

**VENDOR**  
**CODE OF CONDUCT AND COMPLIANCE EXPECTATIONS**

Wexner Heritage Village (the “Company”) is committed to providing high quality care services, and to providing those services in a highly ethical manner. Our high standards apply to our relationships with our agency staff/vendors (“Vendors”) and the Company requires our Vendors to act in compliance with all applicable state and federal laws and regulations, Company compliance policy, and in a manner that avoids even the appearance of impropriety. The Company does not and will not tolerate any form of unlawful or unethical behavior by our Vendors. To ensure that these expectations are met, the Company has developed and implemented a compliance and ethics program, which includes a Code of Conduct. Please direct any questions about this document or Company’s policies to the Company’s Compliance Officer.

**Code of Conduct**

*Wexner Heritage Village’s employees, vendors and other individuals associated with the company shall strive to deliver exceptional health, housing and supportive services that are necessary to attain or maintain the resident’s highest physical, emotional, spiritual and social well being.*

- Vendors shall respect a resident’s dignity and will treat the resident with consideration, courtesy and respect.
- It is everyone’s job to maintain Company’s integrity and reputation.
- Vendors will provide appropriate treatment and services based upon a comprehensive assessment and plan of care that address each resident’s clinical conditions.
- Vendors will assure its personnel have sufficient education, licenses, background experiences, training, and supervision to render service to its residents.
- No deficiency or error can be ignored or covered up. A problem must be brought to the attention of those who can properly assess and resolve the problem.
- No claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate or fictitious may be submitted. No falsification of medical, time or other records that are used for the basis of submitting claims will be tolerated.
- Company will bill only for the services that are medically appropriate, ordered by the resident’s physician, actually rendered and which are fully documented in the resident’s medical records. If the services must be coded, only billing codes that accurately describe the services provided will be used.
- Vendors shall respect and protect the confidentiality of resident records and other personal information.
- Vendors shall promptly report all suspected violations of the Code of Conduct, compliance policies, operational policies, laws or regulations to the Compliance Officer.
- No goods or services shall be given, solicited, offered, or accepted related to the attempt to influence business relationships. Vendors are prohibited from providing gifts or other items or services of value for free or at a discount to residents which are likely to influence their decision to receive items or services from Company or to influence them to continue to receive such items or services from Company.

**Reporting Potential Violations**

The Company’s commitment to ethical and legal business practices cannot succeed without open lines of communication between the Compliance Officer and Vendors. The Compliance Hotline is 614-559-0316. Such reports may be made anonymously, however all individuals making reports are encouraged to provide as much information as possible, including name, in order to facilitate investigation of all allegations. The identity of all individuals making reports to the Compliance Officer will be held in strict confidence, but depending on the circumstances, the identity of the reporter may become known or have to be revealed.

**The Confidential Compliance Hotline is 614-559-0316.**

## **Fraud, Waste and Abuse**

As required by 42 U.S.C 1396a(a)(68) and Ohio Revised Code 5162.15, Company must provide the following detailed information to all employees, agents and contractors of Company about federal and state False Claims Acts and laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, and Company's policies and procedures to detect and prevent fraud, waste, and abuse.

### **A. Federal False Claims Act**

The federal False Claims Act, 31 USC 3729-3733, among other things, applies to the submission of claims for payment under any federal program, including claims submitted by health care providers for payment by Medicare, Medicaid, and other federal health care programs. The False Claims Act provides the federal government a civil remedy for fraudulent claims.

The False Claims Act prohibits, among other things:

1. Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;
2. Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government;
3. Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid; and
4. Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

“Knowingly” means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. Examples of false claims include falsifying medical records submitted, billing for services not rendered or goods not provided, duplicating billing to obtain double compensation, and billing certifying or prescribing medically unnecessary services.

The United States Attorney General may bring civil actions against individuals and entities for violations of the False Claims Act. As with most other civil actions, the government must establish its case by preponderance of the evidence rather than by meeting the higher burden that applies in criminal cases. Penalties under the False Claims Act include three times the amount of any overpayment, and civil monetary penalties ranging from \$5,500 to \$11,000 per claim (for violations prior to November 2, 2015), \$10,781 - \$21,563 per claim (for violations between November 2, 2015 – February 2, 2017), \$10,957 - \$21,916 per claim (for violations that occurred between February 3, 2017 – January 28, 2018), and \$11,181 - \$22,363 (for violations on or after January 29, 2018) and annual inflation adjustments to the penalty range thereafter, plus attorney fees. The False Claims Act allows private individuals to bring "whistleblower" actions on behalf of the federal government for violations of the Act. The government may decide to intervene and take over the whistleblower action, or decline to intervene and allow the whistleblower to pursue the action. The False Claims Act protects whistleblowers by imposing penalties, including two times back pay, interest and attorneys' fees, upon individuals and entities that retaliate against whistleblowers.

