



# Southern Tier Independence Center

## Corporate Compliance Plan and Code of Conduct

Revised October 2019



### **Corporate Compliance Overview**

Southern Tier Independence Center is committed to compliance with all applicable federal, state and local laws and regulations including those that govern participation in the Medical Assistance Program (Medicaid). It is the policy of Southern Tier Independence Center that employees, contractors, volunteers and Board Members comply with all applicable laws and regulations, both civil and criminal, including but not limited to: the Deficit Reduction Act, the Federal False Claims act, all applicable regulations governing participation in the Medicaid program, federal and state anti-kickback laws and all federal and state laws that relate to detection and prevention of fraud and abuse in federal healthcare programs. Appendix A contains a summary of the aforementioned applicable laws.

Additionally, STIC is dedicated to managing and operating its programs in keeping with the highest of business, ethical and moral principals. Each employee, Board Member, contractor, and volunteer contributes to achieving these principals by conducting business activities with integrity and high ethical standards. Supervisors also contribute to achieving these principles by exercising good leadership and being a good example in creating and promoting a workplace environment in which compliance and ethical business conduct are expected. The Corporate Compliance Plan has been established to prevent the occurrence of illegal or unethical behavior, to stop any such behavior as soon as reasonably possible after it has been discovered, to discipline the individuals involved (including those who know of violations but fail to report them), and to recommend and implement changes in policy and procedure necessary to avoid a recurrence of any prior violation.

It is the policy of STIC that:

- All employees are educated about the applicable laws and trained in matters of compliance,
- There is periodic auditing, monitoring and oversight of compliance with those laws,
- There exists an atmosphere that encourages and enables the reporting violations without fear of retribution,
- Responsibility is not delegated to persons with a propensity to act in a non-compliant manner, and
- Mechanisms exist to investigate, discipline and correct violations.

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### **Changes to the Plan**

This plan is effective upon approval from STIC's Board of Directors. Additionally, any subsequent changes to the Plan will require Board approval. The Plan will be disseminated whenever a material change is made.

### **All Other Corporate Compliance Plans Declared Null and Void**

All other Corporate Compliance Plans/Codes of Conduct, whether written or oral, are declared null and void, ceasing to have any effect whatsoever by the publication and dissemination of this Plan. This plan supercedes all other Plans.

### **Corporate Compliance Plan**

A Corporate Compliance Plan is a system, which is designed to detect and prevent violations of law, as well as the likelihood of unethical activity by agency employees, volunteers, contractors, and Board Members. Southern Tier Independence Center has established this Corporate Compliance Plan tailored to the agency's principle line of business.

The Plan is intended to provide a framework for individual or departmental compliance efforts and to apply generally to all STIC employees, volunteers, contractors and agents and functions.

In addition to this Compliance Plan, the following documents, policies and procedures govern STIC's operations:

- Code of Conduct (included in the Plan)
- Employee and Agency Policies and Procedures Manual
- HIPAA Policies and Procedures Manual
- Incident Reporting Policies and Procedures
- Criminal Background Check Policies and Procedures
- Abuse Reporting Policy
- Financial Policies
- Various Program Policies and Procedures

### **Education and Training**

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#### **Orientation**

As a part of orientation all employees and Board Members will receive an accessible copy of STIC's Corporate Compliance Plan, as well as training on this topic appropriate for their position. This will include the nature and scope of the Corporate Compliance Plan, methods to report violations, and disciplinary measures for violating the plan. Employee orientation will also be supplemented by specific regulatory training geared toward the employee's responsibilities within the first three months of employment.

**Periodic Training**

All employees, Board Members, and contractors will receive periodic training related to compliance issues, expectations and the Compliance Plan as required to perform the essential functions of their positions. This training will be provided on an annual basis at a minimum.

**Attendance**

All education and training related to the Compliance Plan is mandatory. A signed acknowledgement of training and receipt of the Compliance Plan will verify attendance. Employees that fail to attend Corporate Compliance training through their own accord may be subject to disciplinary action up to and including termination.

**Consumer Education**

Consumers and/or appropriate family members will be informed of STIC's Corporate Compliance efforts appropriate to the services that they will receive. Consumers acting as Employers in STIC's Consumer Directed Personal Assistance Program will receive additional training in light of their position supervising Personal Assistants. All consumers will be notified of STIC's fraud reporting guidelines and will be encouraged to report fraudulent activity should they become aware of it

**Corporate Compliance Officer and Corporate Compliance Committee****Corporate Compliance Officer**

This Plan provides for the existence of a Corporate Compliance Officer (CCO) who has responsibility and accountability for compliance matters. However, each individual employee or agent of STIC remains responsible and accountable for his or her own compliance with applicable laws. At STIC, the Quality Management Specialist assumes the role of Corporate Compliance Officer and is responsible for:

- Development of the Compliance Plan
  - Overseeing and monitoring implementation of the Compliance Plan
  - Providing guidance to management and individual departments regarding policies and procedures, and applicable laws, rules and regulations
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- Coordinating, developing, and participating in the educational training program
  - Ensuring that employees receive a copy of the Compliance Plan
  - Informing employees of changes in the laws or regulations periodically and systematically through written communications and in-service training
  - Receiving reports of violations of the Compliance Plan
  - Assisting the Executive Director with investigations into reported violations.

