DEPARTMENT: Compliance	**POLICY DESCRIPTION**: False Claims Act and Whistleblower Protections
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REVISION DATES: 1/15/2021	**EFFECTIVE DATE**: March 13, 2020

SCOPE

This policy is applicable to all company affiliated Centers and employees.

PURPOSE

To inform employees, agents, and contractors about the federal False Claims Act, certain administrative remedies for false claims and statements, applicable state laws pertaining to civil or criminal penalties for false claims and statements, whistleblower protections under such laws and Diversicare's policies and procedures for detecting and preventing fraud, waste and abuse.

DEFINITIONS

According to the Centers for Medicare and Medicaid, "employee" includes any officer or employee of the entity and "agent' or "contractor" includes any contractor, subcontractor, agent or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid healthcare items or services, performs billing or coding functions, or is involved in monitoring of healthcare provided by the entity.

POLICY

It is our policy to educate our employees, agents and contractors so that activity that could be characterized as fraud, waste, or abuse will be prevented, including by reporting any such suspected activity to a supervisor, a center administrator, the Corporate Compliance Officer ("CCO"), or the Compliance Hotline. Examples of fraud, waste, and abuse include, but are not limited to, the activities listed below:

- Billing for services that are not rendered;
- Billing for undocumented services;
- Providing services that are not necessary to treat a resident's medical condition and billing for them;
- Intentionally billing incorrect codes to secure higher reimbursement;
- Including improper entries on cost reports; and
- Participating in kickbacks, particularly conduct that induces greater utilization of program reimbursed services than are medically necessary.

We will also inform our employees, agents and contractors of the avenues of redress and underlying laws relating to fraud, waste and abuse and whistleblower protections described below, as well as in the Employee Handbook. A major role of such laws is to help combat fraud waste and abuse in government programs, including in healthcare programs like Medicare and Medicaid.

FEDERAL AND STATE FALSE CLAIMS ACTS

A. Federal

The Federal Civil False Claims Act ("FCA"), established under Sections 3729 through 3733 of Title 31 of the United States Code (a full copy of the text of this and other laws referenced herein may be obtained for free online), permits civil lawsuits so that the federal government can recover penalties and damages against persons and entities that submit fraudulent claims for payment. The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment. Violations of the FCA include:

(A) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;
(B) knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
(C) 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;
(D) being 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, making or delivering the receipt without completely knowing that the information on the receipt is true;
(E) 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;
(F) knowingly making, 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; or
(G) conspiring to commit a violation of (A), (B), (D), (E), (F), or (G);

A few examples of false claims in the healthcare context include: knowingly billing for a procedure or service that was not performed, knowingly billing for more time than was provided, or falsifying eligibility requirements to secure payment. "Knowingly" means that a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information.

The FCA allows for lawsuits alleging violations to be filed by the government or by private persons on behalf of the government to recover funds paid by the government as a result of the false claim. If initiated by a private person, such a lawsuit is known as a *qui tam* action. If the suit is ultimately successful, the person bringing it (commonly referred to as a "whistleblower") generally is eligible to receive a portion of any recovery against the party sued, although a whistleblower convicted of criminal conduct arising from their role relating to the false claim will be dismissed from the civil suit without receiving any portion of the recovery. The FCA

imposes monetary penalties from $11,665 to $23,331 (or as adjusted annually for inflation) per false claim, and a triple damages penalty for damages incurred by the government.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 ("PFCRA") which provides administrative remedies for knowingly submitting false claims and statements. A violation results in a maximum civil penalty of $11,665 per claim, plus up to twice the amount of each claim. If a healthcare provider is found to have submitted false claims to the government, it faces other administrative sanctions in addition to those described above, such as being excluded from participating in any federally-funded healthcare program (such as Medicare and Medicaid).

Reference: 31 United States Code §§ 3729 through 3733 and §§ 3801 through 3812.

B. State Laws Pertaining to Civil/Criminal Penalties for False Claims and Statements

In addition to the FCA, a number of states have passed their own state false claims laws. A state-specific, detailed list of the various state laws discussed below is included at this end of this policy in the Employee Handbook; a detailed summary of such laws is attached as Exhibit A to this policy at http://MyDiversicare . Like the FCA, these state false claims laws permit such states to recover damages and also impose significant monetary penalties based on double or triple damages multipliers (*i.e.*, a penalty two or three times the amount of the false claims) and a per claim monetary penalty (*e.g.*, a $11,463 - $22,927 (or as adjusted for inflation) penalty for each false claim filed for payment). They also allow private citizens to file *qui tam* suits on behalf of the government and receive a percentage of the money recovered as a result of the suit. Examples of such states in which Diversicare operates include: Florida, Indiana, Tennessee and Texas.

