

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SMDL #06-025

Dear State Medicaid Director:

We are writing to offer guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a) (68) of the Social Security Act (the Act), and relates to "Employee Education about False Claims Recovery."

The following definitions are included in the accompanying State Plan Preprint, although additional guidance in this letter further clarifies the Preprint:

An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an entity (e.g., a State mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of "each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

An "employee" includes any officer or employee of the entity,

A "contractor" or "agent" includes any contractor, subcontractor agent or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

It is the responsibility of each entity to establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. Although section 1902(a)(68)(C) refers to "any employee handbook," there is no requirement that an entity create an employee handbook if none already exists.

An "entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The Centers for Medicare & Medicaid Services (CMS) is not providing model language, though States may elect to do so.

The provisions of section 1902(a) (68) of the Act must be implemented no later than January 1, 2007, except as provided in the section 6034(e) delayed effective date of the Deficit Reduction Act of 2005. To the extent a State determines that it requires legislation to implement this section and wishes to avail itself of the section 6034(e) delayed effective date, it must request through CMS that the Secretary concur with the determination that legislation is required.

The requirements of this law should be incorporated into each State's provider enrollment agreements. Each State must also determine the manner by which it will ensure an entity's compliance with section 1902(a) (68), which information each State must include in its State Plan along with a description of the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis. Each State shall so amend its State Plan not later than March 31, 2007, or by the end of the quarter in which the effective date of delayed implementation occurs, as described in section 6034(e). CMS may, at its discretion, independently determine compliance through audits of entities or other means. CMS *may* also review a State's procedures through its routine oversight of States.

If you have any questions on this guidance, please direct them in writing to: Mr. Robb Miller, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 7500 Security Boulevard, Mailstop 82-J 5-24, Baltimore, MD 21244 or Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or rohb.millerrti1@cms.hhs.gov or claudia.simonson@cms.hhs.gov.

Sincerely,

Dennis G. Smith
Director

Enclosure

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cc:

CMS Regional Administrators

CMS Associate Regional Administrators
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Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

Citation
1902(a) (68) of
the Act,
P.L.109-171
(section 6032)

Employee Education about False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a) (68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

Approval Date: _____ Effective Date: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5~000~000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

- (2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

Approval Date: _____ _ Effective Date: _____ _

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

- (5) The State will implement this State Plan amendment on 10/01/2007.

- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a) (68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

Approval Date: _____ Effective Date: _____

Saratoga Pharmacy FALSE CLAIMS ACT POLICY

Purpose of Policy

The purpose of this policy is to ensure that Saratoga Pharmacy does not engage in conduct that violates the federal or state False Claims Act as well as other laws punishing the making of false claims and statements.

Applicable Law

The federal False Claims Act is violated if a person 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 federal government. 31 U.S.C. § 3729. The potential penalties for violating the False Claims Act include treble damages (damages equal to three times the amount of the false claims), civil penalties of up to \$11,000 per claim and exclusion from federal health care programs. In addition, the federal government may impose administrative sanctions of up to \$5,500 plus twice the amount of the false claim under the Federal Program Civil Remedies Act of 1986 (31 U.S.C. § 3801).

A similar New York State False Claims Act (Article 13 of the State Finance Law) covers claims submitted to state or local government agencies. Several other New York State laws also prohibit the making of false claims and statements. Criminal penalties may be imposed for intentionally submitting a false claim to the Medicaid program (Section 366-b of the Social Services Law), knowingly making a false entry in a business record or filing a false instrument with a government agency (Article 175 of the Penal Law), committing a fraudulent insurance act (Article 176 of the Penal Law) or engaging in health care fraud (Article 177 of the Penal Law).

Definitions

Claim means any request or demand for payment submitted to another party if the federal government directly or indirectly covers the cost of any portion of the claim.

Fraud means any type of intentional deception or misrepresentation made by a person with the knowledge that that the deception or misrepresentation could result in some unauthorized benefit to himself/herself or another person.

Knowing and knowingly mean that a person, with respect to information (i) has actual knowledge of the information, (ii) acts in deliberate ignorance of the truth or falsity of the information or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of a specific intent to defraud is required for a person to act knowingly.

Statement of Policy

Types of Conduct Implicating the False Claims Act

Saratoga Pharmacy may be subject to liability under the False Claims Act for knowingly engaging in the following types of conduct:

- Submitting claims to the Medicaid program for services not actually rendered or for which Saratoga Pharmacy is not otherwise entitled to reimbursement.
- Submitting cost reports to Medicaid that are inaccurate or incomplete.
- Failing to bill Medicare or a private insurer as the primary payer prior to submitting a claim to the Medicaid program.