**Compliance Committee**

The Corporate Compliance Officer directs the Compliance Plan with the support of the Corporate Compliance Committee. The Corporate Compliance Committee will meet at least quarterly to review the status of the Corporate Compliance Plan, present and discuss potential compliance concerns and issues, and recommend changes regarding programs and departments to the Executive Director.

The Corporate Compliance Committee, will at a minimum, will consist of the Executive Director, Assistant Director, Comptroller, Quality Management Specialist, Human Resources Coordinator, and at least one Program Supervisor.

An Ad-Hoc sub-committee may be created depending on issue or situation that arises. The sub-committee may consist of current Corporate Compliance Committee members as well other appropriate STIC staff. The Executive Director will appoint members to the sub-committee.

**Auditing and Monitoring**

The Corporate Compliance Officer and Corporate Compliance Committee are responsible for ensuring that internal corporate compliance auditing takes place on a regular basis. Compliance related audits are conducted as a result of an investigation or as a proactive means of monitoring compliance in areas of actual or potential risk.

- The Corporate Compliance Officer is primarily responsible for auditing the Corporate Compliance Plan. This shall include periodic and regularly scheduled reviews of documentation, billing, claims processing and reimbursement procedures as well as practices that are mandated to ensure adherence to federal and state regulations.

Ongoing evaluation is critical in detecting non-compliance in STIC's various programs. STIC's Quality Management Team is responsible for monitoring and auditing the programs and services offered by STIC and reporting issues to the Assistant Director and/or Executive Director. This reduces the risk of non-compliance within the agency and ensures that the agency and staff comply with all regulatory, state and federal requirements and guidelines as well as STIC's mission, values, and philosophy.

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**STIC's Quality Management Team**

STIC's Quality Management Specialist/CCO is responsible for overseeing the Quality Management team. This team is comprised of employees who are responsible for monitoring the quality of our services, conducting satisfaction surveys of consumers, and other activities involved in directly reviewing service, billing and other pertinent records.

The Quality Management Specialist/CCO is responsible for:

- Developing agency and program monitoring/auditing tools and reports, as needed.
- Conducting regularly scheduled program and internal audits

- Collecting and analyzing data and reporting findings, trends and recommendations to the Executive Director.
- Maintaining cooperative working relationships with staff and various departments in order to gather and analyze information, with the overall goal to proactively resolve potential compliance risks.
- Working directly with staff to improve services, provide education regarding quality systems and offer guidance in adhering to the agency's guiding principles.
- Assuring that the agency and the staff comply with all regulatory, state and federal requirements and guidelines as well as STIC's mission, values, and philosophy.
- Evaluating existing policies, procedures and practices and recommending changes to ensure consistency in program operation.
- Ensuring that employees are trained on all policies, procedures and quality system related documents.
- Periodically reporting to the Board of Directors on compliance related activities.

STIC's Quality Management Assistant (QMA) is responsible for:

- Conducting phone satisfaction surveys/interviews of consumers with disabilities and/or their family members or guardians.
- Producing and submitting monthly summary reports of survey responses.
- Assisting with the development of the survey instrument and suggesting changes if needed.
- Advising the Quality Management Specialist of any serious issues identified during phone interviews that warrant immediate attention (such as allegations of abuse, harassment, etc.).

### **External Audits**

STIC's Comptroller arranges for an independent financial audit every year to provide for verification of records, processes or functions in a sufficiently independent manner from the agency, to add its value and improve its operations. The audit is also performed to meet the requirements of outside agencies, including funding sources, which have a fiscal or legal interest in STIC. Specifically, its objectives are:

- To independently identify information which is essential to develop an overall picture of the agency.
- To identify any weaknesses or administrative flaws which otherwise would not be identified.
- To identify strengths and weaknesses of the administrative structures in order to inform decisions on overall strengthening of the agency.

- To provide baselines on which reforms can be assessed.
- To provide the government (other governing bodies) and general public with credible information that result in public faith or trust of the institution and/or pressure for any reforms to address problems identified.
- In addition to the aforementioned monitoring, STIC's various funding sources regularly conduct Fiscal and Programmatic audits.

### **Reporting a Violation**

Any suspected violation of the Plan including the Code of Conduct must be immediately reported to STIC's Corporate Compliance Officer or the Executive Director or Assistant Director in the Corporate Compliance Officer's absence. All employees have the responsibility to comply with applicable laws and regulations and to report any violations. Any employee found to have known of such acts but who failed to report them will be subject to disciplinary action.

The initial report may be made orally. However, the reporter may be asked to provide a written statement (or another documentable format) to the Corporate Compliance Officer, Executive or Assistant Director. Reports can also be made anonymously, via telephone/voicemail, email or regular mail to the Executive Director, Corporate Compliance Officer or Assistant Director at:

Southern Tier Independence Center  
135 East Frederick Street  
Binghamton, NY 13904  
(607) 724-2111

**Anonymous Toll Free Hotline-1 (855) 210-8495**

It is important to note that providing an identity generally makes investigating reports easier and more effective. Every effort will be made to preserve the confidentiality of reports of violations. All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases disclosures will be on a "need to know" basis only.

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Upon receipt of an allegation, the Corporate Compliance Officer will conduct an investigation into the incident in consultation with the Executive and/or Assistant Director. The results of the investigation will be put in writing and will be provided to the Executive Director within 10 business days.

In the event that the Executive Director is suspected of participating in or condoning any type of Plan violation including fraud, the allegations will be reported directly to the Board President who will then work with the Board to investigate the suspicions.

