Vendor/Contractor Requirements

I. Equal Opportunity Requirements, as Applicable

To the extent applicable, all parties agree that they will abide by the provisions of 29 CFR Part 471 Appendix A to Subpart A. Additionally, this contractor and subcontractor shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a), 60-300.10 and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability.

II. Detection and Prevention of Fraud, Waste and Abuse

Policy:

In compliance with the Deficit Reduction Act of 2005, this policy provides information to all Thompson Health associates, medical staff members, contractors, agents and volunteers who are involved in providing or furnishing health care items or services, performing billing or coding functions, or monitoring health care regarding the following laws, regulations and policies:

- The Federal False Claims Act
- The New York State False Claims Act
- Federal administrative remedies for false claims
- New York laws pertaining to civil and criminal penalties for false claims
- Whistleblower protections contained in the foregoing law
- Thompson Health policies and procedures for detecting and preventing waste, fraud and abuse

Thompson Health requires all associates, medical staff, contractors, agents and volunteers to report suspicions of fraud, waste, or abuse. In support of this requirement, Thompson Health educates all of its associates, medical staff, contractors, agents and volunteers to enable them to detect, prevent and report suspected incidents of fraud, waste, and abuse.

Thompson Health prohibits any associates from intentionally or recklessly submitting a claim, which includes fraudulent information or is based on fraudulent documentation to any federally funded or state-funded program for payment approval.

In further support of this Policy, the CEO/President of Thompson Health has appointed a Chief Compliance Officer who is responsible for the day-to-day operation of the Corporate Compliance Plan, and who shall provide oversight and guidance on all Ethics and Compliance matters.

Please review the following summaries of laws and regulations and keep this document as a reference.

Summary of Federal and New York State False Claims Laws

The Centers for Medicare and Medicaid Services (CMS) define "fraud" as:

an intentional deception or misrepresentation that an individual knows or should know, to be false, or does not believe to be true, and makes knowing that the deception or misrepresentation could result in some unauthorized benefit to himself or some other person(s).

CMS also describes fraud as:

> ***To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.***

CMS defines "abuse" as a range of improper behaviors or billing practices, including, but not limited to:

(i) billing for a non-covered service;
(ii) misusing codes on the claim; or
(iii) inappropriately allocating costs on a cost report.[1]

There are both **federal and New York State criminal and civil laws** pertaining to fraud and abuse in the submission of claims for payment or approval to the federal and state governments and to private payors. These laws:

- ***Provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities;***
- ***Impose criminal, civil and administrative penalties for fraudulent or abusive activities; and***
- ***Establish anti-retaliation provisions for individuals who make good faith reports of waste, fraud and abuse.***

Following is a detailed summary of information about major federal and state laws regarding healthcare fraud, waste and abuse.

Important Definitions:

Claim: *any request or demand for money that is submitted to the federal government or its contractors.*

Contractor or Agent: *includes any contractor, subcontractor, agent or other person who, on behalf of Thompson Health, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by Thompson Health.*

A. The False Claims Act[2]

The False Claims Act (the "Act") imposes civil liability on any person who commits fraudulent acts including, without limitation, one who:

(i) *knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval;*
(ii) *conspires to defraud the government by getting a false or fraudulent claim allowed or paid;*
(iii) *uses a false record or statement to avoid or decrease an obligation to pay the government; or*
(iv) *after having identified an overpayment, fails to repay such overpayment within 60 days.*

The term "knowingly" is broadly defined under the Act to mean:

(*a) having actual knowledge that the information on the claim is false;*

(b) acting in deliberate ignorance of whether the claim is true or false; or

(c) acting in reckless disregard or whether the claim is true or false.

For *each* violation of the Act, a person or entity may be subject to: 1) civil monetary fines equal to the sum of between $10,957 and $21,916, 2) three times the amount paid for each false claim, plus 3) the costs of any civil action brought to recover such penalties or damages.

In addition, such violations can subject a person to exclusion from participation in federally funded health care programs, such as Medicare and Medicaid.

The Act is enforced by the Attorney General of the United States, who is required to investigate violations of the Act. The Act also permits private persons to bring suit on behalf of the United States and entitles the private persons bringing suit to receive a percentage of monies obtained through settlements, penalties and/or fines collected in such action. Actions brought by private persons, or "relators" for violations of the Act are known as "qui tam" actions. If a qui tam action

brought by a relator is frivolous or commenced in order to harass the defendant, the relator may be liable to pay the defendant's fees and costs associated with such action.

