OOMC

VENDOR CONTRACTING

Corneal Associates of New Jersey

Omni Eye Services

Kremer Eye Center

Phillips Eye Specialists

Ludwick Eye Center

A Family of Ophthalmic Practices

Vendors and Contractors

OOMC has a long and proud history of providing quality healthcare services and conducting business in full compliance with the letter and spirit of all applicable laws and in accordance with the highest ethical standards. Our commitment to providing quality health care in a legal and ethical environment has been a fundamental part of our tradition and continues to set the standard of how we do business. The Board of Directors has adopted a corporate compliance program to ensure that this commitment is upheld. The OOMC Vendor Code of Conduct, the cornerstone of the compliance program, translates that commitment into a written statement of standards of behavior for all vendors and independent contractors who act on our behalf.

Relationships with vendors. subcontractors and suppliers are handled in a fair and reasonable manner, consistent with all applicable laws and good business practices. Vendors, subcontractors and suppliers are selected on the basis of objective criteria, including standards of quality, service, price, delivery capability and technical excellence. OOMC actively pursues competitive bidding through available resources including national group purchasing affiliations, regional and local alliances. All purchasing decisions are based on price and the supplier's abilities to meet our needs. Under no circumstances are decisions based on personal relationships, whether the relationship involves the employee, an officer or director of OOMC, a family member, or a friend. We employ the highest ethical standards in business practices in source selection. negotiation, determination of contract awards and the administration of all purchasing activities. OOMC does not knowingly enter into contracts or do business with vendors convicted of a criminal offense related to health care or have been excluded from or are otherwise ineligible to participate, in federal or state healthcare programs.

OOMC does business with only those vendors, subcontractors and suppliers that comply with applicable laws and whose business conduct is consistent with our Code of Conduct and compliance program. In accordance with the Deficit Reduction Act of 2005, OOMC is committed to educating vendors and contractors about its compliance program and policies. A complete copy of the Vendor Code Conduct and relevant documents is available below. Questions regarding any aspect of the compliance program or policies should be directed to the Compliance Office at 732-510-2588 or Compliance@OOMC.com.

- VENDOR CODE OF CONDUCT
- POLICY ON DETECTION AND PREVENTION OF FRAUD, WASTE, AND ABUSE
- SANCTIONS AND EXCLUSIONS

If you are interested in contracting opportunities with OOMC, please contact our contracting department at Contracts@OOMC.com

For more information or questions regarding Compliance & Risk, please contact:

Regina F. Gurvich, MBA, CHC
Vice President, Chief Compliance Officer
Phone: 732-510-2588
Regina.Gurvich@OOMC.com

OMNI

OPHTHALMIC MANAGEMENT CONSULTANTS

OMNI EYE SERVICES

Vendor Code of Conduct

2018

OMNI
OPHTHALMIC MANAGEMENT CONSULTANTS

Vendor Code of Conduct
2018

OMNI Ophthalmic Management Consultants, LLC and its affiliated professional corporations ("OOMC") is committed to providing quality services, fully complying with Federal and State laws, and meeting the highest ethical practices for business conduct. We strive to live the values of integrity, honesty, fairness, and responsibility in all of our daily work activities.

To assure vendor compliance with the policies, vendor representatives who work on site with OOMC or who have access to sensitive information created or maintained by OOMC are required to follow the OOMC Vendor Code of Conduct and Compliance Program. Vendors furnishing goods and services to OOMC are required to comply with OOMC policies designed to promote ethical conduct and facilitate regulatory compliance.

OOMC's Compliance Program provides a framework which helps OOMC ensure that it conducts business in an honest and ethical manner in accordance with state and federal laws, rules and regulations. The Compliance Program also establishes a mechanism to detect, correct and prevent errors that result in violations of the laws, rules and regulations applicable to OOMC, as well as violations of OOMC policies. Ongoing auditing and monitoring projects are completed to assess compliance with all laws, rules, regulations and OOMC policies. Open communication of possible violations of OOMC policies and procedures or the federal and state laws, rules and regulations governing health care is an important part of the success of OOMC's Compliance Program.

We have created this OOMC Vendor Code of Conduct to communicate the minimum standards by which all OOMC vendors are expected to conduct themselves when providing goods or services to our organization.

