2022

ABH CORPORATE COMPLIANCE PLAN

and

Anti-Fraud, Abuse, and Overpayment Plan

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I. INTRODUCTION

A. The ABH Compliance Program intends to establish methods for consistent adherence to applicable laws, regulations, and requirements governing Corporate Compliance as well as for preventing, detecting, and investigating fraud, abuse, and overpayment. ABH has established a centralized mechanism via the Corporate Compliance Program, the Anti-Fraud Unit, and the Quality Management Committee, to track compliance and achieve the goal of preventing fraud and abuse. These mechanisms have created a corporate culture of strict adherence to federal, state, and local laws. To demonstrate our commitment to the highest standards of ethical conduct, to prevent and deter criminal activity, and to encourage employees to report potential problems that will allow for appropriate internal inquiry and corrective action, the following Compliance Plan has been structured to meet the guidelines as set forth by The Area for HealthCare Administration (ACHA), Contract No. FA601, Attachment IV-2, Florida Statute 409.91212, 42 CFR 438.608, and the Deficit Reduction Act.

B. The purpose of the ABH compliance plan is to create and maintain a corporate culture that:

   a. Promotes integrity and ethical behavior,
   b. Establishes formal standards that comply with increased governmental regulation, and
   c. Demonstrates the commitment of Lakeview Center, Inc. d/b/a Access Behavioral Health, to act in compliance with all legal and ethical responsibilities.

C. The ABH Compliance Plan ensures that the organization as a whole has ethics, culture, and values, which are consistent with the highest standards of business conduct, and provides uniform guidance for fraud, abuse, and overpayment activities. This plan is a broad and comprehensive strategy to ensure the following:

   a. The risk for fraud, abuse, or overpayment is eliminated and/or reduced;
   b. All employees of ABH, its contracted network providers and its employees, conduct themselves in accordance with the high standards of business and professional conduct established by ABH;
   c. Encounter data accurately reflects the documented services provided;
   d. Compliance with all general regulatory matters;
   e. Reporting of potential violations of applicable laws, rules and regulations is encouraged; and
   f. Subcontracted providers take responsibility for the actions of their employees.

D. Key Components of the ABH Corporate Compliance Plan include:

a. An oversight committee responsible for ensuring the proper implementation and continued operation of ABH policy, procedures and services;
b. An ABH Corporate Compliance Officer responsible for implementation and operation of the Plan;
c. An ABH Corporate Compliance Liaison for the network providers;
d. A strict non-retaliation/non-retribution policy;
e. Communication channels to provide employees, staff, and consumers an opportunity to report problems and concerns directly to the ABH Compliance Officer;
f. Ongoing monitoring initiatives to identify and address compliance-related matters;
g. Training and education of employees and providers that encourage the creation and maintenance of an ethical work force;
h. Appropriate reporting and disciplinary mechanisms for instances of misconduct; and
i. An ABH Designated Anti-Fraud Unit.

II. The ABH Anti-Fraud Plan

A. **Overview**: ABH has made a commitment to detecting, correcting, and preventing fraud, abuse, and overpayment. The ABH Anti-Fraud Plan is part of the ABH Compliance Plan, but narrower in scope to address specifically how ABH prevents, detects, investigates, reports, and holds accountable providers and staff with regard to fraud, abuse, and overpayment. This Anti-Fraud Plan is in compliance with contractual obligations as well as Florida Statute 409.91212.

ABH has established procedures that ensure employees and providers at every level will receive training about federal and state laws to detect and prevent overpayment, fraud, and abuse related to the provision of Medicaid services. A report of suspected fraud, abuse, or overpayment can come from any source, including anonymous tips to the hotline, staff, clients, or providers. All reports are held in strictest confidence. All reports or concerns regarding fraud, abuse, or overpayment, no matter the source, are taken seriously and investigated and reported as outlined in this plan. Alleged violations are reported to the ABH Director of Quality Management and Improvement either directly or through a well publicized toll-free hotline. Potential instances of fraud, abuse, or overpayment may also be detected by ABH using one of the methods outlined in this plan.

In all cases, the ABH Director of Quality Management and Improvement ensures that a timely and effective investigation is completed by reporting the suspicion or detection of Fraud, Waste, or Abuse to the appropriate Health Plan. Results of the investigation, when available, are reported to the ABH Quality Management Committee and other state agencies as required by law.

The network providers and their employees are required to fully participate in any investigation instigated by ABH or the Health Plans.

All records related to compliance are kept for ten (10) years.

