Policy: Compliance Standards of Conduct

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Approved by:	Mia Meloni, Vice President and Chief Compliance Officer
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Accountable for:	Madeline Bell, President & Chief Executive Officer

1 Policy Statement

The Children's Hospital of Philadelphia maintains these Compliance Standards of Conduct in recognition of our responsibility to our patients, staff, physicians, and the community. These Compliance Standards of Conduct affirm our commitment to conduct our activities with ethics and integrity, and in compliance with applicable laws, regulations, and policies and procedures.

2 Scope

This policy applies to the Trustees and Officers, employees, and Medical and Research Staffs of The Children's Hospital of Philadelphia, The Children's Hospital of Philadelphia Foundation, The Children's Hospital of Philadelphia Practice Association, CHOP Clinical Associates, and the CHOPPA Practice Plans (currently Children's Anesthesiology Associates, Children's Health Care Associates, Children's Surgical Associates, and Radiology Associates of Children's Hospital, and their New Jersey entities)(collectively, "Hospital" or "CHOP"). It also applies to any other persons or entities acting or providing services on behalf of the Hospital.

3 Guidelines

All persons covered by this policy are responsible for following the attached Compliance Standards of Conduct.

CHILDREN'S HOSPITAL OF PHILADELPHIA COMPLIANCE STANDARDS OF CONDUCT

SETTING THE STANDARD:
Your Compliance Guide

Policy: Compliance Standards of Conduct

TO: Trustees, Officers, Employees and Members of the Medical and Research Staffs of Children's Hospital of Philadelphia and its affiliates

Children's Hospital has always been a place where ethics and integrity guide our mission of quality pediatric medical care, education, and research. Full compliance with applicable laws and regulations is an important component of our philosophy. In support of this effort, CHOP publishes these Compliance Standards of Conduct, which have been approved by the Board of Trustees.

The Hospital maintains a comprehensive compliance program to help us detect and prevent violations of law and fraud, waste, and abuse as well as to educate everyone regarding key legal and regulatory standards.

These Standards and our commitment to compliance have been embraced by our executive management, department chairs, and Trustees. While this Guide is not comprehensive, these Standards summarize key compliance principles. These Standards do not replace or supersede any existing policies.

If you still have questions about particular matters after reviewing this document, please contact the Hospital's Chief Compliance Officer at 267-426-6037 or email Compliance@chop.edu. You can also raise a compliance concern or ask a question about a compliance matter by calling the Safe to Say compliance hotline at 866-246-7456 or visiting the Safe to Say website, www.mycompliancereport.com, using access code "CHOP".

We recognize that getting the job done is not the only thing that counts. It is also about how we achieve our outcomes. The Hospital's reputation as an industry leader in pediatric healthcare, education, and research requires us to do the right things and to do them the right way. It goes beyond complying with laws, regulations, and policies. It means conducting ourselves with integrity in everything we do.

Please take the time to read these Compliance Standards of Conduct, paying particular attention to the sections that apply to your job. For detailed information, refer to specific policies referenced in each section. The policies may be found in the Hospital's Administrative Policy Manual, the Patient Care Manual, the Human Resources Policy Manual, or specific clinical/departmental policies and procedures that apply to you (e.g., Finance Department, Emergency Department, Operating Room, Blood Bank, Infection Control, Environmental Safety, etc.). The Hospital's Policy, Procedures, and Standards Manuals may be found in Policy Manager on the CHOP home page at SharePoint Online: https://chop365.sharepoint.com.

With the personal commitment of all employees and Medical and Research Staff members, we can maintain our excellent reputation. Please join us in dedicating your best efforts to our compliance program.

Sincerely,

Madeline Bell
President and Chief Executive Officer

Children's Hospital of Philadelphia

Policy: Compliance Standards of Conduct

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APPLICATION OF THIS GUIDE

These Compliance Standards of Conduct apply to the Trustees and Officers, employees, and Medical and Research Staffs of The Children's Hospital of Philadelphia and of entities controlling, controlled by or under common control with The Children's Hospital of Philadelphia, including, without limitation: The Children's Hospital of Philadelphia Foundation; The Children's Hospital of Philadelphia Practice Association; CHOP Clinical Associates; and the CHOPPA Practice Plans (currently Children's Anesthesiology Associates, Children's Health Care Associates, Children's Surgical Associates, and Radiology Associates of Children's Hospital, and their New Jersey counterparts)(collectively, "Hospital). It also applies to any other persons or entities acting or providing services on behalf of the Hospital, including persons acting or providing services on behalf of the Hospital at CHOP affiliate locations.

CODE OF CONDUCT STATEMENT

Ethics, integrity, and compliance have always been valued principles at CHOP. Our compliance program has been established to formally educate the Medical Staff and employees about the laws, regulations, and policies and procedures governing our activities and to detect and prevent fraud, waste, and abuse. By encouraging the identification, communication, and correction of compliance issues, our compliance program helps ensure that all our activities are ethical and legally compliant.

Please review the applicable sections of these Compliance Standards of Conduct. The Hospital expects you to comply with both the letter and spirit of the compliance program.

Our compliance program is intended to be a formal statement of the Hospital's approach to compliance matters. However, some situations may arise in which you are unclear whether the conduct is acceptable or not. In those situations, *raise the concern with your supervisor, or the Chief Compliance Officer, or if it is a legal issue, contact the Office of General Counsel.*

Each employee is a valued member of the team and each has an obligation to see that the Hospital maintains its high standards of professional, ethical conduct.

