# Compliance Plan

# Home Health and Hospice Care, Inc (3HC)

# Corporate Compliance

**Reviewed by Third Party Compliance Consultant:**
**Matt Wolfe, Attorney and Stephanie Doyle Baker,**
**Donelson, Bearman, Caldwell & Berkowitz** **Date: 2-6-24**

**Reviewed by 3HC Staff Compliance Committee:**

**_____ Date: 1/9/2025**

**Reviewed by Professional Management Team**

**_____ Date: 1-20-2025**

**Reviewed by 3HC Board Compliance Committee:**

**_____ Date: 2-10-2025**

**Adopted by 3HC Board of Directors:**

**_____ Date: 3-10-2025**

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# CODE OF CONDUCT AND FRAUD AND ABUSE COMPLIANCE PLAN

Home Health and Hospice Care, Inc.

## Code of Conduct

Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") strives to establish relationships of trust with those with whom it works.

Personnel of the Company uphold professional standards of conduct, clarify their professional roles and obligations, take appropriate responsibility for their actions, and seek to manage conflicts of interest that could lead to exploitation or harm. The Company promotes accuracy, honesty, and truthfulness in the provision of home health and hospice services.

The Company and its personnel do not steal, cheat, or engage in fraud, abuse or misrepresentation of fact. The Company and its personnel strive to keep their promises.

Specifically, employees and independent contractors of the Company have an affirmative obligation to prevent and/or correct instances of fraud and abuse related to the Medicare and Medicaid Programs and other state and federal health care programs.

## 3HC Professional Management Team and Board of Directors Letter of Commitment to Compliance

***The 3HC Compliance Plan presented in the following pages is a comprehensive document that is developed to protect the patients, families, staff, and communities served each day. The highest standards of discipline and professionalism are incorporated to ensure all regulatory, clinical, and business requirements are met. Adherence by all stakeholders is expected performance that will ensure safety and quality of care is delivered at the right place, at the right time. Accountability and Excellence will be the result of these efforts by a compassionate 3HC Team.***

***3HC Board of Directors and the Professional Management Team have approved and endorse this 3HC Compliance Plan that ensures 3HC will continue to be leaders in setting the standard for community-based care for all.***

**Sincerely,**

**3HC Home Health and Hospice Care, Inc Professional Management Team and Board of Directors**

## Compliance Plan

The Governing Body recognizes that there are many areas of risk for potential fraud and abuse, including, but not limited to, illegal remuneration or kickbacks and rebates and the submission of false claims. The Governing Body adopts this Compliance Plan to ensure the Company takes proactive steps to address these risk areas. Professional Management Team and members of the Governing Body recognize and acknowledge that there are areas of potential risk of violations of fraud and abuse prohibitions related to the business of the Company. Risk areas identified by the Company are included in the Company's Policy on Identification of Potential Risks.

**3HC's existing policies and procedures for detecting and preventing fraud**

a. 3HC's policies and procedures for detecting and preventing fraud are located in its Compliance Plan that is accessible to all employees on Power DMS.
b. All personnel are required to report known or suspected wrongdoing.
c. There are several ways to report a concern:
    i. Supervisor - You may report your concerns to your supervisor. Your supervisor will then be responsible to report it up the chain of command or directly to the Compliance Officer, Stephanie Harris.
    ii. HOTLINE- Call Toll Free 1-866-489-3395 (reports can be made anonymously)
    iii. Written - Interoffice Mail: Stephanie Harris in the Corporate Office or email sharris@3hc.org.
    iv. Call Compliance Officer: Stephanie Harris, Compliance Officer, Corporate Office, 1-800-260-4442 or (919) 735-1387 ext. 1005.
d. If the employee, or subcontractor reasonably believes that the Compliance Officer is involved in the suspected wrongdoing or believes that his/her report cannot be fairly handled by the Compliance Officer, the report of suspected wrongdoing or violation shall be made to the CEO, who shall in turn promptly report the matter to the Board.

APPLICABLE STATUTES (*Summary*)

## FALSE CLAIMS LAWS

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often permit qui tam suits as well, which are lawsuits brought by lay people, typically employees or former employees of healthcare facilities that submit false claims. There is a federal False Claims Act. North Carolina has adopted a similar false claims act that contains qui tam and whistleblower protection provisions that are similar to those found in the federal False Claims Act. In addition, North Carolina's Workers' Compensation Act and Medical Assistance Provider False Claims Statute both allow for penalties against health care providers in the event of fraud.

## FEDERAL FALSE CLAIMS LAWS

Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds, or knowingly retains an overpayment of such funds more than 60 days, is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from $14,308 to $28,619 per false claim, plus the costs of the civil action against the entity that submitted the false claims.

Generally, the federal False Claims Act applies to any federally funded program. The federal False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid. One of the unique aspects of the federal False Claims Act is the "qui tam" provision, commonly referred to as the "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government to recover the funds paid by the Government as a result of the false claim The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. A similar federal law is the Program Fraud Civil Remedies Act of 1986 (the "PFCRA"). It provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of $5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

## NORTH CAROLINA FALSE CLAIMS ACT

The North Carolina False Claims Act was passed in 2009 and allows an individual to file a lawsuit on behalf of the State of North Carolina in certain situations.

Claims made under the Act are generally known as a *qui tam* claims. A qui tam claim is a lawsuit filed for the benefit of the state against a person or business entity for submitting, or causing to be submitted, false or fraudulent claims to the state. Additionally, it can be filed where a person or business entity becomes aware of a claim submitted by mistake but fails to repay the state.

The North Carolina General Statutes Article 51 provides that a person is liable to the state where he or she:

1. Knowingly presents a false or fraudulent claim for payment.
2. Knowingly makes or uses a false record or makes a statement material to a false or fraudulent claim.
3. Conspires to make a false or fraudulent claim.
4. Has possession or control of money used or to be used by the State and knowingly delivers less than all of that money or property.
5. Is authorized to make or deliver a document certifying receipt of property used or to be used by the State and makes or delivers the receipt without knowing whether the information is true, with intent to defraud the State.
6. Knowingly buys public property from any officer or employee of the State who lawfully may not sell the property.
7. Knowingly makes or uses a false record regarding an obligation to pay the State, or knowingly conceals, avoids, or decreases an obligation to pay to the State.

A violator will be liable to the State for three times the amount of damages that the State sustains because of the act of the violator, plus a civil penalty of not less than $5,500 and not more than $11,000 per claim. The North Carolina Attorney General may issue a civil investigative demand if the Attorney General has reason to believe that a person has information relevant to an investigation of the NCFCA or any other false claims law.
The North Carolina False Claims Act contains an anti-retaliation provision which indicates any employee, contractor, or agent who experiences retaliatory action because of lawful acts done by the individual in furtherance of an action under the North Carolina False Claims Act or other efforts to stop violation(s) of the North Carolina False Claims Act.

## ILLEGAL RENUMERATION OF KICKBACKS AND REBATES

The Anti-Kickback Statute is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business. As a result, violation of the AKS is a felony, punishable by ten years in jail and fines of $100,000 per violation. It also makes the resulting bills to the government false under the False Claims Act. As a result, the violator is responsible for three times the value of the bills, and a False Claims Act Penalty of up to $23,000 per bill. Violation of the AKS also triggers liability under the Civil Monetary Penalties Law (CMPL). The CMPL carries penalties of up to $50,000 per kickback, in addition to three times the amount of the remuneration. The AKS prohibits anyone from requesting, receiving, offering, or paying kickbacks intended to generate health care business.

The AKS Statute states:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

(2)Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.

42 U.S.C. § 1320a-7b(b).

PREVENTION AND CORRECTION:

The Governing Body and Professional Management Team have agreed that the following actions are appropriate in order to prevent and/or correct potential violations:

(1) Appointment of Corporate Compliance Officer.

- The Governing Body shall appoint a Compliance Officer from among the employees of the Company. The Chief Financial Officer shall not serve as the Compliance Officer under any circumstances. The Compliance Officer is responsible to carry out the functions described in the Policies of the Company related to prevention and correction of potential violations. The Compliance Officer shall report to the Chief Quality Officer with an indirect line to the Chief Executive Officer and Governing Body.
- The Compliance Officer shall have the authority to conduct internal investigations of alleged violations independent of influence by the Governing Body and Professional Management Team. Internal investigations shall ordinarily be completed within sixty (60) calendar days from the date on which the Compliance Officer identified a potential violation. Overpayments, if any, will be reported and repaid to applicable government contractors, intermediaries, carriers, state or the Secretary of the Department of Health and Human Services (HHS) within sixty (60) days after the overpayment is identified or the date any corresponding cost report is due, whichever is later.
- The Compliance Officer shall make recommendations directly to the President and the Governing Body regarding corrective action needed in order to prevent or remedy possible fraudulent or abusive conduct, including, but not necessarily limited to, disciplinary action that may be reasonably imposed on responsible employees consistent with the Company's policy on progressive discipline. Disciplinary action may be taken, which includes

termination for violation of these policies and/or requirements.

