ElderServe Health™

PROVIDER MANUAL

2026

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I. INTRODUCTION

Welcome and thank you for participating with ElderServe Health, Inc. Our three health plans are:

- ElderServe at Home MLTCP (Medicaid Managed Long Term Care Partial Capitation Plan);
- ElderServe MAP (HMO D-SNP) (dual Medicare MA-PD/Medicaid Advantage Plus Plan); and
- ElderServe STAR (HMO I-SNP) (Medicare Institutional Special Needs Plan), serving individuals residing in a long-term care facility, or in the community and requiring an institutional level of care.

Our collective goal is to maximize the health and functioning of our Members by working with you to develop care plans that incorporate preventative, medical, mental and behavioral health, social services and other creative measures as needed, given each individual's particular circumstances.

This Provider Manual is designed to tell you about our care management approach and serve as a reference guide to policies, procedures and operations. This Manual is an extension of your ElderServe provider contract and offers additional information to help you understand our Plan benefits as described in our materials, including the Member Handbook and Evidence of Coverage.

We encourage you to keep this Provider Manual for ready reference. With changes over time in Medicare and Medicaid policies and ElderServe operations, the policies and procedures herein are subject to updates and modifications. ElderServe will provide ongoing updates through provider mailings, newsletters, and the ElderServe web site. Please keep your email address with us current so that you can receive our electronic communications as we update policies and operations to improve services and or comply with federal and state regulatory changes.

CONTACT INFORMATION

ElderServe Health, Inc.

Contact	Information
General	ElderServe Health, Inc. 80 West 225th Street Bronx, NY 10463 1-800-771-0088
Website	www.elderservehealth.org
ElderServe Health at Home MLTCP	1-800-370-3600
ElderServe MAP (HMO D-SNP)	1-800-362-2266
ElderServe Star (HMO I-SNP)	1-800-580-7000
Member Services (General)	1-800-771-0088
Provider Relations	ProviderRelations@elderservehealth.org
Intake and Enrollment	Fax number for all Plans: 1-866-721-3128 MLTCP Referrals: ManagedCareReferrals@elderservehealth.org MAP Referrals: MAPReferrals@elderservehealth.org
Service Authorization	**Fax number for service authorization requests:** Transportation: 1-866-889-3114 Facility Discharge: 1-347-923-3923 DME & Medical/Incontinence Supplies: 1-866-645-5072 Rehabilitation (PT/OT/ST): 1-866-507-4915 **Fax number for all other service authorization requests:** Queens/Nassau/Suffolk 1-866-889-1552 Kings/Richmond 1-866-889-4387 Bronx/Westchester/Manhattan 1-888-339-4325 Or call Member Services
Billing and Claims	ElderServe Health, Inc. PO Box 211465 Eagan, MN 55121 MLTCP: MLTCClaims@elderservehealth.org MAP & Star: Claims@elderservehealth.org Provider Portal: elderservehealth.ppi.com

CONTACT INFORMATION

ElderServe Health, Inc.

Grievance and Appeals	MLTCP: MLTCQADept@elderservehealth.org MAP & Star: QA@elderservehealth.org
Fraud Waste and Abuse Hotline (Anonymous)	Reportfraud@elderservehealth.org 1-855-265-6106 Or report to OMIG: 1-877-873-7283
Self-Disclosure Program	MLTCSelfDisclosure@elderservehealth.org
Dental Services	Liberty Dental Plan of New York 50 Charles Lindbergh Boulevard Uniondale, NY 11556 1-866-544-4795
Pharmacy Services	Express Scripts P.O. Box 66562 St. Louis, MO 63166 1-800-922-1557

HELPFUL LINKS

Enrollment	➢ Medicare Enrollment Periods ➢ Medicare Advantage Enrollment and Disenrollment Manual
Billing & Claims Processing	➢ Provider Portal ➢ Smart Data Stream Clearinghouse
Compliance	➢ False Claims Act Summary and Policy
HIPAA & HITECH	➢ Report a breach to DHHS
Forms	➢ Appointment of Representative Form ➢ Waiver of Liability Statement
Training	➢ Fraud Waste and Abuse Training
Self-Disclosure Program	➢ Self-Disclosure Program

