CERTIFICATION OF COMPLIANCE AGREEMENT BETWEEN THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE HARRIS COUNTY HOSPITAL DISTRICT

I. PREAMBLE

The Harris County Hospital District (HCHD) hereby enters into this Certification of Compliance Agreement (CCA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS). Contemporaneously with this CCA, HCHD is entering into a Settlement Agreement with the United States.

The effective date of this CCA shall be the date on which the final signatory of this CCA executes this CCA (Effective Date). Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

II. INTEGRITY REQUIREMENTS

HCHD shall, for a period of three years from the Effective Date of this CCA:

A. Continued Implementation of Compliance Program. HCHD shall continue to implement its Compliance Program, as described in the attached Declaration (which is incorporated by reference as Appendix A), and continue to provide and make available to the Compliance Program, at a minimum, the same aggregate level of resources currently provided, throughout this time period. HCHD may amend its Compliance Program and support functions as it deems necessary, so long as those amendments are consistent with the overall objective of ensuring compliance with the requirements of Medicare, Medicaid, and all other Federal health care programs, as defined in 42 U.S.C. § 1320a-7b(f).

B. Reporting of Overpayments. HCHD shall promptly refund to the appropriate Federal health care program payor any identified Overpayment(s). For purposes of this CCA, an "Overpayment" shall mean the amount of money HCHD has received in excess of the amount due and payable under any Federal health care program requirements. If, at any time, HCHD identifies or learns of any Overpayment, HCHD 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, HCHD 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, HCHD 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 CCA. Notwithstanding the above, notification and repayment of any Overpayment amount that is routinely reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

C. Reportable Events. HCHD shall report to OIG in writing within 30 days after making a determination (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) that there is a Reportable Event, which shall mean anything that involves: (1) a substantial Overpayment, (2) 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 (3) the filing of a bankruptcy petition by HCHD. In such report, HCHD shall include the following information:

1. If the Reportable Event results in an Overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section II.B, 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;

2. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

3. a description of HCHD's actions taken to correct the Reportable Event; and

4. any further steps HCHD plans to take to address the Reportable Event and prevent it from recurring.

5. If the Reportable Events involves the filing of a bankruptcy petition, the report to the OIG shall include documentation of the filing and a description of any Federal health care program authorities implicated.

D. Notification of Government Investigation or Legal Proceedings. Within 30 days after discovery, HCHD shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to HCHD conducted or brought by a governmental entity or its agents involving an allegation that HCHD 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. HCHD 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 investigation or proceedings, if any.

E. Annual Reporting Requirements. HCHD shall submit to OIG annually a report that sets forth the following information for each Reporting Period (Annual Report):

1. A description of any material amendments to its Compliance Program and the reasons for such changes;

2. Any changes to the level of resources dedicated to its Compliance Program and the reasons for such changes;

3. A summary of all internal or external reviews, audits, or analyses of its Compliance Program (including, at a minimum, the objective of the review, audit, or analysis; the protocol or methodology for the review, audit, or analysis; and the results of the review, audit, or analysis) and any corrective action plans developed in response to such reviews, audits, or analyses;

4. A summary of all internal or external reviews, audits, or analyses related to Medicare secondary payer claims (including, at a minimum, the objective

of the review, audit, or analysis; the protocol or methodology for the review, audit, or analysis; and the results of the review, audit, or analysis) and any corrective action plans developed in response to such reviews, audits, or analyses;

5. 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 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; and

6. A certification by the Compliance Officer that: (a) to the best of his or her knowledge, except as otherwise described in the Annual Report, HCHD is in compliance with the requirements of this Section II; and (b) he or she has reviewed the Annual Report and has made reasonable inquiry regarding its content and believes that the information in the Annual Report is accurate and truthful.

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.

F. Notifications and Submission of Annual Reports. Unless otherwise specified in writing after the Effective Date, all notifications and Annual Reports required under this CCA shall be submitted to the following addresses:

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, DC 20201
Telephone: 202-619-2078
Facsimile: 202-205-0604

HCHD: Walter E. Freitag, Jr.
Vice President Corporate Compliance
Harris County Hospital District
2525 Holly Hall Street
Houston, Texas 77054
Telephone: 713-566-6461
Facsimile: 713-566-6543

With a copy to:

Mercedes Leal
Harris County Attorney's Office
Harris County Hospital District
2525 Holly Hall, Suite 190
Houston, Texas 77054
Telephone: 713-566-6550
Facsimile: 713-566-6558

Unless otherwise specified, all notifications and reports required by this CCA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such report or notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

G. 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 HCHD's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of HCHD's locations for the purpose of verifying and evaluating: (a) HCHD's compliance with the terms of this CCA; and (b) HCHD's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by HCHD 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 HCHD's employees, contractors, subcontractors, 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. HCHD shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. HCHD's employees may elect to be interviewed with or

without a representative of HCHD present.

