1. WASTE, FRAUD AND ABUSE & ABILITY TO REPORT WRONGDOING

1.A STANDARD OF CONDUCT

Colquitt Regional Medical Center shall be operated in a manner that prevents waste and fraud and abuse. Therefore, all employees, management, contractors and agents of Colquitt Regional Medical Center shall abide by (1) the Federal False Claims Act; (2) the Program Fraud Civil Remedies Act; and (3) all federal, state and local fraud, waste and abuse laws.

1.B FEDERAL FALSE CLAIMS ACT

The False Claims Act ("FCA") is a federal law that prohibits a person from knowingly submitting claims or making a false record or statement in order to secure payment of a false or fraudulent claim from the federal government. The requirement that a person "knowingly" make a false claim is met when such person (1) has actual knowledge of falsity of a claim; (2) acts in deliberate ignorance of the truth or falsity of a claim; or (3) acts in deliberate disregard to the truth or falsity of a claim.

False claims can result from overcharging for a product or service, delivering less than the promised amount or type of goods or services, underpaying money owed to the government and charging for one thing while providing another.

Health care providers and suppliers found to have violated the FCA can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. Additionally, violators may be required to pay three times the actual damages sustained by the government. Finally, the violator may be excluded from participation in federal health care programs.

1.B.1 Qui Tam "Whistleblower" Provisions

Any person with actual knowledge of allegedly false claims on the government may file a lawsuit on behalf of the government. Such person, called a "relator", initiates the action by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The lawsuit is kept confidential while the government reviews and investigates the allegations. After a 60 day period, or longer if extended, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the relator may continue the action in federal court. If the government proceeds with the case, the lawsuit will be directed by the U.S. Department of Justice.

If the lawsuit is successful, the relator may receive an award ranging from 15 to 30 percent of the amount recovered. The relator may also be entitled to reasonable expenses, including attorney's fees and costs for bringing the lawsuit. Any case must be brought within 6 years after the alleged false claim is filed.

1.B.2 Non-Retaliation

Anyone initiating a Qui Tam case may not be discriminated or retaliated against in any manner by their employer by virtue of bringing the claim. The employee may also receive additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against the whistleblower for filing an action under the False Claims Act.

1.C PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims separate from and in addition to, the judicial or court remedy for false claims provided by the FCA. The PFCRA deals with submission of improper "claims" or "written statements" to a federal agency.

Specifically, a person violates the PFCRA if they know or have reason to know they are submitting a claim that is:

- False, fictitious or fraudulent; or
- Includes or is supported by written statements that are false, fictitious or fraudulent; or
- 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 submitting the statement has a duty to include the omitted facts; or
- For payment for property or services not provided as claimed.

A violation of the PFCRA carries a $5,000 civil 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.

A person also violates the PFCRA if such person submits a written statement which they know or should know:

- Asserts a material fact which is false, fictitious or fraudulent; or
- 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 that the statement submitted contains a certification of the accuracy or truthfulness of the statement.

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

1.D. GEORGIA ANTI-FRAUD LAW

1.D.1. O.C.G.A. § 49-4-146.1. Unlawful to obtain benefits and payments under certain circumstances; penalties; procedures.

Georgia law provides that it is illegal for a person or a provider to obtain, attempt to obtain, or retain any medical assistance or other benefits or payments to which such person or provider is not entitled, or in an amount greater than to which the person or provider is entitled from Georgia public assistance, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program through:

- knowingly and willfully making a false statement or false representation;
- deliberate concealment of any material fact; or
- any fraudulent scheme or device.

The law further prohibits any person or provider from knowingly and willfully accepting medical assistance payments to which he or she is not entitled or in an amount in excess of what he or she is entitled, or to knowingly and willfully falsify any report or document.

The law is a criminal statute and thus the state has the burden of proving beyond a reasonable doubt that a defendant intentionally committed the alleged act. A violation of this Georgia law is a felony punishable by a fine of up to $10,000 and/or imprisonment for not less than one year or more than ten years.

In addition, a person who committed abuse could further be held liable for civil monetary penalties of two times the amount of any excess benefit or payment. "Abuse" is defined as a provider knowingly obtaining or attempting to obtain medical assistance or other benefits or public assistance to which the provider is not entitled, and such benefit results in unnecessary costs to the benefit program. Isolated instances of unintentional errors in billing, coding and cost reports shall not constitute abuse. Further, pursuant to the above definition, miscoding shall not constitute abuse if there is a good faith basis that the codes used were appropriate under the department's policies and procedures manual and there was no deceptive intent on the part of the provider.

Additionally, any person violating the law shall be liable for a civil penalty equal to the greater of (1) three times the amount of any such excess benefit or payment or (2) $1,000.00 for each excessive claim. Interest on the penalty shall be paid at the rate of 12 percent per annum.

