

POLICY AND PROCEDURE MANUAL

TITLE: COMPLIANCE PROGRAM

DEPARTMENT: ADMINISTRATION

I. INTRODUCTION

On February 8, 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005 (DRA). The DRA includes numerous provisions designed to reduce and control Medicaid costs, including costs that result from Medicaid fraud. This policy was designed to educate employees, contractors and agents of LHCC and its affiliates (hereafter "LHCC") about systems that it maintains to ensure compliance with applicable federal and state laws related to false claims, false statements and whistleblower protections. A summary of applicable statutes appears at the end of this policy.

II. LHCC COMPLIANCE PROGRAM

LHCC is committed to conducting business in an ethical manner; complying with all federal and state laws; implementing and enforcing procedures to detect and prevent fraud, waste and abuse regarding payments to LHCC from federal or state healthcare programs, and providing protections for those who report actual or suspected wrongdoing. Regular education, monitoring, audits and investigations occur throughout the organization to ensure compliance with this policy.

The LHCC Compliance Program was developed to provide for the consistent and accurate communication of corporate policies and procedures in the areas of compliance with laws, regulations and LHCC's Standards of Conduct. The Compliance Program is intended to guide, direct and support each employee in undertaking responsibility for and supporting an environment of compliance. High standards of ethical conduct shall be maintained in all practices including, but not limited to: resident care; admissions, transfers, and discharges; billing and marketing; as well as relationships with other healthcare providers, educational institutions, and payors.

III. STANDARDS OF CONDUCT FOR LHCC STAFF MEMBERS

In the performance of their jobs, all LHCC staff members are expected to:

- a. Follow laws, rules, and regulations of several federal, state and local agencies, as well as the facility's policies and procedures;
- b. Be honest in all business dealings;
- c. Not request or accept gifts or gratuities;
- d. Avoid conflicts of interest. Examples of conflicts of interest include:
 - i. Accepting substantial gifts from vendors or contractors;
 - ii. Promoting, on company time, a business in which you have either a direct or indirect interest;
 - iii. Using your position to influence the hiring of a family member or close friend;
 - iv. Engaging in political activities at work;
 - v. Misusing confidential information for personal gain or benefit of others;
 - vi. Serving as an officer, consultant, director or employee of an organization which is a competitor of LHCC; and

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- vii. Hiring LHCC vendors or contractors to perform personal work for you or your family without administrative approval;
- e. Keep accurate and timely records;
- f. Not to offer, solicit, or accept bribes or kickbacks; and
- g. Report any known or suspected violations.

In addition to the responsibility for personal compliance, each staff member has a responsibility LHCC to report any activities which he or she either knows or suspects are in violation of federal, state, or local laws, rules, regulations or LHCC's policies and procedures. If a staff member knows or suspects that something is being done that violates either regulatory requirements or policies and procedures, s/he is expected to report that information through the appropriate channels, starting with the immediate supervisor, if it is possible. Failure to report illegal, immoral, unethical, or non-compliant activities will result in appropriate disciplinary action.

Any staff member who has questions or concerns about an activity which s/he either knows or suspects is illegal, immoral, unethical, or non-compliant is advised to do the following:

1. Talk to the immediate supervisor. Staff members are always encouraged to speak with their supervisor first about questions or concerns. If a staff member feels uncomfortable talking to his/her supervisor, or if the supervisor is involved in something you are concerned about, LHCC has provided several other ways for to ask questions and express your concerns.
2. Call the confidential LHCC Corporate Compliance Hotline Telephone Number at 973-839-5296, extension #3. This Compliance Hotline is a reporting line that is available 24 hours a day, 7 days a week. Calls are answered by an automated answering machine, and not by an employee of LHCC. Staff members who call the Hotline are protected against retaliation for reporting an issue in good faith. The Compliance Line does not have caller ID, or tracking devices. Callers to the Hotline are encouraged to leave their name, since this may assist the Compliance Officer with investigating the report. However, callers who wish to remain anonymous may certainly do so.
3. Contact the LHCC Corporate Compliance Officer. If you choose not to use the confidential Compliance Hotline, you may contact the Compliance Officer in several ways:
 - a. By e-mail at complianceofficer@lakelandhcc.com
 - b. By letter addressed to:
Corporate Compliance Officer
R&D Health Management, Inc.
25 Fifth Avenue
Haskell, NJ 07420
 - c. In person by scheduling a meeting with the Compliance Officer.

The Compliance Officer will seek assistance from LHCC personnel with the required knowledge and expertise to perform an effective investigation. Investigations will be conducted promptly. The



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conclusion of any investigation will be entered in the Compliance Log. Any disciplinary or corrective action deemed appropriate will be coordinated with the Human Resources Department and other staff members as appropriate.