B. Federal Whistleblower Protection

The Act provides protection from retaliatory actions by Thompson Health against an employee who acts as a "relator" in initiating a False Claims action and any other whistleblower who questions a perceived violation of the Act. The Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed or in any manner discriminated against by his or her employer as a result of reporting violations of the Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorney's fees and costs.

C. Program Fraud Civil Remedies Act of 1986[3]

The Program Fraud Civil Remedies Act (PFCRA) provides for the imposition of administrative remedies against any person who makes, presents or submits (or causes to be made, presented or submitted) to certain federal agencies a claim or statement that the maker knows or has reason to know:

(i) is false, fictitious or fraudulent;
(ii) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;
(iii) includes or is supported by any written statement which omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact; or
(iv) is for the provision of items or services which the person or entity has not provided as claimed.

The PFCRA authorizes the imposition of federal administrative charges. It imposes on any person who submits, or causes to be submitted, a false claim or a false statement a **civil penalty of up to $5,000** for each wrongfully filed statement or claim, regardless of whether property, services, or money is actually delivered or paid. If any payment is made, property is transferred, or services are provided in reliance on a false claim, the person submitting it is **also subject to an assessment of not more than twice the amount of the false claim.** This assessment is in lieu of damages sustained because of the false claim.

D. New York State Laws

1. New York False Claims Act- New York State Finance Law §§187-194

Section 189 of the New York State Finance Law makes it unlawful for a person or entity to commit any of the fraudulent acts set forth in the federal False Claims Act. Both the federal and New York False Claims Acts impose civil liability on any person who commits fraudulent acts including, without limitation, one who:

(i) knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval;
(ii) knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim; or
(iii) conspires to defraud the government by getting a false or fraudulent claim allowed or paid.

The New York False Claims Act (the "Act") also makes it unlawful for a person or entity to:
(i) have property or money used, or to be used, by the state or a local government and knowingly delivers, or causes to be delivered, less than all of that property or money;
(ii) make or deliver a document certifying receipt of property used, or to be used, by the state or local government intending to defraud the state or a local government and without completely knowing that the information on the receipt is true;
(iii) knowingly buys, or receives as a pledge of an obligation or debt, public property from a state or local government employee or officer, knowing that employee or officer is violating a law when selling or pledging that property; or
(iv) 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 state or a local government.

The term "knowingly" is defined in Section 188 of the Act with language identical to that of the federal False Claims Act. Proof of specific intent to defraud is not required, however acts occurring by mistake or as a result of mere negligence do not subject a person to liability.

For the commission of any single fraudulent act, a violator shall be liable to the State for a civil penalty of between $6,000 and $12,000, and to both the State and local government for three times the amount of damages each sustained as a result of the fraudulent act. Section 190 of the Act allows for civil enforcement actions to be commenced by either the Attorney General of the State of New York, by any local government or by any private person who brings an action on behalf of the state or any local government.

Section 191 of the Act provides protection for whistleblowers. It protects any employee of any private or public employer from retaliatory actions by his or her employer because of lawful acts done in furtherance of this Act. The employee will be entitled to legal relief.

2. New York Social Services §145-b

This statute makes it unlawful to knowingly make a false statement or representation (or by deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain, or to obtain, payment from public funds for services or supplies furnished under the New York State Medical Assistance Program.

The local social services district has the right to recover civil damages equal to three times the amount by which the claim was falsely overstated or, in the case of non-monetary false statements or representations, three times the amount of damages sustained as a result of the violation or $5,000, whichever is greater. Interest will be charged at the maximum legal rate

in effect on the date payment was made and will accrue for the period from which the fraudulent money was paid by the government until the date of repayment.

Additionally, the New York State Department of Health may impose **a civil monetary penalty, up to $10,000 for each item or service inappropriately provided (or up to $30,000 for each item or service, for prior violations in the last five years)** as restitution to the Medical Assistance Program, if the person or entity knew, or had reason to know that:

(i) the payment related to care, services or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;

(ii) the care, services or supplies were not provided as claimed;

(iii) the person who ordered or prescribed care, services or supplies which were medically improper, unnecessary or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from the Medical Assistance Program at the time the care, services or supplies were furnished; or

(v) the services or supplies for which payment was received were not, in fact, provided.

