Encl. #11.15
December 18, 2014

Horseheads Central School District

Business Office
One Raider Lane • Horseheads, NY 14845
(607) 739-5601, x4260 • Fax (607) 795-2415

TO: Board of Education

FROM: Katy Buzzetti, School Business Administrator

DATE: December 18, 2014

RE: Agreement with Chemung County for UPK Special Education Evaluations

Able2 closed the segment of its business that conducted preschool evaluations for special needs children. The District applied with NYSED seeking approval to operate a preschool multidisciplinary evaluation (MDE) program in Chemung County. The District received notification it was approved by NYSED on September 9, 2014 to conduct these evaluations. Chemung County and the District have reached an agreement in which the District will perform these evaluations for in-district children only. The County will then place the children in the appropriate school or program based on the results of these evaluations and the recommendations of the Committee on Preschool Special Education. The District will charge the County at rates determined by New York State as payment for these evaluations. The District will be using its current psychologists, occupational therapists, physical therapists, and speech therapists to conduct these evaluations.

The District will submit for reimbursement from the County based on the following rates:

Psychological Evaluation	$243
Physical Therapist Evaluation	$163
Occupational Therapist Evaluation	$163
Speech Therapist Evaluation	$163
Social History Evaluation	$143

AGREEMENT

THIS AGREEMENT made between the **COUNTY of CHEMUNG** on behalf of its applicable department(s), (hereinafter referred to as the "**COUNTY**"), a municipal corporation of the State of New York, having its principal office at 203-205 Lake Street, Elmira, New York 14902-0588.

AND

HORSEHEADS CENTRAL SCHOOL DISTRICT, (hereinafter referred to as **PROVIDER**"), conducting business at 1 **RAIDER LANE, HORSEHEADS, NEW YORK 14845.**

WITNESSETH

WHEREAS the parties hereto desire to make available to the **COUNTY** the services as authorized by applicable Laws of the State of New York; and as outlined in **ATTACHMENT A**, and

WHEREAS the **PROVIDER** is qualified to provide and is willing and authorized to furnish such services to the **COUNTY** and,

WHEREAS the **COUNTY** desires to contract with the **PROVIDER** for the furnishing of such services as aforesaid, and the said **PROVIDER** has agreed to render and furnish such services to the **COUNTY** to the extent indicated herein, and under the terms and conditions hereinafter provided, and

WHEREAS the **COUNTY** wishes to make these services available to those persons eligible under applicable Laws.

NOW, THEREFORE, it is mutually agreed between the parties involved as follows:

TERM OF AGREEMENT

1. This Agreement shall become effective **OCTOBER 1, 2014** and shall terminate on **DECEMBER 31, 2014**.

BUDGET AND TOTAL AMOUNT OF AGREEMENT

2. The **COUNTY** will provide payment to the PROVIDER as described in **ATTACHMENT B**, attached hereto and made a part hereof.

RELATIONSHIP AS INDEPENDENT PROVIDER

3. The relationship of the **PROVIDER** to the **COUNTY** shall be that of independent **PROVIDER**. The **PROVIDER,** in accordance with this status as an independent provider, covenants and agrees that it will conduct itself in accordance with such status, that it will neither hold itself out as, nor claim to be an officer or employee of the **COUNTY** by reason thereof and that it will not by reason thereof make any claim, demand or

application to or for any right or privilege applicable to an officer or employee of the **COUNTY**, including, but not limited to Worker's Compensation coverage, or retirement membership or credits.

ASSIGNMENTS

4. The **PROVIDER** shall not assign, transfer, convey, sublet, sub-contract or otherwise dispose of this contract or the right, title or interest therein or the power to execute such contract to any other person, company or corporation without prior written consent of the **COUNTY**, which consent shall not be unreasonably held.

COMPLIANCE WITH APPLICABLE LAWS

5. The **PROVIDER** shall have the overall administration and responsibility for carrying out the terms of this contract and shall comply with all applicable Federal, State and local statutes, rules and regulations.

The **PROVIDER** shall furnish services in accordance with applicable requirements of law and shall cooperate with the **COUNTY** as may be required so that the **COUNTY** shall be able to fulfill its function and responsibilities in order to meet all of the applicable County, State and Federal requirements pertaining thereto.

STATE CENTRAL REGISTER REQUIREMENT

6. The PROVIDER shall comply with Pre-K Services requirement, prior to employment, that each therapist will be screened through the Office of Children and Family Services State Central Register of Abuse and Maltreatment. A State Central Register form (LDSS-3370) will be provided to the applicant for completion along with their signature.

The Department of Human Services has an agency liaison who will assist in processing this material. The agency liaison will be the person to whom the SCR will respond once the clearance activity has occurred.

NEW FEDERAL OR STATE REQUIREMENTS

7. In the event that Federal or State Departments issue new or revised requirements to the **COUNTY** pertaining to services rendered in the performance of this Agreement, then the **COUNTY** shall promptly notify the **PROVIDER** of said change(s) and the **PROVIDER** shall comply with said requirements.

RECORDS RETENTION

8. The **PROVIDER** agrees to retain all books, records and other documents relevant to this Agreement for seven years after final payment. Federal and/or State auditors and any persons duly authorized by the **COUNTY** shall have full access and the right to examine any of said materials during said reporting period.

CONFIDENTIALITY

9. The **PROVIDER** and the **COUNTY** shall observe and require the observance of applicable County, Federal and State requirements relating to the confidentiality of records and information.

CLAIMS, PAYMENTS AND AUDITS

10. The **PROVIDER** agrees that all claims submitted for reimbursement to the **COUNTY** shall be true and correct and that reimbursement by the **COUNTY** does not duplicate reimbursement received by the **PROVIDER** from any other sources.

INSURANCE AND HOLD HARMLESS INDEMNIFICATION

11. The **PROVIDER** agrees to procure and maintain at its own expense and without direct expense to the County (until final acceptance by the County for the services covered by this Agreement), insurance of the kinds and in the amounts hereinafter specified in **Exhibit #1.**

Before commencing the work, the **PROVIDER** shall furnish the **COUNTY** a Certificate of Insurance or Binder showing that it has complied with this Exhibit, which certificate or certificates shall provide that the policies shall not be changed or canceled until thirty (30) days written notice has been given to the **COUNTY**.

This Certificate of Insurance, if required, shall name the **COUNTY** as additional insured and will be attached to this Agreement as **ATTACHMENT C**.

HOLD HARMLESS INDEMNIFICATION

12. **Each Party** agrees to indemnify and hold harmless the **other party**, its officers and agents, against all liability, judgments, costs and expenses upon any claims arising from the negligence of the **indemnifying party**, its agents, officers or employees, in performing the work under this Agreement.

NEPOTISM/CONFLICT OF INTEREST

13. The **PROVIDER** agrees and is obligated to disclose that no current officer, director or incorporator of the **PROVIDER** shall be hired or retained by the **PROVIDER** to fill any staff position or perform any services required under this Agreement and that parents, spouses, siblings and children of current officers, directors or incorporators will not be employees paid from these funds without prior written approval of the **COUNTY**.

TERMINATION

14. Each party shall have the right to terminate this Agreement by giving 30 days prior written notice to the other party.

A. Notwithstanding the above, if, through any cause, the **PROVIDER** fails to comply with legal, professional, **COUNTY,** Federal or State requirements for the provision of services or with the provisions of this Agreement, or if the **PROVIDER** becomes bankrupt or insolvent or falsifies its records or reports, or misuses its funds from whatever source, the **COUNTY** may terminate this Agreement effective immediately, or, at its option, effective at a later date, after sending notice of such termination to the **PROVIDER.**

B. The **COUNTY** shall be released from any and all responsibilities and obligations arising from the services covered by this Agreement, effective as of the date of termination, but the **COUNTY** shall be responsible for payment of all claims for services provided and costs incurred by the **PROVIDER** prior to termination of this Agreement, that are pursuant to, and after the **PROVIDER's** compliance with, the terms and conditions herein, subject to any adjustments the **COUNTY** may have.

C. In the event of termination of the Agreement prior to the termination date set forth in the project description, the **PROVIDER** agrees to:

(1) Account for and refund to the **COUNTY,** within 30 days, any unexpended funds which have been paid to the **PROVIDER** pursuant to this Agreement.

(2) Not incur any further obligations pursuant to this Agreement beyond the termination date.

(3) Submit, within 30 days of termination, a full report of fiscal and program activities, accomplishments and obstacles encountered related to this Agreement.

NON-DISCRIMINATION

15. The **COUNTY** and **PROVIDER** agree to comply with all applicable rules and regulations regarding non-discrimination regarding work to be performed under this Agreement. In compliance with New York State and Federal Laws, **PROVIDER** and **COUNTY** shall not discriminate because of age, race, creed, sex, color, disability, national origin, marital status, sexual preference, sponsorship, employment, source of payment or retaliation in the performance of this Agreement.

EXECUTORY BASED ON AVAILABILITY OF MONIES

16. This contract shall be deemed executory only to the extent of the monies appropriated and available for the purpose of the contract, and no liability on account thereof shall be incurred by the purchase beyond the amount of such monies. It is understood that neither this contract nor any representation by any public employee or officer creates any legal or moral obligation to request, appropriate or make available monies for the purpose of the contract.

COOPERATION

17. The **PROVIDER** and the **COUNTY** recognize that in the performance of this contract, the greatest benefits will be derived by promoting the interest of both parties, and each of the parties does, therefore, enter into this contract with the intention of loyally cooperating with the other in carrying out the terms of this contract and each party agrees to interpret its provisions insofar as it may legally do, in such manner as will thus promote the interest of both and render the highest service to the public and in accordance with the provisions of this Agreement.

