COMMITMENT TO COMPLIANCE

CODE OF CONDUCT

AND

COMPLIANCE PROGRAM SUMMARY

SEPTEMBER 2009

REVIEWED: 3/12, 9/13, 5/14, 6/15

REVISED: 8/12, 8/16, 7/17, 2/18, 7/18, 3/20, 3/21, 2/22, 8/22, 4/23, 6/24, 5/25, 5/26

I. **Purpose**

This Commitment to Compliance Handbook establishes the Code of Conduct for Jamaica Hospital Medical Center (the "Hospital"). 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, including Federal health care program requirements (*e.g.*, the Medicare and Medicaid programs) 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-intimation, non-retaliation policy for good faith participation in the Compliance Program.

II. **Definitions**

Affected Individuals. "Affected Individuals" means all persons who are affected by the Hospital's compliance risk areas, including employees; the Chief Executive; other senior administrators and managers; contractors, agents, subcontractors, and independent contractors ("Contractors"); governing body members and corporate officers. Contractors are only subject to the Hospital's compliance program to the extent it is related to their contracted role and responsibilities within the Hospital's identified risk areas.

Compliance Committee. "Compliance Committee" means the group of senior managers that the Hospital has designated to coordinate with and assist the Chief Compliance Officer in overseeing and carrying out aspects of the Program.

Chief Compliance Officer. "Chief Compliance Officer" means the person designated by the Hospital with responsibility for the day-to-day operation of the Program.

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.

Good Faith Participation in the Compliance Program. "Good faith participation in the Compliance Program" includes, but is not limited to the following actions:

- Reporting potential compliance issues to appropriate Personnel (e.g., the Chief Compliance Officer);
- Cooperating with/participating in the investigation of potential compliance issues;
- Assisting the Hospital with self-evaluations and audits;
- Assisting the Hospital with implementing remedial actions;

- Reporting instances of intimidation or retaliation; and
- Reporting potential fraud, waste or abuse to appropriate state or federal entities.

III. COMMITMENT TO COMPLIANCE

The Hospital 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 Hospital. 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 Hospital 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 Hospital 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 Hospital will provide our personnel, including employees, the Chief Compliance Officer, the Chief Executive and other senior administrators, managers and Board members 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 Hospital's intranet. Hard copies are also maintained in various Hospital departments.

IV. CODE OF CONDUCT

The Hospital 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 Hospital. 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.** Affected Individuals must refuse to participate in unethical or illegal conduct, and must report any unethical or illegal conduct to the Chief Compliance Officer. In addition, as neither this Handbook nor our overall Compliance Program can cover every situation that you might face, 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). All good faith reports will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement or if disclosure is a requirement in connection with a legal proceeding.

- **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. For more information, see the policy entitled "Non-Retaliation and Non-Intimidation for Participation in the Compliance Program" in Appendix C to this document.

V. CODE OF CONDUCT STANDARDS

The Code of Conduct provides a high-level overview of the expectations that the Hospital has for Affected Individuals. The Hospital 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 Hospital'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 Hospital 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 federal health care programs (such as Medicare and Medicaid) and – in some cases – criminal fines and/or imprisonment. The Hospital'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, federal health care program requirements and with all policies and procedures that comprise the Compliance Program.

B. Standards Relating to Quality of Care and Services/Medical Necessity

The Hospital 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 Hospital will ensure that necessary quality assurance systems are in place and functioning effectively.

- ***Quality of Care Principles***. In keeping with the Hospital's mission and values, the following quality of care and services principles have been incorporated into the Hospital's Compliance Program:
  - The Hospital will provide appropriate, timely and medically necessary 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 Hospital 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 Hospital 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 hospital staff comply with these directives.

- The Hospital will ensure that all patients are properly evaluated and treated by a qualified practitioner.

- The Hospital will provide reasonable accommodations and modifications for patients with disabilities.

- When a patient presents with an emergency medical condition, Hospital 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 Hospital 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 Hospital 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.