B. The Anti-Fraud unit is comprised of the ABH Director, the Director of Quality Management and Improvement, the Accreditation and Quality Improvement Manager, the Quality Specialist, and the Reporting and Data Analysis Manager. The QMC provides oversight of this unit.

C. Non-Retaliation Policy

ABH has a strict non-retaliation policy. This means that no action of retaliation will be taken against anyone voicing an inquiry or complaint. ABH has a confidential and anonymous reporting mechanism to enable employees/providers and Medicaid recipients to disclose any practice they believe to be inappropriate, in violation of ABH policies, or in violation of state or federal laws, rules or

regulations. Concerns about possible retaliation or harassment are to be reported to the ABH Director of Quality Management and Improvement or through the reporting hotline. The ABH Director of Quality Management and Improvement is responsible for following up on allegations of retaliation. Disciplinary action may result if it is determined that retaliation did occur.

Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need to assist with the prosecution of these cases.

D. Applicable Statutes and Regulations

ABH adheres to all applicable statutes and regulations regarding fraud, abuse, and overpayment and incorporates these statutes and regulations into this plan.

Role of False Claims Laws: The laws described in this plan create a comprehensive scheme for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations.

Florida False Claims Act 68.082 F.S. was created to serve as a deterrent to persons who might consider submitting a false claim to the state government.

Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)
The Federal False Claims Act (FCA) imposes civil liability on any person or entity who, in order to receive payments from Medicare, Medicaid or other federally funded health care programs, knowingly 1) files a false or fraudulent claim; 2) uses a false record or statement to obtain payment on a false or fraudulent claim; or 3) conspires to defraud Medicare, Medicaid or other federally funded health care program. “Knowingly” means 1) actual knowledge that the information on the claim is false; 2) acting in deliberate ignorance of whether the claim is true or false; or 3) acting in reckless disregard of whether the claim is true or false. Knowingly requires no proof of specific intent to defraud. A person or entity found liable under the Federal False Claims Act is subject to a civil monetary penalties plus damages. Anyone may bring a qui tam action under the Federal False Claims Act in the name of the United States in federal court. If the government proceeds with the case, the person who filed the action will receive between 15 percent and 25 percent of any recovery if he or she was not involved with the wrongdoing, If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own and if successful, is entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys’ fees and costs. Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their

employer. Substantive and procedural amendments to the FCA were enacted in 2009 and 2010 in the Fraud Enforcement and Recovery Act of 2009 (“FERA”), the Patient Protection and Affordable Care Act (“PPACA”), and the Dodd-Frank Wall Street Reform and Consumer Protection Act (“Dodd-Frank”). All of these amendments will make it easier for the government and qui tam relators to conduct investigations and obtain recoveries under the FCA in the future.

Federal Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 – 3812) The Program Fraud and Civil Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act. PFCRA imposes liability on people or entities who file a claim that they know or have reason to know: 1) is false, fictitious, or fraudulent; includes or is supported by any written statement that contains false, fictitious, or fraudulent information; 2) includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or 3) is for payment for property or services not provided as claimed. A violation of this section of the PFCRA is punishable by a $5,500 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

Patient Protection and Affordable Care Act (PPACA: PL 111-148 – MARCH 2010). The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010. The PPACA links the retention of program overpayments to potential liability under the False Claims Act. Failure to report and repay any overpayment within the timeframe may result in a violation of the False Claims Act, civil monetary penalty, or other penalties. Unpaid overpayments are also grounds for program exclusion. Furthermore, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan or Medicare. In addition, a claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act.

E. ABH Anti-Fraud Unit Administration and Governance

The Director of Quality Management and Improvement serves as the ABH Corporate Compliance Officer and as the liaison with the network providers under the direction of the Director of ABH. The Compliance Officer has unrestricted access to ABH’s governing body and to the Health Plans for reporting purposes related to fraud, abuse, and overpayment.

The Director of Access Behavioral Health oversees submission of all Fraud and Abuse Activity Reports to the Health Plans and serves as a member of the Governance Oversight Committee, the Quality Management Committee.

F. Direct Access to Organizational Leadership

The Corporate Compliance Officer has direct access, when necessary, to the Director of Access Behavioral Health, the CEO of Lakeview Center, Inc., and the Board of Directors of Baptist Hospital for the purposes of reporting on instances of fraud, abuse, and overpayment.

G. **Contact Information for the ABH Anti-Fraud Program Administration**:

Corinne Whitlock, Corporate Compliance Officer
corinne.whitlock@bhcpns.org
Phone: 850.432.1222
Fax: 850.469.3661

Brent Patton, PMP, Director of Access Behavioral Health
Brent.patton@bhcpns.org
Phone: 850.432.1222
Fax: 850.469.3661

H. Governance and Oversight

The ABH Quality Management Committee serves as the oversight body that governs operations of the ABH Corporate Compliance and Anti-Fraud Plans. This committee meets quarterly and reviews all Corporate Compliance issues and all fraud, abuse, and overpayment detection and investigative activities of the ABH Anti-Fraud Unit. A report of activities is generated quarterly and forwarded to the Health Plans.

