AGREEMENT

THIS AGREEMENT is 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

ELMIRA HEIGHTS SCHOOL DISTRICT, (hereinafter referred to as **PROVIDER**"), conducting business at **2083 COLLEGE AVENUE, ELMIRA HEIGHTS, NEW YORK 14903**

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 **1/1/2023** and shall terminate on **12/31/2023.**

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 **CONTRACTOR**. The **PROVIDER,** in accordance with this status as an independent contractor, 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. Neither party hereto shall assign any of its rights or obligations herein without the prior written consent of the other party. Any assignment without said consent shall be void.

COMPLIANCE WITH APPLICABLE LAWS

5. 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 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 Exhibit #1, which certificate or certificates shall provide that the policies shall not be canceled until thirty (30) days written notice has been given to the **COUNTY**.

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

HOLD HARMLESS INDEMNIFICATION

12. The **PROVIDER** agrees to indemnify and hold harmless the **COUNTY**, its officers and agents, against all liability, judgments, costs and expenses upon any claims arising from the negligence of the **PROVIDER**, 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, 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. Upon termination of this Agreement, 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.

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 Agreement 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 Agreement 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 Agreement, the greatest benefits will be derived by promoting the interest of both parties, and each of the parties does, therefore, enter into this Agreement 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** 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 spends any non-federal funds for these purposes, Provider 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 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:

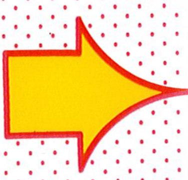
EXHIBIT #1 – 7 If Applicable

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers on the date first set forth above.

DATE: 3/22/23 **COUNTY OF CHEMUNG**

BY: ______________________________
COUNTY EXECUTIVE

DATE: ______________ **ELMIRA HEIGHTS SCHOOL DISTRICT**



BY: ______________________________
PROVIDER

Services II

Attachment A = Service Description
Attachment B = Budget
Attachment C = Insurance Certificate
Attachment D = Business Associate Agreement
Attachment E = Compliance Plan
Attachment F = Confidentiality & Information Security Policy
Exhibit #1 = Insurance Requirements
Exhibit #2 = Statement of Reassignment
Exhibit #3 = NYS Provider Agreement
Exhibit #4 = CMS Letter
Exhibit #5 = Medicaid Exclusion List
Exhibit #6 = Authorizing Resolution

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:

The PROVIDER shall, per Section 4410(4) of the Education Law, ensure that the documentation of each evaluation includes all assessment reports, 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 Commissioner 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. There will be a financial penalty assessed for evaluation reports not received within the designated time frame.

Note: PROVIDER is not always able to schedule evaluations far enough in advance to allow time for the full report to be completed and submitted five (5) business days in advance of a scheduled CPSE meeting. In such cases, a summary will be provided prior to the CPSE meeting with a full report to follow.

ATTACHMENT B
BUDGET

The COUNTY, in accordance with the provisions of this Agreement, shall compensate 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 pay 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-10 Code

II. PROGRAM: Pre-School Evaluations will be paid at the current NYSED CPSE Evaluation Rates:

Psychological	$240.00
PT/OT/ST	$163.00
Social History	$143.00

NOTE: The above rates are subject to change by New York State.

Notwithstanding any other provision of this Agreement, the rate for any service hereunder shall not exceed the amount paid or to be paid to the COUNTY for such service by any Federal or State governmental authority.

ATTACHMENT "C"

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/07/2022

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 have ADDITIONAL INSURED provisions or 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
NEW YORK SCHOOLS INSURANCE RECIPROCAL
333 Earle Ovington Blvd.
Uniondale NY,11553

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	New York Schools Insurance Reciprocal	34843
INSURER B :		
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
Elmira Heights Central SD
2083 College Avenue
Elmira Heights, NY 14903

COVERAGES CERTIFICATE NUMBER: 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	COMMERCIAL GENERAL LIABILITY; X CLAIMS-MADE; X OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC; X OTHER:	X		SSP EMH 001	07/01/2022	07/01/2023	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	UNLIMITED
							PRODUCTS - COMP/OP AGG	$1,000,000
								$
A	AUTOMOBILE LIABILITY; X ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; X HIRED AUTOS ONLY; X NON-OWNED AUTOS ONLY; X GARAGE LIABILITY			CAP EMH 001	07/01/2022	07/01/2023	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$1,000,000
A	UMBRELLA LIAB; X OCCUR; X EXCESS LIAB; CLAIMS-MADE; DED; RETENTION $			ECL EMH 001	07/01/2022	07/01/2023	EACH OCCURRENCE	$10,000,000
							AGGREGATE	UNLIMITED
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	SCHOOL BOARD LEGAL LIABILITY			SBL EMH 001	07/01/2022	07/01/2023	PER CLAIM	$1,000,000
							AGGREGATE	$3,000,000
							DEDUCTIBLE	$1,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Certificate holder is an Additional Insured as per the terms stated on Additional Insured Endorsement CG 2026 04 13.Re: Use of premises/facilities for the Pre-K evaluations scheduled during the policy term.

