HORIZON HOME CARE SERVICES INC.

Consumer Directed Personal Assistance Program Policy and Procedure Manual

HORIZON HOME CARE SERVICES INC.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

POLICY AND PROCEDURE MANUAL

TABLE OF CONTENTS

HORIZON HOME CARE SERVICES INC.

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POLICY AND PROCEDURE MANUAL

INTRODUCTION

The Consumer Directed Personal Assistance Program (CDPAP) regulations provide local stakeholders with a single, standardized operational framework supportive of the program's unique design and philosophy.

The regulations include a description of the program as defined in Social Services Law Section 365-f, followed by definitions of term referenced throughout the regulations.

The regulations describe the role and responsibilities of program participants and of the Fiscal Intermediary that acts as the employer of record on behalf of the consumer.

The policies and procedures in this manual promote uniformity and comparability of benefits by providing stakeholders with a clear understanding of their respective roles and responsibilities, the purpose of the program, and procedures to be used by the Fiscal Intermediary in providing services to the CDPAP.

DEFINITIONS

Consumer: Medicaid recipient who a social services district or MCO has determined to participate in the consumer directed personal assistance program.

Consumer Directed Personal Assistance: Provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistance under the instruction, supervision and direction of a consumer or the designated representative.

Consumer Directed Personal Assistant: An adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision, and direction of the consumer's designated representative. A consumer's spouse, parent, or designated representative may not be the consumer designated personal assistant for that consumer; however a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because of the amount of care the consumer requires makes such relative's presence necessary.

Continuous Personal Services: Provision of uninterrupted care by more than one consumer directed personal assistant, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

Designated Representative: Adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities specified in subdivision (g) of Section 505.28 of Title 18 of the New York Codes, Rules and Regulations ("NYCRR) and is willing and able to perform these responsibilities. With respect to the non-self-directing consumer, a "designated representative" means the consumer's parent, legal guardian or, subject to the MCO approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

Fiscal Intermediary: Entity that has a contract with an MCO to provide wage and benefit processing for consumer directed personal assistant and other Fiscal Intermediary responsibilities specified in subdivision (i) of Section 505.28 of Title 18 of the NYCRR.

Home Health Aide Services: Services within the scope of practice of a home health aide pursuant to Article 36 of the Public Health Law including simple health care tasks, personal hygiene services, housekeeping tasks essential to the consumer's health and other related supportive services. Such services may include, but are not necessarily limited to, the following: preparation of meals in accordance with modified diets or complex modified diets; administration of medications; provision of special skin care; use of medical equipment, supplies and devices; change of dressing to stable surface

wounds; performance of a maintenance exercise program; and care of an ostomy after the ostomy has achieved its normal function.

Levels of Care:

I. **Level I**: Limited to the performance of nutritional and environmental support functions.
   a. Making/changing beds
   b. Dusting and vacuuming the rooms which the patient uses
   c. Light cleaning of the kitchen, bedroom and bathroom
   d. Dishwashing
   e. Listing needed supplies
   f. Shopping for the patient if no other arrangement are possible
   g. Patients' laundering, including necessary ironing and mending
   h. Payment of bills and other essential errands
   i. Preparing meals and other simple modified diets

II. **Level II:** The performance of nutritional and environmental support functions
   a. Bathing of the patient in the bed, tub or shower
   b. Dressing
   c. Grooming
      i. Including care of the hair
      ii. Shaving
      iii. Ordinary care of nails, teeth and mouth
   d. Toileting
      i. Assisting on and off the bedpan, commode or toilet
   e. Walking within and outside the home beyond that provided by durable medical equipment
   f. Transferring from bed to chair/wheelchair
   g. Preparing meals in accordance with modified diets, including low sugar, low fate, low salt and low residue
   h. Feeding
   i. Administration of medication by the patient, including prompting the patient as to time, identifying the medication to the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and material and storing medication properly.
   j. Providing routine skin care
   k. Using medical supplies and equipment such as walkers and wheelchairs
   l. Changing simple dressings

Live in 24-hour personal care services: The provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more

personal care functions during the day and night an whose need for assistance during the night is infrequent or can be predicted.

Personal Care Services: Consists of nutritional and environmental support functions, personal care functions or both such functions. Means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, ordered by the Attending Physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services provided by a qualified person in accordance with a plan of care; and supervised by a professional nurse.

Self-Directing Consumer: A consumer who is capable of making choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands the impact of these choices; and assumes responsibility for the results of these choices.

Skilled Nursing Tasks: Those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to Section 6908 of the Education Law.

Some Assistance: A specific personal care service, home health aide service or skilled nursing task is performed or completed by the consumer with the help from another individual.

Stable Medical Condition: A condition that is not expected to exhibit sudden deterioration or improvement and does not require frequent medical or nursing evaluation or judgement to determine changes in the consumer's plan of care.