The above list is intended to be illustrative and not exhaustive. False Claims Act liability exists for any knowing submission of false claims or statements that result in payment by a state or federal health care program to which Saratoga Pharmacy is not entitled.

All employees and contractors are strictly prohibited from engaging in any conduct that violates the False Claims Act. Employees and contractors must take all steps specified in this policy to protect Saratoga Pharmacy from False Claims Act liability.

Reporting of False Claims Act Violations by Employees

Employees will be expected to report the preparation or submission to Medicaid or any other state or federal health care program of any claim or report that appears to be false or fraudulent, or any other conduct that appears to violate the False Claims Act. Employees may make such reports through any of the mechanisms described in Saratoga Pharmacy's Whistleblower Policy. All reports received from employees will be evaluated and investigated as necessary pursuant to such policy. Employees are encouraged to contact their supervisor or the Compliance Officer if they have questions as to whether certain practices violate the False Claims Act.

Employees have the legal right to file *qui tam* lawsuits if they become aware that Saratoga Pharmacy has submitted claims for reimbursement to Medicaid or other government programs in violation of the False Claims Act. In a *qui tam* lawsuit, the employee, referred to as a "relator," files the case under seal and requests that the federal government intervene and take over prosecution of the matter. If the case results in a recovery for the government, the relator may be awarded a portion of the funds recovered. Saratoga Pharmacy will not seek to impede any employee from filing a *qui tam* lawsuit, through threats of retaliation or otherwise. However, all employees are encouraged to report and attempt to resolve suspected False Claims Act violations through the internal procedures established by Saratoga Pharmacy prior to filing such a case.

Employee and Contractor Education

Saratoga Pharmacy provides compliance training to all employees. This training will include a component addressing the False Claims Act as well as State laws punishing the making of false claims or statements. Saratoga Pharmacy administrative staff will work with the Compliance Officer to ensure that the Saratoga Pharmacy Employee Handbook contains information about the False Claims Act and relevant state laws. The Compliance Officer will ensure that, in connection with the execution of each contract by Saratoga Pharmacy with a Covered Contractor, the contractor receives a copy of Saratoga Pharmacy's False Claims Act policy as well as pertinent Saratoga Pharmacy policies designed to detect and prevent fraud and abuse. A Covered Contractor shall mean any contractor that furnishes or authorizes the furnishing of items or services covered by Medicaid, performs billing or coding functions, or is involved in the monitoring of health care.

Internal Auditing

The Compliance Officer will ensure that the periodic compliance audits conducted by or on behalf of Saratoga Pharmacy cover the submission of accurate claims and cost reports to the Medicaid program, as well as any other activities deemed by the Compliance Officer to raise potential risks under the False Claims Act. The Compliance Officer will oversee the development and implementation of a corrective action plan to address any compliance issues identified through such audits.

Disclosure of False Claims

Under the False Claims Act, Saratoga Pharmacy may avoid treble damages and civil penalties if it discloses to the relevant federal health care program any false or fraudulent claims, and makes appropriate restitution of any overpayments, within 30 days of discovery of the false claim. Accordingly, the Compliance Officer will promptly investigate all reports of potential False Claims Act violations to provide Saratoga Pharmacy with an opportunity to make disclosure and restitution within this 30-day period.

Record Retention

All records relating to Saratoga Pharmacy's compliance with this policy, including but not limited to, copies of Saratoga Pharmacy employee handbook and anti-fraud policies, will be maintained by the Compliance Officer for a period of six years.

Enforcement

Employees who do not comply with this policy will be subject to disciplinary action by Saratoga Pharmacy. Depending on the facts and circumstances of each case, Saratoga Pharmacy may reprimand, suspend or dismiss any employee who fails to comply with this policy.

Saratoga Pharmacy
FALSE CLAIMS ACT LANGUAGE FOR EMPLOYEE HANDBOOK

The Federal and State False Claims Acts

Scope of the FCA

The federal False Claims Act (the "FCA") is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term "knowingly" means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth. A similar New York State False Claims Act (Article 13 of the State Finance Law) covers claims submitted to state and local government agencies.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include "treble" damages (damages equal to three times the amount of the false claims) and civil penalties of up to \$11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs. Under the State False Claims Act, civil penalties range from \$6,000 to \$12,000 per claim plus treble damages.

