claim or statement is false, fictitious or fraudulent, (ii) acting in deliberate ignorance of the truth or falsity of the claim or statement, or (iii) acting in reckless disregard of the truth or falsity of the claim or statement. The law specifically provides that a specific intent to defraud is not required to prove that the law has been violated. The AFCA provides for civil penalties for each false claim paid by the government, and, in certain circumstances, an assessment of twice the amount of each claim.

In addition, if a written statement omits a material fact and is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy

of the contents of the statement, the law provides for a money penalty for each such statement.

The AFCA, codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Violation of the AFCA may include civil money penalties. As of 2025, the civil monetary penalty is approximately $14,308 per false claim or statement, plus an assessment of up to twice the amount of the claim. The amount of the penalty is adjusted periodically for inflation in accordance with a federal formula.

On 12/23/24 the 2025 National Defense Authorization Act was signed renaming the AFCA to the Administrative False Claims Act of 2023 (AFCA) revamping the PFCRA of 1986.

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

The Anti-Kickback Statute (AKS) is a federal criminal statute prohibiting transactions intended to induce or reward referrals for items or services reimbursed by federal healthcare programs. It provides both criminal and civil penalties for violations of the statute. If "one purpose" of the transaction is to induce referrals, then the entire transaction is tainted. This statute is designed to protect federal healthcare program beneficiaries from referral decisions based on monetary influence.

The AKS prohibits the direct or indirect exchange (or offer to exchange), of anything of value, (such as cash, free goods, free services or payment), in an effort to influence the referral of federal health care program business, including Medicare and Medicaid. Although the government must establish intent (an individual knowingly and willfully engaged in the prohibited conduct) in order to convict an individual of the Statute, if one purpose of any payment made is to induce future referrals of federal health care program business, including Medicare and Medicaid, the Anti-Kickback Statute (AKS) has been violated; it does not matter that such a payment was also offered, paid, solicited or received for lawful purpose. The Statute establishes severe monetary and criminal penalties and result in exclusion from participation in federal health care programs. The Patient Protection and Affordable Care Act of 2010 amended the intent requirement to clarify that the government no longer had to prove that the defendant intended to violate the law.

The Statute makes it unlawful for any individual to

1. Knowingly and willfully solicit or receive 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 furnishing or arranging for furnishing of any item of service for which payment may be made in whole or in part under a Federal health care program (such as Medicare) or a State 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 (such as Medicare) or a State health care program

The AKS expressly prohibits anyone from knowingly and willfully soliciting patients, goods, facilities, and services covered under a federal healthcare program for compensation. Further, everyone, including healthcare organizations, is prohibited from offering or paying compensation for referrals of patients, goods, facilities, and services covered under a federal healthcare program. Lastly, attempting to buy, sell, or distribute patient beneficiary identification numbers or providers' health identifier numbers given under Medicare, Medicaid, or SCHIP is strictly prohibited. The Statute makes it unlawful for any individual to:

2. Knowingly and willfully offer to pay any remuneration (including 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.

Penalties: Any person or entity convicted of such conduct is guilty of a felony and "shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both". In addition the Secretary of Health and Human Services (HHS) shall exclude any individual or entity convicted of such conduct from participating in any Federal health care program or State health care program. Even absent a conviction, the Secretary of HHS possesses the discretion and authority to exclude individuals or entities from participating in any Federal health care program or State health care program. The government may also assess civil monetary penalties, which are subject to inflation adjustment and may exceed $1000,000 per violation, plus treble damages.

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor in the statute and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to bona fide employees.

d. Federal Stark Law, 42 U.S.C.A. § 1395nn.

The Stark Law is a healthcare fraud and abuse law that prohibits physicians from referring patients for certain designated health services paid for by federal programs including Medicare to any entity in which they have a "financial relationship." The federal government interprets the term "financial relationship" broadly to include any direct or indirect ownership or investment interest by the referring physician, as well as any financial interests held by any of the physician's immediate family members. Unlike the federal Anti-Kickback Statute, the Stark Law is not a criminal statute. However, the Office of the Inspector General (OIG) for the Department of Health and Human Services ("HHS") can pursue a civil action against Stark Law violators under the civil monetary penalties law. Stark Law violations can result in civil penalties of up to $15,000 for violation (i.e.each billed service that is based on a prohibited referral), plus three times the amount of the government overpayment. Civil penalties are subject to annual inflation adjustments and may exceed $15,000 per service for prohibited referrals.

