EXHIBIT 1

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY, FLORIDA
D/B/A
JACKSON HEALTH SYSTEM

I. PREAMBLE

The Public Health Trust of Miami-Dade County, Florida d/b/a Jackson Health System (hereinafter "JHS") hereby enters into this Corporate Integrity Agreement ("CIA") with the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to promote compliance by Jackson Memorial Hospital ("JMH"), selected Covered Clinics (as defined herein), and JHS's Covered Persons and Covered Contractors (as those terms are also defined herein) with the statutes, regulations, and written directives of Medicare, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ggg (hereinafter the "Medicare Program"), Medicaid, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (hereinafter the "Medicaid Program"), and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (collectively hereinafter "Federal health care program requirements"). Contemporaneously with this CIA, JHS is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

JHS represents that it has previously established a Corporate Compliance, Ethics, and Integrity Program (hereinafter the "Compliance Program") as indicated below. JHS and OIG agree that JHS may utilize and adapt any components of the Compliance Program existing at the time of the execution of the CIA, as necessary to be in compliance with the corporate integrity obligations assumed by JHS pursuant to this CIA. JHS shall modify its existing Compliance Program, as appropriate, in a manner that allows JHS to meet the corporate integrity obligations assumed by JHS pursuant to this CIA.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by JHS under this CIA shall be five (5) years from the effective date of this CIA (as defined below) (unless otherwise specified herein). The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA (hereinafter the "Effective Date"). Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, VIII, IX, X, and XI shall expire no later than 120 days after OIG's receipt of: (A) JHS's final Annual Report (as defined in Section V.B); or (B) any additional materials submitted by JHS pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions and shall apply to JHS and the following entities:

1. "Covered Clinics" include (i) South Miami Health Center (d/b/a Rosie Lee Wesley Center); (ii) Liberty City Health Center; (iii) North Dade Health Center; (iv) North Miami Health Center; (v) Juanita Mann Center; and (vi) Jefferson Reaves Senior Health Center, Inc.; (vii) ACC West Pediatric Comprehensive Care Center; (xiii) ACC West Obstetrics and Gynecology Clinics; and (ix) ACC West General Medicine Clinics.

2. "Covered Persons" include: (i) JHS's officers; (ii) JHS's trustees; (iii) JHS's employed physicians; (iv) employed healthcare professionals working at JMH and the Covered Clinics including but not limited to all employees of JHS's Ambulatory Services Division; and (v) any other employee involved directly in the submission of reimbursement claims to one of the Federal health care programs on behalf of JHS.

3. "Covered Contractors" include all contractors, agents, and other third parties engaged to bill or submit reimbursement claims to one of the Federal health care programs on behalf of JMH or the Covered Clinics, and all other individuals responsible on behalf of JMH and the Covered Clinics for the provision or documentation of items or services reimbursable by Federal health care programs, or in the

preparation of claims, reports, or other requests for reimbursement for such items or services.

4 "New" includes any individual or entity that is newly engaged or hired, as well as any JHS affiliated individual or entity whose changing circumstances result in responsibilities that satisfy the definitions of "Covered Persons, Covered Contractors, Relevant Covered Persons or Relevant Covered Contractors."

5. "Relevant Covered Persons" includes only those Covered Persons who are involved directly or in a supervisory role in the assignment of diagnosis or procedure codes or the preparation or submission of claims for reimbursement from any Federal health care program for services rendered at JMH and the Covered Clinics.

6. "Relevant Covered Contractors" includes only those Covered Contractors who are involved directly or in a supervisory role in the assignment of diagnosis or procedure codes or the preparation or submission of claims for reimbursement from any Federal health care program for services rendered at JMH and the Covered Clinics.

7. Notwithstanding the above provisions, individuals who work less than one hundred and sixty (160) hours per year on behalf of JHS are not Covered Persons or Covered Contractors.

III. CORPORATE INTEGRITY OBLIGATIONS

JHS shall continue to maintain its Compliance Program, which shall include the following elements for the term of this CIA:

A. Compliance Officer and Committee.

1. *Compliance Officer.* Prior to the Effective Date, JHS appointed an individual to serve as its Chief Compliance Officer. At all times during the term of this CIA, JHS shall continue to have an individual serving as its Chief Compliance Officer. The Chief Compliance Officer shall continue to be responsible for developing and implementing policies, procedures, and practices designed to promote compliance with the requirements set forth in this CIA and with Federal health care program requirements.

The Chief Compliance Officer shall continue to be a member of senior management of JHS, shall continue to make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Trustees of JHS, via the Board's Audit Subcommittee of the Fiscal Affairs Committee, and shall be authorized to report on such matters to the Board of Trustees at any time. The Chief Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by JHS as well as for any reporting obligations created under this CIA, and shall be assisted in his or her duties by JHS's Compliance Coordinator and other compliance staff, as appropriate.

JHS shall report to OIG, in writing, any changes in the identity or position description of the Chief Compliance Officer, or any actions or changes that would affect the Chief Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change is effective.

2. *Compliance Committee.* Prior to the Effective Date, JHS appointed an Executive Compliance Committee. The Executive Compliance Committee shall continue, at a minimum, to include the Chief Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Chief Compliance Officer shall chair the Executive Compliance Committee and the Executive Compliance Committee shall support the Chief Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations). Within 120 days of the Effective Date, JHS shall establish a new Task Force that will assist the Chief Compliance Officer in overseeing compliance activities at the Covered Clinics, including the implementation of those obligations assumed by JHS under the CIA that are applicable to the Covered Clinics.