Several other states have laws that resemble the FCA but differ in some significant respects, including in that these laws do not have *qui tam* provisions allowing private persons to file suit on behalf of, or share in any money recovered by, the government. Nevertheless, these laws typically carry a substantial monetary penalty and multiple damages provisions (*e.g.*, a penalty of $11,463 for each false claim plus triple damages), which provide an incentive for state prosecutors and enforcement agencies to pursue legal remedies using these laws. Examples of such states in which Diversicare operates include: Kansas, Kentucky, Missouri and Ohio. Although these laws do not presently allow private citizens to file *qui tam* lawsuits, strong financial incentives provided by the Deficit Reduction Act of 2005 ("DRA") (*i.e.,* states can keep more of the federal healthcare funds that they recover if their false claims law is DRA-compliant) may likely result in several of these laws being amended to include *qui tam* provisions.

Presently, Alabama is the only state in which Diversicare operates that does not have a state false claims or enhanced monetary penalty law. However, Alabama does have a criminal Medicaid fraud law, which prohibits making a false statement in a claim or application for Medicaid payments or benefits. A conviction under this law is a felony which carries a fine up to $10,000,

imprisonment for a period ranging from one to five years, or both. Alabama also has administrative regulations that provide for restitution of improper payments and other administrative sanctions.

Many states have a variety of statutes imposing civil and/or criminal penalties for false claims and statements. For example, Ohio Revised Code § 5164.35 prohibits a Medicaid provider from engaging in deception to obtain Medicaid payments, willfully receiving payments to which the provider is not entitled or payments above the appropriate amount, or falsifying any report or document relating to Medicaid payments. Penalties for violations include repayment at three times the original payment, fines for each deceptive claim or falsification, and payment of court expenses. In addition, under this law, a false claimant can lose the right to receive all Medicaid payments. Ohio also has Ohio Revised Code § 2913.40, which provides for monetary fines and criminal penalties, including potential felony conviction, for Medicaid fraud and Ohio Revised Code § 2913.401, which imposes substantial monetary penalties and a potential felony penalty for false statements or incomplete disclosures in connection with securing Medicaid coverage (such as failing to disclose a prior transfer of property). Each of the states in which Diversicare operates has applicable criminal penalties (potential fines and imprisonment), as listed by specific state below and as summarized in Exhibit A to this policy at http://MyDiversicare.

WHISTLEBLOWER PROTECTIONS UNDER FALSE CLAIMS LAWS

In addition to the provisions allowing whistleblowers to share in any money recovered by the government, the FCA protects whistleblowers from retaliation resulting from their decision to file a whistleblower lawsuit on the government's behalf or from other efforts to stop violations of the FCA. For example, the FCA "whistleblower protection" provisions provide that an employee, agent or contractor who is discriminated against because of lawful acts done by that person in the filing or furtherance of a false claims lawsuit or other efforts to stop FCA violations "shall be entitled to all relief necessary to make that employee, contractor, or agent whole." Such relief can include, but is not limited to, two times the amount of back pay, reinstatement to the job held, and interest on back pay.

Many of the states in which Diversicare operates also have statutes protecting whistleblowers. For example, Ohio Revised Code §§ 4113.51 and 4113.52 prohibit improper disciplinary or retaliatory action against employees who report violations of law. Remedies may include reinstatement of the employee to the same position or to a comparable position, payment of back wages, full reinstatement of fringe benefits and seniority rights, or any combination of these remedies. Such statutes are listed by specific state below and summarized in Exhibit A to this policy at http://MyDiversicare . A major role of the anti-retaliation laws is to provide specified protections for those who help the government combat fraud, waste and abuse in government programs, including in healthcare programs like Medicare and Medicaid.

DIVERSICARE'S POLICIES AND PROCEDURES

FOR DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Diversicare is actively committed to conducting its business operations in an ethical and legally compliant manner. Part of this commitment is the operation of the corporate compliance program, which provides a medium for employees, agents, contractors and others to report all suspected incidents of fraud, waste and abuse, and provides the company an opportunity to investigate and resolve such allegations. It encourages all employees, agents and contractors to be aware of the laws regarding false claims, fraud, waste and abuse and to identify and resolve any issues immediately. Specific reference also is made to Diversicare's Code of Conduct and to the following policies and procedures for detecting and preventing fraud, waste and abuse: The Foundations of the Compliance Program, The Corporate Compliance Program, The Corporate Compliance Committee and Corporate Compliance Officer, Compliance Orientation and Training, Reporting Requirements, the Compliance Hotline, and the Policy of Non-Retaliation, The Compliance Investigation, Report, and Disciplinary Process, Gifts, Meals and Entertainment, Billing, Cost Reporting, and Recordkeeping and Documentation. Each of the above is available at http://MyDiversicare.

