DEPARTMENT: Legal	**POLICY DESCRIPTION:** Georgia False Claims Statutes Policy
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EFFECTIVE DATE: September 2, 2018	**REFERENCE NUMBER:** LL.GA.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 Georgia or providing services to Medicare or Medicaid providers located in the State of Georgia, 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 Georgia or provide services to Georgia 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. Georgia has adopted a similar false claims act that contains qui tam and whistleblower protection provisions that are similar to those found in the federal False Claims Act. Additionally, Georgia has adopted a generally applicable Medicaid antifraud statute that is intended to prevent the submission of false and fraudulent claims to the Georgia 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 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.

GEORGIA MEDICAID FALSE CLAIMS ACT

The State of Georgia has adopted a State Medicaid False Claims Act (the "GMFCA") which mirrors the federal false claims act and prohibits any person or entity from submitting a false or fraudulent claim to the State of Georgia, including Medicaid. Under the GMFCA, it is unlawful for any person to among other things,: (1) knowingly present or cause to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval; (2) knowingly make, use, or case to be made or used a false record or statement material to a false or fraudulent claim; (3) conspire to commit a violation under this subsection; (4) knowingly make, use, or cause to be made or used a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit property or money to the Georgia Medicaid program. *See* Ga. Code Ann. § 49-4-168.1(a).

Violations of the GMFCA are civil offenses and consists of significant monetary penalties of not less than $5,500 and not more than $11,000 for each false claim or fraudulent claim, plus three times the amount of damages which the Georgia Medicaid program sustains because of the act. *See* Ga. Code Ann. § 49-4-168.1(a).

The Georgia Attorney General investigates suspected violations of the GMFCA and may bring a civil action against a person that has violated the GMFCA. An individual may also bring a private civil action on behalf of the individual and the State. In the event the qui tam action is successful, the individual bringing the civil action may be awarded a percentage of the funds recovered. *See* Ga. Code Ann. §§ 49-4-168.2(a)-(b) & (h).

Allegations may not be based on public information or on allegations which are already the subject of a civil or administrative proceeding involving the State of Georgia. The individual bringing a claim must be the 'original source', meaning that person has direct and independent knowledge of the information and voluntarily presented it to the state before filing a civil action. *See* Ga. Code Ann. §§ 49-4-168.2(l).

Whistleblower Protections

The GMFCA contains an employee protection provision that prohibits an employer from discharging, demoting, suspending, threatening, harassing, or otherwise discriminating against an employee, contractor, or agent for lawfully disclosing information regarding a false claims action against the employer.

Such relief under GMFCA's whistleblower protections include, but are not limited to, the following: reinstatement with the same seniority status as if the discrimination had not occurred, twice the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation cost and reasonable attorney's fees. *See* Ga. Code Ann. §§ 49-4-168.4.

GEORGIA MEDICAID ANTIFRAUD STATUTE

Georgia's antifraud law, the Georgia Medical Assistance Act ("GMAA") makes it unlawful for any person to: (1) obtain, attempt to obtain, or retain for himself, herself, or any other person any medical assistance or other benefits or payments under Medicaid, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by: (a) knowingly and willfully making a false statement or false representation; (b) deliberate concealment of any material fact; or (c) any fraudulent scheme or device; or (2) knowingly and willfully accept medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled or knowingly and willfully to falsify any report or document required under the GMAA. Any person that violates the GMAA shall be guilty of a felony, and punishable by a fine and/or imprisonment. *See* Ga. Code Ann. §§ 49-4-146.1(b), (c.1), (d), (f) & (g).

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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.0.15-Correction of Errors Related to Federal and State Healthcare Programs 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.

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.

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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. Ga. Code Ann. §§ 49-4-146.1(b), (c.1), (d), (f), (g); 49-4-146.3; 49-4-168
2. Ga. Code Ann. § 16-10-20
3. 31 U.S.C. §§ 3801-3812
4. 31 U.S.C. §§ 3729-3733
5. Deficit Reduction Act of 2005, Sections 6031, 6032
6. HCA Code of Conduct, “Resources for Guidance and Reporting Concerns”