### **B. Program Fraud Civil Remedies Act of 1986**

The Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 USC Chapter 38, authorizes federal agencies such as the Department of Health and Human Services ("HHS") to investigate and assess penalties for the submission of

false claims or statements to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. A person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim or statement that the person knows or has reason to know:

- a) Is false, fictitious, or fraudulent;
- b) Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
- c) Includes or is supported by any written statement that –
  - i. Omits a material fact;
  - ii. Is false, fictitious, or fraudulent as a result of such omission; and
  - iii. Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
- d) Is for payment for the provision of property or services, which the person has not provided as claimed.

The government agency may assess twice the amount of its damages and a civil penalty of up to \$11,282 (2020) for each false or fictitious claim. The United States Attorney General has exclusive authority to enforce such assessments and penalties in federal court.

### **C. Ohio Laws**

There also may be liability under Ohio laws for false or fraudulent claims with respect to the Medicaid program expenditures, including:

- a) Medicaid Fraud, Ohio Revised Code Sec. 2913.40  
The Medicaid Fraud Act imposes criminal penalties for among other things:
  - i. Knowingly making or causing to be made a false or misleading statement or representation for use in obtaining Medicaid reimbursement.
  - ii. Doing either of the following with the purpose to commit fraud or knowingly facilitating a fraud:
    1. charging, soliciting, accepting or receiving any amount in addition to the amount of reimbursement due from Medicaid and any authorized deductibles or co-payments;
    2. soliciting, offering or receiving any remuneration other than authorized deductibles and co-payments, in cash or in kind, including kickbacks or rebates, in connection with the furnishing of goods or services for which payment may be made under the Medicaid program.
  - iii. Knowingly altering, destroying concealing or removing any records necessary to support a Medicaid claim or cost report.
- b) Medicaid Eligibility Fraud, Ohio Revised Code Sec. 2913.401  
The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.
- c) Falsification, Ohio Revised Code Sec. 2921.13  
Ohio criminal law prohibits persons from knowingly making false statements or swearing or affirming the truth of a false statement for the purpose of securing payment of benefits administered by a governmental agency or paid out of a public treasury, for the purpose of securing a provider agreement with the government, or in connection with any report that is required or authorized by law, such as the Medicaid cost report.
- d) Offenses by Medicaid Providers, Ohio Revised Code Sec. 5111.03  
The Medicaid Provider Offenses Statute prohibits Medicaid providers from acting “by deception” to obtain or receive or attempt to obtain or receive payments to which the provider is not entitled, or to falsify any report or document relating to Medicaid. “Deception” includes acting with reckless disregard or deliberate ignorance of the truth or falsity of information or withholding information. Penalties for

violation of the Medicaid Provider Offenses Statute include interest on excess payments, three times the amount of excess payments, civil penalties of \$5,000 to \$10,000 per claim, recovery of the costs of enforcement, and termination of the Medicaid provider agreement. The Ohio Attorney General may enforce the provisions of this statute in state court.

- e) Any other state law pertaining to civil or criminal penalties for false claims and statements with respect to the Medicaid program, including any law that prohibits:
  - i. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to the Medicaid program;
  - ii. Knowingly 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 Medicaid program;
  - iii. Conspiring to defraud the Medicaid program by getting a false or fraudulent claim allowed or paid;
  - iv. Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medicaid program.

#### **D. Protection for "Whistleblowers"**

It is the policy of Company to detect and prevent any activity that may violate the False Claims Act, the Program Fraud Civil Remedies Act of 1986 or the State Medicaid Fraud Laws cited in this policy. If any vendor of Company has knowledge or information that any such activity may have taken place, such Vendor should contact the Compliance Officer or call the Compliance Hotline at 614-559-0316. Information may be reported to the Hotline anonymously. In addition, federal and state law and Company policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Compliance Officer or the Hotline.

#### **E. Fraud, Waste and Abuse Prevention and Detection**

Company has developed, as part of its Compliance Program, detailed written policies for the prevention and detection of fraud, waste, and abuse in government and commercial health care programs, and for the role of employees, contractors and agents in preventing and detecting fraud, waste and abuse in such programs. If any employee, contractor, or agent has any questions regarding such policies and procedures, the employee should contact the Compliance Officer at 614-559-0314.