H. Document and Record Retention. HCHD shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CCA, for four years (or longer if otherwise required by law) from the Effective Date.

III. BREACH AND DEFAULT PROVISIONS

HCHD is expected to fully and timely comply with all of the Integrity Requirements set forth in this CCA.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, HCHD and OIG hereby agree that failure to comply with the Integrity Requirements set forth in this CCA 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 HCHD fails to establish and implement any of the following compliance program elements as described in Section II and the Declaration attached to this CCA as Appendix A:

a. a Compliance Officer;

b. a Compliance Committee;

c. a written Code of Conduct for Federal Health Care Programs

d. written Policies and Procedures;

e. the annual training of the Board of Managers, officers, directors, employees, and other persons who provide patient care items or services on behalf of HCHD, or who perform billing or coding functions on behalf of HCHD, and the availability of annual training for medical staff;

f. billing and coding compliance and other personnel who perform periodic reviews to monitor HCHD's compliance with Federal health care program requirements, including, but not limited to billing and coding reviews;

g. a Disclosure Program;

h. Ineligible Persons screening and removal requirements; and

i. notification of government investigations and legal proceedings.

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 HCHD fails to submit the Annual Reports to OIG in accordance with the requirements of Section II.E by the stated deadlines for submission.

3. A Stipulated Penalty of $1,500 for each day HCHD fails to grant access to the information or documentation as required in Section II.G of this CCA. (This Stipulated Penalty shall begin to accrue on the date HCHD fails to grant access.)

4. A Stipulated Penalty of $5,000 for each false certification submitted by or on behalf of HCHD as part of its Annual Reports or otherwise required by this CCA.

5. A Stipulated Penalty of $1,000 for each day HCHD fails to comply fully and adequately with any Integrity Requirements of this CCA. OIG shall provide notice to HCHD, stating the specific grounds for its determination that HCHD has failed to comply fully and adequately with the Integrity Requirement(s) at issue and steps HCHD shall take to comply with the Integrity Requirements of this CCA. (This Stipulated Penalty shall begin to accrue 10 days after HCHD 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 1-4 of this Section III.A.

B. Timely Written Requests for Extensions. HCHD 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 CCA. 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 HCHD 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 HCHD 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 HCHD has failed to comply with any of the obligations described in Section III.A and after determining that Stipulated Penalties are appropriate, OIG shall notify HCHD of: (a) HCHD's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, HCHD 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 III.E. In the event HCHD elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until HCHD 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 CCA and shall be grounds for exclusion under Section III.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 II.F.

4. *Independence from Material Breach Determination.* Except as set forth in Section III.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that HCHD has materially breached this CCA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section III.D, below.

D. Exclusion for Material Breach of this CCA.

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

a. a failure by HCHD to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section II.C;

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

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

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

3. *Opportunity to Cure.* HCHD 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. HCHD is in compliance with the requirements of the CCA 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) HCHD has begun to take action to cure the material breach; (ii) HCHD is pursuing such action with due diligence; and (iii) HCHD has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30-day period, HCHD fails to satisfy the requirements of Section III.D.3, OIG may exclude HCHD from participation in the Federal health care programs. OIG shall notify HCHD in writing of its determination to exclude HCHD (this letter shall be referred to as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section III.E, below, the exclusion shall go into effect 30 days after the date of HCHD's receipt 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. After the end of the period of exclusion, HCHD may apply for reinstatement by submitting 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 HCHD of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CCA, HCHD 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 CCA. 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 Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CCA shall be: (a) whether HCHD was in full and timely compliance with the requirements of this CCA for which OIG demands payment; and (b) the period of noncompliance. HCHD 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 CCA and orders HCHD to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless HCHD 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 Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CCA shall be:

a. whether HCHD was in material breach of this CCA;

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) HCHD had begun to take action to cure the material breach within that period; (ii) HCHD has pursued and is pursuing such action with due diligence; and (iii) HCHD provided to OIG within that period a reasonable timetable for curing the material breach and HCHD 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 HCHD, only after a DAB decision in favor of OIG. HCHD's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude HCHD 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 HCHD 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. HCHD 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 HCHD, HCHD 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 CCA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CCA.