If you suspect that a person is engaging in conduct that violates Diversicare policies or that may result in fraud, waste or abuse against a government program, please contact the Corporate Compliance Officer via telephone at (615)771-7575, by mail at 1621 Galleria Blvd., Brentwood, Tennessee 37027, or call the Compliance Hotline at 1-888-508-9774. We have a policy of non-retaliation for all good faith reports made to us.

STATE LAW LIST

As discussed above, each state in which Diversicare operates facilities has a variety of laws prohibiting and penalizing false claims. See the list below for references to particular state laws. A full copy of the text of the laws referenced below may be obtained for free online. These laws also are summarized in Exhibit A to this policy at http://MyDiversicare.

ALABAMA: Alabama Code § 22-1-11; Alabama Administrative Code r. 560-X-4-.04.

INDIANA: Indiana Code §§ 5-11-5.5-1 through 5-11-18; §§ 12-15-23-1 through 12-15-23-10;§ 35-43-5-7.1.

KANSAS: Kansas Statutes Annotated §§ 21-5925 through 21-5934; §§ 75-7501 through 75-7511.

MISSISSIPPI: Mississippi Code Annotated §§43-13-129 and §§ 43-13-201 through 43-13-*233.*

MISSOURI: Missouri Revised Statutes §§ 191.900 through 191.910; §§ 198.139 through 198.171.

OHIO: Ohio Revised Code § 2913.40, § 2913.401, § 2921.13, §§ 4113.51 through 4113.52; §5164.35.

TENNESSEE: Tennessee Code Annotated §§ 4-18-101 through 4-18-108; § 71-5-118; §§ 71-5-181 through 71-5-185; §§ 71-5-2501 through 71-5-2521; §§ 71-5-2601 through 71-5-2604.

TEXAS: Texas Human Resources Code Annotated § 32.039 – 0391; § 36.001 - .132; Tex. Gov't Code Annotated § 531.101; Texas Penal Code §§ 35A.01 through 35A.02.

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ALABAMA

Alabama has not adopted a false claims act containing *qui tam* or generally applicable whistleblower provisions similar to those found in the federal FCA. However, Alabama has adopted a Medicaid Fraud Act ("MFA") prohibiting the submission of fraudulent claims to the state Medicaid program. Unlike the federal FCA, Alabama law does not allow for a private citizen to share a percentage of monetary recoveries.

Under the MFA, the state may bring criminal actions against any person who, with the intent to defraud or deceive, makes or causes to be made or assists in the preparation of any false statement, representation or omission of a material fact in any claim or application for payment, regardless of the amount, from the Medicaid agency. The MFA further prohibits any person from soliciting or receiving any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind in exchange for referring an individual to a person for the furnishing of any item or service for which payment may be made by the Medicaid agency or in return for purchasing, leasing, ordering any good, facility, service, or item for which payment may be made in whole or in part by the Medicaid agency. These acts are punishable by a fine up to $10,000 and/or imprisonment for between one and five years.

In addition to criminal penalties, Alabama Medicaid regulations provide for restitution of improper payments and other administrative sanctions when there has been fraud or abuse against the Medicaid program. Potential administrative sanctions include the suspension of Medicaid payments and termination of Medicaid participation. Alabama also has enacted other statutes that generally prohibit fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to the Alabama Medicaid program.

Reference: Alabama Code § 22-1-11; Alabama Administrative Code r. 560-X-4-.04.

INDIANA

The Indiana False Claims and Whistleblower Protection Act ("IFCWPA") mirrors many of the provisions of the federal FCA. The IFCWPA prohibits the knowing submission to Indiana of false or fraudulent claims for payment or approval or making or using a false statement to receive payment or approval. The IFCWPA also prohibits someone from knowingly or willingly causing someone else to submit a false or fraudulent claim. Persons violating the IFCWPA may be liable for civil penalties of at least $5,000 per claim plus three times the amount of damages sustained by the state and the costs of bringing the civil action.

Like the federal FCA, the IFCWPA includes *qui tam* provisions and provides for relator recovery from the proceeds of a successful IFCWPA action. However, if the person who initially files the *qui tam* complaint planned and initiated the fraud or was convicted of a crime related to the person's fraud, that person is not entitled to a share of the state's recovery. Also like the federal FCA, the IFCWPA has a whistleblower provision. An employer may not discharge, demote,

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suspend, threaten, or harass an employee because of lawful acts done by the employee in order to assist with or participate in an IFCWPA action. If an employer violates these prohibitions, the employee is entitled to "all relief necessary to be made whole," including reinstatement, double back pay, interest on back pay, and compensation for any special damages (such as litigation costs and attorneys' fees).