- The Compliance Officer may delegate responsibilities under the Compliance Plan in writing only to persons reasonably believed to be honest and capable of making judgments called for in the Compliance Plan.
- The Compliance Officer shall bring to the attention of the Governing Body's Legal Counsel all changes in circumstances that could reasonably suggest that the Compliance Plan should be modified.

(2) Quality Assurance/Performance Improvement (QAPI).

- Employees, Professional Management Team, and the Compliance Officer shall develop appropriate risk indicators to continuously monitor, evaluate, detect, and remedy circumstances that led to the commission of fraudulent or abusive conduct.
- Monitoring activities shall include, at a minimum, both concurrent and retrospective review of patients' charts for appropriateness of patients for the services and appropriate utilization of health benefits. The Compliance Officer shall involve clinicians as appropriate for these reviews.
- Both Professional Management Team and the Governing Body shall receive quarterly written reports on compliance activities related to prevention and/or correction of possible fraudulent or abusive conduct.

(3) Governing Body.

- The Governing Body shall be charged with responsibility to ensure that the Company complies with all applicable legal authority.
- The Governing Body shall review the "Compliance Plan" at least annually and shall make

appropriate modifications to the Plan in consultation with Legal Counsel. At a regularly scheduled meeting of the Governing Body, on at least an annual basis, the members of the Governing Body will also address the issues described in the Company' s Policy on Governing Body Compliance Activities.

(4) Training and Education of All Employees.

- The Company will not employ, retain, or contract with individuals who have been convicted of a crime or suspended or excluded from participation in the Medicare/Medicaid Programs, or other state or federal health care programs or are on the List of Excluded Individuals and Entities published by the Office of Inspector General for the United States Department of Health and Human Services. The Company will conduct appropriate screening activities consistent with the Company's Policy on Background Screenings of Potential Employees, Members of the Governing Body, and Independent Contractors.
- At least annually, all employees of the Company shall receive training and education regarding potential fraudulent and abusive activity, the Company's Code of Conduct and Compliance Plan, and reporting and self-disclosure obligations and procedures.
- Participation in such training is a condition of continued employment. Failure to participate in training activities may result in disciplinary action, up to and including termination of employment. Adequate records of such training, including attendance logs and copies of materials distributed at such training sessions, will be maintained by the Compliance Officer.
- Managers and supervisors will be disciplined for failure to adequately instruct their subordinates or for failing to detect noncompliance with applicable policies and legal

requirements when reasonable diligence on the part of managers or supervisors would have led to the discovery of any problems or violations and given the Company the opportunity to correct them earlier.

(5) Relationships with Independent Contractors.

- A copy of the then current Compliance Plan shall be provided to each independent contractor of the Company on the anniversary date of each contract or such other date as the Compliance Officer may establish, but no less frequently than once per calendar year, if the services provided by such contractor have the potential to include fraudulent activity. The Compliance Officer shall maintain documentation that the Company has provided each independent contractor with a copy of the current Compliance Plan.
- Each independent contractor will sign an acknowledgement stating that he/she has read and understands the Compliance Plan of the Company. The receipt of this signed statement shall be a prerequisite to payment for services rendered and/or continuation of contractual relationships.

(6) Retention of Records.

- The Company will create, distribute, retain, store, retrieve, and destroy documents related to compliance and the requirements of the Compliance Plan consistent with policies of the Company.
- Records are maintained for the length of time required by federal and state law and private payors or by the Company's records retention policies, whichever is longer, including:
  - All records and documentation required either by Federal or State law for participation in Federal health care programs or other applicable Federal and State laws and regulations

- All records necessary to protect the integrity of the Company's compliance process and confirm the effectiveness of the Program
- Documentation that employees were adequately trained
- Reports of potential noncompliance, including the nature and result of any investigation that was conducted
- Documentation of corrective action, including any disciplinary action taken and policy improvement introduced in response to any internal investigation or audit
- Modifications to the compliance program
- Self-disclosures
- Results of auditing and monitoring efforts

(7) Self-Disclosure of Violations.

- The Company will self-report only after consulting with legal counsel and the Governing Body. If the Company self-reports violations to regulators consistent with the Company' s Policy on Investigations and Corrective Action, the Company will provide the following information:
- A complete description of the circumstances surrounding the overpayment
- A full explanation of how review criteria that were used to identify violations were determined
- A complete explanation of how the problem was corrected

(8) Compliance with Deficit Reduction Act (DRA).

- Because the Company receives annual payments from State Medicaid Programs of at least $5,000,000.00 per calendar year, as a condition of receiving such payments, the Company has established this Compliance Plan that provides detailed information about

the False Claims Act, any State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs. This Compliance Plan includes detailed provisions regarding the Company's policies and procedures for detecting and preventing fraud, waste, and abuse.

Modifications to this Compliance Plan may be made only upon a vote of an appropriate number of the members of the Governing Body of Home Health and Hospice Care, Inc. d/b/a 3HC.

## IDENTIFICATION OF POTENTIAL AREAS OF RISK RELATED TO FRAUD AND ABUSE COMPLIANCE

**POLICY:** Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") will continuously identify and develop appropriate mechanisms to address potential risks related to fraud and abuse compliance.

**PROCEDURE:**

1. The Company will develop and continuously revise a list of potential risks related to fraud and abuse compliance. A copy of the current list is attached to this Policy as Exhibit A.

2. The Compliance Officer is responsible to review and update the attached Exhibit A as needed.

3. When the Compliance Officer makes changes to the attached Exhibit A, the Compliance Officer will notify employees, contractors, and members of the Board of Directors, as appropriate.

4. The Compliance Officer is responsible for developing and implementing mechanisms to manage risks included in Exhibit A.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other Effective Date:

February 2020

Review Date: January 2023, January 2025

Revision Date: February 2021, January 2022, January 2024

EXHIBIT A

- Claims for home health, home care, or hospice services provided to Medicare/Medicaid beneficiaries who do not meet the criteria of the respective benefits, such as claims for services to patients that do not meet the medical necessity criteria.

- Claims for services that were never provided, including services rendered by subcontractors .

- Discriminatory admission and discharge of patients.

- Failure to adhere to licensing requirements applicable to the Company and Medicare Conditions of Participation (COP's), including requirements for criminal background checks.

- Failure to provide for sufficient and timely documentation of all services, including services provided by subcontractors, *prior* to billing to ensure that only accurate and timely documented services are billed.

- Claims for services not authorized by a physician or other appropriately licensed individual.

- Offering free services or services at or below fair market value to beneficiaries, such as transportation and meals, if they agree to receive services or switch providers. Company staff will not engage in prohibited or inappropriate conduct to carry out their initiatives and activities designed to maximize business growth and patient retention. Information offered by the Company to patients is generally clear, correct, non-deceptive and fully informative.

- Billing for inadequate or substandard care.

- Billing for services provided by unqualified or unlicensed clinical personnel.

- Forged beneficiary signatures on visit slips/logs that are intended to verify services that were performed.

- Submission of inaccurate and/or incomplete OASIS data.

- Knowingly making or causing to be made any false statement, omission, or misrepresentation or a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services under a federal health care program.

- Obstructing any government investigation or audit to include both internal and external audits and investigations.

- Failure to comply with requirements regarding face-to-face encounters and documentation of face-to-face encounters.

- Failure to maintain and document an infection control program that has as its goal the prevention and control of infections and communicable diseases.

- Failure to ensure that all services received by patients are provided by personnel who meet all applicable state and federal requirements, including state licensure requirements.

- Failure to meet all applicable requirements for supervision of personnel who provide services to patients.

## Federal And State Government Agency Audits, Interviews, Searches, And Other Contacts

POLICY:

The federal and state governments have many initiatives to review the activities of health care providers, including audits. The policy of Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company'') is to provide full cooperation to government agencies while protecting the rights of the Company and its employees.

The Company strives to comply with the complicated rules and regulations governing the health care industry. Nevertheless, the Company acknowledges that government health care regulations and their enforcement are complex areas. This policy provides a uniform method for employees to respond to requests for information about the Company or other individuals who provide health care items or services.