Gifts

OOMC discourages vendors from providing any gifts or other items of value to our employees, physicians or contractors. The following items are never acceptable:

- Gifts given to OOMC employees for the purpose of influencing a purchasing or contracting decision;
- Gifts that reasonably could be perceived as a bribe, payoff, deal, or any other attempt to gain a competitive advantage;
- Cash or items redeemable for cash such as checks, gift cards, stocks, etc.;
- Gifts to, or from, government representatives;
- Gifts or other incentives given for the purpose of encouraging or rewarding patient referrals;
- Gifts that may violate a law, rule or regulation.

Conflicts of Interest

Conflicts of interest, in which an OOMC employees' relationship with a vendor conflicts, or could appear to conflict, with OOMC's business interests, must be avoided. We recognize there are circumstances in which a member of an OOMC household may work for a vendor. OOMC requires our employees to disclose such relationships to the Compliance Department in a timely manner. We also expect our vendors to bring any actual, potential, or perceived conflicts of interest to the attention of someone at OOMC (Director level or above) other than the person who has a relationship with the vendor.

Compliance with Laws

Vendors are required to conduct their business activities in compliance with all applicable laws, rules and regulations, including laws, rules and regulations that are applicable to individuals and entities receiving Medicare, Medicaid and other federal or state funds.

Vendors must also retain records consistent with applicable laws and regulations and any applicable provisions of their contracts with OOMC.

Vendors are required to cooperate with all reasonable requests for information from Federal and State government and regulatory agencies pertaining to their business dealings with OOMC. It is essential that the legal rights of OOMC and of our personnel are protected. Any governmental or regulatory inquiry, subpoena, or other legal document regarding our business, must be communicated immediately in writing to the OOMC Compliance Department.

Privacy and Security

Federal and state laws require OOMC and our vendors to maintain the privacy and security of OOMC personal health information ("PHI"). Vendors are responsible for ensuring that all vendor personnel who provide services to OOMC are aware of, and familiar with, the requirements of both the Health Insurance Portability and Accountability Act ("HIPAA") Privacy and Security Rules and, where applicable, those state laws that provide more stringent protection of PHI. If the business relationship with OOMC will require access to or usage of PHI, the vendor will be required to sign a Business Associate Agreement with OOMC.

In accordance with the Health Insurance Portability and Accountability Act of 1996 and its related regulations ("HIPAA"), Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and other applicable federal and state laws, any PHI obtained as part of the contract performance may not be disclosed to third parties, persons or entities outside of OOMC unless proper written authorization to share such information is in place.

Fraud, Waste and Abuse ("FWA")

OOMC will promptly investigate any reports of alleged violations of laws, rules, regulations or OOMC policies involving a supplier or a supplier's personnel, including allegations of FWA involving federal or state health care programs. Vendors are expected to fully cooperate in such investigations and, where appropriate, take corrective actions in response to confirmed violations. The Federal False Claims Act and similar state laws make it a crime to present a false claim to the government for payment. These laws also protect "whistleblowers" – people who report noncompliance or fraud, or who assist in investigations - from retaliation. OOMC policy prohibits retaliation of any kind against individuals exercising their rights under the Federal False Claims Act or similar state laws.

Non-Retaliation and Non-Intimidation Policy

In accordance with the Federal Enforcement and Recovery Act of 2009, "FERA", OOMC maintains a strict policy of non-retaliation and non-intimidation that protects individuals who report ethical or legal issues in good faith. This includes, but is not limited to, any employee, contractor, agent, or associated others who, in good faith, raises concerns or allegations of possible violations of the OOMC Code of Conduct, any OOMC policies or procedures, Federal and/or State laws, or regulations. Any individual or entity who in good faith reports a potential ethical or legal issue or concern will not be retaliated against, intimidated, threatened, harassed or discriminated against in any other manner.

Reporting Potential Violation

Vendors may use the OOMC Compliance Hotline to report any actual or suspected violations of this Vendor Code of Conduct, including FWA matters, or other matters, on an anonymous basis without fear of retaliation. The OOMC Compliance Hotline is available 24 hours a day, 365 days a year, at 1-833-424-2020. Regina Gurvich is OOMC's Chief Compliance Officer and can be reached at 732.510.2588 or regina.gurvich@oomc.com. Vendors may also file reports online at www.OOMC.ethicspoint.com.