SECTARIAN PURPOSES

18. The **PROVIDER** agrees that no funds received pursuant to this Agreement will be used for sectarian purposes or to further the advancement of any religion. This paragraph does not in any way limit expenditure of funds due the **PROVIDER'S** employees through this Agreement which become part of the employees personal spending money.

LOBBYING

19. The **PROVIDER/Contractor** will not spend Federal appropriated funds to pay any person for influencing or attempting to influence an officer or employee of Congress, a member of Congress, an employee of a member of Congress, or an officer or employee of any Federal agency in connection with any of the following Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative agreement. Furthermore, if the Provider/Contractor spends any non-federal funds for these purposes, Provider/Contractor will make and file any disclosures required by State or Federal Law.

GENERAL PROVISIONS

20. This Agreement contains all the terms and conditions agreed upon by the parties. All items incorporated by reference are to be attached. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

21. If any term or provision of this Agreement or the application thereof shall, to any extent be held invalid or unenforceable, the remainder of this Agreement, other than those as to which it is held invalid or unenforceable, shall not be affected.

22. The paragraph headings in this Agreement are inserted for convenience and reference only and shall not be used in any way to interpret this Agreement.

23. The following additional schedules are attached and made a part hereof:

EXHIBIT #1 – 6 If Applicable

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers on the date herein written.

DATE: 11/13/14

COUNTY OF CHEMUNG

BY: _____
COUNTY EXECUTIVE

DATE: _____

HORSEHEADS CENTRAL SCHOOL DISTRICT

BY: _____
PROVIDER

Services II

Attachment A = Service Description/Protocols
Attachment B = Budget
Attachment C = Insurance Certificate
Attachment D = Business Associate Agreement
Attachment E = Privacy of Student Records
Attachment F = Compliance Plan
Attachment G = Confidentiality & Information Security Policy
Exhibit #1 = Insurance Requirements
Exhibit #2 = Licenses/Certificates - If Applicable
Exhibit #3 = NYS Provider Agreement
Exhibit #4 = CMS Letter
Exhibit #5 = Medicaid Exclusion List
Exhibit #6 = Authorizing Resolution #14-050

Mgr. Head Approval/Initials _____

ATTACHMENT A
SERVICE DESCRIPTION

II. PROGRAM: EVALUATIONS FOR PRE-SCHOOL

A. GENERAL DESCRIPTION: Evaluations which are family-centered, comprehensive, domain-integrated, functional, inter/trans-disciplinary will be conducted for children aged three (3) through (5) to identify developmental delays and disabilities.

B. PROTOCOL:

According to Section 4410(4) of the Education Law, the documentation of the evaluation must include all assessment reports and a summary report of the findings of evaluation on a form prescribed by the Commissioner and a detailed statement of the preschool child's individual needs. The evaluator shall not include on the summary evaluation report recommendations about the type, frequency and duration of Special Education Services and programs or address the manner in which the special services or programs can be provided in the LRE, but may include such recommendations in the full evaluation. Evaluation findings must not refer to any specific provider of special services or programs.

The individual evaluation must be conducted in accordance with Section 200.4(b) of the regulations of the Commission of Education. The approved evaluator should review other assessments or evaluations to determine if such information fulfills the requirements of the regulations.

Documentation of evaluation should be transmitted as follows:

> **The approved evaluator must provide, in a timely basis,**
> **a copy of the full evaluation, including summary report,**
> **to each member of the CPSE and to the person designated**
> **by the municipality in which the pre-school child resides.**

EVALUATIONS must be submitted to the COUNTY five (5) business days prior to scheduled CPSE meeting.

ATTACHMENT B
BUDGET

All financial arrangements for services covered under this Agreement shall be between the COUNTY and the PROVIDER.

The COUNTY, in accordance with the provisions of this Agreement, shall reimburse the PROVIDER for services as follows:

A. The PROVIDER shall submit a voucher to the COUNTY for services rendered no later than fifteen (15) days after the end of each quarter (at least quarterly) during which the services were rendered.

B. The COUNTY shall reimburse the PROVIDER for services at least quarterly upon receipt of vouchers from PROVIDER.

C. All claims for payment made to the COUNTY by the PROVIDER shall be submitted on forms prescribed by the COUNTY.

D. The COUNTY shall undertake and be responsible for processing of claims for reimbursement under third party insurance and Medicaid.

As part of each voucher submitted by the PROVIDER, the following information for each child shall be included:

a. Date of attendance
b. Type of Service
c. Location of service provided
d. Name and qualification of provider(s)
e. NPI#
f. ICD-9 Code

I. PROGRAM: Pre-School Program Services will be paid at Rates Determined by Chemung County

II. PROGRAM: Pre-School Evaluations will be paid at Approved State Education Department Rates

ATTACHMENT "C"

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/12/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER: The Partners Insurance & Financial Services 825 Vestal Pkwy W Vestal NY 13850	CONTACT NAME: Linda Padgett, AAI, CISR PHONE (A/C, No, Ext): (607) 754-1411 FAX (A/C, No): (607) 754-6143 E-MAIL ADDRESS: linda.padgett@thepartners.com
	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A: Utica National Assurance 10687 INSURER B: Utica National Insurance Co of 13998 INSURER C: INSURER D: INSURER E: INSURER F:
INSURED: Horseheads Central School Dist 1 Raider Lane Horseheads NY 14845	

COVERAGES CERTIFICATE NUMBER: 2014/15 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PROJECT LOC	X		CPP1388111	7/1/2014	7/1/2015	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
								$
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS			BAC1388112	7/1/2014	7/1/2015	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							PIP-Ded:	$ 50,000
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			CUP1388113	7/1/2014	7/1/2015	EACH OCCURRENCE	$ 15,000,000
							AGGREGATE	$ 15,000,000
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N/A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	School District Legal Liability	X		CPP1388111	7/1/2014	7/1/2015	Each Occurrence	$1,000,000
							Aggregate	$2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Contract for 2014 Pre-K Student Evaluations

CERTIFICATE HOLDER	CANCELLATION
County of Chemung 203-205 Lake Street Elmira, NY 14902-0588	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE W Oliver, CIC/LTC

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ATTACHMENT "D"

BUSINESS ASSOCIATE AGREEMENT

County Contracts Attachment

This Agreement ("Agreement") is made and entered into the effective date of the associated contract by and between PROVIDER and the COUNTY and its designated departments.

WHEREAS, PROVIDER is in the business of providing health-related care and/or services;

WHEREAS, COUNTY and its designated departments wish to engage, or has engaged, PROVIDER in connection with said Offering,

NOW, THEREFORE, in consideration of the premises and mutual promises herein contained, it is agreed as follows:

1. Definitions. Terms used, but not otherwise defined in this Agreement, shall have the same meaning as those terms in the Privacy Rule, Security Rule, and HITECH Act.

a. **Agent.** "Agent" shall have the meaning as determined in accordance with the federal common law of agency.

b. **Breach.** "Breach" shall have the same meaning as the term "breach" in 45 CFR §164.402.

c. **Business Associate.** "Business Associate" shall mean a provider or vendor under contract with the County of Chemung.

d. **Covered Entity.** "Covered Entity" shall mean the County of Chemung and its designated departments, including Health Department, Nursing Facility, Office for Aging, Mental Health and Department of Social Services.

e. **Data Aggregation.** "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR §164.501.

f. **Designated Record Set.** "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §164.501.

g. **Electronic Health Record.** "Electronic Health Record" shall have the same meaning as the term in Section 13400 of the HITECH Act.

h. **Health Care Operations.** "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR §164.501.

i. **HITECH Act.** "HITECH Act" shall mean The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009 ("ARRA" or "Stimulus Package"), specifically DIVISION A: TITLE XIII Subtitle D—Privacy, and its corresponding regulations as enacted under the authority of the Act.

j. **Individual**. "Individual" shall have the same meaning as the term "individual" in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

k. **Privacy Rule**. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

l. **Protected Health Information**. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Business Associate on behalf of Covered Entity.

m. **Required By Law**. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR §164.103.

n. **Secretary**. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

o. **Security Rule**. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts §160 and §164, Subparts A and C.

p. **Subject Matter.** "Subject Matter" shall mean compliance with the Privacy and Security Rules, and with the HITECH Act, and its corresponding regulations.

q. **Unsecured Protected Health Information.** "Unsecured Protected Health Information" shall have the same meaning as the term "unsecured protected health information" in 45 CFR §164.402.

