SECTION 4- Regulatory and Quality Reporting Requirements

4.1- Quality Improvement Program (QIP)

VNSNY CHOICE's Quality Improvement Program mission is to serve as a best-in-class health plan and continually improve the quality of healthcare for our members. This is accomplished by providing access to affordable, appropriate, and timely healthcare and services, which is routinely assessed for compliance with established standards. VNSNY CHOICE will develop its Quality Improvement standards in consultation with participating providers. Participating providers must comply with all VNSNY CHOICE Quality Management policies, procedures, and programs. The overriding principle of the VNSNY CHOICE Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improving care and service to meet or exceed our members' expectations.

Program Description
The VNSNY CHOICE QIP provides a framework for the evaluation of the delivery of health care and services provided to members. This framework is based upon the philosophy of continuous quality improvement and includes:

- Development of quality improvement initiatives
- Quality measurement and evaluation
- Corrective action implementation and evaluation
- Communication with and education of our members and providers
- Annual evaluation of the program's effectiveness

Program Scope
The goal of the QIP is to improve the health outcomes of care to our membership by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care. The QIP encompasses both clinical care and non-clinical activities, which have either direct or indirect influence on the services members receive from VNSNY CHOICE participating providers and on the quality of care.

Authority

As the governing body of the plan, the Board of Directors is accountable for the QIP. The President of VNSNY CHOICE is responsible for its implementation. The plan's Chief Medical Officer in conjunction with the Vice President of Quality Management and Member Safety has overall responsibility for the plan's quality improvement strategies and activities. The Vice President of Clinical Operations plays a key role in operationalizing the quality improvement clinical activities. The Board of Directors receives written reports on the progress of the QIP Work Plan for all product lines.

Program Objectives

- Implement and manage a Quality Improvement structure that facilitates the identification, development, and implementation of clinical and non-clinical qualityimprovement activities throughout VNSNY CHOICE.

- Improve organizational processes to evaluate their ability to support VNSNY CHOICE's current or new health care products, by identifying, developing and implementing strategies to facilitate improvement.

- Improve organizational communication, by identifying, developing, and implementing strategies to facilitate improvement.

- Improve data collection and analysis for the purpose of identifying and developing improvement activities.

- Collaborate with the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (NYSDOH), the Island Peer Review Organization (IPRO) and the NYSDOH AIDS Institute to ensure quality monitoring efforts align with methodologies and compliance with regulatory requirements

- Assess the health care delivery system's access and availability of services, and identification, development, and implementation of strategies to facilitate improvement.

- Evaluate the QIP's effectiveness by performing an annual evaluation of the activities generated by the program.

- Develop an annual QIP Work Plan based upon the results obtained from the prior year's evaluative process.

- Establish thresholds and evaluate patterns or trends through the analysis of data for all products

QI Work Plan

On an annual basis, the Quality Improvement Committee (QIC) will oversee the development of the QIP Work Plan. The QIP Work Plan outlines the quality improvement monitoring and evaluation activities for the upcoming year. The QIP Work Plan is a document in progress and activities can be re-evaluated or updated as needed. The QIP Work Plan is presented to the QIC for recommendations and approval. The QIP Work Plan is then presented to the Board of Directors for final approval.

Each year VNSNY CHOICE will develop an annual QIP Work Plan that includes specific quality improvement initiatives and measurable objectives for each scheduled initiative. The QIP Work Plan activities are derived from:

- The opportunities for improvement that were identified during the previous year
- Data Analysis
- Analysis of customer satisfaction surveys
- Any other activities that are required by state, federal and accreditation entities

The following are some of the issues monitored through the QIP plan:

- Member satisfaction
- Member complaints and compliments
- Medical record documentation
- Utilization management
- Access and availability of services
- Medical and psychosocial case management
- Provider credentialing/recredentialing
- Network compliance, quality, and provider issues
- Quality of Care Concerns and Incident Reports

Annual Review and Evaluation
The QIP and Work Plan are reviewed on an annual basis for its effectiveness. The results of this evaluation process are contained within a document known as the Quality Improvement Program Evaluation (QIPE). The QIPE is presented to the Quality Improvement Committee for review and to establish VNSNY CHOICE's quality improvement activities for the following year. Due to the dynamic process of continuous quality improvement, the need to comply with external accrediting organizations, regulatory requirements, and business decisions, the QIP andWork Plan can be subject to change at any time during the year to improve care and service to its members. This QIPE will elicit the information necessary to assist in development of the QIP Work Plan for subsequent years.