1.D.2. Georgia Patient Self Referral Act

Georgia has a Patient Self Referral Act which, while similar to the federal Stark Law in some ways, is significantly different in terms of when it applies and to whom it applies. It can be found at O.C.G.A. § 43-1B-1. It is not included in this policy since it generally addresses physician financial arrangements and investment interest issues.

1.D.3. Georgia Administrative Regulation § 290-9-7-.12. Human Resources Management

Georgia hospital licensing regulations require hospitals to train their employees on the hospital's policies and procedures. Specifically, Georgia Administrative Code Section 290-9-7-.12 pertains to Personnel training programs and provides that:

(d) Personnel Training Programs. The hospital shall have and implement a planned program of training for personnel to include at least:

1. Hospital policies and procedures;
2. Fire safety, hazardous materials handling and disposal, and disaster preparedness;
3. Policies and procedures for maintaining patients' medical records;
4. The infection control program and procedures; and
5. The updating of job-specific skills or knowledge.

1.D.4. Georgia Administrative Regulation § 290-9-7-.41. Enforcement of Rules and Regulations

Georgia hospital licensing regulations also contain enforcement provisions. Georgia Administrative Regulation Section 290-9-7-.41 provides "A hospital that fails to comply with these rules and regulations shall be subject to sanctions and/or permit revocation as provided by law. The enforcement and administration of these rules and regulations shall be as prescribed in the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6, pursuant to O.C.G.A. § 31-2-6."

1.E. PREVENTING AND DETECTING FRAUD, WASTE, AND ABUSE IN FEDERAL AND STATE HEALTH CARE PROGRAMS

The laws described in this policy create a comprehensive process for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate

and prosecute violations. Enforcement activities are pursued in three available forums: criminal, civil and administrative. This provides a broad spectrum of remedies to address fraud and abuse problems.

Moreover, whistleblower protections, such as those included in the federal False Claims Act, provide protections for individuals reporting fraud and abuse in good faith.

1.F EXISTING POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FRAUD

Colquitt Regional Medical Center's Policy No. 400.30 (the "Compliance Policy") provides the policies and procedures for the Compliance Program. The Compliance Policy represents the Hospital Authority of Colquitt County's continued commitment to quality and performance and applies to all employees, physicians, agents and contractors of Colquitt Regional Medical Center and its affiliated providers.

In summary, the Compliance Policy provides as follows:

- The Compliance Policy establishes the expectations of all hospital officials, staff, physicians, contractors and other agents to conduct their respective obligations in a manner that complies with all federal, state and local laws and regulations.

- The Compliance Policy establishes a list of risk areas that should be closely monitored to ensure compliance.

- The Compliance Policy provides specific policies and procedures for:

    a. claim development and submission;
    b. outpatient services rendered in connection with an inpatient stay;
    c. submission of claims for laboratory services;
    d. cost reports;
    e. medical necessity and reasonable and necessary services;
    f. anti-kickback and self referral;
    g. bad debts;
    h. credit balances
    i. retention of records; and
    j. hiring new employees.

- The Compliance Policy states that promotion and adherence to the compliance program will be a factor in evaluating the performance of managers and supervisors. Further, the Compliance Policy sets out required tasks of managers and supervisors to ensure compliance with federal, state and local laws. The Compliance Policy creates the position of Compliance Officer and establishes the chain of command and responsibilities of such officer. The Compliance Committee and its functions are also created.

- The Compliance Policy requires that all affected employees, physicians, independent contractors and agents complete training on a periodic basis. This training shall relate to the compliance program, fraud and abuse laws, coding requirements, claim development and submission processes and a review of marketing process.

- The Compliance Policy creates methods of confidential reporting to the Compliance Officer. Methods of reporting include Direct Line, Meditech e-mail, internet e-mail, written correspondence or telephone and a toll free hotline (1-866-370-5993).

- The Compliance Policy provides that failure to comply with the compliance program, as established therein, may result in disciplinary action.

- The Compliance Policy calls for regular, periodic compliance audits to be conducted by internal or external sources and an annual review to be completed by independent individuals. The reviewers will complete written evaluation reports.

- Upon indication of suspected non-compliance, the compliance officer or other management officials will initiate prompt steps to investigate the conduct in question. Should the investigation determine that a violation has occurred, prompt steps will be taken to correct the problem. If credible evidence of misconduct that may violate criminal, civil, or administrative law is discovered and verified, the hospital will, upon review with its legal council, promptly report the existence of the misconduct to the appropriate governmental authority no more than 60 days after the verification.

I have received and accept the above compliance program policies fulfilling the requirements of the Deficit Reduction Act of 2006.

Vendor Name_____

Representative Signature _____

Date:_____