II. PLANS, ELIGIBILITY, COVERED SERVICES

OUR PLANS AND ELIGIBILITY

Plan Name	Eligibility Criteria	Service Area – Counties
ElderServe at Home MLTCP	• Adults 18 and older • Medicaid Eligible • Resides in Plan service area • Determination of eligibility for MLTC service after assessment • Requires long-term care services for a continuous period of more than 120 days • Able to remain safely at home when joining plan	New York City, Nassau, Suffolk and Westchester
ElderServe MAP (HMO D-SNP)	• Adults 18 and older • Resides in Plan service area • Eligible for Medicare and full Medicaid • Requires long-term care services for a continuous period of more than 120 days • Able to remain safely at home when joining plan	New York City, Nassau, and Westchester
ElderServe Star (HMO I-SNP)	• Eligible for Medicare • Resides in Plan service area • Resides in a Nursing Home participating with the Plan, or • Lives at home and NY certifies that nursing home level of care is needed	New York City, Nassau and Westchester

COVERED SERVICES

In general, most of the benefit limits for ElderServe covered services follow federal and state guidelines. Limitations based on number of visits per year are based on a calendar year. Please contact ElderServe Member Services for any questions about a Member's exhaustion of benefit limits before providing services.

Covered services may require prior authorization. Please visit our website at www.elderservehealth.org for the up-to-date lists of services that require prior authorization, or contact ElderServe Service Authorization.

A. ElderServe at Home MLTCP

ElderServe at Home is a NYS Medicaid plan that arranges, coordinates and provides health and long-term care services on a capitated basis for its Members. ElderServe at Home offers a broad selection of covered services through our network of providers and provides each Member with a nurse care manager who consults with the Member, their family, caregivers and physicians to coordinate services including those covered by Medicare.

ElderServe at Home covers a wide range of home, community and facility based long-term care and health services. A complete list of current MLTCP benefits and covered services is available in the Plan Member Handbook at www.elderserveathome.org
For more information, please contact ElderServe Member Services.

B. ElderServe MAP (HMO D-SNP)

ElderServe MAP (HMO D-SNP) is a Medicare and Medicaid Advantage Plus Special Needs Plan that contracts with the Centers for Medicare & Medicaid Services (CMS) and the NYS Department of Health (DOH) to provide benefits of both programs to eligible beneficiaries. ElderServe MAP brings together and coordinates both Medicare and Medicaid services for Members under one Plan and provides access to care 24 hours a day, 7 days a week, 365 days a year.

ElderServe MAP covers the Medicaid MLTC services and all original Medicare covered services, including Part D prescription drugs and supplemental Over-the-Counter health items. A complete list of current Plan benefits and covered services is described in the Plan Evidence of Coverage and Member Handbook and is available at www.elderservemap.org. The complete Plan Formulary or List of Covered Drugs is also available at this website. For more information, please contact ElderServe Member Services. For questions related to Part D, you can also contact ElderServe Pharmacy Services.

C. ElderServe Star (HMO I-SNP)

ElderServe Star (HMO I-SNP) is a Medicare Advantage plan for Medicare eligible individuals who live in the community or in a participating nursing home. Our goal is to provide personalized care coordination and attention to the Members' individual health needs. ElderServe Star (HMO I-SNP) provides 24/7 telephone access to a clinician, and have skilled Nurse Practitioner services available to deliver an added level of care and coordination.

ElderServe Star covers all original Medicare covered services, including Part D prescription drugs and supplemental Over-the-Counter health items. A complete list of current Plan benefits and covered services is described in the Plan Evidence of Coverage and is available at www.elderservestar.org. The complete Plan Formulary or List of Covered Drugs is also available

at this website. For more information, please contact ElderServe Member Services. For questions related to Part D, you can also contact ElderServe Pharmacy Services.

ENROLLMENT

Referrals or inquiries regarding enrollment into any ElderServe Health Plan can be made by calling ElderServe Member Services, or contacting ElderServe Intake and Enrollment. Our enrollment staff will verify Medicare and Medicaid eligibility by checking the EPACES and MARX systems, and clinical eligibility by checking as applicable with the state and by performing clinical health assessments.

