AMENDMENT

This **AMENDMENT** made by and between the **COUNTY OF CHEMUNG**, on behalf of its applicable department(s), hereinafter referred to as **COUNTY**, and **HORSEHEADS CENTRAL SCHOOL DISTRICT, OPERATING AT 1 RAIDER LANE, HORSEHEADS, NEW YORK 14845,** hereinafter referred to as **PROVIDER**.

WITNESSETH

WHEREAS, the parties hereto have executed an Agreement pursuant to Resolution #14-050; and

WHEREAS, the said parties desire to amend the aforesaid Agreement,

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

1. That pursuant to Resolution **#15-099,** the aforesaid Agreement be and the same is hereby amended by extending the term of said agreement from **JANUARY 1, 2015 to DECEMBER 31, 2015**.

2. That the total budget amount of this **agreement shall not exceed One Million Seven Hundred Fifty Thousand ($1,750,000)** in conjunction with similar agreements.

3. That the newly revised Compliance Plan attached replaces the previous plan in your 2014 contract.

4. That the Agreement between the parties shall remain in full force and effect except as herein amended.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed on the date indicated below.

DATE: X 2/19/15

COUNTY OF CHEMUNG

BY: X _____
THOMAS J. SANTULLI
CHEMUNG COUNTY EXECUTIVE

DATE: X _____

HORSEHEADS CENTRAL SCHOOL DISTRICT

BY: X _____
Authorized Signature

Service II

Phone: _____

Dept.Head Approval: _____

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) 754-6463 E-MAIL ADDRESS: linda.padgett@thepartners.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A: Utica National Assurance — 10687
INSURED Horseheads Central School Dist 1 Raider Lane Horseheads NY 14845	INSURER B: Utica National Insurance Co of — 13998 INSURER C: INSURER D: INSURER E: INSURER F:

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 PRO-JECT LOC	X		CPP1988111	7/1/2014	7/1/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS			BAC1988112	7/1/2014	7/1/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) PIP-Basic	$ 1,000,000 $ $ $ $ 50,000
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			CUP1988113	7/1/2014	7/1/2015	EACH OCCURRENCE AGGREGATE	$ 15,000,000 $ 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		CPP1988111	7/1/2014	7/1/2015	Each Occurrence Aggregate	$2,000,000 $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/EMP

ACORD 25 (2010/05)

ADDITIONAL COVERAGES

Ref #	Description	Coverage Code	Form No.	Edition Date
	Employee Benefits	EBLIA		

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium
1,000,000	3,000,000		1,000		

Ref #	Description	Coverage Code	Form No.	Edition Date
	PIP-Additional	APIP		

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium
100,000					

Ref #	Description	Coverage Code	Form No.	Edition Date
	PIP-Other Expenses			

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium
50					

Ref #	Description	Coverage Code	Form No.	Edition Date
	PIP-Work loss benefits	WLB		

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium
4,000					

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

Ref #	Description	Coverage Code	Form No.	Edition Date

Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type	Premium

CFADTLCV

The University of the State of New York
Education Department
Office of the Professions
REGISTRATION CERTIFICATE
Do not accept a copy of this certificate

License Number 014473-1 Certificate Number 2466128

DICKINSON MARCIA ANNE
307 SUMNER STREET
ELMIRA NY 14904-0000

is authorized to practice in New York State through 11/30/2017 as a(n)
PHYSICAL THERAPIST

LICENSE/CERTIFICATE HOLDER

EXECUTIVE SECRETARY

EDUCATION DEPARTMENT
STATE BOARD FOR THE PROFESSIONS

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 the 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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- Use your browser's back key to return to licensee list.
- You may search to see if there has been recent disciplinary action against this licensee.
- 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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License Information *

10/28/2014

Name : HRYGLOT 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: 015371
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 : 01/16

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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 *

10/28/2014

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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License Information *

10/28/2014

Name : CLOSE ABAGAIL MARGARET
Address : MONTOUR FALLS NY
Profession : SPEECH - LANGUAGE PATHOLOGY
License No: 006247
Date of Licensure : 03/12/90
Additional Qualification : Not applicable in this profession
Status : REGISTERED
Registered through last day of : 03/17