If a violation has occurred a Plan of Corrective Action will be developed and implemented immediately. Additionally, the issue will be reported to all appropriate authorities, as necessary. (See Self-Disclosure below)

Any violation that could potentially result in STIC having to repay over \$5,000 to a funding source will be reported to STIC's Board of Directors by the Executive Director at the next regularly scheduled Board meeting following discovery of the issue. Additionally, the Executive Director may also make an immediate report of an issue to the Board President prior to the next regularly scheduled Board meeting as he/she deems necessary.

A written record of every report received will be kept for a minimum period of six years, or longer as required by law.

### **Investigation and Audit Findings**

The Corporate Compliance Officer will complete and present a quarterly report to the both Corporate Compliance Committee and the Board, which summarizes Corporate Compliance violations and audit findings over the previous three months.

### **Whistleblower Protection and Non-Retaliation**

This Plan is intended to encourage and enable employees and others to raise serious concerns within STIC, prior to seeking resolution outside the organization. It is the responsibility of all STIC staff to prevent and report fraudulent and unlawful activities or suspected fraudulent or unlawful activities in accordance with the Compliance Plan.

Any employee or other complainant reporting suspected or actual fraudulent activity should not contact the suspected individual(s) or discuss the case, facts, suspicions or allegations with anyone unless directed to do so by STIC's legal counsel or the lead investigator (e.g. Executive Director, Board President, Corporate Compliance Officer or Assistant Director). Any inquiries concerning the activity under investigation from the suspected individual, his or her attorney or representative, or any other inquirer should be referred directly to the STIC's legal counsel or the lead investigator.

No employee, who in good faith reports fraudulent or unlawful activities, participates in an investigation or hearing, refuses to follow an unlawful order, or reports service violations will suffer harassment, retaliation, adverse employment consequences or any other manner of discrimination.

Any employee that retaliates against a person who in good faith participates in the reporting of unlawful or fraudulent activity, will be subject to disciplinary action as outlined in STIC's Employee and Agency Policies and Procedures Manual, as well as criminal and civil charges if appropriate. Furthermore, if any employee is aware of retaliation against another employee for the aforementioned reasons, he/she should immediately report it to the Executive Director.

Knowingly making false allegations of fraudulent or unlawful activities is considered an extremely serious offense and will result in the employee's immediate dismissal.

### **Self-Disclosure**

In some cases, upon completion of an investigation of an incident that is determined to be a violation of the Corporate Compliance Plan, a report must be made to the New York State Office of the Medicaid Inspector General's (OMIG) Office. This is known as a Self-Disclosure. In most cases STIC will consult with an attorney to make a determination whether to self-disclose an incident and what type of information is to be included in the disclosure.

Many factors must be taken into account to determine whether an incident warrants a self-disclosure or whether it would be better handled through administrative billing processes. These factors include, but are not limited to:

- The exact issue and circumstances that led to the non-compliance problem,
- The amount involved,
- Any patterns or trends that the problem may demonstrate within STIC's system,
- The period of non-compliance,

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

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

### **Initial Report**

Once STIC makes the determination to disclose a problem, an initial report must be made to OMIG. At a minimum, the following information must be included in the initial report:

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

In addition to the initial report, STIC may have to provide further information to OMIG upon request. This may include, but is not limited to:

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

### **Overpayments**

If a billing or documentation error results in an overpayment to STIC, which does not meet the level of self-disclosure, the amount overpaid will be returned promptly upon discovery in accordance with the payer's required procedures.

### **Sanctions**

Every confirmed violation of the Corporate Compliance Plan including the Code of Conduct, may result in corrective action or discipline. Any employee or contractor who violates or knowingly fails to report any violation of the Plan including the Code of Conduct, any applicable law or regulation, Agency policy, procedure or practice is subject to appropriate disciplinary action, up to and including termination and may also be subject to legal action where indicated.

### **Medicaid Billing Standards**

STIC submits claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons. Information provided in relation to any claim for payment must be true, accurate, and complete. Claims are submitted on officially authorized claim forms in the manner specified in conformance with the standards and procedures for claims submission.

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### **Record Retention**

STIC will prepare and maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program, other contracts and fees-for-service. Upon request, STIC will furnish such records and information to the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control, the Medicaid Inspector General and the New York State Department of Health and other authorized personnel. This includes:

- All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service. These records will

be kept for a period of six years from the date services were furnished or billed, whichever is later.

- All fiscal and statistical records and reports which are used for the purpose of establishing rates of payment made in accordance with the medical assistance program and all underlying books, records, documentation and reports which formed the basis for such fiscal and statistical records and reports. These records will be kept and maintained for a period of at least six years from the date of filing of such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which STIC's rate or fee was based on the fiscal or statistical reports, whichever is later.
- Reports and documentation submitted pursuant to an appeal of a provisional rate. These records must be maintained for a period of six years from the submission of material in support of such appeal or two years following certification of any revised rate resulting from such appeal, whichever is later.

STIC will permit audits of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program, including patient/consumer histories, case files and consumer-specific information. All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. It is understood that this limitation does not apply to situations in which fraud may be involved or where STIC or an agent thereof prevents or obstructs an audit.