JHS shall report to OIG, in writing, any changes in the composition of the Executive Compliance Committee, or any actions or changes that would affect the Executive Compliance Committee's ability to perform the duties necessary to meet the CIA obligations, within 15 days after such a change is effective.

B. Written Standards.

1. *Code of Conduct.* Prior to the Effective Date, JHS created and made available JHS's "Standards and Code of Conduct" to Covered Persons and Covered Contractors. The Standards and Code of Conduct shall be distributed to all of JMH's and

the Covered Clinics' Covered Persons and Covered Contractors who have not already received it within 120 days after the Effective Date. Distribution may include sending the Standards and Code of Conduct via e-mail or other electronic method. If JHS uses such an electronic method of distribution, JHS shall track the distribution and maintain written or electronic records showing that all appropriate individuals have received the Standards and Code of Conduct. Within 120 days after the Effective Date, JHS shall make the promotion of, and adherence to, the Standards and Code of Conduct an element in evaluating the performance of all employees. The Standards and Code of Conduct shall, at a minimum, set forth:

a. JHS's commitment to compliance with all applicable Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;

b. JHS's requirement that all Covered Persons and Covered Contractors are expected to comply with all applicable Federal health care program requirements and with JHS's own Policies and Procedures as implemented pursuant to Section III.B (including the requirements of this CIA);

c. the requirement that Covered Persons and Covered Contractors shall be expected to report to the JHS's Office of Compliance suspected violations of any Federal health care program requirements or of JHS's own Policies and Procedures;

d. the possible consequences to JHS, Covered Persons, and Covered Contractors for failure to comply with Federal health care program requirements and with JHS's own Policies and Procedures and the failure to report such noncompliance; and

e. the right of all individuals to use the Disclosure Program described in Section III.E, and JHS's commitment to maintain confidentiality, as appropriate, and nonretaliation with respect to such disclosures.

Within 120 days after the Effective Date, each Covered Person and Covered Contractor shall certify, in writing or electronically, that he or she has received, read, understood, and shall abide by JHS's Standards and Code of Conduct. New Covered Persons and Covered Contractors shall receive the Standards and Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or Covered Contractor or within 120 days after the Effective Date, whichever is later.

JHS shall periodically review the Standards and Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any such revised Standards and Code of Conduct shall be distributed within 30 days after finalizing such changes, in accordance with the distribution guidelines set forth above. Each Covered Person and Covered Contractor shall certify, in writing or electronically, that he or she has received, read, understood, and shall abide by the revised Standards and Code of Conduct within 30 days after the distribution of such revisions.

2. *Policies and Procedures.* Prior to the Effective Date, JHS's Office of Compliance began preparation of Policies and Procedures that would govern the operation of JHS's Compliance Program. Within 120 days after the Effective Date, to the extent not already accomplished, JHS shall implement written Policies and Procedures regarding the operation of JHS's Compliance Program and its compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall address:

a. the subjects relating to the Standards and Code of Conduct identified in Section III.B.1;

b. the submission of accurate claims to the Federal health care programs, in accordance with applicable Federal and state laws, regulations, and policies, including but not limited to the submission of accurate claims to the Medicaid program for outpatient services provided at the Covered Clinics; and

c. the requirement that JHS shall not submit claims with the 510 outpatient revenue code for services rendered at the Covered Clinics to Medicaid beneficiaries when prohibited under Florida's Medicaid law, regulations, or policies.

Within 120 days after the Effective Date, the relevant portions of the Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures. Distribution may include publishing such Policies and Procedures on JHS's intranet or other internal web site available to all employees. If JHS uses such an electronic method of distribution, it must notify the individuals receiving the Policies and Procedures that the Policies and Procedures will be distributed in such a manner and it must track the distribution to ensure that all appropriate individuals received the Policies and Procedures. The distribution requirements of this Section may also be satisfied by providing one copy of the Policies and Procedures to separate offices or departments, where appropriate, and notifying all individuals required to receive such Policies and Procedures of the central location, availability, and accessability of such Policies and Procedures. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), JHS shall assess and update as necessary the Policies and Procedures. Within 30 days after the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be distributed, in accordance with the distribution guidelines set forth above, to all individuals whose job functions relate to those Policies and Procedures.

C. Training and Education.

1. *General Training*. Within 120 days after the Effective Date, JHS shall provide reasonable and appropriate general training either in written or electronic form to all Covered Persons and Covered Contractors. This training, at a minimum, shall explain JHS's:

a. CIA requirements; and

b. Compliance Program (including the Standards and Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

New Covered Persons and New Covered Contractors shall receive the general training described above within 30 days after becoming a Covered Person or Covered Contractor or within 120 days after the Effective Date, whichever is later. After receiving the initial training described above, each Covered Person shall receive at least one hour of general training annually.

2. *Specific Training.* Within 120 days after the Effective Date, each Relevant Covered Person and Relevant Covered Contractor shall receive at least five hours of specific training in addition to the general training required above. This specific training shall address:

a. the requirement for submission of accurate claims for services rendered to Federal health care program beneficiaries in accordance with relevant federal and state law, regulations, and policies;

b. policies, procedures, and other requirements applicable to the documentation of medical records;

c. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

d. applicable statutes, regulations, and program requirements and directives governing Medicaid reimbursement claims;

e. the legal sanctions for the submission of improper claims;

f. examples of proper and improper claims submission practices; and

g. the requirements of this CIA.

