

MEDISYS AMBULANCE SERVICES

COMMITMENT TO COMPLIANCE

**CODE OF CONDUCT
AND
COMPLIANCE PROGRAM SUMMARY**

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I. PURPOSE

This Commitment to Compliance Handbook establishes the Code of Conduct for MediSys Ambulance Services (the “Company”). It also summarizes how the Compliance Program operates. The Compliance Program is designed to implement the Code of Conduct and prevent violations of applicable laws and regulations and, where such violations occur, to promote their early and accurate detection and prompt resolution through education, monitoring, disciplinary action, and other appropriate remedial measures. All Affected Individuals (as that term is defined below) are expected to read and be familiar with the Code of Conduct and to abide by its requirements, including, but not limited to, requirements for reporting compliance issues and the non-intimidation, non-retaliation policy for good faith participation in the Compliance Program.

II. DEFINITIONS

Affected Individuals. “Affected Individuals” means all employees, executives, governing body members, and any other person or affiliate who is involved in any way with the Company’s entitlement to payment under Federal health care programs or private health insurance plans, including independent contractors, interns, students, volunteers, vendors, and, as relevant, affected appointees.

Federal health care programs. “Federal health care programs” means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans’ programs and the State Children’s Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

III. COMMITMENT TO COMPLIANCE

The Company is committed not only to providing patients with high quality and caring medical services, but also to providing those services pursuant to the highest ethical, business, and legal standards. These high standards apply to our interactions with everyone with whom we deal. This includes our patients, the community, other healthcare providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all Affected Individuals must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. While the legal rules are very important, we must hold ourselves up to even higher ethical standards.

In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Company. We expect and require all Affected Individuals to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Company has prepared a comprehensive Code of Conduct and standards of conduct. The Code of Conduct and standards are designed to assist you in navigating the various compliance obligations of the highly regulated industry in which we do business. By adhering to the Code of Conduct and standards, you enable the Company to

continue to achieve its goal of providing excellent service to our patients in a legal and ethical fashion.

Because of the importance of the Compliance Program, we require that Affected Individuals cooperate fully. All Affected Individuals will be given a copy of this Commitment to Compliance handbook (the "Handbook"). You will be required to review and become familiar with its contents. In addition to this Handbook, the Company will provide you with formal training regarding the Code of Conduct and Compliance Program policies. The Compliance Program standards and policies are maintained by the Chief Compliance Officer and are available to Affected Individuals on the Company's intranet. Hard copies are also maintained in various Company departments.

IV. CODE OF CONDUCT

The Company has adopted the following Code of Conduct as a central part of our Compliance Program. Everyone should adhere both to the spirit and the language of the Code, maintain a high level of integrity in their conduct and avoid any actions that could reasonably be expected to adversely affect the integrity or reputation of the Company. Compliance with the Code of Conduct is a condition of employment, contract or affiliation and violation of the Standards (as defined below) will result in discipline being imposed, up to and including possible termination of employment, contract or affiliation.

- **Honesty and Lawful Conduct.** Affected Individuals must avoid all illegal conduct, both in business and personal matters. No person should take any action that he or she believes violates any statute, rule, or regulation. In addition, Affected Individuals must comply with the Code and departmental compliance policies and procedures, strive to avoid the appearance of impropriety, and never act in a dishonest or misleading manner.
- **Cooperation with the Compliance Program.** We require everyone to cooperate fully with the Compliance Program because the Program is effective only if everyone works together to ensure its success and understands the requirements under the law and the Code. Affected Individuals are expected to cooperate with all inquiries concerning improper business, documentation, coding or billing practices, respond to any reviews or inquiries, and actively work to correct any improper practices that are identified.
- **Reporting Concerns/Raising Questions.** Neither this Handbook nor our overall Compliance Program can cover every situation that you might face. As a result, if you are unsure of what the proper course of conduct might be in a specific situation, or if you believe that the Code of Conduct, Code of Conduct Standards, or any compliance standards or policies (whether set forth in this Handbook or elsewhere) may have been violated, then you are expected to contact the Chief Compliance Officer, who can be reached at:

8900 Van Wyck Expressway
Jamaica, New York 11418
(718) 206-7892

corporatecompliance@jhmc.org

or by calling the

Compliance “Hotline” at 718-206-7892

You may contact the Chief Compliance Officer at any time, either in person, by telephone or in writing, with any compliance-related question or concern you may have. Affected Individuals may report anonymously, if they wish (whether through the Compliance Hotline or otherwise). In addition, all good faith calls to the Hotline will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

- **No Retaliation or Intimidation.** Retaliation or intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct or otherwise participates in the Compliance Program is strictly prohibited. Acts of retaliation or intimidation should be immediately reported to the Chief Compliance Officer or to the Hotline, and if substantiated, the individuals responsible will be appropriately disciplined .