ElderServe Health Plans abides by all enrollment and disenrollment rules and regulations set forth by CMS and NYS DOH relating to Medicare Advantage and MLTC plans.

For a brief summary about different Medicare enrollment periods, click on this link: Medicare Enrollment Periods. Additional information is available at: Medicare Advantage Enrollment and Disenrollment Manual.

MEMBER IDs

ElderServe Health Plans provides each Member an identification (ID) card. The card supplies Members and providers with important information, such as Member ID number, primary care physician name and telephone number, and key telephone numbers. ElderServe issues a unique ID (unrelated to Social Security Number/Medicare or Medicaid ID) to our Members to protect against potential fraud or identity theft.

Your staff should become familiar with our ID cards to assist in Member verification and to readily obtain information and answers to your questions by calling the numbers listed on the cards.



MEMBER VERIFICATION

All primary care physicians, specialists and providers must verify a Member's eligibility prior to, or at the time of service. All ElderServe Health Plans Members are instructed to present their ID card each time they obtain healthcare services. Please ask to see the ElderServe Member's ID and photo ID on each visit. However, because ElderServe is not able to retrieve ID cards from Members when they disenroll or lose coverage, an ID card alone does not ensure eligibility. It is the provider's responsibility to check the Member's current eligibility at time of service delivery, and failure to do so may result in non-reimbursement for services rendered. For verification, please call ElderServe Member Services.

III. PARTICIPATING PROVIDERS

PARTICIPATING PROVIDER NETWORK

ElderServe Health Plans' comprehensive provider network promotes high-quality and cost effective care to our Members in the home and community. The network for each of our Plans – ElderServe at Home (MLTCP), ElderServe Star (HMO I-SNP) and ElderServe MAP (HMO D-SNP), covers the full spectrum of covered services for our eligible Members. We recognize that our providers play a critical role in delivering the services and supports that enable our Members to live well and flourish with independence and dignity. We value your partnership and appreciate your participation.

ROLE OF THE PCP

The Primary Care Physician (PCP) supervises the Member's overall care and coordinates the Member's specialty care and ancillary services. PCPs include general practitioners, family practitioners, nurse practitioners, internists, and qualified specialists who agree to serve as PCP for a Member with a life-threatening or degenerative/disabling condition. PCP responsibilities include, but are not limited, to:

- Conduct baseline and periodic health examinations.
- Provide routine and preventative health care services.
- Arrange inpatient care, specialist consultations, lab and radiological services when needed, and coordinate follow-up care.
- Request required prior authorizations from ElderServe.
- Work with ElderServe Care Managers.

All PCPs must be available, or ensure coverage by a participating provider, to provide PCP services, 24 hours a day, seven (7) days a week. PCPs and their staff agree to follow and comply with our administrative, clinical, quality, and reimbursement policies and procedures.

PROVIDER RIGHTS & RESPONSIBILITIES

ElderServe Health Plans is committed to making informed decisions regarding the review and approval of providers into our network. ElderServe does not discriminate against any provider based on race, ethnic/national identity, gender, age, sexual orientation, specialization in serving high-risk Members or the treatment of costly conditions. Consistent with our policy, ElderServe may refuse to grant participation status to providers that ElderServe, at its sole discretion, deems not necessary or not appropriate in the management of our provider network.

ElderServe ensures that providers maintain certain rights throughout the credentialing and recredentialing process, including the right to:

- Correct erroneous information in their credentials file;
- Review information submitted to support their credentialing application;
- Receive the status of their credentialing or recredentialing application upon request.

ElderServe's provider agreements incorporate provider and plan responsibilities consistent with industry standards and in compliance with NYS requirements for persons and entities receiving federal funds. The following requirements are applicable to ElderServe participating providers:

Provider Information

Providers are responsible for reporting changes in their practice to ElderServe Health Plans. It is imperative that we maintain accurate provider information because it helps to connect our Members with providers when they search for care, facilitate proper payment of claims, and comply with state and federal reporting requirements. Please submit changes in demographic information and other updates including change in ownership, to ElderServe Provider Relations at least two weeks prior to the effective date of the change.