III. Anti-Fraud Procedures

The following procedures describe ABH's methods for Prevention and Training, Detection, Investigation, Reporting and Implementation of Corrective Actions regarding cases of potential fraud, abuse, or overpayment.

A. Definitions

1. **Overpayment:** Overpayment is defined per s. 409.913, F.S., as including any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.
2. **Abuse:** Abuse is defined as per s. 409.913, F.S., as provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professional recognized standards for health care. In addition, it includes enrollee practices that result in unnecessary costs to the Medicaid program.
3. **Fraud:** Fraud is defined as per s. 409.913, F.S., as an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.
4. **Anti-Fraud Unit/Special Investigations Unit:** Identified staff responsible for the investigation and reporting of possible overpayment, abuse, or fraud through detection, identification, and determent of fraud, abuse, and overpayment.
5. **Suspicion:** Information received by any means that warrants further investigation.

B. Prevention and Training

Prevention and training are the first steps in combatting fraud, abuse, or overpayment. ABH approaches prevention with established standards of conduct, credentialing processes, monitoring activities, and provider training. This training includes elements of the Deficit Reduction Act which requires states to establish whistleblower protections for employees reporting possible fraud, waste or abuse as well as establishment of policies.

Contracted Network providers are required to undergo training on Compliance and Anti-Fraud plan as part of the contract requirements. Each network provider must agree to abide by the ABH Compliance Plan, and must agree to conduct initial and ongoing training of all employees on corporate compliance policies. Training of staff includes employee guidelines to govern workplace conduct and activities. The ABH toll-free number to report a violation of policy must be made available to all network provider staff.

ABH network providers, as part of the contracting and credentialing process, agree to either provide training to their staff on corporate compliance or to have their staff trained by ABH on compliance standards. Training must be provided on the duties related to corporate compliance and on pertinent state and federal laws related to corporate compliance. ABH monitors for such training and requires documentation that said training has occurred.

While supervisory staff are responsible for ensuring no employee suffers retaliation for reporting problems or concern, however, reporting does not provide protection from disciplinary action. The disciplinary process is carefully documented at every step. A file is opened for each alleged violation containing a review of the allegation, a description of the investigation and the results thereof, including the response of the accused provider, the conclusion reached and disciplinary measures imposed (if any) (See Disciplinary Action)

When Training is conducted:

1. Within 30 days of new hire: ABH provides information to organizational and contracted providers regarding fraud and abuse. Providers must give the training to new hires within 30 days of start date and provide signature sheets to ABH.
2. Annually: ABH annually conducts a fraud and abuse training for all contracted providers.

C. Detection

Detection of potential fraud, abuse, or overpayment can be flagged through routine methods described below or through receipt of any information from any source that raises suspicion. The ABH Anti-Fraud Unit is responsible for investigating all detected or suspected indicators of fraud, abuse, or overpayment.

The following methods are used to review providers' corporate compliance protocols and to detect potential instances of fraud, abuse, or overpayment:

1. **Routine Monitoring**: Frequency of routine monitoring is based on annual Risk Assessments completed by the ABH Corporate Compliance officer. During these monitorings, which may be on-site, desktop, or a combination thereof, clinical records are reviewed according to the Agency for Healthcare Administration's *Community Behavioral Health Services Coverage and Limitations Handbook*.

   Monitorings also review administrative and clinical operations to ensure that operations are conducted to ABH standards. Reviews include consumer interviews. Consumers are interviewed about the type and frequency of

services they receive and this is compared to the documentation in the medical record and to claims data.

Focused monitoring in form of one-case reviews or special circumstances reviews may be conducted on an as-needed basis, or as the result of quality initiative projects. ABH reserves the right to monitor the providers of ABH services at any time.

ABH also reviews clinical documentation of clients who presented at the provider location but were not admitted to services to ensure that consumers are not being turned away from needed treatment.

2. **Outlier Reports:** The ABH Anti-Fraud Unit and the ABH Care Management Department review internal reports that detect high-use and over-use of units by each provider; ABH also looks at under- utilization patterns as a possible indicator of the need for further investigation. ABH uses statistical methods to detect deviations from the utilization targets to determine if an investigation is warranted.