Persons providing the training shall be knowledgeable about the subject area.

New Relevant Covered Persons and New Relevant Covered Contractors shall receive this training within 30 days after the beginning of their employment or becoming a Relevant Covered Person or a Relevant Covered Contractor, or within 120 days after the Effective Date, whichever is later. A JHS employee who has completed the specific training shall review a New Relevant Covered Person's work, to the extent that the work relates to the assignment of diagnosis or procedure codes or the preparation or submission of claims for reimbursement from any Federal health care program on behalf of JMH and

the Covered Clinics, until such time as the New Relevant Covered Person completes his or her applicable training.

After receiving the initial training described in this Section, each Relevant Covered Person, including Relevant Covered Persons who work in JHS's Medicaid Billing and Collections Department, shall receive at least five hours of specific training annually. JHS shall annually review the training, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or IRO audits, and any other relevant information.

3. *Certification.* Each individual who is required to attend training shall certify, in writing or electronically, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications in written or electronic form, along with all course materials. These shall be made available to OIG, upon a request made in accordance with Section VI. General and specific training provided via computer-based training modules, intranet, internet, or other electronic means may be credited towards the training time requirements of Section III.E, provided that such training otherwise meets the requirements of Section III.E (e.g., covers the appropriate topics).

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 120 days after the Effective Date, JHS shall retain an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform reviews to assist JHS in assessing and evaluating its billing and coding practices and certain other obligations pursuant to this CIA and the Settlement Agreement. Each IRO retained by JHS shall have expertise in the billing, coding, reporting, and other requirements of the hospital industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which JHS seeks reimbursement. Each IRO shall assess, along with JHS, whether it can perform the IRO review in a professionally independent and/or objective fashion, as appropriate to the nature of

the engagement, taking into account any other business relationships or engagements that may exist. The IRO(s) review shall address and analyze JHS's billing and coding of claims for outpatient services to the Florida Medicaid program ("Claims Review") and shall analyze whether JHS sought payment for certain unallowable costs ("Unallowable Cost Review").

b. Frequency of Claims Review. The Claims Review shall be performed annually and shall cover each of the Reporting Periods. The IRO(s) shall perform all components of each annual Claims Review for the first three Reporting Periods. Subject to approval from OIG, and subject to the conditions set forth in Section III.D.8, JHS may elect to conduct an Internal Claims Review for the fourth and fifth Reporting Periods.

c. Frequency of Unallowable Cost Review. The IRO shall perform the Unallowable Cost Review for the first Reporting Period.

d. Retention of Records. The IRO and JHS shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (including those exchanged between the IRO and JHS) related to the reviews.

2. *Claims Review.* The Claims Review shall include an Outpatient Revenue Code Evaluation, two Discovery Samples, and, if necessary, one or two Full Samples and one or two Systems Reviews. The applicable definitions, procedures, and reporting requirements are outlined in Appendix A to this CIA, which is incorporated by reference. The following Covered Clinics shall be included within the scope of the Outpatient Revenue Code Evaluation, but shall otherwise be excluded from the scope of the Claims Review (e.g., the Discovery Samples, Full Sample(s), and Systems Review(s)): (i) ACC West Pediatric Comprehensive Care Center; (ii) ACC West Obstetrics and Gynecology Clinics, and (iii) ACC West General Medicine Clinics.

a. Outpatient Revenue Code Evaluation. The IRO, or JHS's Internal Audit Department ("IAD"), subject to the conditions set forth in Section III.D.8 below, shall perform an evaluation of a randomly selected sample of 100 Paid Claims (as defined in Appendix A) submitted to Florida Medicaid by or on behalf of JMH or the

Covered Clinics that were billed on a UB-92 claim form and that included a request for payment based upon an outpatient revenue code (e.g., a 510 facility fee). The objective of the Claims Evaluation shall be to determine whether Medicaid was billed appropriately for such outpatient revenue codes in accordance with Florida Medicaid laws, regulations, and policies, including but not limited to the Florida Medicaid Hospital Services Coverage and Limitations Handbook (hereinafter "Relevant Medicaid Authority").

b. Discovery Sample. The IRO or IAD, as applicable, shall randomly select and review a sample of 50 Paid Claims (as defined in Appendix A) for services provided at each of two Covered Clinics (i.e., 100 Paid Claims). For each annual Claims Review, OIG shall select the two Covered Clinics that shall be subject to the Claims Review. No later than 120 days before the end of each Reporting Period, JHS shall provide OIG with the following information for each Covered Clinic: (i) the total number of Medicaid patients treated; and (ii) the total dollar amount of Paid Claims associated with such treatment during the applicable Reporting Period. Upon review of this information, and before the end of the Reporting Period, OIG shall provide JHS with the names of the two Covered Clinics to be reviewed for the Reporting Period. The Paid Claims shall be reviewed based on the supporting documentation available at JMH, the Covered Clinics, or under JMH's control or the Covered Clinics' control, and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed under Relevant Medicaid Authority.

i. If the Error Rate (as defined in Appendix A) for each of the two Discovery Samples set forth above is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, JHS should, as appropriate, further analyze any errors identified in the Discovery Sample. JHS recognizes that OIG or another HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority, may also analyze or

review Paid Claims included, or errors identified, in either Discovery Sample.)