Provider Agreement Compliance

Providers must comply with all contractual, administrative, and regulatory requirements outlined in our provider participation agreement and otherwise with regulatory guidance, this Manual, and updates thereof. Providers are required to cooperate with ElderServe to meet our reporting and regulatory responsibilities, to respond to audits, surveys and other requests for information, and to implement our internal program activities.

NYSDOH Compliance Requirement

The New York State Department of Health (NYSDOH) requires each participating provider or practice to complete the Participating Provider Owner/Manager Disclosure Certification form to verify compliance with the statutes, rules, regulations, and applicable Medicaid Updates governing the provision of care, services, and/or medical supplies under the Medicaid program.

Providers who are individually contracted with ElderServe must each sign and submit the form themselves. Providers who are part of group contracts should have their group sign and submit the form on their behalf.

Nondiscrimination

Providers may not differentiate or discriminate against any prospective or current Members on the quality or accessibility of services based on race, ethnicity, national origin, ancestry, religion, sex, age, mental or physical disability or type of illness or medical condition, sexual orientation, sexual identification, marital status, place of residence, actual or perceived health status, evidence of insurability, genetic information, or type of payment. Our participating providers must comply with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA) of 1990 and other laws applicable to recipients of Federal Funds.

Provider Accessibility & Availability

Providers must adhere to the federal and state accessibility standards including those defined by the ADA and by the NYS DOH for ADA compliance by managed care organizations and their participating providers.

ElderServe recognizes that service quality includes ensuring appropriate provider access and availability to meet the needs of our Members. For this reason, ElderServe reviews provider appointment availability and access, and takes appropriate corrective action with providers who do not meet reasonable standards.

ElderServe's standards for timeliness of appointments are:

- Urgently needed services or emergency - immediately;
- Services that are not emergency or urgently needed, but in need of medical attention - within one week; and
- Routine and preventive care - within 30 days.

Cultural Competency

It is important for providers to ensure that health care services and information about treatment are provided in a manner that meets the social, cultural and linguistic needs of our Members. ElderServe recognizes that the cultural competence of providers is associated with improved Member outcomes, satisfaction, and adherence to treatment, and works with our providers to meet the specific needs of our diverse Member population by arranging appropriate supports such as:

- Arranging language assistance to facilitate provision of care in a sensitive manner, respectful of each Member's beliefs, practices and language.
- Recruiting staff that is representative of our Members' demographic characteristics.
- Contracting with providers that demonstrate cultural sensitivity and make appropriate accommodations when serving culturally and linguistically diverse groups.
- Providing materials in prevalent languages.

Medical Records and Auditing

ElderServe participating providers must maintain medical records in accordance with good professional medical documentation standards, provide ElderServe with Members' medical records upon our request, and allow access by ElderServe staff for on-site chart reviews. Providers and staff shall maintain strict confidentiality of all medical records.

Provider Training

Providers and staff shall complete, and attest to their completion of education and training pursuant to regulatory requirements, ElderServe policies and procedures and provider's corrective action plans.

CREDENTIALING AND RECREDENTIALING

ElderServe's credentialing program applies to all providers and was developed in accordance with state and federal requirements, accreditation guidelines, and recognized industry standards. This section provides an overview of our credentialing and recredentialing process. For more information, please call ElderServe Provider Relations.

No Discrimination

ElderServe's commitment to nondiscrimination applies in the same manner to credentialing and recredentialing, provider participation and reimbursement.

Baseline Requirements

ElderServe exercises due care in the selection, review and periodic evaluation of our participating providers. We ensure that all providers are credentialed prior to participation, and recredentialed periodically, to meet and maintain the criteria and qualifications of our credentialing plan. In general, providers must:

- Possess and maintain Insurance coverage as specified by ElderServe.
- Possess and maintain a valid NYS license, operating certificate, certification and/or current registration.
- Enroll in Medicaid and/or Medicare.
- Permit a site review of provider's office, upon request.
- Provide and update on an ongoing basis information regarding:
  - Physical or mental capacity impairments; criminal charges or convictions; professional liability claims;
  - Limitation or restriction of license; loss or limitation of Drug Enforcement Agency (DEA) certification;
  - Status of clinical privileges; change in OIG and OMIG Sanction, SAM debarment status or CMS Preclusion status.