YOUR OBLIGATION TO REPORT

If you encounter any situation that you believe may be in violation of any applicable law or Hospital policy or procedure, you should immediately contact your supervisor, the Chief Compliance Officer, or a member of the Office of General Counsel. You may also call the anonymous, toll-free Safe to Say compliance hotline at 866-246-7456, or go to www.mycompliancereport.com (enter "CHOP" for the access ID). Everyone is responsible for promoting compliance.

USING THE COMPLIANCE PROGRAM

Purpose of Our Compliance Standards of Conduct

These Compliance Standards of Conduct provide those of us who work at the Hospital with information to help carry out our job responsibilities within appropriate ethical and legal parameters. These obligations apply to all our relationships in connection with the Hospital, including relationships with patients, families, physicians, third-party payors, subcontractors, independent contractors, vendors, consultants, and each other.

These Standards are a critical component of our overall compliance program, developed to help you meet ethical standards and comply with applicable laws and regulations.

These Compliance Standards of Conduct are not intended to be an all-inclusive statement of our duties and obligations. The Hospital maintains numerous detailed policies and procedures that govern our activities, duties, and obligations. In some cases, a subject discussed in this Guide involves such complexity that additional guidance may be needed. In these cases, you should consult the applicable policy or procedure for further information or contact your supervisor, the Office of General Counsel, or the Chief Compliance Officer for additional guidance.

Management's Compliance Obligations

We expect leaders to set the example and be models for their staff members. As the caretakers of our quality and reputation, you must strive to assure that everyone on your team has sufficient information to comply with applicable laws, regulations, and policies, as well as the resources to resolve ethical and compliance dilemmas. As leaders, you must help sustain the culture within the Hospital that promotes high standards of ethics and compliance. Managers and supervisors are also accountable for appropriately educating their staff about our compliance program.

Disciplinary Action

If you violate applicable laws or the Hospital's policies or procedures, you may be subject to disciplinary action. The specific action will depend on the nature and severity of the violation (and, where applicable, will be consistent with the Hospital's Human Resources Policy Manual or other applicable disciplinary standards).

Discipline may include:

- General counseling
- Oral warning
- Written warning
- Final Warning
- Termination
- Medical Staff sanctions (set forth in the Medical Staff Bylaws)

Chief Compliance Officer

The Hospital's compliance program demonstrates the Hospital's commitment to high ethical standards and compliance with applicable laws, regulations, and policies and procedures. The Chief Compliance Officer assists the Hospital with the following activities:

- Assesses the Hospital's compliance activities;
- Monitors implementation of the Hospital's compliance program;

- Provides/facilitates education and training regarding laws and regulations affecting the organization;
- Communicates to senior leaders and the Board of Trustees, including its Audit, Compliance and Risk Committee, on the compliance program and presents compliance policies, reports, and plans for approval as appropriate;
- Follows up on compliance findings, ensuring that appropriate corrective action has been taken; and
- Continuously monitors the effectiveness of compliance activities, including the effectiveness of the compliance program.

Reporting Compliance Concerns

It is your duty to report any conduct that you reasonably believe violates our policies or applicable law to your supervisor, the Office of Compliance and Privacy, a member of the Office of General Counsel, or the Safe to Say compliance hotline. If you wish, you may make an anonymous report to the Safe to Say compliance hotline (866-246-7456 or www.mycompliancereport.com). Under Hospital policy, no attempt should be made to learn the identity of persons making anonymous reports to the Safe to Say compliance hotline.

The Hospital will not take any action against someone for reporting a compliance violation in good faith. The Hospital prohibits intimidation and any retaliation against persons for making good faith compliance reports. If you were a party to the non-compliant activity you reported, your good faith efforts will be considered in assessing whether disciplinary action against you is appropriate.

We are committed to investigating all reports promptly and protecting your confidentiality and anonymity as much as possible. If you contact the Safe to Say compliance hotline anonymously and wish to obtain an update on the status of the matter reported, you will be given a special case number and information about when and how to call back at the time of your initial call. Alternatively, you may provide an email address that will be hidden from view which will enable communication through the Safe to Say compliance hotline. To the extent that is possible and appropriate, an update will be provided to you. Once an investigation is completed, action to address the issue will be taken as soon as practicable.

Employees are protected by federal and state whistleblower statutes, which protect employees who report fraud, waste, abuse, or other violations of law. For additional information on whistleblower actions under the False Claims Act and certain state laws and immunity under federal trade secret law, please refer to the attached Appendix. Whistleblower protection statutes also apply to employees who work on federal grants and contracts. For details on whistleblower actions and protections applicable to federal grants, please refer to the attached Appendix.

Education and Training

The Hospital is committed to effectively communicating our standards and procedures to all employees. We provide education and training to develop compliance awareness and commitment. You must complete annual mandatory compliance training that is applicable to your job function.

We will track your participation in the annual mandatory compliance training and will maintain records of participation in accordance with our compliance training procedures.

Compliance Monitoring

The Hospital is committed to responsibly monitoring implementation of the compliance program. Department managers are responsible for monitoring compliance in their areas on an ongoing basis. In addition, the Office of

Compliance and Privacy develops annual compliance plans.

RELATIONSHIPS WITH PATIENTS

Patient Care and Rights

In our mission to provide quality healthcare, research, and education, we work hard to treat all patients and their families with respect and dignity and to provide care that is necessary and appropriate. We seek to make no distinctions in the admission, transfer, or discharge of patients or in the care we provide based on race, color, age, sex, gender identity or expression, sexual orientation, national origin, religion, and disability.

Upon admission, each patient/family is given a statement of patient rights and responsibilities, including information about the right to make decisions regarding medical care.

We encourage patient and family involvement in all aspects of care. the Hospital's Patient and Family Rights and Responsibilities policy (RI-2-01) and associated Job Aid provide additional guidance. Please refer to these documents if you have any questions regarding related issues.