In addition to the IFCWPA, the Indiana Medicaid Fraud law also prohibits, among other acts, a person from knowingly or intentionally filing a false or fraudulent claim to the Indiana Medicaid program. Under Indiana law, Medicaid fraud constitutes a criminal offense ranging from a Class a misdemeanor to a level 5 felony, depending on the value of the offense. Indiana has further enacted a Medicaid improper payments law, under which the administrator may enter into an agreement with an overpaid provider to deduct the overpayment plus interest from future payments or certify the activity to the fraud unit. If the fraud unit determines that there is a meritorious action, the unit shall certify the facts for prosecution to the prosecuting attorney of the circuit where the crime was committed, who in turn may refer it to the attorney general to bring an action. If the action is successful, the court may award damages of not more than three times the excess paid, plus a civil penalty of not more than $500 for each instance of overpayment and reasonable costs of investigation and enforcement.

Indiana also has enacted other statutes that are generally intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to the state.

Reference: Indiana Code §§ 5-11-5.5-1 through 5-11-18; §§ 12-15-23-1 through 12-15-23-10; § 35-43-5-7.1.

KANSAS

The Kansas False Claims Act ("KFCA") creates civil liability for knowingly presenting or causing to be presented any false of fraudulent claim for payment or approval to any officer of agent of the state of Kansas. The KFCA allows the state to recover three times the amount of damages, plus civil penalties of not less than $1,000 and up to $11,000 for each violation. Unlike the federal FCA, Kansas law does not allow for a private citizen to share a percentage of monetary recoveries. An employer may not discharge, suspend, threaten, or harass an employee because of lawful acts done by the employee in order to assist with or participate in a KFCA action. The KFCA contains whistleblower provisions, entitling employees to all relief necessary to make them whole.

Kansas also has adopted a Medicaid Fraud Control Act ("KMFCA") that makes it unlawful for a person to submit false and fraudulent claims to the Kansas Medicaid program. Violation of the KMFCA is a criminal offense punishable by imprisonment and payment of full restitution to the state plus interest and all reasonable expenses. Obstruction of a Medicaid fraud investigation constitutes a criminal offense under Kansas law, ranging from a class A nonperson misdemeanor up to a level 1 person felony, depending upon the facts. A violator also may be subject to fine of not less than $1,000 and not more than $11,000 for each violation.

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In addition, Kansas has enacted other statutes that are generally intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to a state medical assistance program.

Reference: Kansas Statutes Annotated §§ 21-5925 through 21-5934; §§ 75-7501 through 75-7511.

MISSISSIPPI

Mississippi has enacted the Medicaid Fraud Control Act which prohibits various practices related to the Medicaid program. This Act prohibits any person, including healthcare providers, from making, presenting or causing to be made or presented a claim for Medicaid benefits, knowing the claim to be false, fictitious or fraudulent. It also prohibits any person from soliciting, offering, or receiving a kickback or bribe in the furnishing of goods and services for which payment is or may be made in whole or in part pursuant to the Medicaid program and from making or receiving any such payment or a rebate of a fee or a charge for referring an individual to another person for the furnishing of such goods or services. This Act also prohibits any person from knowingly and willfully making, inducing or seeking to induce the making of a false statement or false representation of a material fact with respect to the conditions or operation of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, to receive Medicaid benefits as a hospital, skilled nursing facility, intermediate care facility or home health agency. This Act further prohibits any person from entering 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 health care provider or vendor committing any act or omission in violation of the Medicaid Fraud Control Act is 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. Enforcement of the Act is through the State Attorney General, acting through the Director of the Fraud Control Unit. In conducting such actions, the Attorney General, acting through the director, has all the powers of a district attorney, including the powers to issue or cause to be issued subpoenas or other process.

In addition to civil liability, Mississippi has enacted statutes that make it a crime to violate certain provisions of the Medicaid Fraud Control Act. A person who violates any relevant provision shall be guilty of a felony, and, upon conviction thereof, shall be punished 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. Also, the Act provides that any person making application for benefits under the Medicaid program for himself or for another person, and any provider of services, who knowingly makes a false statement or false representation or fails to disclose a material fact to obtain or increase any benefit or payment under this article shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not to exceed five hundred dollars ($500.00) or imprisoned not to exceed one (1) year, or by both such fine and imprisonment.

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The State of Mississippi has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act.

Reference: Mississippi Code Annotated §§43-13-129 and §§ 43-13-201 through 43-13-*233*.

MISSOURI

Missouri law prohibits healthcare providers from knowingly making a false statement or false representation in order to receive a healthcare payment. The law also prohibits any person from presenting or seeking to induce for consideration, false information to obtain certification or recertification as a Missouri Medicaid provider. If convicted, restitution to federal and state governments is required in an amount at least equal to that unlawfully paid plus reasonable costs attributable to the investigation and prosecution. Violations of these prohibitions are felony offenses punishable by imprisonment for up to fifteen years. However, any person who discovers a violation, committed by themselves or their organization, and reports such information, before it is public or known to the state attorney general, shall not be prosecuted for a criminal violation. In addition, violators may be liable for damages of up to three times the amount of damages the federal and state government sustained plus civil penalties ranging from $5,000 to $10,000 for each unlawful act.