DEFINITION -OF "FEDERAL AND STATE GOVERNMENT AGENCY"

1. A federal or state government agency includes, but is not limited to, the following organizations and any of their designated contractors:
   a. U.S. Department of Health and Human Services (HHS)- Federal agency overseeing administration of healthcare services
   b. Centers for Medicare and Medicaid Services (CMS)- Federal agency overseeing administration of the Medicare and Medicaid programs
   c. Enforcement Agency (DEA) - Federal agency overseeing administration of controlled substances
   d. Federal Bureau of Investigation (FBI) - Investigative arm of federal government programs
   e. United States Attorney's Office
   f. Medicaid Fraud Control Unit (MFCU) or Medicaid Investigations Unit (MIU) - Investigative arm of state Medicaid agency
   g. Medicaid Programs - State health insurance programs for the medically indigent
   h. North Carolina Department of Health and Human Services
   i. Division of Health Service Regulation (DHSR)—state licensure body
   j. Medicare Intermediary- Claims processors of the Medicare Part A program
   k. DMERCs/Medicare Carrier - Claims processors of the Medicare Part B program
   l. Office of the Inspector General (OIG) - Investigative arm of federal government programs
   m. State Attorney General's Office -Arm of the state responsible for investigating/prosecuting violations of state laws

n. Occupational Safety and Health Administration (OSHA)
o. U.S. Department of Labor
p. North Carolina Department of Labor

2. If employees are contacted by representatives of organizations that are not on this list or are unsure about whether the organization is a federal or state government agency, including designated contractors, employees should do the falling:
   a. Contact your supervisor immediately.
   b. If the supervisor is unavailable, contact the Compliance Officer or a member of the Professional Management Team.
3. During initial inquiries, government agents may not disclose that an investigation is underway. If an auditor or other government representative raises questions about matters unrelated to an employees' customary dealings with them, employees should not disregard the information, but should report the inquiry to the Compliance Officer. Examples of areas often asked about relate to closed contracts or business transactions or suggestions of irregularities in business practices or accounting procedures.

PROCEDURES

When representatives from federal or state government agencies contact employees anywhere, such as at home or at the office, for information about the Company, any affiliated entity or any other entity with which the Company does business, employees should:

1. If in person, contact a member of the Professional Management Team. The Chief Compliance Officer or PMT member will contact legal counsel. Where appropriate, legal counsel will meet with the investigators and then advise staff regarding the scope of the investigation and procedures regarding staff interaction with the investigators. Otherwise, the Chief Compliance Officer or Professional Management Team member will give instructions about how to proceed.
2. Ask to see the government representative's identification and business card. Otherwise, ask for the person's name and office, address and telephone number, identification number, and call the government office to confirm his or her authority.
3. If the government representative wants to speak with employees personally, employees should find out why without getting into details. (See interview section below after completing all other tasks in this section).
4. If the government representative wants to search a Company facility or obtain any documents from the Company, employees must ask to see a legal document requesting the search, such as a search warrant and any affidavit supporting the warrant. Make a copy of this legal documentation.
5. Look at the date and time on the legal documentation to make sure that the government

representative has a valid document. A government representative may not search a business at a time other than within the time period specified in the legal document. (See search procedures below after completing all other tasks in this section).

6. Relay all information and documentation from business cards/legal documents to the Chief Compliance Officer or Professional Management Team member.
7. If employees receive requests in the mail from government representatives for documents or a subpoena, employees will immediately notify their supervisor who will in turn contact the Chief Compliance Officer or Professional Management Team member. A copy of the request will be immediately faxed to Legal Counsel by the Chief Compliance Officer or Professional Management Team member. Employees may not respond to requests until they have received instructions from Legal Counsel, Chief Compliance Officer or Professional Management Team member.
8. Maintain a complete and accurate listing of all documentation supplied to government representatives and complete and accurate copies of such documentation.

INTERVIEWS

Occasionally, agents/investigators may suggest that employees must speak to them. In fact, it is quite common for agents/investigators to arrive unannounced and attempt to persuade employees to consent to interviews.

In some situations, employees are entitled to have someone with them during interviews with agents/ investigators. The Company will arrange to have Legal Counsel for the Company present at no cost to employees. The Company's Legal Counsel represents the Company and does not represent the individual employees. Employees may also consult with attorneys of their own choosing at their expense. Employees should be cautious of agents/investigators who suggest that employees have nothing to worry about or suggest that by talking to him/her things will be easier for employees. Agents/ investigators do not have the authority to promise such things to witnesses. Only government attorneys working with legal counsel can make promises that bind the government.

Employees are encouraged to take notes during interviews.

During the interview with government representatives, employees should:

1. Always tell the truth. When employees do not recall something or have no knowledge about the topic, they should say so. Employees are not required to guess or speculate.
2. In talking with government representatives, employees should be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding as to what they are saying. It is important to make clear to government representatives whether the information

provided is first-hand
know ledge, something they have heard, or speculation. It is good practice to avoid speculation, but if employees do speculate, it is important to make sure they let government representatives know that they are doing so.

3. Employees must contact the Chief Compliance Officer or Professional Management Team member as soon as possible after the interview to debrief the content of the interview and to discuss any additional actions needed.

SEARCHES

If government representatives want to obtain documents or search the premises of the Company, employees should remember the following:

A "search" occurs any time a government representative enters the Company's premises and begins to look for any documents or ask questions. A search may not be conducted without legal authority to do so. The type of authority varies depending on the type of investigation/audit. Employees should always ensure such authority exists before granting access. Some government agencies have the authority to assess penalties if their representatives are not granted immediate access upon reasonable request to health care providers. Thus, it is important to be timely in responding to such requests.

If the legal authority is valid, employees may not interfere with the search. It is appropriate, however, to ask government representatives to allow employees to contact Legal Counsel to determine the authority to search or obtain documents. Employees should follow these steps after Legal Counsel determines the validity of the legal authority and instructs employees about how to proceed:

1. Employees must remember that it is a crime to obstruct agents in the lawful exercise of their duties, including the exercise of a valid search warrant. Some other examples of unlawful behavior are: altering or destroying documents sought in an investigation; falsely denying knowledge of information; corruptly influencing another person to exercise the privilege against self-incrimination; or intimidating witnesses with the intent of influencing testimony or retaliating against witnesses for testifying in an official proceeding. Asking questions and asking for a copy of the warrant are permitted. Employees should remain calm, polite, and observant. If employees notice any other employees engaging in any prohibited conduct, they should notify the Compliance Officer or PMT member immediately.
2. Employees should observe government representatives and note everything they look at or ask questions about . Employees should be especially careful to note documents, physical items, samples or photographs taken.

3. Employees should discourage government representatives from using copying machines themselves or removing documents from the premises without making copies first. Instead, employees should make two copies at of all documents requested by government representatives. Originals and copies should be segregated so that after government representatives leave, employees have retained one full set of copies and there is a clear record identifying what documents were copied for the government. The originals and the second set of copies should be clearly marked: "Documents provided to the government." Legal counsel will direct employees about what to do with the documents.
4. Employees should obtain a detailed receipt from government representatives for all documents/items taken by them, including the number of pages copied for purposes of possible future reimbursement.
5. Employees are required to answer questions concerning the location of documents.
6. Employees are not required to answer other questions and can tell government representative that they prefer to wait until legal counsel is present as described above.
7. If employees are asked to sign affidavits of any kind, they should not comment on the validity of the contents. Instead, they should explain that they are not authorized to sign any document prior to review by legal counsel.

COMMUNICATIONS REGARDING AN INVESTIGATION

Except as otherwise provided in this Policy, employees may not discuss an audit or investigation with other employees or with people outside of the Company. Inquiries from the media should be referred to the President/CEO. Employees should not attempt to provide any explanation other than to state that all questions will be answered by the President/CEO. Employees should obtain the identity and telephone number of the inquiring party and forward to the President/CEO.

ADMINISTRATIVE ISSUES

Once a government contact is initiated, responsible employees must establish a specific file for communications to and from the Compliance Officer and outside counsel. Caption the file and all communications to the Compliance Officer and legal counsel with the words "CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION".

**DO NOT make copies other than a file copy or further distribute confidential communications with** legal counsel. Distribution to third parties may destroy the privilege of confidentiality.