Emergency Treatment

The Hospital provides medical screening and treatment to all patients who come to the Hospital seeking treatment for an emergency medical condition, as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"). We do not deny emergency treatment to any patient who comes to the Hospital based upon inability to pay or lack of insurance. EMTALA establishes detailed requirements on when and how a patient who has an emergency medical condition may be transferred to another institution. If you have any questions about EMTALA requirements, please refer to the Hospital's EMTALA policy (A-4-24) or contact the Office of General Counsel.

Charity Care and Discounts

The Hospital provides services that are medically necessary to all pediatric patients in our Primary Service Area, regardless of ability to pay, in accordance with our Financial Assistance (formerly Charity Care) policy. For more information, please refer to the Financial Assistance policy (A-2-03) in the Administrative Policy Manual. The Hospital offers prompt payment discounts for the prompt payment of patient/family financial obligations, in accordance with the Prompt Payment policy (A-2-04). The Hospital does not grant any routine waivers or discounts in other circumstances and does not extend professional courtesy to patients based on their relationship with Hospital providers and other personnel, officers, or directors. For more information refer to the Discounts and Reductions of Patient/Family Financial Obligations policy (A-2-05).

CONFIDENTIALITY OF PATIENT AND INSTITUTIONAL INFORMATION

Patients and their families trust their healthcare providers with highly personal and sometimes sensitive or embarrassing information regarding their personal and medical history. If patients or families do not feel confident that their providers will keep such information private, they may hesitate to discuss intensely private issues, which could hinder their medical care. In addition, federal, state, and local laws provide protection for the confidentiality of patient medical records and require that only authorized personnel shall have access to that information and that disclosures are limited.

It is critical that healthcare providers protect patient information and patient privacy. Because this protection is one of our highest duties as a healthcare provider, you are expected to understand when disclosures are allowable and/or required and when they are not. These rules are outlined in detail in the Hospital's policies related to patient health information.

In addition, it is important to remember that Hospital institutional information must be protected. Hospital proprietary information such as non-public research information, intellectual property, trade secrets, and the private information of our workforce (e.g., payroll information) should remain confidential.

For more information, refer to the Confidentiality of Patient and Institutional Information policy (A-3-05) and related policies.

RELATIONSHIPS WITH PAYORS

Coding and Billing for Services

The Hospital takes great care to assure that there are systems in place for submitting claims for reimbursement to government and private insurance payors that are truthful, accurate, and conform to the requirements of federal, state, and local laws and regulations. These laws include the federal False Claims Act as well as state false claims act legislation and other laws prohibiting schemes to defraud a healthcare benefit program.

The federal False Claims Act prohibits an individual or organization from knowingly or recklessly submitting a false claim for payment or approval to a federal or state health care program. It also prohibits knowingly or recklessly making, using, or causing to be used a false record or statement to get a false or fraudulent claim paid by the government. Violations may result in civil, criminal, and administrative actions and may be punishable by substantial monetary penalties, fines, imprisonment, and exclusion from federal and state health care programs. We prohibit any employee or agent of the Hospital from knowingly presenting or causing claims to be presented for payment or approval that are false, fictitious, intentionally misleading, fraudulent, or in violation of any law. For a further description of the federal False Claims Act, please refer to the attached Appendix.

Both Pennsylvania and New Jersey have laws prohibiting persons from knowingly or intentionally submitting false claims or statements in connection with providing services or merchandise under medical assistance, or in connection with applying for or continuing to receive medical assistance benefits or payments. New Jersey enacted the New Jersey False Claims Act as well as the Health Care Claims Fraud Act which also prohibits health care practitioners licensed in New Jersey and others from committing health care claims fraud in the course of providing professional services. Violations of these laws may result in criminal actions punishable by imprisonment, substantial monetary penalties, and fines. For a further description of Pennsylvania's and New Jersey's laws, please refer to the attached Appendix.

The Hospital makes diligent efforts to maintain systems that result in fair, reasonable, and accurate claims submission with the following specific objectives:

(1) Billing only for items or services actually rendered;

(2) Billing only for medically necessary services;

(3) Preventing upcoding (i.e., the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient);

(4) Submitting accurate cost reports;

(5) Appropriately bundling or combining services that should be billed together;

(6) Billing the appropriate per-diem rate for patient transfers to another hospital;

(7) Creating and maintaining supporting medical record documentation for services billed to patients or payors;

(8) Billing for the services of teaching physicians only in accordance with applicable laws; and

(9) Avoiding submission of claims arising from impermissible -kickback arrangements.

We maintain oversight systems to verify that claims are submitted only for services actually provided and that services are billed as provided. Failure to follow these principles could result in submission of false claims.

Any subcontractors engaged to perform billing or coding services should have the necessary skills, quality assurance processes, systems, and appropriate procedures to ensure that all billings for government and private insurance programs are accurate and complete.

It is the obligation of all staff to bring to the attention of your supervisor or the Chief Compliance Officer, or report to the Safe to Say compliance hotline, any billing practices you observe that are not truthful, accurate, or in conformity with the requirements of federal, state, and local laws and regulations.

In addition, the federal False Claims Act allows private persons to bring "whistleblower" actions in the name of the government if they believe the False Claims Act has been violated and to recover substantial monetary rewards if the action results in a settlement or judgment. The False Claims Act protects the rights of whistleblowers; it is a violation of the Act for an employer to take any action against someone for participating in an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action under the False Claims Act. Other laws also provide protection of whistleblowers in certain circumstances. We prohibit any individual or agent of the Hospital from violating the non-retaliation provisions of the False Claims Act or any other applicable law.