V. CODE OF CONDUCT STANDARDS

The Code of Conduct provides a high-level overview of the expectations that the Company has for Affected Individuals. The Company has also adopted the following standards of conduct (“Standards”) that all Affected Individuals are expected to follow. These Standards outline and summarize the basic concepts underlying the Company’s Code of Conduct and its Compliance Program (which is described in more detail in Section VI below). These Standards must be carefully reviewed and closely followed by all Affected Individuals. Supplemental information relating to these Standards will be provided through periodic formal and informal training and educational programs.

A. Compliance with the Law and High Ethical Business Standards

The Company operates in a heavily regulated industry and is subject to a large number of federal and state civil and criminal laws and regulations. Violation of these laws and regulations can result in harm to the public, severe financial penalties, exclusion from participation in government health care programs (such as Medicare and Medicaid) and – in some cases – criminal fines and/or imprisonment. The Company’s Code of Conduct and Compliance Program are designed to prevent and detect fraud, waste and abuse. Accordingly, it is critical that all Affected Individuals comply with all applicable federal and state laws and regulations and with all policies and procedures that comprise the Compliance Program.

B. Standards Relating to Quality of Care and Services

The Company is fully committed to serving our patients and the community in a way that is second to none in accordance with all applicable laws, rules and regulations. As part of this commitment, the Company will ensure that necessary quality assurance systems are in place and functioning effectively.

- ***Quality of Care Principles.*** In keeping with the Company's mission and values, the following quality of care and services principles have been incorporated into the Company's Compliance Program:
 - The Company will provide appropriate and timely care to all patients without regard to race, religion, age, gender, national origin, sexual orientation, disability or military status and without regard to the patient's insurance coverage.
 - The Company will ensure that patient care conforms to acceptable clinical and safety standards.
 - All patients will receive considerate and respectful care in a clean and safe environment free of all forms of harassment, abuse and unnecessary restraints.
 - The Company will protect and promote the rights of every patient, including, but not limited to, the patient's right to respect, privacy, a dignified existence, self-determination, and the right to participate in all decisions about their own care, treatment and discharge.
 - All patients have the right to formulate advance directives and have company staff comply with these directives.
 - The Company will ensure that all patients are properly evaluated and treated by a qualified practitioner.
 - The Company will provide reasonable accommodations and modifications for patients with disabilities.
 - When a patient presents with an emergency medical condition, Company clinical staff will provide that patient with a screening examination and stabilization of any emergency condition in accordance with applicable laws, rules and regulations, regardless of the patient's ability to pay.
 - Patients will be transferred only after they have been medically stabilized and an appropriate transfer has been arranged.
 - The Company will maintain complete and thorough records of patient information to fulfill the requirements set forth in our policies, accreditation standards and applicable laws and regulations.
 - The Company will conduct background checks pursuant to federal and state law (which includes, but is not limited to, criminal convictions and/or exclusion from participation in any Federal health care program) on all Affected Individuals involved in patient care, or who have access to patients' possessions.
 - The Company will conduct routine checks to ensure that all practitioners employed by, or contracted on behalf of, the Company will have the proper credentials, licensure, experience and expertise required to discharge their responsibilities.

- The Company will continuously strive toward a culture of patient safety and provide quality, medically necessary care to its patients. To this end, we have implemented and maintain an effective, ongoing, company-wide, data-driven quality assessment and performance improvement program.
- The Company will inform each patient (or support person, where appropriate) of their right to receive visitors whom he or she designates, and to withdraw or deny consent to such visitation at any time. The Company will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
- The Company maintains an emergency preparedness program that meets federal and state requirements, including, but not limited to: (i) risk assessment and planning; (ii) policies and procedures; (iii) a communication plan; and (iv) a training and testing program.