Total Assistance: A specific personal care service, home health aide service or skilled nursing task is performed or completed for the consumer.

HORIZON HOME CARE SERVICES INC.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

POLICY AND PROCEDURE MANUAL

CONTRACTS

PURPOSE: To have a written agreement outlining respective responsibilities.

POLICY: A contractual arrangement similar to the sample administrative agreement issued by the Department of Health (DOH) will be in place with every Managed Care Organization and Local District of Social Services that [FI NAME] provides Fiscal Intermediary services for.

PROCEDURE:

1. Fiscal intermediaries are not providers of care
2. The rate of payment on the contract must be the rate promulgated by the LDSS for that county.
3. If Horizon Home Care Services Inc. is serving less than five (5) consumers in a county, the insurer may encourage the enrolled to use an alternative Fiscal Intermediary to minimize the number of Fiscal Intermediaries that the insurer must have under contract. The insurer is prohibited from coercing or threatening the consumer or the Personal Assistant to change Fiscal Intermediaries.
4. The insurer must have at least two (2) Fiscal Intermediary contracts per county. Network adequacy is required whether the county has voluntary or mandatory enrollment into any MCO.
5. The Fiscal Intermediary shall maintain consumer records for a period of six (6) years after the date of service. In the case of a minor the later date of either three years after the age of majority or six years after the date of service, or for such a period as required by law, regulation or the contractual arrangement.
6. Fiscal Intermediaries are not required to have a license to provide Fiscal Intermediary services to insured consumers.

ELIGIBILITY

PURPOSE: To provide criteria related to a medical care recipient to participate in the Consumer Directed Personal Assistance Program.

POLICY: All Consumers who choose Horizon Home Care Inc. as the Fiscal Intermediary will meet the criteria to participate in the program established by the NYS Medicaid Program and approved by the Managed Long Term Care Plan or Local Social Services Department.

PROCEDURE:

1. The individual must be eligible for medical assistance.
2. The individual must be eligible for long term home care services provided either by CHHA, LTHCCP, MCO, Aids Home Care Program, personal care services, or private duty nursing services.
3. The individual should have a stable medical condition.
4. The consumer should be self-directing or if not self-directing, have a designated representative.
5. The consumer should need some or total assistance with one or more personal care services, home health aide services or skilled nursing tasks.
6. The consumer must be able to meet the following:
    a. Collaboration with the development plan of care
    b. The individual/designated representative must participate as needed in the assessment and reassessment process
    c. Schedule the weekly amount of hours authorized per consumer needs
    d. Manage the plan of care, recruit and hire a sufficient amount of qualified individuals who can provide the consumer with services needed.
    e. Train the personal assistance to implement the plan of care
    f. Notify the insurance of any changes in the medical condition and/or demographics to include address and telephone number
    g. Arrange for substitute coverage when the primary personal assistant is temporarily unavailable for whatever reason
    h. Ensure the accuracy of the personal assistant's timesheets and transmit the time sheets to the Fiscal Intermediary for the paycheck to be issued
7. The MCO must monitor the consumer's continued eligibility for CDPAP.
8. The MCO must notify the Fiscal Intermediary if the member has fallen off the MCO Roster.
9. The MCO must notify the Fiscal Intermediary of any change in circumstances that may affect the consumer's ability to carry out their responsibilities above.

PHYSICIAN ORDER

PURPOSE: The patient must have a medical examination to determine that they have a stable medical condition and that they require the need for assistance with tasks and they would like to have the Consumer Directed Personal Assistance Program. Physician's orders are obtained and maintained at the approving Managed Long Term Care Organization or at the Local Social Services Department. The FI does not have the responsibility to procure or maintain physician's orders.

POLICY: A licensed physician must sign an order after a medical examination is conducted by the physician, a physician assistant, a specialist assistant (Article 131-B) or a nurse practitioner. In New York City the form M11Q is used as the physician order.

PROCEDURE:

1. A physician must sign the order.
2. The order must be signed within 30 calendar days after the medical examination is conducted.
3. The Consumer's medical condition and medical regimen must be accurately described.
4. The Consumer's need for assistance with personal care services, home health aide services and/or skilled nursing tasks must be accurately described.
5. The person who completes the medical examination will not recommend the number of hours of services that the Consumer will receive.
6. The physician must certify that the Consumer can be safely cared for at home.
7. If the Consumer requires continuous Consumer Directed Personal Assistance or if there is a disagreement over the level, amount, or duration of services, the Medical Director of the contractual agreement must make the final decision. The decision must be made within five (5) business days of receipt of the physician order and complete assessment.

ASSESSMENT

PURPOSE: The recipient must be assessed by a registered nurse employed by the Managed Long Term Care Organization, or Local Social Services Department who has enrolled the Consumer who will use the Consumer Directed Personal Assistance Program at specific intervals to ensure they are eligible for the program.