CERTIFICATE HOLDER
County of Chemung
P.O. Box 588
Elmira, NY 14901

CANCELLATION
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 [signature]

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ACORD 25 (2016/03)

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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"

COUNTY OF CHEMUNG

Compliance Plan

(Medicare, Medicaid & Insurance Plans)

for

EMPLOYEES, CONTRACTORS & AGENTS

R- 1/20 (3/00, 11/07, 12/09, 6/11, 11/13, 11/14, 2/18)

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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
- Training and education of all affected employees and persons
- Communication lines to the responsible compliance officials including Nursing Facility Administrator, Public Health Director, Human Services Commissioner, County Treasurer, Health and Human Services Chairperson, 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: Nursing Facility Administrator, Public Health Director, Human Services Commissioner, Department of Aging and Long Term Care 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;

C. The Compliance Officers, Nursing Facility Administrator, Public Health Director, Human Services Commissioner, and 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 maybe 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 applicable Compliance Officer(s) shall report directly to the Nursing Facility Administrator, Public Health Director, and/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 Nursing Facility Administrator, Public Health Director, and 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 ensure 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 ensure 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 Nursing Facility Administrator, Public Health Director, Human Services Commissioner and Compliance Committee regarding Compliance Program changes and improvements as warranted.

I. To ensure 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 Nursing Facility Administrator, Public Health Director, and/or Human Services Commissioner immediately and to the Compliance Committee at its next meeting.

J. To assist the Nursing Facility Administrator and Public Health Director, acting as Co-chairs of the Compliance Committee, in preparation of agenda materials for the Compliance Committee meetings and to assume temporary chair of any Compliance Committee meeting at which the Nursing Facility Administrator and Public Health Director are unable to attend.

Designated Compliance Officers shall be:

- Nursing Facility: Supervisor of Fiscal Services
- Health Department: Supervisor of Fiscal Services
- Human Resources Center: Early Intervention Program Representative

Compliance Committee. There shall be a Compliance Committee established to maintain countywide oversight of Compliance Program activities.

The Compliance Committee shall hold regularly scheduled meetings on a quarterly basis. A secretary shall be appointed to take minutes of each meeting. The Nursing Facility Administrator and Public Health Director shall serve as Co-Chairs on a rotating basis, except in the event of their absences one of the ~~a~~ Compliance Officers shall be delegated to chair a meeting. Committee membership shall consist of the following persons:

Health Center:

- Nursing Facility Administrator
- Public Health Director
- Director of Nursing, Nursing Facility (Alternate: Assistant Director ofNursing)
- Director of Patient Services, Home Health (Alternate: Assistant Director of Patient Services)
- Supervisor of Fiscal Services, Nursing Facility
- Supervisor of Fiscal Services, Health Department
- Principal Account Clerks for Billing Offices of Nursing Facility and Health Department
- Secretary (Ex Officio, non-voting)

Human Resources Center:

- Director of Administrative Services (Alternate: Supervisor of Fiscal Services)
- Coordinator, Care and Adult Services (Alternate: Coordinator of Aging Services, Care Unit)
- Coordinator of Early Intervention Program

County Government:

- 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
- Ensuring 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, where applicable
- Review and revision of Compliance Plan annually
- Recommendations to Nursing Facility Administrator, Public Health 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 ofConduct
- 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, Nursing Facility Administrator, Public Health 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: Supervisor of Fiscal Services, (607) 737-2855
  - Human Resource Center: Early Intervention Representative, (607) 737-5516

- Confidential reports may also be made to:
  - Nursing Facility Administrator, (607) 737-2068
  - Public Health Director, (607) 737-2868
  - Human Services Commissioner, (607) 737-5400
  - County Executive (607) 737-2912
  - 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 Nursing Facility Administrator, Public Health 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 Nursing Facility Administrator, Public Health Director, or 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 prompt notification and repayment to Medicare or Medicaid, 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 and/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

D. 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. Computer Access, Security and Confidentiality

It is prohibited for any employee, contractor or agent to download and/or store any protected health information on any type of mobile device that is not owned and/or authorized by the County, including cell phones, laptops, i-Pads, and electronic notebooks. Mobile devices owned by individuals may be used for secure access to protected health information that is stored in a cloud-based application, but access must be authorized by the County and is subject to the County's security measures. Access to protected health information shall be limited to work-related purposes only, and no employee, contractor or agent may access information for personal reasons or purposes. Violations of this policy may be grounds for disciplinary action, civil penalty, or criminal prosecution.