The Stark Law is a strict liability statute, meaning that proof of a physician's specific intent to violate the law is not required. Therefore, physicians who make prohibited referrals for designated health services even accidentally or unknowingly will still be subject to civil penalties. Physicians who are found to have knowingly and intentionally violated the Stark Law may be subject to increased penalties in the form of an imposed period of debarment or exclusion from participation in Medicare, Medicaid, and all other federal plans and programs that provide health benefits.

There are multiple exceptions to the Stark Law that permit physicians, in certain limited circumstances, to make referrals for federally-covered designated health services. Some of these exceptions include:

- In-Office Ancillary Services Exception – One primary exception permits a group medical practice to make referrals for in-office ancillary services such as laboratory or radiology services.
- Fair Market Compensation Exception – A second useful exception to the Stark Law allows for fair market value compensation. The fair market value exception applies where a compensation arrangement is in writing, specifies a timeframe and the compensation that will be provided, involves a commercially reasonable transaction, and meets the "safe harbors" under the Anti-Kickback Statute.
- Indirect Compensation Exception – Another exception to the Stark Law permits indirect compensation arrangements between a physician and an entity if the compensation received by the referring physician is of fair market value, does not take into account the value or volume of referrals, and is set out in writing and signed by the parties.

- Non-Monetary Exception – This exception to the Stark Law applies to the payment of non-monetary compensation to a physician of up to $300 per year, if the physician did not solicit the compensation and it does not take into the account the volume or value of referrals.

However, irrespective of the application of one or more of these, or other, exceptions, referring physicians must at all times remember that even though an arrangement may fall within one of the exceptions to the Stark Law, if the referrals are being made in exchange for any type of remuneration they may still violate the federal Anti-Kickback Statute.

e. Eliminating Kickbacks in Recovery Act of 2018 (EKRA) 18 U.S.C§ 220

The Eliminating Kickbacks in Recovery Act of 2018 (EKRA) is part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT), which was signed into law on October 25, 2018, and includes provisions on a wide range of topics related to the opioid crisis. It targets patient brokers who seek to profit from illegal patient referrals by prohibiting laboratories, clinics, recovery centers, and other clinical treatment facilities from accepting or paying kickbacks for such referrals.

EKRA applies to services that are paid under any health care benefit program, including both governmental payers and commercial insurers. EKRA prohibits knowingly and willfully:

1. Soliciting or receiving any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient or patronage to a recovery home, clinical treatment facility or laboratory; or
2. Paying or offering any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind
    a. To induce a referral of an individual to a recovery home, clinical treatment facility or laboratory; or
    b. In exchange for an individual using the services of that recovery home, clinical treatment facility or laboratory.

The terms "recovery home," "clinical treatment facility" and "laboratory" are defined in the law. EKRA includes seven statutory exceptions that describe situations where EKRA will not apply, some of which are similar to the federal Anti-Kickback Statute (AKS) safe harbors. However, one big difference between the AKS safe harbors and the EKRA exceptions is how compensation to employees and independent contractors is treated. The EKRA exception:

- Applies to both employees and independent contractors (the AKS safe harbor only protects compensation to bona fide employees); and
- Will only protect payments made by an employer to an employee or independent contractor if the payment is NOT determined by or DOES NOT vary by:
    - the number of individuals referred to a particular recovery home, clinical treatment facility or laboratory;
    - the number of tests or procedures performed; or
    - the amount billed to or received from, in part or in whole, the health care benefit programs of the individuals referred to a particular recovery home, clinical treatment facility or laboratory.

The AKS safe harbor for bona fide employees protects such commission-based compensation methods. As a result, EKRA prohibits certain marketing practices from being used by the substance abuse treatment community and creates criminal penalties (fines of up to $200,000, imprisonment for up to 10 years or both) for each violation.

2. New Jersey Anti-Fraud and False Claims Laws

a. The New Jersey False Claims Act, N.J.S.A. 2A:32C-1 et seq; ("NJ FCA").

The NJFCA is a state law that prohibits, among other things, knowingly presenting or causing to be presented to

an employee, officer or agent of the State of New Jersey, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State. The NJFCA also prohibits conspiring to defraud the State by getting a false or fraudulent claim approved or paid by the State. The NJFCA defines "knowingly" as having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Acts occurring by innocent mistake or as a result of mere negligence will be a defense to an action under the NJFCA.