3. Social Services Law, Section 145 - Penalties

Any person who by means of a false statement or representation, or by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain, or aids or abets any person to obtain public assistance or care, including Medicaid, to which he is not entitled, or does any willful act designed to interfere with the proper administration of public assistance and care, shall be guilty of a misdemeanor, unless such act constitutes a violation of a provision of the penal law of the state of New York, in which case he shall be punished in accordance with the penalties fixed by such law.

4. New York Public Health §238-a

With certain limited exceptions, this statute prohibits the submission of Medicaid claims which are the result of a referral from a health care provider or a referring practitioner to a health care service provider (clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services) who has a financial or familial relationship with the health care provider or referring practitioner.

5. New York Labor Law §740

This law prohibits any retaliatory behavior (i.e. discharge, suspension, demotion or other adverse action in terms of the employee's conditions of employment) by an employer against a current or former employee who reports or testifies to an investigatory agency a violation of a law, rule or regulation which presents a substantial danger to public health or safety or which constitutes health care fraud, or the employee refuses to participate in a violation of such law, rule or regulation. The law allows employees who are retaliated against to bring a civil action for:

(i) injunctive relief to restrain continued retaliation;
(ii) reinstatement to the same or equivalent position held before the retaliatory action;
(iii) reinstatement of benefits and seniority;
(vi) compensation for lost wages, and benefits; and
(vii) the payment of reasonable costs, disbursements and attorney's fees.

6. New York Labor Law § 741

Section 741 provides similar protections for employees reporting concerns regarding quality of care. In addition to the foregoing remedies, Labor Law § 215 provides for **a fine of between $1,000 and $10,000 for each violation of Section 740 or 741.** The protections of these statutes are only available if the employee has notified his or her supervisor of the violation of the law and has afforded the employer a reasonable opportunity to correct such activity, policy or practice.

7. New York Social Services §366-b

This statute identifies which acts constitute fraudulent practices in the Medical Assistance Program. A person commits a fraudulent act if he or she does the following, with intent to defraud:

(i) presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise;

(ii) knowingly over-bills for services or merchandise; or

(iii) knowingly submits false information to obtain authorization to furnish services or merchandise.

A violation of this Act is a **class A misdemeanor or violation** under the New York Penal Code.

8. Penal Law Article 175 - False Written Statements

Four crimes in the Penal Law relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor.

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

c. §175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.

d. §175.35 - Offering a false instrument for filing in the first degree includes the

elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

9. Penal Law Article 176 - Insurance Fraud

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

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.

b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a class E felony.

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

d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a class C felony.

e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

10. New York Penal Code Article 177

This statute makes it a crime to commit "health care fraud," an act which is defined as any time a person:

> *with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of such information or omission, he or she or another person receives payment in an amount that he, she or such other person is not entitled to under the circumstances.*

The penalty for the commission of health care fraud ranges from a **class A misdemeanor to a class B felony,** based upon the amount of payment fraudulently obtained from a single health plan during a one-year period.

Procedure:

What Is Required:

Any Associate, member of the Medical Staff, contractor, agent or volunteer who suspects healthcare fraud, waste or abuse is required to notify Thompson Health via his or her supervisor, other manager in the chain of command (to the extent the supervisor or manager is not involved in the fraud, waste or abuse), the Chief Compliance Officer (CCO), or the President/CEO.

Process:

A. Any individual covered by this policy who witnesses or becomes aware of misconduct or violations of policy, law or regulation is responsible to report this information to his or her supervisor or manager, the Chief Compliance Officer, or President/CEO.
B. Potential violations of Thompson Health's policies, procedures, laws or regulations may be reported by phone, email, mail, or face-to-face.
C. Any individual covered by this policy may also call the Thompson Health Compliance Hot Line at **(585) 396-6234** to report violations anonymously.

How to Contact the Chief Compliance Officer:

You may call the CCO directly at **(585) 396-6714** to report any potential compliance concern or incident, or to schedule an appointment to meet with the CCO. There will be appropriate follow up by the CCO and/or a designee appointed by the CCO.

You may also report perceived incidents of non-compliance on a strictly confidential basis by calling the Thompson Health Compliance Hotline at **(585) 396-6234.**

Investigations:

In accordance with its policies, Thompson Health will promptly evaluate and investigate all allegations an individual brings forward and make every attempt to correct those found to be true and to prevent further violations. All records and any subsequent investigation of reported matters shall be confidentially retained by the CCO in so far as possible. The records shall be subject to disclosure only as required by Thompson Health policy, through advice of counsel, or as otherwise required by law.