Examples of Potential FCA Violations

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting claims to the Medicaid program for services not actually rendered or for which Saratoga Pharmacy is otherwise not entitled to reimbursement;
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports; and
- Knowingly failing to seek payment from other insurers or government programs that provide coverage to a client before billing Medicaid.

The FCA's Qui Tam Provisions

The FCA contains a *qui tam*, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government. These individuals are referred to as "relators." The relator's lawsuit is filed under seal, which means it is kept confidential until the U.S. Justice Department reviews the case and decides whether to take over prosecution of the matter. An individual is considered a relator only if he or she is the "original source" of the report to the federal government. An individual is not the original source if the report involves activities that are already the subject of a government investigation or have previously been disclosed by the provider to the government. If a relator's lawsuit is successful, the relator may receive a share of the award, plus reasonable expenses and attorneys'

fees. While all employees are encouraged to seek to resolve concerns through Saratoga Pharmacys' internal compliance mechanisms, no employee will be impeded from filing a *qui tam* case.

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a *qui tam* lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. Saratoga Pharmacy Whistleblower Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

Federal Program Fraud Civil Remedies Act of 1986

The Federal Program Fraud Civil Remedies Act of 1986 (31 U.S.C. § 3801) authorizes the federal government to impose administrative penalties against any person who files a false claim with certain government agencies, including the U.S. Department of Health and Human Services. The definition of a false claim under this law is similar to the definition under the FCA. The maximum penalties under the law are \$5,500 per false claim and an assessment of twice the amount of the claim.

State Laws Punishing False Claims and Statements

In addition to the State FCA, there are a number of other New York State laws punishing the submission of false claims and the making of false statements:

- Section 145-b of the Social Services Law makes it unlawful for any person to knowingly seek payment of public funds for services furnished under a social services program by making a false statement or deliberately concealing a material fact. Violations of this law may be punished through civil damages equal to three times the amount of the false claims or \$5,000, whichever is greater.
- Section 366-b of the Social Services Law makes it a misdemeanor for any person, with intent to defraud, to present a false or fraudulent claim for Medicaid reimbursement.
- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.

- Article 176 of the Penal Law makes it a misdemeanor to commit a "fraudulent insurance act," which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds \$1,000, the crime is punishable as a felony.
- Article 177 of the Penal Law makes it a misdemeanor to engage in "health care fraud," which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds \$3,000, the crime is punishable as a felony.
- Section 403 of the Insurance Law authorizes the Insurance Department to impose civil penalties for any action that constitutes a fraudulent insurance act under Article 176 of the Penal Law. Civil penalties may be up to \$5,000 plus the amount of the claim for each violation.
- Sections 740 and 741 of the Labor Law prohibit an employer from taking any retaliatory action against an employee because the employee (i) discloses or threatens to disclose to a supervisor or government agency any illegal policy or practice of the employer that threatens public health or safety, or constitutes health care fraud, (ii) provides information to or testifies before any government agency conducting an investigation into such a policy or practice, or (iii) objects to or refuses to participate in any such policy or practice. However, retaliatory action is prohibited only if the employee, prior to providing information to a government agency, notifies his or her supervisor of the illegal policy or practice and affords the employer a reasonable opportunity to correct the problem. An employee subject to illegal retaliation may file a civil action against the employer and is entitled to reinstatement, lost wages and attorneys' fees.

Policies and Procedures to Detect and Prevent Fraud, Waste and Abuse

Saratoga Pharmacy has adopted a Compliance Program to detect and prevent fraud, waste and abuse. The Compliance Program includes a Code of Conduct as well as specific procedures for identifying, reporting, investigating and correcting improper activity. Employees are expected to promptly report any suspected fraud, abuse or other misconduct. Saratoga Pharmacy has established a Compliance Hotline at (585)458-9807. The *hotline* is available from **3pm** to **6am** Monday through Saturday and all day on Sunday. This *hotline* is available for use to any employee wanting to file an *anonymous* report relating to Saratoga Pharmacies' Compliance Program. Leave a detailed message on the voice mail at this number regarding the alleged *compliance misconduct* and the situation will be reviewed and, if warranted, an internal investigation will be started. If it is found that the misconduct report is accurate, all steps will be taken to not only rectify the situation but to prevent future improper compliance program activity. All employees receive basic compliance training, during which they receive a copy of and review the Compliance Program. Annual refresher training through self-learning modules is also provided. In addition, Saratoga Pharmacy has adopted more detailed policies governing the proper performance of sensitive functions such as billing and record keeping that is available to employees engaged in such activities.

