VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.1- Quality Improvement Program (QIP)

VNSNY CHOICE’s Quality Improvement mission is to exceed the expectations of the customer and to continually improve the quality of healthcare for our members. This is accomplished by providing access to affordable, appropriate and timely health care 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, and
- 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 Lead Medical Officer in conjunction with the Director of Quality Management has overall responsibility for the plan’s quality improvement strategies and activities. The Vice President of Health Services 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 a Quality Improvement structure that will facilitate the identification, development and implementation of improvement 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), and the NYSDOH AIDS Institute for establishing and reporting quality improvement.

- 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 coming 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.

- Analysis of data reports.

- Analysis of customer satisfaction surveys.

- Any other activities that are required by state, federal and accreditation entities.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.1- Quality Improvement Program (QIP)

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

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 and Work 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 a products 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.
VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.2- Standards of Care (cont.)

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.

History: When the HIV Clinical Guidelines Program was established in 1986, the complexity of HIV care and prevention and the need to integrate rapid changes into clinical practice necessitated a coordinated response to meet the practice and informational needs of clinicians, support service providers, and consumers. The HIV Clinical Guidelines Program met those needs by drawing on the experience of clinical experts familiar with providing medical care to New York State’s HIV-infected population. Since then, the program has successfully collaborated with a broad array of stakeholders and experts to develop HIV care and prevention guidelines that are current, clear, and accessible.

Over the course of its thirty-year history, the program has successfully addressed the broad spectrum of HIV care throughout the State, and with the expanded mission of the AI, now also addresses guidelines topics in HCV care, STI care, drug user health, and LGBT health.

Mission: The mission of the Clinical Guidelines program is to develop, disseminate, and guide the implementation of state-of-the-art clinical practice guidelines to improve the quality of care provided to persons living with HIV, HCV, STIs, and related comorbidities in New York State.

For more information on the HIV Clinical Guidelines and the VNSNY CHOICE policy, you can read more by accessing the links on the Appendix for Quality.

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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.2- Standards of Care (cont.)

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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.3- Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high volume participating specialists will 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.

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

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. Below are the committees most important to providers:

Pharmacy and Therapeutics Subcommittee
The Pharmacy & Therapeutic Subcommittee’s responsibilities include overall oversight of the delegated relationship with the contracted Pharmacy Benefits Manager (PBM) for the Medicare Part D Plan and the New York State Medicaid Pharmacy Benefit for the HIV Special Needs Plan, the development of the formulary, required reporting for regulatory compliance with the drug plan and monitoring the utilization of Part B drugs. The committee will review new drugs that enter the market to determine if they will be covered. The committee will also track all regulatory changes to Medicare Part D and the New York State Medicaid Pharmacy Benefit and report regularly to the Quality Improvement Committee on these changes as they affect plan members. This includes recommendations for benefit and formulary revisions and development/implementation of utilization management protocols.

Medical Advisory Subcommittee
The role of the Medical Advisory Subcommittee is to review clinical guidelines, disease state management protocols, authorization policies and other chronic care improvement efforts to ensure they are consistent with established evidenced based best practice standards.

In addition, the Medical Advisory Subcommittee, or a subgroup of the subcommittee, will be responsible for peer review activities and/or review of quality of care issues, on an ad hoc basis. Physicians who perform peer review within the health plan are required to be credentialed providers within the plan, unless an external peer review is required as determined by the QIC.

Inter-rater review of the peer reviewers’ performance is carried out with established policies and procedures. All documents reviewed and all documentation developed and maintained in the peer review process is a product of “medical peer review” which provides protection, within the extent of the law, from discoverability.

The Medical Director is the Chairperson of the Medical Advisory and responsible for the peer review activities performed by the subcommittee structure within VNSNY CHOICE as well as ad-hoc utilization management peer review activities.
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.

Psychosocial Subcommittee
The Psychosocial Committee exists to integrate and coordinate the delivery of psychosocial case management services for VNSNY CHOICE 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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

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, and 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 for the purpose of tracking and developing performance improvement activities related to care and service.