All reports made to the confidential Compliance Hotline will be documented and reviewed by the Corporate Compliance Officer for referral or investigation if necessary. Hotline cases will be investigated within 10 business days of receipt under normal circumstances. If the investigation cannot be concluded within that time-frame, an interim status notice will be sent to inform the caller, if possible.

The identity of anyone who reports a known or suspected violation in good faith will be kept confidential to the extent permitted by law, unless doing so prevents a full and effective investigation of the reported violation.

LHCC will neither tolerate nor allow any punishment or reprisal against a staff member who reports in good faith a compliance concern to a supervisor, the Compliance Hotline or the Corporate Compliance Officer.

LHCC takes all reports of known or suspected violations very seriously, and, as noted above, protects against reprisal individuals who report a known or suspected violation in good faith. However, reports of non-compliance that are known to be false when they are reported constitutes a violation of this policy, and may result in disciplinary action.

IV. EDUCATION AND TRAINING

LHCC is committed to effectively communicating our standards and procedures to all staff members. Education and training is provided to develop compliance awareness and commitment. All staff members must attend required compliance training that is applicable to their job functions.

V. COMPLIANCE MONITORING

LHCC is committed to responsibly monitor implementation of the compliance program. Department managers are responsible to monitor compliance in their areas on an ongoing basis. In addition, the Administrator/Designee is responsible to develop and implement annual Compliance Workplans.

VI. RELATIONSHIPS WITH PAYORS

A. Coding and Billing for Services

LHCC maintains systems to ensure that billing submissions to government and private insurance payors are truthful, accurate and conform to the requirements of federal, state, and local laws and regulations. These laws include the federal False Claims Act, as well as laws prohibiting schemes to defraud a healthcare benefit program.

LHCC makes diligent efforts to maintain systems that result in fair, reasonable and accurate claims submission, including the following specific objectives:

1. Billing only for items or services actually rendered;

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2. Billing only for medically necessary services;
3. Preventing upcoding (the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient);
4. Submitting accurate cost reports;
5. Appropriately bundling or combining services that should be billed together;
6. Creating and maintaining supporting medical record documentation for services billed to patients or payors; and
7. Avoiding submission of claims arising from impermissible anti-kickback arrangements.

LHCC maintains oversight systems to verify that claims are submitted only for services actually provided and that services are billed as provided. Failure to follow these principles could result in submission of false claims.

Any subcontractors engaged to perform billing or coding services should have the necessary skills, quality assurance processes, systems and appropriate procedures to ensure that all billings for government and private insurance programs are accurate and complete.

B. Credit Balances and Bad Debts

LHCC treats credit balances and bad debt in compliance with applicable law and regulations.

In some instances, a credit balance will exist in a patient account after payment by both the patient and a federal or state healthcare program. LHCC endeavors to accurately track, report, and refund credit balances.

C. Cost Reports

LHCC activities include reimbursement under government programs that require us to submit certain reports of our costs of operation. LHCC complies with all federal, state, and local laws relating to cost reports. These laws and regulations define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of these requirements, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with our Finance Department.

VII. RELATIONSHIPS WITH REFERRAL SOURCES

Federal law generally prohibits payments in exchange for the referral of patients or business to other healthcare providers or suppliers. This prohibition is very broad, and applies both to those who offer or make such payments and to those who receive such payments. In addition, a payment may be anything of value, not just cash payments. There may be criminal as well as civil sanctions for violation of this prohibition.

LHCC accepts resident referrals and admissions based on patients' clinical needs and our ability to render the needed services. LHCC does not pay or offer anything of substantive value to anyone for referring patients or business to us.

Similarly, LHCC makes referrals to other healthcare providers or suppliers based on residents' clinical needs, the ability of other providers or suppliers to render needed services, and patient/family

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preferences. LHCC does not solicit or receive anything of value, directly or indirectly, in exchange for referring patients to any other healthcare provider or supplier.

Federal law also generally prohibits us from giving anything of value to patients or families that we know (or should know) would likely influence their decision to receive services from LHCC. There are permitted exceptions to this general prohibition when the value being offered relates to the promotion of certain preventive care services or involves situations where the patient/family is indigent or in financial need. Federal law also has prohibitions against a physician referring patients to certain other providers (such as clinical labs) in which the referring physician (or a family member of that physician) has a financial interest or relationship. Violations can result in fines and exclusion from Medicare or Medicaid. The law is complex; it applies only to certain services and has many exceptions.

The Administrator shall be contacted with questions about these laws or to discuss proposed arrangements with other providers, to be sure those arrangements comply with applicable law.

