DOCUMENT TITLE: Detecting and Preventing Fraud, Waste, Abuse and Misconduct	SYSTEM POLICY AND PROCEDURE MANUAL
POLICY #: 800.09	**CATEGORY:** Compliance and Ethics
System Approval Date: 07/22/2025❖ **Site Implementation Date:** 07/22/2025❖	**Origination Date:** 01/01/2007 **Previously Reviewed/Approved:** 02/2025
Prepared by: Office of Corporate Compliance	**Notations:** N/A

GENERAL STATEMENT of PURPOSE

It is the obligation of Northwell Health and its affiliated entities ("Northwell Health") to prevent and detect any actions within the organization that are illegal, violative of federal and state health care programs (Medicare, Medicaid, and other governmental payer programs), fraudulent or in violation of any applicable Northwell Health policy. For purposes of this policy, "any applicable Northwell Health policy" shall include policies that are designed to prevent financial wrongdoing; policies prohibiting fraud, theft, embezzlement, bribery, kickbacks and abuse or misuse of corporate assets; conflict of interest policies; policies addressing unethical conduct; and harassment and discrimination policies.

To satisfy this obligation, Northwell Health maintains a vigorous Compliance Program and strives to educate our work force regarding Northwell Health policies, the requirements, rights and remedies of federal and state laws governing the submission of false claims, including the rights of employees to be protected as whistleblowers under such laws and the importance of submitting accurate claims and reports to federal and state governments.

POLICY

Northwell Health prohibits the violation of state and federal law, applicable Northwell Health policy and 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. Any individual who in good faith reports any action or suspected action taken by or within the organization in violation of these laws or that is otherwise illegal, fraudulent or in violation of any applicable policy of Northwell Health shall not suffer intimidation, harassment, discrimination or other retaliation or, in the case of employees, adverse employment consequences.

SCOPE

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell or the Hofstra Northwell School of Nursing and Physician Assistant Studies conducting research on behalf of the Zucker School of Medicine on or at any Northwell Health facility; and any other Affected Individual.

DEFINITIONS

Affected Individuals: "Affected Individuals" is defined as all persons who are affected by Northwell Health's risk areas including, but not limited to, Northwell Health's employees, the chief executive and other senior administrators, managers, medical staff members, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

PROCEDURE

A. Northwell Health Fraud, Waste, Abuse and Misconduct Detection, Prevention and Employee Protection

To assist Northwell Health in meeting its legal and ethical obligations, Northwell Health expects and encourages any employee, contractor, agent or any other Affected Individual who is aware of or reasonably suspects conduct that is illegal, against Northwell Health policy or in furtherance of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a federal or state-funded health care program, to report such information to the individual's supervisor, senior management, the Compliance Director of the Northwell Health facility where the individual is employed, the Chief Corporate Compliance Officer of Northwell Health (516-465-8097), or to call the confidential Compliance HelpLine at (800) 894-3226 which is available 24 hours a day, 7 days a week or by visiting www.northwell.ethicspoint.com and a mobile texting option using the below QR code where individuals can make reports about compliance issues online.

- All reports received by the Office of Corporate Compliance are investigated and resolved to the fullest extent possible. The confidentiality of persons reporting compliance issues shall be

maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by Medicaid Fraud Control Unit, U.S. Department of Health and Human Services (HHS) Office for Civil Rights, HHS Office of Inspector General, Office of Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under Northwell Health's policy for non-intimidation and non-retaliation. Violations of this policy will be subject to disciplinary action as outlined in the Human Resources Policy and Procedure Manual and *Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees*.

Where appropriate, the Chief Corporate Compliance Officer will report the issue to the Board of Trustees Audit and Corporate Compliance Committee. A record will be kept of all whistleblower interactions.

Any individual who reports such information in good faith will have the right and opportunity to do so anonymously and will be protected against intimidation, harassment, discrimination, or other retaliation or, in the case of employees, adverse employment consequences. Northwell Health also prohibits anyone from intimidating an individual into not disclosing compliance concerns.