EMPLOYEES WHO ARE UNCERTAIN OF HOW TO PROCEED SHOULD CONTACT THE COMPLIANCE OFFICER OR A MEMBER OF THE PROFESSIONAL MANAGEMENT

TEAM IMMEDIATELY.

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|---|---|
| This policy is required by: | □ DHSR □ ACHC □ Medicare □ Other Effective Date: December 2011 |
| Review Date: | June 2012, June 2013, June 2014, November 2016, January 2017, December 2019, January 2022, January 2024, January 2025 |
| Revision Date: | May 2015, February 2021 |

## Education and Training of All Employees Regarding Fraud and Abuse Compliance

**POLICY:**

All employees of Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") will receive training regarding fraud and abuse compliance during their initial orientation as new employees. Thereafter, all employees of the Company will receive training each year on a continuous basis regarding fraud and abuse compliance. The Compliance Officer is responsible for providing and documenting such training in files that shall be maintained by the Corporate Compliance Officer. Participation in compliance activities is a condition of initial and continued employment.

**PROCEDURE:**

1. As a condition of initial and/or continued employment, all current employees of the Company will receive a digital copy of the Company' s Code of Conduct and Compliance Plan and related policies and procedures. Upon receipt of these documents, all employees will sign the statement attached to this Policy as Exhibit A that they:

    - Have received, read, and understand the Code of Conduct and Compliance Plan and related policies and procedures.

    - Are not under investigation or suspended or excluded from participation in the Medicare/Medicaid or other state and federal health care programs, as a condition of employment.

    - Will inform the Company immediately in writing if they are under investigation for alleged fraud and abuse, or if they are suspended or excluded from participation in the Medicare and Medicaid Program or other state and federal programs.

    - Currently hold valid licenses in effect to perform the functions described in their job descriptions and will notify the Company immediately in writing of any threat of loss or actual loss of any licenses required to perform the duties in their then-current job descriptions.

The Compliance Officer will ensure that all signed acknowledgements are retained.

2. As a condition of initial and, thereafter, continued employment, all employees must participate in at least one (1) hour of in-service education during each calendar year. Failure to participate in training activities or to document attendance as required by the Compliance Officer may result in disciplinary action, up to and including termination of employment. The Compliance Officer will maintain records of participation and copies of materials utilized.

3. As a condition of continued employment, all employees must participate in continuous education regarding fraud and abuse compliance. The Corporate Compliance Officer shall be responsible for continuous education of the staff regarding compliance, and documentation of

participation and materials utilized. Such documentation will not be included in employees' personnel records.

Education may include, but is not limited to:

- Distribution of bulletins on compliance updates and reminders;

- Distribution of audio or video on various risk areas;

- Presentations at meetings of employees; and

- Circulation of recent health care articles covering fraud and abuse in the health care industry.

At minimum, the Corporate Compliance Officer shall provide employees with written information on fraud and abuse compliance on a quarterly basis. The Corporate Compliance Officer will maintain copies of post-tests, if any, in his/her files.

4. As condition of continued employment by the Company, each time revisions are made to the Code of Conduct or Compliance Plan, every employee will be provided with a digital copy of the revised Code and/or Plan and related policies and procedures. Employees will be required to sign Exhibit A upon receipt of such revised documents. Acknowledgement will be maintained as described in Paragraph (1) above.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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|---|---|
| Effective Date: | February 2020 |
| Review Date: | January 2022, January 2024, January 2025 |
| Revision Date: | February 2021 |

**Exhibit B**

Compliance Attestation

_____ 1. I have reviewed the 3HC 2024 Compliance Plan.

_____ 2. I acknowledge that I have access to an electronic copy of the 3HC 2024 Compliance Plan through the 3HC Intranet.

_____ 3. I understand that I may request a printed copy of the 3HC 2024 Compliance Plan from my supervisor.

_____ 4. I have received, read, and understand the standards of conduct.

Printed Name: _____Initials: _____

Signature: _____ Date: _____

## Policy To Provide Information About Combating Waste, Fraud And Abuse And The Ability Of Employees To Report Wrongdoing

1. It is the policy of 3HC to obey the law and to work to stop and eliminate waste fraud and abuse with respect to payments to 3HC from federal or state programs providing payment for patient care. This policy applies to all employees, management, contractors and agents of 3HC.
2. This policy and the information contained in it shall be distributed to all current and new employees and to all current and future contractors of 3HC. This policy is included in the 3HC Personnel Policy Manual and 3HC's Policy Manual.
3. This policy includes the following information concerning tools this organization, federal and state agencies and individuals use to fight fraud, waste and abuse in the administration of federal and state health programs at 3HC:
   a. A summary of the Federal False Claims Act
   b. A summary of administrative remedies found in the Program Fraud Civil Remedies Act
   c. A summary of laws of the state of North Carolina that impose civil or criminal penalties for false claims or statements
   d. A summary of protections for employees (whistleblowers) who report suspected violations of these federal and state laws.
   e. The role of such laws in preventing and detecting fraud, waste, and abuse in federal and state health care programs, and
   f. 3HC's existing policies and procedures for detecting and preventing fraud.
4. A detailed description of the foregoing points are included in the Applicable Statutes portion of the Compliance Plan and summaries as follows.

### 1. The Federal False Claims Act

The Federal False Claims Act (FCA) was first enacted during the Civil War to fight fraud in supplying goods to the Union Army. The law has undergone a number of changes since then and now applies to any federally funded contract or program, except tax fraud. The FCA was expanded to include Medicare and Medicaid programs in 1986.

e. **Summary of Provisions:** The FCA prohibits knowingly making a false claim against the government. False claims can take the form of overcharging for a product or service, delivering less than the promised amount or type of goods or service, underpaying money owed to the government and charging for one thing while providing another.

f. **Penalties:** The FCA imposes civil penalties and is not a criminal statute. Therefore, no proof of specific intent (as required for violation of a criminal statute) is necessary.

g. Persons (including organizations such as hospices and home health agencies) may be fined a civil penalty of not less than $14,308 and not more than $28,619 per claim, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages in health care terms is the amount paid for each false claim that is

filed.

h. **Qui Tam (Whistleblower) Provisions:** Any person may bring an action under this law (called a qui tam relator or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time for good cause. The government on its own initiative may also initiate a case under the FCA.

i. After the 60-day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court.

j. If the government proceeds with the case, the qui tam relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, the qui tam relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney's fees and costs awarded against the defendant.

k. Any case must be brought within six years of the filing of the false claim.

l. **Anti-discrimination:** Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job-related losses resulting from any such discrimination or retaliation.

**2. Program Fraud Civil Remedies Act**

The Program Fraud Civil Remedies Act creates administrative remedies for making false claims separate from and in addition to, the judicial or court remedy for false claims provided by the Civil False Claims Act. The Act is quite similar to the Civil False Claims Act in many respects, but is somewhat broader and more detailed, with differing penalties. The Act deals with submission of improper "claims" or "written statements" to a federal agency.

m. Specifically, a person violates this act if they know or have reason to know they are submitting a claim that is
    i. False, fictitious or fraudulent; or,
    ii. Includes or is supported by written statements that are false, fictitious or fraudulent; or,
    iii. Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person sub mitting the statement has a duty to include the omitted facts; or
    iv. For payment for property or services not provided as claimed.

n. A violation of this prohibition carries a $13,508 civil monetary penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

o. A person also violates this act if they submit a written statement which they know or should know:
   i. Asserts a material fact which is false, fictitious or fraudulent; or,
   ii. Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

p. A violation of the prohibition for submitting an improper statement carries a civil penalty of up to $5,000.

**3. North Carolina Medical Assistance Provider False Claims Act**

q. Liability for Certain Acts. It shall be unlawful for any provider of medical assistance under the Medical Assistance Program to:
   i. Knowingly present, or cause to be presented to the Medical Assistance Program a false or fraudulent claim for payment or approval; or
   ii. 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 the Medical Assistance Program.
   iii. Each claim presented or caused to be presented in violation of this section is a separate violation.

r. Damages
   i. Except as provided in subdivision (2) of this subsection, a court shall assess against any provider of medical assistance under the Medical Assistance Program who violates this section of 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 the Medicaid Assistance Program sustained because of the act of the provider.
   ii. A court may assess a penalty of not less than two times the amount of damages which the Medical Assistance Program sustains because of the act of the provider if a court finds that:
      1) The provider committing a violation of this section furnished officials of the State responsible for investigating false claims violations with all information known to the provider about the violation within 30 days after the date the provider first obtained the information;
      2) The provider fully cooperated with any State investigation of the violation; and
      3) At the time the provider furnished the State with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the provider did not have actual knowledge of the existence of an investigation into the violation.
      4) In addition to other damages and penalties, a provider violating the North Carolina laws shall be also be liable for other costs as allowed by statute.

s. Effect of Repayment. - Intent to repay or repayment of any amounts obtained by the provider as a result of any acts described in subsection (a) of this section shall not be a defense to or grounds for dismissal of an action brought pursuant to this section. However, a court may consider any repayment in mitigation of the amount of any penalties assessed.

