Standards of Conduct for First Tier, Downstream, and Related Entities (FDRs) of Gateway Health℠

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Introduction:

Gateway Health[SM] strives to assure an ethical, compassionate, efficient and compliant approach to healthcare delivery and to management services. Gateway Health is committed to conducting its business with the highest ethical standards and in compliance with all applicable federal and state laws and regulations.

In reviewing and becoming familiar with these Standards of Conduct, FDRs and their employees should keep in mind that ethical behavior and compliance with laws begin the these general principles:

- Honesty and integrity are expressed through truthfulness, objectivity and freedom from deception or fraud. These qualities should remain constant in any situation, whether involving operational staff, management staff or officers of Gateway Health or its FDRs.
- Books, records and documents created and maintained in furtherance of Gateway Health's business must be accurate.
- Willingness to accept responsibility for one's own actions is not only valued, but also essential. FDRs have a responsibility to use the authority delegated to them in the best interest of Gateway Health.
- There should be no conflicts between attention to business and attention to ethics; together, they contribute to Gateway Health's good relationship with its FDRs.

Gateway Health maintains that it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to report such an issue or concern. This obligation to report applies even if the individual with the information is not in a position to solve the potential problem.

First tier, Downstream and Related Entities (FDRs) are expected to adhere to these Standards of Conduct when conducting business on behalf of Gateway Health.

1. **Compliance with Laws and Regulations**

   A. Gateway Health expects FDRs to operate in accordance with all applicable federal and state laws, regulations and Medicare program requirements including, but not limited to the following:

      i. Title XVIII of the Social Security Act

      Title XVIII of the Social Security Act established regulations for the Medicare program, which guarantees access to health insurance for all Americans, aged 65 and older, younger people with specific disabilities, and individuals with end stage renal disease. Title XVIII includes provisions regarding the collection, disclosure, and use of Medicare beneficiaries' health information.

      ii. Medicare regulations governing Parts C and D (42 C.F.R. §§ 422 and 423 respectively)

         a. 42 CFR §422: Medicare Advantage program. This is the authoritative regulation that implements the Medicare Advantage Program under the Social Security Act.

         b. 42 CFR §423: Prescription drug program. This is the authoritative regulation that implements the Prescription Drug Program under the Social Security Act.

      iii. Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)

      The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:

         a. Knowingly submit a false or fraudulent claim for payment to the United States Government;

         b. Knowingly make a false record or statement to get a false or fraudulent claim paid or

approved by the government;

c. Conspire to defraud the Government by getting a false or fraudulent claim paid or approved by the government; or

d. Knowingly make a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

iv. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001): Federal laws makes it a criminal offense for anyone who makes a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offence carries a criminal penalty of 5 years in imprison and a monetary fine.

v. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. This can take many forms, such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is not consistent with fair market value. It also may include the routine waiver of co-payments and/or co-insurance. The offense is classified as a felony and is punishable by fines of up to $25,000, imprisonment for up to five years, civil money penalties up to $50,000, and exclusion from participation in federal health care programs.

vi. The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))
Makes it illegal to offer remuneration that a person knows (or should know) is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.

vii. Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)
The Stark Law provides criminal penalties for individuals or entities that do not adhere to the regulations regarding financial arrangements between referring physicians (or a member of the physician's immediate family) and entities that provide designated health services payable by Medicare or Medicaid. It does not require any showing of the "wrongdoer's" intent.

viii. Health Insurance Portability and Accountability Act
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was developed as part of a broad Congressional effort to reform healthcare. HIPAA was developed to satisfy many purposes, such as the transferring of health insurance, the reduction of fraud and abuse and the improvement of access to long-term care services. However the regulations regarding the simplification of the administration of health insurance is the area that has the greatest impact on the Plan.

ix. Fraud Enforcement and Recovery Act (FERA)of 2009
FERA makes significant changes to the False Claims Act (FCA). FERA makes it clear that the FCA imposes liability for knowing an improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids or decreases an "obligation" to pay money to the government.

x. Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal government.

xi. Other applicable criminal statutes.

xii. Applicable provisions of the Federal Food, Drug, and Cosmetic Act.

xiii. All sub-regulatory guidance produced by Centers for Medicare & Medicaid Services (CMS) such as manuals, training materials, Health Plan Management System (HPMS) memos, and guides.

xiv. Contractual commitments.

B. Any violation or suspected violation of the above mentioned regulations must be reported promptly to Gateway Health. See section 2 for details on how to report potential issues of non-compliance.

2. Duty to Report suspected Compliance or Fraud, Waste, and Abuse Violations

A. First Tier, Downstream, and Related Entities must report all suspected incidents of non-compliance or FWA violations promptly to Gateway Health's Medicare Compliance Department.
B. Gateway Health prohibits intimidation and retaliation against any person or entity for reporting potential or actual violations.
C. Report violations of federal or state law, regulations and/or Medicare program requirements to Gateway Health's Fraud and Compliance Hotline at 412-255-4340 or 1-800-685-5235. Calls can be anonymous.
D. Reports may also be made via e-mail to MedicareComplianceOfficer@GatewayHealhPlan.com.
E. Must cooperate with all investigations of potential or actual violations. Gateway Health will conduct a prompt and thorough investigation of all suspected violations.

3. Conflicts of Interest

A. Must avoid actual or apparent conflicts of interest.
B. Must disclose any personal interest or involvement that might be an actual or apparent conflict of interest.
C. Must not accept gifts, entertainment and/or other favors from any individual or company that does business with, is seeking to do business with or is a competitor of Gateway Health.

4. Confidentiality and Privacy

A. Must protect confidential information and individuals' right to privacy in accordance with applicable laws, regulations and contract terms.

5. Fraud, Waste and Abuse

A. Must understand and comply with applicable fraud, waste & abuse (FWA) laws, regulations and CMS FWA training requirements.
B. Must not submit false statements and/or claims to Federal and State funded programs.
C. Must identify and return overpayments promptly in order to comply with the Fraud Enforcement and Recovery Act (FERA).

6. Complying with Government Investigations and Audits

A. Government investigations include those conducted by agencies or departments of federal, state and local government, for example The Department of Health and Human Services (HHS), and The Centers for Medicare and Medicaid Services (CMS).
B. Gateway Health will require FDRs to cooperate fully in any investigations or audits by Government agencies.
C. Additionally, FDRs will be required to cooperate fully and participate in any audits conducted by Gateway Health's Medicare Compliance or Internal Audit staff.

7. **Excluded or Ineligible Parties**
   A. Gateway Health is prohibited by law from contracting or doing business with any person or entity that has been excluded from federal program participation.
   B. Gateway Health monitors the OIG and GSA Exclusion Lists on a monthly basis for First Tier, Downstream, and Related Entities.
   C. Gateway Health requires FDRs to monitor the OIG and GSA Exclusion Lists on a monthly basis for employees of their organizations.

Violations of these Standards of Conduct:

Suspected violations of these Standards of Conduct must be reported to Gateway Health immediately. Any individual who makes a report in good faith will not be subject to retaliation or any other form of reprisal. Gateway Health will make every effort to protect the rights of any individual accused of violating these Standards of Conduct. However, any person who deliberately makes a false accusation with the intention of harming or retaliating against another person or Gateway Health itself will be subject to disciplinary action.

Gateway Health will impose disciplinary actions for violations of law and ethics, CMS regulations, non-compliance with Medicare program, and FWA including, but not limited to, oral or written warnings, suspensions, financial penalties, potential reporting of the conduct to law enforcement, and/or contract termination.