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Exhibit(s): Exhibit A: State Laws Pertaining to False Claims and Colleague Protections;		
Document Type: Policy and Procedure		

PURPOSE

The purpose of this Policy is to explain Section 6032 of the Deficit Reduction Act of 2005 and the provisions of the Federal False Claims Act. In addition, this Policy establishes responsibilities of CVS Health® Colleagues to ensure compliance with the Federal False Claims Act, Section 6032 of the Deficit Reduction Act of 2005 and similar state laws.

SCOPE

This document applies to all CVS Health Colleagues, as required by Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), that furnish Medicaid healthcare items or services, perform billing or coding function or are involved in the monitoring of healthcare services for the company.

POLICY

This document is to provide detailed information about CVS Health's commitment to and processes for preventing, detecting, and resolving fraud, waste and abuse. Moreover, this document, pursuant to the DRA, provides detailed information about (i) the federal False Claims Act, (ii) similar state laws, (iii) administrative remedies for false claims and statements, and (iv) applicable Colleague (commonly known as "whistleblower") protections.

CVS Health's Processes for Detecting and Preventing Fraud, Waste and Abuse

1. CVS Health is committed to operating its business with high ethical standards and in compliance with law. This commitment includes complying with all laws that prohibit fraud, waste, and abuse in the government health programs with which CVS Health deals, such as Medicare and Medicaid.
2. CVS Health is committed to proper and timely documentation of all items and services prior to billing to ensure that all such items and services are actually ordered or performed and that appropriate documentation supports all claims. In furtherance of this commitment, CVS Health has established a Compliance Program and detailed policies for detecting, preventing and resolving fraud, waste and abuse.
3. As more fully described in the CVS Health Code of Conduct and related policies and procedures, CVS Health's compliance program consists of the following components:
    a. Designation of high-ranking Chief Compliance Officer and Compliance Structure
    b. Development of Standards/Written Policies and Procedures (Code of Conduct)
    c. Compliance Education and Training
    d. Auditing, Monitoring and Risk Assessment
    e. Communication Systems (Ethics Line)
    f. Response and Prevention—Investigations
    g. Enforcement and Discipline

4. The CVS Health Colleague Handbook further describes the CVS Health mission, values and standards of behavior expected of Colleagues. The CVS Health Colleague Handbook also describes the process to be followed for solving problems.
5. The Compliance and Integrity Group administers the CVS Health Compliance Program and is available to advise and assist in dealing with matters of ethics and/or compliance with laws, regulations and any applicable laws designed to protect federal and state health care programs from fraud, waste and abuse, including the application of such laws to any situation that you may encounter.
6. All CVS Health Colleagues have an affirmative obligation to report any ethical misconduct or compliance concerns such as false claims or false statements, to their manager, the Compliance Officer, or by using the toll-free Ethics Line at 1-877-CVS-2040 (1-877-287-2040); TTY: 711.
7. Examples of federal or state health care program activities that could result in false claims include:
    a. Payment of an incentive when a patient is referred to a CVS Health business.
    b. Provision or receipt of free or significantly discounted billing, rent or other services.
    c. Payment for services in excess of their fair market value.
    d. Forgiveness of a debt absent a charitable or risk management purpose.
    e. Billing for supplies or services not provided or provided in less than billed amounts.
    f. Misrepresenting or overcharging for products or services actually provided.
    g. Duplicate billing for services actually rendered.
    h. Falsely certifying services were medically necessary or failure to perform a service.
    i. Falsely certifying an individual meets the Medicare requirements for certain services.
    j. Seeking to increase reimbursement by improper billing procedures such as "upcoding" (changing a procedure code in order to obtain higher reimbursement for the procedure actually performed), or "unbundling" (dividing a procedure or service into two or more parts to obtain higher reimbursement).
    k. Offering to or transferring money, gifts, or other items of value to a private party in order to receive that party's business.
    l. Accepting money, gifts, or other items of value from a private party.
    m. Accepting and failing to timely refund overpayments from the government.