ii. If either of the Discovery Samples indicates that the Error Rate is 5% or greater, the IRO, or IAD, as applicable, shall perform a Full Sample and a Systems Review for that facility, as described below.

c. Full Sample. If necessary, as determined by procedures set forth in Section III.D.2.b, the IRO or IAD, as applicable, shall perform an additional sample of Paid Claims, using commonly accepted sampling methods and in accordance with Appendix A. The Full Sample shall be designed to: (i) estimate the actual Overpayment (as defined in Appendix A) in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate; and (ii) conform with the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Paid Claims shall be reviewed based on supporting documentation available at JMH, the Covered Clinics, or under JMH's or the Covered Clinics' control, and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed under Relevant Medicaid Authority. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, JHS may use the Items sampled as part of the Discovery Sample, and the corresponding findings for those 50 Items, as part of its Full Sample, if statistically appropriate. OIG, in its full discretion, may refer the findings of the Full Sample (and any related workpapers) received from JHS to the Florida's Agency for Health Care Administration for appropriate follow-up.

d. Systems Review. If either of the Discovery Samples identifies an Error Rate of 5% or greater, JHS's IRO or IAD, as applicable, shall also conduct a Systems Review for that facility. Specifically, for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO or IAD, as applicable, shall perform a "walk through" of the system(s) and process(es) that generated the

claim to identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO or IAD, as applicable, shall provide its observations and recommendations on suggested improvements to the system(s) and process(es) that generated the claim.

e. Repayment of Identified Overpayments. In accordance with Section III.H.1, JHS shall repay any Overpayment(s) identified in any Outpatient Revenue Code Evaluation, Discovery Sample, or Full Sample, regardless of the Error Rate, to the appropriate payer and in accordance with payor refund policies. JHS shall make available to OIG any and all documentation that reflects the refund of the Overpayment(s) to the payer.

3. *Claims Review Report.* The IRO or IAD, as applicable, shall prepare a report based upon the Claims Review performed (the "Claims Review Report"). Information to be included in the Claims Review Report is detailed in Appendix A.

4. *Unallowable Cost Review.* The IRO shall conduct a review of JHS's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether JHS has complied with its obligations not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from the United States, or any State Medicaid program. This unallowable cost analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by JHS or any of its subsidiaries. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

5. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed. The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Costs Review and whether JHS has complied with its obligation not to charge to, or

otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from such payor.

6. *Validation Review.* In the event OIG has reason to believe that: (a) JHS's Claims Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or IAD's findings, as applicable, or the Claims Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review results are inaccurate ("Validation Review"). JHS shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents so long as it is initiated within one year after JHS's final submission (as described in Section II.B) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify JHS of its intent to perform such a review and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, JHS may request a meeting with OIG to discuss the results of any Claims Review or Unallowable Cost Review submissions or findings; present any additional or relevant information to clarify the results of the Claims Review or Unallowable Cost Review or to correct the inaccuracy of the Claims Review; or propose alternatives to the proposed Validation Review. JHS shall provide any additional information as may be requested by OIG under this Section in an expedited manner. OIG will attempt in good faith to resolve any Claims Review or Unallowable Cost Review with JHS prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

7. *Independence/Objectivity Certification.* The IRO shall include in its report(s) to JHS a certification or sworn affidavit that it has evaluated its professional independence and/or objectivity, as appropriate to the nature of the engagement, with regard to the Claims Review or Unallowable Cost Review and that it has concluded that it is, in fact, independent and/or objective.

8. *Internal Claims Review Option.*

a. Subject to approval from OIG and subject to the conditions set forth below, after the IRO has completed the Claims Review for the first three Reporting Periods, JHS may, at its option, conduct the

Claims Review in lieu of engaging an IRO to perform such reviews for the fourth and fifth Reporting Periods. If JHS chooses to exercise the Internal Claims Review Option, and the OIG concurs, the results shall be validated by an IRO and shall comply with all of the requirements outlined herein and in Section III.D.2 above.

b. Prior to exercising the Internal Claims Review Option, JHS agrees that IAD shall: (i) develop and adopt a written formal audit workplan for JHS consistent with the terms of the CIA and in conjunction with the IRO; (ii) devote sufficient resources and staff to enable it to implement the audit workplan; and (iii) assign persons to the Claims Review who are qualified and experienced in accepted auditing and control processes, and who possess expertise in billing, coding, and Medicaid program requirements. In addition, JHS agrees that the persons assigned to implement the Claims Review shall not include persons who were involved in the submission of bills or claims to the Medicaid program during the period to be audited and shall not include persons who are presently involved in such submissions.

c. Consistent with the requirements of Section III.D.2, the Claims Review shall include two Discovery Samples, as applicable, one or two Full Samples and one or two Systems Reviews, and an Outpatient Revenue Code Evaluation. A Claims Review Report shall be prepared for each Claims Review in accordance with Section III.D.3. The Claims Review Report shall also include a certification from an IRO that verifies that the requirements of Section III.D.2 have been satisfied. As part of any such verification performed by an IRO under this CIA, the IRO shall review at least 10% of the claims for each Claims Review reviewed by IAD in each year. If, in its sole discretion, OIG determines that the Claims Review performed for the fourth Reporting Period satisfactorily establishes the adequacy of JHS's billing and compliance practices pursuant to this CIA during the Reporting Period, OIG will allow JHS to conduct the Claims Review (with verification from the IRO) in lieu of the IRO conducting the Claims Review for the fifth Reporting Period.