**b. Remedies**

i. In the absence of fraud or malice, no person who furnishes information to officials of the State responsible for investigating false claims violations shall be liable for damages in a civil action for any oral or written statement made or any other action that is necessary to supply information required pursuant to this Part.

ii. Any employee of a provider who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions or employment by the employee's employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under G.S.108A-70.12, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under G.S.108A- 70.12, shall be entitled to all relief necessary to make the employee whole.

**4. North Carolina Prohibition Against Submission of False Claims to Insurers**

Section 58-2-161 of the North Carolina General Statutes levies civil and criminal penalties against any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant:

a. Presents or causes to be presented a statement or claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a material fact, or

b. Assists, solicits, or conspires with another person to prepare or make a statement or claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a material fact.

**5. Whistleblower Protections**

" Whistleblowers" are generally employees who observe activities or behavior that may violate the law in some manner. These individuals report their observations either to management or to governmental agencies. Laws have been enacted to protect these individuals. Protections afforded to *qui tam* relators are discussed above.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

| | |
|---|---|
| Effective Date: | December 2006 |
| Review Date: | June 2007, June 2008, July 2009, October 2010, July 2012, May 2013, July 2014, June 2015, January 2017, November 2018 |
| Revision Date: | November 2016, December 2019, February 2021, January 2022, January 2024, January 2025 |

# DISCLOSURES

## POLICY:

All employees of Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") will be informed of the Company's disclosure program and will be encouraged to report potential instances of non-compliance without fear of retaliation.

## PROCEDURE:

1. The Company has established a disclosure program that enables individuals to disclose to the Compliance Officer or some other person who is not in disclosing individuals' chain of command any identified issues or questions associated with the Company' s policies, conduct, practices or procedures with respect to federal or state health care programs believed by individuals to be potential violations of criminal, civil or administrative law.

2. Individuals who make disclosures will not be subject to retribution or retaliation. Confidentiality of reports received will be maintained to the extent possible consistent with the Company' s commitment and obligation to thoroughly investigate.

3. The Compliance Officer shall maintain a disclosure log. The Compliance Officer shall record each disclosure in the disclosure log within forty-eight (48) hours of receipt of disclosures. The disclosure log shall include a summary of each disclosure received, whether or not anonymous, the status of respective internal reviews and any corrective action taken in response to internal reviews.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

Effective Date: January 2020

Review Date: January 2022 , January 2024, January 2025

Revision Date:

## EXCESS PAYMENTS

1. If the Agency receives payment from a patient, insurance company or other source in excess of the charges, the Agency shall reimburse the excess amount.
2. Any excess payments received from patient advance payments will be refunded at the conclusion of the episode of care.
3. When directed by insurance company a refund request is initiated.
4. The Billing/Collections Specialist shall prepare a refund request and forward to the Director of Revenue Cycle for confirmation. Refund requests under $500 may be approved by the Director of Revenue Cycle. The Chief Financial Officer must notify the Compliance Officer of refund requests over $500.
5. Each Billing/Collections Specialist should review the accounts receivable at least every 30 days to ensure prompt payment of any appropriate refunds.
6. Overpayments will be reported and returned to appropriate payors not more than sixty (60) days after determining an overpayment exists.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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|---|---|
| Effective Date: | September 1990 |
| Review Date: | 1992, 1993, 1993, 1995, 1996, 1997, 1998, November 200, October 2004, December 2005, June 2007, October 2010, April 2011, May 2012, November 2013, June 2014, May 2015, February 2017, January 2025 |
| Revision Date: | November 2002, June 2006, October 2008, September 2009, May 2016, August 2018, May 2019, February 2021, January 2022, January 2024 |

## COMMUNITY EDUCATION AND GIFT POLICY (REFERRAL SOURCES AND PATIENTS)

**PURPOSE:** To clarify what is the acceptable practice in giving gifts to providers who may be **referral sources (potential), patients (potential),** and others, as well as what is the acceptable practice in receiving gifts. To affirm 3HC's commitment to ethical behavior in all areas of operations, including education practices with providers, **vendors** and others.

**PROCEDURE:**

1. If a gift or item of any value is promised or given in return for a referral of a patient to 3HC from any source, this is illegal behavior. 3HC does not engage in t is type of activity and does not tolerate this activity. The provision of free or voluntary services by personnel for patients/families may violate applicable laws a1d is therefore prohibited. Any employee knowingly engaging in this type of activity will be subject to immediate termination.
2. Giving gifts is an acceptable practice, when not used as an inducement for referrals from any source, in the circumstances outlined below.
3. Acceptable Practices:
   a. Professional Educational Seminars: Providing inexpensive meals/ refreshments occasion ally, and educational materials is acceptable behavior, as long as the accompanying education is reasonable and of mutual benefit. The value of these educational meetings will not be considered as gifts and will not be included in the annual gift limits.
      i. Meetings, luncheons, receptions, or similar events to kick off a new or revised program, service, or protocol are permissible. 3HC may provide physicians and the physician s' staff with compliance training, including reasonable meals associated with such t raining , provided it complies with other 3HC policies .
      ii. Such events should not provide meals or other items or services with a value exceeding $15 .00 maximum value per individual with an annual aggregate maximum of $75.00 per individual per calendar year per 3HC established guidelines.
      iii. The meal should be modest by local standards.
   b. Gifts Generally:
      i. It is acceptable to give up to $15.00 maximum per gift *per individual* with an annual aggregate maximum of $75.00 *per individual* per calendar year. This is per physician, hospital, business associate, vendor, patient/family, nursing home, assisted living facility, etc. Non-cash items may include: coffee mugs, mouse pads, pens, pencils, fruitcakes, baskets, etc. Holiday gifts should be included in these limits.
      ii. The Company may give referral sources/ potential referral sources non-cash items or

service of nominal value that do not exceed a total value of five hundred nineteen ($519.00) per calendar year .

iii. Gifts may be given to individual physicians and not to a physician group.

iv. Items or services provided must not be solicited by the physician or the group.

v. Gifts cannot be related in any way to the volume or value of referrals by the physician.

vi. The size or value of holiday gifts cannot be based on the amount or value of referrals by a provider. This holds true for all referral sources, e.g., physicians, hospitals, nursing homes, etc., as well as non-referral sources.

vii. Offering or giving anything of value to any governmental employees or their contractors is strictly prohibited. This includes, but is not limited to, surveyors, third-party contractors, and Medicare or Medicaid officials.

viii. Gifts cannot be a part of an entertainment or recreational event.

ix. Gift must be provided in a manner conducive to informational communication.

x. Cash or cash equivalents including, but are not limited to gift cards and certificates, may not be given.

4. Community Screening/ Health Fairs/ Community Education/ Free Screenings:

   It is permissible to participate at senior health fairs, community screenings, community education, and other events to provide members of the public with free screenings and education about health and fit ness. Promotional materials about these screenings or health fairs may include the address or phone number of 3HC.

5. Gifts from Vendors and Other Business Associates:
   Gifts may not be cash or cash equivalents and are limited to a retail value of $15.00 per item and no more than $75.00 total retail value per calendar year per vendor/business associate.

6. If an employee is in doubt or not clear of the content of the above stated policies at procedures, he or she should contact the Compliance Officer.

7. Gifts shall be tracked to demonstrate compliance with these policy limits. The Compliance Officer is responsible for tracking and ensuring compliance.

8. The Compliance Officer must give advance written permission to staff to provide
   new items or services of non-cash nominal value before they are given to referral s9urces or patients.

9. The Compliance Officer must ensure that all free items and services provided to each referral source/patient is documented.

10. The Compliance Officer or designee will review the documentation received and take appropriate corrective action as needed.

11. Any variations from this policy should be reported by the Chief Quality Officer or CQO to the

Compliance Officer.