A good faith report is a report that a whistleblower reasonably believes to be true regarding conduct that the individual reasonably believes to constitute illegal conduct, fraud or a violation of Northwell Health policy. Northwell Health will immediately investigate and take appropriate action with respect to all suspected acts of retaliation or intimidation. Reports will be kept confidential to the extent permitted by law.

Northwell Health obligates itself to swiftly and thoroughly investigate any reasonable and credible report of fraud, waste, abuse, or misconduct or any reasonable suspicion thereof through Northwell Health's Compliance Program.

Northwell Health has the right to take appropriate action against an employee who has participated in a violation of law or Northwell Health policy. The failure to comply with the laws and/or to report suspected violations of state or federal law can have very serious consequences for Northwell Health and for any applicable individual who fails to comply or report a suspected violation. As a Northwell Health employee or any applicable individual, you have an obligation to report concerns using the internal methods listed above and to understand the options available should your concerns not be resolved.

Northwell Health educates its trustees, officers, employees, contractors, agents and volunteers who provide substantial services to Northwell Health on the importance of this policy on a periodic basis through written or oral communications and by distributing a copy of this policy via the Northwell Health public website.

Any person who is the subject of a whistleblower complaint may not be present at or participate in Northwell Health Board of Trustees, or its committee, deliberations or voting on the matter relating to the complaint. The Northwell Health Board of Trustees or its committee can request that person present background information or answer questions prior to the commencement of deliberations or voting.

Any employee who also holds a position on the Northwell Health Board of Trustees shall not take part in any deliberations concerning the administration of this policy.

The following list of relevant state and federal laws is illustrative but non-exhaustive.

B. State and Federal Fraud and Abuse Detection, Prevention and Employee Protection

I. FEDERAL LAWS

False Claims Act (31 U.S.C. §§ 3729-3733)
The False Claims Act ("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 $13,946 and not more than $27,894, plus three times the amount of damages which the Government sustains because of the act of that person…

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

While the FCA imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the Act.

In sum, the FCA imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled and then uses the false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year and then

knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

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

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

Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)
This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $13,946 for each claim. The agency may also recover twice the amount of the claim.

Unlike the FCA, a violation of this law occurs when it is submitted, not when it is paid. Also, unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties are made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

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

The New York False Claims Act closely tracks the Federal FCA. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $13,946 - $27,894 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

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.

OMIG Compliance Program Guidance Title 18 NYCRR § 521
The OMIG guidance requires that as a condition of receiving payment under the Medicaid program Northwell as the provider shall adopt, implement, and maintain an effective compliance program which satisfies the requirements of the guidance.

Social Services Law § 145-b False Statements
It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation for more serious violations of Medicaid rules, including billing for services not rendered, providing excessive services and failing to report and return a Medicaid overpayment. If repeat violations occur within 5 years, a penalty of up to $30,000 per violation may be imposed.

Social Services Law § 145-c Sanctions
If any person applies for or receives public assistance, including Medicaid, and is found to have intentionally made a false or misleading statement for the purpose of establishing or maintaining the eligibility of the individual or of the individual's family for aid or of increasing (or preventing a reduction in) the amount of such aid, then the needs of such individual shall not be taken into account in determining his or her need or that of his or her family (i) for a period of six months upon the first occasion of any such offense, (ii) for a period of twelve months upon the second occasion of any such offense or upon an offense which resulted in the wrongful receipt of benefits in an amount of between at least one thousand dollars and no more than three thousand nine hundred dollars, (iii) for a period of eighteen months upon the third occasion of any such offense or upon an offense which results in the wrongful receipt of benefits in an amount in excess of three thousand nine hundred dollars, and (iv) five years for any subsequent occasion of any such offense.