Clinical and Investigational Studies
The Medical Management Department makes recommendations to the QIC concerning proposed clinical studies. The QIC, with oversight by the Board of Directors, is responsible for allocating resources, assigning responsibilities, and determining methods for communicating results to providers and staff.

VNSNY CHOICE conducts an internal study addressing services provided to its adult members and an internal study addressing services to its pediatric/adolescent members on an annual basis.

4.2- Standards of Care

VNSNY CHOICE has adopted practice guidelines to support the medical, utilization and care management of its members enrolled in various products. These guidelines are evidence based and consistent with prevailing standards of medical practice. These standards are established and consistent with Federal and State requirements. These standards include, but are not limited to, CMS and the National Committee for Quality Assurance (NCQA) Special Needs Plan, NYSDOH Medicaid Managed Care, the New York State Department of Health AIDS Institute (e.g., the provision and monitoring of antiretroviral therapy) and/or the U.S. Department of Health and Human Services. VNSNY CHOICE clinical practice guidelines comply with the recommendations of professional specialty groups. Clinical practice guidelines are reviewed annually and updated as necessary. Guidelines are disseminated to providers, with all relevant updates, as they are released by the state or federal government.

HIV Clinical Guidelines
Introduction: The HIV Clinical Guidelines Program is a collaborative effort of the New York State Department of Health (NYSDOH) AIDS Institute (AI), Office of the Medical Director (OMD), and the Johns Hopkins University (JHU) School of Medicine, Division of Infectious Diseases.

Conflict of Interest
To ensure that all quality issues are reviewed, without bias, and actions taken are in the best interest of VNSNY CHOICE members, VNSNY CHOICE mandates the following policies:

- To avoid actual or perceived conflicts of interest, VNSNY CHOICE requires all committee members to provide appropriate disclosure.

- Any committee member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such member about the recommendation in question, which might reasonably be construed as adverse to the VNSNY CHOICE's interests. This includes, but is not limited to, situations in which a committee member is a competitor of the provider in question.

- If the committee determines that a conflict of interest exists, it shall require the disclosing member to excuse him or herself from voting on the issue at hand.

Access and Availability Standards
All Primary Care and Specialist Services provided by participating providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment; ii) the provisions of VNSNY CHOICE's QIP and Medical Management Program; iii) the requirements of State and Federal Law; and iv) the standards of accreditation organizations such as NCQA and the Joint Commission for Accreditation of Healthcare Organizations.

Each participating provider is required to provide advance written notice to VNSNY CHOICE in the event of any change in the capacity of the participating provider to continue services under the terms of the participating provider's agreement with VNSNY CHOICE.

Participating providers are solely responsibility for the medical care and treatment of members and will maintain the physician-patient relationship with each member. Nothing contained in the participating provider's agreement is intended to interfere with such physician-patient relationship, nor is the participating provider agreement intended to discourage or prohibit participating providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by participating providers.

VNSNY CHOICE assesses that its panel of participating providers can meet the racial, ethnic, cultural, and linguistic needs of its members. VNSNY CHOICE also requires that network providers assist members with limited English-speaking proficiency and physical disabilities.

4.3- Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high-volume participating specialists are subject to be included in an accessibility audit/review for all categories and appointment types. Member complaints may also trigger an ad hoc measurement of a provider's accessibility. Data will be analyzed on a system wide and individual provider level for the development of system wide and/or individual improvement activities. VNSNY CHOICE participates in established AIDS Institute research on access to care, member satisfaction and quality of life and other specific QI studies developed by the AIDS Institute.

4.4 - Quality Management Subcommittee Structure

The full organizational structure of committees reporting to the VNSNY CHOICE Quality Improvement Committee is available by contacting the plan and requesting this information. The Quality Improvement Committee meets on a quarterly basis. responsible for identifying, selecting, and prioritizing quality improvement issues. The QIC identifies opportunities for improvement, directs the selection of indicators and reviews trended information related to quality of service and satisfaction for both internal and external customers. The primary responsibility of the QIC is to develop and implement an annual QI program and work plan which includes monitoring of clinical care and performance indicators and evaluation of any implemented improvement actions. The QIC receives recommendations and approves the formation of all Quality Process Improvement initiatives to address issues that affect the delivery of care and service to members. Representation of the Quality Improvement Committee include the Medical Director, an HIV Specialist, and member representation. Below are the committees most important to providers.