QARR Reporting
The NYSDOH Quality Assurance Reporting Requirements (QARR) are an integral component of the VNSNY CHOICE Quality Improvement Program. The NYSDOH uses QARR data to work with HIV-AIDS Special Needs Plans and providers to enhance the health care outcomes of managed care enrollees through performance feedback, quality improvement programs, technical assistance and highlighting of best practices. VNSNY CHOICE must report QARR data to the NYSDOH on an annual basis.

Submission and Oversight
To submit data for HEDIS and QARR, VNSNY CHOICE relies on accurate and timely encounter data from its providers. VNSNY CHOICE staff may also conduct chart reviews to obtain documentation for the selected HEDIS and QARR measures for the year’s report requirements or as part of its internal auditing responsibilities.

Oversight of HEDIS and QARR reporting remains the responsibility of the QIC. Day to day operational management and reporting of HEDIS data rests with the Quality Management Department and Health Economics Unit.

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 New York City Department of Health 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

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

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 or illness and treatments and serve as a mode of communication between physicians and other professionals participating in the care rendered. The entire 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.

Medical Record Review

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

Standards for Medical Record Documentation Criteria

The following criteria are considered essential elements in the documentation of care and services:

1. Medical records must be readily accessible and available for review by the provider.

2. The record must be legible to someone other than the writer.

3. A separate medical record must be maintained for each member.

4. Medical records must be maintained for a period of six (6) years after date of service, and in the case of a minor, three (3) years after majority or six (6) years after the age of majority, whichever is later.

5. Medical records must include entries that are current, legible, signed and dated by the person making the entry and authenticated.

6. Medical records must include, as appropriate: name, identification number, age, sex and date of birth, consent forms, past medical history and physical examinations, record of immunizations, screening for chemical dependency (drug use) including history and current usage, notation of allergic or adverse reactions to medications, quantitative assessment of antiretroviral treatment adherence monitoring, physical examination reports, diagnostic procedures/test reports, consultative findings, diagnosis or medical condition, medical orders, psychosocial assessment and reassessment, case management information, documentation of services required and referrals made, progress notes and follow-up plans.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.6- Reporting Requirements

Standards for Medical Record Documentation Criteria (cont.)

7. The medical record must include relevant information concerning emergency room treatment, services rendered by specialists and/or non-participating providers and any hospitalizations.

8. For members receiving prenatal care only: the obstetrical care provider must maintain centralized medical records for the provision of prenatal care and all other services.

9. Presenting complaints, diagnoses and treatment plans.

10. A return visit date and follow up plan that is documented for each encounter.

11. Prescribed medications, including dosages and date of initial or refill prescriptions.

12. Identification of all providers participating in the member’s care and information on services furnished by these providers.


14. Information on Advanced Directives or documentation of discussion of advanced care planning with the member.

15. Provider Signature Attestation; the Centers for Medicare and Medicaid Services (CMS) requires each date of service in a member's medical record to be accompanied by a legible provider signature and credentials. Some examples of appropriate credentials are MD, DO and Ph.D. In general, for your medical records to be deemed compliant, you must authenticate each note for which services were provided. Acceptable physician authentication includes handwritten and electronic signatures or signature stamps.

16. Clinical progress notes describing patient services and events.

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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

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 VNSNY CHOICE and in compliance with National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Review (Appendix V) and NYSDOH regulations. Further, providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network providers.

Periodically, VNSNY CHOICE requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. All VNSNY CHOICE medical record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Providers must make medical records available upon request by VNSNY CHOICE or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid, or Medicare Advantage 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 VNSNY CHOICE to review records is also obtained by VNSNY CHOICE at the time of the member’s enrollment with VNSNY CHOICE.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.7- Medical Record Reviews and Documentation Standards

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.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six (6) years after the last visit date or, in the case of minor children, for six (6) years from the age of majority for New York State programs and ten (10) years for Medicare programs and for New York State of Health (NYSOH) enrollees.
VNSNY CHOICE- Regulatory and Quality Reporting Requirements

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; and/or
• 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 www.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.
VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.8- Fraud and Abuse Prevention (cont.)

What Can You Do to Promote a Culture of Compliance?

