

DEPARTMENT: Legal	POLICY DESCRIPTION: South Carolina False Claims Statute Policy
PAGE: 1 of 4	REPLACES POLICY DATED: 1/1/07, 9/1/07, 2/10/09, 1/1/10, 9/1/13
EFFECTIVE DATE: September 1, 2018	REFERENCE NUMBER: LL.SC.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All employees and, as defined below, contractors or agents of Company affiliates located in the State of South Carolina or providing services to Medicare or Medicaid providers located in the State of South Carolina, 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: 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 affiliates who are Medicare or Medicaid providers in South Carolina or provide services to South Carolina Medicare or Medicaid providers 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. Although the State of South Carolina has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions, it has adopted a generally applicable medical assistance anti-fraud statute that is intended to prevent the submission of false and fraudulent claims to the South Carolina Medicaid program

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 \$10,957 to \$21,916 per false claim, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, 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. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. In addition, the United States Government may elect to join the qui tam suit. In this case, if the suit is

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successful, the percentage of the funds awarded to the whistleblower is lower because the Government will take over the expenses of the suit. 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 false claim, 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 or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her 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 attorney's 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.

SOUTH CAROLINA FALSE CLAIMS LAWS

South Carolina has enacted a statute that makes it unlawful for any person to knowingly and willfully: (1) make or cause to be made a false claim, statement, or representation of material fact upon requesting payment or reimbursement from the State's medical assistance or Medicaid program; (2) make or cause to be made a false claim, statement, or representation of material fact on a report, certificate, or similar document submitted to a state or federal agency that administers the South Carolina's Medicaid program in order for the provider to qualify or remain qualified under South Carolina's Medicaid program; or (3) conceal or fail to disclose any material fact, event, or transaction which affects the provider's initial or continued entitlement to payment or the amount of payment under South Carolina's Medicaid program.

A person found to have violated this statute is guilty of a misdemeanor and subject to up to three years imprisonment and a fine of up to \$1,000 per offense. The South Carolina Attorney General may also bring action to recover up to treble damages of the amount of overstatement or overpayment. The court may also impose a penalty of \$2,000 per each false claim. The state agency that administers the Medicaid program may also impose administrative sanctions. See S.C. Code Ann. § 43-7-60; S.C. Code Ann. Regs. 126-403.

In addition, a person who knowingly causes a false claim to be presented for payment by the State commits a criminal offense. If the claim amount is more than \$10,000, the individual is subject to up to ten years in prison, a fine of up to \$5,000, or both. If the claim is more than \$2,000, the individual

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is subject to a fine in an amount to be decided by the court, up to five years in prison, or both. False claims of \$2,000 or less are subject to a fine of up to \$1,000, up to thirty days in prison, or both. See S.C. Code Ann. § 38-55-170.

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. Therefore, the Company 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 discuss the situation with the Company's human resources manager, the Company'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 Policy; (2) REGS.GEN.015-Correction of Errors Related to Federal and State Healthcare Program FFS Reimbursement Policy; and (3) RB.009-Reporting of Cost Report Overpayment Policy. Note that employees, contractors, and agents of Company affiliates providing services to other, non-affiliated facilities should also understand that all such facilities are expected to have similar policies applying to contractors (including the Company) requiring (1) compliance with federal and state laws, including false claims laws; (2) reporting of potential overpayments and compliance concerns; and (3) the whistleblower protections described above.

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 Medicare or Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the facility.

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PROCEDURE:

Company 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 Company handbook includes a detailed summary of this policy.
- c. Revising this policy as necessary to comply with changes in the law. Changes must be documented and implemented. When policies and procedures are revised, the previous versions of the policies and procedures must be retained for ten (10) years.

REFERENCES

1. S.C. Code Ann. § 38-55-170
2. S.C. Code Ann. § 43-7-60
3. S. C. Code Regs. 126-403
4. 31 U.S.C. §§ 3801-3812
5. 31 U.S.C. §§ 3729-3733
6. Deficit Reduction Act of 2005, §§ 6031, 6032
7. HCA Code of Conduct, "Resources for Guidance and Reporting Concerns"