2. Obligations and Activities of Business Associate.

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement. Business Associate further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information, as provided for in the Security Rule and as mandated by Section 13401 of the HITECH Act.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Business Associate further agrees to report to Covered Entity any use or disclosure of Protected Health Information not provided for by this Agreement of which it becomes aware, and in a manner as prescribed herein.

d. Business Associate agrees to report to Covered Entity any security incident, including all data Breaches or compromises, whether internal or external, related to Protected Health Information, whether the Protected Health Information is secured or unsecured, of which Business Associate becomes aware.

e. If the Breach, as discussed in paragraph 2(d), pertains to Unsecured Protected Health Information, then Business Associate agrees to report any such data Breach to Covered Entity

within ten (10) business days of discovery of said Breach; all other compromises, or attempted compromises, of Protected Health Information shall be reported to Covered Entity within twenty (20) business days of discovery. Business Associate further agrees, consistent with Section 13402 of the HITECH Act, to provide Covered Entity with information necessary for Covered Entity to meet the requirements of said section, and in a manner and format to be specified by Covered Entity.

f. If Business Associate is an Agent of Covered Entity, then Business Associate agrees that any Breach of Unsecured Protected Health Information shall be reported to Covered Entity ***immediately*** after the Business Associate becomes aware of said Breach, and under no circumstances later than one (1) business day thereafter. Business Associate further agrees that any compromise, or attempted compromise, of Protected Health Information, other than a Breach of Unsecured Protected Health Information as specified in 2(e) of this Agreement, shall be reported to Covered Entity within ten (10) business days of discovering said compromise, or attempted compromise.

g. Business Associate agrees to ensure that any Agent, including a subcontractor, to whom Business Associate provides Protected Health Information, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. Business Associate further agrees that restrictions and conditions analogous to those contained herein shall be imposed on said Agents and/or subcontractors via a written agreement, and that Business Associate shall only provide said Agents and/or subcontractors Protected Health Information consistent with Section 13405(b) of the HITECH Act. Further, Business Associate agrees to provide copies of said written agreements to Covered Entity within ten (10) business days of a Covered Entity's request for same.

h. Business Associate agrees to provide access, at the request of Covered Entity and during normal business hours, to Protected Health Information in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in order to meet Covered Entity's requirements under 45 CFR §164.524, provided that Covered Entity delivers to Business Associate a written notice at least three (3) business days in advance of requesting such access. Business Associate further agrees, in the case where Business Associate controls access to Protected Health Information in an Electronic Health Record, to provide similar access in order for Covered Entity to meet its requirements under Section 13405(c) of the HITECH Act. These provisions do not apply if Business Associate and its employees, subcontractors and Agents have no Protected Health Information in a Designated Record Set of Covered Entity.

i. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR §164.526, at the request of Covered Entity or an Individual. This provision does not apply if Business Associate and its employees, subcontractors and Agents have no Protected Health Information from a Designated Record Set of Covered Entity.

j. Unless otherwise protected or prohibited from discovery or disclosure by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures (collectively "Compliance Information"), relating to the use or disclosure of Protected Health Information, available to the Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule, Security Rule, and the

HITECH Act. Business Associate further agrees, at the request of Covered Entity, to provide Covered Entity with demonstrable evidence that its Compliance Information ensures Business Associate's compliance with this Agreement over time. Business Associate shall have a reasonable time within which to comply with requests for such access and/or demonstrable evidence. In no case shall access, or demonstrable evidence, be required in less than five (5) business days after Business Associate's receipt of such request, unless otherwise designated by the Secretary.

k. Business Associate agrees to maintain necessary and sufficient documentation of disclosures of Protected Health Information as would be required for Covered Entity to respond to a request by an Individual for an accounting of such disclosures, in accordance with 45 CFR §164.528.

l. On request of Covered Entity, Business Associate agrees to provide to Covered Entity documentation made in accordance with this Agreement to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R.§164.528. Business Associate shall provide said documentation in a manner and format to be specified by Covered Entity. Business Associate shall have a reasonable time within which to comply with such a request from Covered Entity and in no case shall Business Associate be required to provide such documentation in less than three (3) business days after Business Associate's receipt of such request.

m. Except as provided for in this Agreement, in the event Business Associate receives an access, amendment, accounting of disclosure, or other similar request directly from an Individual, Business Associate shall redirect the Individual to the Covered Entity.

3. Permitted Uses and Disclosures by Business Associate.

a. Except as otherwise limited by this Agreement, Business Associate may make any uses and disclosures of Protected Health Information necessary to perform its services to Covered Entity and otherwise meet its obligations under this Agreement, if such use or disclosure would not violate the Privacy Rule, or the privacy provisions of the HITECH Act, if done by Covered Entity. All other uses or disclosures by Business Associate not authorized by this Agreement or by specific instruction of Covered Entity are prohibited.

b. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used, or further disclosed, only as Required By Law, or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 CFR §164.504(e)(2)(i)(B). Business Associate agrees that such Data Aggregation services shall be

provided to Covered Entity only wherein said services pertain to Health Care Operations. Business Associate further agrees that said services shall not be provided in a manner that would result in disclosure of Protected Health Information to another covered entity who was not the originator and/or lawful possessor of said Protected Health Information. Further, Business Associate agrees that any such wrongful disclosure of Protected Health Information is a direct violation of this Agreement and shall be reported to Covered Entity ***immediately*** after the Business Associate becomes aware of said disclosure and, under no circumstances, later than three (3) business days thereafter.

e. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with §164.502(j)(1).

4. Obligations and Activities of Covered Entity.

a. Covered Entity shall notify Business Associate of the provisions and any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such provisions and limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that the changes or revocation may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR §164.522, and also notify Business Associate regarding restrictions that must be honored under section 13405(a) of the HITECH Act, to the extent that such restrictions may affect Business Associate's use or disclosure of Protected Health Information.

d. Covered Entity shall notify Business Associate of any modifications to accounting disclosures of Protected Health Information under 45 CFR §164.528, made applicable under Section 13405(c) of the HITECH Act, to the extent that such restrictions may affect Business Associate's use or disclosure of Protected Health Information.

e. Covered Entity shall provide Business Associate, within thirty (30) business days of Covered Entity executing this Agreement, a description and/or specification regarding the manner and format in which Business Associate shall provide information to Covered Entity, wherein such information is required to be provided to Covered Entity as agreed to by Business Associate in paragraph 2(e) of this Agreement. Covered Entity reserves the right to modify the manner and format in which said information is provided to Covered Entity, as long as the requested modification is reasonably required by Covered Entity to comply with the Privacy Rule or the HITECH Act, and Business Associate is provided sixty (60) business days notice before the requested modification takes effect.

f. Covered Entity shall provide Business Associate, within thirty (30) business days of Covered Entity executing this Agreement, a description and/or specification regarding the manner and format in which Business Associate shall provide information to Covered Entity, wherein such information is required to be provided to Covered Entity as agreed to by Business Associate in paragraph 2(l) of this Agreement. Covered Entity reserves the right to modify the manner and format in which said information is provided to Covered Entity, as long as the requested modification is reasonably required by Covered Entity to comply with the Privacy Rule or the HITECH Act, and Business Associate is provided sixty (60) business days notice before the requested modification takes effect.

5. Term and Termination.

a. Term. The Term of this Agreement shall be effective as of the effective date of the associated contract/agreement and shall terminate when **all** of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Agreement.

b. Termination for Cause by Covered Entity. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity shall give Business Associate written notice of such breach and provide reasonable opportunity for Business Associate to cure the breach or end the violation. Covered Entity may terminate this Agreement, and Business Associate agrees to such termination, if Business Associate has breached a material term of this Agreement and does not cure the breach or cure is not possible. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Termination for Cause by Business Associate. Upon Business Associate's knowledge of a material breach of this Agreement by Covered Entity, Business Associate shall give Covered Entity written notice of such breach and provide reasonable opportunity for Covered Entity to cure the breach or end the violation. Business Associate may terminate this Agreement, and Covered Entity agrees to such termination, if Covered Entity has breached a material term of this Agreement and does not cure the breach or cure is not possible. If neither termination nor cure is feasible, Business Associate shall report the violation to the Secretary.

d. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement for any reason, Business Associate shall **return or destroy all** Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or Agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity, within ten (10) business days, notification of the conditions that make return or destruction infeasible. Upon such determination, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. Entire Agreement.

a. This Agreement supersedes all other prior and contemporaneous written and oral agreements and understandings between Covered Entity and Business Associate regarding this Subject Matter. It contains the entire Agreement between the parties.

b. This Agreement may be modified only by a signed written agreement between Covered Entity and Business Associate.

c. All other agreements entered into between Covered Entity and Business Associate, not related to this Subject Matter, remain in full force and effect.

7. Governing Law.

a. This Agreement and the rights of the parties shall be governed by and construed in accordance with Federal law as it pertains to the Subject Matter and shall be governed by and construed in accordance with the laws of the State of New York as it pertains to contract formation and interpretation, without giving effect to its conflict of laws. The parties agree that any appropriate state court sitting in Chemung County, New York or any Federal Court with jurisdiction for Chemung County shall have exclusive jurisdiction of any case or controversy arising under or in connection with this Agreement and shall be a proper forum in which to adjudicate such case or controversy.

b. Each party irrevocably consents to the jurisdiction of such courts, and irrevocably waives, to the fullest extent permitted by law, the defense of an inconvenient forum to the maintenance of such suit, action, or proceeding in any such court and further waives the right to object, with

respect to such suit, action, or proceeding, that such court does not have jurisdiction over such party.

8. Miscellaneous.

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule, Security Rule, or HITECH Act means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, Security Rule, the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), and the HITECH Act, and its corresponding regulations.

c. Survival. The respective rights and obligations of Business Associate under Section 5(d) of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), and the HITECH Act, and its corresponding regulations.

e. Severability. If any provision or provisions of this Agreement is/are determined by a court of competent jurisdiction to be unlawful, void, or unenforceable, this Agreement shall not be unlawful, void or unenforceable thereby, but shall continue in effect and be enforced as though such provision or provisions were omitted.

9. Counterparts.

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one original Agreement. Facsimile or electronically authenticated signatures shall be accepted and enforceable in lieu of original signatures.

