



**HEALTH PLUS POLICY PURSUANT TO  
THE FEDERAL DEFICIT REDUCTION ACT OF 2005  
SUMMARY**

**Detection and Prevention of Fraud, Waste, and Abuse  
and Applicable Federal and State Laws**

Health Plus is committed to preventing and detecting fraud, waste, or abuse, especially as related to Federal and State health care programs. To this end, Health Plus maintains a vigorous compliance program and strives to educate its work force, vendors, contractors and agents on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments.

As part of commitment and in compliance with Section 6032 of the Deficit Reduction Act of 2005, Health Plus provides the following information about its policies and procedures and the role of certain federal and state laws in preventing and detecting fraud, waste and abuse in federal health care programs to all employees, vendors, contractors, and agents.

Health Plus has instituted policies and procedures and a compliance program for detecting and preventing fraud. The Compliance Officer oversees these programs and, depending on the nature of the allegations, works collaboratively with the Senior Leadership or individual departments to conduct investigations in these areas. Those policies and procedures are set forth in detail in Health Plus's Code of Ethics and Business Conduct, and Vendor Code of Conduct which are available on Health Plus's Internet in the Ethics and Compliance Section. Applicable compliance policies are accessible to agents, contractors and vendors on Health Plus's website at <http://www.healthplus-ny.org>.

As part of Health Plus's commitment to ethical and legal conduct, employees, vendors, contractors, and agents are required to immediately bring to the attention of their supervisor or the Compliance Officer any information regarding suspected improper conduct by contacting Compliance Hotline at 800-826-6762, or directly by e-mailing [EthicsandCompliance@HealthPlus-ny.org](mailto:EthicsandCompliance@HealthPlus-ny.org). Health Plus is committed to investigating any allegation of fraud, waste, or abuse swiftly and thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, Health Plus requires that all involved fully cooperate in such investigations.

The Compliance Program is very important and Health Plus devotes substantial resources to investigate allegations of fraud and abuse. Therefore, all are encouraged to bring their concerns to the institution first so Health Plus can investigate and correct any fraudulent or improper activity. Any compliance violation or allegation could be reported anonymously, and those reporting will be protected against retaliation for coming forward with such information under Health Plus's internal compliance policies and procedures and Federal and State law. Health Plus retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or policy.

Health Plus vendors, contractors, and agents have a duty to bring their concerns relating to fraud and/or abuse to Compliance Officer for investigation and correction of any problems that may exist. However, certain State and Federal laws, discussed more fully below, provide that any private citizen may bring their concerns of fraud and abuse directly to the government.



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**RELEVANT FEDERAL AND STATE STATUTES**

The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act, certain relevant State laws and the Federal and State laws that pertain to whistleblowing.

**Federal Laws**

The False Claims Act (“FCA”) and Program Fraud Civil Remedies Act (PFCRA) address fraud in federally funded programs. Health Plus must comply with these regulations because Medicaid, Family Health Plus and Child Health Plus programs are partially federally funded. The FCA and PFCRA make it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment or statement to the federal government. Under these regulations, the term “knowingly” means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth. The federal government may impose harsh penalties under the FCA and PFCRA, including fines and civil penalties up to \$11,000 per violation and an assessment of double the amount of the claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs. Some examples of conduct that may violate the FCA are:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by the plan;
- Knowingly failing to provide members with access to services for which the plan has received premium payments; and
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports.

Health Plus is also subject to State law and regulation regarding the prevention of fraud and abuse. These New York State Laws are summarized in *Attachment A*.

**The Fraud Enforcement and Recovery Act of 2009 (FERA)**

FERA is aimed primarily at financial institutions, but it contains a section, “Clarifications to the False Claims Act to reflect the Original Intent of the Law” which expands on the False Claims Act. Among other changes, the new law creates liability for a knowing and improper failure to return an overpayment. Also FERA eliminates the requirement that a claim be presented to a government official for liability to attach. FERA expands the FCA’s anti-retaliation provision from only employees to contractors and agents as well. Finally FERA effectively allows the government more time for intervention in whistleblower actions.