Department of Health and Human Services: OIG Update: December 2016

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|---|---|
| This policy is required by: | □ DHSR □ ACHC □ Medicare □ Other |
| Effective Date: | September 2005 |
| Review Date: | September 2006, October 2007, June 2008, July 2009, July 2014, June 2015, November 2016, January 2017, January 2022, January 2023 |
| Revision Date: | October 2010, June 2013, May 2019, January 2020, February 2024, January 2025 |

## INVESTIGATIONS AND CORRECTIVE ACTION

**POLICY:**

Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") will investigate all possible violations of fraud and abuse prohibitions and will take corrective action, as appropriate. Investigative and corrective actions proceed in the same manner with the same type of progressive discipline, regardless of the level of the employee within the organization being investigated.

**PROCEDURE:**

1. The Compliance Officer will take affirmative action to identify potential fraudulent or abusive activity in the Medic are/Medicaid Programs and other state and federal healthcare programs.

2. The Corporate Compliance Officer will also receive information from employees, patients and others regarding potential violations.

3. Verbal reports will be promptly reduced to writing by the Compliance Officer.

4. The anonymity of reporting employees, patients and others will be protected to the maximum extent possible consistent with appropriate compliance activities. No promises will be made to the party making the disclosure regarding li ability or what steps the Company may take in respo1se to the report of wrongdoing. Retaliation against individuals who make reports is not permitted.

5. The Compliance Officer shall have the authority to conduct internal investigations of alleged violations independent of influence by the Board of Directors and Management. Internal investigations shall ordinarily be completed within sixty (60) calendar days from the date on which the Compliance Officer received initial information regarding a potential violation.

6. The Compliance Officer shall prepare written reports of the results of investigations that, at a minimum, shall include the following information:

    a. Description of how the possible violation was identified and the origin of the information that led to the disclosure.

    b. Description of efforts to investigate and document the practice, such as use of internal or external legal and/or audit resources.

    c. Detailed description and chronology of the investigative steps taken in connection with the Compliance Officer' s inquiries into the potential violation including:

        - A list of all individuals interviewed, the dates of those interviews, the subject matter of each interview, business and home addresses, and telephone number of each witness interviewed and the positions and titles in the Company, both currently and during the relevant time period.

        - A description of the files, documents, and records reviewed.

- A summary of auditing activity undertaken, and a summary of the documents relied upon in support of cost impact determinations, if any.

7. Based upon this review, the Compliance Officer will make recommendations directly to the Chief Quality Officer, Chief Executive Officer, Chairperson of the Board and/or the Board of Directors as needed regarding corrective actions needed in order to prevent or remedy possible fraudulent or abusive conduct. Corrective action may include, but is not necessarily limited to, disciplinary action that may be reasonably imposed on responsible employees consistent with the Company' s policy on progressive discipline and restitution to the Government. Disciplinary action may be taken that includes termination for violation of prohibitions on fraudulent and abusive activities and/or the policies and procedures of the Company.

8. Appropriate corrective action may also include self-disclosure to regulators/enforcers. The Board of Directors in consultation with legal counsel must approve self- disclosure of violations / possible violations. Such approvals must be included in the minutes of meetings of the Board of Directors.

9. If the Board of Directors approves self-disclosure of violations/ possible violations, the Board of Directors will ensure that the Company complies with then current guidance from applicable regulators/enforcers regarding self- disclosure.

10. Self-disclosure will be made in consultation with Legal Counsel.

11. Reports of misconduct will be made to the appropriate federal and state authorities not more than sixty (60) days after determining that there is credible evidence of an overpayment.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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|---|---|
| Effective Date: | February 2020 |
| Review Date: | February 2021, January 2024, January 2025 |
| Revision Date: | February 2021, January 2023 |

## NON-RETALIATION POLICY:

Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") will not retaliate against employees, contractors, patients and other individuals who report possible violations of applicable requirements to management or third parties outside of the Company.

## PROCEDURE:

1. Consistent with the Company's Medicare/Medicaid Fraud and Abuse Compliance Plan and related policies; employees, independent contractors, patients and other individuals are expected to report possible violations to the Compliance Officer or a manager/supervisor.

2. Upon receipt of reports of possible violations, the Compliance Officer will document reports and initiate an investigation of alleged violations consistent with the Company's Medicare/Medicaid Fraud and Abuse Compliance Plan and related policies. Investigations will normally be completed within sixty (60) days of the date on which potential violations were reported to the Company.

3. Regardless of the outcome of investigations, the Company will not retaliate against employees, independent contractors, patients and other individuals who report potential violations.

4. Employees of the Company who retaliate against individuals who make reports of possible violations will be disciplined consistent with the Company's Policy on progressive discipline. Disciplinary action may include termination of employment or contractual relationships.

5. Investigations and corrective actions proceed in the same manner with the same type of progressive discipline, regardless of the level of the employee within the organization being investigated.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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|---|---|
| Effective Date: | February 2020 |
| Review Date: | February 2021, January 2024, January 2025 |
| Revision Date: | February 2021, January 2023 |

## Sanctions/Exclusions Screening For Employees, Contracted Personnel, Physicians, Volunteers and Vendors

**POLICY:**
3HC shall ensure a screening process is in place to identify sanctions/exclusions from participation in federal health care programs for employees, contracted personnel, physicians, volunteers, vendors and other individuals who might give orders for 3HC to provide care or services to patients.

**PROCEDURE:**

1. 3HC shall screens employees, contracted personnel, physicians, volunteers, vendors and other individuals who order care, services, etc. The screening confirms that the party is not excluded from participation in federal healthcare programs such as Medicare and Medicaid.

    - Initial and periodic screening shall include these websites:
        - www.exclusions.oig.hhs.gov. OIG-LEIE (Health and Human Services - Office of Inspector General List of Excluded Individuals and Entities)
        - SAM-HHS/GSA (System for Award Management – Health and Human Services/General Services Administration) www.sam.gov
        - Exclusion databases of the states that currently have them.

2. If any name screened is identical or similar, the responsible designee shall immediately notify the Compliance Officer who shall investigate the match to verify whether the individual/entity is the same the excluded individual/entity. The Compliance Officer shall immediately notify the CEO or COO if an individual/entity is identified as excluded from participation in a federal healthcare program.

3. INITIAL SCREENING:
    A. EMPLOYEES/VOLUNTEERS/CONTRACTED PERSONNEL: The Human Resources Department shall screen all prospective employees, volunteers, and contracted personnel. See 3HC Personnel Policy Manual Section on Hiring.
    B. VENDORS: The Finance Department shall screen all new vendors. Refer to Finance – General.06 Sanctions and Exclusions Checks.
    C. PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS: The Intake Department shall screen all new physicians and other individuals who give orders for 3HC to provide services to patients. Refer to Intake Policy #01 - Responsibilities of the Intake Department.

4. MONTHLY CHECKS:
    A. The Compliance Officer shall submit a current listing of all agency employees, vendors, and referring physicians monthly to Verify Comply to ensure all of the above individuals and entities are re-screened on a monthly basis to identify new sanctions/exclusions that occur after the initial screening process.
    B. The Compliance Officer will maintain reports of monthly screening verifications.
    C. The Compliance Officer shall investigate the list of name matches to verify whether there is a true match. The process shall include comparing state license information and/or NPI when appropriate and other data from the government exclusion databases.

D. The President/CEO and appropriate Chief Officer shall be immediately notified of any individuals determined to be excluded from participation in federal health care programs. The appropriate Chief Officer or the President/CEO will contact the individual(s) involved to notify them of our inability to work with them until the exclusion is reversed and the individual or entity is reinstated for participation in federal health care programs. If the excluded party is a physician or other individual who has given orders for care, the Chief Clinical Officer or designee shall contact the physician, physician assistant or nurse practitioner to refer the patient to another eligible physician or to allow the patient to choose another physician. 3HC's Medical Director may be consulted as necessary.

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This policy is required by: ☐ DHSR ☑ ACHC ☐ Medicare ☐ Other

Effective Date: April 2005
Review Date: June 2008, October 2010, May 2011, August 2012, July 2014, November 2016, January 2017, July 2018, August 2019, February 2021, January 2024, January 2025
Revision Date: June 2006, June 2007, July 2009, May 2013, June 2015, August 2015, January 2020, January 2023

# CONFLICT OF INTEREST

POLICY:

A fiduciary relationship exists between directors, officers, and employees and Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") that includes a strict and unbending duty of loyalty and fidelity. It is the responsibility of directors, officers, and employees of the Company to administer its affairs honestly and economically, exercising their best care, skill, and judgment for the benefit of the Company. It is also the responsibility of directors, employees, and officers of the Company to make full disclosure of any interest that might result in a conflict on their part .