A person who has violated the NJFCA will be jointly and severally liable to the State of New Jersey for a civil penalty of not less than and not more than the civil penalty allowed under the federal FCA, for each false or fraudulent claim, plus three times the amount of damages which the State sustains (i.e., treble damages). The court may reduce the treble damages to not less than twice the amount of damages the State sustains if the court finds certain factors are met.

Violations of the NJFCA also give rise to liability under the Medical Assistance and Health Services Act (see below), N.J.S.A. 30:4D-17 et seq. Specifically, any person, firm, corporation, partnership, or other legal entity that violates the provisions of the NJFCA will, in addition to other penalties provided by law, be liable for civil penalties of (i) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to the person, firm, corporation, partnership or other legal entity, for the period from the date upon which the payment was made to the date upon which repayment is made to the State of New Jersey; (ii) payment of an amount not to exceed three-fold the amount of such excess benefits or payments; and (iii) payment in the sum of not less than and not more than the civil money penalty allowed under the Federal FCA for each excessive claim for assistance, benefits or payments.

b. <u>Whistleblower Provisions and Protections under the NJFCA, N.J.S.A. 2A:32C-10</u>

A person may bring a civil action for a violation of the NJFCA for the person and for the State of New Jersey. The person must also serve the State Attorney General. If the State Attorney General proceeds with and prevails in an action brought by an individual under the NJFCA, the individual is entitled to at least 15% but not more than 25% of the proceeds recovered under any judgment or any proceeds of any settlement, depending on the extent of the individual's involvement. If the State Attorney General does not proceed with an action, the individual will receive an amount the court decides is reasonable, which will be between 25% and 30% of the proceeds of the action or settlement of a claim.

An employee who is discharged, demoted, suspended, threatened, harassed or any in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the NJFCA, including preliminary investigation, may be entitled to special protection. The protection afforded may include reinstatement with the same seniority status such employee would have had, but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees.

c. <u>The New Jersey Insurance Fraud Prevention Act ("NJIFPA"), N.J.S.A. 17:33A-1 et seq</u>.

The NJIFPA makes it unlawful to (i) present or cause to be presented (including the assisting, conspiring or urging of another to present) any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing the statement contains false or misleading information concerning any fact or thing material to the claim, or (ii) conceal or knowingly fail to disclose the occurrence of an event which effects any person's initial or continued right or entitlement to any insurance benefit or payment or the amount of any benefit or payment to which the person is entitled. A violation of this law can subject a person or entity to civil damages equal to three times the amount of damages, tiered money penalties based upon the number of offenses, and a State surcharge. In addition, the law authorizes the State Attorney General to pursue additional criminal penalties.

d. <u>The NJ Medical Assistance and Health Services Act ("MAHSA"), N.J.S.A. 30:4D-1 et seq</u>.

Provisions in this comprehensive law allow for the imposition of criminal fines and terms of imprisonment for various violations involving the submission of claims for payment under the Medical Assistance Program. For instance, such criminal penalties may be imposed upon a health care provider who willfully receives Medical Assistance payments to which the provider is either not entitled or that are in a greater amount than that to which the provider is entitled. The law also allows penalties to be imposed upon an individual or entity that (i) knowingly and willfully makes or causes to be made any false statement or false representation of a material fact in any claim form in order to receive payment, (ii) knowingly and willfully makes or causes to be made any written or oral false statement for use in determining such payment, or (iii) conceals or fails to disclose the occurrence of an event which affects the right to receive such a payment. Penalties may also be imposed if false statements or representations of a material fact are made in connection with the conditions or operations of any institution during an initial or recertification process entitling the facility to payments under the Medical Assistance Program. Under the MAHSA, it is also unlawful for an individual or entity to solicit, offer or receive a kickback, rebate or bribe in connection with the furnishing of items or services for which payment is made or the furnishing of items or services whose cost is or may be reported to obtain benefits or payments under Medical Assistance Program. In addition to criminal fines and jail sentences, violators of this law are also subject to civil penalties, which can include treble damages, interest on the overpayments, and not less than and not more than the civil penalty allowed under the federal FCA for each false claim submitted.