- The Hospital will conduct routine checks to ensure that all practitioners employed by, or contracted on behalf of, the Hospital will have the proper credentials, licensure, experience and expertise required to discharge their responsibilities.

- The Hospital 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, hospital-wide, data-driven quality assessment and performance improvement program.

- The Hospital 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 Hospital 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 Hospital 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 Billing, Coding and Payments

The Hospital 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 Hospital'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 Hospital 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 Hospital's Compliance Program and should consult with the Chief Compliance Officer (who may confer with the Hospital's legal counsel, as needed) if they have questions about the application of these laws to their job.

- The Hospital does not retain any payments to which it is not entitled. The Hospital will timely report, return and explain any identified overpayments in accordance with applicable law, rules, regulations and contractual requirements. ***For more information, see "Mandatory Reporting" below.***

D. Standards Relating to Credentialing

- The Hospital complies with all applicable federal and state laws, rules and regulations governing the credentialing process. This is a key element to ensuring that the Hospital provides high quality care and services to its patients. The Hospital has processes in place for the on-going and continuous credentialing and competency reviews of clinical and non-clinical staff. Moreover, The Hospital 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 Hospital 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.**

E. **Standards Related to Governance**

- The Hospital has integrated the Program into its operations and the Program is supported by the highest levels of the organization, including the Chief Executive, senior management, and the governing body. The Hospital's governing body, Chief Executive, and Compliance Committee receive reports from the Chief Compliance Officer no less frequently than quarterly regarding the status of the Program, including results of any internal or external audits and annual Program reviews.

- The governing body ensures that the Chief Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Program based on the Hospital's risk areas and organizational experience.

- The governing body ensures that the Chief Compliance Officer and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their responsibilities.

F. **Standards Relating to Mandatory Reporting**

- The Hospital 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 Hospital 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 Hospital'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.

- Moreover, in some circumstances (e.g., after an internal investigation confirms possible fraud, waste, abuse) and with the assistance of legal counsel, as necessary and appropriate, the Hospital will avail itself of the appropriate self-disclosure process (e.g., to the New York State Department of Health, Office of the Medicaid Inspector General, Federal Office of Inspector General, etc.).

G. Standards Related to Ordered Services

Physicians and other practitioners that order services for the Hospital's Medicaid program recipients must ensure such orders are in accordance with the patient's treatment plan, are in writing (or if given verbally in an emergency, followed by a written order), and that payment of any item of medical care is made only to the provider who actually furnished such care, not to the ordering physician/practitioner.

H. Standards Relating to Business Practices

The Hospital will conduct its business affairs with integrity, honesty and fairness to avoid conflict between personal interests and the interest of our Hospital. The Hospital 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 Hospital 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 Hospital maintains and monitors a system of internal accounting controls. The Hospital 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 Hospital. Even the appearance of illegality, impropriety, a conflict of interest or duality of interests can be detrimental to the Hospital 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 Hospital.

- ***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 Hospital does not pay incentives to any person based upon the number of patients admitted, or the value of services provided, nor does the Hospital pay physicians, or anyone else, either directly or indirectly, for patient referrals. All financial relationships with other providers who have referral relationships with the Hospital 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.

I. Standards Relating to Contractor Oversight

The Chief Compliance Officer will ensure that contracts with Contractors specify that such individuals/entities are subject to the Hospital's Program, to the extent that such individuals/entities are affected by the Hospital's compliance risk areas. The Hospital will confirm the identity and determine the exclusion status of Contractors affected by the Hospital's compliance risk areas. All such contracts must include termination provisions for failure to adhere to the Hospital's Program requirements.

J. Standards Relating to Confidentiality and Security

The Hospital safeguards confidential information regarding its patients, such as individually identifiable health information, and confidential and proprietary information regarding the business of the Hospital, such as patient lists, development plans, marketing strategy, financial data, proprietary research, and information about pending or contemplated business deals. Inappropriate disclosure of the Hospital's confidential business information, whether intentional or accidental, may adversely affect the Hospital.

Due to this risk of harm to the Hospital, Affected Individuals who learn confidential business information about the Hospital 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 Hospital, or as required by applicable law.