C. Standards Relating to Credentialing.

- The Company complies with all applicable federal and state laws, rules and regulations governing the credentialing process. This is a key element to ensuring that the Company provides high quality care and services to its patients. The Company has processes in place for the on-going and continuous credentialing and competency reviews of clinical and non-clinical staff. Moreover, The Company is committed to using good faith efforts to not employ, contract or affiliate with individuals or entities that are currently excluded, debarred or otherwise ineligible to participate in Federal health care programs. The Company has a system for checking such individuals and entities against the government exclusion databases. You are required to notify the Chief Compliance Officer within two (2) business days of being found to have violated the law, or receiving notification that you have been excluded from a Federal health care program.
- **For more information, see the Compliance Reviews for Excluded Individuals/Entities and For Current Licensure and Registration Policy.**

D. Standards Relating to Mandatory Reporting.

- The Company will ensure that all incidents and events that are required to be reported are done so in timely manner to the appropriate agency (including but not limited to Office of Medicaid Inspector General, Federal Office of Inspector General, Centers for Medicare and Medicaid Services, etc.). The Company will also ensure compliance with mandatory reporting obligations under New York's Social Services Law, 18 N.Y.C.R.R. Part 521, and other reporting obligations, as necessary and appropriate.
- All identified overpayments are timely reported, explained and returned in accordance with applicable law and contractual requirements. It is the Company's policy to not retain any funds which are received as a result of

overpayments and to report, return and explain any overpayments from Federal health care programs within 60 days from the date the overpayment was identified (or within such time as is otherwise required by law or contract). Any monies improperly collected from Federal health care programs are promptly refunded to the Department of Health, the Office of the Medicaid Inspector General, the Medicare fiscal intermediary or other payor, as applicable.

E. Standards Relating to Billing and Coding

The Company is committed to conducting the coding, billing and collection process with integrity. We, therefore, adhere to current coding principles and applicable billing laws, regulations and guidelines to facilitate the proper documentation, coding and billing of claims.

- ***Billing Generally.*** In conformity with the Company's mission and values, claims will only be submitted based upon the patient's clinical condition, services actually rendered, and sufficient and adequate documentation of such services. All Affected Individuals responsible for billing will be trained in the appropriate rules governing billing and documentation and will follow all regulations governing billing procedures. Affected Individuals will not knowingly engage in any form of up-coding of any service in violation of any law, rule, or regulation. The Company takes all reasonable steps to ensure that our billing software reliably and accurately codes and bills all services according to the most recent federal and state laws and regulations.
- ***Compliance with Federal and State Laws Regarding the Submission of Claims.*** Affected Individuals shall comply with all applicable federal and state laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in Appendix A to this Handbook. Affected Individuals will receive training on these laws as part of the Company's Compliance Program and should consult with the Chief Compliance Officer (who may confer with the Company's legal counsel, as needed) if they have questions about the application of these laws to their job.

F. Standards Relating to Business Practices

The Company will conduct its business affairs with integrity, honesty and fairness to avoid conflict between personal interests and the interest of our Company. The Company will forego any transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to induce the use of our services.

- ***Accuracy and Integrity of Books and Records.*** The Company keeps accurate books, records, and accounts and accurately reflects the nature of transactions and payments. This includes, but is not limited to, financial transactions, cost reports, and other documents used in the normal course of business. No false or artificial entries shall be made for any purpose. No payment or other remuneration shall be

given or received, nor purchase price agreed to, with the intention or understanding that any part of such payment or remuneration is to be used for any purpose other than that described in the document supporting the payment or other remuneration.

To this end, the Company maintains and monitors a system of internal accounting controls. The Company records and reports facts accurately, honestly and objectively, and does not hide or fail to record any funds, assets, or transactions.

- ***Conflicts of Interest.*** Affected Individuals must exercise the utmost good faith in all transactions that touch upon his or her duties and responsibilities for, or on behalf of, the Company. Even the appearance of illegality, impropriety, a conflict of interest or duality of interests can be detrimental to the Company and must be avoided. All Affected Individuals who are in positions to influence any substantive business decision must complete an annual Conflict of Interest Disclosure Statement, disclosing all direct and familial interests which compete or do business with the Company.
- ***Gifts and Benefits.*** Affected Individuals are strictly prohibited from offering, giving, soliciting or receiving any gift or benefit for personal gain or inducement. This policy applies to our interactions with providers who refer patients to us or to which we make referrals, and to our interactions with our vendors (including, but not limited to, pharmaceutical companies with which we do business). This policy also applies to gifts or benefits received or offered by patients, their families, visitors, or others. The guiding principle is simple: Affected Individuals may not be involved with gifts or benefits that are undertaken: (i) in return for or to induce referrals, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of any of the foregoing) of any item or service.
- ***Compliance with Medicare and Medicaid Anti-Referral Laws.*** Federal and state laws make it unlawful to pay or give anything of value to any individual on the basis of the value or volume of patient referrals. The Company does not pay incentives to any person based upon the number of patients admitted, or the value of services provided, nor does the Company pay physicians, or anyone else, either directly or indirectly, for patient referrals. All financial relationships with other providers who have referral relationships with the Company are based on the fair market value of the services or items provided. All marketing and advertising of services are based solely on the merits of the services provided.