Certain states also have false claims laws with private enforcement and whistleblower protection provisions comparable to the federal False Claims Act. Of the states in which the Hospital operates or has affiliates, New Jersey and Delaware have such a law, while Pennsylvania currently does not. New Jersey and Pennsylvania have separate whistleblower protection laws that, along with New Jersey's and Delaware's false claims laws, are more fully described in the attached Appendix.

For possible improper practices involving Pennsylvania Medicaid billing you may also choose to contact the Pennsylvania Department of Human Services Fraud Tip Hotline at 1-844-DHS-TIPS (1-844-347-8477). For possible improper practices involving New Jersey Medicaid billing you may choose to contact the New Jersey Office of the State Comptroller at 1-877-937-2835.

Excluded Parties

There are restrictions on healthcare providers and other entities employing or entering into contracts with individuals or entities that are (at the time of employment or contract) excluded from participation in federal or state health care programs.

We require individuals applying for employment to disclose in their application any felonies or other crimes or exclusion action. Screening of potential employees and Medical Staff members includes consulting applicable government lists of excluded persons/entities.

We conduct monthly checks of federal and state databases to verify that our employees, Medical Staff members and certain contractors/vendors are not excluded, unlicensed, or uncertified, where applicable.

If an employee or member of the Medical Staff is investigated by any government agency for violation of a licensure, certification, or health care law or regulation, the investigation should be reported immediately to the Office of General Counsel and/or the Chief Compliance Officer.

If an employee or member of the Medical Staff is indicted, convicted, debarred, suspended or excluded from participation in federal or state healthcare programs while affiliated with the Hospital, or receives notice of proposed debarment or exclusion, this fact must be reported in accordance with applicable policies or standards of the Hospital and/or its Medical Staff, as applicable.

Credit Balances & Bad Debts

The Hospital will treat credit balances and bad debt in compliance with applicable law and regulations.

In some instances, a credit balance will exist in a patient account after payment by both the patient and a federal or state healthcare program. We endeavor to accurately track, report, and refund credit balances.

Cost Reports

Our activities include reimbursement under government programs that require us to submit certain reports of our costs of operation. The Hospital will comply with all federal, state, and local laws relating to cost reports. These laws and regulations define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of these requirements, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with our Finance Department.

RELATIONSHIPS WITH REFERRAL SOURCES

Federal law generally prohibits payments in exchange for or to induce referral of patients or business to other healthcare providers or suppliers. This prohibition is very broad and applies both to those who offer or make such payments and to those who receive such payments. In addition, a payment may be anything of value, not just cash

payments. There may be criminal as well as civil sanctions for violation of this prohibition.

The Hospital accepts patient referrals and admissions based on patients' clinical needs and our ability to render the needed services. We do not pay or offer anything of value, directly or indirectly, to anyone for referring or to induce the referral of patients or business to us.

Similarly, the Hospital makes referrals to other healthcare providers or suppliers based on patients' clinical needs and the ability of other providers or suppliers to render needed services and patient/family preferences. We do not solicit or receive anything of value, directly or indirectly, in exchange for or to induce referring patients to any other healthcare provider or supplier.

Federal law also generally prohibits us from giving anything of value to patients or families that we know (or should know) would likely influence their decision to receive services from the Hospital. There are permitted exceptions to this general prohibition when the value being offered relates to the promotion of certain preventive care services or involves situations where the patient/family is indigent or in financial need.

Federal law also has prohibitions against a physician referring patients for certain services (such as clinical labs) to facilities or providers with which the referring physician (or a family member of that physician) has a financial relationship or financial interest. Violations can result in fines and exclusion from Medicare or Medicaid. The law is complex; it applies only to certain services and has many exceptions. Please contact the Office of General Counsel with questions about these laws or to discuss proposed arrangements with other providers, to be sure those arrangements comply with applicable law.

RELATIONSHIPS WITH COMPETITORS

Antitrust

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing Hospital business with a competitor (such as what our prices are or how our prices are set), disclosing the terms of supplier relationships, allocating markets among competitors, or agreeing with a competitor to refuse to deal with a supplier. Questions related to these matters should be directed to the Office of General Counsel.

Marketing Our Services

We may use our marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and recruit employees. We will present only truthful, fully informative, and non-deceptive information in these materials and announcements.

RELATIONSHIPS WITH VENDORS

We select the vendors and contractors with which we do business on the basis of arms-length and appropriate business criteria and not on the basis of gifts to persons the existence or amount of other support a vendor or contractor provides to the Hospital (except in connection with a legally appropriate discount or rebate), vendor or contractor support of Hospital research, or other inappropriate factors. We endeavor to conduct business with vendors and contractors in a way that maximizes the ability of the Hospital to carry out its patient care, research, and education missions and in accordance with legal and ethical standards aimed at preventing conduct that may

inappropriately influence purchasing decisions. Please refer to the Interactions with Vendors policy (A-3-07) and related policies, such as the Control of On-site Activity by Vendors (A-3-08) and Conflicts of Interest policy (A-3-1) for more information.

RELATIONSHIPS WITH FOREIGN GOVERNMENTS AND OFFICIALS

We conduct activities in foreign countries and with foreign officials in full compliance with potentially applicable anti-corruption laws, including the U.S. Foreign Corrupt Practices Act, the UK Bribery Act, and other potentially applicable local anti-corruption laws. We are committed to the highest ethical standards in all of our activities and interactions. Hospital personnel will not give or offer anything of value, directly or indirectly, to any foreign official or any other individual for the purpose of improperly obtaining or retaining a business advantage. Bribes, kickbacks, or similar payments are never permitted.

Please refer to the International Anti-Corruption Compliance policy (A-3-16) and related policies for more information.