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

1. **Written Policies and Procedures**. The Hospital 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, no less than annually, review these documents to determine if they (i) have been implemented; (ii) are being followed by all Affected Individuals; (iii) are effective and (iv) require any updates.

The Hospital's written Compliance Policies and Procedures and the Code of Conduct are designed to:

- articulate the Hospital's commitment and obligation to comply with all applicable federal and state standards;
- describe compliance expectations as embodied in the Code of Conduct Standards;
- implement the operation of the Compliance Program;
- provide guidance to all Affected Individuals on dealing with potential compliance issues;
- identify how to communicate compliance issues to appropriate compliance personnel;
- describe how potential compliance issues are investigated and resolved;
- include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to:
    - Reporting potential compliance issues to appropriate Personnel (e.g., the Chief Compliance Officer);
    - Cooperating with/participating in the investigation of potential compliance issues;
    - Assisting the Hospital with self-evaluations and audits;
    - Assisting the Hospital with implementing remedial actions;
    - Reporting instances of intimidation or retaliation; and
    - Reporting potential fraud, waste or abuse to appropriate state or federal entities.

- establish disciplinary standards for Affected Individuals who fail to comply with the written policies and procedures, standards of conduct, or state and federal laws, rules and regulations; and

- include all requirements listed under Section 6032 of the Deficit Reduction Act of 2005 (42 U.S.C. § 1396a[a][68]) as to maintaining and disseminating policies regarding false claims laws and whistleblower protections.

2. **Designation of Compliance Officer and Compliance Committee.** The Hospital 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 ensuring that all elements described herein are in effect and are fully operational, including, but not limited to, overseeing and monitoring the adoption, implementation and maintenance of the Program and evaluating its effectiveness.

   - At the direction of the President and Chief Executive Officer (CEO), the Chief Compliance Officer reports directly and is accountable to the Vice President of Legal Affairs and Corporate Compliance, General Counsel. The Chief Compliance Officer is also authorized to report to the CEO and to the Board of Trustees.

   - The Chief Compliance Officer chairs a Compliance Committee, which has been formed to coordinate activities with the Chief Compliance Officer to ensure that the Hospital is conducting its business in an ethical and responsible manner, consistent with its Program. The Compliance Committee meets at least quarterly and also directly reports and is accountable to the Vice President of Legal Affairs and Corporate Compliance, General Counsel.

   For more information see: The Compliance Personnel Policy.

3. **Training and Education**. The Hospital's compliance training and education program is designed to train and educate our Personnel, including the Chief Compliance Officer, the Board of Trustees, the CEO, senior administration, managers, and employees.[1] Our training and education covers, among other things, compliance issues/risk areas, expectations and the operation of the Compliance Program. At a minimum, such training will take place annually and will be made part of the orientation for all new employees promptly upon hire and upon new appointment of a CEO, manager or Board member.

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

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

4. **Effective Lines of Communication**. The Hospital has established and implemented effective lines of communication, ensuring confidentiality, between the Chief Compliance Officer, members of the Compliance Committee and the Hospital's employees, managers and the Board of Trustees. The lines of communication are accessible to all Affected Individuals and all patients receiving services from the Hospital.

    - 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 reports will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement, or if disclosure is a requirement in connection with a legal proceeding.

5. **Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program**. The Hospital has established well-publicized disciplinary standards to encourage good faith participation in the Compliance Program by all Affected Individuals. 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:

    - Failure to report suspected problems;
    - Participating in non-compliant behavior;
    - Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
    - Failure by a violator's supervisor(s) to detect and report a compliance violation, if such failure reflects inadequate supervision or lack of oversight;
    - Refusal to cooperate in the investigation of a potential violation; and
    - Retaliation against, or intimidation of, an individual for his or her good faith participation in the 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. **<u>The System for Routine Monitoring and Identification of Compliance Risk Areas</u>**. The Hospital has established and implemented procedures and a process for the routine identification and assessment of compliance risk areas relevant to its operations. This process includes internal, and, as appropriate, external reviews, audits, and other practices to evaluate the Hospital's continuous compliance with federal health care program requirements (*e.g.,* the Medicare and Medicaid Programs) and the overall effectiveness of the Program.