An Associate also has the right to report potential violations to the appropriate government agency.

Thompson Health will not retaliate against associates, medical staff, contractors, agents or volunteers who, in good faith, report concerns of fraud, waste, and/or abuse.

III. Non-Intimidation/Non-Retaliation

Policy:

Thompson Health is committed to maintaining a work environment which is free of harassment, intimidation, discrimination, or retaliation and upholds this commitment as it pertains to "whistleblowers." All Associates, as well as directors, volunteers, patients, residents, participants, medical staff, vendors, contractors, agents and visitors to our workplace, are covered by this policy.

Procedure:

No one covered by this Policy may harass, intimidate, threaten, coerce, discriminate against, or take any other retaliatory action (collectively referred hereinafter as "retaliation") against any other individual covered by this Policy for the good faith filing of a complaint, or for testifying, assisting, or participating in any manner in an investigation, review, proceeding or hearing regarding concerns about quality of care or an alleged violation of a law, rule or regulation which presents a substantial and specific danger to public health or safety or which constitutes health care fraud at Thompson Health.

Those covered by this Policy will report retaliation by others.

One is protected from retaliation if he or she has a good faith belief that the conduct opposed is unlawful or below standards of care, the manner of the opposition is reasonable and such opposition does not involve an unauthorized disclosure of protected health information.

Reporting a Concern

Associates who believe they have been the subject of retaliation are to report their concerns immediately to their supervisor, the Chief Compliance Officer and/or the Vice President of Associate Services. Thompson Health will promptly and thoroughly investigate all complaints.

Confidentiality and Retaliation

It is Thompson Health's intention that anyone who reports a concern as noted above or participates in an investigation, review, proceeding or hearing will not be retaliated against in any way. The concern will be investigated promptly and confidentiality will be maintained to the greatest degree possible, consistent with our obligation to thoroughly investigate the allegation.

Corrective Action

If a retaliation complaint is found to be valid, immediate and appropriate corrective action will be taken. If the retaliation complaint is found to be intentionally and knowingly fraudulent, immediate and appropriate corrective action will be taken. Anyone who has violated this Policy will be subject to discipline up to and including termination. This determination will be based on all of the facts of the case.

Supervisor's Responsibilities

Supervisors have a responsibility for activities in their department(s) of which they are aware or should be aware. Supervisors are responsible for assuring continued objective, non-retaliatory treatment of any Associates involved in an investigation.

A supervisor who observes an Associate or non-Associate engaging in retaliatory conduct, is to take immediate action to stop the conduct. The supervisor must notify the VP of Associate Services of the situation so a prompt investigation may be conducted. Supervisors who receive a complaint of retaliation, or who by other means obtain knowledge of such activity must notify

the VP of Associate Services even if no complaint has been made by an Associate, or even if the Associate complaining has requested that no action be taken.

All investigations of retaliation must be carried out by the Associate Services Department, under the direction of the VP of Associate Services. If there is any retaliation related to a compliance matter, the VP of Associate Services will notify the VP of Legal and Regulatory Affairs/General Counsel. The VP of Associate Services and The VP of Legal and Regulatory Affairs/General Counsel will jointly investigate and act on the complaint.

Therefore, supervisors must notify the VP of Associate Services immediately when they learn of a retaliation complaint or incident.

During the investigation, reasonable efforts will be made to protect the privacy of the individuals involved. Any Associate who is found to have retaliated against an Associate, director, volunteer, patient, resident, participant, medical staff member, vendor, contractor, agent or visitor will be subject to appropriate disciplinary action up to and including termination.

All Associates who supervise at Thompson Health are responsible for the implementation of this Policy.

Policy Administration

The VP of Associate Services is responsible for administering this policy at Thompson Health. (S)he is to be informed immediately of any complaints received pursuant to this policy or incidents which potentially constitute retaliation.

IV. Vendors also must comply with the following:

- Thompson Health Code of Compliance
- Thompson Health Code of Ethics & Professionalism
- Thompson Health Terms and Conditions

[1] Centers for Medicare and Medicaid Services, http://www.cms.gov/apps/glossary.

[2] 31 U.S.C. §§3729-3733.

[3] 31 U.S.C. § 3801 – 3812.