### **Required Service Documentation**

STIC will maintain all records necessary to disclose the nature and extent of services provided and the medical necessity of such services, to support all claims made for reimbursement. These records will be kept for a minimum of six years from the last date services were furnished to or billed for the individual, whichever is later.

### **Medicaid Service Coordination (MSC)**

MSC assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, ~~implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with~~ developmental disabilities or mental retardation. MSC promotes the concepts of choice, individualized services and supports, and consumer satisfaction. MSC is provided in accordance with state mandates as put forth in the MSC Vendor Manual, the Waiver Key, STIC's consumer rights, Waiver Enrollment, Intake Process, and Internal Review, MSC Intake Manual and Administrative Memoranda, which delineates what STIC may bill. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

- Consumer's name and Medicaid number
- Identification of vendor providing service
- The month and year the service was provided.
- An Individualized Service Plan (ISP), covering the time period of all payment claims.

- Service coordination progress notes that document the service coordination activities that occurred during the month, including, but not limited to, one "A" contact ("Face to Face", LCED update, or ISP review), or two "B" contacts (Phone call or personal contact, e-mail exchange or other correspondence exchange with a qualified for linkage/referral or to maintain benefits)
- If applicable, case notes that substantiate any transition payments billed by the vendor
- For HCBS Waiver enrollees, all required Waiver enrollment documentation
- Consumer response to service
- The monthly service note, including the monthly summary must be completed by the 15<sup>th</sup> of the month following the month of service.
- Date service was provided and documented, including the day, month and year; these dates must be concurrent.
- Service Location
- The full name, title and signature of the MSC providing service

#### Appendix B: MSC Chart Review Tool

##### **HCBS (Home and Community Based Services) Waiver Supported Employment**

Supported Employment services are planned and designed to assist the recipient to engage in paid work in regular integrated work settings. These services are especially designed for persons with disabilities facing severe impediments to employment irrespective of age or vocational potential. These services are targeted to persons for whom employment without support at or above the minimum wage is unlikely. Services include assessment, counseling, job development and placement, on-the-job training, work skill training, ongoing supervision and monitoring, and ongoing support necessary to assure job retention, including assistance with arranging transportation. Supported Employment services are provided in accordance with state mandates as put forth in the Waiver Key, STIC's consumer rights, Waiver Enrollment and Administrative Memoranda, which delineates what STIC may bill. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

- A. Progress note including the following:
- Consumers' name and Medicaid number (the Medicaid number need not be included in daily documentation, it can appear in the consumer's Supported Employment Plan).
  - Category of waiver service provided
  - Date service was provided.
  - A description of the individualized service provided by Supported Employment staff, which is based on the person's Supported Employment Plan.
  - An indication that the contact with the consumer was delivered "face-to-face".
  - The consumer's response to the service
  - Location of the service provided, including a notation as to whether or not the service was provided at the person's job site.
  - Verification of service provision (The Supported Employment staff person who delivered the service must sign, provide his/her work title, and include the date the service note was written.)
  - The date the note was written must be by the 15<sup>th</sup> of the month following the month of service.
  - As necessary, documentation verifying that the DDSO has granted a waiver of off-site work visits.

In addition to the above documentation requirements, the file will contain:

- A current ISP, covering the time period of all payment claims, which reflects a service provision for Supported Employment
- A Supported Employment Plan which covers the time period of the payment claim and has the consumer's name and Medicaid Number, the category of waiver service provided (Supported Employment), the agency providing the Supported Employment service, the valued outcomes of the consumer, derived from the ISP, the date the plan was last reviewed (Reviews must be every six months), the anticipated level of support, the locations where the service will be provided, a description of the individualized services, safeguards (as applicable), the signature and title of the staff person writing the plan and the date the plan was written.
- Evidence that a 6 month review was conducted, including the staff person's signature and title who conducted the review, the date of the review and any changes in the Supported Employment Plan.
- Documentation of Consumer's Disability
- Current LCED ( Level of Care Eligibility Determination) and LCEDs for previous 6 years, if available

#### Appendix C: Supported Employment Audit Tool

##### **Community Habilitation**

Community Habilitation is a waiver service, which provides assistance to a person in order to acquire, retain, or improve the skills needed to perform daily activities in the home. These activities may include housekeeping, personal care, meal preparation, communication, health care and/or social engagements. Community Habilitation is provided in accordance with state mandates as put forth in the Waiver Key, STIC's consumer rights, Waiver enrollment, and Administrative Memorandums, which delineates what STIC may bill. In addition to a prior authorization of service, the following documentation elements are required:

- Consumer's name and Medicaid number
- Identification of category of service
- A daily description of at least one face-to-face service provided by staff during each "session"
- Documentation of start and stop times
- Documentation of staff to consumer ratio
- Consumer response to service
- The date the service was provided
- The primary service location
- ~~Verification of service provision by the Community Habilitation staff person delivering the service.~~
- Signature and title of the Community Habilitation staff person documenting the service
- The date the service was documented

Additionally, the file will contain:

- A current ISP, covering the time period of all payment claims, which reflects a service provision for Community Habilitation
- A Community Habilitation Service Plan which covers the time period of the payment claim and has the consumer's name and Medicaid Number, the category of waiver service provided (Community Habilitation), the agency providing the Community Habilitation service, the valued outcomes of the consumer, derived from the ISP, the date the plan was last reviewed (Reviews

must be every six months), the anticipated level of support, the locations where the service will be provided, a description of the individualized services, safeguards (as applicable), the signature and title of the staff person writing the plan and the date the plan was written.

