

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 1 of 8
--	--	--	--------------------

I. BACKGROUND

Submitting of false information and claims to the federal or state governments or government programs may constitute a fraud that is actionable by enforcement agencies. The OIG conducts a large number of Medicaid audits and evaluations due to improper or fraudulent payments, which result in a substantial drain on state and federal funds. The Deficit Reduction Act of 2005 mandates that any entity receiving or making annual payments under the State Medicaid plan of at least \$5 million must:

- “establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)); and,
- “include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.”

II. PURPOSE

Health Plus is committed to complying with all applicable laws and regulations. Health Plus supports the efforts of federal and state authorities in identifying incidents of fraud, waste, and abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud, waste, and abuse in accordance with contractual, regulatory and statutory requirements. This policy sets forth the guidelines to be followed by all employees regarding the False Claims Act and in detecting and preventing fraud, waste and abuse.

III. DEFINITIONS

Fraud: An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. This also includes member practices that result in unnecessary cost to government programs.

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 2 of 8
--	--	--	--------------------

IV. FEDERAL and STATE LAWS

Federal False Claims Act

The Federal False Claims Act is a federal law that prohibits certain fraudulent acts against the Government, including:

- knowingly presenting or causing to be presented a false or fraudulent claim to the Federal government for payment;
- knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal government; or
- conspiring to defraud the Federal government by getting a false or fraudulent claim allowed or paid.

Under the Federal False Claims Act, a person acts “knowingly” if he or she:

- has actual knowledge that the information is false or fraudulent;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

Under the Federal False Claims Act, a “claim” is any request or demand for money or property if the Federal government provides any portion of the money or property in question. This includes requests or demands submitted to a contractor of the Government and **includes Medicaid and Medicare claims.**

A violation of the Federal False Claims Act results in a civil penalty between \$5,500 and \$11,000 for each false claim submitted (for example, a claim for one patient is one claim, even if the same scheme is used for multiple claims), plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the Government may exclude the violator from participation in all Federal health care programs.

The False Claims Act allows a private person to file a *qui tam* lawsuit on behalf of the Federal government. This person, also called a “whistleblower,” must file his or her lawsuit under seal in a federal district court. The Government may decide to intervene the lawsuit and become the plaintiff and prosecute the case. If the Government does not decide to intervene, the whistleblower may still continue the lawsuit independently.

If a *qui tam* lawsuit is successful, the whistleblower may receive between 10 to 30% of the recovery, depending on many factors, as well as reasonable attorney’s fees and costs. In addition, there can be **no retaliation against the whistleblower** for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant’s attorney’s fees and costs, and other sanctions.

Date Approved:	08/31/2007	Approved By: _____	
----------------	-------------------	--------------------	--

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 3 of 8
--	--	--	--------------------

Federal Enforcement and Recovery Act of 2009

The Federal Enforcement and Recovery Act of 2009 (“FERA”), specifically Section 4 provides ‘clarifications to the False Claims Act to Reflect the Original Intent of the Law’ in that it :

1. redefines “claims” to include a claim submitted “to a contractor, grantee, or other recipient” acting on behalf of the Government or ‘to advance a Government program or interest.” This enables the Government to pursue FCA and actions arising from *qui tam* actions affecting subcontractors and contractors.
2. redefines “obligation” to include “an established duty, whether or not fixed,” arising from a variety of relationships, and specifically including obligations “arising from statute or regulation, or from the retention of any overpayment.” This allows the government and whistleblowers to pursue FCA penalties and see documentation which are ‘material to an obligation to pay or to transmit money... to the government” regardless of whether a false claim has been submitted.
3. expands the anti-retaliation provisions to include “contractors and agents” who “act to stop one or more violations.”

Federal Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986 is similar to the False Claims Act, establishing an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent to certain Federal agencies, and again, includes Medicaid and Medicare claims.

Similar to the False Claims Act, a person who “knows or has reason to know” is defined as one who:

- has actual knowledge of the falsity of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

A violation of the Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to \$5,500 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing rather than a court case.

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.

Civil and Administrative Laws

Date Approved:	08/31/2007	Approved By:	_____
----------------	-------------------	--------------	-------

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 4 of 8
--	--	--	--------------------

A. New York State False Claims Act (State 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.

B. False Statements – Social Services Law 145-b

It is 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.

C. Sanctions – Social Services Law 145-c

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

A. Penalties – Social Services Law 145

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

B. Penalties for Fraudulent Practices – Social Services Law 366-b

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.

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.

C. Larceny – Penal Law Article 155

The crime of larceny applies to a person who, with intent to deprive another of is 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.