d. In the event that OIG determines, in its sole discretion, that JHS is unable to satisfactorily implement the audit workplan, devote sufficient resources or appropriate qualified staff, or properly conduct (e.g., make correct payment determinations) the Claims Review, JHS agrees to engage an IRO to complete all remaining Claims Review requirements under this CIA. To the extent that OIG permits JHS to perform one or more Claims Reviews, JHS shall submit all information required in Section III.D.2 as well as the results of the IRO's verification. If JHS decides not to exercise its Internal Claims Review Option, the requirements applicable to engagement of an IRO to perform the Claims Reviews shall remain in effect for the term of this CIA.

E. Disclosure Program.

Prior to the Effective Date, JHS established a Disclosure Program, which includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose identified issues or questions associated with JHS's policies, conduct, practices, or procedures with respect to a Federal health care program, believed by the individual to be a potential violation of criminal, civil, or administrative law. The Disclosure Program further allows individuals to disclose such issues or questions to the Chief Compliance Officer, his or her designee, or some other person who is not in the reporting individual's chain of command. At all times during the term of this CIA, JHS shall continue to maintain its existing Disclosure Program. JHS shall continue to appropriately publicize the existence of the disclosure mechanism (e.g., via facility-wide distributions to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a nonretribution, nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Chief Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Chief Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for

taking corrective action, JHS shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted.

The Chief Compliance Officer (or designee) shall continue to maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be available to OIG, upon request.

F. Ineligible Persons.

1. *Definition.* For purposes of this CIA, an "Ineligible Person" shall be an individual or entity who: (a) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

2. *Screening Requirements.* JHS shall not hire as employees, engage as a contractor, or grant staff privileges to any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, JHS shall screen all prospective employees and prospective contractors prior to engaging their services and screen physicians prior to granting staff privileges by: (a) requiring applicants to disclose whether they are Ineligible Persons; and (b) appropriately querying the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov) (these lists shall hereinafter be referred to as the "Exclusion Lists"). Nothing in this Section affects the responsibility of (or liability for) JHS to refrain from billing Federal health care programs for services of the Ineligible Person.

JHS may perform its review of the Exclusion Lists with its own resources. JHS may also choose to contract with a third party company for review of the Exclusion Lists. Either method chosen by JHS is acceptable and will satisfy its screening requirements under this CIA, provided that the requirements of this Section III.F are otherwise met. Under either method, JHS is responsible for ensuring that the reviews are appropriately performed.

3. *Review and Removal Requirement.* Within 120 days after the Effective Date, JHS shall review its list of current Covered Persons, Covered Contractors, and physicians with staff privileges against the Exclusion Lists. Thereafter, JHS shall review its list of current Covered Persons, Covered Contractors, and physicians with staff privileges against the Exclusion Lists annually. In addition, JHS shall require Covered Persons, Covered Contractors, and physicians with staff privileges to disclose immediately any debarment, exclusion, suspension, or other event that makes the Covered Person, Covered Contractor, or physician with staff privileges an Ineligible Person.

If JHS has actual notice that a Covered Person, Covered Contractor, or physician with staff privileges has become an Ineligible Person, JHS shall remove such person from responsibility for, or involvement with, JHS's business operations related to the Federal health care programs and shall remove such person from any position for which the person's compensation or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If JHS has actual notice that a Covered Person, Covered Contractor, or physician with staff privileges is charged with a criminal offense related to any Federal health care program, or is proposed for exclusion during his or her employment or contract term or during the term of the physician's medical staff privileges, JHS shall take all appropriate actions to ensure that the responsibilities of that Covered Person, Covered Contractor, or physician with staff privileges have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or the accuracy of any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings.

Within 30 days after discovery, JHS shall notify OIG, in writing, of any ongoing investigation known to JHS or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that JHS has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. JHS shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any.

H. Reporting.

1. *Overpayments*

a. Definition of Overpayments. For purposes of this CIA, an "Overpayment" shall mean the amount of money JHS has received in excess of the amount due and payable under any Federal health care program requirements.

b. Reporting of Overpayments. If, at any time, JHS identifies or learns of any Overpayment, JHS shall notify the payor (e.g., Medicare fiscal intermediary or carrier) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. Also, within 30 days after identification of the Overpayment, JHS shall repay the Overpayment to the appropriate payor to the extent such Overpayment has been quantified. If not yet quantified, within 30 days after identification, JHS shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies, and for Medicare contractors, shall include the information contained on the Overpayment Refund Form, provided as Appendix B to this CIA. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. *Material Deficiencies.*

a. Definition of Material Deficiency. For purposes of this CIA, a "Material Deficiency" means anything that involves:

i. a substantial Overpayment;

ii. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; or

A Material Deficiency may be the result of an isolated event or a series of occurrences.

b. Reporting of Material Deficiencies. If JHS determines through any means that there is a Material Deficiency, JHS shall notify OIG, in writing, within 30 days after making the determination that the Material Deficiency exists. The report to OIG shall include the following information:

i. If the Material Deficiency results in an Overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section III.H.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the Overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) by which the Overpayment was repaid/refunded;

ii. a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

iii. a description of JHS's actions taken to correct the Material Deficiency; and

iv. any further steps JHS plans to take to address the Material Deficiency and prevent it from recurring.