POLICY: The Consumer must receive a comprehensive assessment after a physician order to ensure that the Consumer requires assistance with services/tasks. The assessment will also review for Consumers who already have personal assistants, whether the Fiscal Intermediary is fulfilling their responsibilities.

PROCEDURE:

1. The Consumer must have an assessment after receipt of the physician's order.
2. The assessment will include a social assessment and a nursing assessment on approved forms.
3. The assessment will be conducted by a registered nurse.
4. The assessment will be completed within thirty (30) days of receipt of the physician's orders.
5. The assessment will include a primary diagnosis and the primary diagnosis code that the Consumer is receiving services for.
6. The assessment will include an evaluation whether the consumer would require frequent nursing evaluations.
7. The assessment will include an evaluation of the services/tasks that the consumer requires and whether the consumer requires some or total assistance with the services/tasks and whether some or all of the consumer's needs can be met through the use of medical equipment or supplies.
8. When a minor child is assessed for Consumer Directed Personal Assistance Program the same conditions apply as would any assessment for home care services. The ability of the child to do age appropriate tasks is taken into account as well as a determination of formal and informal supports.
9. The Consumer must be self-directing and willing and able to instruct, supervise and direct the Consumer's personal assistant in performing any tasks that are deemed to be needed by that consumer.
10. The Consumer/Designated Representative must have an evaluation to determine the Consumer's perception of their circumstances and preferences.
11. An assessment will include an evaluation of the personal assistant who will be fulfilling the plan of care developed for the Consumer.
12. The assessment will include an evaluation of the informal supports that the Consumer can rely upon.

13. Based upon a completed assessment, a plan of care is developed in collaboration with the Consumer/Designated Representative. The plan of care will identify the personal care services, home health aide services and/or skilled nursing tasks that the Consumer needs assistance within the home and the amount of assistance required and a recommendation for the number of hours per week for such assistance.
14. When live in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.

HORIZON HOME CARE SERVICES INC.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

POLICY AND PROCEDURE MANUAL

AUTHORIZATON

PURPOSE: To provide a mechanism to the Fiscal Intermediary that the Consumer is a part of the Consumer Directed Personal Assistance Program.

POLICY: Approval to provide services according to the Consumer's plan of care developed after a completed assessment is done. The insurer will notify the Fiscal Intermediary when there is any change in authorization, reauthorization or denial of reauthorization.

PROCEDURE:

1. Authorization will be given with reasonable expectation that the personal assistant can maintain the Consumer's health and safety in the home.
2. Authorization will cover only the hours of frequency of services that are recommended and approved.
3. For minor child consumers receiving services in the school setting, the authorization may need to cover tasks identified in the assessment when school is not in session. The authorization must be clear to ensure timesheets submitted to the Fiscal Intermediary are accurate.
4. The authorization will be received by the Fiscal Intermediary prior to the initiation of services.
5. The duration of the authorization period is based upon the Consumer's needs, but is not to exceed six months unless otherwise specified by the contractual agreement with the Fiscal Intermediary.
6. The initial authorization for Level I services shall not exceed eight (8) hours per week, except under the following conditions:
    a. The Consumer requires some or total assistance with meal preparation, including simple modified diets as a result of the following conditions:
        i. Informal caregivers such as family and friends are unavailable, unable or unwilling to provide such assistance or are unacceptable to the Consumer; and
        ii. Community resources to provide meals are unavailable or inaccessible, or inappropriate because of the Consumer's dietary needs.
    b. In such a situation, the local social services department may authorize up to four additional hours of service per week.
7. Documentation of the following must be complete for continuous Consumer Directed Personal Assistance cases:
    a. The functions the Consumer requires
    b. The degree of assistance required for each function including
        i. The Consumer requires total assistance with toileting, walking, transferring or feeding
        ii. The time required with this assistance.
8. The Service Authorization Determination will serve as a Notice of Action if:

   a. CDPAP is denied, even if personal care, home health aide and/or skilled nursing tasks are authorized at the level requested, or
   b. CDPAP is authorized, but at a level that is less than requested

9. When CDPAP is authorized, the MCO will notify the consumer with the name, address and phone number of all Fiscal Intermediaries available to the consumer.
10. The consumer will choose the Fiscal Intermediary and arrange for wage and benefit processing for the consumer's personal assistant.
11. The MCO will provide reasonable assistance to the consumer to establish the relationship with the Fiscal Intermediary. The MCO will confirm in writing with the consumer and Fiscal Intermediary which Fiscal Intermediary the consumer has selected.
12. Prior to the end of the authorization period the MCO will initiate a process to obtain a new medical request for services and conduct another assessment to determine the consumers need for continued services and the level of care those services should be at. The MCO will alert the Fiscal Intermediary so that the consumer can be reminded to fill out forms.

