Dear Vendor/Agent/Contractor:

St. Jude Children's Research Hospital (SJCRH) is committed to providing the highest quality care to our patients and conducting our business with integrity and in compliance with applicable federal and state laws and regulations. As our partner in conducting business according to the highest ethical standards, we expect that you will understand and abide by our policies. As a participant in the Medicaid Program that receives the minimum amount in payments annually, we are obligated to comply with the terms and requirements of the Deficit Reduction Act of 2005 (the "DRA").

Under the DRA, SJCRH is required to provide information to all vendors, agents and contractors about: (1) our policies and procedures for detecting and preventing fraud, waste, and abuse; (2) the federal False Claims Act and similar state laws; and (3) the rights of employees and others to be protected as whistleblowers. We ask your cooperation in ensuring this information is reviewed by your Compliance Officer or appropriate senior manager to ensure your company's support in our work.

SJCRH's Compliance Program has been established to formally consolidate the institution's compliance effort and education about the laws, regulations, and policies and procedures governing our activities. By encouraging the identification, communication and correction of compliance issues, our Compliance Program helps ensure that our activities continue to be ethical and in compliance with applicable laws. Suspected misconduct and/or violations of SJCRH policy should be reported with the confidence that anonymity and confidentiality will be preserved if the reporter wishes. Reports will be handled promptly and as discreetly as possible, with facts made available only to those who evaluate and resolve the matter. Suspected misconduct and/or violations of SJCRH policy should be reported to any of the following:

Director of Employee Relations in Human Resources 901-595-2770

VP of Human Resources 901-595-3258

SVP & Chief Legal Officer 901-595-2288

As an extension of these resources, SJCRH has selected EthicsPoint, a third party vendor, to provide you with an additional way to report activities that may involve misconduct or violations of SJCRH policy. This method or reporting assures anonymity if the reporter desires to remain unidentified. You may file a report online at www.ethicspoint.com or by dialing 800-433-1847.

SJCRH's Corporate Compliance policy prohibits retaliatory action against anyone for reporting or inquiring about potential breaches of SJCRH policies or laws affecting SJCRH. Anyone who engages in retaliation or any form of harassment directed against an employee, faculty member, staff member, affiliate, contractor, subcontractor or vendor for reporting a false claim concern will be subject to discipline.

Federal False Claims Act (FCA)

The federal 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) is 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. While the False Claims Act 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. The prohibitions of the FCA apply to fraud involving any federally funded contract or program, including, but not limited to, the Medicare and Medicaid programs.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement. 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.

Administrative Remedies for False Claims

Federal law allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

State False Claims Acts

Many states have also enacted false claims laws. Some of these laws also permit private citizens to file suits on behalf of the state government against those providers who violate the state false claims laws. The specific prohibitions and penalties under these laws vary from state to state.

Tennessee has both a False Claims Act and a Medicaid False Claims Act. The Tennessee False Claims Act imposes liability of not less than two thousand five hundred dollars ($2,500) and not more than ten thousand dollars ($10,000) for each false claim on persons who knowingly present false or fraudulent claims for payment to the state, misappropriate state property, or deceptively avoid binding obligations to pay the state. Additionally, the Act protects whistleblowers from retaliation by their employers. The Tennessee Medicaid False Claims Act imposes a civil penalty of not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), plus three (3) times the amount of damages which the state sustains on people and corporations who knowingly submit false claims to Tennessee's Medicaid program. The Act also protects whistleblowers from retaliation by their employers for filing a claim or assisting the state with its own claim.

Mississippi law has two provisions directed at prosecuting health care fraud: (i) the Medicaid Fraud Control Act and (ii) the Insurance Integrity Enforcement Bureau Provisions.

1. The Medicaid Fraud Control Act prohibits a person from making, presenting or causing to be made or presented a claim for Medicaid benefits, knowing the claim to be false, fictitious or fraudulent. A person shall not enter into an agreement, combination or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious or fraudulent claim for Medicaid benefits. A person who violates the Medicaid Fraud Control Act shall be guilty of a felony, punishable by imprisonment for not more than five (5) years, or by a fine of not more than Fifty Thousand Dollars ($50,000.00) or both. A health care provider or vendor committing any act or omission in violation of the Medicaid Fraud Control Act shall be directly

liable to the state and shall forfeit and pay to the state a civil penalty equal to the full amount received, plus an additional civil penalty equal to triple the full amount received.

2. The Insurance Integrity Enforcement Bureau has the duty to investigate and prosecute claims of insurance abuses and crimes involving insurance. A person or entity shall not, with the intent to appropriate to himself or to another any benefit, knowingly execute, collude or conspire to execute or attempt to execute a scheme or artifice to defraud any insurance plan in connection with the delivery of, or payment for, insurance benefits, items, services or claims. Penalties for violations include felony conviction with imprisonment for not more than three (3) years, or a fine of not more than Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or both. If the defendant found to have violated any provision of Section 7-3-303 is an Organization, then the penalty shall be a fine of not more than One Hundred Fifty Thousand Dollars ($150,000.00) for each violation.

The *Arkansas* Medicaid Fraud False Claims Act ("AMFFCA") is a civil statute that helps the state combat fraud and recover losses resulting from fraud in the Arkansas Medicaid program. In addition, Arkansas has a criminal statute, the Arkansas Medicaid Fraud Act ("AMFA"), which provides for criminal sanctions in cases of Medicaid fraud. Violations of the AMFFCA include: (1) knowingly making false statements or concealing relevant knowledge related to any benefit or payment under the Medicaid program or to the condition or operation of an entity; (2) knowingly converting a benefit to a use other than for the use and benefit of another person; (3) knowingly soliciting or receiving any remuneration (kickback, bribe, or rebate) in exchange for referrals or recommendations; (4) knowingly charging in excess of the established rates or requiring additional payment as a condition of admission or continued stay; and (5) knowingly participating in the Medicaid program after having been found guilty or pleading guilty or no contest to a Medicaid fraud charge, theft of public benefits, or abuse of adults or employing a person who has abused adults. Actions that violate the AMFA include the actions (1) through (4) listed above under the AMFFCA except where there is a lower intent standard. A person must act "knowingly" under the AMFFCA in order for a violation to occur. Knowingly means a person has actual knowledge or acts in deliberate ignorance or reckless disregard of the truth. In contrast, the AMFA requires that a person act "purposely," which means that a person had a "conscious object" to engage in unlawful conduct. The AMFFCA and AMFA do not contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. However, both statutes allow individuals who report fraud to the Attorney General to receive up to 10% of the total amount recovered, but in no case no more than $100,000. The AMFFCA and AMFA protect individuals who provide records to the state from civil or criminal liability.