3. **Retrospective Review of Paid Claims:** This review consists of a clinical records review, typically desktop, by the ABH Anti-Fraud unit of claims paid by ABH that may be in excess of ACHA's liability. Documentation is reviewed to determine if, among other requirements, there is clinical justification for the level of care and services provided, length of stay is appropriate to diagnosis and treatment needs, if the documentation meets ACHA requirements, and if service documentation matches utilization data. Submitted claims and encounter data are compared to the services documented in the consumer record to ensure that they are congruent. This type of review will result in a request for payback if paid claims are found that are not consistent with required documentation, do not match claims or encounter data, or do not clinically justify the level of care, service rendered, or length of stay in treatment.

4. **Internal or External Reports of Suspicion:** Any information received from any source by ABH that warrants further investigation will trigger a review.

5. **Excessive or Duplicate Claims Review**: ABH has initiated safe guards so that providers may only file claims for services for which they are contracted. There is a claims review process to ensure that submitted claims meet providers' the contractual requirements. Providers who submit excessive duplicate claims will be reviewed to ensure that there is no fraud or abuse. Specifically ABH has claims editing process to deny claims for duplicate services, ineligible members, diagnoses that are not covered by the plan, services not approved for providers, and improper coding.

Examples of potential false claims include, but are not limited to, the following:

1. Claiming reimbursement for services that have not been rendered;
2. Characterizing the service differently than the service actually rendered;
3. Falsely indicating that a particular health care professional attended a procedure;
4. Billing for services/items that are not medically necessary;
5. Forging or altering a prescription or claim; and
6. Improperly obtaining prescriptions for controlled substances or card sharing.

The Plan's Employees and Contractors who prepare, process and/or review claims are trained on how to be alert for false claims or billing errors.

6. **Complaints**: Consumer and provider complaints are used to determine indicators of fraud and abuse at the plan or provider level.

D. Investigation

The ABH Anti-Fraud unit conducts investigations on allegations of fraud, abuse, or the overpayment at the direction of the Health Plan.

E. Disciplinary Actions

Upon completion of the investigation, if the allegations of fraud, abuse, or overpayment are determined to be founded in any way, the ABH Corporate Compliance Officer and the ABH Director of Managed Care jointly determine what action(s) should be taken. The nature and severity of the disciplinary action varies depending on the facts and circumstances of the event. Disciplinary actions include but are not limited to:

- Corrective Action Plan
- Increased monitoring activity and oversight
- Focused monitoring activities
- Required independent financial review
- Financial restitution
- Reduction of contracted services
- Termination of contract
- Legal action

The results of all investigations are reported to the Health Plan(s).

Providers who are terminated for fraud/waste/abuse are not eligible to be reinstated as an ABH provider. Terminations are reported immediately to the Health Plan(s).

F. Reporting

ABH will report all suspected or confirmed instances of internal and external fraud, waste, or abuse related to the provision of, and payment for, Medicaid services through the following process, as specified in s. 409.91212, F.S.:

1. Within five (5) days of the date of detection of suspected or confirmed fraud, ABH shall provide advanced notice to the appropriate Health Plan, of the details of the investigative subject (provider), potential fraud scheme, and estimated exposed amount in a manner and format specified by the MPI;
2. Within ten (10) days of submission of the advanced notice to the Health Plan, ABH shall submit a supplemental referral attachment to the Health Plan in a format specified by the MPI;
3. The Health Plans shall refer incidents of suspected/confirmed fraud to MFCU within ten (10) calendar days following submission of the suspected/confirmed fraud report to MPI.

The online report can be found at: https://apps.ahca.myflorida.com/mpi-complaintform/ and shall contain at the minimum:
For members:

1. Name of the member
2. Medicaid ID number (if applicable)
3. A description of the suspected fraudulent act
4. A narrative report of the suspected fraudulent act

For providers:

1. Name of the provider
2. Provider Medicaid ID
3. Provider Tax ID number
4. A description of the suspected fraudulent act
5. A narrative report of the suspected fraudulent act

For employees:

1. Name of the employee
2. Employee ID Number
3. A description of the suspected fraudulent act
4. A narrative report of the suspected fraudulent act

Additional information to be included if known:

1. Source of complaint
2. Business Name and address
3. NPI Number
4. Type of provider
5. Nature of complaint
6. Approximate dollars involved (if known)
7. Legal and administrative disposition of the case
8. Resolution

G. Confidential/Anonymous Reporting

Confidential reporting of alleged violations may be made directly to the ABH Director of Quality Management and Improvement. A reporting employee's name or member's name and other identifying information will be held in confidence and not included in the documentation available to the network provider. If the individual chooses not to reveal their name, an anonymous report will be taken. No effort will be made to find out any identifying information about an anonymous reporter.