Social Services Law § 363-d
This statute requires all providers who obtain payment for items or services furnished under any Social Services program, including Medicaid, to adopt and implement a compliance program which satisfies the statute's requirements. These requirements include, but are not limited to, the establishment and implementation of an effective system for routine monitoring and identification of compliance risks, and the establishment and implementation of procedures for promptly responding to compliance issues as they are raised. A provider who fails to implement a compliance program which adheres to the statute's requirements will be subject to a penalty of up to $5,000 per month, as well as additional sanctions, including potential exclusion from the Medicaid program. If repeat violations occur, a penalty of up to $10,000 per month may be imposed.

The statute also requires providers to report, return and explain in writing to the Office of the Medicaid Inspector General any Medicaid overpayments within 60 days of receipt of the overpayment, and specifies when this 60-day time period may be tolled. Providers who fail to comply with this requirement are subject to penalties and sanctions under Social Services Law § 145-b.

CRIMINAL LAWS

Social Services Law § 145 Penalties
Any person, who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment 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.

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 crime 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.

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.

Penal Law Article 176 Insurance Fraud

This statute applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes.

a. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

b. Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the third degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. Insurance fraud in the second degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. Insurance fraud in the first 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.

Penal Law Article 177 Health Care Fraud

This statute applies to claims for health insurance payment, including Medicaid, and contains five crimes.

a. Health care fraud in the fifth degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health care fraud in the fourth degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the third degree is filing false claims and annually receiving over $10,000 in aggregate. It is a Class D felony.

d. Health care fraud in the second degree is filing false claims and annually receiving over $50,000 in aggregate. It is a Class C felony,

e. Health care fraud in the first degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. CONNECTICUT STATE LAWS

Connecticut False Claims Act (Conn. Gen. Stat. §§ 4-275 - 4-289)
The Connecticut False Claims Act (the "CFCA") makes it unlawful for any person to: (1) Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval; (2) Knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim; (3) Conspire to commit a violation of this section; (4) Having possession, custody or control of property or money used, or to be used, by the state, knowingly deliver, or cause to be delivered, less property than the amount for which the person receives a certificate or receipt; (5) Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and intending to defraud the state, make or deliver such document without completely knowing that the information on the document is true; (6) Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the state who may not lawfully sell or pledge the property; (7) Knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state; or (8) Knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the state.

It is a crime in Connecticut to bill Medicaid or the general assistance program fraudulently. All employees, contractors and agents of the Connecticut Department of Children.

Violations of the CFCA are civil offenses and can result in a range of significant monetary penalties, plus three times the amount of damages that the State sustains because of a violation of the CFCA. In addition, certain liabilities may be reduced if the violator furnishes the State with all information known to the violator within thirty (30) days or receiving such information, provided that the violator does not have knowledge of an investigation at the time the violator furnishes such information. See Conn. Gen. Stat §§ 4-275(b)-(c).

Criminal Statutes

Receiving and Paying Kickbacks (Conn. Gen. Stat. § 53a-161d)
A person is guilty of paying a kickback when he knowingly offers or pays any benefit, in cash or kind, to any person with intent to influence such person: (1) To refer an individual, or to arrange for the referral of an individual, for the furnishing of any goods, facilities or services for which a claim for benefits or reimbursement has been filed with a local, state or federal agency; or (2) to purchase, lease, order or arrange for or recommend the purchasing, leasing or ordering of any goods, facilities or services for which a claim of benefits or reimbursement has been filed with a local, state or federal agency. Paying a kickback is a class D felony.

Health Insurance Fraud Act (Conn. Gen. Stat. §§ 53-440 - 443)
A person is guilty of health insurance fraud when he, with the intent to defraud or deceive any insurer, (1) presents or causes to be presented to any insurer or any agent thereof any written or oral statement as part of or in support of an application for any policy of insurance or claim for payment or other benefit from a plan providing health care benefits, whether for himself, a family member or a third party, knowing that such statement contains any false,

incomplete, deceptive or misleading information concerning any fact or thing material to such claim or application, or omits information concerning any fact or thing material to such claim or application, or (2) assists, abets, solicits or conspires with another to prepare or present any written or oral statement to any insurer or any agent thereof, in connection with, or in support of, an application for any policy of insurance or claim for payment or other benefit from a plan providing health care benefits knowing that such statement contains any false, deceptive or misleading information concerning any fact or thing material to such application or claim. For purposes of this section, "misleading information" includes but is not limited to falsely representing that goods or services were medically necessary in accordance with professionally accepted standards.