PLAN OF CARE

PURPOSE: To provide a level of service authorized by the Managed Long Term Care Organization or the Local Social Services Department.

POLICY: Identification of the tasks necessary to keep the member safely in the home. The Plan of Care is developed by the consumer with the assistance of the insurer, provider and any other individual the consumer chooses to include.

PROCEDURE:

1. The Plan of Care developed in conjunction with the consumer, and Managed Long Term Care Organization, considers the number of hours authorized to accomplish the tasks needed.
2. The tasks may include personal care services, home health aide services and/or skilled nursing visits.
3. The hours or frequency of services that the consumer requires must include services received outside of the home.
4. The CDPAP services are managed by the consumer. The consumer will decide how the authorized hours are arranged over the week.
5. The MCO maintains the right to determine if the number of hours is appropriate to the plan of care.
6. The Fiscal Intermediary is not responsible for assuring the member is managing the plan of care.

CONSUMER RESPONSIBILITIES

PURPOSE: To document the consumer responsibility in the Consumer Personal Assistance Program.

POLICY: The Consumer/Designated Representative must carry out their responsibilities under this program.

PROCEDURE:

1. The Consumer/Designated Representative must manage their plan of care developed post assessment/reassessment.
2. Plan of care management is to include the recruiting, hiring and training a sufficient number of individuals who meet the definition of personal assistant.
3. The Consumer/Designated Representative will direct the personal assistant(s) to provide the services that are authorized on the plan of care.
4. The Consumer/Designated Representative must comply with applicable labor laws and provide equal employment opportunities to Consumer Directed Personal Assistants in accordance with applicable laws.
5. The Consumer/Designated Representative will be responsible to train, supervise and schedule the personal assistant(s).
6. The Consumer/Designated Representative will be responsible to ensure that each personal assistant performs personal care services, home health aide services and/or skilled nursing tasks included on the consumer's plan of care competently and safely.
7. The Consumer/Designated Representative is responsible for notifying the MCO within five (5) business days of any change in the Consumer's medical condition or change in social/environmental circumstances to include hospitalization or demographic changes.
8. The Consumer/Designated Representative is responsible to notify the Fiscal Intermediary of any changes in the employment status of each personal assistant employed by the Consumer.
9. The Consumer/Designated Representative must attest to the accuracy of the personal assistant(s) time sheets.
10. The Consumer/Designated Representative must transmit the time sheets to the Fiscal Intermediary according to the Fiscal Intermediary's procedures which will be communicated and written for the Consumer.
11. Timely distribution of each Consumer Directed Personal Assistant's paycheck, if applicable.
12. The Consumer/Designated Representative will be responsible to arrange and schedule substitute coverage when a personal assistant is temporarily unavailable.
13. The Consumer/Designated Representative is responsible for letting the Fiscal Intermediary know that they have enrolled in a new MCO.

14. The Consumer/Designated Representative must acknowledge and agree that an overpayment, directly or indirectly, from the Medicaid program is to be reported and returned within sixty (60) days of identification of the overpayment.
15. The Consumer cannot become a Personal Assistant.
16. The Personal Assistant cannot provide and receive services simultaneously.

FISCAL INTERMEDIARY RESPONSIBILITIES

PURPOSE: To document the Fiscal Intermediary responsibility in the Consumer Directed Personal Assistance Program.

POLICY: The Fiscal Intermediary must carry out their responsibilities under this program through an administrative agreement with the Managed Long Term Care or LDSS.

PROCEDURE:

1. The Fiscal Intermediary shall not discriminate against any Consumers based on color, race, creed, age, gender, sexual orientation, and disability, place of origin or source of payment or type of illness condition.
2. The Fiscal Intermediary shall comply with the Federal Americans with Disabilities Act.
3. The Fiscal Intermediary must process each personal assistant's wages and benefits.
4. The Fiscal Intermediary must process all income tax and other required wage withholdings for each personal assistant and comply with worker's compensation, disability, and unemployment requirements.
5. The Fiscal Intermediary must ensure the health status of each personal assistant is assessed prior to service delivery to the Consumer and annually thereafter according to 10 NYCRR 766.11.
6. Health Status screening will include:
    a. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior;

       (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact:

       (1) a certificate of immunization against rubella which means:

(i) a document prepared by a physician, physician assistant, specialist assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of rubella antibodies; or

(ii) a document indicating one dose of live virus rubella vaccine was administered on or after the age of twelve months, showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; or

(iii) a copy of the document described in subparagraph (i) or (ii) of this paragraph which comes from a previous employer or the school which the individual attended as a student;

(2) a certificate of immunization against measles for all personnel born on or after January 1, 1957, which means:

(i) a document prepared by a physician, physician assistant, specialist assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of measles antibodies; or