H. Contracting for Services

ABH will not employ or engage, with or without pay, an individual whom ABH knows or reasonably should know was convicted of a criminal offense related to a government program or listed by a state or federal agency as debarred, excluded or otherwise ineligible for participation in a government program. In order to carry out this policy, ABH may, at it's discretion, through the Human Resources Department or ABH's credentialing process, make reasonable inquiry into the status of every potential employee, including reviewing the General Services Administration's list of Parties Excluded from Federal Programs, the HHS/OIG Cumulative Sanction Report, and the AHCA Fraud and Abuse Report.

Compliance with the ABH Corporate Compliance Program is an important component of the provider monitoring activities. The ability of management, administrative, and supervisory personnel (including Department Directors) to detect, prevent, and appropriately respond to conduct which may violate the ABH Corporate Compliance Program is an ongoing component of the evaluation of all providers.

ABH and providers will remove individuals who are charged with a criminal offense or against whom civil penalties related to health care are sought to be imposed or who are proposed for debarment, suspension or exclusion from a government program, from a position as a corporate officer or from responsibility for or involvement with ABH's business affairs with health care or government programs. If such individual is convicted, debarred, suspended or excluded or such civil penalties are imposed against such individual(s), ABH will immediately terminate that individual from employment or contract with ABH.

CONCLUSION

The ABH Corporate Compliance Program is designed to aid ABH in attaining its mission and goals by ensuring that the activities of ABH and its component entities comply with applicable laws, rules and regulations, including those regarding billing for and documentation of clinical services provided. The ABH Corporate Compliance Program is intended to be an integral part of the operations of ABH and designed to be flexible enough to adapt both to the changing needs of ABH and to changes in health care laws, rules and regulations.

Attachment 1: ABH Code of Conduct

The Code of Conduct is an integral part of the ABH Corporate Compliance Plan. Employees are expected to follow the standards set forth in this Plan as well as all applicable laws.

A. Purpose of the Code of Conduct:

This Code of Conduct has been adopted by Access Behavioral Health (ABH) to provide standards by which all members of the organization will conduct themselves. Individual conduct must be in a manner that protects and promotes organizational-wide integrity and enhances ABH's ability to achieve its organizational mission. The Code is intended to serve as a guide to help workforce members make sound ethical decisions during day to day activities, and applies to all employees, officers, administrators, board members, medical staff, vendors, contracted employees, consultants, students and volunteers.

B. Access Behavioral Health's Commitment to Legal and Ethical Conduct:

Access Behavioral Health complies with all federal and state laws and regulations, including the requirement not to contract with sanctioned individuals or companies. Offers of employment or contract arrangements will be contingent upon ensuring that Access Behavioral Health does not employ or contract with any ineligible person. As such, a background investigation will be initiated after a conditional job offer has been made. Such background information may include various degrees of information based on the levels of responsibility of that position. If you have ever been listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federally funded health care programs, you will not be qualified to work for or contract with Access Behavioral Health. This stipulation also applies to any company/business associate doing business with or on behalf of Access Behavioral Health.

C. Quality of Care

ABH is committed to providing the highest quality of service by meeting the needs of our customers with the utmost care and courtesy.

- We will perform our duties in a responsible, reliable, appropriate, and cost effective manner.
- We respect our customers' dignity, comfort, and convenience and will treat each with consideration, courtesy, and respect.
- We recognize that our customers' time is valuable and so we will provide them with prompt service, always keeping them informed of delays and making them comfortable while they wait.
- We will demonstrate sensitivity and responsiveness to customers and their families by listening attentively and patiently to our customers in order to fully understand their needs, including the recognition and acceptance of diverse backgrounds.

- We will ensure that customers and their families are well informed about treatment alternatives and the various risk factors associated with each treatment.
- We will not distribute unauthorized materials and information, nor solicit our employees, customers, or visitors for any purpose that is not approved or sanctioned by ABH.
- We will make care decisions based solely on clinical needs and medical necessity.
- We will only use personnel with the proper license, credentials, experience, and expertise in meeting the needs of our customers.
- We will provide equal access to high quality care to our customers without discrimination to their age, gender, disability, race, creed, national origin, or ability to pay.
- We will ensure that all medical record documentation is legible, accurate, complete, and timely to include dating and timing of entries. Authorized corrections will be done strictly according to policy.

D. Compliance with Laws and Regulations:

ABH operates in accordance with high legal, moral, and ethical standards and with all applicable laws, regulations, and standards.

