Letter From Our CEO

Our commitment to our patients and families, team members, healthcare partners and payors is to provide Exceptional care while remaining compliant with the rules and laws that govern our services. **WE must do the right thing, always.** This simple truth is put into everyday action and a routine part of our culture. At Careline, Compliance is #1.

Careline's Compliance Program is designed to promote a culture of ethics and compliance while detecting and preventing fraud, waste and abuse. We continuously monitor compliance within our practices and provide ongoing compliance education that encourages all Careline team members to maintain a continuous vigilance for potential risks. Our entire organization is a part of Compliance and is expected to honor the Standards of Conduct and act in good faith.

We have outlined our compliance program in the information that follows as well as how to contact us if you have a compliance question or concern. Simply stated, if you see something, say something.

Thank you for choosing Careline. We are honored to care for patients, support their families and collaborate with our community partners while maintaining the highest standards of care.

Expect Exceptional,

Joseph D. Mead, JD, MBA
Founder and Chief Executive Officer
Careline Health Group

Careline Compliance Program

Introduction to Compliance

A compliance plan is a formal statement of a healthcare practice's intention to conduct itself ethically in regard to business operations, government regulations, patient services and care, and beneficiary regards. The purpose of a formal compliance plan is twofold:

It provides a platform for the practice's compliance program and accomplishing the succeeding goals, and (2) it encourages everyone to report unethical and unlawful conduct. Careline Health Group has based our program on the Office of the Inspector General's (OIG) program guidance.

Objectives

The objectives of this guideline are to:

- Explain why compliance plans are important for healthcare practices
- Review federal fraud and abuse laws
- Describe the seven essential elements of an effective compliance plan
  Describe how an employee can enhance ethical and lawful conduct

Careline Compliance Program

Background

Since 1976, the Department of Health and Human Service' Office of Inspector General (HHA-OIG) has been working to prevent fraud, waste, and abuse in federally funded healthcare programs, such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). HHS-OIG's primary function is to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries.

HHS-OIG has published voluntary compliance program guidance for individual and small group healthcare practices for a number of years. In the 1990's, HHS-OIG began providing voluntary compliance tools and resources to help healthcare providers avoid submitting erroneous claims and engaging in unlawful conduct involving federal healthcare programs.

However, because HHS-OIG's guidance was voluntary, not all healthcare providers and organizations felt compelled to develop compliance programs.

With the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, compliance programs became mandatory. Section 6401 of the ACA stipulates that healthcare providers must establish compliance programs as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

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Fraud and Abuse Laws

All healthcare administrators and practicing healthcare providers should have a basic understanding of state and federal abuse laws. The government agencies responsible for enforcing these laws are the U.S. Department of Justice, HHS-0IG, and the Centers of Medicare & Medicaid (CMS).

Office of Inspector General (OIG) has Fraud and Abuse Laws to protect Federally funded healthcare programs such as:

- The Anti-Kickback Statute
- The Physician Self-Referral Law (Stark Law)
- The False Claims Act
- The Exclusion Authorities
- The Civil Monetary Penalties Law

The section herein will give a brief description of these laws affecting healthcare providers and vendors.

Anti-Kickback Statute

The Anti-Kickback Statute prohibits the knowing and willful offering, paying, soliciting, or receiving of anything of value (“kickbacks”) to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs. This statute has safe harbor provisions that protect certain business arrangements; however, very specific requirements must first be met for those provisions to apply.

Violations of the Anti-Kickback Statute can result in administrative sanctions, fines, jail terms, and exclusion from participation in federal healthcare programs.

The HHS-OIG warns that healthcare providers are an attractive target for kickback schemes because they are a potential source of referrals for other healthcare providers, pharmaceutical organizations, and medical supply companies.

Careline Compliance Program

The Physician-Referral Law (Stark Law)

The Stark Law prohibits healthcare providers from referring Medicare and Medicaid patients for certain designated health services to an entity with which the healthcare provider or an immediate family member has a financial relationship unless an exception applies under the law*. A financial relationship may include any form of ownership interest, an investment interest, or some other form of compensation arrangement.

The Stark Law also prohibits the entity providing the designated health services from submitting claims to Medicare or Medicaid for services that involved a prohibited referral.