(ii) a document indicating two doses of live virus measles vaccine were administered with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; or

(iii) a document indicating a diagnosis of the person as having had measles disease prepared by the physician, physician assistant, specialist assistant, licensed midwife or nurse practitioner who diagnosed the person's measles; or

(iv) a copy of the document described in subparagraph (i), (ii), or (iii) of this paragraph which comes from a previous employer or the school which the

person attended as a student;

(3) a written statement, if applicable, from any licensed physician, physician assistant, specialist assistant, licensed midwife or nurse practitioner, which certifies that immunization with measles and/or rubella vaccine may be detrimental to the person's health. The requirements of paragraphs (1) and (2) of this subdivision relating to measles and/or rubella immunization shall be inapplicable until such immunization is found no longer to be detrimental to such person's health. The nature and duration of the medical exemption must be stated in the individual's personnel record and must be in accordance with generally accepted medical standards (for example, the recommendations of the American Academy of Pediatrics and the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services);

(4) either tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, prior to assuming patient care duties and no less than every year thereafter for negative findings. Positive findings shall require appropriate clinical follow up but no repeat tuberculin skin test or blood assay. The agency shall develop and implement policies regarding follow-up of positive test results; and

(5) an annual, or more frequent if necessary, health status assessment to assure that all personnel are free from any health impairment that is of potential risk to the patient, family or to employees or that may interfere with the performance of duties;

(6) documentation of vaccination against influenza, or wearing of a surgical or procedure mask during the influenza season, for personnel who have not received the influenza vaccine for the current influenza season, pursuant to section 2.59 of this Title.

7. The Fiscal Intermediary must share information with the Consumer/Consumer Designated Representative regarding each party’s respective responsibilities under the Consumer Directed Personal Assistance Program.
8. The Fiscal Intermediary must maintain personnel records for each consumer directed personal assistant. These will include clock in and clock out verifications, time sheets

and other documentation needed for wages and benefits processing and copies of all medical documentation required per
10 NYCRR 766.11

9. The Fiscal Intermediary must maintain records for each Consumer to include copies of all authorizations for services and contracts between the Consumer and the Fiscal Intermediary.
10. The Fiscal Intermediary will compensate the Consumer's Personal Assistant(s) for only the authorized weekly hours worked. The Consumer/Designated Representative assumes full responsibility for payment to the Personal Assistant(s) for any and all unauthorized hours of service.
11. The Fiscal Intermediary must maintain documentation to support time spent in the provision of services to the Consumer.
12. The Personal Assistant will be paid for the actual hours clocked in via the HHA Exchange system. In the event phone clocking is not accessible a time sheet will be utilized. Both the Consumer/Designated Representative and the Personal Assistant must sign and date the time sheet as verification of hours worked.
13. The Fiscal Intermediary Organization will make random calls on a monthly basis to verify the Personal Assistant's presence in the home at the specified time of service.
14. The Fiscal Intermediary Organization will make random calls to the Consumer/Designated Representative to solicit feedback on the quality of care being provided by the Personal Assistant.
15. The Fiscal Intermediary must monitor the Consumer/Consumer's Designated Representative continuing ability to fulfill the Consumer's responsibilities under the Consumer Directed Personal Assistance Program. If it appears that this is not the case, the Fiscal Intermediary must notify the contractual arrangement of the outcomes.
16. The Fiscal Intermediary must exercise reasonable care in properly carrying out its responsibilities.
17. The Fiscal Intermediary shall maintain consumer records for a period of six (6) years after the date of service. In the case of a minor the later date of either three years after the age of majority or six years after the date of service, or for such a period as required by law, regulation or the contractual arrangement.
18. The Fiscal Intermediary, at a minimum, is responsible for verifying plan enrollment and Medicaid eligibility through EPaces or eMedNY the first and the fifteenth of the month to ensure the enrollee has had no changes in Medicaid coverage or MLTC enrollment.

19. On a monthly basis the Fiscal Intermediary will check the Consumer Directed Personal Assistants against the Excluded Provider List, which includes updates for the List of Excluded Individuals and Entities (LEIE) and the Restricted, Terminated or Excluded Individuals or Entities List. In the event that the Consumer Directed Personal Assistant is not eligible based searches completed, the consumer and the approving Managed Long Term Care Plan shall be informed.

20. As part of the credentialing process, the department shall verify on behalf of the consumer a personal assistant's eligibility for employment within three business days of accepting the Personal Assistant position under the Consumer Directed Program. All verification shall be done via the E-verify site, and a determination letter printed and placed in each of the Personal Assistant's file. In the event that the Consumer Directed Personal Assistant is not eligible to work, the consumer and the approving Managed Long Term Care Plan shall be informed.

CLAIMS PAYMENT

PURPOSE: To ensure that claims submitted are done correctly to be paid in a timely fashion.

