HCA

DEPARTMENT: Legal	**POLICY DESCRIPTION:** Mississippi False Claims Statutes Policy
PAGE: 1 of 3	**REPLACES POLICY DATED:** 1/1/07, 9/1/07, 2/10/09
EFFECTIVE DATE: September 1, 2013	**REFERENCE NUMBER:** LL.MS.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All employees and, as defined below, contractors or agents of Company-affiliated facilities in the State of Mississippi, including but not limited to, hospitals, ambulatory surgery centers, outpatient imaging centers, home health agencies, physician practices, service centers, and all Corporate Departments, Groups, Divisions and Markets.

PURPOSE: The purpose of this policy is to comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

POLICY: Company-affiliated facilities in Mississippi must ensure that all employees, including management, and any contractors or agents are educated regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

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, and there are also Mississippi laws that address fraud and abuse in the Mississippi Medicaid program. 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 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 $5,500 to $11,000 per false claim, and 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 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 allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. Sometimes the United States Government decides to join the qui tam suit. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. Because the Government assumes responsibility for all of the expenses associated with a suit when it joins a false claims action, the percentage is lower when the Government joins a qui tam claim.

However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorneys fees.

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.

The State of Mississippi has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the Mississippi Medicaid program. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties.

REPORTING CONCERNS REGARDING FRAUD, ABUSE AND FALSE CLAIMS

The Company takes issues regarding false claims and fraud and abuse seriously. The Company encourages all employees, management, and contractors or agents of the Company's affiliated facilities to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately. Issues are resolved fastest and most effectively when given prompt attention at the local level. The Company, therefore, encourages its affiliated facilities' employees, managers, and contractors to report concerns to their immediate supervisor when appropriate. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should be encouraged to

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discuss the situation with the facility's human resources manager, the facility's ECO, another member of management, or with the Company's Ethics Hotline (1-800-455-1996).

Employees, including management, and any contractors or agents of Company-affiliated facilities should be aware of related facility policies regarding detection and prevention of health care fraud and abuse. These policies and procedures can be accessed on Atlas, the Company's Intranet site, or the Company website at www.hcahealthcare.com. The following are some of the policies that are relevant to this policy and to the prevention and detection of fraud and abuse: (1) EC.025-Reporting Compliance Issues and Occurrences to the Corporate Office Reportable Events Policy; (2) REGS.BILL.005-Confirming and Processing Overpayments; (3) REGS.GEN.001-Billing Monitoring; and (4) RB.009-Error in Reporting.

DEFINITION:

Contractor or **agent** includes any contractor, subcontractor, agent, or other person which or who, on behalf of the facility, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the facility.

PROCEDURE:

Facility responsibilities include, but are not limited to:

a. Ensuring that all employees, including management, and any contractors or agents of the facility, are provided with this policy, within 30 days of commencing employment or contractor status.

b. Ensuring that the facility's employee handbook, if one exists, includes a detailed summary of this policy.

REFERENCES

1. Miss. Code Ann. §§ 43-13-209, -211, -213, -215, & -225
2. 31 U.S.C. §§ 3801-3812
3. 31 U.S.C. §§ 3729-3733
4. Deficit Reduction Act of 2005, Sections 6031, 6032
5. HCA Code of Conduct, "Resources for Guidance and Reporting Concerns"