Member Advisory Subcommittee
The responsibilities of the Member Advisory Subcommittee is to identify opportunities for improvement through evaluation of internal statistics, member complaints, medical record reviews, and satisfaction surveys. To report results to the QIC regularly for corrective action and Solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes; key stakeholders may include members, family members, subcontracted Plans, RPCs, and other member serving agencies.

Behavioral Health and Utilization Management
The BH UM review assists in the development of baseline data measurements of utilization and determines outlier thresholds. It develops and implements corrective action plans, monitors results, and reports its findings to the QIC. The UM review analyzes, trends, and tracks utilization data for inpatient and outpatient services to identify potential under or overutilization of services and quality of care issues through identified clinical indicators. It evaluates intervention strategiesfor measurable outcomes and improvements.

Behavioral Health and Quality Management
The Behavioral Health subcommittee's responsibilities include carrying out the planned activities of the Behavioral Health Quality program. The Plan's BH Medical Director and BH QM Administrator/ Director shall lead the quarterly BH QM Subcommittee meetings and maintain records documenting attendance by members, family members and providers as well as committee findings, recommendations, and actions. A summary of Subcommittee meetings will besubmitted to the QIC and Board of Directors for final review and approval.

Policy and Procedures Subcommittee
The Policy and Procedure review includes identifying the need for new policies, and the review and revision of existing policies across the Plan to maintain compliance with regulatory, Plan needs and operational efficiencies.

Utilization Management (UM) Subcommittee
The responsibilities of the Utilization Management Subcommittee are to:

- Review and analyze utilization data from claims, encounters, referrals, authorizations,and denials to determine potential over and underutilization.
- Review quality of care issues.
- Target utilization management efforts accordingly.
- Develop and provide recommendations for corrective action plans
- Assist in the development of baseline data measurements of utilization and determine outlier thresholds
- Monitors results and reports the findings to the QIC

Out-of-plan utilization will be reviewed on a monthly basis to identify possible areas of under/over utilization. This data will be member and population specific categories to identify possible patterns of under-utilization, over utilization and/or inappropriate utilization within those categories.

Benchmarks and goals for performance are developed for utilization measures and action plans are developed to respond appropriately to under/over utilization and inappropriate medical services. Behavioral Health utilization data is also reviewed with a focus. The Medical Director is the Chairperson of the Utilization Management Subcommittee.

Credentialing Subcommittee
The responsibilities of the Credentialing Subcommittee are to recommend approval or denial of providers and facilities for either initial or continued participation in the healthcare delivery system to the plan QIC. The Lead Medical Director is the Chairperson of the Credentialing Subcommittee.

The Psychosocial Committee exists to integrate and coordinate the delivery of psychosocial case management services for SelectHealth members. Its responsibilities include:

- To review, evaluate and update policies and procedures related to psychosocial case management including those in accordance with guidelines prescribed by the New York State Department of Health AIDS Institute.

- To identify opportunities for improvement through evaluation of encounter information, member/provider complaints and satisfaction surveys. To report results to the QIC regularly for corrective action.

- To evaluate the effectiveness of implemented quality improvement initiatives and to assess the compliance with case management guidelines throughout the plan.

- To ensure optimal communication between the members' medical and psychosocial care teams.

- To evaluate and make recommendations to the QIC concerning proposed quality studies.

4.5- Data & Reporting

VNSNY CHOICE complies with all Federal and State reporting requirements.

HEDIS Reporting
The Healthcare Effectiveness Data and Information Set (formerly known as the Health Plan Employer Data Information Set - HEDIS), developed by NCQA, is the most widely used set of performance measures in the managed care industry. VNSNY CHOICE collects and reports HEDIS data for its Medicare lines of business on an annual basis. The auditor approved HEDIS rates are used to identify opportunities to improve the quality of healthcare for Medicare beneficiaries.