- A Notice of Decision
- Documentation of Consumer's Disability
- Current LCED ( Level of Care Eligibility Determination) and LCEDs for previous 6 years, if available

#### Appendix D: Community Habilitation Audit Tool

**Community Habilitation, Self-Directed and Family Directed Option**

Community Habilitation, Self-Directed and Family Directed Option is a waiver service, which provides assistance to a person in order to acquire, retain, or improve the skills needed to perform daily activities in the home. These activities may include housekeeping, personal care, meal preparation, communication, health care and/or social engagements. Community Habilitation is provided in accordance with state mandates as put forth in the Waiver Key, STIC's consumer rights, Waiver enrollment, and Administrative Memorandums.

The difference between Community Habilitation and Community Habilitation Self-Directed and Family Directed Option is that self-direction provides the ability for individuals and/or the individual's family members to have more flexibility and control over their supports and services by choosing what is done, when the supports and services occur and who delivers them. A Memorandum of Understanding (MOU) is a requirement of the self/family-directed community habilitation option. The MOU describes the responsibilities of the individual or identified adult and STIC. Either party may discontinue the MOU without jeopardizing access to community habilitation services.

In addition to a prior authorization of service, the following documentation elements are required:

- Consumer's name and Medicaid number
- Identification of category of service
- A daily description of at least one face-to-face service provided by staff during each "session"
- Documentation of start and stop times
- Documentation of staff to consumer ratio
- Consumer response to service
- The date the service was provided
- The primary service location
- Verification of service provision by the Community Habilitation staff person delivering the service.
- Signature and title of the Community Habilitation staff person documenting the service
- The date the service was documented

Additionally, the file will contain:

- A current ISP, covering the time period of all payment claims, which reflects a service provision for Community Habilitation. ~~The individual's profile should indicate preference for self-directed and/or family directed option.~~
- A Community Habilitation Service Plan which covers the time period of the payment claim and has the consumer's name and Medicaid Number, the category of waiver service provided (Community Habilitation), the agency providing the Community Habilitation service, the valued outcomes of the consumer, derived from the ISP, the date the plan was last reviewed (Reviews must be every six months), the anticipated level of support, the locations where the service will be provided, a description of the individualized services, safeguards (as applicable), the signature and title of the staff person writing the plan and the date the plan was written.
- A Notice of Decision
- Documentation of Consumer's Disability

- Current LCED (Level of Care Eligibility Determination) and LCEDs for previous 6 years, if available

Appendix D: Community Habilitation Audit Tool (Same Audit tool used for Community Habilitation and Community Habilitation Self-Directed and Family Directed Option.

### **Intensive Behavioral Services**

Intensive Behavioral Services is a service available only to OMRDD HCBS waiver enrolled individuals that provides time-limited funding for up to six months for behavioral supports and services. IB Services are for individuals who live in non-certified settings or Family Care Homes and who present with substantial challenging behaviors that put them at imminent risk of placement into a more restrictive living environment. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

- Consumer's name and Medicaid number  
An Individualized Service Plan (ISP)
- Functional Behavioral Assessment with required elements
- Behavior Management Plan with required elements  
For HCBS Waiver enrollees, all required Waiver enrollment documentation
- Identification of category of waiver service provided
- A daily description of the services provided by staff
- Documentation of start and stop times for each session
- Consumer response to service
- Date service was provided and documented; these dates must be concurrent
- Primary Service Location
- Verification of service provision by staff delivering service including the name, signature and title of staff providing service

### **Plan of Care Support Services**

Plan of Care Support Services will be provided only to consumers enrolled in the HCBS Waiver who have chosen not to receive Medicaid Service Coordination. These are services needed to review and maintain a current Individualized Service plan (ISP) for the consumer, and to maintain documentation of the consumer's level of care eligibility. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

- Consumer's name and Medicaid number
- ~~Identification of category of waiver service provided~~  
An Individualized Service Plan (ISP)
- A description of the minimum number of face-to-face services provided by staff
- Documentation that minimum service duration was met
- Consumer response to service
- Date service was provided and documented; these dates must be concurrent
- Service Location
- Verification of service provision by staff delivering service
- Signature and title of staff providing service

**Family Education and Training (FET)**

Family Education and Training is training given to the families of consumers enrolled in the Home and Community Based Waiver who are under 18 years of age. The purpose of Family Education and Training is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of developmental disability upon the consumer and his or her family and teach them about service alternatives. Family Education and Training is distinct from service coordination in that the purpose is to support the family unit in understanding and coping with the developmental disability. The information and knowledge imparted in Family Education and Training increases the chances of creating a supportive environment at home and decreases the chances of a premature residential placement outside the home. Family Education and Training is given in a two-hour segment twice a year. Sessions may be in private or groups of families. Any personnel knowledgeable in the topics covered may conduct the sessions. FET is provided in accordance with state mandates as put forth in the Waiver Key, CSEP functional notebook, STIC's consumer rights, Waiver Enrollment, and Administrative Memoranda, which delineates what STIC may bill. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

- Consumer's name and Medicaid number
- Identification of category of waiver service provided  
Required Waiver enrollment documentation
- Topic and description of session
- Date of session
- Duration of session (Must be two hours)
- Whether the training session was provided to a group or individual
- Verification of service provision by staff delivering service