Eligibility for Participation in Government Business

Vendors must verify that their employees engaged in work for OOMC are eligible to participate in OOMC's government business, and must certify that those employees have been screened against OIG's List of Excluded Individuals/Entities ("LEIE"), the System for Award Management ("SAM"), OMIG's List of Restricted, Terminated or Excluded Individuals or Entities ("RTEIE"), and any other applicable state healthcare exclusion lists. This must occur prior to the hiring or

contracting of any new employee, temporary employee, volunteer, consultant, and/or governing body member, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal or state programs. If any vendor employee is found to be excluded from participation in government business, vendors are required to immediately notify OOMC's Chief Compliance Officer and immediately remove the person from his/her assignment at OOMC.

Use of OOMC Resources

Vendors must use OOMC's assets with care and respect, guarding against misuse, waste, abuse, loss, and theft, when authorized by OOMC to use such assets. Any use may be further regulated in accordance with the provisions of the Vendor's contract with OOMC. OOMC's assets include, but are not limited to, corporate data, business strategies and plans, financial or clinical data, and other trade secrets or confidential information about OOMC business or its employees, as well as equipment, furniture, office supplies, corporate funds, credit cards, employee time, and computer supplies and software.

Contacts with the Public

Vendors must not speak to the public or to representatives of the media about or on behalf of OOMC without first receiving express written authorization to do so from OOMC's President or Chief Operating Officer unless another approach is required or permitted by the Vendor's contract with OOMC.

Employment Practices

Vendors are expected to conduct their employment practices in compliance with all applicable laws, rules and regulations. Additionally, vendors must respect OOMC's commitment to maintaining a work environment where we treat each other with honesty, dignity, and respect. OOMC values diversity and the cultural contributions of all employees, regardless of their position, sexual orientation, family status, age, race, sex, disability, religion, or national origin.

OOMC respects its employees' right to work in an environment free from harassment and discrimination, and will not tolerate sexual advances, actions, comments, inappropriate physical contact, or any other conduct that is intimidating or otherwise creates an offensive or hostile work environment. Employees and agents of vendors must comply with this policy at all times.

OOMC maintains a drug-free work place. Employees or agents of a vendor may not possess, distribute, or use illegal drugs or be under the influence of illegal drugs or alcohol at any time while on OOMC premises or providing services on behalf of OOMC.

Vendors are expected to act in a manner that will not disturb OOMC business. To this end, vendors' employees or agents, if on-site at OOMC facilities, must only engage in duties they are specified to perform, and not in other business, or in political, charitable or other duties. Vendors must not recruit on OOMC's premises and are responsible for maintaining satisfactory standards for employee competency, conduct, appearance and integrity. Vendors are expected to take such disciplinary action with respect to its employees or agents as may be necessary.

Failure to follow the Code

OOMC takes the Code of Conduct for Vendors seriously. Any violation of the Code may result in the termination of your contract with us and/or disqualification from consideration for future business opportunities with us. In addition, the failure to comply with applicable laws and regulations may result in our reporting the circumstances of the violation to a governmental authority.

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OPHTHALMIC MANAGEMENT CONSULTANTS

Vendor Code of Conduct Acknowledgment

When you enter into a contract with OOMC, you must certify that:

- You acknowledge that you have received, read and understand the OOMC Vendor Code of Conduct.
- You understand that the Vendor Code of Conduct has been adopted as a guide designed to alert those who do business with OOMC to the types of conduct expected of them.
- You understand that as a vendor doing business with OOMC, you are expected to abide by applicable provisions of the Vendor Code of Conduct and to act legally and ethically at all times.
- You understand that it is your responsibility to report questions or concerns regarding compliance with laws, rules, regulations, contract provisions, or OOMC policies to OOMC's Chief Compliance Officer or his/her designee.
- You understand that there will be no retaliation or intimidation for raising a compliance issue in good faith.
- You understand that any violation of the Vendor Code of Conduct may result in the termination of your contract with OOMC.