- We require that all statements, communications, and representations are accurate, complete, and truthful.
- We will not tolerate false statements by employees to a government agency or other payer, or to ABH. Deliberate misstatements to government agencies or other payers or to ABH will be grounds for disciplinary action.
- Agreements with an actual or potential referral source must be in writing and approved by management. All forms of compensation paid to referral sources must be for the services provided and at the rates called for in the contract. Every payment must also be supported by proper documentation that the services contracted for were in fact provided.
- We will not pay employees, physicians, or health care professionals for referral of patients, or accept payments for referrals we make.
- We will ensure that all reports or other information required by and federal, state, or local government agency are filed timely, accurately, and in conformance with the applicable laws and regulations. We require our contractors to do the same.
- We will not engage, either directly or indirectly, in any corrupt business practice, including bribery, kick-backs or payoffs, intended to induce, influence, or reward favorable decisions of any customer, contractor, vendor, government personnel, or anyone in a position to benefit us in any way.
- We will ensure that all drugs or other controlled substances used in the treatment of patients shall be maintained, dispensed, and transported in conformance with all applicable laws and regulations.
- We will not sacrifice our professional standards, judgment, or objectivity to anyone. Any individual with any difference of opinion will be referred to the appropriate management for resolution.

- We will not hire or contract with any individual who is currently excluded, suspended, debarred, or otherwise ineligible to participate in the federal health care programs or has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in the federal health care programs after a period of exclusion, suspension, debarment, or ineligibility.
- We will ensure that all contracts are in compliance with applicable laws, regulations, and accreditation standards by strictly following established ABH contract review and authorization policies.
- We will engage in open and fair marketing practices, based on the needs of our community and consistent with our mission.
- We recognize the critical role of research in improving the health status of our community, and we are committed to conducting all research activities with the highest ethical, moral, and legal standards.

E. Conflicts of Interest

ABH will perform it's duties on behalf of the company and our customers in a truthful and loyal manner.

- We will avoid any actions that may be reasonably construed to cause an actual or potential conflict of interest with us or our job responsibilities.
- We will act in the best interest of ABH whenever dealing with suppliers, customers, or governmental agencies. This obligation includes not only those acts formalized in written contracts, but also covers the everyday business relationships with vendors, customers, and government officials.
- We may accept unsolicited gifts of food or flowers from customers or business associates; however, these items should be shared with other department employees and should not exceed $25 in value. In most settings, gifts of cash are not allowed. Any exceptions must be approved by the Chief Financial Officer.
- We will not become involved for personal gain with an ABH competitor, consumer, or supplier.
- We will not, under any circumstances, use or share inside information, which is not otherwise available to the general public, for any improper use.
- We will not conduct business with any company in which there is a family relationship, without permission of the Compliance Office. This is allowed only after other appropriate companies have been considered.
- We will ensure that all gifts are approved by Administration or the Corporate Compliance Office.

F. Maintaining a Safe Healthcare Environment

ABH will operate in an environment wherein the health, safety, privacy, and comfort of our consumers and employees come first.

- Consumer safety is specifically considered and is given highest priority throughout the organization when consumer processes, functions, or services are designed or redesigned.

- We shall comply with all laws and regulations concerning the handling and disposal of protected health care information.
- We shall comply with all of the safety rules, regulations, and procedures that we have created to protect the well-being of our consumers, employees, and business.
- We support an alcohol and drug-free workplace and therefore will not tolerate on the premises or on duty, the manufacture, dispensation, possession, distribution, use of illegal drugs, or other inappropriate substances.
- We will report to our supervisor any practice or condition that might impact the health and safety of the facility health environment.
- It is inappropriate for anyone to be on ABH premises with any substance or device when its intended use is to cause harm. Weapons such as knives, firearms and explosives are not allowed on ABH premises. The only exception to the possession of firearms on ABH premises will be limited to National Guard personnel, licensed armed guards, or law enforcement officers on official duty. An employee that is suspicious or knowledgeable about anyone carrying any type of weapon on the premises should immediately contact security personnel.

G. Proper Consideration of Human Resources

All staff contributes directly to our success and as such, ABH is committed to reasonably protect, support, and develop our staff to its fullest potential in a fair and equitable manner. ABH supports a culture that taps the full potential of employees and builds an environment that allows all people to feel appreciated, included, and valued. Professional growth, career development, and individual empowerment are actively encouraged and rewarded.