The state attorney general may bring a civil action against any person who receives a health care payment as a result of a false statement or false representation made or caused to be made by that person, with liability for up to double the amount of all payments received by that person based on the false statement or representation, plus reasonable costs attributable to prosecution. Missouri has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the FCA but it permits a person, who is the original source of information used by the attorney general to bring an action, to receive ten percent of any recovery by the attorney general, unless that person planned, initiated, or participated in the conduct. "Original source of information" means information no part of which has been previously disclosed to or known by the government or public.

Missouri prohibits employers from discharging, demoting, suspending, threatening, harassing, or otherwise discriminating against an employee because the employee initiates, assists in, or participates in a proceeding or court action under these laws, unless the court finds brought the employee: brought a frivolous or clearly vexatious claim; planned, initiated, or participated in the conduct upon which the action is brought; or is convicted of criminal conduct arising from a violation of these laws. An employer who violates this prohibition is liable to the employee for reinstatement to the employee's position without loss of seniority, two times the amount of lost back pay, and interest on the back pay at the rate of one percent over the prime rate.

Under the state's Omnibus Nursing Home Act a healthcare provider or vendor also is prohibited from making or causing to be made any false statement or false representation in any application for any benefit or payment, or in determining eligibility for any benefit or payment,

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under Medicaid for services provided to any resident, from concealing or failing to disclose any material fact affecting eligibility for any benefit or payment with the intent to secure such in greater quantity than is due or when no such benefit or payment is permitted, from converting a benefit or payment under Medicaid for services provided to a resident for a use or benefit other than that for which it was specifically intended, from knowingly making or causing to be made any false statement or representation for certification or recertification and from knowingly inducing or seeking to induce any such statement or representation for consideration. Violations are felonies and those convicted are prohibited from future participation in Medicaid, subject to reinstatement for good cause. Violators are civilly liability to the state for any moneys obtained under Medicaid as a result of such act or omission. The director of the fraud investigation division may seek civil restitution of any moneys dispensed under Medicaid for services provided to any resident which have been misappropriated, fraudulently obtained, or constitute overpayments. No person who directs or exercises any authority shall evict, harass, dismiss, or retaliate against any resident or employee because such resident or employee or any member of such resident's or employee's family has made a report of any violation or suspected violation of laws, ordinances, standards, or regulations, applying to the facility which the resident, resident's family or employ has reasonable cause to believe has been committed or has occurred.

Missouri also has enacted other statutes that are generally intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to the Missouri Medicaid program.

Reference: Missouri Revised Statutes §§ 191.900 through 191.910; §§ 198.139 through 198.171.

OHIO

No Ohio Medicaid provider shall by deception, obtain or attempt to obtain payments under the Medicaid program to which the provider is not entitled; willfully receive payments to which the provider is not entitled; willfully receive payments in a greater amount than that to which the provider is entitled; or falsify any report or document required by state or federal law, rule, or provider agreement relating to Medicaid payments. Any Medicaid provider who violates this law is liable for (1) interest on the amount of the excess payments; (2) three times the amount of any excess payments; (3) not less than $5,000 and not more than $10,000 dollars for each deceptive claim or falsification; and (4) all reasonable expenses necessarily incurred by the state in the enforcement of this statue.

In addition to the civil penalties provided above, the Medicaid director shall terminate the provider's provider agreement and stop payment to the provider for Medicaid services rendered from the date of conviction or entry of judgment, unless the provider or owner can demonstrate that it did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the conviction or entry of a judgment. The provider and various others can be excluded from Medicaid participation, unless the person can demonstrate they had no knowledge of an action of the violating party the person was formerly associated with. The attorney general on behalf of the state may commence proceedings to

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enforce this section; all moneys collected are deposited in the state treasury. See Ohio Revised Code § 5164.35.

Under Ohio Revised Code § 2913.40 it is a violation to (1) knowingly make, or cause to be made, a false or misleading statement or representation or knowingly falsifying or destroying records in order to obtain reimbursement from Ohio medical assistance programs; (2) with purpose to commit fraud or knowing that the person is facilitating fraud, (a) charge, solicit, accept, or receive any property, money, or other consideration for goods or services that the person provides under the Ohio Medicaid program in addition to the amount of reimbursement such person is entitled to under such program or (b) solicit, offer, or receive any remuneration, other certain authorized cost-sharing expenses, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the Medicaid program; and (3) knowingly alter, falsify, destroy, conceal or remove any records that are necessary to fully disclose the nature of all goods or services for which a claim for payment was submitted to or for which reimbursement was received from the Ohio Medicaid program, or that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based, within six years after such claim or payment was made. Violations are criminal offenses with penalties varying from first degree misdemeanor to third degree felony punishable by imprisonment for a term of up to five years, depending on the value of the property, services or funds obtained.