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COUNTY OF CHEMUNG

Compliance Plan

(Medicare, Medicaid & Insurance Plans)

for

EMPLOYEES, CONTRACTORS & AGENTS

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 Department of Aging and Long Term Care. 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
- Compliance Committee which provides program oversight and submits minutes and reports to the County Executive and County Legislature verifying effectiveness of the Compliance Program
- Training and education of all affected employees and persons
- Communication lines to the responsible compliance officials including Health Center Director, Human Services Commissioner, County Treasurer, County Attorney and County Executive
- 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, including training and provision of Code of Conduct copies.

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 Compliance Officers for the Health Center and Human Resource Center with input and advice from Department Heads;

B. Establishment of a Compliance Committee to provide oversight of the Compliance Program and to report on activities to the County Executive and County Legislature;

C. The Compliance Officers and Health Center Director/Human Services Commissioner/Department of Aging and Long Term Care Director, in conjunction with the Compliance Committee, 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(s) 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 insure that there is ongoing education and training of employees regarding the policies related to the Compliance Program and related matters such as "False Claims Acts and Whistleblower Protections",

G. To insure that there is an effective system, where applicable, to conduct 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 Health Center Director/Human Services Commissioner and Compliance Committee regarding Compliance Program changes and improvements as warranted.

I. To insure that there is an effective countywide system for monitoring the Medicaid Exclusion List for employees, contractors and vendors on a monthly basis and for reporting any positive findings to the Health Center Director/Human Services Commissioner immediately.

J. To assist the Health Center Director in preparation of agenda materials for the Compliance Committee meetings and to assume temporary chair of any Compliance Committee meeting at which the Health Center Director is unable to attend.

Designated Compliance Officers shall be:

- Nursing Facility: Supervisor of Fiscal Services
- Health Department: Deputy Public Health Director
- Human Resources Center: Early Intervention Program Coordinator

Compliance Committee. There shall be a Compliance Committee established to maintain countywide oversight of Compliance Program activities, and the Committee shall submit minutes and reports to County Executive and County Legislature.

The Compliance Committee shall hold regularly scheduled meetings on a quarterly basis on the second Friday of January, April, July and October, but meeting dates may be changed to accommodate the schedules of members. A

secretary shall be appointed to take minutes of each meeting. The Health Center Director shall serve as Chair, except in the event of his/her absence a Compliance Officer shall be delegated to chair a meeting. Committee membership shall consist of the following persons:

Health Center:

- Health Center Director
- Director of Nursing, Nursing Facility (Alternate: Assistant Director of Nursing)
- Director of Patient Services, Home Health (Alternate: Assistant Director of Patient Services)
- Clinical Services Director, Health Department
- Supervisor of Fiscal Services, Nursing Facility
- Deputy Public Health Director, Health Department
- Accounts Receivable Supervisor, Health Center
- Staff Development Coordinator
- Secretary (Ex Officio, non-voting)

Human Resources Center:

- Director of Administrative Services (Alternate: Supervisor of Fiscal Services)
- Coordinator, NY Connects and Adult Services (Alternate: Director, Department of Aging & Long Term Care
- Coordinator of Early Intervention Program

County Government:

- County Legislator
- County Treasurer (Alternate: Deputy County Treasurer)

Committee responsibilities shall include:

- Oversight of County's Compliance Program
- Reviewing audit reports, survey reports, complaints, and disciplinary actions pertinent to Compliance Program such as professional misconduct, abuse/neglect, and fraud
- Reviewing results of Medicaid Exclusion List monitoring and insuring appropriate action is taken in a timely manner for any positive findings on the list
- Insuring that plans of correction, overbilling repayments, audit recoveries, and any penalties are administered in a timely manner in compliance with applicable laws and regulations
- Conducting investigations into complaints, whistleblower allegations, and audit findings and reporting findings to County Executive and County Attorney
- Making regular reports on Compliance Program activities and distributing Committee minutes to the County Executive and County Legislature
- Review and revision of Compliance Plan annually
- Recommendations to Health Center Director, Human Services Commissioner or County Executive on Compliance Program improvements

Compliance Committee agenda shall include the following items:

- Audits in progress and audits completed by external authorities, including independent auditors, Office of Medicaid Inspector General, Office of Attorney General, and Medicare
- Regulatory reports or investigations, including Article 28 surveys, abuse/neglect investigations, and Office of Professional Discipline complaints
- Verification of employee training on Compliance Program and Code of Conduct
- Results of Medicaid Exclusion List monitoring

- Complaints and Whistleblower reports
- Changes in personnel with key Compliance Program responsibilities

A meeting quorum shall be attendance by 51% or more of the regular membership as stated above.