RELATIONSHIPS WITH EMPLOYEES AND MEMBERS OF THE MEDICAL STAFF

We use our best efforts to comply with all state and federal laws governing relationships with employees and independent contractors. The Hospital maintains policies that address many issues relating to employment at the Hospital. For additional guidance on any employee policy or practice, please refer to the Administrative and Human Resources Policy Manuals. In particular, please refer to:

- **Equal Employment Opportunity and Affirmative Action – Human Resources policy (2-1)**
- **Non-Discrimination, Harassment and Retaliation – Administrative policy (A-4-18)**
- **Workplace Violence – Administrative policy (A-4-34)**
- **Drug Free Workplace – Administrative policy (A-4-23)**

Environmental Health and Safety

The Hospital is committed to providing a safe workplace. You may work in a variety of situations or with a variety of materials, some of which may pose a risk of injury. You are required to comply with our policies and procedures for workplace safety, which have been designed to comply with federal, state, and local safety laws and regulations and workplace safety directives. If you have a question about safety, you should seek advice from the Environmental Health and Safety Department.

It is essential that you report any workplace injury or any situation presenting a danger of injury so that timely corrective action may be taken. Please refer to the Hospital's Safety Manual and relevant safety policies such as the Hazard Communication (S6.1policy) and Chemical Spill Response policy (S7.1) which provide guidance related to chemical hazards.

Background Checks and Credentialing

The Hospital endeavors to conduct formal background and credentialing checks on all employees, Medical Staff members and certain vendors/contractors. The Hospital reserves the right to deny employment or continued employment or Medical Staff membership or work/contracts for goods or services to any individual who fails to meet our standards. See also "Excluded Parties," at page 14.

CONFLICTS OF INTEREST

Conflicts of interest are those circumstances in which your personal interests actually or potentially conflict with those of the Hospital or are perceived as actually or potentially conflicting with those of the Hospital. the Hospital has adopted a Conflicts of Interest policy (A-3-01). The policy outlines circumstances in which outside interests or activities, such as accepting gifts, holding ownership interests in companies, or engaging in outside activities, create a potential, perceived, or actual conflict of interest. The policy also contains special rules for conflict of interest issues in the research setting.

A potential, perceived, or actual conflict of interest situation may arise at any time. The Conflicts of Interest Policy requires that such situations be disclosed promptly, as soon as the existence of the potential, perceived, or actual conflict of interest is or should be known, so that you can obtain guidance about the situation at the earliest possible time. If there is any doubt about a situation, it should be fully disclosed to the Office of Compliance and Privacy so that a determination can be made.

Please refer to the Conflicts of Interest policy (A-3-01) and the Office of Compliance and Privacy @CHOP SharePoint online site for more information regarding Conflicts of Interest.

INSIDER TRADING

The Hospital and/or its personnel may have access to information about the Hospital or companies and entities with which it has some relationship that would be considered material non-public information under the securities laws. Information that an investor might consider important in deciding whether to buy, sell, or hold securities is considered "material." Information is considered to be "non-public" unless it has been effectively and broadly disclosed to the public, for example by a press release and the stock market has had ample time to digest the information. Information that is discussed widely within the Hospital is not, in and of itself, considered public information.

Insider trading includes buying or selling securities (e.g., stocks, bonds, options, etc.) while in possession of material non-public information, and it also includes communicating ("tipping") material nonpublic information to another person who trades in publicly held securities on the basis of the information or who in turn passes the information on to someone who trades.

Penalties for violating these federal rules can include civil fines, criminal fines, and imprisonment.

The Hospital has an Insider Trading policy (A-3-15) to address this issue. All individuals affiliated with the Hospital and their family members (defined in the policy) must abide by this policy. The policy includes restrictions on the ability of hospital personnel to trade under certain circumstances. Please refer to the policy and consult with the Hospital's Office of General Counsel with questions or when required under the policy.

INFORMATION AND COMMUNICATION SYSTEMS

You may have access to Hospital technology resources. Specifically, this may include computers, networks, electronic mail services, electronic information sources, information systems, applications, software, communication devices and other systems such as identity tokens, telephones, smartphones, tablets, faxes,

external storage devices, other portable devices, and wireless systems, as well as new technologies that may become available to conduct Hospital Activities. These technology resources are the property of the Hospital and are intended to be used for purposes related to the Hospital's business and operations. As a general rule, only minimal personal use of the Hospital's technology resources is permitted.

You should assume that communications using Hospital systems are not private. The Hospital has the right to access, monitor, and disclose the contents of our communications systems without notice to the users to the extent allowable by law.

All uses of the Hospital's technology resources must comply with applicable Hospital policy, including the Acceptable Use of Technology Resources policy (A-3-06). This includes the use of Artificial Intelligence (AI) technologies. Hospital patient information (whether or not de-identified) and/or institutional information (whether or not anonymized) may not be provided to, or used in connection with, AI technologies that have not been approved by the Hospital.

The Hospital may revoke access to our technology resources or take disciplinary action if you use them in violation of our policies or in violation of any applicable law or regulation.

GOVERNMENT INQUIRIES/INVESTIGATIONS

The Hospital expects you to cooperate appropriately in government investigations. However, it is essential that the legal rights of the Hospital and our employees, Medical Staff members, and patients be protected.

If you receive a subpoena, inquiry, or other document from any government agency regarding the Hospital's business or patients, whether at home or in the workplace, notify the Office of General Counsel (with a copy to the Office of Compliance and Privacy) immediately. Please notify the Health Information Management Department in the case of subpoenas for medical records.

If you are aware of an imminent or ongoing investigation, audit, or examination, you should retain all documents (including computer records) in your custody or control relating to the matter under review.

Any questions regarding government inquiries or investigations should be addressed to the Office of General Counsel.