ATTACHMENT "E"

PRIVACY OF STUDENT RECORDS

1. The parties understand and agree that this agreement covers educational records of pre-school students at Horseheads Central School District, and that therefore the Family Educational Rights and Privacy Act (FERPA) and the individuals with Disabilities in Education Act (IDEA) attach to all records About students created pursuant to this agreement.

   Both parties agree that no student records created pursuant to this agreement will be used for any commercial purposes and that no documents can be released to third parties without the prior written consent of the student, or the parents or legal guardians of the student where the student is a minor, except as authorized by FERPA, IDEA, or otherwise authorized by law.

2. Section 2-c and 2-d of the New York State Education Law require that third party contractors comply with the parents' Bill of Rights and ensure privacy of any personally identifiable data shared under this contract. Contractor agrees to comply in every respect with all applicable provisions of section 2-c and 2-d of the NYS Education Law and any subsequently promulgated rules, regulations or laws regarding the same. Contractor has read the Parent's Bill of Rights and has read the District's Student Records Policy and agrees to fully comply with both including any amendments.

ATTACHMENT "F"

COUNTY OF CHEMUNG

Compliance Plan

(Medicare, Medicaid & Insurance Plans)

for

EMPLOYEES, CONTRACTORS & AGENTS

R June 13, 2011 (3/00, 11/07, 12/09)
Resolution 11-308

Index

NOTE: The Compliance Plan and its attachments are posted on the County's intranet site under Public Information Office. This site is accessible by all County employees.

COUNTY OF CHEMUNG

Compliance Plan: Medicare, Medicaid & Insurance Plans

I. Compliance Program Overview

A. This document summarizes the overall Compliance Plan and Compliance Program for the applicable departments and services sponsored by the County of Chemung that receive Medicaid, Medicare or third party insurance reimbursement, either directly or indirectly. Specifically, this Plan pertains to services provided at the Chemung County Health Center, including Health Department and Nursing Facility, and at the Chemung County Human Resource Center, including Departments of Social Services, Mental Hygiene and Office for Aging. It sets forth applicable policies regarding compliance with state and federal laws, rules and regulations pertaining to Corporate Compliance, Medicaid Compliance Program, false claims acts, ethics, personal conduct and quality assurance. It is Chemung County's philosophy and policy to comply strictly with the letter and spirit of all laws and ethical standards applicable to the business of county government. In furtherance of this end, this document specifies particular policies, practices and the overall plan to promote compliance by employees, contractors and agents of the County.

B. This Compliance Plan is intended to implement an effective countywide Compliance Program that will prevent and detect fraud and abuse by organizing provider resources to resolve payment discrepancies and detect inaccurate billings as quickly and efficiently as possible and to impose systemic checks and balances to prevent further recurrences.

C. A key purpose of this Plan is compliance with New York Medicaid regulations 18 NYCRR Section 521 and Social Services Law Section 363-d that state: "Every provider of medical assistance program items and services...shall adopt and implement an 'effective' compliance program."

D. The County's Compliance Program shall consist of the following key elements:

- Written policies and procedures
- Employees (Compliance Officers) who are vested with responsibility for day-to-day Compliance Program operation
- Training and education of all affected employees and persons
- Communication lines to the responsible compliance position
- Disciplinary policies to encourage good faith Compliance Program participation
- System to routinely identify compliance risk areas
- System for responding to compliance issues as they arise
- Policy of non-intimidation and non-retaliation for good faith Compliance Program participation

II. Code of Conduct

It is the County's policy to comply strictly with the letter and spirit of all laws and ethical standards applicable to the business of County departments and services, including those receiving Medicare and/or Medicaid funding.

Any employee, contractor or agent of the County who believes that conduct by an individual or organization is not consistent with the requirements of applicable law or ethical standards, or is otherwise not consistent with the requirements of this plan and the County's overall Compliance Program, shall be obligated to report the conduct to the designated Compliance Officer or to other County Administration officials including Health Center Director, Human Services Commissioner, Office for Aging Director, County Executive, County Attorney, Independent Auditors or New York State Office of the Medicaid Inspector General.

The Code of Conduct (Attachment A) is an integral part of the Compliance Plan.

The County shall reasonably assist its employees, contractors and agents in all areas of compliance.

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III. **Standards, Rules and Procedures to Promote Compliance**

It is the policy of the County to comply with all requirements of law and ethical standards. All employees, contractors and agents of the County shall strive to ensure that all activities undertaken by or on behalf of the County are in compliance with applicable laws and ethical standards.

As part of the County's Compliance Program, the Compliance Officers and other appropriate individuals shall define and articulate, from time to time, specific standards and procedures to promote compliance. Such standards shall be intended to provide guidance to assist in their compliance with applicable laws. However, such standards will not be viewed as exclusive or complete.

Notwithstanding the specific requirements stated in such standards, employees, contractors and agents shall be required to comply with all applicable laws and ethical requirements, whether or not specifically addressed in these policies or standards. If questions regarding the existence or interpretation of any law or ethical requirement shall arise, such question shall be directed to a department's designated Compliance Officer or other County Administrative Official.

IV. **Compliance Oversight Responsibilities**

General: The County, through its appointed department heads, shall maintain ultimate responsibility and authority for the Compliance Program. To this end, the County and its affected departments in the Health Center and Human Resource Center shall undertake at least the following activities:

A. Appointment of a Compliance Officers for the Health Center and Human Resource Center with input and advice from Department Heads;

B. The Compliance Officers and Health Center Director/Human Services Commissioner/Office for Aging Director shall undertake the following activities:

1. Develop and implement a Compliance Plan and review/revise it on an annual basis;

2. Ensure that the Compliance Program's objectives reflect, and are consistent with, the County and individual department's mission, culture, vision and Code of Conduct;

3. Provide that the Compliance Program's objectives are appropriately reflected in the policies and systems, including those relating to governance, risk management, information management, financial and operational activities;

4. Receive and review reports regarding the Compliance Program and the County's overall compliance activities, including reports of conduct that may be deemed to be in violation of applicable legal and /or ethical standards, remedial action to address such conduct and steps taken to prevent the recurrence of such incidents, and other matters

5. Review audit and inspection reports prepared by public accountants and regulatory agencies;

6. Monitor Compliance Program effectiveness and consider changes to enhance effectiveness; and

7. Serve as participants in the Compliance Program consistent with the County's overall role in governance and management, including accepting reports and undertaking appropriate action in the event that standards and procedures related to compliance may be violated.

Compliance Officer. The Compliance Officer shall be responsible for the coordination of the Health Center or Human Resources Center's Compliance Program, subject to Administrative Authority.

The Compliance Officer shall report directly to the Health Center Director or Human Services Commissioner and shall have independent authority to seek advice of legal counsel or independent auditors regarding compliance-related issues as needed.

The duties and responsibilities for the Compliance Officer are hereby incorporated into this plan. The Compliance Officer shall be obligated to comply with all standards and requirements including the following:

A. To serve as the lead official to whom reports related to compliance and potential non-compliance may be made, including reports made in person, phone calls or other means;

B. To serve as the lead official responsible for the coordination and continual improvement of the Compliance Program, including overall responsibility to work to promote compliance with all applicable laws, regulations, rules, policies and procedures of governmental authorities and payers;

C. To work with Health Center Director/Human Services Commissioner to develop program rules, procedures and policies reasonably capable of reducing the prospect of wrongdoing, to monitor the Compliance Program's effectiveness, and to recommend appropriate modifications;

D. To oversee training and education of employees, contractors and agents regarding the Compliance Program and the policies regarding compliance, as well as specific program requirements related to billing, coding and other specific issues that are subject to the Compliance Plan;

E. To institute policy dissemination and other activities as stated in the Compliance Plan, and to maintain current records and documentation related to employee training and other compliance related activities;

F. To coordinate and/or provide ongoing education and training of new employees regarding the policies related to the Compliance Program and related matters such as "False Claims Acts and Whistleblower Protections",

G. To coordinate and manage, where applicable, Criminal History Record Checks, pre-employment drug screens and other employment related activities as otherwise defined in the County's personnel policies;

H. To provide recommendations to the regarding Compliance Program changes and improvements as warranted.

V. Standards Related to Conditions of Employment

Compliance with all applicable legal requirements and industry standards is a condition of employment by the County. This requirement shall be effectively communicated to employees during initial orientation and annually thereafter.

The Health Center and Human Resource Center shall comply with existing human resource policies related to reference checks, Sheriff's Department criminal background checks or FBI Criminal History Record Checks and related activities as set forth in human resource policies. Such policies are incorporated herein by reference and are contained in the Health Center's Personnel Guide, Administrative Policy Manuals for Health Center and Human Resources Center departments, and County Administrative Policy Manual.

VI. False Claims Act and Whistleblower Protections

It is the policy of the Chemung County government to obey laws and regulations and to detect and eliminate waste, fraud or abuse relating to payments from federal and state programs including Medicare and Medicaid. The County of Chemung, and its relevant departments, does not tolerate making or submitting false or misleading billing claims or statements to any agency, individual or third party payer source, and the County expects all employees, contractors and agents to adhere to and comply with state and federal False Claims Acts and with Section 1902 of the Social Security Act as well as other applicable laws and regulations.

The County is committed to providing education or information to employees, contractors and agents on the expected standards of conduct, both personal and professional, and County and departmental policies, as well as this Compliance Plan, set forth expected codes of conduct. An essential provision of these codes of conduct is the obligation on the part of all employees, contractors and agents to report issues, suspicions or concerns that could indicate false claims, fraud, waste or abuse. Such reporting must be done without fear of retaliation and can be done

confidentially through the designated Compliance Officer, Health Center Director or Human Services Commissioner, County Executive's Office, County Attorney's Office, Independent Auditors or New York State Office of the Medicaid Inspector General.