Any person who violates any provision of sections 53-440 to 53-443, inclusive, shall be subject to the penalties for larceny under sections 53a-122 to 53a-125b, inclusive. Each act shall be considered a separate offense. In addition to any fine or term of imprisonment imposed, including any order of probation, any such person shall make restitution to an aggrieved insurer, including reasonable attorneys' fees and investigation costs.

Vendor Fraud (Conn. Gen. Stat. §§ 53a-290 - 296)
It is a crime to commit vendor fraud. A person commits vendor fraud when acting with intent to defraud provides goods or services to a person receiving benefits from the Connecticut Department of Social Services or a Medicaid recipient and:

- Presented for payment a false claim for goods or services performed;
- Accepted payment for goods or services performed which exceeds the amount due for goods or services performed or the amount authorized by law for the cost of the goods or services;
- Solicited to perform services for or sells goods to a beneficiary, knowing that the beneficiary does not need the goods or services; or
- Accepted additional compensation more than the amount authorized by law from a person or source other than the state of Connecticut.

Additional provisions of law exist. All participants of the Medicaid program are covered under this law.

Larceny (Conn. Gen. Stat. § 53a-119)
A person commits larceny when, with intent to deprive another of property or to appropriate the same to himself or a third person, he wrongfully takes, obtains or withholds such property from an owner. Larceny includes, but is not limited to:

(1) Embezzlement. A person commits embezzlement when he wrongfully appropriates to himself or to another property of another in his care or custody.
(2) Obtaining property by false pretenses. A person obtains property by false pretenses when, by any false token, pretense or device, he obtains from another any property, with intent to defraud him or any other person.

(3) Obtaining property by false promise. A person obtains property by false promise when, pursuant to a scheme to defraud, he obtains property of another by means of a representation, express or implied, that he or a third person will in the future engage in particular conduct,

and when he does not intend to engage in such conduct or does not believe that the third person intends to engage in such conduct.

Material False Statement (Conn. Gen. Stat. Ann. § 19a-500)
A person cannot make a material false statement in a document or record that an institution licensed by the Connecticut Department of Public Health must either submit to the Connecticut Department of Public Health or maintain on file. A person that violates this law faces class A misdemeanor charges.

False or Misleading Statements Regarding Hospitals Receiving State Aid (Conn. Gen. Stat. Ann. § 17b-238)
A hospital receiving aid from the state of Connecticut that submits false or misleading information may have their aid payment suspended. A person that knowingly does either of the following faces class D felony charges: (i) makes a false or misleading statement to the Connecticut Department of Social Services; or (ii) submits false or misleading fiscal information or data to the Connecticut Department of Social Services.

WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. § 3730(h))
The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 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.

New York False Claims Act (State Finance Law § 191)
The New York False Claims Act also provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law § 740
An employer may not take any retaliatory action against an employee if the employee discloses or threatens to disclose information about the employer's policies, practices or activities to a regulatory, law enforcement or similar agency or public official. Protected disclosures are those that an employee reasonably believes; (i) violates a law, rule or regulation; or (ii) poses a substantial and specific danger to the public health and safety.

The law further requires that before disclosing information about the employer's policies, practices or activities to a regulatory, law enforcement or similar agency or public official, the employee first make a good-faith effort to raise the matter with a supervisor ~~a~~nd give the employer a reasonable opportunity to correct the alleged violation. Employees 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 activity; (iii) the activity would endanger the welfare of a minor; (iv) physical harm will result to the employee or another person; or (v) the reporting of such would lead to the destruction of evidence or other concealment of the activity.