Name of the Company: ____

Name and Title of Signatory: ____

Signature: ____ Date: ____________________

OMNI Ophthalmic Management Consultants

POLICY TITLE: DRA FCA – Detection Prevention of Fraud Waste and Abuse	DEPARTMENT: CORPORATE COMPLIANCE
POLICY #: 100.109.00	CATEGORY: General Compliance
EFFECTIVE DATE: April 2, 2018 APPROVED BY: Regina Gurvich, VP CCO	REVIEW DATE: LAST REVISION DATE:
SUPERSEDED POLICY#: N/A	PAGE 1 of 16

I. PURPOSE

OMNI Ophthalmic Management Consultants ("OOMC") is committed to complying with the requirements of all laws and regulations related to preventing and detecting any fraud, waste, or abuse within OOMC and the provider organizations it owns or manages, including without limitation laws such as Section 6032 of the Federal Deficit Reduction Act of 2005 (the "Deficit Reduction Act"), and. To this end, OOMC maintains a Compliance Program and strives to educate all personnel on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and state governments. OOMC has instituted various procedures, which are set forth in OOMC's Code of Conduct, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal health care programs. In furtherance of this policy and to comply with the Deficit Reduction Act, OOMC disseminates this policy to all affected persons (including employees, contractors and other agents- "Personnel") to ensure that such persons are aware of certain relevant Federal and state laws, and that submission of a false claim can result in significant administrative and civil penalties under the Federal False Claims Act and other State laws.

II. SCOPE

This policy applies to OMNI Ophthalmic Management Consultants, LLC, its subsidiaries and other affiliates and, as may be approved or directed by the OOMC Board of Directors, third party organizations that are managed by OOMC and that are subject to Compliance Program requirements .

III. POLICY

To assist OOMC in meeting its legal and ethical obligations, any employee 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 the Chief Compliance Officer. Any employee 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, OOMC retains the right to take appropriate action

against any such reporting employee who has participated in a violation of Federal or state law or our related policies, or who intentionally makes a false claim.

OOMC is committed to investigate any suspicions of fraud, waste, or abuse swiftly and thoroughly, and require all employees to assist in such investigations. If an employee believes that OOMC is not responding to his or her report within a reasonable period of time, the employee shall bring these concerns about the 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 employee's obligations and may result in disciplinary action, up to, and including termination.

STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

A. The Federal False Claims Act

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

(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 $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

Pursuant to 28 CFR 85.5, for civil penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015, the civil monetary penalties provided by law within the jurisdiction of the Department range from $11,000 to $21,563.

(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.

31 U.S.C. § 3729.

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.

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 or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows 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 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 may obtain money from the Federal government to which he 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" may include 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 and shall be not less than 25 percent and not more than 30 percent.

B. The Program Fraud Civil Remedies Act ("PFCRA")

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 for each claim. The agency may also recover twice the amount of the claim.

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: civil and administrative and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

1. NY False Claims Act (State Finance Law, §§187-194)

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

2. **Social Services Law 145-b False Statements**

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 incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

3. **Social Services Law 145-c Sanctions**

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 person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and 5 years for 4 or more offenses.

B. CRIMINAL LAWS

1. **Social Services Law 145, Penalties**

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

2. **Social Services Law 366-b, Penalties for Fraudulent Practices**

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

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.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

4. Penal Law Article 175, False Written Statements

Four crimes in this Article 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.

5. **Penal Law Article 176, Insurance Fraud**

Applies to claims for insurance payment, 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.

6. **Penal Law Article 177, Health Care Fraud**

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

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. NEW JERSEY STATE LAWS

A. New Jersey Medical Assistance and Health Services Act (NJSA 30:4D-17(a)-(d))

The criminal provisions of the New Jersey Medical Assistance and Health Services Act (MAHA) allow the imposition of penalties of $10,000, and imprisonment of up to 3 years, or both, upon a recipient or a provider who is convicted for willfully receiving monies to which he or she was not entitled.

The civil provisions of MAHA (NJSA 30:4D-17(e) - (i)) allow: interest on the amounts of excess benefits or payments made; payment of up to three times the amount of excess benefits or payments received; and payment of $2000 for each excessive claim for assistance, benefits or payments.

B. New Jersey Health Care Claims Fraud Act (NJSA §§ 2C:21-4.2 and 4.3; NJSA § 2C:51-5)

This statute provides for the automatic permanent forfeiture of health care licenses for persons convicted of health care claims fraud for crimes of the second degree, and a one-year suspension for those convicted of health care claims fraud for crimes of the third degree. One can also be imprisoned up to 10 years for fraudulent claims submitted for professional services as well as required to pay fines up to 5 times the amount of the fraudulent claim.