POLITICAL AND LEGISLATIVE ACTIVITIES

The Hospital is exempt from federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Code. In order to maintain this status, the Hospital may not participate in any political campaign on behalf of or in opposition to any candidate for public office. This is an absolute prohibition. In addition, the Hospital cannot engage in more than insubstantial lobbying on legislative issues. Individuals are free to engage in political and legislative activities in their personal capacity on their personal time. The Hospital titles, letterhead, and resources may not be used for political activities; and they may be used for legislative activities only with the permission of a member of senior management.

APPENDIX
Summary of Federal and State Laws

FEDERAL LAWS

a. The False Claims Act

The False Claims Act ("FCA") provides, in pertinent part, that:
31 U.S. Code § 3729 (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 a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; 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 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 plus 3 times the amount of damages which the Government sustains because of the act of that person.

The civil penalties for False Claims Act violations in 2024 are a minimum of $13,946 per violation and a maximum of $27,894, per violation.

(1) 31 U.S. Code § 3729 (b)For purposes of this section—
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

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. 31 U.S.C. § 3729(b).

In sum, the FCA imposes liability on any person who submits a claim to 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 hospital 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. 31 U.S.C. § 3730(b). 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% but not more than 25% 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% and not more than 30%.

The FCA 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 FCA. 31 U.S.C. § 3730(h). 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.

b. Program Fraud Civil Remedies Act ("PFCRA")

This federal law makes it illegal for a person or entity to make, present, or submit (or cause to be made, presented, or submitted) a "claim" (i.e., a request, demand, or submission) for property, services, or money to an "authority" (i.e., an executive department of the federal government such as the U.S. Department of Health and Human Services which oversees Medicare and Medicaid programs) when the person or entity "knows or has reason to know" that the claim: (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 that omits a material fact, is false, fictitious, or fraudulent as a result of such 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. 31 U.S.C. § 3802(a)(1).

In addition, it is illegal to make, present, or submit (or cause to be made, presented, or submitted) a written "statement" (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity "knows or has reason to know" such statement: (i) asserts a material fact which is false or (ii) omits a material fact making the statement false, fictitious, or fraudulent because of the omission. 31 U.S.C. § 3802(a)(2).

Similar to the Federal False Claims Act, the PFCRA broadly defines the terms "knows or has reason to know" as (1) having actual knowledge that the claim or statement is false, fictitious, or fraudulent; (2) acting in deliberate ignorance of the truth or falsity of the claim or statement; or (3) acting in reckless disregard of the truth or falsity of the claim or statement. The law provides that a specific intent to defraud is not required in order to prove that the law has been violated. 31 U.S.C. § 3801(a)(5).

The PFCRA provides for civil penalties of up to $5,000 (adjusted yearly for inflation) for each false claim paid by the government and in certain circumstances, an assessment of twice the amount of each claim.

In addition, if a written statement omits a material fact and 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 and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, the law provides for a penalty of up to $5,000 (adjusted yearly for inflation) to be imposed for each such statement.

The PCFRA civil penalty for false claims and statements in 2024 is $13,946.

c. Federal Whistleblower Protections for Employees of Contractors, Subcontractors, and Grantees

The employee whistleblower statute applies to all employees working for contractors, grantees, subcontractors, and subgrantees on federal grants and contracts and states that such persons "may not be discharged, demoted, or otherwise discriminated against as a reprisal for [whistleblowing]." 41 U.S.C. § 4712(a)(1).

Whistleblowing is defined as making a disclosure "that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant." 41 U.S.C. § 4712(a)(1).

To qualify under the statute, the employee's disclosure must be made to "(A) a member of Congress or a representative of a committee of Congress; (B) an Inspector General; (C) the Government Accountability Office; (D) a Federal employee responsible for contract or grant oversight or management at the relevant agency; (E) an authorized official of the Department of Justice or other law enforcement agency; (F) a court or grand jury; or (G) a management official or other employee of the contractor, subcontractor, or grantee who has the responsibility to investigate, discover, or address misconduct." 41 U.S.C. § 4712(a)(2).

d. Federal Trade Secrets Law Whistleblower Provision

Pursuant to the 2016 Defend Trade Secrets Act (DTSA), no individual will be held criminally or civilly liable under Federal or State trade secret law for disclosure of a trade secret (as defined in the Economic Espionage Act) that is: (A) made in confidence to a Federal, State, or local government official, either directly or indirectly, or to an attorney and made solely for the purpose of reporting or investigating a suspected violation of law; or, (B) made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal so that it is not made public. 18 U.S.C. § 1836 et seq. An individual who pursues a lawsuit for retaliation by an employer for reporting a suspected violation of the law may disclose the trade secret to the attorney of the individual and

use the trade secret information in the court proceeding, if the individual files any document containing the trade secret under seal and does not disclose the trade secret, except as permitted by court order.

PENNSYLVANIA LAWS

a. Fraud and Abuse Control under the Public Welfare Code

This law contains provisions relating to acts prohibited by providers (62 P.S. §1407) and other acts relating to applications for medical assistance or the receipt of benefits under the program (62 P.S. § 1408). Under Pennsylvania law, it is unlawful for providers to: knowingly or intentionally submit false information, or false claims or costs reports for furnishing services or merchandise under the medical assistance program, or claims or cost reports for medically unnecessary services or merchandiser, 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 or claimed reimbursement; submit a 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 such things as the services provided, supplies or equipment provided, date of service, or identify of the practitioner or provider; submit claims for reimbursement higher than the provider's charge to the general public; submit claim 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). Violations can result in criminal and civil penalties, including monetary penalties and termination of participation as a provider in the medical assistance program.