POLICY: The Fiscal Intermediary will provide claims with the correct billing codes to the insurer.

PROCEDURE:

1. The insurer/Managed Long Term Care Plan must provide to the Fiscal Intermediary the rate codes, their description and associated specialty codes needed for claims processing.
2. The insurer/Managed Long Term Care Plan must include the appropriate ICD-10 code.
3. There are 10 rate codes for CDPAP
    a. Eight (8) increment rate codes cross walked to specialty code 675
    b. Two (2) Live-in rate codes cross walked to specialty code 676
4. The insurer/Managed Long Term Care Plan will notify the Fiscal Intermediary of its claims procedures and will pay all clean claims in a timely manner.
5. The insurer/Managed Long Term Care Plan will notify the Fiscal Intermediary in writing as to the reason for the denial or partial payment.
6. If the insurer/Managed Long Term Care Plan consistently delays payment to the Fiscal Intermediary without cause, the State Department of Health may require a plan of correction or take other regulatory action.
7. The Fiscal Intermediary should obtain a National Provider Identifier (NPI) number. If the Fiscal Intermediary is not a provider of health care services and does not meet the definition of a health care provider they are ineligible to apply for and NPI number.
8. Where a Fiscal Intermediary does not have an NPI number the insurer may assign a number to the Fiscal Intermediary that works with the MCO claims submission logic.

DISENROLLMENT

PURPOSE: To minimize interruption of services.

POLICY: To provide a means to ensure that members that disenrollment from one MCO have communication between the MCO, the member, the Fiscal Intermediary and the new MCO.

PROCEDURE:

1. Consumers with the Fiscal Intermediary should be tracked by both the MCO and the Fiscal Intermediary. This should be done at the first of the month and again on the 15th of the month to ensure there are no changes in Medicaid coverage or MCO enrollment. Once either the Fiscal Intermediary or MCO is aware that the consumer is no longer on the MCO roster, there will be communication between the Fiscal Intermediary and the MCO.
2. The MCO will notify the Local District of Social Services (LDSS) that a member receiving CDPAP services has been disenrolled. This information will be communicated on the appropriate form; NYC-HCSP 3018 and in other counties the State Department of Health form will be utilized.
3. The member is responsible to notify the Fiscal Intermediary if they have enrolled into a new MCO. The Care Manager at the MCO may also notify the Fiscal Intermediary for services provided after the date of disenrollment.
4. The MCO is not responsible for payment to the Fiscal Intermediary for services provided after the date of the disenrollment.
5. The consumer and/or the Fiscal Intermediary on the consumer's behalf must notify the MCO to obtain transitional care and provide information to the new MCO as necessary.
6. If the consumer has voluntarily enrolled with a new MCO, the Fiscal Intermediary or consumer must contact the new MCO to note whether services are authorized at the same level or if there is a change in the amount, scope or duration of the authorization.
7. The MCO must note if it has an administrative agreement with the current Fiscal Intermediary.
8. The MCO must continue the current authorization and Fiscal Intermediary services until the MCO conducts an assessment, authorization and arrangement for provisions of the services.
9. Upon disenrollment the Fiscal Intermediary shall:
    a. assist in effecting an orderly transfer of services and obligations to another Fiscal Intermediary to which the MCO has assigned Consumers to prevent any disruption in services to such consumers;
    b. provide the MCO and NYSDOH with access to all books, records and other documents relating to the performance of services that are required or requested, at no charge;

c. subject to all applicable laws and regulations, stop using and return and/or destroy all proprietary information.

HOME CARE WORKER WAGE PARITY

PURPOSE: To establish a minimum wage for home care aides who perform Medicaid reimbursed work for certified home health agencies (CHHAs), long term home health care programs (L THHCPs) and managed care organizations (MCOs) within New York City and within the counties of Nassau, Suffolk and Westchester.

POLICY: The Public Health Law of § 3614-c, Home Care Worker Wage Parity establishes a minimum wage for home care aides who perform Medicaid reimbursed work within New York City and within the counties of Nassau, Suffolk and Westchester. The Fiscal Intermediary organization will ensure that all staff are receiving minimum wage according to city and state law. In addition, all employees will receive orientation to the agency's Home Care Worker Wage Parity at the start of their employment with the agency.

DEFINITIONS:

§ 3614-c. Home care worker wage parity. 1. As used in this section, 25 the following terms shall have the following meaning:

"Living wage law" means any law enacted by Nassau, Suffolk or Westchester county or a city with a population of one million or more which establishes a minimum wage for some or all employees who perform work on contracts with such county or city.

"Total compensation" means all wages and other direct compensation paid to or provided on behalf of the employee including, but not limited to, wages, health, education or pension benefits, supplements in lieu of benefits and compensated time off, except that it does not include employer taxes or employer portion of payments for statutory benefits, including but not limited to FICA, disability insurance, unemployment insurance and workers' compensation.