- We will conform to the high professional standards maintained by ABH.
- We will offer equal employment opportunity and equal access to quality health care for all with no discrimination in hiring, transfer, or promotions because of age, gender, disability, race, creed, or national origin.
- We will maintain a working environment free from all forms of harassment. Any and all forms of harassment, including those based on age, gender, disability, race, creed, or national origin, by co-workers, supervisors, physicians, vendors, volunteers, or consumers will not be tolerated. Harassment may consist of offensive comments, jokes, innuendoes, or other verbal, graphic, or physical conduct relating to an individual's age, gender, disability, race, creed, or national origin.
- We will conform to the standards of our professions and exercise judgment and objectivity in the performance of our duties. Any differences of opinion in professional judgment should be referred to appropriate management levels for resolution in accordance with standard grievance procedures.
- We will show courtesy and consideration to all employees and personnel of ABH, without regard to position or status.
- We recognize the value of a diverse workforce and will remain open to new viewpoints, ideas, and talents.

- We will not engage in retaliation or reprisal against anyone who properly reports violations of law, regulations, or ABH policies. We promote an environment where reporting concerns are encouraged by all employees. Any employee who feels that he/she has been retaliated against after reporting a concern should immediately notify the Compliance Office. We will not tolerate false reports or reports made in bad faith about an ABH employee or entity. An employee acting in good faith will not be penalized in any way for reporting such conduct concerning himself/herself or another person.
- We will devote our working time to the responsibility of proper performance of our duties.
- We will honor our commitment to report for scheduled shifts during times of natural or man-made disasters such as hurricanes, epidemics, or hazardous material exposure.
- We will work to eliminate perceived or real barriers to diversity in operational, governance, and leadership positions.
- We will not use the health information of our employees, their dependents or anyone else for any employment-related decisions unless such use is ethical and legal.

H. Claims Processing Integrity

We shall promptly report to management any transaction that is not recorded in compliance with our policies and procedures.

- We require accurate claims, which include only services actually rendered, using billing codes that accurately describe the services, and are based on documented medical necessity.
- We will take every reasonable precaution to ensure that our claims processing work is accurate, timely, and in compliance with our policies and with federal and state laws and regulations.
- We will not tolerate the submission of any claims that contain any kind of false, fraudulent, or inaccurate statements. We have adopted policies and procedures to prevent and detect fraud, waste and abuse that are in compliance with both federal and state law. Any employee who lawfully reports a concern is protected from retaliation by these same policies, as well as federal and state laws governing false claims.
- We will pay claims only for l services rendered and covered by the contract.
- Consumers are not to be billed for services covered under the contract, or for no shows for appointments.
- We will establish lawful and positive relationships with payer sources by negotiating treatment benefits in good faith, maintaining ongoing communication about consumer progress and claims within the parameters negotiated.
- Consumer care needs will be based solely on clinical decisions and not how the health care facility is compensated for care provided.

I. Stewardship of Property and Interests

ABH will protect against the loss, theft, destruction, misappropriation, and misuse of our assets and those of others entrusted to us, including physical property and proprietary information.

- We will safeguard all property that is placed in our care.
- We will properly use all assets, property, equipment, and supplies that belong to ABH.
- We will not engage in financial misconduct, including the outright theft of property, embezzlement of money, or the use of money belonging to ABH or our customers for any unauthorized purpose.
- We will dispose of surplus, obsolete, and junked property or anything of value according to the established policies and procedures.
- We will conserve resources and utilities such as natural gas, water, electricity and telephone service.
- We will dispose of all hazardous or environmentally unfriendly material in the proper manner.
- We will not use ABH resources for any unauthorized personal reasons.
- We will obey all traffic laws and regulations while operating automobiles that belong to ABH or are rented by ABH.
- We will not inappropriately share details about our building or computer security systems, surveillance systems or our policies and procedures that are designed to prevent unauthorized access or criminal conduct at our facilities.
- We will protect our ABH identification badge to prevent theft or unauthorized use or access.

J. Privacy and Security of Information

The purpose of the Privacy and Security Program is to ensure the confidentiality, integrity and availability of the information we collect and use for health care and business purposes. The program extends to all information regardless of location or storage medium and it applies to both paper and electronic based information.

Confidential information is protected by federal and state law and must receive the highest degree of protection. For our purposes, we've grouped this information into two categories:

- Confidential Personal Information – Any information that can be considered personal in nature, such as diagnosis and treatment information, individual names, social security numbers, insurance numbers, credit card numbers, drivers' license numbers, dates of birth, automobile tags and registration information.
- Sensitive Business Data – Any information that we collect and use for business purposes such as budgeting and financial data, staffing schedules and turnover statistics.