Saratoga Pharmacy WHISTLEBLOWER POLICY

Purpose of Policy

The purpose of this policy is to promote Saratoga Pharmacy's compliance with applicable laws and government standards by requiring all Saratoga Pharmacy employees to report suspected fraud or abuse, and ensuring that all reports are handled appropriately and employees filing such reports in good faith are not subject to retaliation.

Applicability of Policy

This policy is applicable to all Saratoga Pharmacy employees.

Statement of Policy

Reporting Responsibilities

It is the responsibility of all employees to report observed or suspected fraud, abuse or other improper activity relating to the operation of Saratoga Pharmacy. For purposes of this policy, *fraud* means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or to Saratoga Pharmacy or to another person. *Abuse* means practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or Saratoga Pharmacy, or in reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care. Fraud or abuse may be committed by Saratoga Pharmacy employees, contractors, patients or others.

Examples of the types of activity that must be reported by employees include, but are not limited to, the following:

- Billing Medicaid or other third-party payers for clients to whom Saratoga Pharmacy has not rendered services.
- Inflating or otherwise misrepresenting Saratoga Pharmacy costs on cost reports filed with government agencies or private funders.
- Billing Medicaid for services rendered to a client if the employee is aware that the client or his or her family has obtained Medicaid coverage fraudulently.
- Submitting inaccurate or misleading data or reports to government agencies.
- Theft or other misuse of Saratoga Pharmacy funds or property by employees or contractors.
- Violations of Saratoga Pharmacy compliance policies or other guidance.
- Violations of laws, regulations or government contracts.

Reporting Mechanisms

Employees have several options for reporting fraudulent, abusive or other improper conduct. Employees may file reports with their supervisor or department director, the Compliance Officer or any other member of the Compliance Committee with whom the employee feels comfortable.

Saratoga Pharmacy has also established a telephone hotline that employees may call to file reports anonymously. The hotline may be accessed by calling (585)458-9807. (Please refer to False Claim Language for Employee Handbook section **Policies and Procedures to Detect and Prevent Fraud, Waste and Abuse** for details on Saratoga Pharmacy's hotline) The Compliance Officer will be responsible for overseeing the operation of the hotline, responding to complaints filed through the hotline and ensuring that all employees are aware of the hotline number and understand that reports may be filed through the hotline on an anonymous basis. The Compliance Officer will also publicize the availability of the hotline through regular reminders, posters and organized compliance awareness events.

As set forth in Saratoga Pharmacy False Claims Act Policy, employees have the legal right to file *qui tam* lawsuits under seal if they become aware that Saratoga Pharmacy has submitted claims for reimbursement to Medicaid or other government programs in violation of the False Claims Act. Employees may not be retaliated against for filing such a lawsuit. Employees will be advised of this right through Saratoga Pharmacy compliance training program and employee handbook, but will be encouraged to report and attempt to resolve compliance concerns through the internal procedures described in this policy.

Investigations

All reports of fraudulent, abusive or other improper conduct, if not made to the Compliance Officer or through the hotline, will be promptly forwarded to the Compliance Officer for review. The Compliance Officer, in consultation with other Saratoga Pharmacy staff and counsel as appropriate, will determine whether the report warrants an investigation. If the Compliance Officer determines an investigation is warranted, he or she will promptly coordinate an investigation in accordance with Saratoga Pharmacy Policy.

Non-Retaliation

No individual who files a report under this policy in good faith may be subject to retaliation in any form. Retaliation is also prohibited against an employee for refusing to carry out any activity that is the subject of a report made under this policy in good faith. No employee may threaten to retaliate against another employee for filing a report. Prohibited retaliation includes, but is not limited to, terminating, suspending, demoting, failing to consider for promotion, harassing or reducing the compensation of an employee due to the employee's intended or actual filing of a report under this policy. Retaliation is prohibited even if it is determined that the allegedly improper conduct was proper or did not occur, provided that the report was made in good faith. Saratoga Pharmacy reserves the right to take disciplinary action against any employee who maliciously files a report he or she knows to be untrue. Any actual or threatened retaliation should be reported by the affected employee or any other employee to the Compliance Officer. The Compliance Officer will investigate such allegations in the same manner as other investigations carried out under this policy.

Enforcement

Employees who do not comply with this policy will be subject to disciplinary action by Saratoga Pharmacy. Depending on the facts and circumstances of each case, Saratoga Pharmacy may reprimand, suspend or dismiss any employee who fails to comply with this policy.