Information Regarding the Federal False Claims Acts

1. The Federal False Claims Act (the "FCA") helps the Federal government combat fraud and recover losses resulting from fraud in Federal programs, purchases, or contracts. The FCA is found at 31 U.S.C. §§ 3729-3733. Several states have enacted similar laws and detailed descriptions of these laws may be found at the bottom of this document.
2. A person or entity may violate the FCA by knowingly: (a) presenting a false claim for payment, (b) making or using a false record or statement material to a false claim, (c) delivering less than all Government money or property owed, (d) concealing or knowingly and improperly avoiding an obligation to pay the Government, or (e) conspiring to violate any of the above provisions.
3. The FCA imposes civil penalties of $11,000 to $23,000 per claim (as adjusted for inflation annually), plus three times the amount of damages to the Government for FCA violations. Lawsuits must be filed by the later of either: (1) three years after the violation was discovered

by the Federal official responsible for investigating violations (but no more than ten years after the violation was committed), or (2) six years after the violation was committed. In various situations, the government has also attempted to extend the statute of limitations beyond the statutory time frames.

4. An individual has the right to file a civil suit for him or herself and for the Government to challenge a suspected FCA violation. The suit must be filed in the name of the Government. Such an individual is called a *qui tam* plaintiff or "relator." Successful relators may receive between 15 and 30 percent of the total amount recovered (plus reasonable costs and attorney fees) depending on the involvement of the relator and whether the Government prosecuted the case. A *qui tam* lawsuit will be dismissed if the lawsuit is based on public information unless the Government opposes dismissal or the relator is the original source of the information.
5. The FCA contains important protections for whistleblowers. Employees, contractors or agents who file a civil suit to challenge a suspected FCA violation or make other efforts to stop violations of the FCA (including reporting suspected fraud) and consequently suffer discrimination because of their actions (or the actions of others associated with the employee, contractor, or agent in furtherance of such a civil suit or other efforts to stop FCA violations) are entitled to all relief necessary to be made whole. Such relief includes two times their back pay plus interest, reinstatement at the seniority level they would have had except for the discrimination, and compensation for any costs or damages they have incurred. Lawsuits alleging this type of discrimination must be brought within three years of the date the discrimination occurred.

Federal Administrative Remedies

Federal law also provides administrative remedies against any person who makes, or causes someone else to make, a false claim or a false statement in the amount of $5,000 for each false claim or statement, and an assessment of up to twice the amount of each false or fraudulent claim. The administrative remedies for false claims and statements are found at 31 U.S.C. §§ 3801-3812.

State False Claims Acts

Most states have also passed laws prohibiting false or fraudulent claims. Many of these laws mirror the terms of the federal False Claims Act, but some do not. Detailed examples of some state false claims acts are provided in Attachment A as well as citations to relevant laws in other states.

PROCEDURE

NA

DEFINITIONS:

1. **Claim:** For the purposes of the FCA, "claim" includes any request or demand, whether under a contract or otherwise, for money or property whether or not the Government has title to the money or property that (a) is presented to an officer, employee or agent of the Government, or (b) is made to a contractor, grantee, or other recipient if the money or

property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the Government provides or has provided any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

2. **Colleague**: Any full-time, part-time, temporary, or casual employee of CVS Health® and each of its subsidiaries and affiliates, along with paid interns and externs employed by CVS Health® and each of its subsidiaries and affiliates.
3. **CVS Health®:** CVS Health® Corporation and each of its subsidiaries and affiliates.
4. **CVS Health Code of Conduct:** A document that sets forth appropriate legal and ethical behavior which Colleagues must follow. In addition, members of the Board of Directors, when acting in that capacity, must follow.
5. **CVS Health Colleague Handbook:** This document is designed for CVS Health Colleagues and further describes the CVS Health mission, values, and standards of behavior expected of CVS Health Colleagues. The CVS Health Colleague Handbook describes the process to be followed for solving problems. The CVS Health Colleague Handbook is applicable to CVS Health Colleagues only.
6. **False Claim:** For the purposes of the administrative remedies provisions, a "false claim" is defined as a claim that the person knows or has reason to know: is false; includes or is supported by any written statement which asserts a material fact which is false; includes or is supported by any written statement that omits a material fact; is false as a result of such omission; and is a statement in which the person making such statement has a duty to include such material fact; or is for payment for the provision of products or services which the person has not provided as claimed. For purposes of the FCA, a "false or fraudulent claim" also means a claim that includes items or services resulting from a violation of the Anti-Kickback Statute, which is found at 42 U.S.C. §§ 1320-7b. Payments made by, though, or in connection with an American Health Benefit Exchange are subject to the False Claims Act if those payments include any Federal funds.
7. **False Statement**: For the purposes of the administrative remedies provisions, a "false statement" is defined as a statement that the person knows or has reason to know asserts a material fact which is false or omits a material fact that makes the statement false.
8. **Government**: The United States Government.
9. **Knowingly**: For the purposes of the FCA, "knowingly" means that a person: (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.
10. **Material**: For purposes of the FCA, "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.
11. **Obligation**: For purposes of the FCA, "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual or other relationship, from statute or regulation, or from the retention of any overpayment past the deadline for reporting and returning the overpayment. An overpayment must be reported and returned by the later of 60 days after identification of the overpayment, or the date the corresponding cost report is due.