6. Social Media Policy: Privacy and Confidentiality

No personal or private information, images or discussions relating to County residents, patients or clients shall be distributed or referenced on any form of social media or in any other multimedia format. It is prohibited to take photographs or video images of any residents, patients, or clients without their written consent, and it is further prohibited to release or distribute such photographs or video images without the written consent of the resident, patient or client. Making references to residents, patients or clients on social media, even if the individual is not identified, shall be prohibited. Violations of this policy may be grounds for disciplinary action, civil penalty, or criminal prosecution.

7. 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 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.

<u>Penal Law Article 177, Health Care Fraud,</u>

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

<u>Federal False Claims Act (31 U.S.C. §3730(h))</u>

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 Attachment2).

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 byOMIG.

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 reviewprocess.

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)*

<u>Overpayment Reporting should occur when the following conditions are met:</u>

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.)

<u>Reporting Options</u>

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

ATTACHMENT "F"

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:

____________________/______________________ ________________
Contractor Name/Signature Date

____________________/______________________ ________________
Witness Name/Signature Date

Both Need to Print + Sign

(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.

EXHIBIT "2"

Statement of Reassignment

ELMIRA HEIGHTS SCHOOL DISTRICT
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 Education Program (IEP). 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.

____
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 "3"
NYS PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND
THE SERVICE PROVIDERS UNDER CONTRACT WITH THE SCHOOL DISTRICT WHICH IS ENROLLED IN THE NEW YORK STATE MEDICAID SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)

Based upon a request by the school district to participate in the New York State Medicaid SSHSP Program under Title XIX of the Social Security Act,

ELMIRA HEIGHTS SCHOOL DISTRICT
(Organization/Contracted Provider's Name)

will hereinafter be called the (outside contracted) Provider, agrees as follows to:

A)
1) Keep any record necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance.

2) On request, furnish the New York State Department of Health, or its designee and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A)(1), and any information regarding any Medicaid claims reassigned by the Provider.

3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B.

B) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national original, handicap, age, sex, religion and/or marital status.

C) Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York Social Services Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York.

(Outside Contract) Provider's Authorized Signature: ________________________________

Address: ____

City: ____________________ State: ____________________ Zip: ____________________

Telephone: ____________________________ Date Signed: ________________________

Please list the School District(s) under contract with on the back of this form.

C-1

Additional School Districts with Which you Contract:

C-2

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

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;

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* 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

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[†] 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. 23-069

RESOLUTION AUTHORIZING AGREEMENTS WITH VARIOUS PRESCHOOL PROVIDERS ON BEHALF OF THE CHEMUNG COUNTY DEPARTMENT OF SOCIAL SERVICES

By: Margeson

Seconded by: Drake

WHEREAS, the Chemung County 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 2023 for three-to-five year old children with developmental delays and disabilities; and

WHEREAS, the County Executive and the Health and Human Services 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 2023, the terms and conditions of such agreement to be subject to the review and approval of the County Attorney, at a total cost of $2,250,000 ($1,338,750 State share, $911,250 local share); and, be it further

RESOLVED, that the agreements with the various service providers for Pre-K services are 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.

Ayes: Morse, Saglibene, Sweet, Brennan, Donovan, Pickering, Burin Chalk, McCarthy, Drake, Smith, Strange, Margeson (Chairman) (13); Opposed: None (0); Excused: Palmer, Sterner (2)

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 13th day of February 2023, 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 14th day of January 2023.

_____*Cynthia G. Kalweit*_____________
Cynthia G. Kalweit, Clerk
Chemung County Legislature

RESOLUTION NO. 23-069 **BACKGROUND INFORMATION**

Requested by: Commissioner of Human Services

Purpose: to authorize agreements

Authority: Section 203 of Chemung County Charter

Funds involved: $2,250,000

Aid: $1,338,750 State share, $911,250 local share

Approved by: Health and Human Services Committee, January 23, 2023