New York Labor Law § 741
A health care employer may not take any retaliatory action against an employee if the employee discloses, or threatens to disclose, certain information about the employer's policies, practices or activities to a supervisor, regulatory, law enforcement, other similar agency, public official, news media outlet or social media forum . Protected disclosures are those that are asserted by employees in good faith and with the reasonable belief that the policy, practice or activity constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected only if the employee first brought up the improper quality of patient care to the attention of 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.

New York Not-for-Profit Corporation Law § 715-b
Not-for-Profit Law § 715-b similarly prohibits intimidation, harassment, discrimination, or other retaliation and adverse employment consequences where an employee makes a good-faith report of suspected improper conduct.

Connecticut General Statute § 31-51m
This statute that protects employees against discharge, discipline, or other penalty for reporting a violation or suspected violation of any local, state, or federal law to a public body. The protection applies to both verbal reports and those made in writing, but does not apply when the employee knows that such report is false.

Connecticut General Statute § 4-37j
Requires the establishment of a written policy for the investigation of any matter involving corruption, unethical practices, violation of state laws or regulations, mismanagement, gross waste of funds, abuse of authority or danger to the public safety occurring in such foundation. The statute prohibits any officer or employee from taking or threatening to take any personnel action against any foundation employee who transmits information concerning any such matter, provided that the information is made in good-faith. The policy requires that a copy of such policy be provided to its employees and to periodically notify the employees of the existence of the policy.

Connecticut General Statute § 19a-498a
No health care facility shall discriminate or retaliate in any manner against an employee of such facility because the employee submitted a complaint or initiated or cooperated in an investigation by or proceeding before a governmental entity relating to the care or services by, or the conditions in, such facility.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

- 31 U.S.C. §§ 3729-3733
- 31 U.S.C. § 3730(h)
- 42 U.S.C. §1396a(a)(68)
- Non-profit Revitalization Act of 2013 (S5845/A8072/10365B)
- New York State Labor Law §§740- 741
- New York Not-for-Profit Corporation Law §715-b
- New York State Finance Law § 191
- New York State Social Services Law §§145 and 363
- Penal Law Article 175
- Office of Medicaid Inspector General, Deficit Reduction Act of 2005 References at https://omig.ny.gov/compliance/compliance-library
- OMIG Compliance Program Guidance, Title 18 NYCRR § 521 – Fraud, Waste and Abuse Prevention (March 28, 2023)
- Northwell Health Policy #800.01 – Non-Intimidation and Non-Retaliation
- Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees
- Northwell Health Human Resources Policy and Procedure Manual, Part 5-3 – Workforce Conduct – Progressive Discipline
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
- Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a)
- Eliminating Kickbacks in Recovery Act ("EKRA") (18 U.S.C. § 220)
- Physician Self-Referral ("Stark") Law (42 U.S.C. § 1395nn)
- OIG's Exclusion Statute (42 U.S.C. § 1320a-7)
- Conn. Gen. Stat. §§ 4-275 - 4-289
- Conn. Gen. Stat. § 53a-161d
- Conn. Gen. Stat. §§ 53-440 - 443
- Conn. Gen. Stat. §§ 53a-290 – 296
- Conn. Gen. Stat. § 53a-119
- Conn. Gen. Stat. Ann. § 19a-500
- Conn. Gen. Stat. Ann. § 17b-238
- Conn. Gen. Stat. § 31-51m
- Conn. Gen. Stat. § 4-37j
- Conn. Gen. Stat. § 19a-498a

CLINICAL REFERENCES/PROFESSIONAL SOCIETY GUIDELINES
N/A

ATTACHMENTS
N/A

FORMS
N/A

CURRENT REVIEW/APPROVALS:	
Service Line/Department Review	07/03/2025
Northwell Health Policy Committee	07/22/2025❖
System PICG/Clinical Operations Committee	07/22/2025❖

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Approvals: * =Northwell Health Policy Committee; ** = PICG/Clinical Operations Committee; ◙ = Provisional; ❖ = Expedited

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