Under Pennsylvania law, it is also unlawful for other persons 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. Violations can result in criminal and civil penalties, including monetary penalties and restrictions on continued eligibility for medical assistance benefits. (62 P.S. §.1408).

b. Whistleblower Law

Pennsylvania law protects the rights of employees of public bodies, such as state or local governments, who make good faith reports about wrongdoing or waste, or who participate in an investigation, hearing or inquiry. (43 P.S. §§ 1421-1428).

c. Reporting Medicaid or Insurance Fraud

To report Medicaid fraud in Pennsylvania, you can contact the Pennsylvania Office of Inspector General at (855) 372-8372 or the Pennsylvania Bureau of Program Integrity at (866) 379-8477. You can also call the Fraud Tip Line at (844) 347-8477. To report insurance fraud in Pennsylvania, you can contact the Pennsylvania Attorney General

Insurance Fraud Section at (717) 787-0272 or by visiting https://www.attorneygeneral.gov/protect-yourself/insurance-fraud/insurance-fraud-referrals/.

NEW JERSEY LAWS

a. New Jersey False Claims Act

The New Jersey False Claims Act (the "New Jersey FCA", N.J. S. 2A:32C-1 to 32C-17 (2008)) is comparable to the federal False Claims Act, making it unlawful for a person to knowingly make false or fraudulent claims, including to: present or cause 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; make, use or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State; conspire to defraud the State by getting a false or fraudulent claim allowed or paid; or knowingly make, use, or cause 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 FCA results in a civil penalty equal to the civil penalty under the Federal FCA for each act constituting a violation, plus 3 times the amount of the damages sustained by the State (or 2 times the amount of damages if the person committing the violations provides full information and cooperation to the government officials investigation the false claims violations). In addition to its substantive provisions, the New Jersey FCA provides that private parties may bring an action in the name of the State for a violation of the FCA. These private parties may share in a percentage of the proceeds from an action or settlement. With some exceptions, when the government has intervened in the lawsuit, this law provides that the private party shall receive at least 15% but not more than 25% of the proceeds depending upon the extent to which the person substantially contributed to the prosecution of the action. When the government does not intervene, the private party is entitled to receive an amount that the court decides is reasonable, which shall be not less than 25% and not more than 30%.

A civil action under the New Jersey FCA may not be brought on the later of the two following dates: (1) more than 6 years after the date on which the violation is committed; or (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the New Jersey official charged with responsibility to act in the circumstances. However, in no event may an action be brought under the New Jersey FCA more than 10 years after the date on which the violation is committed. The New Jersey FCA provides protection to private parties who are discharged, demoted, suspended, threatened, harassed, denied promotion or in any other manner discriminated against in the terms and conditions of their employment as a result of their disclosure of information to the State or furtherance of an action under the New Jersey FCA. Remedies include reinstatement with comparable seniority as the party 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. New Jersey Medical Assistance and Health Services Act – Criminal Penalties and Civil Remedies

The New Jersey Medical Assistance and Health Services Act contains provisions relating to acts prohibited by persons receiving medical assistance benefits and providers receiving medical assistance payments. The law makes it a crime for a provider to knowingly receive medical assistance payments to which he is not entitled or in a greater amount than entitled. It is also a crime for a provider or other person or entity to knowingly and willfully make materially false statements in applying for payments under the medical assistance program or for use in determining rights to such payment, to conceal or fail to disclose the occurrence of an event affecting the

initial or continued right to a payment with the fraudulent intent to secure payments not authorized or in a greater amount than authorized under the law, or to knowingly and willfully convert payments to a use other than the use and benefit of the provider or other person. It is also a crime for a provider or other person to solicit, offer or receive a kickback, rebate or bribe in connection with the receipt of a payment under the Act or the furnishing of items or services for which payment is or may be made or whose cost is or may be reported in order to obtain such payments (except for lawful discounts or price reductions and payments to an employee under a bona fide employment relationship). Finally, it is a crime to knowingly and willingly make or induce, or seek to do so, the making of false statements or representations of material facts with respect to the conditions or operations of an institution or facility in order for it to qualify for certification or recertification of a hospital and thereby entitled to receive medical assistance payments. Violations can result in criminal penalties including fines up to $11,000 and imprisonment of up to three years. (N.J.S. 30:4D-17 (a)-(d)).

In addition, various civil remedies are available to the government under the Medical Assistance and Health Services Act. Persons or entities committing the crimes described in the previous paragraph are liable for civil penalties (recoverable in an administrative proceeding) including all of the following: interest on the excess payments, three times the amount of the payments unlawfully obtained and $5,000 - $10,000 per excessive claim for payments. Persons or entities who obtain medical assistance payments in amounts in excess of that to which they are entitled, but without intent to violate the Act, may be subject to a civil penalty in the amount of interest on the excess payments. Finally, the director of the Medical Assistance Program has the authority to suspend, debar or disqualify for good cause any provider (or an agent, employee, or contractor of one) or other person or entity participating in the Medicaid program. (N.J.S. 30:4D- 7.h; 30:4D-17 (e) – (i); 30: 4D-17.1.a).

c. Health Care Claims Fraud Act

This law makes it a crime for licensed health care practitioners and persons who are not practitioners to knowingly or recklessly commit health care claims fraud in the course of providing professional services. Conviction under the Health Care Claims Fraud Act subjects the person to criminal penalties imprisonment of up to ten years, as permitted under New Jersey law, fines of up to five times the pecuniary benefit received or sought and license or certificate forfeiture. Health care claims fraud includes the making of false or misleading statements in, or omission of material facts from, a record, bill, claim, or other document submitted for payment or reimbursement for health care services. (N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5).