IV. NEW BUSINESS UNITS OR LOCATIONS

In the event that, after the Effective Date, JHS changes locations or sells, closes, purchases, or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, JHS shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change of location, sale, closure, purchase, or establishment. This notification shall include the address of the new business unit or location, phone number, fax number, Medicare or Medicaid provider number (if any), and the corresponding contractor's name and address that has issued each Medicare or Medicaid provider number. All Covered Persons at each such business unit or location shall be subject to the applicable requirements in this CIA (e.g., completing certifications and undergoing training).

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 150 days after the Effective Date, JHS shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (the "Implementation Report"). This Implementation Report shall include:

1. the names and positions of the members of the Executive Compliance Committee referenced in Section III.A;

2. a revised summary of the Policies and Procedures required by Section III.B.2;

3. to the extent not already provided to the OIG, a copy of all training materials used for the training required by Section III.C, a description of such training, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;

4. a certification by the Compliance Officer that:

    a. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been

distributed to all appropriate Covered Persons and Covered Contractors;

b. all Covered Persons and Covered Contractors have completed the Code of Conduct certification required by Section III.B.1; and

c. all Covered Persons and Covered Contractors have completed the applicable training and executed the certification(s) required by Section III.C.

The documentation supporting this certification shall be available to OIG, upon request.

5. the identity of the IRO(s), a summary/description of all engagements between JHS and the IRO, including, but not limited to, any outside financial audits or reimbursement consulting, and the proposed start and completion dates of the Claims Review, Unallowable Cost Review, or Systems Review, if applicable;

6. a certification from the IRO regarding its professional independence and/or objectivity from JHS;

7. a summary of personnel actions (other than hiring) taken with regard to Ineligible Persons pursuant to Section III.F.;

8. a list of all of JHS's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare and Medicaid provider identification number(s), and the name and address of the Medicare and Medicaid contractor to which JHS currently submits claims; and

9. the certification required by Section V.C.

B. Annual Reports. JHS shall submit to OIG Annual Reports with respect to the status of, and findings regarding, JHS's compliance activities for each of the five Reporting Periods. Each Annual Report shall include:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Chief Compliance Officer and any change in the membership of the Executive Compliance Committee or the Compliance Task Force for the Covered Clinics described in Section III.A;

2. a certification by the Compliance Officer that:

   a. all Covered Persons and Covered Contractors have completed any Code of Conduct certifications as required by Section III.B.1;

   b. all Covered Persons and Covered Contractors have completed the applicable training and executed the certification(s) required by Section III.C; and

   c. JHS has complied with its obligations under the Settlement Agreement: (i) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (ii) not to charge to or otherwise seek payment from Federal or State payors for unallowable costs (as defined in the Settlement Agreement); and (iii) to identify and adjust any past charges or claims for unallowable costs.

   The documentation supporting this certification shall be available to OIG, upon request.

3. a summary of any significant changes or amendments to JHS's Policies and Procedures required by Section III.B.2 and the reasons for such changes (e.g., change in contractor policy). Copies of Policies and Procedures identified in Section III.B.2 shall be made available to the OIG upon request;

4. a description of all training initiatives required by Section III.C (to the extent it has not already been provided as part of the Implementation Report), a description of such training conducted during the Reporting Period, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;

5. a complete copy of all reports prepared pursuant to the IRO's or IAD's, as applicable, Claims Review, Unallowable Cost Review, and Systems Review, including a copy of the methodology used, along with a copy of the IRO's engagement letter;

6. JHS's response and corrective action plan(s) related to any issues raised by the IRO(s) or IAD, as applicable;

7. a revised summary/description of all engagements between JHS and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, only to the extent that it differs from what was submitted as part of the Implementation Report or, if there are no such differences, a statement to that effect;

8. a certification from the IRO regarding its professional independence and/or objectivity from JHS;

9. a summary of Material Deficiencies (as defined in Section III.H) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

10. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted

pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

11. a summary of the disclosures in the disclosure log required by Section III.E that: (a) relate to Federal health care programs; or (b) allege abuse or neglect of patients;

12. a description of any personnel actions (other than hiring) taken during the Reporting Period by JHS as a result of the obligations in Section III.F, and the name, title, and responsibilities of any person who is determined to be an Ineligible Person under Section III.F., and the actions taken in response to the obligations set forth in that Section;

13. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

14. a description of all changes to the most recently provided list (as updated) of JHS's locations (including addresses) as required by Section V.A.11, the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare and Medicaid provider identification number(s), and the contractor name and address that issued each Medicare and Medicaid provider number; and

15. the certification required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include a certification by the Compliance Officer that: (1) to the best of his or her knowledge, except as otherwise described in the applicable report, JHS is in compliance with all of the requirements of this CIA; and (2) the Compliance Officer has reviewed the Report

and has made reasonable inquiry regarding its content and believes that the information is accurate and truthful.