Credentialing of Independent Practitioners (IP):

- Each applicant must submit a completed application with a signed attestation dated not more than 6 months prior to the credentialing decision.
- Criteria subject to primary source verification:
  - Current valid licensure or certification without material restrictions.
  - Required medical or professional education and training.
  - Board certification.
- Additional criteria include:
  - Valid DEA registration.
  - Participation in Medicare/Medicaid and history of Medicare/Medicaid sanctions.
  - No exclusion, suspension, ineligibility, preclusion from participation in state or federal health care programs.
  - Current insurance coverage meeting ElderServe requirements.
  - Hospital admitting privileges in good standing

- ElderServe may conduct an initial site visit and evaluation of IP's medical record keeping. ElderServe follows established quality improvement policies and procedures related to site visits for evaluating and scoring sites.

Credentialing of Facilities

- Each applicant must submit a completed application with a signed attestation dated not more than 6 months prior to the credentialing decision.
- Criteria subject to primary source verification:
  - Current required license(s) to operate in NYS.
  - Insurance coverage as specified by ElderServe.
  - Medicare/Medicaid program participation eligibility. No exclusion, suspension, ineligibility, preclusion from participation in federal or state health care programs. No sanctions levied by OIG, OMIG, or SAM.
  - Accreditation information. Lack of appropriate accreditation does not preclude participation, and will be reviewed by ElderServe on a case-by-case basis.
- Applicant's internal credentialing and recredentialing policy, and representation that its workforce comply with such policy.

Credentialing Review and Decision Process

ElderServe credentialing staff collects, reviews and verifies the credential information to assess whether an applicant meets ElderServe's credentialing requirements. Applicants that satisfy all the credentialing criteria requirements will be approved for contracting. Applicants otherwise will be reviewed by ElderServe's Medical Director based on the collected credentials, and additional requested information. The Medical Director will make a recommendation that the applicant be approved, denied, or deferred pending further review or investigation by the Credentialing Committee, which is comprised of the Medical Director, Executive Vice President and SVP of Regulatory Affairs.

Recredentialing Requirements

In accordance with regulatory requirements, each participating provider will be recredentialed at least every 36 months. IPs and facilities must meet all the initial credentialing criteria and:

- Demonstrate compliance with ElderServe's terms of participation, specifically including participation in quality improvement activities requested by ElderServe;
- Satisfactory review of malpractice claims history and potential quality of care concerns;
- Satisfactory site visit, if any

IV. REFERRALS & SERVICE AUTHORIZATION

REFERRALS

ElderServe Members in our Medicare plans are not required to obtain referrals from their PCP prior to obtaining services from specialists. However, it is part of the PCP's role to assist Members in obtaining specialty services. Please call ElderServe Member Services if you encounter any difficulty in finding a specialist for a Member.

AUTHORIZATION OF SERVICES

Authorizations for health care services can be obtained by contacting ElderServe Service Authorization. When requesting an authorization, please provide the following information as recommended by the NYS DOH Work Group on the minimum data necessary for a service request for which a response is required (approval, IAD or request for more information):

Member Information

1. Member Name
2. Member Date of Birth
3. Member ID [may be Plan assigned ID, Medicaid # or Medicare #]

Provider Information

1. Prescribing/Ordering/Referring Provider ID (may be Plan assigned ID, NPI or Tax ID)
2. Prescribing/Ordering/Referring Provider Name
3. Prescribing/Ordering/Referring Provider telephone/fax/address/email
4. Servicing/Requesting Provider ID (may be Plan assigned ID, NPI or Tax ID)
5. Servicing/Requesting Provider Name
6. Servicing/Requesting Provider telephone/fax/address/email

Clinical Information

1. Member symptoms and duration
2. Summary of Clinical Findings
3. Order Description [service codes are acceptable if known]
4. Medical justification
5. Written Diagnosis (ICD-10 codes are acceptable if known)
6. Date of Service or Start and End Date

Service Amount and Duration Information

1. Order Date
2. Quantity Requested

3. Times Requested
4. Place of Service

All services that require prior authorization from ElderServe must be authorized before the service is delivered. ElderServe is not able to pay claims for services for which prior authorization is required but not obtained by the provider. Please refer to the applicable ElderServe plan Evidence of Coverage or Member Handbook for services that require prior authorization. Please also keep current your fax number for receipt of authorizations and other service related communications from ElderServe.