PROCEDURE:

1. Directors, officers, and employees should exercise the utmost good faith in all transactions touching upon their duties to the Company and its property. In their dealings with and on behalf of the Company they are held to a strict rule of honest and fair dealing between themselves and the Company. They shall not use their positions, or knowledge gained there from, so that a conflict might arise between the Company's interest and that of the individual.

2. All acts of directors, officers, and employees shall be for the benefit of the Company in any dealing that may adversely affect the Company.

3. No director, officer, or employee shall accept any favor that might influence his/her actions affecting the Company or its patients. This does not include the acceptance of items of nominal or minor value that are of such a nature as to indicate that they are merely tokens of respect, gratitude, or friendship and not related to any particular transaction or Company activity.

4. Directors, officers, and employees shall avoid any employment, activity, investment, or other interest that might involve obligations that may compete with or be in conflict with the interest of the Company or its patients, and shall promptly disclose the same as they may exist.

5. Although it is impossible to list every circumstance giving rise to a possible conflict of interest, the following will serve as a guide to the types of activities that might cause conflicts that should be fully reported to the Company.

    a. Holding by a director, officer, or employee, directly or indirectly, of a position or of a material financial interest in any outside concern from which the Company secures goods or services, or that provides services competitive with the Company. Ownership interests in any entity that is five percent (5%) or greater must be disclosed to the Company.

b. Competition with the Company by an individual, directly or indirectly, in the purchase or sale of property, or property rights or interests.

c. Rendering by an officer, director, or employee of directive, managerial, or consultative services to any outside concern that does business with or is a competitor of the Company.

d. Participation by employees in any activity; whether for personal profit or incident to industry, civic, or charitable organization affairs; that is likely to involve use of the individual's time during normal business hours or property of the Company.

e. Acceptance by directors, officers, or employees of gifts, excessive or unusual entertainment, or other favors from any outside concern that does or is seeking to do business with, or is a competitor of the Company under circumstances from which it might be inferred that such action was intended to influence the individual in the performance of his/her duties. This does not include the acceptance of items of nominal or minor value that are of such a nature as to indicate that they are merely tokens of gratitude, respect, or friendship and unrelated to any particular transaction or Company activity. Employees of the Company shall also be subject to the Company's policy on receipt of gifts included in the Company's Personnel Policy Manual.

f. Disclosure or use of Company information for the personal profit or advantage of the individual or anyone else.

6. Directors and officers shall refrain from voting on any transaction or other matter in which the director has a conflict of interest. If a director believes he/she has a conflict of interest or is perceived by any members of the Board of Directors to have a conflict of interest, the director may not vote on any transaction or other matter in which he/she has an actual or perceived conflict, unless the Board of Directors determines that the Company's interests would not be adversely affected by the director's voting on the matter or transaction.

7. The Chief Compliance Officer shall, at least annually , send to all directors, officers, and selected employees a copy of this policy and procedure of Conflicts of Interest along with the appropriate disclosure form, Disclosure and Acknowledgement form for members of the Board of Directors and officers or Disclosure and Acknowledgement form or employees that each director, officer, and employee is required to complete and return to the Chief Compliance Officer within a specified time period. The Chief Compliance Officer shall submit a confidential report to the President/CEO and the Board of Directors concerning any conflicts of interest of directors, officers, and employees and the Chief Compliance Officer' s actions concerning such conflicts of interest. A report of action taken, with regard to conflicts of

interests by an employee, shall be documented and placed in the employee's personnel file.

8. At least annually, each employee shall be required to review this policy and procedure on conflicts of interest and acknowledge by his/her signature on attached Exhibit B that he/she is acting in accordance with the letter and spirit of this policy.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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|---|---|
| Effective Date: | February 2020 |
| Review Date: | February 2021, January 2024, January 2025 |
| Revision Date: | February 2021, January 2022 |

## Members of the Board of Directors and Officers
## Disclosure and Acknowledgment Form

PURPOSE: It is the policy of Home Health and Hospice Care, Inc. d/b/a 3HC (the "Company") that all directors and officers shall refrain from engaging in either potential or actual conflicts of interest with the Company. Directors and officers are required to complete this Disclosure Form on at least an annual basis. They will also be asked on an annual basis to review a copy of the Company's policy and procedure on Conflicts of Interest and to acknowledge in writing that they have done so. A copy of the Company's current policy on Conflicts of Interest is attached to this Form. Please review it carefully before completing the Form. The Form must be returned to the Compliance Officer of the Company within thirty (30) days of receipt.

| | YES | NO | COMMENTS *(If you answered "yes", please provide details. If necessary, use another sheet of paper.)* |
|---|---|---|---|
| 1. Do you currently hold, either directly or indirectly, a position or a material financial interest in any outside concern from which the Company secures goods or services, or that provides services competitive with the Company? [Ownership interests in any entity that is five percent (5%) or greater must be disclosed to the Company.] | | | |
| 2. Have you competed with the Company, either directly or indirectly, in the purchase or sale of property or property rights or interests? | | | |
| 3. Have you or are you currently rendering directive, managerial, or consultative services to any outside concern that does business with or is a competitor of the Company? | | | |
| 4. Have you or do you currently participate in any activity; whether for personal profit or incident to industry, civic, or charitable organization affairs; which is likely to involve use of property of the Company? | | | |
| 5. Have you accepted any gift, excessive or unusual entertainment, or other favors from any outside concern that does or is seeking to do business with, or is a competitor of, the Company under circumstances from which it might be inferred that such action was intended to influence you in the performance of your duties? (Do not include in your answer the acceptance of items of nominal or minor value that are of such a nature as to indicate that they are merely tokens of respect or friendship and unrelated to any particular transaction or Company activity.) | | | |
| 6. Have you disclosed or used Company information for the personal profit or advantage of yourself or anyone else? | | | |
| 7. Have you participated in any activity that involved the use of your personal time or 3HC property during normal business hours for personal profit? | | | |

I understand that I have a continuing obligation to report potential and/or actual conflicts of interest to the Chief Compliance Officer of the Company.

My signature below is evidence that I have received, read, and understand the Company's policy and procedure on Conflicts of Interest that is attached to this Form, and that I am acting in accordance with both the letter and the spirit of this policy and procedure.

_____
Signature

_____ _____
Printed Name Date

Rev. 1/22

# BOARD OF DIRECTORS COMPLIANCE ACTIVITIES

## POLICY:

The Board of Directors of 3HC (the "Company") is responsible to ensure that the Company complies with all requirements related to healthcare fraud and abuse. At a minimum, the Board of Directors of the Companies will engage in the activities described below.

## PROCEDURE:

1. The Boards of Directors will receive reports from the Compliance Officer regarding compliance activities, risk areas, etc. on at least a quarterly basis. These reports will be included in the minutes of meetings of the Boards of Directors.

2. The Board of Directors will receive recommendations from the Compliance Officer regarding corrective action on an as needed basis. Recommendations received from the Compliance Officer and corrective action authorized by the Board of Directors will be documented in the minutes of the meetings of the Board of Directors.

3. The Board of Directors will review the Company's Code of Conduct and Compliance Plan and related policies and procedures at least annually and shall make appropriate modifications in consultation with legal counsel. At a minimum, the Board of Directors will address the issues included in Exhibit A that is attached to this Policy at a regularly scheduled meeting of the Board of Directors. The results of these reviews will be included in minutes of the meeting of Board of Directors at which the reviews were conducted.

4. The Board of Directors shall ensure that an audit is conducted at least bi-annual by a neutral third party knowledgeable in the area of healthcare fraud and abuse to help ensure compliance with applicable requirements.

5. All changes to the Code of Conduct and the Compliance Plan and related policies and procedures must be approved by the Board of Directors.

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This policy is required by: □ DHSR □ ACHC □ Medicare □ Other

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| Effective Date: | February 2020 |
| Review Date: | February 2021, January 2022, January 2024 |
| Revision Date: | February 2021, January 2025 |

## Exhibit C

- How is the Compliance Program structured and who are the key employees responsible for its implementation and operation? How is the Board structured to oversee compliance issues?

- How does the Company's compliance reporting system work? How frequently does the Board receive reports about compliance issues?

- What are the goals of the Company's compliance program? What are the inherent limitations in the compliance program? How does the Company address these limitations?

- Does the compliance program address the significant risks of the Company? How were those risks determined and how will new compliance risks be identified and incorporated into the Program?

- What will be the level of resources necessary to implement the compliance program as envisioned by the Board? How has management determined the adequacy of the resources dedicated to implementing and sustaining the compliance program?

