This Policy is applicable to the following Chapters Health System organization or organizations (the "Organization(s)"): **LifePath Hospice, Inc., Chapters Health System, Inc., Good Shepherd Hospice, Inc., Chapters Health Staffing, LLC, Chapters Health Pharmacy, LLC, Chapters Health Palliative Care, LLC, Chapters Health Senior Independence, Inc**

Policy

It is the Policy of the above Organization(s) to comply with all relevant federal and state laws and regulations. To ensure compliance with such laws, policies are frequently adopted that serve to inform employees and contractors of the Organization(s) regarding the requirements of certain federal and state health care laws. Numerous operational features are also incorporated to detect and prevent fraud, waste and abuse.

This Policy provides an overview of the federal False Claims Act (the "FCA"), the Fraud Enforcement and Recovery Act of 2009 ("FERA"), the Program Fraud Civil Remedies Act of 1986 (the "Fraud Civil Remedies Act"), the Civil Money Penalty Law (the "CMPL"), federal criminal laws relating to the submission of false claims, and applicable Florida state laws, including the role of whistleblower protections afforded under such laws. In addition, this Policy refers to various policies of the Organization(s) that pertain to detecting, reporting and preventing fraud, waste and abuse, including the Chapters Health System Corporate Compliance Program.

Purpose

No employee or contractor (collectively, "Employee") of the Organization(s) may knowingly submit to a federal or state health care program, including the Medicare and Medicaid programs, a false claim for reimbursement or a claim that the Employee suspects is false. Such conduct is unlawful under federal law and may be unlawful under certain state laws and/or regulations.

The Organization(s) strive to ensure that all Employees are fully aware of conduct that constitutes a false claim under federal law and any applicable state law. For this reason, a detailed overview of the FCA as amended by the FERA, the Program Fraud Civil Remedies Act of 1986, and relevant Florida state laws, including their respective whistleblower provisions is provided below.

The Chapters Health System Corporate Compliance Program sets forth procedures for identifying fraud, waste and abuse, including procedures for the detection of conduct that may amount to submission of false claims. To the extent you have reason to believe that false claims or statements may exist, you should report immediately your concerns to your superior and/or to the Chief Compliance & Clinical Officer. You may submit your concerns via the toll-free Compliance Alert Line at **(888) 749-7343** or online at the following website address: https://secure.ethicspoint.com/domain/media/en/gui/21294/index.html. The confidentiality of your report will be maintained regardless of whether the conduct that you are disclosing amounts to activities that violate federal or state law.

FEDERAL FALSE CLAIMS LAWS

1. Detailed Overview of the Federal Civil False Claims Act

a. Description of Unlawful Conduct

The FCA (codified at 31 U.S. C. §§ 3729-33), as amended by FERA, prohibits any person from:

- Knowingly presenting, or causing to be presented a false or fraudulent claim for payment or approval to an officer or employee of the United States government; 31 U.S.C. § 3729(a)(1).
- Knowingly making or using, or causing to be made or used, a false record or statement, which is material to a false or fraudulent claim, to get a false or fraudulent claim paid or approved by the government; 31 U.S.C. § 3729(a)(2).
- Knowingly making or using, or causing 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 concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government; 31 U.S.C. § 3729(a)(7).
- Having possession, custody, or control of property or money used, or to be used, by the government and knowingly delivering, or causing to be delivered, less than all of that money or property.
- Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the government and making or delivering the receipt without completely knowing that the information on the receipt is true.
- Knowingly buying, or receiving 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.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid, or conspiring to commit a violation of any of the above; 31 U.S.C. § 3729(a)(3).

Importantly, pursuant to the Affordable Care Act ("ACA"), 42 U.S.C. § 1320a-7k(d) makes the failure to report and return any federal program overpayments within sixty (60) days after the date on which the overpayment was identified, or the date any corresponding cost report is due, a violation of the FCA.

b. **Definitions**

- Claim. A claim is a request or demand for money or property made to an officer, employee or agent of the government, or a contractor, grantee, or other recipient, if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimbursement such contractor, grantee, agent or other recipient for any portion of the money or property; 31 U.S.C. § 3729(b)(2). A claim includes claims submitted to the Medicaid programs. False claims or fraudulent documents do not have to be submitted to the government directly.