EXHIBIT(S):

Exhibit A
State Laws Pertaining to False Claims and Colleague Protections

As referenced in this policy, the following are detailed summaries of certain state laws. These state summaries are intended to comply with Section 6032 of the Deficit Reduction Act of 2005. This list will be updated from time to time. If you have any questions regarding these summaries or other state laws, please contact the Chief Compliance Officer.

STATE	CITATION
Alabama	**Ala. Code 1975 § 22-1-11**
Alaska	**AS §§ 47.05.210 – 290** **AS §§ 39.90.100 – 120**
Arizona	**A.R.S. § 36-2918; A.A.C. § R9-22-1101** **A.R.S. § 36-2918.01** **A.R.S. § 36-2905.04** **A.R.S. § 13-2311** **A.R.S. § 23-1501**
Arkansas	**Ark. Code Ann. §§ 20-77-901 – 911** **Ark. Code Ann. §§ 5-55-101 *et seq.***
California	**Cal. Gov't Code §§ 12650 – 12656**
Colorado	**Colo. Rev. Stat. §§ 25.5-4-304 - 25.5-4-306; 26-1-127**
Connecticut	**C.G.S.A. § 4-274 *et seq.*, 17b-25a, 17b-99, 17b-102, 31-51m, 31-51q, 53-440 *et seq.*, 53a-118 *et seq.*, 53a-155, 53a-157b, 53a-290 *et seq.*** **Conn. Agencies Reg. §§ 4-61dd-1 *et seq.*, 17-83k-1 *et seq.*, and 17b-102-01 *et seq.***
Delaware	**Del. Code Ann. 6 §§ 1201-1209**
Florida	**F.S.A. §§ 68.081 – 68.092**
Georgia	**Ga. Code Ann. § 49-4-168 - 49-4-168.6;** **Ga. Code Ann. § 23-3-120 to 23-3-127**
Hawaii	**Haw. Rev. Stat. § 661-21 *et seq*;** **Haw. Rev. Stat. § 46-171 *et seq***
Idaho	**Idaho Code § 56-227 - 227A; 56-209h**
Illinois	**740 ILCS 175/1 – 175/8; 740 ILCS 174/1 *et seq***
Indiana	**Ind. Code Ann. §§ 5-11-5.5-1 *et seq.*** **Ind. Code Ann. §§ 5-11-5.7-1 *et seq.*** **Ind. Code Ann. §§ 35-43-5-7.1**
Iowa	**I.C.A. § 249A, 685, and §§ 714.8(10)-714.14**
Kansas	**K.S.A. 75-7501 *et seq.*** **K.S.A. 21-5925 *et seq.***