D. Designation of Information. JHS shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552. JHS shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise agreed by the OIG and JHS in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: (202) 619-2078
Facsimile: (202) 205-0604

Jackson Health System:

Juan Reyes, ARM, LHCRM, ABQUARP
Jackson Memorial Hospital
1500 N.W. 12th Avenue, Suite 1112
Miami, FL 33136
Telephone: (305) 585-5986
Facsimile: (305) 585-6600

With a Courtesy Copy to:

Sara Kay Wheeler, Esquire
Powell Goldstein Frazer & Murphy LLP
191 Peachtree Street, NE
Sixteenth Floor
Atlanta, GA 30303
Telephone: (404) 572-6905
Facsimile: (404) 572-6999

However, for purposes of this notice requirement, submission of notice to JHS at the JHS address listed above shall be sufficient. Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of JHS's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of JHS's locations for the purpose of verifying and evaluating: (a) JHS's compliance with the terms of this CIA; and (b) JHS's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by JHS to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of JHS's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. JHS shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. JHS's employees may elect to be interviewed with or without a representative of JHS present.

VIII. DOCUMENT AND RECORD RETENTION

JHS shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years from the Effective Date (or longer if otherwise required by law).

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify JHS prior to any release by OIG of information submitted by JHS pursuant to its obligations under this CIA and identified upon submission by JHS as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, JHS shall have the rights set forth at 45 C.F.R. § 5.65(d). Nothing in this CIA, or any communication or report made pursuant to this CIA, shall constitute a waiver of, or be construed to require JHS to waive, JHS's attorney-client, work product, or other applicable privileges. Notwithstanding that fact, the existence of any such privilege does not affect JHS's obligation to comply with the provisions of this CIA, e.g., by providing all documents necessary to determine whether JHS is in compliance with the terms of the CIA.

X. BREACH AND DEFAULT PROVISIONS

JHS is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, JHS and OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day JHS fails to have in place any of the obligations described in Section III:

a. a Chief Compliance Officer;

b. an Executive Compliance Committee;

c. a written Code of Conduct;

d. written Policies and Procedures;

e. a requirement that Covered Persons be trained; and

f. a Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day JHS fails to retain an IRO, as required in Section III.D.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day JHS fails to meet any of the deadlines for the submission of the Implementation Report or the Annual Reports to OIG.

4. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day JHS employs, contracts with, or grants staff privileges to an Ineligible Person and that person: (a) has responsibility for, or involvement with, JHS's business operations related to the Federal health care programs; or (b) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this Subsection shall not be demanded for any time period during which JHS can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.F) as to the status of the person).

5. A Stipulated Penalty of $1,500 for each day JHS fails to grant access to the information or documentation as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date JHS fails to grant access.)

6. A Stipulated Penalty of $1,000 for each day JHS fails to comply fully and adequately with any obligation of this CIA. In its notice to JHS, OIG shall state the specific grounds for its determination that JHS has failed to comply fully and adequately with the CIA obligation(s) at issue and steps JHS shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after JHS receives notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1-5 of this Section.

B. Timely Written Requests for Extensions. JHS may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any

notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after JHS fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after JHS receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that JHS has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify JHS of: (a) JHS's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, JHS shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event JHS elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until JHS cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by certified or cashier's check, payable to: "Secretary of the Department of Health and Human Services," and submitted to OIG at the address set forth in Section VI.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that JHS has materially breached this CIA,

which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA.

1. *Definition of Material Breach.* A material breach of this CIA means:

a. a failure by JHS to report a Material Deficiency, take corrective action, and make the appropriate refunds, as required in Section III.H;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or

d. a failure to retain and use an IRO in accordance with Section III.D.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by JHS constitutes an independent basis for JHS's exclusion from participation in the Federal health care programs. Upon a determination by OIG that JHS has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify JHS of: (a) JHS's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude").

3. *Opportunity to Cure.* JHS shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. JHS is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) JHS has begun to take action to cure the material breach; (ii) JHS is pursuing such action with due diligence; and (iii) JHS has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30-day period, JHS fails to satisfy the requirements of Section X.D.3, OIG may exclude JHS from participation in the Federal health care programs. OIG shall notify JHS in writing of its determination to exclude JHS (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. If, at the end of the period of exclusion, JHS wishes to apply for reinstatement, JHS shall submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to JHS of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, JHS shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether JHS was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. JHS shall have the burden of

proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders JHS to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless JHS requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether JHS was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) JHS had begun to take action to cure the material breach within that period; (ii) JHS has pursued and is pursuing such action with due diligence; and (iii) JHS provided to OIG within that period a reasonable timetable for curing the material breach and JHS has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for JHS, only after a DAB decision in favor of OIG. JHS's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude JHS upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that JHS may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. JHS shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of JHS, JHS shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, JHS and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of JHS;

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

D. OIG may agree to a suspension of JHS's obligations under the CIA in the event of JHS's voluntary cessation of participation in Federal health care programs. If JHS withdraws from participation in Federal health care programs and is relieved of its CIA obligations by OIG, JHS shall notify OIG at least 30 days in advance of JHS's intent to reapply as a participating provider or supplier with the Federal health care programs. Upon receipt of such notification, OIG shall evaluate whether the CIA should be reactivated or modified; and

E. The undersigned JHS signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

ON BEHALF OF
THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY, FLORIDA
D/B/A
JACKSON HEALTH SYSTEM

IRA C. CLARK
President and CEO

5/24/03
DATE

LAURIE NUELL
Secretary

5/27/03
DATE

EUGENE SHY, JR.
Assistant County Attorney
Miami-Dade County, Florida

5/21/03
DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Larry J. Goldberg
LARRY J. GOLDBERG
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