*Disclaimer: The Stark Law does not apply to providers for Hospice Services.

The False Claims Act

The Civil False Claims Act prohibits the submission of claims for payment to Medicare or Medicaid that the healthcare provider knows or should have known to be false or fraudulent.
Examples of False Claims Act include:

Billing for services not rendered or products not delivered, misrepresenting services rendered by upcoding or inappropriate coding and by misrepresenting the nature of the patient's condition, duplicate billing, Falsifying records to meet or continue to meet the conditions of participation; this includes the alteration of dates, the forging of physicians' signatures, and the adding of additional information after the fact.

Violations under the federal False Claims Act can result in significant fines and penalties. Financial penalties to the person or organization may be up to three times the actual false claim amount, plus an additional penalty of $5,500.00 to $11,000.00 per claim.

Violation of the Michigan Medicaid False Claims Act (MMFCA) constitutes a felony punishable by imprisonment, or a fine of $50,000 or less, or both, for each violation.

Careline Compliance Program

Whistleblower Protection Under the False Claims Act

The federal False Claims Act protects employees who report a violation under the False Claims Act from discrimination, harassment, suspension or termination of employment as a result of reporting possible fraud.

The Exclusion Authorities Law

Under the Exclusion Statute, HHS-OIG must exclude individuals or entities from participation in all federal healthcare programs when certain offenses are committed. Examples of criminal offenses that will result in exclusion include:

Medicare or Medicaid fraud, patient abuse or neglect, felony convictions for other healthcare-related fraud, theft, or other financial misconduct, or felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The HHS-OIG also has discretionary exclusion authority for certain offenses such as:

Misdemeanor convictions for unlawful distribution, prescription, or dispensing of controlled substances, suspension, revocation, or surrender of a license for reason bearing on professional competence, professional performance, or financial integrity, Provision of unnecessary or substandard services, submissions of false or fraudulent claims, engaging in unlawful kickback arrangements, and defaulting on health education loans or scholarships.

The Civil Monetary Penalties Law

The Civil Monetary Penalties Law allows HHS-OIG to seek civil monetary penalties and/or exclusion for many offenses. In 2017 an adjustment went into effect allowing for increases in civil monetary penalty ranges due to annual inflation. Penalties can range from several hundred to multimillion dollars based on the violation(s) cited.

Non-Retaliation

Reporting a compliance issue or seeking answers will be private and anonymous. **No one shall, in any way, retaliate against another for reporting an act of non-compliance.**

Any Acts of Retaliation should also be reported and will be investigated by the Compliance Officer. Any confirmed act of retaliation shall result in disciplinary action. An employee who retaliates against someone who has reported a violation or suspected violations in good faith is subject to discipline up to and including termination of employment.

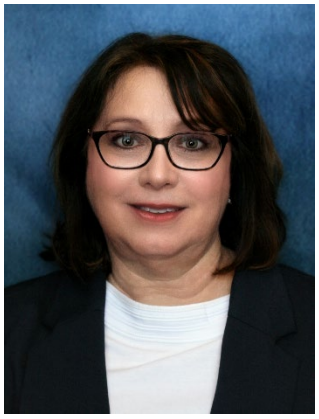
How to Contact Compliance

Careline Health Group Corporate Compliance Officer

If you have a compliance question or concern, please contact:

Catherine Bliss, Certified Compliance Officer

Phone: (877) 665-7330



You may also send correspondence by mail to:

Careline Health Group

Attn: Catherine Bliss

801 Rosehill Rd.

Jackson, MI 49202

For anonymous reporting by email, send to
complaince@carelineahealthgroup.com

Careline Health Group's Compliance Program embodies our organization's commitment to carrying out it's business activities honestly and ethically and in compliance with all applicable Federal, State and Local laws, rules and regulations.

To obtain guidance on a compliance issue, or to report any concerns of unethical activity or a suspected violation of the compliance program, contact your supervisor or the compliance officer in a timely manner.

Please note that intimidation, retribution, or retaliatory action taken against anyone who reports a suspected violation in good faith is strictly prohibited.

Any individual who deliberately makes a false accusation with the purpose of harming or retaliating against another individual will be subject to appropriate disciplinary action.