"Prevailing rate of total compensation" means the average hourly amount of total compensation paid to all home care aides covered by whatever collectively bargained agreement covers the greatest number of home care aides in a city with a population of one million or more. For purposes of this definition, any set of collectively bargained agreements in such city with substantially the same terms and conditions relating to total compensation shall be considered as a single collectively bargained agreement.

"Home care aide" means a home health aide, personal care aide, home attendant, personal assistant performing consumer directed personal assistance services pursuant to section three hundred sixty-five-f of the social services law, or other licensed or unlicensed person whose primary responsibility includes the provision of in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks; provided, however, that home care aide does not include any individual

(i) working on a casual basis, or

(ii) (except for a person employed under the consumer directed personal assistance program under section three hundred sixty-five-f of the social services law) who is a relative through blood, marriage or adoption of:

a. The employer; or

b. The person for whom the worker is delivering services, under a program funded or administered by federal, state or local government.

"Managed care plan" means any managed care program, organization or demonstration covering personal care or home health aide services, and which receives premiums funded, in whole or in part, by the New York State medical assistance program, including but not limited to all Medicaid managed care, Medicaid managed long term care, Medicaid advantage, and Medicaid advantage plus plans and all programs of all-inclusive care for the elderly.

"Episode of care" means any service unit reimbursed, in whole or in part, by the New York state medical assistance program, whether through direct reimbursement or covered by a premium payment, and which covers, in whole or in part, any service provided by a home care aide, including but not limited to all service units defined as visits, hours, days, months or episodes.

"Cash portion of the minimum rate of home care [aid] aide total compensation" means the minimum amount of home care aide total compensation that may be paid in cash wages, as determined by the department in consultation with the department of labor.

"Benefit portion of the minimum rate of home care aide total compensation" means the portion of home care aide total compensation that may be paid in cash or health, education or pension benefits, wage differentials, supplements in lieu of benefits and compensated time off, as determined by the department in consultation with the department of labor. Cash wages paid pursuant to increases in the state or federal minimum wage cannot be used to satisfy the benefit portion of the minimum rate of home care aide total compensation.

PROCEDURE:

1. All individuals defined as home care aides, defined as having primary responsibility for providing in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks and who are employed by covered entities must be paid at the minimum rates established according to the Public Health Law. Individuals who are classified as home care aides include home health aides, personal care aides, home attendants, and any other licensed or unlicensed person

whose primary responsibility is to provide in home assistance with activities of daily living or health related tasks.

a. Total compensation for this purpose means all wages and other direct compensation paid to or provided on behalf of the employee including, but not limited to, wages, health, education or pension benefits, supplements in lieu of benefits and compensated time off.

b. Benefits utilized will be kept electronically and be made available upon request to any employee.

c. Total compensation does not include employer taxes or employer portion of payments for statutory benefits, including but not limited to FICA, disability insurance, unemployment insurance, and workers' compensation.

2. The living wage requirement applies to all dually eligible cases where Medicaid is the payer in part or in whole.

3. The Fiscal Intermediary Organization must provide all necessary information necessary to verify compliance to their contracts on a quarterly basis. The information to be included can be negotiated between The Fiscal Intermediary Organization and the contractor.

4. The Fiscal Intermediary Organization will maintain records of compliance for at least 10 years and will be made available the NYS Department of Health upon request.

5. Overtime in excess of 40 hours, a week is paid at a rate 1.5 times the minimum wage paid to the worker which does not include any additional wages and supplemental wages the agency pays out to meet wage parity.

6. Any required rate changes will be effective March 1st or otherwise specified by the DOH. This information will be provided to payroll through the agency payroll system.

7. The agency will review and revise its wage rate for the case assignments and hours each payroll period to assure that the home care wage parity is paid for hours worked on Medicaid Contract at a minimum of the wage established by the HCWWP law and its additional and supplemental wages as required.

HORIZON HOME CARE SERVICES INC.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

POLICY AND PROCEDURE MANUAL

FRAUD, WASTE AND ABUSE

PURPOSE: To provide information to the Consumer/Designated Representative and Personal Assistant regarding laws related to false claims, statements and whistleblower protection under the laws. In addition, the Consumer/Designated Representative and Personal Assistant will be informed on the process Horizon Home Care INC has for preventing and detecting fraud, waste and abuse.