The director of the program may also take certain actions against individuals and entities found to be in violation of this law. Specifically, the director may suspend, debar or disqualify, for good cause, any provider presently participating or who has applied for participation in the program, or may suspend, debar or disqualify, for good cause, any individual or entity who is participating directly or indirectly in the Medicaid program, including their agents, employees or independent contractors. Additionally, if an individual or entity fails to respond within ten (10) days to any order of the director, or any person designated by the director, requiring payment or re-payment of any amount found to be due under this law, the director may issue certificate to the clerk of the Superior Court of New Jersey stating that the person or entity is indebted to the state for the payment of the outstanding amount.

- **<u>Criminal Penalties, N.J.S.A. 30:4D-17(a)-(d)</u>**

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to $10,000, imprisonment for up to 3 years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to $10,000, imprisonment for up to 3 years, or both; (c) kickbacks, rebates and bribes: fine of up to $10,000, imprisonment for up to 3 years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to $3,000, or imprisonment for up to 1 year, or both. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

- **<u>Civil Remedies, N.J.S.A. 30:4D-7. h., N.J.S.A. 30:4D-17(e)-(i); N.J.S.A. 30:4D-17.1. a.:</u>**

In addition to the criminal sanctions discussed in section 3 above, violations of N.J.S.A. 30:4D-17(a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation: recovery of overpayments, interest, up to triple damages, and, as indicated in section V.D.8, below, a penalty (which was increased from $2,000 to $5,500 to $11,000) for each false claim as a result of the NJ False Claims Act. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

e. Health Care Claims Fraud, N.J.S.A. 2C:21-4.2, 4.3 and 2C:51-5

The crime of Health Care Claims Fraud is committed when a false, fictitious or fraudulent or misleading statement of material fact is knowingly or recklessly submitted (or is attempted to be submitted) or a material fact is omitted from any record, bill, claim or other document in connection with payment or reimbursement for health care services by either a licensed health care practitioner or an unlicensed person. In addition to other criminal penalties allowed by law, the penalty for each violation of this law includes but may not be limited to a fine of up to five times the monetary amount obtained or sought. A health care practitioner may also be subject to additional penalties, including but not limited to, suspension or forfeiture of his/her license.

f. False Claim for Payment of a Government Contract.

Another New Jersey law, N.J.S.A. 2C:21-34 et seq., makes it a crime to (i) knowingly submit to the government any claim for payment for performance of a government contract knowing that the claim is false, fictitious or fraudulent, and (ii) knowingly making a material representation that is false in connection with the negotiation, award or performance of a government contract. The criminal penalties for violations of this law vary from a crime in the fourth degree to a crime in the second degree depending on the amount of the claim.

g. Conscientious Employee Protection Act, Whistleblower Protections.

Under the New Jersey Conscientious Employee Protection Act (CEPA), N.J.S.A. § 34:19-1 et seq., employers are prevented from taking any retaliatory action against an employee who discloses (or threatens to disclose) to a supervisor or to a public body any activity, policy or practice of the employer that the employee reasonably believes is fraudulent or criminal and that may defraud an individual or governmental entity, among others. In addition, the law protects employees who object or refuse to participate in such activity, policy or practice. Specific protection are also given to licensed or certified health care professionals who object to or refuse to participate in any activity, policy or practice that the employee reasonably believes constitutes improper quality of care.

h. The Uniform Enforcement Act, N.J.S.A 45:1-21.b and o.

Provides that a licensure board within the N.J. Division of Consumer Affairs "may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board" who has engaged in "dishonesty, fraud, deception, misrepresentation, false promise or false pretense:, or has "[a]dvertised fraudulently in any manner."

i. Consumer Fraud Act, N.J.S.A 56:8-2, 56:8-31, 56:8-13, 56:8-14 & 56:8-15

Makes unlawful the use of "any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact", with the intent that others rely upon it, in connection with the sale, rental or distribution of any items or services by a person, or with the subsequent performance of that person.

This law permits the N.J. Attorney General, in addition to any other penalty provided by law, to assess a penalty of not more than $10,000 for the first offense and not more than $20,000 for the second and each subsequent offense. Restitution to the victim also can be ordered.

3. Pennsylvania Anti-Fraud and False Claims Laws.

a. Pennsylvania Statutes Title 62 P.S. Poor Persons and Public Welfare § 1407.

Pennsylvania's Medical Assistance (MA or Medicaid) fraud statute, 62 P.S. § 1407, provides that

(a) It shall be unlawful or any person to:

1. Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or

payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.

2. Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the medical assistance program.
3. Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.
4. Submit a claim for services, supplies or equipment which were not rendered to a recipient
5. Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient.
6. Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.
7. Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider.
8. Submit a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item.
9. Submit a claim for a service or item which was not rendered by the provider.
10. Dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient, except in emergency situations, or submit a claim for a service or item which was dispensed, or provided without the consent of the recipient, except in emergency situations.
11. Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without making a reasonable effort to ascertain by verification through a current medical assistance identification card, that the person or patient is, in fact, a recipient who is eligible on the date of service and without another available medical resource.
12. Enter into an agreement, combination or conspiracy to obtain or aid another to obtain reimbursement or payments for which there is not entitlement.
13. Make a false statement in the application for enrollment as a provider.
14. Commit any of the prohibited acts described in section 1403(d)(1), (2), (4) and (5).

(b)

1. A person who violates any provision of subsection (a), excepting subsection (a)(11), is guilty of a felony of the third degree for each such violation with a maximum penalty of fifteen thousand dollars ($15,000) and seven years imprisonment. A violation of subsection (a) shall be deemed to continue so long as the course of conduct or the defendant's complicity therein continues; the offense is committed when the course of conduct or complicity of the defendant therein is terminated in accordance with the provisions of 42 Pa.C.S. § 5552(d) (relating to other offenses). Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of subsection (a), a subsequent allegation, indictment or information under subsection (a) shall be classified as a felony of the second degree with a maximum penalty of twenty-five thousand dollars ($25,000) and ten years imprisonment.
2. In addition to the penalties provided under subsection (b), the trial court shall order any person convicted under subsection (a):

(i) to repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal

rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth;
(ii) to pay an amount not to exceed threefold the amount of excess benefits or payments.

3. Any person convicted under subsection (a) shall be ineligible to participate in the medical assistance program for a period of five years from the date of conviction. The department shall notify any provider so convicted that the provider agreement is terminated for five years, and the provider is entitled to a hearing on the sole issue of identity. If the conviction is set aside on appeal, the termination shall be lifted.
4. The Attorney General and the district attorneys of the several counties shall have concurrent authority to institute criminal proceedings under the provisions of this section.
5. As used in this section the following words and phrases shall have the following meanings:

"Conviction" means a verdict of guilty, a guilty plea, or a plea of nolo contendere in the trial court.
"Medically unnecessary or inadequate services or merchandise" means services or merchandise which are unnecessary or inadequate as determined by medical professionals engaged by the department who are competent in the same or similar field within the practice of medicine.
(c)

1. If the department determines that a provider has committed any prohibited act or has failed to satisfy any requirement under section 1407(a), 2 it shall have the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider in the court of common pleas for twice the amount of excess benefits or payments plus legal interest from the date the violation or violations occurred. The department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider.
2. Providers who are terminated from participation in the medical assistance program for any reason shall be prohibited from owning, arranging for, rendering or ordering any service for medical assistance recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the department or indirect payments of medical assistance funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.
3. Notice of any action taken by the department against a provider pursuant to clauses (1) and (2) will be forwarded by the department to the Medicaid Fraud Control Unit of the Department of Justice and to the appropriate licensing board of the Department of State for appropriate action, if any. In addition, the department will forward to the Medicaid Fraud Control Unit of the Department of Justice and the appropriate Pennsylvania licensing board of the Department of State any cases of suspected provider fraud.

b. <u>Pennsylvania Statutes Title 62 P.S. Poor Persons and Public Welfare § 1408.</u>

Pennsylvania's Medical Assistance (MA or Medicaid) fraud statute, 62 P.S. § 1408, makes it unlawful for a person to:

1. Knowingly or intentionally make or cause to be made a false statement or misrepresentation or to willfully fail to disclose a material fact regarding eligibility, including, but not limited to, facts regarding income, resources or potential third-party liability, for either themselves or any other individual, either prior to or at the time of or subsequent to the application for any medical assistance benefits or payments;
2. Having knowledge of the occurrence of any event affecting his initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;

3. Having made application to receive any such benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally converts such benefit or any part thereof to a use other than for the use and benefit of himself or such other person;
4. Knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of one month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the department) for the treatment of a diagnosed condition of the recipient.
5. Borrow or use a medical assistance identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the medical assistance program if he has not been determined eligible for the program.