**Consumer Directed Personal Assistance**

The Consumer Directed Personal Assistance (CDPA) Program is designed to allow eligible consumers who receive personal assistance services to hire, and train, supervise and dismiss their own Personal Assistants. STIC acts as the fiscal intermediary on behalf of eligible consumers for the purposes of payroll and record retention and Medicaid billing. Consumers must be eligible for Medicaid and require personal assistance to receive CDPA. In addition to a prior authorization of service, the following documentation elements are required to support a claim for reimbursement:

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- ~~Consumer's name and Medicaid number~~
  - An approved Care Plan
  - Date of Service Provision
  - Daily start and end times of service provision
  - Verification of service provision by consumer receiving service
  - Verification of service provision by staff delivering service

### **Code of Conduct**

Southern Tier Independence Center is committed to conducting business and providing service in an ethical and honest manner and within the bounds of the law. The Code of Conduct is intended to provide employees, volunteers, contractors, and other agents of STIC with guidelines for appropriate conduct in a manner, which fulfills STIC's ethical commitment. The Code of Conduct is supplementary to the mission, vision and values of STIC, included below, and applies to all that provide services under the auspices of STIC.

The standards contained in the Code of Conduct are important, and therefore any violation will be handled in accordance with the Disciplinary Policy, as outlined in STIC's Employee and Agency Policies and Procedures Manual or other applicable policies and procedures of STIC. In addition, referral of certain matters will be made to government and regulatory agencies as appropriate. The offender may also be responsible for civil or criminal penalties or other damages caused by his or her inappropriate conduct.

### **STIC Mission Statement**

STIC's mission is to shape a world in which people with disabilities are empowered to live fully integrated lives in their communities.

We offer assistance, advocacy and services to children and adults with all disabilities, increasing their independence and allowing them to pursue their dreams.

We also support their families and friends, as well as businesses, agencies, and governmental entities, enabling them to better meet the needs of people with disabilities.

Finally, we educate and influence our community and public policy so that everyone can "Access Their World."

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### **STIC Values Statement**

- We value the ability of every human being to reach for their dream.
- We hold that each individual has strengths and weaknesses that must be taken into account in their journey toward their dreams. Each individual must accept the responsibility for the dream, the journey, as well as the work to get there.
- We offer support, ideas, tools, training, respect, and concern.
- We will not do for, when the person can do it.
- We will not patronize for the sake of efficiency, or in the guise of caring. We will try to understand when this causes fear, anger, and frustration.

- As we develop programs and policies, we will be guided by the dreams and abilities of the people we serve.
- No matter how difficult the road, we will always choose the path of inclusion and integration.
- We will not sacrifice our principles or values for money, convenience, or expediency.
- We will not shy away from controversy if that controversy will further our mission.
- We offer hope and continue to look at each person as a unique and joyful experience that will teach us, and take us on a journey where we've never been.

STIC has established the Code of conduct in recognition of its responsibility to consumers, employees and contractors and the communities we serve. It is the responsibility of every person connected with STIC to act in an ethical manner that is consistent with this organizational statement, supporting policies and procedures and appropriate laws and regulations.

***Toward this end STIC strives to...***

**Uphold our Mission, Values and Philosophy at all Times**

When representing STIC on other boards, committees, etc. in the community, employees will uphold and represent the philosophy, mission, values, and ethics of STIC, and will portray STIC and its employees in a positive manner.

**Maintain Professional Relationships with Consumers**

Employees shall not engage in sexual activities or relationships with consumers that they are serving, or with those consumers' families, friends or other close associates. It is the responsibility of employees to set/define appropriate boundaries for relationships with consumers. Employees should not give their home phone numbers to consumers for the purpose of conducting work at home, except in rare cases when the employee, as part of their regular job duties, may be expected to render legitimate emergency services, AND a specific consumer is likely to legitimately need such. The nature of STIC's Consumer Directed Personal Assistance Program is such that personal relationships between Consumers and Personal Assistants are encouraged and permitted in accordance with State Law.

Employees will not expect or require consumers to render a personal service to any employee as a condition for receiving services from that employee, nor will they exploit consumers in any way or violate any laws or regulations in the course of their relationships with consumers. Additionally, Employees shall not touch the service animals, wheelchairs, or other personal assistive devices of consumers without the consumer's consent.

**Provide Excellent Services**

STIC employees shall strive to treat all consumers with a spirit of dignity and respect. Each consumer is an individual and should be treated as such. Steps shall be taken so that each consumer understands his or her options and services. STIC will provide services in a manner that does not discriminate against any person because race, color, religion, national origin, age, disability, sexual orientation, or gender. At all times, competent and qualified staff will provide appropriate services, while considering the safety and well being of the consumers, in accordance with STIC's philosophy and mission.

**Employ Qualified Individuals**

STIC will ensure that all individuals meet the qualifications of the positions in which they are employed. Upon hire, STIC's Human Resources Coordinator will verify the credentials and/or licensure, if appropriate, of employees to confirm that they are qualified according to the standards of the Program in which they work. Documentation substantiating an employee's qualifications will be maintained in the employee's personnel file.

Additionally, all new hires will be checked against the NYS OMIG's and the U.S. DHHS OIG's website to ensure that they are not excluded or disqualified providers. Documentation substantiating that the initial check has been completed will be maintained in the employee's personnel file. All employees will be checked against the aforementioned websites on a monthly basis thereafter. The Human Resources Department will maintain documentation substantiating that this has been completed.