- How has the Plan been incorporated into corporate policies across the Company?

  How does the Board know that the Plan is understood and accepted across the Company? Has management taken affirmative steps to publicize the importance of the Plan to all its employees?

- Has the Company implemented policies and procedures that address compliance risk areas and establish internal controls to counter those vulnerabilities?

- Does the Compliance Officer have sufficient authority to implement the compliance program? Has management provided the Compliance Officer with autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?

- Have compliance-related responsibilities been assigned across the appropriate levels of the Company? Are employees held accountable for meeting these compliance-related objectives during performance reviews?

- What is the scope of compliance-related education and training across the organization? Has the effectiveness of such training been assessed? What policies/procedures have been developed to enforce training requirements and to provide remedial training as warranted?

- How is the Board kept apprised of significant regulatory and industry developments affecting the Company's risk? How is the compliance program structured to address such risks?

- How are "at risk" operations assessed from a compliance perspective? Is conformance with the Company's program periodically evaluated? Does the Company periodically evaluate the effectiveness of the compliance program?

- What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?

- What is the process by which the Company evaluates and responds to suspected compliance violations? How is the reporting system monitored to verify appropriate resolution of reported matters?

- Does the Company have policies that address the appropriate protection of "whistleblowers" and those accused of misconduct?

- What is the process by which the Company evaluates and responds to suspected compliance violations? What policies address the protection of employees and the preservation of relevant documents and information?

- What guidelines have been established for reporting compliance violations to the Board?

- What policies govern the reporting to government authorities of probable violations of the law?

- What are the goals of the Company's quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals? How is each goal specifically linked to management accountability?

- How does the Company measure and improve the quality of patient care? Who are the key management and clinical leaders responsible for these quality and safety programs?

- How are the Company's quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?

- Does the Board have a formal orientation and continuing education process that helps members appreciate external quality and patient safety requirements? Does the Board include members with expertise in patient safety and quality improvement issues?

- What information is essential to the Board's ability to understand and evaluate the Company's quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the Board receive reports about the quality improvement efforts?

- How are the Company's quality assessment and improvement processes coordinated with its corporate compliance programs? How are quality of care and patient safety issues addressed in the Company's risk assessment and corrective action plan?

- What processes are in place to promote the reporting of quality concerns and medical errors and to protect those who ask questions and report problems? What guidelines exist for reporting quality and patient safety concerns to the Board?

- Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?

- Do the Company's competency assessment and training, credentialing, and peer review processes adequately recognize the necessary focus on clinical quality and safety issues?

- How are "adverse patient events" and other errors identified, analyzed, reported, and incorporated into the Company's performance improvement activities? How do management and the Board address quality deficiencies without unnecessarily increasing the Company's liability exposure?

## Annex A: Statutes

### 42 U.S.C. § 1320a-7b - U.S. Code -The Public Health and Welfare § 1320a-7b. Criminal penalties for acts involving Federal health care programs

***(a) Making or causing to be made false statements or representations***

*Whoever--*

***(1)*** *knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),*

***(2)*** *at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,*

***(3)*** *having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,*

***(4)*** *having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,*

***(5)*** *presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or*

***(6)*** *for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,*

*shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In*

*addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.*

***(b) Illegal remunerations***

***(1)*** *whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--*

***(A)*** *in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or*

***(B)*** *in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,*

*shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.*

***(2)*** *whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--*

***(A)*** *to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or*

***(B)*** *to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,*

*shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.*

***(c) False statements or representations with respect to condition or operation of institutions***

*Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access*

*hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.*

***(d) Illegal patient admittance and retention practices***

*Whoever knowingly and willfully--*

***(1)*** *charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or*

***(2)*** *charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--*

***(A)*** *as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or*

***(B)*** *as a requirement for the patient's continued stay in such a facility,*

*when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,*

*shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.*

***(e) Violation of assignment terms***

*Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.*

*(f) "Federal health care program" defined*

*For purposes of this section, the term "Federal health care program" means--*

***(1)*** *any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of Title 5); or*

***(2)*** *any State health care program, as defined in section 1320a-7(h) of this title.*

***(g) Liability under subchapter III of chapter 37 of Title 31***

*In addition to the penalties provided for in this section or section 1320a-7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of Title 31.*

***(h) Actual knowledge or specific intent not required***

*With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.*

**North Carolina False Claims Statute**

*Article 51. False Claims Act.*

***§ 1-605. Short title; purpose.***

*(a) This Article shall be known and may be cited as the False Claims Act.*

*(b) The purpose of this Article is to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent and to provide remedies in the form of treble damages and civil penalties when money is obtained from the State by reason of a false or fraudulent claim. (2009-554, s. 1.)*

***§ 1-606. Definitions.***

*The following words and phrases when used in this act have the following meanings, unless the context clearly indicates otherwise:*

*(1) "Attorney General." - The Attorney General of North Carolina, or any deputy, assistant, or associate attorney general.*

*(2) "Claim." - Any request or demand, whether under a contract or otherwise, for money or property and whether or not the State has title to the money or property that (i) is presented to an officer, employee, or agent of the State or (ii) is made to a contractor, grantee, or other recipient, if the money or prope1iy is to be spent or used on the State's behalf or to advance a State program or interest and if the State government:*

*a. Provides or has provided any portion of the money or property that is requested or demanded; or*

*b. Will reimburse such contractor, grantee, or other recipient for any portion of the*

*money or property which is requested or demanded.*

*A claim does not include requests or demands for money or prope1iy that the State has paid to an individual as compensation for State employment or as an income subsidy with no restrictions on that individual's use of the money or property.*

*(3) "Judiciary." - A justice or judge of the General Court of Justice or clerk of court.*

*(4) "Knowing" and "knowingly." - Whenever a person, with respect to information, does any of the following:*

*a. Has actual knowledge of the information.*

*b. Acts in deliberate ignorance of the truth or falsity of the inforn1ation.*

*c. Acts in reckless disregard of the truth or falsity of the information.*

*Proof of specific intent to defraud is not required.*

*(5) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.*

*(6) "Obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor- licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.*

*(7) Repealed by Session Laws 2018-41, s. 1, effective June 22, 2018, and applicable to actions brought on or after that date.*

*(8) "Senior executive branch official." - The Governor, Lieutenant Governor, member of the Council of State, or head of depa1iment as defined in G.S. 143B-3. (2009-554, s. l ; 2018-41, s. 1.)*

***§ 1-607. False claims; acts subjecting persons to liability for treble damages; costs and civil penalties; exceptions.***

*(b) Liability. - Any person who commits any of the following acts shall be liable to the State for three times the amount of damages that the State sustains because of the act of that person. A person who commits any of the following acts also shall be liable to the State for the costs of a civil action brought to recover any of those penalties or damages and shall be liable to the State for a civil penalty of not less than five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000), as may be adjusted by Section 5 of the Federal Civil Penalties Inflation Adjustment Act of 1990, P.L. 101-410, as amended, for each violation:*

*(1) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval.*

*(2) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.*

*(3) Conspires to commit a violation of subdivision (1), (2), (4), (5), (6), or (7) of this section.*

*(4) Has possession, custody, or control of property or money used or to be used by the State and knowingly delivers or causes to be delivered less than all of that money or property.*

*(5) Is authorized to make or deliver a document certifying receipt of property used or*

*to be used by the State and, intending to defraud the State, makes or delivers the receipt without completely knowing that the information on the receipt is true.*

*(6) Knowingly buys, or receives as a pledge of an obligation or debt, public property from any officer or employee of the State who lawfully may not sell or pledge the property.*

*(7) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or prope1iy to the State, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or prope1iy to the State.*

*(c) Damages Limitation. - Notwithstanding the provisions of subsection (a) of this section, the court may limit the damages assessed under subsection (a) of this section to not less than two times the amount of damages that the State sustains because of the act of the person described in that subsection and may assess no civil penalty if the court finds all of the following:*

*(1) The person committing the violation furnished officials of the State who are responsible for investigating false claims violations with all information known to that person about the violation within 30 days after the date on which the person first obtained the information.*

*(2) The person fully cooperated with any investigation of the violation by the State.*

*(3) At the time the person furnished the State with information about the violation, no criminal prosecution, civil action, or administrative action has commenced with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.*

*(d) Exclusion. - This section does not apply to claims, records, or statements made under Chapter 105 of the General Statutes. (2009-554, s. l; 2018-41, s. 2.)*