	K.S.A. 21-5903 **K.S.A. 53-601**
Kentucky	**Ky. Rev. Stat. §§ 205.8463 *et seq*.**
Louisiana	**LSA-R.S. § 46:437.1 *et seq*.**
Maine	**22 M.R.S.§ 15** **26 M.R.S. § 833.**
Maryland	**MD Code Ann. Gen. Prov. § 8-101 *et seq*.** **MD Code Ann. Health-Gen § 2-601 *et seq*.**
Massachusetts	**M.G.L.A. 12 § 5A *et seq*.**
Michigan	**M.C.L.A. 400.602 *et seq*.**
Minnesota	**Minn. Stat. § 15C.01 *et seq***
Mississippi	**Miss. Code. Ann. § 43-13-205 -- § 43-13-233**
Missouri	**Mo. Rev. Stat. § 191.905 - § 191.914** **13 Mo. CSR § 70-3.030**
Montana	**Mont. Code Ann. §§ 17-8-401 – 413, § 45-6-313**
Nebraska	**Neb. Rev. St. §§ 68-934 - § 68–947**
Nevada	**Nev. Rev. Stat. §§ 193.130; 197.160; 357.010 – 357.250; 422.410-422.590**
New Hampshire	**N.H. Rev. Stat. § 167:61-a -- §167:61-e**
New Mexico	**NM Stat. Ann. §§ 27-14-1 *et seq*.; §§ 44-9-1 *et seq*.**
North Carolina	**N.C. Gen. Stat. Ann. § 1-605 *et seq*.** **N.C. Gen. Stat. Ann. § 108A-70.10 to 70.16**
North Dakota	**N.D. Cent. Code § 34-01-20** **N.D.A. Code §§ 75-02-05-05 and 75-02-05-07**
Ohio	**Ohio Rev. Code Ann. §§ 2913.40 - 2913.401** **Ohio Rev. Code Ann. § 5164.35** **Ohio Admin. Code § 4113.51-52**
Oklahoma	**Okla. St. Ann. tit. 56 § 1005 -- § 1007** **Okla. St. Ann. tit. 63 §§ 5053 – 5053.7**
Oregon	**Or. Rev. Stat. § 180.750 to 180.785** **Or. Rev. Stat. § 165.690 to 698** **Or Rev. Stat. § 411.670 to 690** **OAR 410-120-1395 to 410-120-1510** **Or. Rev. Stat. § 646.605 to 646.656** **Or. Rev. Stat. § 166.715 to 166.735** **Or. Rev. Stat. § 659A.199 to 224** **Or. Rev. Stat. § 659A.230 to 659A.233**
Pennsylvania	**62 P.S. § 1407** **43 P.S §§ 1421 *et seq*.**
Rhode Island	**R.I. Gen. Laws § 9-1.1-1 to § 9-1.1-9**

South Carolina	**S.C. Code Ann. § 43-7-60 to 43-7-90**
South Dakota	**SDCL § 22-45-1 – § 22-45-11**
Tennessee	**T. C. A. § 4-18-101 *et seq.*** **T. C. A. § 71-5-181 *et seq.***
Texas	**Tex Hum. Res. § 36.001 *et seq.***
Utah	**Utah Code Ann. § 26-20-1 to 26-20-15**
Vermont	**Vt. Stat. Ann. 32 § 630 *et seq.*** **Vt. Stat. Ann. 33 § 141** **Vt. Stat. Ann. 33 § 143** **Vt. Stat. Ann. 13 § 3016**
Virginia	**Va. Code Ann. §§ 8.01-216.1 – 216.19**
Washington	**Wash. Rev. Code 48.80.010 – 030** **Wash. Rev. Code 74.66.005** *et seq.* **Wash. Rev. Code 74.09.230**
Washington DC	**DC Code § 2-223.01 to 223.05** **DC Code § 2-381.01 to 381.03**
West Virginia	**W. Va. Code § 9-7-5** **W. Va. Code § 9-7-6**
Wisconsin	**W.S.A. § 49.485** **W.S.A. § 49.49**
Wyoming	**Wyo. Stat. Ann. § 42-4-111** **Wyo. Stat. Ann. § 42-4-301 to 306**

Iowa

In addition to the Federal False Claims Act that prohibits fraud in federal healthcare programs, Iowa has several state statutes intended to prevent, detect and punish fraud in Medicaid and other state aid programs. Iowa also provides "whistleblower" protections for those who report wrongdoing related to Medicaid and other state aid programs.