***Federal and New York State Whistleblower Provisions***

The **Federal FCA** contains a whistleblower (*qui tam*) provision that permits individuals with knowledge of fraudulent or improper activity to file a lawsuit on behalf of the federal government. Lawsuits are kept confidential until the U.S. Justice Department decides whether to prosecute the matter. If the lawsuit is successful, the whistleblower may receive an award ranging from 15 to 30 percent of the government’s recovery, plus reasonable expenses and attorneys’ fees. The individual must be the “original source” of the report to the federal



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government and the report may not involve activities that are already the subject of a government investigation or previously disclosed by the organization or provider to the government.

The **FCA** prohibits retaliation against employees for filing a *qui tam* lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees subjected to such retaliation may be awarded reinstatement, back pay and other compensation. However, the federal government may impose administrative penalties and fines against a person who files a false claim with certain government agencies.

**New York State False Claim Act (Finance Law)** also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and condition of their employment as a result of their furtherance of an action under the Act.

**The New York State Labor Law, Article 740** states that an employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. The employee's disclosure is only protected if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. Protected disclosures are those that assert an employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes fraud. The employee may sue in state court if retaliatory action by the employer was taken.

**Article 741 of the New York State Labor Law** mandates that a health care employer may not take any retaliatory action against an employee if the employee discloses something the employee believes in good faith constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. Unless the danger is imminent to the public or the patient and the employee believes that reporting to a supervisor would not result in corrective action. The employee may sue in state court if retaliatory action by the employer was taken.

**What the FCA Means to You as a Health Plus Employee**

As a Health Plus employee, you have received Compliance training. This training stressed the need to fully comply with applicable laws, regulations and other regulatory requirements and to engage in ethical business practices. Health Plus has a comprehensive Compliance program and well developed Fraud and Abuse Prevention (F&A) Plan. **Attachment B** describes the activities that Health Plus routinely does in order to identify potential fraud and abuse and areas for improvement.

Health Plus will not take or tolerate actions against an employee who, in good faith, reports a legal concern, an ethical concern or a violation of the Code of Conduct." "In good faith" means an employee actually believes that the reported information is true. You should report potential violations of the FCA, PFCRA, Health Plus standards of conduct and policies and procedures,



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and applicable state and federal laws and regulations to your supervisor, the Compliance Department, or the Health Plus Compliance Hotline.

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**Appendix A - State Laws Punishing False Claims and Statements**

**APPLICABLE NEW YORK STATE LAWS – New York’s false claims laws fall into two categories: civil/administrative and criminal. Some apply to recipient false claims and some apply to provider false claims and while most are specific to healthcare or Medicaid, some of the “common law” crimes apply to areas of interaction with the government.**

New York State laws, listed below, outline civil and criminal penalties for the submission of false claims and the making of false statements:

**Civil & Administrative Penalties**

- *Article 187 through 194 of the Finance Law* closely tracks the federal False Claims Act (previously summarized). It makes it unlawful to knowingly make a false statement or representation (or by deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain, or to obtain, payments from any state or local government, included healthcare programs such as Medicaid. The penalty for filing a false claim is \$6,000-\$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government’s legal fees. The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suite and 15-25% if the government did participate.
- *Article 145-b of the Social Services Law* make it a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or other agency may recover three times the amount incorrectly paid along with civil penalties of up to \$2,000 per violation. If repeat violations occur, more severe penalties may be imposed.
- *Article 145-c of the Social Services Law* makes it a sanctionable offence if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person’s, the person’s family’s needs are not taken into account for 6 months if a first offense, 12 months for a section offense and live years for four or more offenses.

**Criminal Laws**

- *Article 145 of Social Services Law* states that any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
- *Article 366-b of Social Services Law* outlines criminal penalties for fraudulent practices as for any person who obtains or attempts to obtain for himself or others, medical assistance by means of a false statement, concealment or material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.