C. New Jersey False Claims Act (NJSA §§ 2A:32C-1 – 2A:32C-18)
The New Jersey False Claims Act makes it unlawful for a person to knowingly make false or fraudulent claims, which includes: presenting or causing to be presented to an employee, officer, or agent of the State of New Jersey, or any contractor, grantee or other recipient of State funds, a false or fraudulent claim for payment or approval; making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State; conspiring to defraud the state by getting a false or fraudulent claim allowed or paid; or knowingly making use or causing to be made or used a false record or statement to conceal, avoid, increase, or decrease an obligation to pay or transmit money or property to the State.

Liability under the New Jersey False Claims Act results in a civil penalty equal to the civil penalty under the Federal False Claims Act. Penalties under the Federal statute are currently between $5,500 and $11,000 per false claim, plus three times the amount of the damages sustained by the state.

IV. PENNSYLVANIA STATE LAWS

Pennsylvania's Medicaid "False Claims Act" (Title 62 P.S. 1407, et seq.)
This statute makes it unlawful for any person to knowingly or intentionally submit false information or false claims or cost reports for furnishing services or merchandise under the medical assistance program, or claims or cost reports for medically unnecessary services or merchandise, or for the purpose of obtaining greater compensation than that to which the provider is legally entitled; solicit, receive, offer, or pay remuneration, including kickbacks, bribes or rebates in connection with furnishing services or merchandise under the medical assistance program; submit duplicate claims for which the provider has already received reimbursement; submit claims for services, supplies or equipment not rendered to a recipient; submit claims which include costs or charges not related to the services, supplies, or equipment rendered to the recipient; submit claims for or refer recipients to another provider for unnecessary services, supplies or equipment; submit claims which misrepresent information about the services provided, supplies or equipment provided, date of service, or identity of the practitioner or provider; submit claims for reimbursement higher than the provider's charge to the general public; submit claims for a service or item without a practitioner's written order and consent of the recipient (except in emergencies); or render a service or item without making a reasonable effort to verify through a current medical assistance card that the patient is, in fact, currently eligible (except in emergencies). *See* 62 P.S. § 1407(a)(1).

Pennsylvania law also makes it unlawful for any person to knowingly or intentionally make false statements or fail to disclose material facts regarding eligibility for themselves or

another for medical assistance benefits; fraudulently conceal knowledge of events affecting the person's initial or continued right to receive such benefits; convert benefits to a use other than for himself or the person for whom the benefits were intended; visit multiple providers for the purpose of obtaining excessive services or benefits beyond what is reasonably needed; or borrow or use a medical assistance card without entitlement to do so. *See* 62 P.S. § 1408.

62 P.S. § 1403(d)(1),(2),(4) and (5) addresses prohibitions of shared health facilities by leasing on percentage of earnings, paying for referrals in lease, providing improper or unwarranted services, referral to another provider in the facility absent medical justification.

Violations of Pennsylvania's Medicaid false claims statute can result in criminal and civil penalties, including monetary penalties and preclusion from participation in the medical assistance program. An individual who violates the statute is guilty of a felony of the third degree and may be subject to a maximum penalty of $15,000 and up to seven years imprisonment for each violation. If an individual is convicted in any other state court or Federal court for actions that would constitute a violation of Pennsylvania's law, they may be prosecuted under Pennsylvania law for a second degree felony as well as payments of a maximum penalty of $25,000 and up to 10 years' imprisonment. Individuals convicted under Pennsylvania's law will also be required to repay the excess benefits or payments they received plus interest on the amount at the maximum legal rate from the date the payment was made to the date repayment is made, not to exceed three times the amount of excess benefits or payments. *See* 62 P.S. §§ 1407-1408.

V. DELAWARE STATE LAWS

A. The Delaware False Claims and Reporting Act (Del. Code tit. 6 § 1201, et seq.)

The Delaware False Claims and Reporting Act ("DFCRA") makes it unlawful for any person to knowingly present or cause to be presented to an officer or employee of the Delaware government, a false or fraudulent claim for payment or approval; make, use or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved; conspire to defraud the government by getting a false or fraudulent claim allowed or paid; or knowingly make, use, or cause to be used, a false record or statement to conceal, avoid, increase or decrease an obligation to pay or transmit money or property to the government. The DFCRA also imposes liability on any person authorized to make or deliver a document certifying receipt of property used or to be used by the Government and who, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true.