**Appropriately Reimburse Employees for Expenses**

Expenses for Travel and Activities will be reimbursed to employees in accordance with STIC's policies and procedures regarding such reimbursements. All STIC employees, including management level employees, will be reimbursed for travel related expenses in the same manner and at the same rate. Employees working in a program that requires activity reimbursement will be notified of related policies and procedures and will be reimbursed accordingly.

**Comply with the Law**

STIC is subject to numerous local, state and Federal laws pertaining to all aspects of its operation. All employees are required to understand and abide by those laws which are applicable to them in the performance of their jobs.

**Protect Confidential Information**

STIC is committed to maintaining the confidentiality of consumer, personnel, and other proprietary information in accordance with applicable legal and ethical standards. Consistent with HIPAA (Health Insurance Portability and Accountability Act), and other applicable laws and regulations, we do not use, disclose, or discuss consumer specific information with others unless it is necessary to serve the consumer or otherwise required by law.

**Adhere to Anti Referral and Health Care Fraud and Abuse Legislation**

As STIC bills Medicaid for several of the services we provide all employees are required to comply with laws that prohibit billing fraud and abuse. Activities that are prohibited include, but are not limited to:

- Intentionally or knowingly making false or fraudulent claims for payment or approval;
- Offering or receiving remuneration (such as a kickback, bribe, or rebate) as an inducement to make a referral for the furnishing (or arranging for the furnishing) of any item or service;
- Submitting false information for the purpose of gaining or retaining the right to participate in a plan or obtain reimbursement for services

**Encourage Fraud Reporting**

Since a substantial portion of STIC's funding comes from Medicaid dollars, a Medicaid Compliance Plan regarding Medicaid fraud has been formally adopted by the Board of Directors. Additionally, it is the responsibility of all STIC staff to prevent and report fraudulent and unlawful activities or suspected fraudulent or unlawful activities in accordance with STIC's Fraud and Whistleblower

Policies, as outlined in the Employee and Agency Policies and Procedures Manual. No employee, who in good faith reports fraudulent or unlawful activities, participates in an investigation or hearing, refuses to follow an unlawful order, or reports service violations will suffer harassment, retaliation, adverse employment consequences or any other manner of discrimination.

**Not Accept Inappropriate Gifts or Gratuities**

Employees may not accept gifts of significant value, or cash in any amount, from any recipient of STIC services or any person encountered in the course of their work. Employees may encourage those who wish to show appreciation for services received to make a donation to the agency. Gifts of appreciation such as a box of candy, flowers, a plant, a small trinket, etc. are acceptable. Gifts such as expensive jewelry, appliances, out-of-town trips, etc. should not be accepted.

**Avoid Conflicts of Interest**

It is the policy of STIC to prohibit its employees and other associates from engaging in any activity, practice, or act, which conflicts with, or appears to conflict with, the interests of STIC, or its consumers or its vendors. Therefore, Employees, Board members, and other individuals must disclose any potential conflict of interest they have in accordance with STIC's Conflict of Interest Policy. This includes CDPA Personal Assistants, however, in the case of the CDPA Program, Personal Assistants are allowed to provide services to those with whom they have personal relationships in accordance with State and Federal Law.

**Keep Accurate and Complete Records**

It is essential that STIC report accurate information to governmental entities and other third parties. In order to meet this obligation, it is equally essential that every employee accurately and clearly report the relevant facts or the true nature of a situation. No employee should knowingly or with reckless disregard for the truth make any false or misleading statement on any form or to any other officer, employee or auditor for STIC. All consumer records must meet the documentation standards required for quality services and to meet reimbursement regulations. Any individual who contributes to a consumer record must provide accurate documentation and never alter or destroy anything that is part of the official record. Employee travel expenses and timesheets must be accurately documented and supported (where appropriate) when seeking reimbursement from STIC.

**Retain Records According to Appropriate Laws and Regulations**

All records maintained at STIC shall be retained according to Medicaid and all Federal, State and local regulatory guidelines and laws. STIC will institute various document retention policies appropriate to the information being retained with which all employees will comply. All document retention and destruction must take place in accordance with established written policy(ies). STIC shall retain all potentially responsive documents if it has been served with a government subpoena. If the Center has reason to believe that there is an impending government review, it must retain all documents that may pertain to that review.

**Maintain Tax Responsibility and Compliance**

STIC is exempt from Federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Code and engages only in those activities in furtherance of its charitable purpose. STIC ensures that its resources are used in a manner, which furthers the public good rather than the private or personal interest of any individual. STIC shall file or cause to have filed accurate reports and returns required by taxing authority.

**Conduct Political Activities According to the Law**

STIC does not participate or intervene in (including the publishing or distributing of statements), any political campaign on behalf of or in opposition to any candidate for public office. While STIC supports employee participation in the political process, employees are not permitted to use positions in STIC to try to influence the personal decisions of others to contribute or otherwise support political parties or candidates.

STIC may participate in lobbying activities or advocating the passage or defeat of certain legislation that pertains to issues that affect the disability community. Lobbying activities, or advocating the passage or defeat of certain legislation, shall not constitute a substantial part of the activities of STIC.