Iowa law imposes civil liability on persons or corporations who knowingly present false or fraudulent claims for payment to the state, present false documents, fail to disclose relevant information, claim services were performed when they weren't, ask for payment for an ineligible person, and avoid paying an obligation to the state. A person or corporation may be ordered to pay up to three times the actual damages to the state and pay a fine in the amount authorized under the Federal False Claims Act.

In Iowa, a person can file suit on behalf of the state in instances of waste, fraud or abuse and may receive between 15 and 25 percent of any recovery in cases where the state intervenes in the case. If the state does not intervene the person may receive between 25 and 30 percent of the recovery. The court may also award attorney fees and other reasonable expenses. The court may also reduce the amount of the award if the plaintiff's complaint is based primarily on publicly disclosed information, or if the plaintiff planned or initiated the fraud. Iowa law also protects whistleblowers from retaliation by their employers for filing a claim under the state false claims

act. Protections include, as appropriate, reinstatement to same job and seniority, two times the amount of any back pay lost, interest on back pay, and any special damages suffered by the employee like attorney fees and litigation expenses.

See Iowa Code Chapters 249A and 695 and Iowa Code §§ 714.8 (10)-714.1

Ohio

In addition to the federal False Claims Act that prohibits fraud in federal healthcare programs, Ohio has several state statutes intended to prevent, detect and punish fraud in Medicaid and other state aid programs. Ohio also provides "whistleblower" protections for those who report wrongdoing related to Medicaid and other state aid programs.

Ohio Revised Code §2913.40 makes it a crime to knowingly make false claims or statements to obtain benefits from the Medical Assistance Program; with the intention to commit fraud, to receive or pay kickbacks, bribes or rebates related to the Medical Assistance Program; or to knowingly falsify, conceal, or destroy records about goods, services, income related to medical assistance reimbursements. Ohio law (§2913.401) also prohibits knowingly making false statements or claims; concealing property or failing to disclose a property transfer that occurred in the 36 months before applying for medical assistance benefits.

In addition, Ohio Revised Code §5164.35 makes it a crime for a provider by deception to obtain or attempt to obtain payments under Ohio Medicaid when not entitled to do so under a provider agreement; to willfully receive a higher payment than authorized under the provider agreement; to falsify any report or document relating to a Medicaid payment; and provides civil penalties for violation of this Section that include interest on overpayments, fines and termination of the provider agreement between the State of Ohio and the provider. A provider's license may also be suspended or terminated.

Ohio law also provides "whistleblower" protections for those who report suspected fraud to proper authorities. Under Ohio Revised Code §4113.51-4113.52, employees who are discriminated or retaliated against because they lawfully report fraud are entitled to relief. Some forms of discrimination and retaliation include removing or suspending the employee; withholding salary increases or employee benefits; transferring or reassigning the employee; and/or reducing employee pay or job status. A court may grant relief for the employee that includes reinstatement to same pay and position, payment of all back wages, reinstatement of benefits and seniority rights or any combination of these. A court may also award all costs associated with litigation, including attorney and witness fees, if a court determines an employer deliberately discriminated or retaliated against an employee who filed a complaint in good faith. Any back pay awarded may also include interest accrued.

See Ohio Revised Code Annotated §§2913.40 and 2913.401; 5164.35; and 4113.51-4113.52

New Jersey

New Jersey has adopted the New Jersey False Claims Act that is similar to the federal False Claims Act ("FCA"). In addition, New Jersey has several other laws that combat fraud, waste and abuse in the Medicaid program.

New Jersey FCA

The New Jersey FCA provides that the following actions are violations:

- Knowingly presents, or causes to be presented, to any employee, officer or agent of the state or to a contractor, grantee, or other recipient of state funds, a false or fraudulent claim for payment or approval;
- 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 state;
- Conspires to defraud the state by getting a false or fraudulent claim allowed or paid;
- Has possession, custody, or control of property or money used, or to be used, by the state and intending to defraud the entity or willfully to conceal the property, delivers, or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
- Is authorized to make or deliver a document certifying receipt of property used or to be used by the state and knowingly makes or delivers a receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that any person who lawfully may not sell or pledge the property; or
- 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 state.