d. New Jersey Insurance Fraud Prevention Act

This law makes it unlawful for a person to knowingly commit insurance fraud or assist or cause others to commit insurance fraud in New Jersey. A person or a practitioner violates this act if he (1) Presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or (2) Prepares or makes any written or oral statement that is intended to be presented to any insurance company, the Unsatisfied Claim and Judgment Fund or any claimant thereof in connection with, or in support of or opposition to any claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (C.39:6-61 et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or (3) Conceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to (a) any insurance benefit or payment or (b) the amount of any benefit or payment to which the person is entitled; (4) Prepares or makes any written or oral statement, intended to be

presented to any insurance company or producer for the purpose of obtaining an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract; or (5) Conceals or knowingly fails to disclose any evidence, written or oral, which may be relevant to a finding that a violation of this act has or has not occurred. A person or practitioner may also violate this act if he knowingly assists, conspires with, or urges any person or practitioner to violate any of the provisions of this act; he knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this act; is the owner, administrator or employee of any hospital and allows the use of the facilities of the hospital by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this act; and if, for pecuniary gain, for himself or another, he directly or indirectly solicits any person or practitioner to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action, against any person, for damages for negligence, or, for pecuniary gain, for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, or for pecuniary gain, for himself or another, directly or indirectly solicits other persons to make a claim for personal injury protection benefits pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) Violation of this law may result in civil penalties, civil administrative actions and criminal prosecution. (N.J.S.A 17:33A-1 et seq)

e. Conscientious Employee Protection Act

This law prohibits retaliation against an employee who discloses to a supervisor or public body an activity, policy, or practice by an employer that the employee reasonably believes violates a law, rule, or regulation, or is fraudulent or criminal. It also prohibits retaliation against an employee who provides information or testimony to a public body investigating a violation of law, rule or regulation by an employer, or who objects to or refuses to participate in any activity, policy or practice that the employee reasonably believes is in violation of a law, rule or regulation, or is fraudulent, or incompatible with a clear mandate of public policy. The law provides a private right of action for aggrieved employees with available remedies including injunctive relief, reinstatement, lost wages and benefits and other compensatory damages; a defendant may also be subject to civil fines and punitive damages. An employer may, however, recover attorneys fees and costs if an employee is found to have brought an action without basis in law or fact. (N.J.S. 34:19-1 to 19-14.).

f. Reporting Medicaid or Insurance Fraud

New Jersey Medicaid or insurance fraud may be reported to the New Jersey Medicaid Fraud Division at 888-937-2835 or https://www.nj.gov/comptroller/divisions/medicaid/complaint.html and the New Jersey Insurance Fraud Prosecutor Hotline at 877-55- FRAUD or https://njinsurancefraud2.org/#report.

DELAWARE LAWS

a. Delaware False Claims and Reporting Act

The Delaware False Claims and Reporting Act (the "Delaware FCRA", 6 Del. C. 1201-1209) is comparable to the federal False Claims Act, making it unlawful for a person to knowingly: present or cause to be presented to the government of the State of Delaware (including, for example, departments, political subdivisions, state and municipal authorities and State-funded entities) 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 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 government. Liability under the Delaware False Claims and Reporting Act results in a civil penalty of between $12,537 and $25,076 for each act constituting a violation, plus 3 times the amount of the damages sustained by the government (or 2 times the amount of damages if the person committing the violations provides full information and cooperation to the government officials investigation the false claims violations). While the Delaware FCRA 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 addition to its substantive provisions, the Delaware FCRA provides that private parties who are "affected" persons, entities or organizations may bring an action on behalf of the State government for a violation of the FCRA. These private parties may share in a percentage of the proceeds from an action or settlement. With some exceptions, when the government has intervened in the lawsuit, this law provides that the private party shall receive at least 15% but not more than 25% of the proceeds of the Delaware FCRA action depending upon the extent to which the person substantially contributed to the prosecution of the action. When the government does not intervene, the private party is entitled to receive an amount that the court decides is reasonable, which shall be not less than 25% and not more than 30%.

A civil action under the Delaware FCRA may not be brought on the later of the two following dates: (1) more than 6 years after the date on which the violation is committed; or (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the Delaware official charged with responsibility to act in the circumstances. However, in no event may an action be brought under the Delaware FCRA more than 10 years after the date on which the violation is committed. The Delaware FCRA provides protection to private parties 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 Delaware FCRA. Remedies include reinstatement with comparable seniority as the party 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. Reporting Medicaid or Insurance Fraud

Delaware Medicaid fraud can be reported by calling the Delaware Department of Justice Healthcare Provider Fraud Hotline at (302) 577-5000 or visiting https://attorneygeneral.delaware.gov/medicaid-fraud-complaint-form/.

NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

a. Civil And Administrative Laws

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

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.
The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 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 ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3) Social Services Law, Section 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 needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars) and five years for any subsequent occasion of any such offense.

b. Criminal Laws

1) Social Services Law, Section 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, Section 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 a 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. This statute 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

This law 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.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute. This law primarily applies to claims by providers for insurance

payment, including Medicaid payment and it includes six crimes.

a) Health care fraud in the 5th degree – a person is guilty of this crime when, 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 from a health plan. This is a class A misdemeanor.
b) Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
c) Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
d) Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
e) Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

c. New York State False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) 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.

d. Reporting Medicaid or Insurance Fraud

New York Medicaid fraud can be reported by calling the New York Office of the Medicaid Inspector General Medicaid Fraud Hotline at (877) 873-7283 or by visiting https://omig.ny.gov/medicaid-fraud/file-allegation. New York insurance fraud can be reported by calling the New York Department of Financial Services Insurance Fraud Hotline at (888) 372-8396 or by visiting https://www.dfs.ny.gov/form/report-suspected-insurance-fraud.