- Knowing and Knowingly. A claim is false if the person "knowingly": 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information contained in the claim; 31 U.S.C. § 3729(b)(1). It is important to note that the person does not have to deliberately intend to defraud the federal government to be found liable under the FCA. The person need only "knowingly" act in the manner described above.

- Deliberate Ignorance. To act in "deliberate ignorance" means that the person has deliberately chosen to ignore the truth or falsity of the information on a claim submitted for payment, even though the person knows, or has notice, that information may be false.

An example of a person who submits a false claim with deliberate ignorance is a person who ignores guidance from the Centers for Medicare and Medicaid Services ("CMS") and, therefore, does not inform its staff of changes in the Medicare billing guidelines or update its billing system in accordance with changes to Medicare billing practices. As a result, when claims for non-reimbursable services are submitted, the FCA has been violated.

- Reckless Disregard. To act in "reckless disregard" means that the person pays no regard to whether the information on a claim submitted for payment is true or false. An example of a person who submits a false claim with reckless disregard would be a provider that assigns billing functions to an untrained person without inquiring whether the employee has adequate knowledge and training to accurately file such claims.

Examples of false claims include, but are not limited to:

- A claim for a service or supply that was never provided;
- A claim for services or supplies that were not provided specifically as presented, or for which the person is otherwise not entitled to payment;
- A claim indicating the service was provided for some diagnosis code other than the true diagnosis code in order to obtain reimbursement for the service, which would not be covered if the true diagnosis code were submitted;
- A claim indicating a higher level of service than was actually provided;
- A claim for a service that the person knows is not reasonable and necessary;
- A claim for services provided by an unlicensed individual; or
- A claim for an unallowable cost on a cost report.

- Overpayment. Overpayment means any funds that a person receives or retains under the Medicare or Medicaid programs or other federally funded health care programs, to which the person or entity after applicable reconciliation is not entitled; ACA § 6402. Person includes a provider of services, a Medicare or Medicaid managed care organization and the Prescription Drug Plan.

c. **Penalty for Unlawful Conduct**

The civil penalty for violating the FCA is a minimum of $5,500.00 up to a maximum of $11,000.00 for each false claim submitted. In addition to the penalty, a person could be found liable for up to three times the amount of damages the government sustains because of the act of that person.

d. **The False Claims Act's *Qui Tam* Provisions**

The FCA also allows individuals (referred to as "*qui tam* plaintiffs" or "plaintiffs") to bring civil suits, called *qui tam* actions, in the name of the United States government for a violation of the FCA. Generally, the suit must be brought within six years after the violation, but in no event more than ten years. When an individual files the action, it remains under seal (therefore, not public) for at least sixty days. The United States government may choose to join in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the government chooses not to join the suit, the individual, who initiated the lawsuit, has the right to conduct the action independent of the government. Conversely, the government may elect to pursue its claim through alternate remedies, and the person that initiated the action will have the same rights as if the civil action had continued.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. If the *qui tam* plaintiff proceeds with the action without the government, the *qui tam* plaintiff may receive twenty-five to thirty percent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses, plus reasonable attorneys' fees and costs.

If the government does not proceed with the action, and if the defendant prevails and the *qui tam* plaintiff's civil action is clearly frivolous, clearly vexatious or brought primarily for the purposes of harassment, which means it clearly has no merit, the *qui tam* plaintiff may have to pay the defendant its reasonable attorneys' fees and expenses. If the plaintiff planned or initiated the violation, the plaintiffs' share of the proceeds may be reduced and, if the *qui tam* plaintiff is found guilty of a crime associated with the violation, no share will be awarded and the plaintiff will be dismissed from the action.

Additionally, the ACA includes statutory changes that may permit even more *qui tam* actions that would have previously been barred by a public disclosure limitation.

e. **Whistleblower Protection**

The civil FCA also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of lawful acts conducted in furtherance of an action under the FCA, may bring an action in federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages and fees.