Liability for violating the DFCRA includes civil penalties between $5,500 and $11,000 for each act constituting a violation plus three times the amount of actual damages sustained by the Delaware government, and the costs incurred by the government in bringing an action to recover any such penalty or damages, including reasonable attorneys' fees and costs. Under certain limited circumstances in which an individual promptly provides information or otherwise cooperates with the government's investigation, that individual may be subject only to payment of twice the government's actual damages, rather than three times the amount.

B. <u>Delaware's Medicaid False Claims Act (Del. Code tit. 31, §§ 1003 and 1004)</u>

Under Delaware law, it is illegal for any provider to make any false statement or representation, conceal or fail to disclose any material fact, or engage in any other "fraudulent scheme or device" in order to "obtain or attempt to obtain payments or any other property" under a public assistance program where the provider is not entitled to such payments or property. Del. Code tit. 31, § 1003. In addition, it is illegal for a provider to (1) falsify any report, statement, or document that must be filed under the public assistance program; (2) include in any cost or reimbursement-related report any amount or item that the provider knows or should know was not used in providing the service for which reimbursement is being requested; (3) knowingly make a false statement, representation, or omission in order to qualify to provide services under a public assistance program; or (4) knowingly make a false statement or representation of a material fact regarding conditions or operations in order to qualify or remain qualified to provide services under a public assistance program. Del. Code tit. 31, § 1004.

C. <u>Criminal Penalties (Del. Code tit. 31, § 1007)</u>

A provider who knowingly violates Sections 1003 and 1004 is subject to criminal penalties. Del. Code tit. 31, § 1007. In addition, the provider must fully repay any improperly obtained money, goods, or services or the value thereof plus 1.5% interest per month, which begins to accrue from the date on which the original payment was made to the provider. Finally, a provider who is convicted under Delaware's false claims statute is no longer eligible to participate in any public assistance program unless the provider successfully petitions for an exception based on public need or interest.

D. <u>Civil Penalties (Del. Code tit. 31, § 1008)</u>

In addition to or instead of the criminal penalties set forth under Section 1007, a provider who violates the false claims statute may be subject to civil penalties including payment of three times the amount of the improperly received payments; a civil penalty of up to $2,000 for each deceptive claim or falsification; and payment of reasonable expenses

incurred by Delaware in enforcing the statute. A provider who violates the statute without intending to do so will be liable for a civil penalty of three times the amount of the improperly received payments.

E. Crimes and Criminal Procedure – Health Care Fraud (Del. Code tit. 11, § 913A)
Any individual who knowingly presents or causes to be presented any fraudulent health care claim to any health care benefit program or who engages in a pattern of presenting or causing to be presented such fraudulent health care claims is guilty of health care fraud. For purposes of this law, a health care benefit program includes public and private health insurance plans and contracts. Under Delaware law, health care fraud is considered a felony offense subject to criminal penalties. In addition to criminal penalties, a person convicted of health care fraud may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained through the individual's violation of this section of the Delaware Code. A conviction of health care fraud is not required for an act of presenting or causing presentation of a fraudulent health care claim to be used in prosecution of a matter under this section, including an act used as proof of a pattern. Prosecution under this section of the Delaware Code does not preclude prosecution under any other section.

VI. WHISTLEBLOWER PROTECTION

A. Federal False Claims Act (31 U.S.C. §3730[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 Claim Act (State Finance Law §191)
The False Claim 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 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. <u>New York Labor Law §740</u>

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, OOMCs, or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

D. <u>New York Labor Law §741</u>

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, OOMCs or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

E. <u>The New Jersey False Claims Act (NJSA § 2A:32C-10)</u>

The New Jersey False Claims Act provides certain protections to an individual who is discharged, demoted, suspended, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of employment by his or her employer as a result of providing information to the State or in furtherance of an action under the New Jersey False Claims Act. Remedies include reinstatement with comparable seniority as the party would have had but for the discrimination, twice the amount of any back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

F. <u>The New Jersey Conscientious Employee Protection Act (NJSA 34:19-1 et seq.)</u>
Under this statute, an employee is protected from retaliation in his/her employment if he/she: (1) Disclosed, or threatened to disclose, to a supervisor or public body an activity, policy or practice of the employer, or of another employer with whom there is a business relationship, that the employee reasonably believed to be in violation of a law, or a rule or regulation issued under the law or (2) Provided information or testimony to a public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship or (3) Objected to or refused to participate in any activity, policy or practice which the employee reasonably believed: (a) is in violation of a law, or a rule or regulation issued under the law; (b) is fraudulent or criminal; or (c) is incompatible with a clear mandate of public policy concerning the public health, safety and welfare or protection of the environment..