**Provide a Safe Workplace**

It is the policy of STIC to comply with all applicable state and federal laws designed to improve workplace safety. STIC is committed to training employees to carry out their work in a manner that is safe for them, their coworkers and the consumers they serve. STIC does not employ or contract with individuals or entities that are excluded or ineligible to participate in Federal healthcare programs, suspended or debarred from Federal government contracts, or has been convicted of a criminal offense related to the provision of healthcare items or services and has not yet been reinstated in a Federal healthcare program, provided we are aware of such criminal offense.

**Not Tolerate Harassment or Discrimination**

It is STIC's policy not to discriminate on the basis of race, color, religion, national origin, age, disability, sexual orientation, or gender in providing services to consumers or the public, nor in relation to employment practices. Furthermore, STIC prohibits harassment or discrimination of its employees in any form by supervisors, coworkers, customers or vendors. Please refer to STIC's Harassment Policy as contained the Employee and agency Policies and Procedures Manual for further information.

**Protect Access to Information Systems**

STIC is committed to protecting all aspects of its information systems. All employees and other associates with access to STIC's computerized information system shall sign and abide by STIC's Computer Systems Policy, including the protection of confidential passwords and other access information.

## Appendix A

### 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 tracks 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 or 15-25% if the government did participate in the suit.

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#### **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 persons, 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.

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

**Penal Law Article 175, False Written Statements.**

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

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

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

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

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

**Penal Law Article 176, Insurance Fraud,**

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

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

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

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

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

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

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

**Penal Law Article 177, Health Care Fraud,**

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

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

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

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

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

### III. WHISTLEBLOWER PROTECTION

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

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

#### **NY False Claim Act (State Finance Law §191)**

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

#### **New York Labor Law §740**

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

#### **New York Labor Law §741**

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The

employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

#### **Appendix A: Supported Employment Audit Tool**

Employment Specialist:

Consumer:

Month of Review:

##### **A. ISP/ Life Plan Requirements**

1. Does ISP/ Life plan reflect a provision for supported employment?
2. Are the consumer goals: accurately stated?
3. Was the consumer enrolled prior to billing?
4. Is the ISP/Life plan current?

##### **B. Staff Action Plans**

1. Is there a current service plan in place, which includes:
  - a. Consumer's name?
  - b. Medicaid Identification Number (CIN)?
  - c. Category of waiver service (Supported Employment)?
  - d. Consumer Goals (consistent with the ISP/ Life Plan)?
  - e. Description of individualized Supported Employment services?
  - f. Location(s) where services are to be provided
  - g. Safeguards to ensure health and safety?
  - h. Is the plan signed and dated?
  - i. Is there evidence that the plan has been reviewed every 6 months?

##### **C. Documentation**

1. Do the notes include consumer's name and Medicaid number?

2. Do the notes include a category of service  
(Supported Employment Specialist's notes include:)?
  3. Does the
    - a. A description of the Service Provided?
    - b. A date and location it was provided?
    - c. The consumer's response?
  4. Do the Employment Specialist's notes reflect the Staff Action Plan goals and objectives?
  5. Is the Employment Specialist's note signed  
(including title of staff person) dated  
Contemporaneously to the service provided?
- D. Required Documents:
1. LCED date:
  2. DDP2 date:
  3. Documentation of Disability

**Appendix B: Community Habilitation Audit Tool**

Direct Support Professional:

Consumer:

Month Reviewed:

**A. Community Habilitation**

File Requirements:

Does the file contain:

1. Copy of ISP/Life plan:
  2. Notice of Decision:
  3. Documentation of Disability
  4. LCED for past 6 years
- 

**B. ISP/ Life Plan Requirements**

1. Is the ISP/ Life Plan effective on the date of service?
2. Does the ISP/ Life Plan reflect a provision for Community Habilitation at STIC?  
(or At-Home Residential Habilitation before 11/1/2010)
3. Are the consumer goals accurately stated?
4. Was the consumer enrolled in Community Habilitation prior to billing?
5. Is the ISP/ Life plan signed by at least one CM staff?

**C. Service Plans**

Is there a current service plan in place, which includes:

- a. Consumer's name?
- b. Medicaid Identification Number (CIN)?

- c. Category of waiver service (Community Habilitation or At-Home Residential Habilitation before 11/1/2010)?
- d. Consumer Goals (consistent with the ISP/ Life Plan)?
- e. Services to be provided?
- f. Location(s) where services are to be provided,
- g. Safeguards to ensure health and safety?
- h. Is the plan signed and dated?
- i. Is there evidence that the plan has been reviewed within 6 months?

#### D. Service Documentation Requirements

Does documentation include:

- a. Individuals Name?
- b. Individual's Medicaid Number?
- c. Identification of category of service?
- d. Daily description of at least one face- to- face service provided by the community hab staff during each session?
- e. Documentation of start and stop times?
- f. Documentation of staff- to- individual ratio?
- g Individual's response to service?
- h. Date service was provided?
- i. Primary service location?
- j. Verification of the service provision by the community habilitation service provider? (Initials may be used if a "key" is provided which identifies the title, signature, and full name of staff associated with initials)
- k. Signature and Title of DSP documenting service?
- l. Date the service was documented?  
\*\*\* (Date must be concurrent with service date)

#### E. Monthly Note Requirements

Does the monthly summary note include:

- a. Individuals Name?
- b. Individual's Medicaid Number?
- c. Identification of category of service?
- d. A summary of the implementation of the individual's community hab plan?
- e. The individual's response to the service provided?
- f. Any issues or concerns?