PROCEDURE:

1. Horizon Home Care INC. will provide written statements to the Consumer/Designated Representative and Personal Assistant(s) enrolled in the Consumer Directed Personal Assistance Program on the policies related to federal and state laws regarding fraud, waste and abuse and the Consumer Directed Personal Assistance Program.
2. The Consumer/ Designated Representative and Personal Assistant will receive Horizon Home Care INC Home Care's policy on fraud, waste and abuse.
3. Horizon Home Care INC Home Care, upon request of the MCO, shall certify, based on its best knowledge, information and belief that all data and other information directly or indirectly reported or submitted is accurate, complete and truthful.
4. Horizon Home Care INC will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Consumer Directed Personal Assistance Program Agreement and the MCO.
5. Horizon Home Care INC has a reporting mechanism through our compliance hotline on an anonymous basis. In addition, the Consumer/Designated Representative or Personal Assistant(s) can report issues directly to the Corporate Compliance officer.
6. There will be no retaliation permitted against anyone who reports a concern made in good faith to the Corporate Compliance Department/Officer. All reported concerns will be investigated and any Consumer/Designated Representative or Personal Assistant who engages in fraudulent activities will be reported.
7. Horizon Home Care INC will investigate timely and thoroughly all reports of possible fraud, waste and abuse.
8. Horizon Home Care INC will be vigilant regarding fraud, waste and abuse in the Consumer Directed Personal Assistance Program.
9. All federal and state laws pertaining to false claims can be found in Appendix A of this policy.

APPENDIX A

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§187-194)
2) Social Services Law, Section 145-b - False Statements
3) Social Services Law, Section 145-c - Sanctions

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties
2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
3) Social Services Law, Section 145-c - Sanctions
4) Penal Law Article 175 - False Written Statements
5) Penal Law Article 176 - Insurance Fraud
6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. §3730(h))
2) New York State False Claim Act (State Finance Law §191)
3) New York State Labor Law, Section 740
4) New York State Labor Law, Section 741

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:
§ 3729. False claims
(a) Liability for certain acts.--

2) In general.--Subject to paragraph (2), any person who—

(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered less than all of that money or property;

(E) Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C.2461) note; Public Law 104-410, plus 3 times The amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--lf the court finds that-«

(A) The person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) Such person fully cooperated with any Government investigation of such violation; and

(C) At the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of That person.

(3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section—

(1) the terms "knowing" and "knowingly" --

(A) mean that a person, with respect to information--

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"--

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--

(i) is presented to an officer, employee, or agent of the

United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

{3} the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(5) Exemption from disclosure.--Any information furnished pursuant to subsection (a) (2) shall be exempt from disclosure under section 552 of title 5.

(6) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

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, or submits a claim to entities administering government funds 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) are 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 which obtains interim payments from Medicare or Medicaid 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 or Medicaid 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)(I) 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.

3) 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, 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 rather than 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 State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§187-194)

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 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 ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

Social Services Law, Section 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 needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

1) Social Services Law, Section 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.

2) Social Services Law, Section 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 a 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.

3) 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. This statute 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.

4) 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. §I 75.10 - Falsifying business records in the first degree includes the elements of the §I 75.05 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. §I 75.35 - 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.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, 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.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

a. Health care fraud in the 5th degree - a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.

b. Health care fraud in the 4th degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

c. Health care fraud in the 3rd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.

d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.

e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

III. WHISTLEBLOWER PROTECTION

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

The Federal False Claims Act provides protection to qui tam relaters (individuals who commence a False Claims action} 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 relater 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.

2) New York State False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) 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.

3) New York State Labor Law, Section 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.

4) New York State Labor Law, Section 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.

UNITED STATES CODE TITLE 42

Section 1396a (a) (68)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must-

{68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall-

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

New York Social Services Law

363-d. Provider compliance program.

1. The legislature finds that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. The legislature accordingly declares that it is in the public interest that providers within the medical assistance program implement compliance programs. The legislature also recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics. At the same time, however, the legislature determines that there are key components that must be included in every compliance program and such components should be required if a provider is to be a medical assistance program participant. Accordingly, the provisions of this section require providers to adopt effective compliance program elements, and make each provider responsible for implementing such a program appropriate to its characteristics.

2. Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program. The office of Medicaid inspector general shall create and make available on its website guidelines, which may include a model compliance program, that reflect the requirements of this section. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required pursuant to this section may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements:

(a) Written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(b) Designate an employee vested with responsibility for the day-to day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program;

(c) Training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(d) Communication lines to the responsible compliance position, as described in paragraph (b) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(e) Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

(1) failing to report suspected problems;
(2) participating in non-compliant behavior; or
(3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(f) A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits;

(g) A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(h) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section.

(a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(b) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

4. The Medicaid inspector general, in consultation with the department of health, shall promulgate regulations establishing those providers that shall be subject to the provisions of this section including, but not limited to, those subject to the provisions of articles twenty-eight and thirty-six of the public health law articles sixteen and thirty-one of the mental hygiene law, and other providers of care, services and supplies under the medical assistance program for which the medical assistance program is a substantial portion of their business operations.

APPENDIX B

NOTICE OF PRIVACY PRACTICE

[SEE NPP BOOKLET]