The policy detailing the anti-referral laws is set forth in Appendix B to this Handbook.

G. Standards Relating to Confidentiality and Security

The Company safeguards confidential information regarding its patients, such as individually identifiable health information, and confidential and proprietary information regarding the business of the Company, such as patient lists, development plans, marketing

strategy, financial data, proprietary research, and information about pending or contemplated business deals. Inappropriate disclosure of the Company's confidential business information, whether intentional or accidental, may adversely affect the Company.

Due to this risk of harm to the Company, Affected Individuals who learn confidential business information about the Company or its patients, shall not disclose that information to third parties, including family or friends. This includes, without limitation, disclosure of pictures or any patient information on any form of social media. In addition, Affected Individuals may not disclose such confidential information to any third party after leaving employment except with the prior written consent of the Company, or as required by applicable law.

The Company has also implemented and maintains a HIPAA Compliance Program that addresses privacy and security. Affected Individuals must adhere to the standards of the HIPAA Compliance Program.

VI. COMPLIANCE PROGRAM: DESCRIPTION AND SUMMARY

A. The Compliance Program

The Company's Compliance Program consists of the following core components:

1. **Written Policies and Procedures.** The Company has developed and implemented (and will continue to develop and implement) written policies and procedures addressing our commitment to compliance and specific policies and procedures addressing areas of potential fraud and abuse. The policies have all been formalized in writing and adopted by the Board of Trustees. The Chief Compliance Officer or designee will at least annually (or more frequently as necessary) review all Compliance Program documents and recommend any necessary changes.
2. **Designation of Compliance Officer.** The Company has appointed a Chief Compliance Officer who is responsible for running the day-to-day operations of the Compliance Program. Among other things, the Chief Compliance Officer is responsible for: (i) receiving and responding to all reports, complaints, and questions about compliance issues; (ii) investigating instances of potential legal and ethical violations (and violations of the Code of Conduct); and (iii) taking appropriate corrective action in response to such matters. At the direction of the President and Chief Executive Officer (CEO), the Chief Compliance Officer reports directly to the General Counsel/Chief of Compliance. The Chief Compliance Officer is also authorized to report to the CEO and to the Board of Trustees.

The Chief Compliance Officer will chair a Compliance Committee that is responsible for developing, maintaining, and monitoring the Compliance Program.

3. **Training and Education.** The Company provides Affected Individuals, including board members and senior management, with compliance education and training with respect to the Compliance Program, both through formal, periodic training seminars and by maintaining an open line of communication between Affected Individuals and the Compliance Officer. Such training includes: training for all new employees and board members upon hire or affiliation and an annual review for all Affected Individuals¹ of the requirements of the Compliance Program, including any changes which have been implemented.

For more information see: The Compliance Assurance Monitoring, On-Going Risk Assessment and Training Policy.

4. **Communication Lines to the Chief Compliance Officer.** The Company has established procedures for receiving reports concerning possible violations of relevant laws and regulations, the Code of Conduct, or any specific compliance standards and policies, and for protecting the confidentiality and anonymity of the reporting party so as to open the lines of communication between the Company and its Affected Individuals. Affected Individuals are required to report suspected misconduct, possible violations of Federal or State laws or regulations, or possible violations of the Compliance Program to the Chief Compliance Officer. Affected Individuals may report anonymously, if they so choose (by way of the Hotline or otherwise). In addition, all good faith calls to the Hotline will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

5. **Disciplinary Policies to Encourage Participation in the Compliance Program.** Affected Individuals will be subject to disciplinary action if they fail to comply with any applicable laws or regulations, or any aspect of the Compliance Program. This includes:

- Authorizing or participating in actions that violate federal and/or state laws and regulations, the Code of Conduct, Compliance Standards or applicable departmental compliance protocols;
- Failing to report a violation, or suspected violation, of federal and/or state laws and regulations, the Code of Conduct, Compliance Standards or applicable departmental compliance protocols;
- Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
- Refusing to cooperate in the investigation of a potential violation or resolution of a compliance issue; and

¹ Vendors receive information about the Compliance Program upon affiliation and annually thereafter.

