DEPARTMENT: Compliance	**POLICY DESCRIPTION**: False Claims Act and Whistleblower Protections
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REVISION DATES: 1/15/2021, 3/5/2025, 9/25/2025	**EFFECTIVE DATE**: 3/13/2020

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 Chief 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 $14,308 to $28,619 (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 $14,308 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 $14,308 - $28,619 (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.

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 $14,308 for each false claim plus triple damages), which provide an incentive for state prosecutors and enforcement agencies to pursue legal remedies using these laws. 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. 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. 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 Diversicare 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 Diversicare Compliance Committee and Chief 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 Chief 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.

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.*

NORTH CAROLINA: N.C. Gen. Stat. §§108A-70.10 through 70-16; N.C. Gen. Stat. §§ 1-605 through 618.

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.

EXHIBIT A

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.

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.

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.

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.*

NORTH CAROLINA

The North Carolina Medical Assistance Provider False Claims Act, N.C. Gen. Stat. §§ 108A-70.10 through 70-16, is modeled after the FCA, and the same types of behavior that are illegal under the FCA are illegal under North Carolina law. Specifically, it is a violation of North Carolina law to do either of the following:

(1) Knowingly present, or cause to be presented to Medicaid, a false or fraudulent claim for payment or approval; or

(2) Knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by Medicaid.

North Carolina's Medical Assistance Provider False Claims Act does not provide for whistleblower actions but does provide that any person who acts in good faith in providing information to State officials responsible for investigating false claims violations is immune from civil liability. A violation of the Act is can be punished with a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) plus three times the amount of damages which Medicaid sustained because of the act of the provider. In addition, a provider violating this Act will be liable for the costs of a civil action brought to recover any penalty or damages, interest on the damages at the maximum legal rate in effect on the date the payment was made to the provider for the period from the date upon which payment was made to the provider to the date upon which repayment is made by the provider to Medicaid, and the costs of the investigation.

North Carolina also has a general False Claims Act, N.C. Gen. Stat. §§ 1-605 through 1-618, that makes it illegal to submit any sort of false or fraudulent claim to the State in any context. Specifically, it is a violation of North Carolina law to do any of the following:

(1) Knowingly present or cause to be presented a false or fraudulent claim for payment or approval;

(2) Knowingly make, use, or cause to be made or used, a false record or statement that is material to a false or fraudulent claim (i.e., the false record or statement shows that the State should pay money);

(3) Have possession, custody, or control of property or money used or to be used by the State and knowingly deliver or cause to be delivered less than all of that money or property;

(4) Make or deliver a receipt for property used or be used by the State that you do not know to be true, with the intent to defraud the State;

(5) Knowingly buy public property from any State employee or officer who cannot lawfully sell or pledge the property;

(6) Knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State, or knowingly conceal, avoid, or decrease an obligation to pay or transmit money or property to the State; or

(7) Conspire to commit a violation of this law.

The general North Carolina False Claims Act contains a whistleblower provision that tracks the language of the federal FCA, entitling a whistleblower plaintiff to at least 15 percent, but not more than 25 percent, of the proceeds of the action if the State participates, and at least 25 percent, but not more than 30 percent, if the State does not participate. The person bringing the suit shall also receive reasonable attorneys' fees, expenses, and costs.

A violation of the general North Carolina False Claims Act can result in liability to the State for three times the amount of damages sustained by the State; the costs of the lawsuit brought to recover those funds; and a civil penalty ranging from $5,500 to $11,000 for each false claim, as adjusted for inflation.

The North Carolina Attorney General's office is responsible for investigating and bringing lawsuits for violations of the state False Claims Acts. Additionally, the North Carolina Department of Health and Human Services, Division of Health Benefits ("DHB") will investigate cases of suspected provider waste, fraud, and abuse in the Medicaid program.

Reference: N.C. Gen. Stat. §§108A-70.10 through 70-16; N.C. Gen. Stat. §§ 1-605 through 618.

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 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.