   - The Chief Compliance Officer (or a designee) will ensure that internal and external audits, as appropriate, are conducted by auditors with expertise in Federal health care program (e.g., Medicare and Medicaid) requirements and applicable laws, rules and regulations, or have expertise in the audit subject areas. The Chief Compliance Officer and Compliance Committee will also audit and monitor the operation of the Program to determine its effectiveness.

   - The Chief Compliance Officer will monitor areas where there is potential for fraud, waste or abuse. This includes, but is not limited to, reviews of the Hospital's billing and payment practices, business practices, quality of care/medical necessity issues, ordered services; mandatory reporting requirements; the credentialing process, governance standards, contractor oversight and other compliance risk areas that may arise.

   - The Chief Compliance Officer and Compliance Committee will formulate an annual Compliance Work Plan based on developments arising from internal or external reviews and from other areas of compliance concern. The Work Plan will outline the Hospital's strategy for maintaining an effective Program. The annual 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. **<u>The System for Promptly Responding to Compliance Issues</u>**.

   The Hospital has established and implemented procedures and a system for promptly responding to and investigating potential compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with the federal health care program requirements (*e.g.,* the Medicare and Medicaid Programs).

   Corrective action will be implemented promptly and thoroughly and may include (but is not necessarily limited to): conducting training and education; revising or

creating appropriate forms; modifying or creating new Compliance Policies and Procedures; conducting additional internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate; refunds to appropriate payers and/or self-disclosing to appropriate government agencies (*e.g.,* the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services, Office of Inspector General or the Centers for Medicare and Medicaid Services) or other appropriate parties. Corrective Action Plans and other corrective actions will continue to be monitored after they are implemented to ensure that they are effective.

All Affected Individuals are required to cooperate in compliance investigations and to assist in the resolution of compliance issues.

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 reports a compliance issue in good faith or for other good faith participation 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 (Appendix C to this document) and the Protocols for Investigations, Implementing Corrective Action and Discipline Policy.

B. Compliance Responsibilities

- ***Responsibility of the Board***. The Hospital's Board of Trustees is responsible for overseeing the operation of the Compliance Program and ensuring that processes are in place so that the Hospital 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 Hospital. 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 Hospital, 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 Hospital contracts will receive a copy of this Handbook and are required to adhere to and cooperate with the Hospital's Compliance Program. This includes individual physicians, physician groups, vendors, Contractors, and other health care providers.

Appendix A

COMPLIANCE WITH APPLICABLE FEDERAL AND STATE FALSE CLAIMS LAWS

Jamaica Hospital Medical Center (the "Hospital") 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 Hospital. To this end, the Hospital 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 Hospital 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 Hospital 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 Hospital 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 Hospital'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 Hospital retains the right to take appropriate action against anyone who has participated in a violation of Federal or State law or the Hospital's Policy, or intentionally and maliciously makes a false report regarding fraud, waste or abuse.

The Hospital commits itself to investigating 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 Hospital is not responding to his/her report within a reasonable period of time, he or she should bring these concerns about the Hospital'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 Hospital 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

A. 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 $10,000[1]…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.

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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 $14,308 and not more than $28,619 for penalties assessed after July 3, 2025, 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.

B. <u>The Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801-3812)</u>

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 $5,000[2] 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 $14,308 for penalties assessed after July 3, 2025, 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

1. 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 per claim penalty for filing a false claim is the same as the penalty range that may be imposed under the Federal False Claim Act, subject to adjustments for inflation 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.

2. 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.

3. 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

1. 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.

2. **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.

3. **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.

4. **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.

5. 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.

6. 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

A. 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.

B. 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.

C. New York Labor Law § 740

Labor Law § 740 prohibits the taking of "retaliatory" action by an employer against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

(a) discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee

reasonably believes poses a substantial and specific danger to the public health or safety; [2]

(b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or

(c) objects to, or refuses to participate in, any such activity, policy or practice.