2. Detailed Overview of the Federal Program Fraud Civil Remedies Act of 1986

In addition to the FCA, the Fraud Civil Remedies Act Administrative Remedies for False Claims and Statements, codified at 31 U.S.C. §§ 3801, *et seq.* establishes a civil penalty and assessment against any person who makes, presents or submits, or causes to be made, presented or submitted, claims or written statements that the person knows or has reason to know is false, fictitious or fraudulent due to an assertion or omission to certain federal agencies.

a. Definitions

- Knows or has Reason to Know. The term "knows or has reason to know" is defined as a person who has actual knowledge that the claim or statement is false, fictitious or fraudulent, acts in deliberate ignorance of the truth or falsity of the claim or statement, or acts in reckless disregard of the truth or falsity of the claim or statement. No proof of specific intent to defraud is required.

- Claim. The term "claim" includes any request, demand or submission for property, services or money, including money representing grants, loans, insurance or benefits, when the United States government provided the property or services, or any portion of the funds for the purchase of such property or services, provided any portion of the money requested or demanded, or will reimburse the recipient or party for the purchase of property or services of for any portion of money paid on a request or demand.

- Statement: The term "statement" means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made: (1) with respect to a claim or to obtain the approval or payment of a claim, including relating to eligibility to make a claim; or (2) with respect to, including relating to eligibility for, (a) a contract with, or a bid

or proposal for a contract with or (b) a grant, loan, or benefit from, the Department of Health and Human Services ("HHS"), or any state, political subdivision, or other party, if the United States government provides any portion of the money or property, or if the government will reimburse such state, political subdivision, or party for any portion of the money or property.

b. **Penalties**

The Office of Inspector General of HHS "OIG" may investigate, and with the Attorney General's approval, commence proceedings, if the claim is less than $150,000. A hearing must begin within six years from the submission of the claim. The Fraud Civil Remedies Act allows for a civil penalty of not more than $5,000 per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

3. Detailed Overview of the Federal Civil Monetary Penalty Law

The Secretary of HHS is authorized by the CMPL, codified at 42 U.S.C. § 1320a-7a, to administratively impose civil money penalties ("CMP") and assessments against any person who presents, or causes to be presented, a false or fraudulent claim to any federal health care program.

a. **Unlawful Conduct:**

The CMPL provides for, among other things, the following:

- A CMP for knowingly presenting or causing to be presented a claim for an item or service that the person knows or should know was not provided as claimed.
- A CMP for knowingly presenting or causing to be presented a claim for an item or service and the person knows or should know the claim is false or fraudulent.
- A CMP for "upcoding" - submitting a claim for an item or service that is based on a code that the person knows or should know will result in greater payment than the code the person knows or should know is applicable to the item or service actually provided.
- A CMP for submitting a claim for an item or service that a person knows or should know is not medically necessary.
- A CMP for offering or transferring remuneration to individuals enrolled under Medicare or a state health care program that the person knows or should know is likely to influence the individual to order or receive services from a particular provider or supplier.

In addition, ACA brought a number of changes to the CMPL. ACA provides a CMP for:

- Ordering or prescribing medical or other items or service during a period in which a person was excluded.
- Knowingly making, using or causing to make or use a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a federal health care program.
- Knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a federal health care program.
- Failing to grant timely access, upon reasonable request, to the OIG for purposes of audits, investigations, evaluations, or other statutory functions of the OIG.

- Knowing of an overpayment and failing to report and return the overpayment. ACA also increased exceptions to the definition of "remuneration."

b. **Definitions**

- Claim. "Claim" means an application for payments for items and services under a federal health care program.

- Should Know. "Should know" means a person acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

c. **Penalties**

Anyone violating the CMPL can be held liable for up to $10,000 per claim, plus three times the amount claimed for each such item or service in lieu of damages sustained by the United State or a state agency because of such claim. Further, the Secretary of HHS may determine to exclude the person from participation in the federal health care programs and direct the appropriate state agency to exclude the person from participation in any state health care program.