False Claims Act-State and Federal

The False Claims Acts are laws that prohibit an individual or organization that receives money from the state or federal governments from submitting an intentionally false or fraudulent request for payment. The County may be held liable under law if it knew or disregarded information indicating that a claim submitted to the state or federal government for payment of health care services contained false information. Examples of actions which may violate the False Claims Acts include, but are not limited to the following:

- Submitting a claim for services that were not provided;
- Knowingly filing a false or fraudulent claim for repayment or approval;
- Duplicate billing to Medicaid/Medicare and private insurance or private pay;
- Knowingly making or using a false record or statement to obtain payment on a false or fraudulent claim;
- Knowingly making or using a false record or statement to conceal, avoid or decrease an obligation to pay or remit money to the state or federal government;
- Submitting a claim for services that were not "medically necessary;
- Submitting a claim for services that is coded as more complex than indicated in the patient's medical record in order to receive higher reimbursement than is allowable under regulations.

Fines and other legal action, including criminal prosecution, may be imposed for each falsely submitted claim.

Whistle Blower Protections under Law

State and federal laws offer protection to individuals who make reports of suspected fraud or false claims, and these laws are referred to as "whistle blower" protection. The employer may not retaliate against or punish a "whistle blower" who makes a good faith report of possibly fraudulent activities, improper quality of care or abuse and neglect, and these laws provide for employment reinstatement and back pay plus other compensation if an individual is suspended, demoted or terminated for making a report covered by the False Claims Acts. In addition to protection, a "whistle blower" may be entitled to receive monetary rewards of 15% to 30% of claims that the government recovers as the result of investigation and prosecution of legal action against a health care services provider or its employees, contractors and agents.

Measures to Detect, Prevent and Report Fraud and False Claims

The County of Chemung and its applicable departments strive to prevent, detect and report violations of state and federal laws and expect that all of its employees will do the same. Some of the measures that are used to comply with laws and regulations include:

- Policies and procedures to detect and respond to complaints of potential fraud including the County's Compliance Plan, departmental administrative polices, and County policies and procedures.
- A Compliance Officer is available to receive confidential reports of suspected fraud:
  - Health Center: Staff Development Coordinator, (607) 737-2939
  - Human Resource Center: Early Intervention Coordinator, (607) 737-5568
- Confidential reports may also be made to:
  - Health Center Director, (607)737-2068
  - Human Services Commissioner, (607) 737-5400
  - County Executive, (607) 737-2912; or
  - County Attorney, (607) 737-2982;
  - External Auditors:
    - Nursing Facility: Mengel, Metzger and Barr (607) 734-4183
    - Health Department: Freed Maxick, PC (800) 777-4885
    - Human Resource Center: EFP Rottenberg (607) 734-1636
  - Elmira Police Department (if directed by County Attorney)
  - Office of the Medicaid Inspector General:
    - 1-877-873-7283
    - Online Complaint Form at: www.omig.state.ny.us

- When the Compliance Officer, department manager or County official receives a report of suspected fraud, the following steps must be taken immediately:
  - Contact applicable external auditor
  - Contact County Attorney's Office, (607) 737-2982
- Annual training for applicable employees on False Claims Acts and Whistle Blower Protections and distribution of written policies and information to employees such as the Health Center's Personnel Guide as well as access to all County and departmental policies including the Compliance Plan;
- Annual and ongoing training for billing, MDS, and fiscal services personnel on Medicare and Medicaid rules and regulations including seminars, teleconferences, instruction manuals and memoranda;
- Annual audits conducted by independent accountants, regulatory agencies and the Office of the Medicaid Inspector General.

VII. Compliance Related Education and Communication.

Education and training regarding the Compliance Program will consist of the following minimum activities:

A. Availability of this Compliance Plan document to all current employees and all new hires contained in administrative policy manuals located in each department covered by this plan.

B. Mandatory training of all employees annually and during orientation for new hires. Such training and education shall emphasize the following:
- The Code of Conduct
- Employee responsibilities under the Compliance Plan,
- Reporting obligations; and
- Methods of reporting
- Compliance Program update
- False Claims Act and Whistleblower Protections

In addition, each employee shall receive training related to particular areas of compliance (e.g., billing and coding, documentation requirements etc.) in accordance with the training schedule and other requirements associated with the employee's particular position.

VIII. Monitoring, Auditing and Reporting Systems

The County and its Department Heads shall require and actively encourage reporting of potential violations of legal and/or ethical requirements to the Compliance Officer or other County Administration Officials.

All allegations of a failure to comply with an applicable law, regulation or ethical standard shall be referred to the Compliance Officer verbally, in writing or through other means. All reports will be private, and the County and its departments shall endeavor to maintain confidentiality to the extent possible although absolute confidentiality cannot be promised and anonymity cannot be guaranteed.

IX. Investigations for Non-Compliance

When there is information of potential violations or misconduct, the Health Center Director/Human Services Commissioner or Compliance Officer has the responsibility of having the investigation conducted by or under the supervision of legal counsel or independent auditors. To assure protection from coerced disclosure for information gained through investigative interviews, statistical and record analyses and other reports, an internal investigation should include interviews and a review of medical records, billings and other relevant documents where applicable.

X. Program Modifications to Enhance Compliance and Effectiveness

Upon the identification of a compliance problem, it is the Health Center Director/Human Services Commissioner's responsibility to take demonstrable corrective actions, including steps to prevent further similar offenses. Where the investigation has identified the receipt of overpayments or other deviations from federal or state legal standards,

corrective action (including repayment as appropriate) shall be initiated. Corrective actions and the issue of whether there must be disclosure of compliance information to the state or federal government shall be discussed with counsel.

XI. **Discipline Process for Code of Conduct or Compliance Plan Violations**

A. All violators of the Code of Conduct or Compliance Plan will be subject to disciplinary action in accordance with appropriate collective bargaining agreements and/or Civil Service Law Sections 75/76. The level of discipline utilized will depend on the nature, severity and frequency of the violation and may result in any of the following disciplinary actions:

- Record of Conference
- Written Warning
- Letter of Reprimand
- Suspension without pay for up to 30 days
- Termination of employment

B. In addition to actions taken under progressive discipline, criminal or civil action may be taken as appropriate. All potential criminal activity must be reported to Elmira Police Department, Office of the Medicaid Inspector General or applicable federal regulatory agencies.

Attachment A

Code of Conduct

A. Introduction

It is the policy of Chemung County to comply with all laws and ethical standards applicable to the operation of the business of the County and to promote continuous improvement in the quality and performance of its operations. The County has adopted a Compliance Plan and implemented a Compliance Program to further the adherence to this policy. As part of the Compliance Program, the County has adopted this Code of Conduct as a statement setting forth the principles and standards to which employees and contract agents of the County are expected to adhere. The purpose of the Code of Conduct is to articulate the policy and ethical framework within which the County operates. All employees are responsible to ensure that their behavior and activity, and the behavior and activity of contractors and agents are consistent with this Code of Conduct.

Each employee should deal fairly with the county's clients/patients/residents/customers and suppliers. Employees should not discuss prices, costs, products, services or other non-public data with a competitor. To ensure compliance with the Federal False Claims Act, employees are not allowed to knowingly submit false claims to a government program.

B. References

The following items are an integral part of the Code of Conduct. This list is not all-inclusive.

- County of Chemung Administrative Policy Manual
- Health Center and Human Resource Center departmental Administrative Manuals
- Health Center's Personnel Guide
- NYS Public Health Law
- NYS Code of Rules & Regulations
- Quality Assurance Plans
- Federal and NYS False Claims Acts
- Section 1902 of Social Security Act

C. Code of Conduct

1. Principle 1-Legal Compliance

All employees of the County shall strive to ensure that all activity by or on behalf of the organization is in compliance with applicable laws, rules and regulations.

The following standards are intended to provide guidance to employees to assist them in their obligation to comply with applicable laws. These standards are neither exclusive nor complete. Employees are required to comply with all applicable laws, whether or not specifically addressed in these policies. If questions regarding the existence of, interpretation or application of any law should arise, they should be directed to the Compliance Officer, the Health Center Director/Human Services Commissioner, County Executive, County Attorney or state/federal regulatory agencies. Employees whose day to day work is directly impacted by certain laws have a duty to understand them well enough to be aware of potential issues and know when to seek advice. Employees have a duty to follow the policies and procedures and to notify management of any violations.

Standard 1.1 – Billing and Coding

All employees and contract agents responsible for coding and billing for services provided to residents or clients shall comply with all laws, regulations and policies that govern billing federal, state and other third party insurers for services. Employees shall report immediately to the department's Compliance Officer or County Department Head any failure to follow this standard.

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Standard 1.2 – Fraud and Abuse

The County expects its employees to refrain from conduct which may violate fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients/clients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payer, including claims for services not rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service. All employees shall strictly comply with these prohibitions. Any employee who becomes aware that any of these prohibitions may have been violated shall promptly report the suspected conduct to the Compliance Officer or County Department Head.

2. **Principle 2 – Ethical Conduct**

All employees of the County shall conduct themselves in a manner that complies with the high ethical standards expected of individuals who work in the County.

Standard 2.1 – Confidentiality

Employees shall maintain the confidentiality of residents, clients or patients and other confidential information in accordance with applicable legal and ethical standards, including HIPPA Compliance

Standard 2.2 – Kickbacks

No employee may solicit or accept a bribe, kickback, tip or other compensation in exchange for referral of patients/clients, patient/client information or eligibility for benefits under Medicare/Medicaid to which the person is not entitled.