VIII. RELATIONSHIPS WITH COMPETITORS

A. Antitrust

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing LHCC business with a competitor (such as how our prices are set), disclosing the terms of supplier relationships, allocating markets among competitors or agreeing with a competitor to refuse to deal with a supplier. Questions related to these matters should be directed to the Administrator.

B. Marketing Our Services

LHCC may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services and recruit employees. LHCC shall present only truthful, fully informative and non-deceptive information in these materials and announcements.

IX. RELATIONSHIPS WITH VENDORS

LHCC selects the vendors and contractors with which we do business on the basis of arms-length and appropriate business criteria, and not on the basis of gifts to persons, the existence or amount of other support a vendor or contractor provides to LHCC (except in connection with a legally appropriate discount or rebate), or other inappropriate factors. LHCC endeavors to conduct business with vendors and contractors in a way that maximizes the ability of LHCC to carry out its resident care mission, and in accordance with legal and ethical standards aimed at preventing conduct that may inappropriately influence purchasing decisions.

X. SUMMARY OF STATUTES

Set forth below are summaries of certain statutes that provide liability for false claims and statements. These summaries are not intended to identify all applicable laws but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005.

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A. Federal Laws

i. The False Claims Act ("FCA")

This federal law provides, in pertinent part, that:

Civil liability can be imposed on any person or entity who:

- knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally-funded health care program;
- or
- conspires to defraud Medicare, Medicaid or other federally-funded health care program by attempting to have a false or fraudulent claim paid.

"Knowingly" means:

- actual knowledge that the information on the claim is false;
- acting in deliberate ignorance of whether the claim is true or false; or
- acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the FCA is subject to a civil money penalty of between \$5,000 and \$10,000 plus three times the amount of damages that the government sustained because of the illegal act. In health care cases, the amount of damages sustained is the amount paid for each false claim that is filed.

Any person may bring an action under the FCA in the name of the United States in federal court. The case is initiated by filing the complaint; the complaint remains under seal for at least 60 days, and will not be served on the defendant. During this time, the government investigates the complaint and gathers additional evidence as necessary to determine if it wishes to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action can receive a percentage of any monetary recovery, depending upon the contribution of that person to the prosecution of the case.

Anti-discrimination. Anyone initiating an action under the FCA 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 himself or herself whole for any job related losses resulted from any such discrimination or retaliation.

ii. The Federal Program Fraud Civil Remedies Act ("PFCRA")

This federal law makes it illegal for a person or entity to make, present or submit (or cause to be made, presented or submitted) a "claim" (i.e., a request, demand or submission) for property, services, or money to an "authority" (i.e., an executive department of the federal government, e.g., the U.S. Department of Health and Human Services which oversees Medicare and Medicaid programs) when the

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person or entity “knows or has reason to know” that the claim: (i) is false, fictitious or fraudulent; or (ii) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent; or (iii) includes or is supported by any written statement which omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact; or (iv) is for the provision of items or services which the person or entity has not provided as claimed.

In addition, it is illegal to make, present or submit (or cause to be made, presented, or submitted) a written “statement” (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity “knows or has reason to know” such statement: (i) asserts a material fact which is false or (ii) omits a material fact making the statement false, fictitious or fraudulent because of the omission.

Similar to the Federal False Claims Act, the PFCRA broadly defines the terms “knows or has reason to know” as (1) having actual knowledge that the claim or statement is false, fictitious, or fraudulent; (2) acting in deliberate ignorance of the truth or falsity of the claim or statement; or (3) acting in reckless disregard of the truth or falsity of the claim or statement. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

The PFCRA provides for civil penalties of up to \$5,000 for each false claim paid by the government, and in certain circumstances, an assessment of twice the amount of each claim.

In addition, if a written statement omits a material fact and is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, the law provides for a penalty of up to \$5,000 to be imposed for each such statement.

B. New Jersey State Laws

i. New Jersey Medical Assistance and Health Services Act – Criminal Penalties and Civil Remedies

The New Jersey Medical Assistance and Health Services Act contains provisions relating to acts prohibited by persons receiving medical assistance benefits and providers receiving medical assistance payments. The law makes it a crime for a provider to knowingly receive medical assistance payments to which he is not entitled or in a greater amount than entitled. It is also a crime for a provider or other person or entity to knowingly and willfully make materially false statements in applying for payments under the medical assistance program or for use in determining rights to such payment, to conceal or fail to disclose the occurrence of an event affecting the initial or continued right to a payment with the fraudulent intent to secure payments not authorized or in a greater amount than authorized under the law, or to knowingly and willfully convert payments to a use other than the use and benefit of the provider or other person. It is also a crime for a provider or other person to solicit, offer or receive a kickback, rebate or bribe in connection with the receipt of a payment under the Act or the furnishing of items or services for which payment is or may be made or whose cost is or may be reported in order to obtain such payments (except for lawful discounts or price reductions and payments to an employee under a bona fide employment relationship). Finally, it is a crime to knowingly and willingly make or induce, or seek to do so, the making of false statements or representations of material facts with respect

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to the conditions or operations of an institution or facility in order for it to qualify for certification or recertification of a hospital and thereby entitled to receive medical assistance payments. Violations can result in criminal penalties including fines and imprisonment. (N.J.S. 30:4D-17 (a)-(d)).