4. Federal Criminal Laws Relating to the Submission of False Claims

a. **Medicare/Medicaid Antifraud And Abuse Law**

The Medicare/Medicaid Antifraud and Abuse Law (42 U.S.C. § 1320a-7b), among other things, prohibits knowingly and willfully making, or causing to be made, any false statement or misrepresentation of a material fact in any claim or application for benefits under a federal health care program. A violation constitutes a felony, punishable by a fine of not more than $25,000, imprisonment for not more than five years, or both.

b. **The Criminal False Claims Act**

The Federal Criminal False Claims Act (18 U.S.C. §§ 286-287), which is distinct from the Federal Civil False Claims Act, makes it illegal to present a claim upon or against the United States that the claimant knows to be "false, fictitious or fraudulent." In addition, any person who enters into any agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain the payment of any false, fictitious or fraudulent claim is subject to a separate criminal penalty. A violation of the False Claims Act is a felony, punishable by a fine, imprisonment, or both.

c. **False Statements Statute**

The False Statements Statute prohibits the knowing and willful submission of any false or fraudulent statement or representation to the United States, or the knowing and willful falsifying, concealing or covering up by any trick, scheme or device a material fact; 18 U.S.C. § 1001. A violation of this statute is punishable by a fine, imprisonment, or both.

STATE FALSE CLAIMS ACT

1. **Detailed Overview of the Florida False Claims Act**

Florida has enacted the Florida False Claims Act (the "FL FCA") (§ 68.081, *et seq.*, Fla. Stat.) to deter persons from knowingly causing or assisting in causing the state government to pay for claims that are false or fraudulent. The FL FCA prohibits, among other things, knowingly presenting, or causing to be presented, to an officer or employee of a Florida government agency a false claim for payment or approval. Additionally, it prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. It also prohibits conspiring to submit a false or fraudulent claim or deceiving a Florida government agency for the purpose of getting a false or fraudulent claim allowed or paid.

a. **Definitions**

- Knowingly. With respect to information, "knowingly" means that a person: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information. It is important to note that the person does not require specific intent to defraud to be found liable under the FL FCA. Innocent mistake is a defense to an action under the FL FCA.

- Claim. "Claim" includes any written or electronically submitted request or demand for money, property, or services, which is made to any employee, officer, or agent of an agency, or to any contractor, grantee, or other recipient if the agency provides any portion of the money or property requested or demanded, or if the agency will reimburse the contractor, grantee, or other recipient for any portion of the money or property requested or demanded.

b. **Penalties**

The civil penalty for violating the FL FCA is a minimum of $5,000 up to a maximum of $10,000 for each false claim submitted. In addition to the penalty, a person could be found liable for treble the amount of damages the state agency sustains because of the act or omission of that person. The person also may be liable for the costs associated with bringing the action, including attorneys' fees and costs.

c. **The FL FCA's *Qui Tam* Provisions**

The FL FCA also allows individuals, referred to as "*qui tam* plaintiffs" or "plaintiffs," to bring a civil suit, called a *qui tam* action, in the name of the State of Florida for a violation of the FL FCA. Generally, the suit must be brought within six years after the violation, but in no event more than seventeen years. When an individual files the action, it remains under seal (therefore, not public) for a period of up to sixty days. The Florida Department of Legal Affairs or the Florida Department of Financial Services (collectively referred to herein as the "Department") may choose to join in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Department chooses not to join the suit, the individual who initiated the lawsuit has the right to conduct the action independent of the Department.

In the event the Department proceeds with the lawsuit, the plaintiff may receive fifteen to twenty-five percent of the proceeds of the action or settlement. Under certain circumstances, however, the plaintiff's award may be reduced to less than ten percent of the recovery. If the plaintiff proceeds with the action without the Department, the plaintiff may receive twenty-five to thirty percent of the recovery.