D. False Written Statements – Penal Law Article 175

Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. Another offense is presenting

Date Approved:	08/31/2007	Approved By:	_____
----------------	-------------------	--------------	-------

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 5 of 8
--	--	--	--------------------

written information to a public office knowing it contains false information. These are a Class A misdemeanor.

If the falsifying of the business records include the intent to commit another crime or conceal its commission or the written information includes intent to defraud it makes these Class E felonies.

E. Insurance Fraud – Penal Law Article 176

Insurance Fraud involves intentionally filing a health insurance claim knowing that it is false. There are various degrees of penalty depending on the dollar amount involved.

F. Health Care Fraud – Penal Law Article 177

Health care fraud is knowingly filing, within intent to defraud a claim for payment that intentionally has false information or omissions. The penalties relate to the dollar amount involved.

Qui Tam Provisions and Whistleblower Protection

A. Federal False Claims Act

Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as “qui tam” actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims (also known as “relators” or “whistleblowers”) are granted protection under the law. Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys’ fees and costs.

B. State Finance Law – False Claim Act

The False Claim Act 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.

C. New York Labor Law 740

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 disclose 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.

D. New York Labor Law 741

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

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 6 of 8
--	--	--	--------------------

supervisor would not result in corrective action. The employee may sue in state court if retaliatory action by the employer was taken.

V. POLICY

1. All employees must conduct themselves in an ethical and legal manner, including the maintenance of accurate records related to their business activities.
2. All employees, contractors and agents are responsible for reporting potential or suspected incidents of fraud and abuse, and other wrongdoing of Health Plus directly to their supervisor and executive management or by using one of the reporting methods described in the procedures section of this policy.
3. Health Plus educates employees about fraud and abuse, including the applicable provisions of the False Claims Act, administrative remedies, and applicable state laws through mandatory compliance training.
4. The Compliance Officer (CO) in consultation with legal counsel has responsibility for receiving and acting upon all information suggesting the existence of possible fraud, abuse or wrongdoing; and for directing all investigations arising from this information.

VI. PROCEDURE

1. All employees, contractors and agents will receive training relating to the provisions of the FCA during the annual compliance program training. The pertinent information will be posted on Health Plus Intranet and Internet websites. Additionally, pertinent information will be circulated through periodic publications, and mailings.
2. This FCA training will include:
 - Information of the FCA and the administrative remedies for false claims and statements;
 - State laws pertaining to civil or criminal penalties;
 - Whistleblower rights;
 - Health Plus provisions for preventing, detecting and reporting fraud, waste and abuse.
3. All employees with knowledge of potential fraud and abuse situations must report them through any of the following methods:
 - Notifying their direct supervisor or executive management;
 - Contacting the Compliance Office directly either in person or by phone; or
 - Calling the confidential Health Plus Compliance Hotline.
4. Anyone receiving a report of fraud (e.g., management, HR, Legal, etc.) should immediately inform the Compliance Officer (CO) before any employee action is taken. No supervisor or manager should directly confront the employee with the allegation of

Date Approved:	08/31/2007	Approved By:	
----------------	-------------------	--------------	--

HEALTH PLUS

COMPLIANCE POLICIES AND PROCEDURES

Section: CMPL-707	Subject: Fraud & Abuse: FALSE CLAIMS ACT POLICY	Draft Date: 12/30/06 Revision Date: 8/31/07 Review Date: 12/11/2008 Review Date: 8/4/2009	Page 8 of 8
--	--	--	--------------------

VII. ENFORCEMENT

Employees who do not comply with this policy will be subject to disciplinary action by Health Plus. Depending on the facts and circumstances of each case, Health Plus may reprimand, suspend or dismiss any employee who fails to comply with this policy.

VIII. REFERENCE AUTHORITY/ CITATIONS

False Claims Act 31 U.S.C. §§3729-3733, §3730(h)

Fraud Enforcement and Recovery Act of 2009 (“FERA”)

United States. Cong. Senate. 109th Congress, 2nd Session. S. 1932, An Act to Provide for Reconciliation Pursuant to Section 202(a) of the Concurrent Resolution on the Budget for Fiscal Year 2006. 109th Congress. GPO Access. 3 January 2006 <<http://thomas.loc.gov>>.

NYS Penal Law, Articles 175, 176, 177 and Article 155

NYS Insurance Law, Section 403

NYS Labor Law, Section 740

NYS Finance Law, Articles 187-194

NYS Social Services Law, Articles §§ 145 (b, c), 363-d and 366 (b)

OMIG Self-Disclosure Protocol, March 12, 2009

Title 18 NYCRR, Part 521

NYS Public Health Law, Section 21

Date Approved:	08/31/2007	Approved By:	_____
----------------	-------------------	--------------	-------