- Commit to “Doing the Right Thing”
- Obey the regulations and policies that apply to you
- Put the VNSNY CHOICE Code of Conduct in an accessible spot
- Lead by example
- If in doubt, check it out
- Attend training sessions
- Notify your supervisor of possible wrongdoings
- Communicate openly and honestly
- Ethics 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. [http://www.usdoj.gov/opa/pr/2002/December/02_civ_720.htm](http://www.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 of the 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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.8- Fraud and Abuse Prevention (cont.)

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 VNS 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.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.9- Advance Directives/Health Care Proxy

All members, including VNSNY CHOICE members, have the right to make decisions about the amount and type of care that they will receive, including care if they are terminally ill. A terminal illness is defined as any illness that is likely to result in the death of a person within six months. Through the use of written Advance Directives, a VNSNY CHOICE member can indicate and define his/her wishes about the type and amount of care that will be provided or withheld at the end of life. Examples of the types of care that may be addressed in an Advance Directive include the use of ventilators, intubations, and other life-saving procedures, as well as the areas of nutrition and hydration therapy.

VNSNY CHOICE members also have the additional right to appoint a healthcare agent through a Health Care Proxy. This allows someone other than the member to make decisions about the member’s care should the member lose the ability to make decisions on his/her own. A Health Care Proxy is not a living will. It is a formal document enabling a member to designate a trusted individual to make healthcare decisions on his/her behalf if the need arises. All competent adults can appoint a healthcare agent by signing a Health Care Proxy form. A lawyer is not required, but two witnesses must be present and must also sign the form. Members who have questions or would like additional information on these issues should be directed to the Member Services department.

Inpatient facilities must determine if a member has executed an Advance Medical Directive or that the member is aware of the possibility of doing so. If the member has completed a Health Care Proxy, a copy should be kept in the member’s inpatient chart or medical record, or the name, address, and phone number of the healthcare agent should be documented in the member’s inpatient medical records. It must be clearly documented in the inpatient medical record that the member has executed an Advance Directive.

Providers must document in all VNSNY CHOICE Medicare member medical records that there was a discussion about Advance Directives and a Health Care Proxy, and the documentation must be updated annually. If the member is hospitalized at the time, the documentation can include that the member was given the information about Advance Directives in the hospital.

If the facility feels that it is unable to adhere to the member’s wishes, the hospital should notify the member of this fact and recommend that he/she contact the Member Services department. Otherwise, VNSNY CHOICE expects the facility to adhere to the member’s wishes as determined by the chosen healthcare agent.
VNSNY CHOICE

VNSNY CHOICE- Regulatory and Quality Reporting Requirements

4.10- Confidentiality

Providers are expected to ensure the confidentiality of VNSNY CHOICE members. Information contained in the medical record should only be disclosed in a manner that complies fully with HIPAA standards and as necessary to provide medical care, conduct quality assurance functions or respond to a complaint or appeal.

Participating providers must comply with all state and federal laws concerning confidentiality of health and other information about members. Participating providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

• All member clinical information is considered confidential information and will be kept confidential by VNSNY CHOICE staff and committee members.

• All committee discussions are considered confidential. No clinical information will be sent outside of VNSNY CHOICE without express consent of the member or legal guardian except in accordance with regulatory requirements of the NYSDOH, CMS, or where compelled by court order.

Medical Records Duplication

The participating provider is responsible for any costs associated with duplicating and mailing a member’s medical records when referring the member to a consulting physician or other provider where medical records are required. The participating provider shall not charge the member for the cost of copying the medical records that will be used during the member’s course of treatment with a referral physician.

If a member is requesting copies of medical records to be sent to another medical professional as a result of the member’s election to transfer to another PCP, the member may not be charged for copying of the medical record.

When a member, or the member’s representative, requests copies of medical records for reasons other than those stated above, the participating provider may charge a fee for copying the medical record. The member or member’s representative must provide to the provider such request for copies of the medical record in writing. In this case the provider may charge a fee not to exceed seventy-five cents ($0.75) per page.

If VNSNY CHOICE requests copies of medical records, the participating provider may charge a fee for copying the medical record. VNSNY CHOICE follows the New York State Department of Health guidelines regarding reimbursement for the costs associated with copying member records. VNSNY CHOICE will reimburse the provider the rate as determined by the New York State Department of Health.