QARR Reporting
The NYSDOH Quality Assurance Reporting Requirements (QARR) are an integral component of the VNSNY CHOICE Quality Improvement Program. VNSNY CHOICE collects and reports QARR data for the SelectHealth line of business on an annual basis. The auditor approved QARR rates are used to identify opportunities to improve the quality of healthcare for SelectHealth beneficiaries.

Submission and Oversight
VNSNY CHOICE relies on accurate and timely encounter data from its providers to submit data for HEDIS and QARR. VNSNY CHOICE staff may request medical charts to provide documentation to fulfill the selected HEDIS and QARR measures. Staff requests for medical records for chart reviews can happen throughout the year.

The Quality Improvement Committee provides oversight of HEDIS and QARR reporting. The Quality Management Department and Business Intelligence and Analytics Department maintain responsibility for the day-to-day operations of HEDIS and QARR reporting.

Diseases and Conditions Data
Physicians are required by Article 11 of the New York City Health Code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (NYC DOHMH).

Section 11.03 of the New York City Health Code requires the immediate reporting by telephone of a suspected outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestation of disease in an individual.

VNSNY CHOICE account managers are available to assist providers with identification and implementation of NYC DOHMH regulations regarding the reporting of mandated diseases. Educational literature will be made available to providers about reporting diseases and conditions specified in NYC Health Code. The necessary literature and forms will be made available to providers through a newsletter, the VNSNY CHOICE web site, and in Appendix D of this Provider Manual.

VNSNY CHOICE also monitors provider performance through the following process and methodology.

VNSNY CHOICE uses claims, lab, and medical record data to support annual HEDIS/QARR reporting. Monthly gaps in care reports are produced for ongoing monitoring of member, measure, and provider performance. Gaps in care reports are shared with providers to highlight opportunities for improvement and facilitate patient engagement aimed at improving health outcomes. A clinical Quality Manager from VNSNY CHOICE Quality Management conducts a detailed review of the Gaps in Care report and provider performance which facilitates targeted education and training efforts to address care gaps.

Provider performance is evaluated against the methodology outlined in their Value-Based agreement. For SelectHealth providers, this performance is measured against the state recognized benchmarks associated with the eQARR and HIV SNP Quality Incentive Program. VNSNY CHOICE has the ability to generate and disseminate provider quality performance reports upon the request of the provider and is committed to reviewing their quality performance and discussing patient population needs. Further, in accordance with the Quality Management and Performance Improvement Program (QIP), The Quality Improvement Committee (QIC) receives recommendations and approves the formation of allQuality Process Improvement Teams to address issues that affect the delivery of care and service to members. The QIP takes every opportunity to improve quality by communicating results of evaluations conducted by the plan, New York State Department of Health, and the New York State Department of Health AIDS Institute. The Plan's QIC communicates findings SelectHealth providers and staff, via letters and departmental meetings, and reviews the recommended action plans. Findings are also communicated via Provider and Member Newsletters.

4.6- Reporting Requirements

VNSNY CHOICE requires its practitioners to maintain accurate medical records. The primary purpose of the record is to document the course of the member's health, illness and treatments and serve as a mode of medical record of an active member must remain in the primary care physician's office and must be consistent with all relevant local, state, and federal laws, rules, and regulations.

VNSNY CHOICE reviews medical records as part of the following activities:

- Credentialing and recredentialing
- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding
- Monitoring for compliance with approved Practice Guidelines and Standards of Care
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS /QARR measure compliance
- Monitoring of provider compliance with public health regulations on reporting requirements
- Monitoring for compliance with VNSNY CHOICE Medical Record Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical record review or a review conducted by regulatory agencies, providers will be required to participate in a corrective action plan, as necessary.

CMS Risk Adjustment Medical Records Reporting

Medical records play a critical role in CMS' reimbursement for our members. Records must show

all conditions evaluated during the visit; as such, it is important to evaluate and document all chronic conditions at least annually. You should report the appropriate diagnosis code for all documented conditions that coexist at the time of the visit that require or affect care.

For accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the member's condition. This should include specific diagnosis, symptoms, problems, or reasons for the visit. You are responsible for making sure that ICD-10-CM coding adheres to ethical standards.

We may review the charts to identify chronic diseases not coded on claims. CMS conducts assessments to confirm that the Hierarchical Condition Categories (HCCs) triggered for payment, based on ICD10-CM coding, are supported by chart documentation. CMS works through us to obtain these records. We require your cooperation with this.