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Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

- *Article 155 of Penal Law* states that the crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud or other similar behavior and has been applied to Medicaid fraud cases. The penalties increase with the value of the property.
- *Article 175 of the Penal Law* makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- *Article 175 of the Penal Law* also makes it a misdemeanor to knowingly file a false instrument (document) with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.
- *Article 176 of the Penal Law* makes it a misdemeanor to commit a “fraudulent insurance act,” which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds \$1,000, the crime is punishable as a felony.
- *Article 177 of the Penal Law* makes it a misdemeanor to engage in “health care fraud,” which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds \$3,000, the crime is punishable as a felony.
- *Section 403 of the Insurance Law* authorizes the Insurance Department to impose civil penalties for any action that constitutes a fraudulent insurance act under Article 176 of the Penal Law. Civil penalties may be up to \$5,000 plus the amount of the claim for each violation.
- *Section 740 of the Labor Law* prohibits an employer from taking any retaliatory action against an employee because the employee (i) discloses or threatens to disclose to a supervisor or government agency any illegal policy or practice of the employer that threatens public health or safety, or constitutes health care fraud, (ii) provides information to or testifies before any government agency conducting an investigation into such a policy or practice, or (iii) objects to or refuses to participate in any such policy or practice. However, retaliatory action is prohibited only if the employee, prior to



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providing information to a government agency, notifies his or her supervisor of the illegal policy or practice and affords the employer a reasonable opportunity to correct the problem. An employee subject to illegal retaliation may file a civil action against the employer and is entitled to reinstatement, lost wages and attorneys' fees.

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**Attachment B - Health Plus Compliance Activities**

Special Investigation Unit “SIU” - Special Investigations Unit responsible for the investigations of claims and provider-related fraud and/or abuse issues, as well as investigations of marketing personnel and enrollment department referrals of compliance issues. SIU oversees two Facilitated Enrollment Integrity programs: Call Verification and Secret Shopper. Call Verification team outreaches to new applicants to review a sample of monthly applications to ensure quality of applications received by Enrollment Department. Secret Shopper program is assesses Facilitated Enrollers marketing practices in the field.

Auditing & Monitoring - Health Plus conducts audits and reviews a number of operational processes for compliance with internal policies and regulatory guidelines in accordance with identified vulnerabilities.

Health Plus audits all paid claims for aberrant, abusive or fraudulent billing by providers. Cases of identified billing abnormalities further investigated and, if determined inappropriate, such payments to providers are recouped.

Compliance Hotline 1-800-826-6762 – The Health Plus Compliance Hotline is operated by an outside vendor and may be accessed 24-hours a day, 7 days a week. The calls can be anonymous, if the caller so chooses. All matters are thoroughly investigated, logged, and tracked. The results of investigations are reported back to the caller.

Non-Retaliation Policy – Health Plus maintains and adheres to the standards for confidential reporting, which ensure that the identity of individual(s) reporting violation of the Health Plus’s standards of conduct, policies and procedures and applicable state and federal standards, is protected

Code of Conduct and Compliance Training - The Health Plus Code of Ethics and Business Conduct is reviewed during new employee orientation and mandatory Compliance Training. It provides definitions of fraud and abuse and instructs employees what to do if they believe that a physician, provider, member, vendor or employee of Health Plus is involved in an actual or potential fraud and abuse situation. Annual Compliance Training is mandatory. All vendors are provided a copy of the Health Plus Vendor Code of Ethics and Business Conduct and must agree to comply with its terms and are required to acknowledge receipt.

Policies & Procedures – Compliance Department/SIU developed a set of policies and procedures addressing statutory and contractual requirements, outlining auditing, investigative, and reporting processes for the department.

Fraud and Abuse Awareness Program In 2006, Health Plus rolled out targeted training on Fraud & Abuse Awareness Program. The ongoing annual program focuses on the cost, frequency and types of fraud or abuse, and methods by which Health Plus’s enrollees, providers, contractors or employees can prevent fraud and/or abuse.

Health Plus Compliance Program expended it’s outreach through developing dedicated web pages dedicated expanding Health Plus Intranet and Internet websites. These pages are dedicated



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to overview of the Ethics and Compliance Program, Fraud and Abuse Prevention Program, policies relating to Vendors, Contractors, or Agents, and Code of Ethics and Business Conduct.

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