Per Ohio Revised Code § 2913.401 it also is a violation, in a Medicaid program enrollment application or in a document that requires a disclosure of assets for the purpose of determining Medicaid eligibility, to knowingly make or cause to be made a false or misleading statement, conceal an interest in property or fail to disclose a transfer of property that occurred during a specified time period prior to submission. Violations are criminal offenses ranging from first degree misdemeanor to third degree felony, depending upon the value. In addition to imposing a sentence the court shall order restitution in the full amount of any Medicaid services paid on behalf of an applicant for or recipient of Medicaid for which the applicant or recipient was not eligible, plus interest. Any restitution under this section and interest is credited to the general revenue fund, with any applicable federal share returned to the appropriate agency or department of the United States.

Ohio Revised Code at § 2921.13 also prohibits any person from knowingly making a false statement, or knowingly swearing or affirming the truth of a false statement previously made, when the statement is made for certain purposes, including without limitation (1) during any official proceeding, (1) to mislead a public official in performing their official function, (3) to secure payment of benefits administered by a government agency or paid out of a public treasury, (4) to secure issuance of a license, permit, registration or provider agreement, (5) in connection w/ a report or return that is required or authorized by law or (6) on an account, form, record, label or other writing that is required by law. Violations are criminal offenses ranging from first degree misdemeanor to third degree felony. If a person is injured by such acts, the violator is liable for losses plus attorneys' fees, court costs and other prosecution expenses.

Ohio has not adopted any false claims acts or statutes that contain *qui tam* provisions similar to those found in the FCA but it has enacted certain whistleblower protections. An

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employee who becomes aware in the course of employment of a violation of any statute, ordinance or regulation, that the employer has authority to correct or by a fellow employee (and with respect to such employees, also of a violation of any work rule or company policy), and who reasonably believes that the violation is a criminal offense likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety, a felony, or an improper solicitation for a contribution, must orally notify their supervisor or other responsible officer of the employer of the violation and subsequently shall file with that supervisor or officer a written report with sufficient detail to identify and describe the violation. If the employer does not correct the violation or make a reasonable and good faith effort to correct the violation within twenty-four hours, the employee may file a written report with the prosecuting authority of the county or municipal corporation where the violation occurred, with a peace officer, with the inspector general if the violation is within the inspector general's jurisdiction, or with any other appropriate public official or agency that has regulatory authority over the employer and the industry, trade, or business in which the employer is engaged. The employer, within twenty-four hours or by the close of business on the next regular business day following the day, whichever is later, shall notify the employee, in writing, of any effort of the employer to correct the alleged violation or hazard or of the absence of the alleged violation or hazard. However, if an employee becomes aware in the course of employment of a violation of the state's air or water pollution control, solid and hazardous waste or safe drinking water laws, that is a criminal offense, the employee directly may notify, either orally or in writing, any appropriate public official or agency that has regulatory authority over the employer and the industry, trade, or business.

Except as specifically provided below, an employer cannot take any disciplinary or retaliatory action against an employee for making any report concerning a violation of any statute, ordinance or regulation, that the employer has authority to correct or of the state's air or water pollution control, solid and hazardous wastes or safe drinking water laws, or as a result of the employee's having made any inquiry or taken any other action to ensure the accuracy of any information reported under such portions of this law. An employee shall make a reasonable and good faith effort to determine the accuracy of any such information reported. If the employee who makes a report under either division fails to make such an effort, the employee may be subject to disciplinary action by the employee's employer, including suspension or removal, for reporting information without a reasonable basis to do so.

With respect to an employee making any report concerning a violation by a fellow employee as described in the paragraph above, an employer cannot take any disciplinary or retaliatory action if the employee made a reasonable and good faith effort to determine the accuracy of any information reported, or as a result of the employee's having made any inquiry or taken any other action to ensure the accuracy of any information so reported. If an employer takes any disciplinary or retaliatory action against an employee as a result of the employee's having filed a report under this law, the employee may bring a civil action for appropriate injunctive relief or for the remedies set forth below, or both, within 180 days after the date the disciplinary or retaliatory action was taken. As determined by the court, remedies may include reinstatement of the employee to the same position or to a comparable position, payment of back wages, full reinstatement of fringe benefits and seniority rights, or any combination of these remedies. The court also may award the prevailing party all or a portion of the costs of litigation

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and, if the employee who brought the action prevails in the action, may award the prevailing employee reasonable attorney's fees, witness fees, and fees for experts who testify at trial. If the court determines that an employer deliberately has violated the prohibitions against discrimination and retaliation, the court, in awarding back pay, may also order interest. See Ohio Revised Code §§ 4113.51 through 4113.52.