Violation of the New Jersey FCA may result in a penalty that mirrors the federal FCA penalty plus two or three times the amount of damages sustained by New Jersey. Criminal penalties are also available for some knowing submissions of false information to the state. These criminal penalties include imprisonment and fines.

An individual may bring a false claims action in the name of the state. For the individual's part in bringing a successful action, they may be awarded between 10% and 30% of the recovery depending on their level of involvement with the investigation and court proceedings. In addition, the costs, fees and reasonable attorney's fees may also be awarded.

The New Jersey FCA also protects an employee from an employer's discrimination if the employee lawfully brings and action or assists the state in pursuing an action against the employer due to violation of the New Jersey FCA. The employee is specifically protected against discharge, demotion, suspension, threats, harassment, denial of promotion, or any other manner of discrimination. An employer who violates this section shall be liable for all relief necessary to make the employee whole, including 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, compensation for any special damage sustained as a result of the discrimination, and, where appropriate, punitive damages.

Additional New Jersey Laws

New Jersey has other laws pertaining to acts of dishonesty against the Medicaid program. These include:

1. **New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S. 30:4D-17(a)-(d)**

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.

Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a.:

In addition to the criminal sanctions discussed above, violations of N.J.S. 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 a penalty for each false claim that mirrors the penalty amounts under the federal 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.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

2. Health Care Claims Fraud Act

N.J.S. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5

Provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

a. A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;

b. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for not less than 1 year;

c. A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree of that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;
d. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

3. The Uniform Enforcement Act
N.J.S. 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 as engaged in "dishonesty, fraud, deception, misrepresentation, false promise or false pretense:, or has "[a]dvertised fraudulently in any manner."

4. N.J. Consumer Fraud Act
N.J.S. 56:8-2, 56:8-3.1, 56:8-13, 56:8-14 and 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.

5. Conscientious Employee Protection Act,
"Whistleblower Act", N.J.S.A. 34:19-4
New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:
a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee

who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
c. Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
d. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:

i. is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
ii. is fraudulent or criminal; or
iii. is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergent in nature.

For additional information on false claims laws and actions in New Jersey, the following contacts are available:

New Jersey State Department of Health and Human Services: 1-609-826-4701
Toll Free: 1-888-937-2385

New Jersey Medicaid Fraud Division: 1-888-937-2835

Centers for Medicare and Medicaid Services: 1-800-447-8477

N.J. Stat. Ann. §§ 2C:21-4.2-4.3; 2C:51-5 (Health Care Claims Fraud Act); 30:4D-7; 30:4D-17(a)-(d) (New Jersey Medical Assistance and Health Services Act – Criminal Penalties); 30:4D-17(e)-(i) and 30:4D-17.1 (New Jersey Medical Assistance and Health Services Act – Civil Remedies); 34:19-1 *et seq* (Conscientious Employee Protection Act).; and New Jersey False Claims Act, P.L 2007, c.265, N.J. Stat. Ann §2A:32C-1 to 2A:32-17

New York

The state of New York has implemented several laws to combat fraud, waste and abuse of the medical assistance program. These laws include civil and criminal penalties. Civil penalties are available to punish violations of the Social Services Law §145-b, False Statements, regarding the

submission of false statements to a Social Services program including Medicaid and the Social Services Law § 145-c, Sanctions, that punish beneficiaries for using false statements to receive benefits.

Criminal sanctions are available for violators of several criminal laws that protect the Medicaid program from fraud, waste and abuse including various submissions of false statements or false claims including the falsification of business records and knowing submission of claims for payment that intentionally have false information or omissions (Social Services Law § 145, Penalties, and § 366-b, Penalties for Fraudulent Practices; Penal Law Articles 155, Larceny, 175, False Written Statements, 176, Insurance Fraud, and 177, Health Care Fraud).

Additionally, New York Labor Law §§ 740 and 741 provide protections for employees that disclose information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud or information that the employee believes constitute improper quality of patient care. The employee is protected by these laws only if the employee first reported the issue to a supervisor and gave the employer a reasonable opportunity to correct the alleged violation.

New York has adopted a law similar to the federal False Claims Act. The New York False Claims Act ("NYFCA") combats fraud waste and abuse in government programs including the Medicaid program and is detailed below.