K. Guiding Principles of Information Security and Privacy

- We will become familiar and comply with policies and procedures relating to information security and privacy.
- We will safeguard confidential information regarding our customers and coworkers from misuse, theft or unauthorized access.
- We will share confidential information as necessary to provide prompt and effective treatment to our customers.
- When sharing confidential information for purposes other than treatment we will adhere strictly to the minimum necessary standard and only disclose the minimum information necessary to accomplish the task.
- We will use reasonable steps to ensure unauthorized persons do not overhear or see confidential information.
- We will not place any confidential information in public areas where the information can be easily seen by unauthorized persons.
- We will become familiar with the Notice of Privacy Practices and adhere to the consumer privacy rights it contains.
- We will use approved procedures for obtaining our own confidential information or that belonging to our dependents.
- We will not access any confidential information, including our own unless we are doing so as part of our official duties.
- We will not discuss any confidential information pertaining to our coworkers or others that we obtain in our official capacity unless doing so is ethical and necessary to complete our duties.
- We will promptly report any theft or loss of confidential information to our supervisor.

L. Principles Specific to Information in Electronic Form

- We will access computer systems that contain confidential information by using our own unique identification (user ID).
- We will not share our user IDs and passwords and will take reasonable steps to protect them from unauthorized disclosure.
- We will not allow vendors or contractors to access any ABH computer unless approved by Information Services.
- We will not load any unauthorized computer programs onto any ABH computer.
- We will not disable or try to defeat any security device or procedure utilized by ABH.
- We will not connect any unauthorized device to an ABH computer.
- We will only use approved methods for storing confidential information electronically.
- We will properly dispose of media such as floppy disks, DVDs, or CDs that contain confidential information.
- We will not allow unauthorized persons such as family members to use any ABH computer.

M. Principles Specific to Information in Paper Form

- We will properly dispose of confidential information by placing it in approved containers or by shredding.
- We will store confidential information in a way that prevents unauthorized access. When it is necessary to store confidential information, we will follow ABH record retention policies and we will ensure the information is properly destroyed when the retention period has expired.
- We will strictly adhere to company policy regarding the faxing of confidential information, including the verification of fax numbers and the use of approved fax cover sheets.

N. When You Believe There May Be a Problem

If you believe you have information about health care providers, practitioners, entities, or other persons engaging in improper types of activities or arrangements, it is your responsibility to report these concerns. Persons reporting information in good faith will not receive any kind of reprisal or retribution. This provision, however, cannot be used to absolve or clear any personal confessions of wrongdoing.

- **Discuss concern with your immediate supervisor.**

The management structure (starting with your immediate supervisor) and existing policies and procedures should be used as the first approach.

- **Contact the Human Resource Manager or the Corporate Compliance Officer at your facility.**

If you receive an unacceptable response or if you are unsuccessful using the initial reporting mechanism, the Human Resource Manager or Corporate Compliance Officer will arrange for you to meet with the area department head. If your concern is related to your treatment as an employee, you should meet directly with the Human Resources Manager or Corporate Compliance Officer. Should the settlement continue to be unsatisfactory, the Human Resources Manager or Corporate Compliance Officer will, in agreement with the employee, present the grievance to the Administrator.

- **Contact the ABH Corporate Compliance Officer**

The ABH Corporate Compliance Officer will be available to discuss any concerns with you and can be reached at (850) 432-1222 (Corinne Whitlock or Brent Patton).

- **Call the Compliance Hotline**

The Compliance Hotline is also available should you desire to remain anonymous. Your identity will be protected to the limit of the law. The Compliance Hotline can be reached at 1-866-477-6725. Concerns brought to the attention of the Compliance Office will be promptly and thoroughly evaluated and investigated for prompt resolution. Due to the nature of the hotline, detailed feedback may be difficult or impossible to provide due to confidentiality.

The Director of Quality Management and Improvement serves as the Corporate Compliance Officer for ABH. Also, each provider has a Compliance Liaison who can be contacted if you believe there is a problem that needs to be addressed.

O. What Do You Do when You Think a Compliance Concern Exists?
Use FOCUS PDCA

Find
What is your concern or opportunity for improvement?

Organize
Who can help you? Report your concerns beginning with and continuing through the list of following resources until your concern is addressed:
• Supervisor
• Human Resources
• Compliance Office (850-469-3924)
• Management
• Senior Management
• Compliance Hotline (1-866-477-6725)

Clarify
What is the current knowledge of the concern or problem?

Uncover
What is the root cause of the problem?

Select/Start
Start the PDCA cycle. Initiate the improvement/process.

Plan
Plan the improvement.

Do
Implement the improvement.

Check
Has the situation improved or been resolved?

Act
Were the results achieved? If not, repeat PDCA. Make a decision to continue the improvement and track it for three months or try something new and repeat PDCA.