If a court finds that the plaintiff planned or initiated the violation, the plaintiff's share of the proceeds may be reduced and, if the plaintiff is found guilty of a crime associated with a violation of the FL FCA, the plaintiff will be dismissed and no share will be awarded to the plaintiff. In addition, if the Department decides not to join in the case, the court may award reasonable attorneys' fees and costs against the plaintiff if the defendant prevails and the court determines that the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

d. **Whistleblower Protection**

The FL FCA also provides protection to employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed or discriminated against because of lawful acts conducted in furtherance of an action under the FL FCA may bring an action pursuant to Section 112.3187, Florida Statutes.

2. Detailed Overview of the Florida Medicaid Provider Fraud Laws

The Florida Medicaid Provider Fraud Laws (the "FL Medicaid Fraud Laws") (Fla. Stat. §§ 409.920-9203) provides criminal penalties and fines for false statements or representations, among other things, made to the Medicaid program.

a. **Unlawful Conduct**

The FL Medicaid Fraud Laws prohibit, among other things, the following:

- Knowingly making, or causing to be made, or aiding and abetting in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.
- Knowingly making, or causing to be made, or aiding and abetting in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
- Knowingly making, or causing to be made, any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the Agency for Health Care Administration to determine a general or specific rate of payment for an item or service provided by a provider.
- Knowingly using, or endeavoring to use, a Medicaid provider's identification number or a Medicaid recipient's identification number to make, or cause to be made, or aid or abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
- Knowingly making, or causing to be made, or attempting or conspiring to a make a false statement or representation to obtain goods or services from Medicaid.

The repayment of Medicaid payments wrongfully obtained, or the offer or endeavor to pay Medicaid funds wrongfully obtained, does not constitute a defense to, or a ground for dismissal of, criminal charges brought under this statute.

b. **Definitions**

- Knowingly. "Knowingly" means that the act was done voluntarily and intentionally, and not as a result of a mistake or accident. It also includes "willfully" or "willful," which means that an act was committed voluntarily and purposely, with the specific intent to do something that the law forbids, and that the act was committed with bad purpose, either to disobey or disregard the law.

c. **Penalties**

Violations of the FL Medicaid Fraud Laws are punishable as follows:

- Receiving or endeavoring to receive anything of value of $10,000 or less is a felony of the third degree
- Receiving or endeavoring to receive anything of value of more than $10,000 but less than $50,000 is a felony of the second degree
- Receiving or endeavoring to receive anything of value of more than $50,000 is a felony of the first degree

In addition to the sentence authorized by law, a person convicted of a violation of the FL Medicaid Fraud Laws will pay a fine in the amount equal to five times the pecuniary gain unlawfully received or the loss incurred by the Medicaid program or managed care organization, whichever is greater.

Additionally, there are separate criminal penalties for a person that knowingly makes (or causes to be made) or attempts or conspires to a make a false statement or representation to obtain goods or services from Medicaid under FL Stat. § 409.9201.

d. **Rewards for Reporting Medicaid Fraud**

A person who provides the state or any state political subdivision or agency with information about fraud or suspected fraud by a Medicaid provider under FL Stat. § 409.920 is immune from civil liability for providing the information unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Additionally, the Florida Department of Law Enforcement or director of the Medicaid Fraud Control Unit will pay a reward to a person who furnishes original information relating to and reports a violation of the FL Medicaid Fraud Laws, if the information and report:

- Is made to the Office of the Attorney General, the Agency for Health Care Administration, the Department of Health, or the Department of Law Enforcement;
- Relates to criminal fraud upon Medicaid funds or a criminal violation of Medicaid laws by another person; and
- Leads to a recovery of a fine, penalty or forfeiture of property.

The reward may not exceed the lesser of twenty-five percent of the amount recovered or $500,000 in a single case. A person who receives a reward cannot receive any funds under the FL FCA for which a reward is received pursuant to the FL Medicaid Fraud Laws.

References

Regulatory Citations: 18 U.S.C. §§ 286-287; 31 U.S.C. §§ 3729-33; 31 U.S.C. §§ 3801, *et seq*.; 42 U.S.C. § 1320a; §§ 68.081*, et seq.,* Fla. Stat.; § 112.3187, §§ 409.920 – 9203, Fla. Stat.