- Intimidating or retaliating against an individual for reporting a compliance violation or otherwise participating in the Compliance Program.

Such disciplinary actions shall be fairly and firmly enforced. The types of discipline imposed will be commensurate with the severity of the violation, ranging from verbal or written warnings to termination of employment, contract, or affiliation, as appropriate.

For more information see: The Protocols for Investigations, Implementing Corrective Action and Discipline Policy

6. **Identification of Compliance Risk Areas and Non-Compliance.** The Company has a process for the routine identification and assessment of compliance risk areas. This process involves the use of periodic reviews, audits, and other practices. As part of that assessment, and in an effort to detect and prevent fraud, waste and abuse, the Chief Compliance Officer, or designee, will periodically monitor and/or conduct specific reviews of the following risk areas: business practices; coding, billing and documentation practices; reviews of high risk departments; issues relating to quality of care and medical necessity of services; the credentialing process; compliance with mandatory reporting requirements; governance; and other potential compliance risk areas that may arise from complaints, Hotline calls, risk assessments, and as identified by specific compliance protocols and elsewhere.

The Chief Compliance Officer, working with the Compliance Committee, will develop an annual Work Plan based on developments arising from internal reviews and issues, external areas of compliance concern, publications and alerts from the New York State Office of the Medicaid Inspector General, and the U.S. Office of Inspector General of the Department of Health and Human Services, among others. The Work Plan will be reviewed and approved by the governing body.

For more information see: The Compliance Assurance Monitoring, On-Going Risk Assessment and Training Policy.

7. **Responding to Compliance Issues.**
 - (a) **Investigations.** Upon receiving a report of possible unethical or illegal conduct, or upon identification of a compliance issue in the course of audits and/or self-evaluations, the Compliance Officer will oversee or conduct a prompt and thorough inquiry into the issue, using outside counsel or consultants as necessary. All Affected Individuals are required to cooperate in such investigations.
 - (b) **Corrective Action and Responses to Suspected Violations.** All Affected Individuals are also required to assist in the resolution of compliance

issues. Corrective action may include: conducting training and re-education; revising or creating appropriate forms; modifying or creating new policies and procedures; conducting internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate; and making voluntary disclosures and/or refunds to appropriate government agencies (e.g., OMIG) or other payers.

For more information see: The Protocols for Investigations, Implementing Corrective Action and Discipline Policy.

8. **Policy of Non-Intimidation and Non-Retaliation.** All Affected Individuals are expected to participate in and comply with this Compliance Program, including the reporting of any violation or compliance issue. Retaliation or intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct or otherwise participates in the Compliance Program is strictly prohibited and is itself a serious violation of the Code of Conduct. Acts of retaliation or intimidation should be immediately reported to the Chief Compliance Officer and, if substantiated, will be disciplined appropriately.

For more information see: the Non-Retaliation and Non-Intimidation for Participation in the Compliance Program Policy and the Protocols for Investigations, Implementing Corrective Action and Discipline Policy.

B. Compliance Responsibilities

- ***Responsibility of the Board.*** The Company's Board of Trustees is responsible for overseeing the operation of the Compliance Program and ensuring that processes are in place so that the Company can operate in compliance with all federal and state laws, rules and regulations.
- ***Responsibility of All Employees.*** All employees are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job within the Company. All employees are also expected to comply with this Code of Conduct, the Code of Conduct standards set forth herein, and any applicable compliance standards and policies adopted by the affiliated entity for which the employee works. Employees must, upon new hire and annual orientation by the Company, sign and date an acknowledgement that they received a copy of the Code of Conduct and Compliance Program Summary and training on the Compliance Program and false claims acts.
- ***Responsibilities of Department Heads, Supervisors and Managers.*** All department heads, supervisors and managers at each affiliated entity have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that those they supervise understand the importance of the Code of Conduct, Standards, and the entity's specific compliance standards and policies; that

Affected Individuals are aware of the procedures for reporting suspected wrongdoing; and that all Affected Individuals are protected from retaliation and intimidation if they come forward with information about such suspected wrongdoing. Department heads, supervisors and managers who receive compliance-related reports must immediately bring such reports to the attention of the Compliance Officer.