IV. EFFECTIVE AND BINDING AGREEMENT

HCHD and OIG agree as follows:

A. This CCA shall be binding on the successors, assigns, and transferees of HCHD;

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

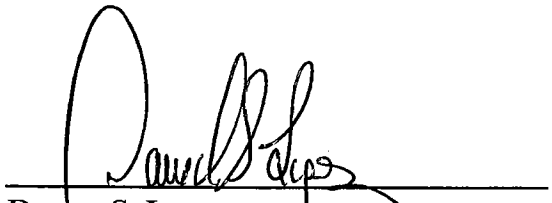
C. Any modifications to this CCA shall be made with the prior written consent of the parties to this CCA;

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

E. The undersigned HCHD signatory represents and warrants that it is authorized to execute this CCA. The undersigned OIG signatory represents that he is signing this CCA in his official capacity and that he is authorized to execute this CCA.

F. This CCA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CCA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CCA.

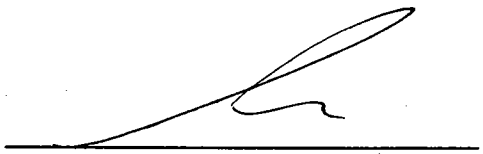
ON BEHALF OF THE HARRIS COUNTY HOSPITAL DISTRICT



DAVID S. LOPEZ
President and Chief Executive Officer
Harris County Hospital District

4/25/07
DATE

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



GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Inspector General
United States Department of Health and Human Services

4/26/07
DATE

Appendix A

DECLARATION

The declarants are currently the President and Chief Executive Officer and Vice President of Corporate Compliance for HCHD and have personal knowledge of the facts stated herein. The following describes the compliance program and practices (Program) currently in place at HCHD.

1. The annual budget for the Program is attached hereto as Exhibit 1 and HCHD shall continue to make available to the Program, at a minimum, the aggregate levels of funding and resources reflected therein for three years subsequent to the Effective Date.

2. The Program includes a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with Federal health care program requirements. The Compliance Officer also is responsible for monitoring the day-to-day compliance activities of HCHD. The Compliance Officer is a member of senior management of HCHD and is not subordinate to the General Counsel or Chief Financial Officer. The Compliance Officer, or other appropriate compliance personnel, makes periodic (at least quarterly) reports regarding compliance matters directly to the Board of Managers of HCHD and is authorized to report on such matters to the Board of Managers at any time.

3. The Program includes a Compliance Committee that is chaired by the Compliance Officer and that is made up of other members of senior management necessary to support the Compliance Officer in fulfilling his/her responsibilities under the Program (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations).

4. HCHD has in place a Code of Conduct for Federal Health Care Programs that includes: (a) HCHD's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements; (b) HCHD's requirement that all of its personnel are expected to comply with all Federal health care program requirements and with the Policies and Procedures described in Paragraph 5 below; (c) the requirement that all of HCHD's personnel are expected to report to the Compliance Officer or other appropriate individual designated by HCHD suspected violations of any Federal health care program

requirements or of HCHD's own Policies and Procedures; (d) the possible consequences to both HCHD and its personnel of failure to comply with Federal health care program requirements and with HCHD's own Policies and Procedures and the failure to report such noncompliance; and (e) the right of HCHD's personnel to use the Disclosure Program described in Paragraph 8 below and HCHD's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures. Each (i) Board of Managers Member, officer, director, and employee; (ii) contractor, subcontractor, agent, and other person who provides patient care items or services or who performs billing or coding functions on behalf of HCHD; and (iii) member of the medical staff of HCHD is required to certify in writing that he or she has received, read, understood, and will abide by the Code of Conduct for Federal Health Care Programs.[1]

5. HCHD has in place Policies and Procedures regarding the operation of the Program and HCHD's compliance with Federal health care program requirements and billing requirements regarding Medicare secondary payer. The Policies and Procedures are made available to all relevant HCHD personnel. At least annually (and more frequently, if appropriate), HCHD reviews and updates as necessary such Policies and Procedures and, if revisions are made, makes available the relevant portions of any revised Policies and Procedures to all HCHD personnel whose job functions relate to the revised Policies and Procedures.

6. HCHD has in place an annual compliance training program that requires all (i) Board of Managers Members, officers, directors, and employees to attend at least one hour of annual compliance training that addresses HCHD's Code of Conduct for Federal Health Care Programs and the operation of the Program[2]; and (ii) contractors,

---

[1] The Certification related to the Code of Conduct for Federal Health Care Programs is not required for part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year. Such individuals shall be required to make the appropriate certification at the point when they work more than 160 hours during the calendar year.