Under Section 740, "retaliatory action" is defined to mean an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under Section 740. This includes: (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment (including but not limited to discharge, suspension, or demotion); (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member.

If an employer takes a retaliatory action against the employee, the employee may bring a civil action within two years after the alleged retaliatory action was taken. The parties to such an action are entitled to a jury trial. A court may order: an injunction to restrain continued violation of the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay;" the reinstatement of full fringe benefits and seniority rights; the compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

2. New York Labor Law § 741

Section 741 prohibits certain defined health care employers from taking "retaliatory action" against an employee because the employee does any of the following:

(a) discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

(b) objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes

[2] The employee's disclosure under this provision will only be protected if the employee first made a good faith effort to notify his or her employer.

constitutes improper quality of patient care or improper quality of workplace safety.

Section 741 defines “retaliatory action” to mean the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

An employee will not be protected under Section 741 unless he or she has brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has afforded the employer a reasonable opportunity to correct the activity, policy or practice.

However, such notice and opportunity to correct is not required in connection with disclosures or threats to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety where it presents an imminent threat to public health or safety or to the health of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

The same relief and enforcement provided for under Labor Law Section 740 (described above) are applicable to retaliatory actions under Section 741.

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 Hospital does not pay incentives to any person based upon the number of patients admitted or the value of services provided, nor does the Hospital 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 Hospital does not accept any form of remuneration in return for referring its patients to other health care providers. The Hospital 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 Hospital 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 Hospital 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 Hospital may enter into, the Hospital will ensure that it obtains and maintains written and signed agreements covering all time periods for which an arrangement is in place. Moreover, the Hospital 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 Hospital 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 Hospital 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 Hospital 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 Hospital 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 Hospital'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 Federal physician self-referral law (the "Stark" law) forbids referrals between physicians and health care entities that have certain prohibited financial relationships. Under the Stark law, 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). The New York State Stark Law prohibits a practitioner (which includes a licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife, physician assistant or specialist assistant, physical therapist, or optometrist) from making referrals for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services covered by any payor (i.e., not just Medicare or Medicaid) to a health care provider authorized to provide such services where such practitioner (or an immediate family member) has a financial relationship with such health care provider.

For more information, please see the Physician Self-Referral (Stark) Law Policy.

References:

42 U.S.C. 1320a-7b
42 U.S.C. 1395nn
42 C.F.R. 1001.952
42 C.F.R. Part 411
NY Public Health Law 238, et seq.
NY Social Services Law 366-d

Appendix C

NON-RETALIATION AND NON-INTIMIDATION FOR PARTICIPATION IN THE COMPLIANCE PROGRAM

I. POLICY

Pursuant to its Compliance Program, Jamaica Hospital Medical Center (the "Hospital") is committed to maintaining compliance with all laws and regulations, including those governing quality of care, documentation, coding, billing and its relationships with other providers.

A key element of the Hospital's Compliance Program is the ability of all Affected Individuals[3] to express problems, concerns or opinions without fear of retaliation or reprisal. At the same time, Affected Individuals have an affirmative duty to report issues or concerns that come to their attention through the appropriate channels. Failure to do so can result in disciplinary action up to and including termination of employment, contract or affiliation.

In furtherance of the Compliance Program and the requirements of Section 715-b of the New York Not-for Profit Corporation Law, the purpose of this Policy is to ensure that Affected Individuals understand the Hospital's commitment to prohibiting intimidation and retaliation for "good faith participation in the Compliance Program" (as that term is defined below). Intimidation and other retaliatory action in any form by any individual associated with the Hospital is strictly prohibited and is itself a serious violation of the Code of Conduct and this Policy.

It is the Hospital's policy that no Affected Individual in good faith reports any action or suspected action taken by or within the Hospital that is illegal, fraudulent, or in violation of any adopted policy of the Hospital shall suffer intimidation, harassment, discrimination or other retaliation, or in the case of employees, adverse employment consequences.