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, Department of Social Services Employee Handbook, 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:
  - Nursing Facility: Supervisor of Fiscal Services, (607) 737-2867
  - Health Department: Deputy Public Health Director, (607) 737-2855
  - 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 or Deputy 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) 962-2567
  - 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 and Department of Social Services Employee Handbook, as well as access to all County and departmental policies including the Compliance Plan that is posted on the County intranet under Public Information Officer;

- 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 shall 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. Disciplinary actions involving suspensions or termination of employment for licensed staff shall be reported, in accordance with NYS Public Health Law, to the Office of

Professional Discipline or other regulatory office having jurisdiction over the licensed person. Allegations of abuse or neglect towards residents/patients shall be reported the New York State Department of Health according to laws and regulations.

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 and Department of Social Service's Employee Handbook
- NYS Public Health Law
- NYS Code of Rules & Regulations
- Quality Assurance and Quality Improvement 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.

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.

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 tines 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.

OMIG Self Disclosure Program
August 2012

Introduction

The New York State Office of Medicaid Inspector General (OMIG) originally issued self-disclosure guidance for Medicaid providers on March 12, 2009. OMIG developed the self-disclosure guide in consultation with health care providers and industry professionals to give providers an easy-to-use method for disclosing overpayments.

OMIG designed this approach to encourage providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds that they identify through self-review, compliance programs, or internal controls that affect the state's Medicaid program. This guide is designed to help the provider through the process, point out advantages of self-disclosure, offer a user-friendly mechanism, and make providers aware of regulatory compliance requirements.

Since its inception, the Self-Disclosure Program has been successful and utilized extensively by providers, benefiting both the providers and the Medicaid program. As a result of the OMIG Self-Disclosure Unit's experience and feedback, the agency has made enhancements and had added resources to the process.

The function is now supplemented by utilizing the OMIG\HMS PORTal, a Web-based site maintained by OMIG's contracted agent, HMS, Inc. The PORTal is an online mechanism used by OMIG\HMS to issue various projects and process recoveries in a simple, effective, and user-friendly electronic medium. OMIG has revised this guide to reflect the consolidation of the self-disclosure function within the agency to better serve the providers and the New York State Medicaid program.

Regulatory Authority

OMIG's Self-Disclosure Program, is 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).

Self-disclosure and repayment of overpayments within 60 days of identification has become mandatory for Medicare and Medicaid providers under section 6402(a) of the Affordable Care Act (ACA) of 2010 and a mandatory part of New York's compliance programs under 18 NYCRR 521.

When to Disclose

Providers should self-disclose **after** they fully investigate and confirm that an overpayment exists. OMIG's self-disclosure protocol assists and enables providers in making disclosures directly to OMIG or through its contracted agent HMS, which maintains the online OMIG PORTal. Through this process, providers who identify that they received reimbursement to which they were not entitled, whether caused by mistake, fraud, or accident, must disclose the parameters of the problem, cause, and its potential Medicaid financial impact in accordance with the self-disclosure guidelines.

In addition, the federal Affordable Care Act requires providers to identify, self-disclose, explain, and repay overpayments within 60 calendar days of identification of the overpayment regardless of the financial threshold of participation in the Medicaid program.

The statute at 42 U.S.C. §1320a-7k(d)(1), requires a person who has received an overpayment to:

1. ***report and return*** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
2. ***notify*** the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

Failure to timely report and return any Medicare and Medicaid overpayment can have severe consequences, including potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs.