Violations and Penalties

The following actions constitute NYFCA violations:

- Knowingly presents, or causes to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval;
- 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 state or a local government;
- Conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid;
- Has possession, custody, or control of property or money used, or to be used, by the state or a local government and, intending to defraud the state or a local government or willfully to conceal the property or money, delivers, or causes to be delivered, less property or money than the amount for which the person receives a certificate or receipt;
- Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee lawfully may not sell or pledge the property; or

- 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 state or a local government.

The person or entity will be liable: (i) to the state for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, as adjusted to be equal to the inflation-adjusted civil penalty allowed under the federal False Claims Act, plus two or three times the amount of damages which the state sustains because of the act of that person; (ii) to any local government for three times the amount of damages sustained by such local government because of the act of that person; and (iii) for the costs, including attorneys' fees, of a civil action brought to recover any such penalty or damages.

In addition, The New York Department of Health can impose civil penalties for false statements made while obtaining or attempting to obtain payment for items or services. The civil penalties include a fine not to exceed $10,000 per violation and, if repeated within 5 years; up to $30,000 per violation.

Notification and Reporting of Violations

After a reasonable and appropriate internal review and investigation, if a violation of law, overpayment, or other reportable compliance issue is confirmed for a CVS Health New York state provider, the following actions will be taken:

Overpayments.

- CVS Health will notify NYS Office of Medicaid Inspector General ("NY OMIG") within sixty days after identification (or such additional time as may be agreed to by NY OMIG) of an overpayment by New York Medicaid. If the overpayment amount has not been quantified within thirty days of identification, CVS Health will notify NY OMIG of its efforts to quantify the overpayment amount along with a schedule of when such work is expected to be completed.

- CVS Health will refund routine overpayments in accordance with CVS Health procedures, payer specific policies and guidelines, and applicable law.

For overpayments of an amount or type that are routinely reconciled or adjusted pursuant to payer policies and procedures, CVS Health will reconcile such overpayments in accordance with such policies and procedures in lieu of the reporting requirement set forth above. Many overpayments and underpayments will be subject to routine reconciliation and adjustment pursuant to payer policies and procedures, including routine reconciliation and adjustment resulting from internal audits and third-party audits.

Violation of Law or Other Reportable Compliance Issue.

- CVS Health will notify the NY OMIG or the NYS DOH within sixty days after confirmation of a reportable compliance issue or violation of law directly pertaining to CVS Health status as a participating provider for the NY Medicaid program.

- Applicable federal agencies will also be notified as appropriate.

Employee Protections

Any employee who has been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against because of his or her involvement in a false claims action is entitled to all relief necessary to make the employee whole including a court order to stop continued discrimination; reinstatement to the position such employee would have had but for the discrimination, including full fringe benefits and seniority rights; two times the amount of back pay plus interest; and compensation for any special damages, including litigation costs and reasonable attorneys' fees.

If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer. New York labor laws also contain a provision specific to health care employers that prohibits them from taking any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. The employee's disclosure is protected only if the employee first raises the matter with a supervisor and gives the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

Actions

The attorney general has the authority to investigate violations and bring a civil action. Local government also has the authority to investigate violations that may have caused damage to the local government and bring appropriate civil actions.

A private individual may bring a civil suit on behalf the state or a local government. The attorney general may choose to intervene in such action and convert the action into a civil enforcement action or he may work with and assist the private individual. The private individual may be entitled to receive 15-30% of the amount recovered through a successful civil action or from the settlement amount, plus costs and attorney's fees. However, if the person bringing the action is also the person who planned or initiated the violation, then the court may reduce or eliminate the share of the individual's proceeds.

NY STATE FIN § 187 – 194; NY SOC SERV § 145-b; NY SOC SERV § 145-c; NY SOC SERV §363-d(g); NY SOC SERV § 366-b; NY PENAL §§ 155.00 - .45; NY PENAL §§ 175.00 - .55; NY PENAL §§ 176.00 - .70; NY PENAL §§ 177.00 - .30; NY LABOR §§ 740 and 741; Title 18 Codes, Rules and Regulations of New York § 521.3(c)(7)