OUT-OF-NETWORK SERVICES

ElderServe Members may utilize out-of-network providers for medically necessary services that can only be received from a non-participating provider, or if a participating provider is not within a reasonable distance from the Member's residence. Except as stated, PCPs must obtain prior authorization from ElderServe before sending a Member to an out-of-network provider. Providers can request prior authorization by calling ElderServe Member Services.

V. BILLING & CLAIMS PROCESSING

GENERAL REQUIREMENTS

Claims Submission Overview

This section provides information on how a provider may submit a clean claim and claims in general, the required data elements, advantages of submitting electronic claims, important information regarding coordination of benefits, member balance billing and our adjudication/remittance process.

CLAIMS: General Information

- Procedures must be defined by current terminology using CPT-4 or HCPCS codes. Diagnoses must be identified by the then current and applicable ICD codes.
- Procedures and diagnoses must be identified to the highest level of specificity: for example, the 7th digit on the ICD-10-CM codes when applicable.
- Place of service codes must be identified using established CMS codes.
- Claims must include a NPI to identify each provider for which data is being reported on a claim.
- Taxonomy codes are required on all claims submissions. Providers with multiple taxonomy codes should only include the code that applies to services performed and reported on claim submission.
- Include the member ID # with claims.
- Submit claims promptly after rendering services – your provider agreement contains the time limits within which claims will be accepted.
- Claims must be complete and correct. Claims missing information will be denied.
- Clean electronic claims are paid within 30 days of receipt.
- ElderServe **Electronic Payer ID# 05178**

Electronic Claim Submission

ElderServe processes electronic claims in accordance with the requirements for standard transactions set forth at 45 CFR Part 162. ElderServe has partnered with Smart Data Stream, a leading healthcare services organization, to provide our electronic claim submission gateway. Through this relationship with Smart Data Stream, we bring to our valued providers a cost-effective, long-term solution for managing HIPAA-compliant 837 EDI transactions for claim submissions.

1. ElderServe Payer ID- 05178
2. Claims must be submitted with the complete member ID number (See Member ID card)
3. A National Provider Identifier (NPI) should reside in:
   a. 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109.
   b. 837 Institutional (UB04) – Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with XX (NPI).

To sign up with Smart Data Stream Clearinghouse, please visit:
https://portal.smartdatastream.us/quickclaim/servlet/quickclaim/template/ClearingHouse,Login.vm
or call 1-855-297-4436

Providers may also continue to submit and track paper claims through Change Healthcare Clearinghouse at no cost to them.

Paper Claims Submission

Paper claims can be mailed to:

ElderServe Health Plans
PO Box 211465
Eagan, MN 55121

Provider Portal

Providers may verify member eligibility, review authorizations, set up electronic payments, and download Explanation of Payments through our Provider Portal: elderservehealth.ppi.com.

To request access to our provider portal, you will need to send an email to Providerportalrequest@elderservehealth.org with the following information:

- Provider NPI#
- Provider TIN# (Tax ID)
- Provider/Facility Name, Address and Telephone Number
- Requester Email (MUST be a business email; gmail, yahoo etc. NOT accepted)
- Affiliation with Provider if 3rd party biller

Once access has been granted you will receive an email with your log-in information.

CLAIMS: Data Elements

All HFCA -1500 claims must include:

- Member's Name
- Member plan ID # - ElderServe MAP (D-SNP), ElderServe Star (I-SNP), or ElderServe at Home (MLTCP)
- Member's Date of Birth
- Provider Name, Tax ID & NPI #
- Date(s) of Service – provided within approved authorization period
- Valid place of service code
- Service code such as HCPCS / CPT
- Number of units
- EOB of co-insurance, if applicable
- Valid Diagnosis Code(s)

All UB-04 claims must include:

- Member's Name
- Member ID # - ElderServe MAP (D-SNP), ElderServe Star (I-SNP), or ElderServe at Home (MLTCP)
- Member's Date of Birth
- Provider Name, Tax ID & NPI #
- Date(s) of Service
- Service code such as HCPCS / CPT
- Number of Units
- EOB of co-insurance, if applicable
- Valid bill type
- Valid Diagnosis Code(s)
- Valid Revenue Code