[2] The compliance training is not required for part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year. Such individuals shall be required to receive the compliance training, however, at the point when they work more than 160 hours during

subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of HCHD to certify that its personnel are required to attend at least one hour of annual compliance training that addresses compliance codes of conduct and the operation of a compliance program. In addition, HCHD will use its best efforts to encourage its entire medical staff to attend the annual compliance training described in this Paragraph 6.

HCHD's Program also requires additional hours of training for all employees, contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing, coding, or claims submission functions on behalf of HCHD. Such additional training addresses: (a) the Federal health care program requirements regarding the accurate coding and submission of claims; (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 reimbursement statutes, regulations, and program requirements and directives; (e) the legal sanctions for violations of Federal health care program requirements; (f) examples of proper and improper claims submission practices; and (g) proper procedures for processing Medicare secondary payer claims. HCHD will require its contractors and subcontractors who provide patient care items or services, or who perform billing, coding, or claims submission functions on behalf of HCHD to certify that its personnel receive additional training listed in subsections (a) through (g) above.

HCHD maintains written or electronic records that identify the type of annual training provided, the date(s) of the training, and the attendees. Persons providing the training are knowledgeable about the subject area. HCHD reviews the training content on an annual basis and, as appropriate, updates the training to reflect changes in Federal health care program requirements and/or any issues discovered during the internal audits described in Paragraph 7 below.

7. HCHD's Corporate Compliance Department includes billing and coding compliance and other personnel who perform periodic reviews to monitor HCHD's compliance with Federal health care program requirements, including focused reviews relating to specific risk areas identified by the OIG and HCHD's Compliance Committee and/or through the Program, including Medicare Secondary Payer and Medicaid Third

---

the calendar year.

Party Resource claims. HCHD has nine full-time qualified employees whose assignments include the review of HCHD's compliance with Federal health care program requirements.

8. HCHD maintains a Disclosure Program that includes a mechanism to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with HCHD'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. HCHD publicizes the existence of the disclosure mechanisms to all personnel.

The Disclosure Program emphasizes a nonretribution, nonretaliation policy and includes a reporting mechanism for anonymous communications for which appropriate confidentiality is maintained. Each disclosure is reviewed by the Compliance Officer, or appropriate compliance personnel, who either investigates the disclosure or refers the disclosure to the relevant department or manager for follow up and any appropriate corrective action.

The Compliance Officer (or designee) maintains a disclosure log, which includes a record and summary of each disclosure received (whether anonymous or not), the status of HCHD's internal review of the allegations, and any corrective action taken in response to the internal review.

9. HCHD has in place a policy and procedure for screening all prospective Board of Managers Members, officers, directors, employees, contractors, subcontractors, agents, and medical staff members to ensure that they are not Ineligible Persons[3] by: (a) requiring such persons to disclose whether they are an Ineligible Person; 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

[3] An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or (ii) 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.

of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov) (these lists shall hereinafter be referred to as the "Exclusion Lists"). HCHD also performs annual screening of its current Board of Managers Members, officers, directors, employees, contractors, subcontractors, agents, and medical staff members against the Exclusion Lists and requires all Board of Managers Members, officers, directors, employees, contractors, subcontractors, agents, and medical staff members to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

HCHD also has a policy in place that, if HCHD has actual notice that an officer, director, employee, contractor, subcontractor, agent, or medical staff member has become an Ineligible Person, HCHD will remove such person from responsibility for, or involvement with, HCHD's business operations related to the Federal health care programs and will remove such person from any position for which the person's compensation or items or services furnished, ordered, or prescribed by the person are paid in whole or in 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. (Nothing in this Declaration affects the responsibility of HCHD to refrain from billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded individuals or HCHD's liability for overpayments received by HCHD as a result of billing any Federal health care program for such items or services.).

If HCHD has actual notice that a Board of Managers Member has become an Ineligible Person, HCHD will initiate steps to remove such person from responsibility for, or involvement with, HCHD's business operations related to the Federal health care programs and will initiate steps to remove such person from any position for which the person's compensation or items or services furnished, ordered, or prescribed by the person are paid in whole or in 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.

The undersigned signatory represents and warrants that he/she is authorized to execute this declaration on behalf of HCHD.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 25th day of April 2007.

David S. Lopez
President and Chief Executive Officer
Harris County Hospital District

Walter E. Freitag, Jr.
Vice President of Corporate Compliance
Harris County Hospital District

APPENDIX B

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	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
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	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		_____
07 - Corrected CPT Code		