Providers must make member records and encounter data available to VNSNY CHOICE to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration, United States Department of Health and Human Services, the Controller of the State of New York, the Controller General of the United States and The Centers for Medicare and Medicaid Services (CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

4.7- Medical Record Reviews and Documentation Standards

Well documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between providers.

All providers rendering healthcare services to VNSNY CHOICE members must maintain a member health record in accordance with standards adopted by CHOICE and in compliance with National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Review. Providersshould maintain compliance with professional standards and take steps to safeguard confidentiality when sharing medical-record information with other network providers.

Medical Record Review

A CHOICE representative may request that records are sent to CHOICE offices for review to obtain information regarding medical necessity, regulatory and internal chart audits, and quality of care for CHOICE members. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below. VNSNY CHOICE applies guidance from NCQA and CMS in reviewing medical record documentation and standards.

VNSNY CHOICE Medical Record Review Documentation Criteria

- Date all entries and identify the rendering provider including their credentials. Acceptable physician authentication includes handwritten and electronic signatures or signature stamps.
- The record must be legible to someone other than the writer.
- Clearly document changes to a medical record entry by including the author and date of change. You must retain a copy of the original entry.
- Include demographic information including name, gender, date of birth, member number, emergency contact name, relationship, phone number(s), and insurance information.
- Include family and social history, including marital status and occupational status or history.
- Document information on whether the member has executed an advance directive or where a discussion of advanced care planning was completed with the member or caregiver.
- Include a problem list with medical history, chronic conditions, and significant illnesses,
- Accidents and operation.
- Include the chief complaint and diagnosis and treatment plan at each visit.
- Include name of current medications, dosages, and route as well as over-the-counter drugs, allergies and adverse reactions or notation of no known allergies or adverse reaction.
- Document member history and health behaviors including but not limited to blood pressure, height and weight, body mass index and other preventive screening services.
- Reflect all services provided, clinical decisions and safety support tools in place to help ensure evidence-based care and follow up care, including and not limited to lab results, X-ray, consultation reports, behavioral health reports, ancillary care providers' reports (example eye care specialist related to medical eye exams), facility records and outpatient records.

All information contained in the records are kept strictly confidential. Providers must make medical records available upon request by VNSNY CHOICE or by CMS, NYS Department of Health, or any other regulatory agency with jurisdiction over Medicaid or Medicare programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the member's explicit consent is not required for the release of such records and information to VNSNY CHOICE. However, the member's authorization to allow CHOICE to review records is also obtained by CHOICE at the time of the member's enrollment.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six years after the last visit date or, in the case of minor children, for six years from the age of majority for New York State programs and 10 years for Medicare programs and for New York State of Health (NYSOH) enrollees.

4.8- Fraud and Abuse Prevention

Visiting Nurse Service of New York (VNSNY) and VNSNY CHOICE are committed to preventing and detecting any fraud, waste, or abuse in the organization, related to Federal and State health care programs. To this end, VNSNY maintains a vigorous compliance program and strives to educate our workforce, members and providers on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments.

All VNSNY CHOICE employees, board members, administrators, members, providers, volunteers, and those with which we do business are required to comply with the organization's Compliance Program.

What are the rules that must be followed?
The standards set forth in the Code of Conduct provide an overview of the laws and rules that our providers and their staff are expected to follow. A copy of the Code of Conduct is available upon request from the Compliance Officer. In short, we expect everyone to conduct themselves pursuant to the highest ethical, business, and legal standards. As part of our Compliance Program, if you suspect that someone is doing anything that is illegal or unethical, you must report it.

Examples of what needs to be reported

- Questionable billing, coding, or medical record documentation practices
- Giving or accepting something of value in exchange for patient referrals or other business
- Quality of care issues
- Stealing from VNSNY or a member
- Altering medical or business records

- Assisting in or ignoring fraud, waste, or abuse concerns
- Any activity or business practice that could possibly be interpreted as unethical or illegal

How to Report Compliance Violations

- If you suspect insurance fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following:
- Contact VNSNY CHOICE Compliance at VNSNY.Ethicspoint.com
- Call the Compliance Hotline at the telephone number listed in Section 1 of this provider manual
- Send a written report to the address listed in Section 1 of this provider manual

Please be assured that there will be no intimidation of, or retaliation against, anyone who in good faith raises a compliance issues. All reported compliance issues will be investigated. You may raise the issue anonymously if you wish.