- ***Responsibilities of Contractors and Other Providers.*** All persons and entities with which the Company contracts will receive a copy of this Handbook and will be asked to cooperate with the Company's Compliance Program. This includes individual physicians, physician groups, vendors, contractors, and other healthcare providers.

Appendix A

COMPLIANCE WITH APPLICABLE FEDERAL AND STATE FALSE CLAIMS LAWS

MediSys Ambulance Services (the “Company”) is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005 (the “Deficit Reduction Act”), and preventing and detecting any fraud, waste, or abuse in the Company. To this end, the Company maintains a compliance program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to Federal and State governments. The Company has instituted various procedures, which are set forth in our Compliance Manual, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal and State health care programs and otherwise. The Company disseminates this Policy to Affected Individuals, to ensure that such persons are aware of certain relevant Federal and State laws, including that submission of a false claim can result in significant administrative and civil penalties under the Federal False Claims Act and other New York State laws, and also to comply with the Deficit Reduction Act.

POLICY

To assist the Company in meeting its legal and ethical obligations, any Affected Individual who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is required to report such information to his/her supervisor and/or the Company’s Chief Compliance Officer. Anyone who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation and intimidation for coming forward with such information both under our internal compliance policies and procedures, and Federal and State law. However, the Company retains the right to take appropriate action against anyone who has participated in a violation of Federal or State law or the Company’s Policy, or intentionally and maliciously makes a false report regarding fraud, waste or abuse.

The Company commits itself to investigate any allegations or reports of fraud, waste, or abuse swiftly and thoroughly and requires all Affected Individuals to assist in such investigations. If an Affected Individual believes that the Company is not responding to his/her report within a reasonable period of time, he or she should bring these concerns about the Company’s perceived inaction to the Chief Compliance Officer. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the Affected Individual’s obligations to the Company and may result in disciplinary action, up to and including termination of employment, contract or affiliation.

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

The Federal False Claims Act (31 U.S.C. §§ 3729-3733)

The False Claims Act (“FCA”) provides, in pertinent part, that:

- (a) (1) any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or

causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit [the above violations]; ... or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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 \$5,000 and not more than \$10,000¹...plus 3 times the amount of damages which the Government sustains because of the act of that person.

(b) For purposes of this section,

(1) the terms “knowing” and “knowingly” (A) mean that a person, with respect to information-- (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud; and

(2) the term “claim” (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that-- (i) is presented to an officer, employee, or agent of the United States; or (ii) 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 United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

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.

¹ Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation and increased by regulation to not less than \$11,181 and not more than \$22,363 for penalties assessed after January 29, 2018, whose associated violations occurred after November 2, 2015. See 28 C.F.R. §85.5.

In sum, the FCA imposes liability on any person who submits a claim to the Federal government or a contractor of the Federal government that he/she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services he/she knows he/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/she 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 obtains money from the Federal government to which he/she may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” includes a healthcare facility 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. 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, but that shall be not less than 25 percent and not more than 30 percent of the proceeds of the FCA action. In any false claims action, the Government or the *qui tam* relator must prove the allegations by a preponderance of the evidence and may not bring an action more than 10 years after the date on which the alleged violation occurred.

The Program Fraud Civil Remedies Act (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 \$5,000² for each claim. The agency may also recover twice the amount of the claim if the agency has made payment.

Unlike the FCA, a violation of this law occurs when a false claim 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, is made by the administrative agency, not by prosecution in the Federal court system.

II. NEW YORK STATE LAWS

New York’s false claims laws fall into two categories: (1) civil and administrative laws and (2) criminal laws. Some apply to recipient false claims and some apply to provider false

² Although the statutory provisions of the Program Fraud Civil Remedies Act authorizes a penalty up to \$5,000, that amount has been adjusted for inflation and increased by regulation to not more than \$11,181 for penalties assessed after January 29, 2018, whose associated violations occurred after November 2, 2015. See 28 C.F.R. §85.5.

claims, and while most are specific to healthcare or Medicaid, some of the “common law” crimes apply to any manner of interaction with the State government.