Ohio has also enacted other statutes that are intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to the state Medicaid program.

Reference: Ohio Revised Code § 2913.40, § 2913.401, § 2921.13, §§ 4113.51 through 4113.52; § 5164.35.

TENNESSEE

Tennessee has a state False Claims Act (the "TFCA") as well as a Medicaid False Claims Act ("TMFCA"). Both laws prohibit conduct similar to the federal FCA. However, the TMFCA prohibits the submission of false or fraudulent claims that would be paid from state Medicaid funds, specifically, including under the TennCare program. The TFCA prohibits false or fraudulent claims that would be paid from state funds except to the extent such conduct is prohibited under the TMFCA. The TFCA differs from the TMFCA in that under the TFCA a person may be liable if the person (a) is a beneficiary of an inadvertent submission of a false claim to the state, (b) subsequently discovers that the claim is false, and (c) fails to disclose the false claim to the state within a reasonable time after discovery. The TFCA also does not apply to any claim less than $500 in value, to any claims, records or statements made pursuant to workers compensation claims or under any statute applicable to any tax administered by the Tennessee Department of Revenue.

Both laws permit state officials to file suits or a private individual to file a *qui tam* lawsuit on behalf of the state. If the case is successful, the individual is entitled to a portion of the money recovered by the state plus reasonable expenses including attorneys' fees and costs, unless the *qui tam* plaintiff is convicted of a violation of the applicable statute(s), in which case they will be dismissed from the lawsuit without any share of the award. Under the TMFCA, if the state does not intervene and the defendant prevails, the defendant may recover reasonable attorneys' fees and expenses if the court finds the action was clearly frivolous, clearly vexatious or brought primarily to harass. Anyone who knowingly presents or causes the presentation of a false claim is liable for damages (under the TMFCA for three times the damages sustained by the state and under the TFCA of not less than two nor more than three times the damages sustained by the state), plus, civil penalties (under the TMFCA of $5,000 to $25,000 per false claim and under the TFCA of $2,500 to $10,000 per claim) as well as the cost of the investigation and prosecution. Under the TFCA, employers cannot make or enforce rules or policies preventing an employee from disclosing information to a government or law enforcement agency or from acting in

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furtherance of a false claims action. Employees who assist state officials or participate in an action under either law or who are otherwise acting in furtherance of an action or other efforts to stop conduct prohibited by either Act are protected from workplace retaliation. Remedies include reinstatement with the same seniority status, up to two times back pay (plus interest) and compensation for any special damages sustained, including litigation costs and attorneys' fees.

Tennessee has adopted several other false claims statutes intended to prevent fraud and abuse in the TennCare program, including the TennCare Fraud and Abuse Reform Act ("TFARA") and the Prevention of Fraud and Abuse in TennCare ("PFATC"). These laws generally prohibit the filing of any false or fraudulent claim or documentation in order to receive compensation from the TennCare program. The PFATC allows the court to refer violators to applicable professional licensure boards for discipline and to disqualify them from participating in TennCare; both Acts authorize restitution and criminal penalties against any person who knowingly defrauds the state Medicaid/TennCare program by submitting false claims or making false representations. Private individuals cannot file *qui tam* lawsuits under these laws; rather, criminal actions are brought by state officials. However, under the TFARA, the Tennessee Office of Inspector General is authorized to pay a monetary reward for information that leads to the arrest and conviction of any person or entity that has engaged in TennCare fraud. The PFATC requires all persons with actual knowledge that is not subject to privilege to notify the TennCare inspector general and Medicaid Fraud Control Unit immediately if a fraud is being or has been committed. Failure to do so is subject to civil penalty of up to $10,000 for each finding. Any person or entity making such a report is immune from civil liability if made in good faith pursuant to this law.

Tennessee additionally enacted the Medical Assistance Act of 1968 which empowers the Commissioner of Finance and Administration to terminate or suspend provider agreements and recover any payments incorrectly paid to providers. Grounds for actions against a provider include, for example, violating provider agreements or Medicaid regulations, billing for services not delivered or not medically necessary, and failing to produce requested substantiation records. Administrative remedy is available to TennCare for recovering amounts improperly paid, to the extent such amount has not already been recovered by TennCare. TennCare also may collect attorneys' fees and reasonable costs plus interest on the amount owed. Tennessee also has enacted other statutes that are intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of money or property through fraud or deception, may be applicable to false claims submitted to the state Medicaid program.

Reference: Tennessee Code Annotated §§ 4-18-101 through 4-18-108; § 71-5-118; §§ 71-5-181 through 71-5-185; §§ 71-5-2501 through 71-5-2521; §§ 71-5-2601 through 71-5-2604.