Overpayment Reporting should occur when the following conditions are met:

1. Overpayment is NOT included in another, separate review or an audit being conducted by OMIG, vendors, or OIG.

2. Overpayment is NOT related to a broader state-initiated rate adjustment, cost settlement, or other broader payment adjustment mechanisms. (These include retroactive rate adjustments, charity care, cost reporting, etc.)

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.

The Process

Prior to contacting OMIG, the provider should fully investigate and determine the issue and prepare the disclosure including all the required information and documentation. Once an inappropriate payment is discovered, providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Each incident must be considered on an individual basis. Factors to consider include: identification of the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's billing system, the extent of the period affected, the circumstances that led to the overpayment and whether or not the organization has an **OMIG corporate integrity agreement (CIA)** which requires self-disclosure.

The providers may choose to self-disclose using one of two methods:

1. Following the Self-Disclosure Submission Guidelines (see Attachment 1); or
2. Using the OMIG PORTal for electronic submission (see Attachment 2).

After receipt of the self-disclosure, the OMIG/HMS staff will consult with the provider and determine the most appropriate process for proceeding. OMIG/HMS staff will discuss the next steps which may include requesting additional information, verification of the overpayments and any regulatory clarification needed.

In the event that the provider is unable to determine if the self-disclosure issue resulted in non-compliance overpayments or has difficulty identifying the overpayments, OMIG staff can possibly assist the provider in the disposition of the issue. The provider, or its designated agent, may request data for the sole purpose of quantifying and validating a potential overpayment (see Attachment 3 – Data Request from Providers).

The use of **statistical sampling** must be approved by OMIG and all documentation related to the review and extrapolation must be submitted to OMIG for review and approval. Data may be provided by OMIG to establish the appropriate universe and sampling method upon request and approval by OMIG.

To submit a self-disclosure or request data to develop same please send to:

Via letter:

The Office of the Medicaid Inspector General
Attention: Self-Disclosure Unit
800 North Pearl Street
Albany, NY 12204

Via Email:

SelfDisclosures@omig.ny.gov

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 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 compliance officer, counsel, or other staff may be necessary to obtain information and agreement to complete the disclosure in a timely manner.

Access to Data

All documentation and data must be protected for confidentiality under the Health Insurance Portability and Accountability Act (HIPAA) by the provider and its representatives (staff, lawyer, or contractor). The US Department of Health and Human Services' HIPAA guidance states that: The "Privacy Rule" requires that a covered entity obtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. **The satisfactory assurances must be submitted in writing to OMIG, whether in the form of a contract or other agreement between the covered entity and the business associate.**

Restitution

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

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. Providers interested in extended repayment terms due to hardship will be required to submit audited financial statements 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.

Self-disclosure limitations

The OMIG Self-Disclosure Program is designed to report and recover overpayments due back to the Medicaid program. Depending on the nature of the issue, the OMIG's staff may refer the matter through established audit or investigation processes or to other state agencies.

Underpayments detected in the process or otherwise are not to be offset in the self- disclosure process. **Underpayments must be re-billed to eMedNY and claims are subject to system edits and verifications. Time-barred claims are pended and reviewed by the Office of Health Insurance Programs (OHIP) for disposition and consideration for payment.**

NYS Office of Medicaid Inspector General (OMIG)
Self-Disclosure Submission Guidelines

A self-disclosure submission requires both a letter and a claim file(s) of impacted Medicaid claims.

Submission Letter

Complete description of circumstances surrounding the disclosure including:

- Provider name
- Medicaid MMIS ID and NPI number of the billing provider
- The error that occurred
- How the error was found
- Any relevant facts including total amount billed and amount of overpayment by Medicaid
- Identify the time period the claims error encompasses
- Actions taken to stop the error and prevent recurrence
- Personnel involved in the error occurrences, those who discovered the problem, and those involved in rectifying the problem
- Legal and Medicaid program rules implicated
- Disclosure contact person name, phone number, and both correspondence and email addresses

File of claims

Enclose a CD containing an encrypted, password-protected Access, Excel, or tab delimited txt (with file structure) file of claims billed to Medicaid. Please notify OMIG of the password via email or phone call. Do not e-mail the data.