Standard 2.3—Conflict of Interest for Service Referrals

No physician or practitioner shall order services, or refer for services, to be provided through an entity in which he/she has a personal or business interest, for residents/clients whose care is being reimbursed to the County by Medicare Part A.

Standard 2.4--Conflict of Interest

A conflict of interest occurs when an employee's personal or private interests conflict with the interests of the County or the interests of a patient/resident/client. Every employee should take care about the appearance of a conflict, and even if there is no actual conflict, the appearance might cause lack of confidence or may harm the reputation of the County and its individual departments. Examples of conflict of interest may include:

- A situation that has the potential to undermine the impartiality of a person because of a possible clash between a person's self-interest and the interests of a profession, the public or an organization.
- A situation in which one person's response to a second person limits the ability to fulfill a responsibility to a third person.

Standard 2.5 – Obligation to Report

Any employee who is aware or has information that fraudulent activities may be taking place and who does not report such concerns to proper authorities may be held accountable for aiding or enabling fraudulent activities. Any provider agency within the County that bills Medicare, Medicaid or third party insurers for services is required to promptly notify the appropriate reimbursing entity when overpayments or incorrect payments have been received and to take action to return/refund such payments as directed by the reimbursing entity.

3. Accounting Practices, Books & Records, and Record Retention

It is the policy of the County and its departments/employees to fully and fairly disclose the financial condition of its operations according to all applicable accounting principles, laws, rules and regulations including cost reporting to governmental agencies. Record retention policies shall be in accordance with Records Retention and Disposition Schedule CO-2 as published by the State Education Department except when applicable state or federal regulations require different record retention procedures for specific providers. Documents related to any pending or possible legal action, investigation or audit shall not be destroyed without approval of the County Attorney. Destroying or altering a document with the intent to impair it is a crime. Employees shall accurately complete all records used to determine compensation or expense reimbursement.

4. **Personal Responsibilities – Conditions of Employment**

Refer to Code of Conduct in the Health Center's Personnel Guide or applicable departmental personnel policies in the Human Resource Center.

Every employee has a personal duty to protect the physical and intangible assets of the County and its individual departments and to ensure their efficient use. Employees may not take opportunities to reward themselves personally through the use of County property, data or relationships.

The County has the right to monitor or review any information on an employee's computer or electronic device that is County property. Internet activity, email and other electronic communication are also subject to monitoring and review. Such tools may not be used to commit illegal acts or break County policies, including discrimination, harassment, pornography or solicitation. Passwords may not be shared, and software may not be put on computers without IT Department approval. No employee shall take part in the illegal use, copying, distribution or modification of computer software.

Current or previous employees may not use confidential information for their own personal use or share that data with others outside of the individual County department. Employees shall comply with HIPAA standards for all protected health information.

Each employee has a duty to report violations of the Code of Conduct. No retribution will be allowed against any employee who reports in good faith.

5. **Administration and Application of This Code of Conduct**

The County expects each person to abide by the principles and standards set forth herein, and to conduct the business and affairs of the County in a manner consistent with the general statement of principles set forth herein.

Failure to abide by this Code of Conduct may lead to disciplinary or legal action. For alleged violations of the Code of Conduct, the County will consider relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of the Code of Conduct, the egregiousness of the behavior, the employee's history with the organization and other factors which may be deemed relevant. Civil Service Law and/or applicable collective bargaining agreements govern discipline for failure to abide by the Code of Conduct.

Nothing in this Code of Conduct is intended to, nor shall be construed to provide any additional employment or contract rights to employees or other persons.

6. **Revisions and Additions to Code of Conduct**

The County may from time to time adopt additional, specific principles and standards or otherwise modify, amend or alter this Code of Conduct and other County or departmental policies and procedures which will be communicated to all applicable employees. In addition, the County and its individual departments have established

and maintain practices, policies and procedures not set forth in this Code of Conduct. These additional practices, procedures and policies are an integral part of the County's Compliance Program, and employees, contractors and agents of the County are expected to comply with all such practices, procedures and policies.

ATTACHMENT B

FEDERAL AND NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

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ATTACHMENT C

MEDICAID SELF-DISCLOSURE GUIDANCE

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FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

> The False Claims Act ("FCA") provides, in pertinent part, that:
>
> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> ***
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. 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.

A. CIVIL AND ADMINISTRATIVE LAWS

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care 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 suit of 15-25% if the government did participate in the suit.

Social Services Law §145-b False Statements

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 the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

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 if a second (or once if benefits received are over $3,900) and live years for 4 or more offenses.

B. CRIMINAL LAWS

Social Services Law §145 Penalties

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

Social Services Law § 366-b, Penalties for Fraudulent Practices.

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. 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.

Penal Law Article 155, Larceny.

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. It has been applied to Medicaid fraud cases.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements.

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud.

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud.

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health cam fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. §3730(h))

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

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 conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

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. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). 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. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes 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 patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

Self-Disclosure Guidance

March 12, 2009

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Introduction

The mission of the New York State Office of the Medicaid Inspector General (OMIG) is to work with providers and our state agency partners to improve the integrity of the Medicaid program, while simultaneously ensuring access to services for enrollees and cost effectiveness to New York State's taxpayers. We are committed to detecting potential fraud, waste and abuse within the state's Medicaid program and recovering inappropriate payments. As part of our multi-disciplinary approach to attaining these goals, we are making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues to the OMIG, and return inappropriate payments.

The OMIG recognizes that many improper payments are discovered during the course of a provider's internal review processes. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments,[1] we appreciate that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both New York State and the provider involved. OMIG has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds—whether intentional or unintentional—under the state's Medicaid program. By forming a partnership with providers through this self-disclosure approach, OMIG's overall efforts to eliminate fraud, waste and abuse will be enhanced, while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

This guidance replaces the existing Department of Health (DOH) disclosure protocol and establishes the process for participating in the OMIG's Self-Disclosure Program, in accordance with OMIG's enabling legislation:

> *[T]o, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.* N.Y. PUB. HEALTH LAW § 32(18).

In addition, the intended use of this guidance is significantly more expansive in scope than the protocol of the federal Department of Health and Human Services (DHHS) Office of the Inspector General's (OIG), which focuses on potential violations of criminal, civil or administrative law. The OMIG recognizes that situations which are subject to this guidance could vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

[1] *See* 18 NYCRR § 515.2

Advantages of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if OMIG staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the OMIG typically extends the following benefits to providers who, in good-faith, participate in a self-disclosure:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of penalties and/or sanctions
- Timely resolution of the overpayment
- Recognition of the effectiveness of the provider's compliance and a decrease in the likelihood of imposition of an OMIG Corporate Integrity Program
- Possible preclusion of subsequently filed New York State False Claims Act qui tam actions based on the disclosed matters[2]

Developing such a partnership with the OMIG during the self-disclosure process may also lead to more thorough understanding of the OMIG's audit and investigatory processes, which could benefit the provider in the future.

When to Disclose

Once an inappropriate payment is discovered that warrants self-disclosure, providers are encouraged to contact OMIG as early in the process as possible to maximize the potential benefits of self-disclosure.[3] However, because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes.[4]

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may

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[2] *See* N.Y. Finance Law § 190(9) and USA ex rel Grant v. Rush-Presbyterian St. Lukes Medical Center, 2000 US Dist. Lexis 19249 (ND Ill. 8/14/2000) (disclosure to a competent public official who has managerial responsibility over the very claims made constitutes public disclosure because it effectuates the purpose of disclosure as to allow the government to take the proper steps in dealing with it).

[3] Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If OMIG is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of the on-site audit staff. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to OMIG, the provider should follow this guidance accordingly.

[4] Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants.

demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of fraud and abuse laws[5]

OMIG is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. Providers should be aware that the OMIG monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. The OMIG highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

The Process

Once a provider makes the determination to disclose a problem, the following steps comprise an initial report:

- At a minimum, gather the following information:
  - The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
  - The Medicaid program rules potentially implicated;
  - Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent reoccurrence; and
  - The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in an appropriate position to speak for the organization.
- Contact the OMIG with the above information by telephone or via formal letter to:

  The Office of the Medicaid Inspector General
  Attention: Provider Self-Disclosure
  800 North Pearl Street
  Albany, NY 12204
  (518) 473-3782

[5] Upon review of the provider's disclosure and related information, the OMIG may conclude that the disclosed matter warrants referral to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, DHHS OIG, the Department of Justice or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws.

Providers may also use the printable version of OMIG's self-disclosure form, which is available at www.omig.state.ny.us.

After this initial reporting phase, the OMIG will consult with the provider and determine the most appropriate process for proceeding. OMIG staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

- A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;
- Detailed list of claims paid that comprise the overpayments (in an electronic medium and preferably in an Excel spreadsheet format). Each claim should list the provider Medicaid ID number, client name and Medicaid ID, dates of service(s), rates or procedure codes, and the amount(s) paid by Medicaid; and
- The names of individuals involved in any suspected improper or illegal conduct.

Assuming complete provider cooperation and timely response to information requests, the OMIG expects that the vast majority of self-disclosures will be completed within six months of submission of this information.

The OMIG will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OMIG cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with the OMIG to resolve the disclosure, the OMIG may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms may no longer apply.[6]

Access to Information

Providers are expected to promptly comply with OMIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OMIG also expects the provider to execute and provide business record affidavits whenever requested, in an acceptable form.

The OMIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's counsel will explore ways to gain access to factual or other non-protected information pertinent to the case in the event that documents or other material contain thought processes or advice from the provider's legal counsel, without the need to waive the protection provided by an appropriately asserted claim of attorney-client privilege or attorney work product. [7]

[6] Assuming the provider acts in good-faith, the mere fact that the provider and OMIG are unable to agree on an amount and resolve the disclosure will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and OMIG are able to agree.

Restitution

All provider self-disclosures are subject to a thorough OMIG review to determine whether the amount identified is accurate. While repayment is encouraged/accepted as early in the process as possible, and any repayment will be credited toward the final settlement amount, the OMIG will not accept money as full and final payment for self-disclosures prior to finalizing the audit/investigatory process.

Following the review, OMIG staff will consult with the provider's respective state oversight agency to establish a repayment amount and schedule and explore the need to pursue any further administrative action. OMIG's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the time period, thoroughness and timing of the provider's disclosure, any potential harm to the health and safety of Medicaid patients, and the provider's efforts to prevent the problem from recurring.

Once a repayment amount has been established, assuming full repayment has not previously been made, the OMIG expects the provider to reimburse the State of New York for the overpayment with a check for the full amount, made payable to the New York State Department of Health or enter into a repayment agreement. Repayments can occur through monthly payments to OMIG or by having OMIG withhold a portion of that provider's weekly reimbursement. The OMIG will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms will be required to submit audited financial statements, if available, and/or other documentation to assist the OMIG in making that determination. Once the repayment has been finalized, the OMIG will issue a letter indicating closure of the matter.

[7] The OMIG will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege or work product protection. A lack of information may make it difficult for OMIG to determine the nature and extent of the conduct which caused the improper payment.

New York State Office of the Medicaid Inspector general
Part I – Provider Self Disclosure

Date Completed	

Type of Self-Disclosure (Check one or more)	
Billing Issues	
Documentation/Records Issues	
Quality of Care	
Cost Report Issues	
Claims for Services Not Provided	
Reporting Health Insurance	
Licensing and/or Certificate of Need	
Falsification/Alteration of Records/Documents	
Employee Licensure and/or Credentialing	
Other:	

Provider Information						
Vendor/Facility Name						
Provider First Name		Last Name				
Provider Type		Provider Specialty				
Medicaid ID No.		License No.				
Physical Address	Street					
	City		State		Zip Code	
Mailing/Alternate Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Work Telephone Number	( )			Ext.		
Fax Number	( )					
Cell Telephone Number	( )					

3/06/2009

First Name		Last Name			
Title					
Employer/Agency/Company					
Division					
Relationship to Organization	☐ Employee ☐ Attorney ☐ Consultant ☐ Other				
Address	Street				
	City		State		Zip Code
Telephone numbers must include the area code					
Work Telephone Number	( )			Ext.	
Cell Telephone Number	( )				
Email Address					

State or Federal Agency and/or Law Enforcement Notified?	☐ State ☐ Federal ☐ Law Enforcement		
AGENCY Notified:			
DATE Notified:			
CONTACT/Person:			
First Name:		Last Name:	
Title:			
Telephone numbers must include area code			
Work Telephone Number	( )		
Cell Telephone Number	( )		

Part II – Other Information

Contractor Company Name:						
Owner Name:						
Company/Owner Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Company Owner Telephone Number	( )			Ext.		

First Name:	*	Last Name:	
Social Security Number		Date of Birth	
Medicaid Number			
Date of Service	Service rate code		
Amount paid by Medicaid			

If more than one patient, attach a computer disk containing an excel spreadsheet with the applicable data listed above.

Patient Medicaid Number					
Insurance Company Name					
Insurance Company Address	Street				
	City		State	Zip Code	
Telephone numbers must include the area code					
Work Telephone Number	( )		Extension:		
Cell Telephone Number	( )				
Policy Holder Name					
Policy Holder SSN					
Employer Name					
Group Number					
Insurance Eff. Date		Insurance Term. Date			

→ List below any family members that are on the Health Insurance Policy.	
1	4
2	5
3	6

You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OMIG self disclosure Guidance for additional information.)

Attached the written, detailed information and any additional relevant documentation to this form and mail the completed form and attachments to the address listed in the instructions above.

I certify that, to the best of my knowledge, the information in this self-report is truthful and is based on a good faith effort to assist the OMIG in it's inquiry and verification of the disclosed matter.

Print Name

Signature

Date

Title

ATTACHMENT "G"

Confidentiality and Information Security Policy

Purpose: To ensure adherence to HIPAA regulations and rules of confidentiality **for contractors and vendors and their employees, interns, volunteers and individuals performing work experience (hereinafter "contractor").**

As a contractor you will come into contact with records and other forms of information. All Chemung County Department of Human Service records are confidential, as is any information that you learn of or acquire at the department. This includes records or information which originates with agencies or individuals outside the department and which come into the department's possession or awareness. Confidentiality requirements apply to, but are not limited to, case files, handwritten notes, computer disks, computer networks or information systems and/or any other identifying information related to our clients. The use of any computer or computer system for any purpose other than as set forth in the Chemung County Computer Use Policy is prohibited. Access to information maintained in all databases is limited to authorized employees and legally designated agents for authorized purposes only. You must have an official purpose to access the information. Anyone not authorized to access the information or who has no official purpose in doing so, will be subjected to termination for the first offense. The cornerstone of our profession is confidentiality and integrity. Actions such as "case surfing" for information in high profile cases, or seeking information on your babysitter, yourself, your neighbor, a family member, or co-worker is strictly forbidden. If you find that you have a personal involvement with someone requesting information, applying for services, or with an active case, notify your supervisor immediately to clarify whether you should respond to a request for information or remain on the case. You will also be terminated for redisclosure of information, otherwise lawfully obtained, to any person not authorized to receive it. The above is meant to be illustrative, and is not exhaustive.

Individuals who unlawfully access or disclose confidential department records or information can be found guilty of a misdemeanor. The department may take action to terminate any contract in the event of any breach of this policy.

The agency is required to notify recipients, applicants and respective governmental offices of the unauthorized acquisition of private information, which resulted from a breach of information security. If staff becomes aware of such a breach, they are required to notify their supervisor/manager immediately. The manager should then notify the LDSS Commissioner and Staff Development Coordinator (HIPAA Officer) to ensure appropriate action. The agency will follow reporting procedures as outlined in GIS 06 MA/002.

It is important that you understand the highly sensitive and confidential nature of our work. You are expected to take personal responsibility for the safekeeping of any information and material related to your work at the department, whether on or off premises.

I have read and understand the Confidentiality and Information Security Policy and agree to abide by the rules set forth in said policy:

X_____/_____X_____
Contractor Name/Signature Date

X_____/_____X_____
Witness Name/Signature Date

(Rev. 1-2014)

EXHIBIT "1"

CERTIFICATE OF INSURANCE REQUIREMENTS

In satisfaction of the insurance requirements of this Agreement, PROVIDER is required to procure and maintain professional liability INSURANCE in the amount of $1,000,000.

PROVIDER is further required to furnish a copy of proof of said coverage to be attached to this agreement. This copy of proof must include the term of this Agreement or PROVIDER shall, on or before thirty (30) days of the expiration date of the above insurance, provide the COUNTY with a Certificate of Insurance with the same coverage for the balance of the term of this Agreement.

Any required insurance will be in companies authorized to do business in New York State, covering all operations under this Agreement, whether performed by the PROVIDER or by subcontractors.

All insurance coverage required to be purchased and maintained by the PROVIDER under this Agreement shall be primary for the defense and indemnification of any action or claim asserted against the COUNTY and/or the PROVIDER for work performed under this Agreement, regardless of any other collectible insurance or any language in the insurance policies which may be to the contrary, except as otherwise modified by this agreement.

EXHIBIT "2"

NYSED.gov

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification

License Information *

10/20/2014

Name : DICKINSON MARCIA RENEE
Address : ELMIRA NY
Profession : PHYSICAL THERAPY
License No: 014473
Date of Licensure : 12/29/94
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 11/14

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License Information *

10/28/2014

Name : MRYGLOT KIMBERLY SMITH
Address : CORNING NY
Profession : SPEECH - LANGUAGE PATHOLOGY
License No: 005165
Date of Licensure : 02/26/87
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 05/16

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License Information *

10/28/2014

Name : DONLON JESSEN REBEKAH
Address : CORNING NY
Profession : SPEECH - LANGUAGE PATHOLOGY
License No: 015373
Date of Licensure : 12/30/04
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 07/16

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License Information *

10/20/2014

Name : TENBUS ALISHA MARIE OWEN
Address : GILLETT PA
Profession : PHYSICAL THERAPY
License No: 019987
Date of Licensure : 06/17/99
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 12/16

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License Information *

10/28/2014

Name : HYER LINDSY RAE
Address : BURDETT NY
Profession : SPEECH - LANGUAGE PATHOLOGY
License No: 020294
Date of Licensure : 07/21/10
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 01/15

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License Information *

10/20/2014

Name : DOTY KIMBERLY L
Address : HORSEHEADS NY
Profession : OCCUPATIONAL THERAPY
License No: 011732
Date of Licensure : 04/10/02
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 03/16

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License Information *

10/26/2014

Name : CUNNINGHAM CELESTINA GREGORIO
Address : SAYRE PA
Profession : OCCUPATIONAL THERAPY
License No: 005335
Date of Licensure : 03/18/91
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 01/17

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- Note: The Board of Regents does not discipline physicians(medicine), physician assistants, or specialist assistants. The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

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Office of the Professions

Verification Searches

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License Information *

10/28/2014

Name : CLOSE ABAGAIL MARGARET
Address : MONTOUR FALLS NY
Profession : SPEECH - LANGUAGE PATHOLOGY
License No: 006247
Date of Licensure : 03/12/98
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 03/17

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EXHIBIT "3"

Exhibit 3
Statement of Reassignment

_____
Name of Pre-K Provider/ Practitioner

By this reassignment, the above-named program or practitioner of pre-k services agrees:

1. To reassign all Medicaid reimbursement for pre-k services to the municipal agency that you contract with to provide pre-k services.