G. <u>Pennsylvania Whistleblowers' Protection Law (*See* 43 P.S. 1421, et Seq.)</u>
Pennsylvania law protects employees who report a violation or suspected violation of State, local or Federal law to "appropriate authorities" and participate in hearings, investigations, legislative inquiries, or court actions. More specifically, under Section 1423 of the Act, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a "good faith" report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste.

Under Sections 1424 through 1426 of the Pennsylvania Whistleblower's Act, a person who claims violation of the act may bring a civil action in court for appropriate injunctive relief, monetary damages or both within 180 days after the occurrence of the alleged violation. Remedies could include reinstatement, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages, or any combination of the above. A court may also award the complainant all or a portion of the costs of litigation, including reasonable attorney fees and witness fees, if the court determines that the award is appropriate. Further, any person who, under color of an employer's authority, violates the Act can be held liable for a civil fine of not more than $10,000.00.

H. <u>Delaware Whistleblower Protection Act (19 Del. Code § 1701, et seq.)</u>
The Delaware Whistleblowers' Protection Act (WPA) provides that public and private employers shall not discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because: (1) the employee, or a person acting on behalf of the employee, reports or is about to report to a public body, verbally or in writing, a violation which the

employee knows or reasonably believes has occurred or is about to occur, unless the employee knows or has reason to know that the report is false; (2) an employee participates or is requested by a public body to participate in an investigation, hearing, or inquiry held by that public body, or a court action, in connection with a violation as defined in this chapter; (3) an employee refuses to commit or assist in the commission of a violation, as defined in this chapter; or (4) the employee reports, verbally or in writing, to the employer or to the employee's supervisor a violation, which the employee knows or reasonably believes has occurred or is about to occur, unless the employee knows or has reason to know that the report is false, and if the report is verbally made, the employee must establish by clear and convincing evidence that such report was made. For purposes of the Delaware WPA, "employee" means full-time and part-time employees as well as independent contractors.

I. Delaware False Claims and Reporting Act (6 Del. Code § 1208)

The DFCRA provides certain protections to employee whistleblowers. Under the Act, any employee, contractor, or agent is entitled to relief if he or she is discharged, demoted, suspended, threatened, or discriminated against in other ways in his or her employment for furthering an enforcement action under DFCRA. Such relief shall include, as applicable, reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages. An action under 6 Del. Code § 1208 may be brought in the Superior Court of the State of Delaware in and for the county where the violation is alleged to have occurred.

VII. RESPONSIBILITY

All Personnel are responsible for ongoing compliance with the within policy. OOMC's Compliance Department is responsible for monitoring compliance through ongoing auditing activities and education.

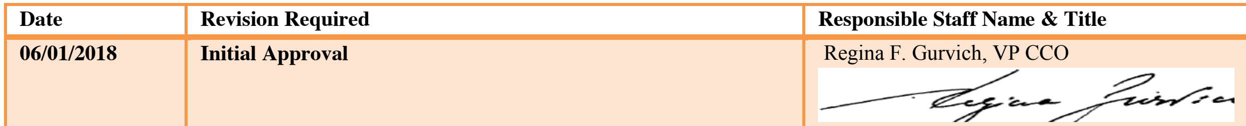
VIII. ENFORCEMENT

Failure to comply with this policy may result in disciplinary actions/sanctions up to, and including, termination of employment, contract, or other engagement.

IX. EFFECTIVE DATE

This policy is effective immediately and will be reviewed periodically and/or revised as necessary. This Policy 100.109.00 is subject to amendment at any time.

Revisions:



Date	Revision Required	Responsible Staff Name & Title
06/01/2018	**Initial Approval**	Regina F. Gurvich, VP CCO