II. PROCEDURES - GENERALLY

The adoption and implementation of, and compliance with this Policy shall be overseen by the Board of Trustees. The Board may, in its discretion, authorize certain functions relating to the implementation of, and compliance with, this Policy to one or more Hospital employees, but the Board will, at all times, retain overall responsibility for all aspects of the oversight of this Policy. The Chief Compliance Officer has been designated by the Board to administer this Policy and report to the Compliance Committee of the Board on issues related to this Policy.

[3] "Affected Individuals" means all persons who are affected by the Hospital's compliance risk areas, including employees; the Chief Executive; other senior administrators and managers; contractors, agents, subcontractors, independent contractors ("Contractors"); governing body members; and corporate officers. Contractors are only subject to the Hospital's Compliance Program to the extent it is related to their contracted role and responsibilities within the Hospital's identified risk areas.

III. PARTICIPATION IN THE COMPLIANCE PROGRAM

Good faith participation in the Compliance Program includes, but is not limited to:

A. reporting actual or potential issues to appropriate personnel, including but not limited to, any action or suspected action taken by or within the Hospital that is illegal, fraudulent or in violation of any adopted Hospital policy;

B. cooperating with or participating in the investigation of such matters;

C. assisting with or participating in self-evaluations, audits, and/or implementation of remedial actions;

D. reporting instances of intimidation or retaliation; and

E. reporting potential fraud, waste or abuse to the appropriate State or Federal entities.[4]

IV. REPORTING AND CONFIDENTIALITY

As required by the Hospital's Compliance Program, Affected Individuals are expected to report suspected misconduct or possible violations of the Compliance Program to the Chief Compliance Officer, at the number or e-mail address below, or to their supervisor. Personnel may also report compliance issues or concerns to the Hospital's Compliance Hotline at the number below. Personnel may report compliance issues or concerns anonymously, if they wish (whether through the Compliance Hotline or otherwise). The identity of the individuals reporting will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement or if disclosure is a requirement in connection with a legal proceeding.

Compliance Program Contact Information	
Chief Compliance Officer George A. Fatoush, CHC	Email: gfatoush@jhmc.org
Compliance Hotline **718-206-7892**	Email: corporatecompliance@jhmc.org

V. INVESTIGATION OF INTIMIDATION/RETALIATION COMPLAINTS

- All allegations of intimidation or retaliation resulting from good faith participation in the Compliance Program will be promptly and thoroughly investigated. The Chief Compliance Officer, or his/her designee, will oversee any investigations and take all necessary and appropriate actions in connection with any investigation. The Chief Compliance Officer, or his/her designee, will be assisted by internal staff and/or may solicit the support of external resources, as needed.

[4] For a brief summary of New York Labor Law §§ 740-741, as of April 2023, please see the appendix to this Policy.

- All individuals who may have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be reminded that retaliation and intimidation is a violation of the Hospital's Code of Conduct and this Policy, and that under certain circumstance, may be unlawful as well. The interviewee will also be reminded of the Hospital's disciplinary policy for failure to cooperate in a compliance-related investigation.

- All documentation related to the investigation will be kept confidential, consistent with the need to investigate the issue(s) raised. Investigative files will be kept secured in a central location under the control of the Chief Compliance Officer or designated staff. Such investigative files will be kept separate from personnel files and will be maintained for no fewer than ten years from the date of the conclusion of the investigation, or the imposition of disciplinary sanctions or corrective actions resulting therefrom, or for such longer period of time as may be required by applicable law.

- If the Chief Compliance Officer, in conjunction with the Chief Executive Officer, determines that an employee was improperly terminated or otherwise disciplined in retaliation for good faith participation in the Compliance Program, the Hospital will promptly take all appropriate corrective action as to the individual who was intimidated or retaliated against. The Board of Trustees will retain oversight of all such corrective action.

- If the Chief Compliance Officer determines that an employee was retaliated against for good faith participation in the Compliance Program, appropriate disciplinary action may be taken against the offending person, subject to the oversight of the Board of Trustees.