TEXAS

Under Texas' medical assistance program administrative statutes, it is unlawful for a

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person to present or cause to be presented to the Texas Health and Human Services Commission ("HHSC") a claim that contains a statement or representation the person knows or should know to be false. Certain intentional or knowing violations are punishable as a state jail felony. Additionally, the Texas Medicaid Fraud Protection Act ("TMFPA") creates penalties for false submissions to the Texas Medicaid program. Under the TMFPA, a person commits an unlawful act if the person knowingly makes or submits, or induces another to make or submit, a false claim for payment of benefit to the Texas Medicaid program. The TMFPA also prohibits a person from knowingly submitting false statements or misrepresentations of material fact in order to certify facilities under the Medicaid program or conspiring to engage in conduct that constitutes a violation of the TMFPA. Additionally, the TMFPA prohibits submission of a claim for payment if the services were rendered by an unlicensed or improperly licensed provider. Violators are required to provide full restitution to the state (the total amount of the fraudulent claims, plus the costs of the investigation and litigation, including attorneys' fees). In addition, violators are subject to civil penalties of between $5,500 and $15,000 for each unlawful act plus damages equal to two times the amount of the fraudulent claim.

The TMFPA allows private individuals to file *qui tam* suits on behalf of the state of Texas to pursue violations of the TMFPA. If the state intervenes and the case is successful, the individual is entitled to a percentage of the state's monetary recovery plus reasonable expenses, reasonable attorneys' fees and costs that the court finds to have been necessarily incurred. Texas law also has a whistleblower provision. Under the TMFPA employees who report their employer's false claims are protected from retaliation. Remedies include reinstatement, not less than two times back pay and interest on the back pay, plus special damages such as litigation costs and reasonable attorneys' fees. The FMFPA also grants certain immunity (from liability for providing access to information) in connection with a FMFPA investigation if the information is given to certain authorized personnel of the Texas or federal governments.

HHSC may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in the Medicaid program, if the attorney general did not have independent knowledge of the activity reported and the disclosure results in a recovery. The amount of any such award is determined by HHSC and the award shall not exceed five percent of the administrative penalty for the violation. However, a person who brings a *qui tam* action as described above is not eligible for such an award.

The Texas Penal Code has a broad statute that makes it a crime to engage in various activities related to a healthcare program. The law defines a health care program to be any program funded by the state, the federal government or both and designed to provide health care services to health care recipients, including a program that is administered in whole or in part through a managed care delivery model. A person commits an offense under this Law if the person: (1) knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under a health care program that is not authorized or that is greater than the benefit or payment that is authorized; (2) knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under a health care program that is not authorized or that is greater than the benefit or payment that is authorized; (3) knowingly applies for and receives a benefit or payment on behalf of another person under a health care program and converts any part of the benefit or payment to a use other than for the benefit of the person on whose

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behalf it was received; (4) knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning: (A) the conditions or operation of a facility in order that the facility may qualify for certification or recertification under a health care program ; or (B) information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to a health care program; (5) except as authorized under a health care program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the health care program, a gift, money, donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under a health care program; (6) knowingly presents or causes to be presented a claim for payment under a health care program for a product provided or a service rendered by a person who: (A) is not licensed to provide the product or render the service, if a license is required; or (B) is not licensed in the manner claimed; (7) knowingly makes or causes to be made a claim under a health care program for: (A) a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner; (B) a service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or (C) a product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate; (8) makes a claim under a health care program and knowingly fails to indicate the type of license and the identification number of the licensed health care practitioner who actually provided the service; (9) knowingly enters into an agreement, combination, or conspiracy to defraud the state or federal government by obtaining or aiding another person in obtaining an unauthorized payment or benefit from a health care program or fiscal agent; (10) is a managed care organization that contracts with the Health and Human Services Commission, another state agency, or the federal government to provide or arrange to provide health care benefits or services to individuals eligible under a health care program and knowingly: (A) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract; (B) fails to provide or falsifies information required to be provided by law, rule, or contractual provision; or (C) engages in a fraudulent activity in connection with the enrollment of an individual eligible under a health care program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under a health care program; (11) knowingly obstructs an investigation by the attorney general of an alleged unlawful act concerning a health care program or provider; or (12) knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state or the federal government under a health care program. Violations are criminal offenses that range from Class C misdemeanor to first degree felony depending upon severity of the offense.

Texas has also enacted other statutes that are generally intended to prevent fraud and abuse. These laws, which typically prohibit the acquisition of another's money or property through fraud or deception, may be applicable to false claims submitted to the state Medicaid program.

Reference: Texas Human Resources Code Annotated § 32.039 – 0391; § 36.001 - .132; Tex. Gov't Code Annotated § 531.101; Texas Penal Code §§ 35A.01 through 35A.02.