Penalties for violations of Section 1408. The law grades violations of Section 1408 according to the total dollar amount of the benefit involved. Penalties for violations of parts 1,2,3 above vary from a third-degree Misdemeanor to Third Degree Felony. Any person violating subsection (a)(1), (2) or (3) commits the grade of crime determined from the following schedule:

Amount of Benefit	Degree of Crime
$3,000 or more	Felony of the third degree
$1,500 to $2,999	Misdemeanor of the first degree
$1,000 to $1,499	Misdemeanor of the second degree
$999 and under or an attempt to commit any act prohibited in subsection (a)(1), (2) or (3)	Misdemeanor of the third degree

Any person committing a crime under Section 1408 (Parts 1-5 above) must also pay restitution of any medical assistance benefits or payments made on behalf of either themselves or another individual, face an administrative penalty of $1,000, and shall upon notification from DPW, forfeit any and all rights to MA benefits for any period of incarceration.
There shall be a five-year statute of limitations on all crimes of Section 1408 and DPW may institute a civil action against violators of parts 1, 3,4, and 5 for the amount of benefits wrongfully obtained by the person, plus legal interest.

c. <u>Pennsylvania Whistleblower Law, 43 Pa, C.S.A. § 1421-1428.</u>

The PA Whistleblower Law applies to all governmental employees and employees or members of any organization which is funded in any amount by or through Commonwealth or political subdivision authority. In essence the Law prohibits employers of the "public body" employees from discriminating against an employee who made a "good faith report" regarding "wrongdoing" or "waste". Specifically the Law states that no employer may discharge, threaten, discriminate or retaliate against an employee who makes a good faith report regarding the employee's compensation, terms and conditions, locations or privileges of employment:

- Because the employee or person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste; or
- Because the employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or court action.

"Good faith report" A report of conduct defined in this act as wrongdoing or waste which is made without malice or consideration of personal benefit and which the person making the report has reasonable cause to believe is true. An employer is not barred from taking disciplinary action against the employee who completed the report if the employee's report was submitted in bad faith.

"Wrongdoing" A violation which is not of a merely technical or minimal nature of a Federal or State statute or

regulation, of a political subdivision ordinance or regulation or of a code of conduct or ethics designed to protect the interest of the public or the employer.

“Waste” An employer's conduct or omissions which result in substantial abuse, misuse, destruction or loss of funds or resources belonging to or derived from Commonwealth or political subdivision sources.

Remedies under the PA Whistleblower Law: Any person alleging a violation of the Law must bring an action of injunctive relief and/or damages within 180 days after the occurrence of the alleged violation. The employee must show that prior to the alleged reprisal, the employee (or someone reporting on the employee’s behalf) verbally or in writing reported, in good faith, an instance of “wrongdoing” or “waste” to the employer. The employer may defend by showing the action taken against the employee was for separate and legitimate reasons and not because the employee’s report of “wrongdoing” or “waste”.
A court, in rendering a judgment in an action brought under this act, shall order, as the court considers appropriate, reinstatement of the employee, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages or any combination of these remedies. A court shall also award the complainant all or a portion of the costs of litigation, including reasonable attorney fees and witness fees, if the complainant prevails in the civil action.

REPORTING VIOLATIONS

Woods Services employees are expected to report any suspected violations of the Code of Conduct and Compliance Plan or other irregularities to their immediate Supervisors/Directors and the Compliance Officer. The Agency also has a dedicated toll-free number to which employees can report issues. To reach the Compliance Hotline, call 1-855-252-7606 or go to https://complianceresource.com/hotline.

Upon receipt of credible reports of suspected irregularities and/or violations, the Compliance Officer shall immediately begin a detailed investigation and take corrective action where appropriate. Woods Services will attempt to treat such reports of suspected irregularities and/or violations of this Code of Conduct confidentially to the maximum extent consistent with fair and rigorous enforcement of the Code of Conduct. Credible or substantiated irregularities and/or violations of the Code of Conduct may result in discipline, up to and including termination.

Alternative means for reporting violations for NJ include the NJ Medicaid Fraud Division Hotline, 888-937-2835 or https://www.nj.gov/comptroller/connect/medcomplaint/ and the New Jersey Insurance Fraud Prosecutor Hotline, 877-55-FRAUD (https://www.njoag.gov/report-fraud/).

Means to report for PA include the PA Health & Wellness Hotline, 866-685-8664 and the PA Department of Human Services Bureau of Program Integrity, 844-347-8477.

Woods Services prohibits retaliation against anyone who, in good faith, reports or participates in the investigation of a violation of this policy.

A violation of this policy may subject Woods Services Personnel to discipline, up to and including termination, of employment or association with Woods Services.