- The Hospital may terminate contracts and affiliations based on retaliation or intimidation for good faith participation in the Compliance Program, subject to the oversight of the Board of Trustees.

- In order to prevent retaliation or intimidation against employees who in good faith participate in the Compliance Program, all terminations of employment must be approved by the Hospital's Chief Operating Officer prior to being effectuated. The Chief Operating Officer or Human Resources Department must be advised of the employee's participation in the Compliance Program prior to the termination decision or other adverse employment action being made.

- A person that is subject of a whistleblower complaint may not be present at or participate in Board or Committee deliberations or vote on the matter relating to such complaint. The Board or designated Committee, in its discretion, may request that a person who is subject of a whistleblower complaint present information as background or answer questions at a Board or Committee meeting prior to the commencement of deliberations or related voting.

VI. REPORTING

The Chief Compliance Officer is designated to administer this Policy and report to the Vice President of Legal Affairs and Corporate Compliance, General Counsel on matters concerning violations and alleged violations of this Policy, both on a periodic and as-needed basis. The Chief Compliance Officer is also authorized to report to the CEO and to the Board of Trustees.

VII. DISTRIBUTION

This Policy shall be distributed to all trustees, officers, key persons, and employees of the Hospital, and to volunteers who provide substantial services to the Hospital.

References:

New York Not-for-Profit Corporation Law § 715-b
New York Social Services Law 363-d
18 NYCRR § 521-1.4

APPENDIX:

A SUMMARY OF NEW YORK LABOR LAW SECTIONS 740 & 741[5]
(Effective: January 26, 2022)

New York Labor Law Sections 740 and 741 are laws that provide protection to "whistleblowers" in certain cases. This Appendix provides a brief summary of these laws.

New York Labor Law Section 740

Section 740 prohibits the taking of "retaliatory action" by an employer against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

2. provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or

3. objects to, or refuses to participate in, any such activity, policy or practice.

Under Section 740, "retaliatory action" is defined to mean an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under Section 740. This includes: (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment (including but not limited to discharge, suspension, or demotion); (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member to a federal, state, or local agency.

Conditions and Exceptions Under New York Labor Law Section 740

An employee's disclosure to a public body of an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee

[5] This summary is informational only. It is neither an interpretation of law nor legal advice. Note that both sections of New York's Labor Law discussed in this summary contain specific definitions and other information that is not discussed herein.

reasonably believes poses a substantial and specific danger to the public health or safety will not be protected under Section 740 unless the employee has made a good faith effort to notify his or her employer. Specifically, when such notice is required, the employee is required to bring the activity, policy or practice to the attention of a supervisor of the employer and to afford the employer a reasonable opportunity to correct it.

However, such employer notification is not required where:

1. there is an imminent and serious danger to the public health or safety;

2. the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;

3. such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;

4. the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or

5. the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct it.

New York Labor Law Section 741

Section 741 prohibits certain defined health care employers from taking "retaliatory action" against an employee because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

2. objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

Section 741 defines "retaliatory action" to mean the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

Conditions and Exceptions Under New York Labor Law Section 741

An employee will not be protected under Section 741 unless he or she has brought the improper quality of patient care or improper quality of workplace safety to the attention of a

supervisor and has afforded the employer a reasonable opportunity to correct the activity, policy or practice.

However, such notice and opportunity to correct is not required in connection with disclosures or threats to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety where it presents an imminent threat to public health or safety or to the health of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

Relief/Enforcement Under Both New York Labor Law Sections 740 and 741

Under both Sections 740 and Section 741, an employee who has been the subject of retaliatory action in violation of the law may bring a civil action within two years after the alleged retaliatory action was taken. The parties to such an action are entitled to a jury trial.

In connection with such an action, a court may order: an injunction to restrain continued violation of the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay"; the reinstatement of full fringe benefits and seniority rights; the compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

Under both Sections 740 and 741, it is a defense that the retaliatory action was predicated on grounds other than the employee's exercise of the rights that these sections of the law protect.[6]

[6] Under Section 740, a court may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the action the employee brings is without basis in law or fact.