In addition, various civil remedies are available to the government under the Medical Assistance and Health Services Act. Persons or entities committing the crimes described in the previous paragraph are liable for civil penalties (recoverable in an administrative proceeding) including all of the following: interest on the excess payments, three times the amount of the payments unlawfully obtained, and \$2,000 per excessive claim for payments. Persons or entities who obtain medical assistance payments in amounts in excess of that to which they are entitled, but without intent to violate the Act, may be subject to a civil penalty in the amount of interest on the excess payments. Finally, the director of the Medical Assistance Program has the authority to suspend, debar or disqualify for good cause any provider (or an agent, employee or contractor of one) or other person or entity participating in the Medicaid program. (N.J.S. 30:4D-7.h; 30:4D-17 (e) – (i); 30: 4D-17.1.a).

ii. Health Care Claims Fraud Act

This law makes it a crime for licensed health care practitioners and persons who are not practitioners to knowingly or recklessly commit health care claims fraud in the course of providing professional services. Conviction under the Health Care Claims Fraud Act subjects the person to criminal penalties as permitted under New Jersey law, fines of up to five times the pecuniary benefit received or sought, and license or certificate forfeiture . Health care claims fraud includes the making of false or misleading statements in, or omission of material facts from, a record, bill, claim or other document submitted for payment or reimbursement for health care services. (N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5).

iii. Conscientious Employee Protection Act

This law prohibits retaliation against an employee who discloses to a supervisor or public body an activity, policy or practice by an employer that the employee reasonably believes violates a law, rule or regulation, or is fraudulent or criminal. It also prohibits retaliation against an employee who provides information or testimony to a public body investigating a violation of law, rule or regulation by an employer, or who objects to or refuses to participate in any activity, policy or practice that the employee reasonably believes is in violation of a law, rule or regulation, or is fraudulent, or incompatible with a clear mandate of public policy. The law provides a private right of action for aggrieved employees with available remedies including injunctive relief, reinstatement, lost wages and benefits, and other compensatory damages; a defendant may also be subject to civil fines and punitive damages. An employer may, however, recover attorneys' fees and costs if an employee is found to have brought an action without basis in law or fact. (N.J.S. 34:19-1 to 19-14.).

iv. New Jersey False Claims Act

This law establishes civil penalties and treble damages against any person who submits or causes the submission of claims to the State for government funds or property knowing that those claims are false or fraudulent, or for acting with reckless disregard or deliberate ignorance of the truth or falsity of such claims.

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Like its federal counterpart, the New Jersey False Claims Act (NJFCA) provides that an individual (referred to as a "relator") may sue on behalf of the state government and receive a portion of any recovery. Such cases, known as "qui tam" actions, are filed under seal to provide the State Attorney General time to decide whether to join the case. If the NJ Attorney General joins the NJFCA action and prevails, the relator will be awarded 15% to 25% of the recovered proceeds. If the relator prevails without the Attorney General having joined the action, the relator may generally receive 25% to 30% of the proceeds. Additionally, the NJFCA contains anti-retaliation provisions to protect employee whistleblowers, and allows such persons to bring civil actions for violation of the Act. The remedies for unlawful retaliation include reinstatement, double back pay, special and punitive damages, and attorneys' fees. Also similar to the federal FCA, if the NJ Attorney General has reason to believe that a person has violated the Act, he/she may issue subpoenas to compel the attendance of witnesses or the production of documents as part of a pre-suit investigation. The NJFCA also provides that, upon violation of the Act by any person licensed or certified by a NJ licensing authority, the Attorney General must notify the licensing authority of the violation for the taking of "appropriate administrative action."

The NJFCA does have a few differences from the federal FCA. The primary difference between the NJFCA and the federal FCA, is that the NJFCA applies to false claims made to the state, or to "any contractor, grantee, or other recipient of State funds," as opposed to the federal government. In addition, NJFCA actions may be brought in either state or federal court, whereas federal FCA matters may be brought only in federal court.

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8/19/2008