Submitting False Claims

VNSNY prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. Such a submission is a violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a Federal statute that allows private citizens to help reduce fraud against the United States government. In addition, in New York State the submission of a false claim can result in civil and criminal penalties under portions of the New York Social Services Law and Penal Law.

What Can You Do to Promote a Culture of Compliance?

- **C**ommit to "Doing the Right Thing"
- **O**bey the regulations and policies that apply to you
- **P**ut the VNSNY CHOICE Code of Conduct in an accessible spot
- **L**ead by example
- **I**f in doubt, check it out
- **A**ttend training sessions
- **N**otify your supervisor of possible wrongdoings

- **C**ommunicate openly and honestly

- **E**thics is part of all activities

Deficit Reduction Act of 2005
The Deficit Reduction Act of 2005 (DRA) introduced incentives for the States to enact False Claims Act statutes and established compliance program and educational requirements for health care entities that receive $5 million or more annually in Medicaid reimbursement or payments (including VNSNY CHOICE). Because compliance with the DRA provisions is a condition of payment, entities that do not update their compliance policies and educational materials risk otherwise qualified reimbursement and potential False Claims Act liability.

Specifically, Section 6032 of the DRA provides that any entity that makes or receives at least $5 million in annual payments under a State Medicaid program must undertake certain measures. These measures include:

- Establishing written policies for all of their employees that furnish information on the federal False Claims Act, federal administrative remedies under that act, applicable State false claims acts, and whistleblower protections under these laws.

- Including provisions as part of those policies in the entity's policies and procedures for:

- Detecting and preventing fraud, abuse, and waste.

- Including in employee handbooks and provider handbooks a specific discussion of these various laws, the rights of employees to be protected as whistleblowers, and the entity's policies for detection and prevention of fraud, abuse, and waste.

Federal False Claims Act
The False Claims Act (FCA) permits any person who discovers a fraud on federal government to report it through the law's specialized procedures. If the government collects from the fraudulent contractor, it permits the whistleblower to share in the proceeds. usdoj.gov/opa/pr/2002/December/02_civ_720.htm.

The FCA is the major law utilized to "ferret out fraud against the federal government." It was enacted during the Civil War to "control fraud" in federal contracts" and was subsequently amended in 1986 to encourage whistleblower protection.

The law contains two sections highly relevant to whistleblowers. The first is a qui tam provision which permits private citizens and "original sources" (i.e., whistleblowers) to file suit on behalf ofthe United States to recover damages incurred by the federal government as a result of

contractor fraud or other false claims. In return for filing the suit, the whistleblower is entitled to a significant portion of the proceeds, should they prevail. The whistleblower can obtain a large monetary award if he or she follows the "complex" procedures set forth in the FCA when seeking to enforce the anti-fraud law.

The second section contains an anti-retaliation provision that prohibits the discharge or harassment of a whistleblower who makes FCA-protected disclosures or files a qui tam suit. The anti-retaliation section permits the whistleblower to file a wrongful discharge suit for double back pay and other damages. The anti-retaliation provision was modeled after other whistleblower laws and operates under the basic principles underlying employment discrimination cases.

Risk Management Program

The Risk Management Process is concerned with reducing, preventing, and eliminating situations that could lead to member risk and/or financial loss. The Risk Management Program is an ongoing, integral component of the Quality Assessment & Improvement Program. It is designed to identify and resolve potential and/or actual administrative, clinical, and service related risk issues of the organization.

Issues that have the potential to cause immediate and/or significant adverse health outcomes(s) may be referred to the Medical Director for review. The Chief Medical Officer or designee, using an educational approach, will collaborate with the provider to develop and document a Corrective Action Plan (CAP) addressing the areas of concern for the provider to implement clinical issues that result in individual provider monitoring will also be considered during re- credentialing. Providers who are noncompliant with required corrective action(s) may be subject to further action(s). A decision to suspend or terminate a VNSNY participating provider is subject to approval by the Quality Improvement Committee of the Plan. If the provider is suspended or terminated, he or she has the right to appeal the decision.