Data needed for each claim line is as follows:

- Claim Reference Number (CRN) or Transaction Control Number (TCN)
- Medicaid MMIS ID
- NPI number of billing provider
- Medicaid group ID number (applicable if only submitted on claim)
- Last name of Medicaid patient
- First name of Medicaid patient
- Medicaid ID of patient (CIN - 8 characters)
- If applicable, Patient Account Number
- If applicable, Medical Record Number
- Date of service (not the date billed)
- Rate or Procedure code
- Amount paid to provider by Medicaid
- Amount overpaid by Medicaid

Please do not send a check for overpayment or void/adjust your claims

After OMIG reviews all disclosure submission material, you will receive a final letter indicating the overpayment dollar amount and the procedure for remitting payment. If the submitted claim data does not materially match OMIG's payment data, you will be contacted before a final letter is issued.

All self-disclosure correspondence and claim files claims should be sent to:

NYS Office of Medicaid Inspector General
Self-Disclosure Unit
800 North Pearl St. Albany, NY
12204-1822

If you have any questions, please email to SelfDisclosures@omig.ny.gov or call 518-473-3782 for assistance.

Guidelines for Provider Overpayment Reporting

The Office of the Medicaid Inspector General Provider Overpayment Reporting Terminal (OMIG PORTal) streamlines the reporting, repayment, and tracking of provider-identified Medicaid overpayments. The platform will act as a conduit to communicate overpayment issues to OMIG and ensure compliance with federal and state regulations regarding overpayment identification and repayment.

Examples of issues appropriate for reporting include, but are not limited to:

- **Routine errors**
  - *Overpayments resulting from incorrect reporting of third-party payments, e.g., balance billing*
  - *Medicare coinsurance reporting with no reported Medicare paid amount*
  - *Multiple overpayments resulting from billing lab services provided during an inpatient stay*
  - *Overpayment resulting from billing an emergency room visit included in an inpatient stay*
  - *Overpayments resulting from billing incorrect ICD-9 assignment*

- **Systemic errors**
  - *Inability to reprocess adjustment(s) through the MMIS (eMedNY)*

Overpayment Reporting should occur when the following conditions are met:

1. Overpayment is NOT included in another separate review or an audit being conducted by OMIG, vendors, or OIG.

2. Overpayment is NOT related to a broader state-initiated rate adjustment, cost settlement, or other broader payment adjustment mechanisms. (These include retroactive rate adjustments, charity care, cost reporting, etc.)

Reporting Options

OMIG/HMS Provider Portal (https://ecenter.hmsy.com/shr/Controller) – Ideal for ongoing, routine self-reporting. To reduce data entry requirements, OMIG and HMS have developed a module in the Provider Portal to accept batch uploads. Please contact HMS at 518-724-7820 for questions regarding registration or the self-reporting process

Self-Disclosure

Date Request from Providers

- Any request for data must be in writing and come from the provider or their designated agent
- This letter should provide assurances to the OMIG that the "business associate" of the provider has entered into a HIPAA-compliant agreement with the provider.
- The request must fully explain the issue or problem they are trying to address
- The request must fully define the universe of claims to be pulled
- OMIG will pull the universe
- If sampling is to be used to develop the overpayment, OMIG will pull the sample
- Upon completion of review, provider/agent must submit all work papers and finding for OMIG review
- If required, OMIG will do extrapolation

RESOLUTION NO. 15-099

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

By: Brennan

Seconded by: Manchester

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 2015 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 2015, 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 $1,750,000 ($1,041,250 State share, $708,750 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. 15-099 BACKGROUND INFORMATION

Requested by: Commissioner of Human Services

Purpose: to authorize agreements

Authority: Section 203 of the Chemung County Charter

Funds involved: $1,750,000

Aid: $1,041,250 State share, $708,750 local share

Approved by: Health and Human Services Committee, January 26, 2015

Ayes: Pastrick, Manchester, Brennan, Miller, Hyland, Milliken, Woodard, Chalk, Collins, Madl, Strange, Draxler (Chair) (12); Excused: Sweet, Fairchild, Jackson (3) ; 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 2015, 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 2015.

Linda D. Palmer
Linda D. Palmer, Clerk
Chemung County Legislature