2. To accept as payment in full from the municipal agency the State Department of Health promulgated payment levels for covered pre-k services.

3. To not bill Medicaid for eligible pre-k services which are specified in a child's Individualized Family Services Plan (IFSP). These services will be directly billed to and reimbursed by the municipal agency.

4. To comply with all the rules and policies as described in your contract with the municipal agency.

X_____
Authorized Signature

Note: Nothing in this statement of reassignment would prohibit a Medicaid provider from billing reimbursement for Medicaid eligible services rendered outside the scope of the pre-k program.

EXHIBIT "4"
CMS LETTER

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL #09-001

January 16, 2009

Dear State Medicaid Director:

The Center for Medicaid and State Operations (CMSO) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter advises States of their obligation to direct providers to screen their own employees and contractors for excluded persons. This letter specifically:

(1) Clarifies Federal statutory and regulatory prohibitions regarding Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs;

(2) Reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities;

(3) Sets forth the Centers for Medicare & Medicaid Services' (CMS) policy with respect to States' responsibility to communicate to providers their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and the manner in which overpayment calculations should be made; and

(4) Identifies the List of Excluded Individuals/Entities (LEIE) as a resource providers may utilize to determine whether any of their employees and contractors has been excluded.

Background

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable*:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

* This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.

- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, CMS shall make no payments to States for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c)). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections 1903(d)(2)(A) and 1903(i)(2) of the Act, and are therefore subject to recoupment. It is thus incumbent on States to take all reasonable steps to prevent making payments that must ultimately be refunded to CMS.

Previous Guidance Regarding Preventing Payments For Goods and Services Furnished by Excluded Individuals and Entities

In a State Medicaid Director Letter issued on June 12, 2008, CMS notified States of their own obligation to attempt to determine whether an excluded individual has an ownership or control interest in an entity that is a Medicaid provider, and of States' obligation to report information regarding such excluded individuals to the HHS-OIG. In a State Medicaid Director Letter issued on March 17, 1999, and in a follow-up State Medicaid Director Letter issued on May 16, 2000 ("Medicare/Medicaid Sanction Reinstatement Report"), CMS described the HHS-OIG's authority to exclude persons based on actions taken by State Medicaid Agencies.

In the State Medicaid Director Letter dated May 16, 2000, CMS reminded States that the Medicare/Medicaid Sanction-Reinstatement Report, formerly known as HCFA Publication 69 and now replaced by the Medicare Exclusion Database (the MED) is a vital resource available to States for ascertaining and verifying whether an individual or entity is excluded and should not be receiving payments. The guidance also stated that the payment prohibition applies to any managed care organization contracting with an excluded party.

In a second State Medicaid Director Letter dated May 16, 2000 ("State's Obligation to notify the Department of Health and Human Services Office of Inspector General"), CMS reminded States of their responsibility to promptly notify the HHS-OIG of any action taken by a State to limit the ability of an individual or entity to participate in its program. *See* 42 CFR section 1002.3(b)(3).

Policy Clarification: States Should Advise Medicaid Providers to Screen for Exclusions

To further protect against payments for items and services furnished or ordered by excluded parties, States should advise all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- States should advise providers of their obligation to screen all employees and contractors to determine whether any of them have been excluded. States should communicate this obligation to providers upon enrollment and reenrollment.
- States should explicitly require providers to agree to comply with this obligation as a condition of enrollment.
- States should inform providers that they can search the HHS-OIG website by the names of any individual or entity.
- States should require providers to search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- States should require that providers immediately report to them any exclusion information discovered.

This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. States must notify the HHS-OIG promptly of any administrative action the State takes against a provider for failure to comply with these screening and reporting obligations. *See* 42 CFR section 1002.3(b)(3). States can satisfy this obligation by communicating the relevant information to the appropriate Regional Office of the OIG Office of Investigations.

States also should inform providers that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs)[†] who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2))

Policy Clarification: Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal health care programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. We recognize that there may be instances when the connection between expended Medicaid funds and the

[†] This State Medicaid Director Letter uses the term "managed care entity" to refer briefly to managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM). States should not confuse this abbreviation with the statutory definition of managed care entity which only refers to MCOs and PCCMs. *See* section 1932(a)(1)(B) of the Act.

items or services furnished by the excluded individual or entity are too attenuated to trace. When such circumstances arise, the overpayment is no more than the amount which the State is certain was paid with Medicaid dollars.

Where Providers Can Look for Excluded Parties

While the MED is not readily available to providers, the HHS-OIG maintains the LEIE, a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, some States maintain their own exclusion lists, pursuant to 42 CFR section 1002.210 or State authority, which include individuals and entities whom the State has barred from participating in State government programs. States with such lists should remind providers that they are obligated to search their State list routinely whenever they search the LEIE.

Conclusion

We know you share our commitment to combating fraud and abuse. We all understand that provider enrollment is the first line of defense in this endeavor. If we strengthen our efforts to identify excluded parties, the integrity and quality of the Medicaid program will be improved, benefiting Medicaid recipients and taxpayers across the country.

If you have any questions or would like any additional information on this guidance, please direct your inquiries to Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601 or claudia.simonson@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

/s/
Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

EXHIBIT "5"

NEW YORK STATE / FEDERAL EXCLUSION LISTS

CMS EXCLUSION REGULATION:

"No payment will be made by Medicare, Medicaid or any of the other federal health care programs for any item or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion."

NYS Exclusion List
http://www.omig.ny.gov/data/content/view/72/52/

Federal Exclusion List
http://www.oig.hhs.gov/fraud/exclusions.asp

Excluded Parties List System
https://www.epls.gov/

Pre-K Service PROVIDERS are expected to be aware of and participate in the requirements of the NYS/Federal Exclusion Lists. PROVIDERS are responsible for being aware of their employee's status in relation to the exclusion lists. It is the responsibility of the PROVIDERS to check exclusion lists on a monthly basis. It is the responsibility of the PROVIDERS to avoid submitting claims for services provided by excluded individuals/agencies. In addition, PROVIDERS must notify the County in writing when an excluded individual or entity has been identified.

EXHIBIT "6"

RESOLUTION NO. 14-050

RESOLUTION AUTHORIZING AGREEMENTS WITH VARIOUS PRE-K PROVIDERS ON BEHALF OF THE CHEMUNG COUNTY DEPARTMENT OF SOCIAL SERVICES

By: Madl

Seconded by: Brennan

WHEREAS, the Commissioner of Human Services on behalf of the Chemung County Department of Social Services has requested authorization to enter into agreements with various service providers for Pre-K services during 2014 for three to five year old children with developmental delays and disabilities; and

WHEREAS, the County Executive and the Health and Human Serviced Committee have recommended that the Chemung County Legislature approve these agreements; now, therefore, be it

RESOLVED, that the County Executive is hereby authorized and directed to enter into agreements with various service providers for Pre-K services during calendar year 2014, the terms and conditions of those agreements to be subject to the approval of the County Attorney at a total cost to the County of $2,300,000 ($1,368,500 State share, $931,500 local share); and be it further

RESOLVED, that the execution of the agreements with the various service providers for Pre-K services is subject to and conditioned upon the receipt by the County of Chemung of the State monies referred to in the Preamble to this Resolution and in the event the County of Chemung does not receive the State monies more particularly described in the Preamble to this Resolution, the agreements with the various service providers for Pre-K services shall be of no force and effect and shall terminate without further action by this Legislature; and be it further

RESOLVED, that these agreements shall not be renewed, the initial terms thereof extended or the agreements amended without the express consent by Resolution of this Legislature.

RESOLUTION NO. 14-050

BACKGROUND INFORMATION

Requested by: Commissioner of Human Services

Purpose: to authorize agreements

Authority: Section 203 of the Chemung County Charter

Funds involved: $2,300,000

Aid: $1,368,500 State share, $931,500 local share

Approved by: Health and Human Services Committee, January 27, 2014

Ayes: Pastrick, Manchester, Sweet, Brennan, Graubard, Hyland, Milliken, Woodard, Hitchcock, Bennett, Milazzo, Madi, Strange, Drake (Chair) (14); Excused: Jackson (1); Opposed: None; CARRIED.

STATE OF NEW YORK)
COUNTY OF CHEMUNG) SS:

THIS IS TO CERTIFY, that I the undersigned Clerk of the Chemung County Legislature, have compared the foregoing copy of resolution with the original resolution now on file in my office, and which was passed by the Chemung County Legislature on the 10th day of February 2014, a majority of all the members elected to the Legislature voting in favor thereof, and that the same is a correct and true transcript of such resolution and of the whole thereof.

IN WITNESS WHEREOF, I have hereunto set my hand and the official seal of the Chemung County Legislature this 11th day of February 2014.

Linda D. Palmer

Linda D. Palmer, Clerk
Chemung County Legislature