May 29, 2003
DATE

APPENDIX A

A. Claims Review.

1. *Definitions.* For the purposes of all parts of the Claims Review, including the Outpatient Revenue Code Evaluation, the Discovery Sample, the Full Sample and the Systems Review, as applicable, the following definitions shall be used:

a. Overpayment: The amount of money JHS has received in excess of the amount due and payable under Florida Medicaid laws, regulations and policies (hereinafter "Relevant Medicaid Authority").

b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).

c. Paid Claim: A code or line item submitted by or on behalf of JHS and for which JHS has received reimbursement from the Medicaid Program for outpatient services provided at any of the Covered Clinics.

d. Population: All Items for which JHS has submitted a code or line item and for which JHS has received reimbursement from the Medicaid Program for outpatient services provided at any of the Covered Clinics (i.e., a Paid Claims) during the 12-month period covered by the Claims Review. To be included in the Population, an Item must have resulted in at least one Paid Claim.

e. Error Rate: The Error Rate for each Discovery Sample or Full Sample (as applicable) shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of each Discovery Sample or Full Sample (as applicable) shall be included as part of the net Overpayment calculation.)

The Error Rate for each Discovery Sample or Full Sample (as applicable) is calculated by dividing the net Overpayment identified in the sample by the

total dollar amount associated with the Items in the sample. If JHS has elected to perform the Claims Review internally with verification by the IRO, the following payment errors shall be included when calculating the Error Rate: (i) all payment errors identified by IAD and not verified by the IRO; (ii) all payment errors identified by the IRO and not identified by IAD; and (iii) all payment errors identified by IAD and verified by the IRO.

2. *Other Requirements.*

a. Paid Claims Without Supporting Documentation. For the purpose of appraising Items included in the Claims Review, any Paid Claim for which JHS cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by JHS for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

b. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate more than one list of random samples and then select one for use with either Discovery Sample or Full Sample.

B. Claims Review Report. The following information shall be included in each Claims Review Report for the Outpatient Revenue Code Evaluation, each Discovery Sample, and each Full Sample (if applicable).

1. *Claims Review Methodology.*

a. Sampling Unit. A description of the Item as that term is utilized for the Claims Review.

b. Claims Review Population. A description of the Population subject to the Claims Review, including the Outpatient Revenue Code Evaluation.

c. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review, including the Outpatient Revenue Code Evaluation.

d. Sampling Frame. A description of the sampling frame, which is the totality of Items from which each Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Source of Data. A description of the documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, claims, remittance advice and Relevant Medicaid Authority).

f. Review Protocol. A narrative description of how the Claims Review, including the Outpatient Revenue Code Evaluation, was conducted and what was evaluated.

2. *Statistical Sampling Documentation.*

a. The number of Items appraised in each Discovery Sample and, if applicable, in the Full Sample.

b. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

c. A copy of the statistical software printout(s) estimating how many Items are to be included in the Full Sample, if applicable.

d. A description or identification of the statistical sampling software package used to conduct the sampling.

3. *Claims Review Findings.*

a. Narrative Results.

i. A description of JHS' billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

ii. A narrative explanation of the IRO's or IAD's, as applicable, findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Outpatient Revenue Code Evaluation, each Discovery Sample, and the results of each Full Sample (if any) with the gross Overpayment amount, the net Overpayment amount, and the corresponding Error Rate(s) related to the net Overpayment.

b. Quantitative Results.

i. Total number and percentage of instances in which the IRO or IAD, as applicable, determined that the Paid Claims submitted by JHS ("Claim Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.

ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to JHS.

iii. Total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.

iv. Error Rate in the sample.

v. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as

determined by the IRO or IAD, as applicable), correct allowed amount (as determined by the IRO or IAD, as applicable), and dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix.)

4. *Systems Review.* Observations, findings, and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s).

5. *Credentials.* The names and credentials of the individuals who: (a) designed the statistical sampling procedures and the review methodology utilized for the Claims Review, including the Outpatient Revenue Code Evaluation; (b) performed the Claims Review, including the Outpatient Revenue Code Evaluation; and (c) performed the verification review, if applicable.

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date:_____
Contractor Deposit Control #_____ Date of Deposit: _____
Contractor Contact Name:_____Phone #_____
Contractor Address:_____
_____
Contractor Fax:_____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIERNAME_____
____
ADDRESS_____
PROVIDER/PHYSICIAN/SUPPLIER #_____CHECK NUMBER#_____
CONTACT PERSON:_____PHONE #_____ AMOUNT OF CHECK $_____ CHECK DATE_____

REFUND INFORMATION

For each Claim, provide the following:
Patient Name_____HIC #_____
Medicare Claim Number_____Claim Amount Refunded $_____
Reason Code for Claim Adjustment:_____ (Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

*Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:*_____

For Institutional Facilities Only:
Cost Report Year(s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____ No

Reason Codes:

Billing/Clerical Error	MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service Documentation	08 - MSP Group Health Plan Insurance	13 - Insufficient
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed		17 - Other (Please Specify)
06 - Billed in Error	12 - Veterans Administration	_____
07 - Corrected CPT Code		

Attachment 1

Claim Review Results

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code (IRO determined)	Correct Allowed Amt Reimbursed (IRO determined)	Dollar Difference between Amt Reimbursed and Correct Allowed Amt