A. CIVIL AND ADMINISTRATIVE LAWS

New York False Claims Act (N.Y. State Fin. Law §§ 187-194)

The NY False Claims Act closely tracks the Federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from State or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000 to \$12,000 per claim and the recoverable damages are between two and three times the amount of damages sustained. 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 percent to 30 percent of the proceeds if the government did not participate in the suit or 15 percent to 25 percent if the government did participate in the suit.

Social Services Law 145-b, False Statements (N.Y. Soc. Serv. Law § 145-b)

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 by which the figure is falsely overstated, three times the amount of damages, or \$5,000, whichever is greater. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. 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 (N.Y. Soc. Serv. Law § 145-c)

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of such individual and that of his/her family are not taken into account for 6 months after the first offense, 12 months after the second offense or once the benefits received are between \$1,000 and \$3,900, 18 months after the third offense or once the benefits received are more than \$3,900, and 5 years after any later offense.

B. CRIMINAL LAWS

Social Services Law 145, Penalties (N.Y. Soc. Serv. Law § 145)

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, or assists another in doing so, is guilty of a misdemeanor.

Social Services Law 366-b, Penalties for Fraudulent Practices (N.Y. Soc. Serv. Law § 366-b)

- 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 any 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 (N.Y. Penal Law §§ 155.00-155.45)

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. It has been applied to Medicaid fraud cases.

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

Penal Law Article 175, False Written Statements (N.Y. Penal Law §§ 175.00-175.45)

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- § 175.05, Falsifying business records in the second degree 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.
- § 175.10, Falsifying business records in the first degree includes the elements of the second degree offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
- § 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.

- § 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, any political subdivision, any public authority, or any public benefit corporation. It is a Class E felony.

Penal Law Article 176, Insurance Fraud (N.Y. Penal Law §§ 176.00-176.35)

Applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes. An insurance fraud act involves intentionally filing a health insurance claim knowing it contains materially false information or conceals information concerning a material fact.

- Insurance fraud in the fifth degree involves committing an insurance fraud act. It is a Class A misdemeanor.
- Insurance fraud in the fourth degree involves committing an insurance fraud act for over \$1,000. It is a Class E felony.
- Insurance fraud in the third degree involves committing an insurance fraud act for over \$3,000. It is a Class D felony.
- Insurance fraud in the second degree involves committing an insurance fraud act for over \$50,000. It is a Class C felony.
- Insurance fraud in the first degree involves committing an insurance fraud act for over \$1,000,000. It is a Class B felony.
- Aggravated insurance fraud involves committing an insurance fraud act after being convicted of committing an insurance fraud act within the past 5 years. It is a Class D felony.

Penal Law Article 177, Health Care Fraud (N.Y. Penal Law §§ 177.00-177.30)

Applies to claims for health insurance payment, including Medicaid, and contains five crimes.

- Health care fraud in the fifth degree involves intending to defraud a health plan by knowingly and willfully providing materially false information or omitting material information for the purpose of requesting payment from such health plan. It is a Class A misdemeanor.
- Health care fraud in the fourth degree involves committing health care fraud in the fifth degree and receiving over \$3,000 in the aggregate in one year. It is a Class E felony.

- Health care fraud in the third degree involves committing health care fraud in the fifth degree and receiving over \$10,000 in the aggregate in one year. It is a Class D felony.
- Health care fraud in the second degree involves committing health care fraud in the fifth degree and receiving over \$50,000 in the aggregate in one year. It is a Class C felony.
- Health care fraud in the first degree involves committing health care fraud in the fifth degree and receiving over \$1,000,000 in the aggregate in one year. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. § 373(h))

The FCA provides protection to any employee, contractor or agent who is 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 lawful acts in furtherance of other efforts to stop violations of the FCA. Remedies include reinstatement with comparable seniority as the employee, contractor or agent 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.

NY False Claims Act (N.Y. State Fin. Law § 191)

The 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 an injunction to restrain continued discrimination, 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 (N.Y. Lab. 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 other similar agency or public official. Protected disclosures are those 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 under New York Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes retaliatory action against the employee, the employee may sue in state court for an injunction to

restrain continued discrimination, reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health care 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 Law § 741 (N.Y. Lab. 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 regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that, in good faith, the employee believes relate to improper quality of patient/resident care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or the patient/resident and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If the employer is a health care 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.

Appendix B

ANTI-REFERRAL LAWS AND RELATIONSHIPS WITH OTHER HEALTH CARE PROVIDERS

I. POLICY

In compliance with federal and state anti-referral laws (briefly described below), the Company does not pay incentives to any person based upon the number of patients admitted or the value of services provided, nor does the Company pay physicians, or anyone else, either directly or indirectly, for patient referrals. The decision to refer patients is a separate and independent clinical decision made by the health care provider. Moreover, the Company does not accept any form of remuneration in return for referring its patients to other health care providers. The Company discharges, transfers or refers patients to other providers based on patients' documented medical needs for the referred services and the ability of the referred provider to meet those needs. The Company at all times respects and honors a patient's freedom to choose a health care provider.

II. PROCEDURES

A. Contract/Financial Relationship Reviews

All contracts, leases, and other financial relationships with providers with whom the Company has a referral relationship will be reviewed to ensure compliance with the anti-referral laws, and compliance with any applicable safe harbor or exception under those laws. Thus, for instance, for any such agreement that the Company may enter into, the Company will ensure that it obtains and maintains written and signed agreements covering all time periods for which an arrangement is in place. Moreover, the Company will engage in a process for making and documenting reasonable, consistent and objective determinations of fair-market value and for ensuring that needed items and services are furnished or rendered. In further compliance with the Stark law, the Company has in place a process for tracking non-monetary compensation provided annually to referring physicians.

All contracts, leases, and other financial relationships with other providers who have a referral relationship with the Company will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

Affected Individuals of the Company will not engage in any practice that violates the anti-referral laws or tends to create an appearance of illegality or impropriety, including, but not limited to:

- Free Services. We will not provide free services or items to, or accept free services or items from, another provider with whom a referral relationship exists.
- Fair Market Value. We will not pay or charge excessive amounts above fair market value for providing equipment, space or personnel services, to or from, another

provider. We will not pay or charge amounts below fair market value for providing equipment, space or personnel services, to or from, another provider.

- Joint Ventures. We will not enter into joint ventures with other providers when applicable safe harbors or exceptions under the anti-referral laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.
- Discounts. Any discount that the Company receives for items or services purchased will be in accordance with the discount safe harbor to the Anti-Kickback Statute. Among other things, that means that discounts will be in the form of a price reduction based on an arm's length transaction and will be properly disclosed and accurately reflected on the institutional cost report.

B. Marketing Activities

All marketing activities and advertising must be based on the merits of the services provided and not on any promise, expressed or implied, of any remuneration for referrals. In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. The Company's best advertisements pertain to the quality of its services. Affected Individuals should not disparage the service or business of a competitor through false or misleading representation.

III. OVERVIEW OF THE ANTI-REFERRAL LAWS

A. Anti-Kickback Statutes

Federal and state laws make it unlawful to pay any individual on the basis of the value or volume of referral of patients. The federal and state Anti-Kickback Statutes prohibit giving or receiving any remuneration (which includes, without limitation, money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid for by Medicare or Medicaid. The federal law contains certain statutory exceptions. Regulations describing additional exceptions for certain business arrangements and payment practices – known as “safe harbors” – also exist. Each exception/safe harbor has a number of specific requirements. Compliance with each requirement of all applicable safe harbors/statutory exceptions removes the risk of criminal, civil or administrative action pursuant to the Anti-Kickback Statute. Failure to fall squarely within a safe harbor or exception, however, does not necessarily render an arrangement illegal per se or otherwise actionable. Instead, in such cases, the arrangement will be analyzed in light of the governing law and regulations and, in particular, the intent of the parties.

B. Physician Self-Referral Laws

The physician self-referral laws (the “Stark” laws) forbid referrals between physicians and health care entities that have certain prohibited financial relationships. Under the Stark laws, a physician cannot refer patients to entities furnishing “designated health services” (“DHS”) which are payable under Medicare (and possibly Medicaid) if the physician or his or her immediate family members have a financial interest in that entity. A prohibited financial

relationship includes an ownership or investment interest and any compensation arrangement. Like the Anti-Kickback exceptions/safe harbors, the “Stark” exceptions are often very complex and very detailed. If the Stark law is implicated, all relevant exceptions must be squarely met, or the law will have been violated (i.e., Stark, unlike the Anti-Kickback Statute, is a “strict liability” law. In other words, under Stark, the intent of the parties is irrelevant). For more information, please see the Physician Self-Referral (Stark) Law Policy.