CLAIMS PROCESSING: Time Frames

ElderServe encourages providers to submit all claims as soon as possible after the date of service. Claims for authorized services must be submitted to ElderServe Health Plans within 120 days of the date of service. In no event should a claim be submitted beyond the time specified in your provider agreement. Services billed beyond 120 days from the date of service are not eligible for reimbursement as stipulated in your agreement, however ElderServe will consider a provider's late claim submission where the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions. Claims submitted beyond 120 days may be subject to an administrative fee. Timely submission will facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements.

CLAIMS PROCESSING: Definitions

- **Rejected claim**: A claim that was received by ElderServe, determined to be unclean, and never loaded to the adjudication system. The claim is returned to the provider with the reason for rejection.
- **Re-submission Claim:** A claim that was rejected ElderServe and resubmitted by provider. **NOTE:** the resubmitted claim is always treated as a new claim and must be resubmitted within timely filing guidelines for new claims.
- **Accepted Claim:** A claim that was received by ElderServe and passed all criteria. The claim was successfully loaded to the adjudication system. The system then makes the final determination of paid or denied.
- **Corrected Claim:** A claim that was accepted by ElderServe. The corrected data elements of the claim will potentially effect the payment of the claim.

CLAIMS PROCESSING: Claim Corrections

- **EDI Corrected Claims**: When submitting an EDI "Corrected" Professional and/or Institutional claim to ElderServe, the following requirements must be met:
    1. The claim type/frequency (CLM05-03) must be a 7.

a. Ex. CLM*8084*96.98***11>B>**7***Y*A*W*I*P

2. The ElderServe original claim ID must be sent in the REF*F8 segment in the 2300 loop. The ElderServe claim number can be found on the EOP and/or 835.

- **Paper Corrected Claim:** When submitting a Paper "Corrected" Professional and/or Institutional claim to ElderServe, Providers should stamp or write on the claim "CORRECTED" or "Corrected Claim" and must include the original claim number being corrected.

ENCOUNTER DATA SUBMISSION

ElderServe is required to report to NYS, CMS, and other regulatory agencies encounter data which lists the types and number of healthcare services Members receive. Encounter data is essential for claims processing and utilization reporting as well as for complying with government reporting requirements.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter ElderServe requires. Participating providers reimbursed on a capitated basis are also required to submit claims so that encounter data is reported to ElderServe.

ElderServe submits encounter and claims data monthly to NYS DOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, including capitated services. MEDS is the standard by which the performance of ElderServe and all other managed care organizations is measured. To meet the state mandate, ElderServe requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to each reporting measure as described in this section for specific measure requirements.

Present on Admission (POA)

The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission. ElderServe requires POA for all primary and secondary diagnosis codes as well as the external cause of injury codes, regardless of how the claims are submitted (i.e., paper or electronic). Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 institutional (837I) forms.

Requirements for Billing by Facilities

Facilities, including hospitals, must submit claim reporting data on Form UB-04 or on electronic media:

- Report the name and NPI for attending provider.
- Include the ElderServe authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in ElderServe system and processed in accordance with applicable ElderServe policies and procedures.

Professional services that are not part of the facility claims should be billed on Form CMS 1500.

Facilities billing on behalf of their employed providers must submit claim reporting data on Form UB-04 for outpatient services directly to ElderServe via electronic claim submission.

COB, EOP, EFT

Coordination of Benefits (COB)

If a Member has coverage with another plan/insurer that is primary to ElderServe, please submit a claim for payment to the other plan/insurer first. When you have received a determination from the primary carrier, you may then submit a copy of the primary carrier's Explanation of Payment (EOP) or Explanation of Benefit (EOB) with your claim to ElderServe. The amount payable by ElderServe will be determined by the amount paid by the primary carrier.

Please note that our ElderServe at Home MLTCP is a partially capitated plan and may not cover all services covered by other insurers (i.e. inpatient admissions, radiology services, medical visits, lab work, etc.). The cost sharing applied for these types of non-covered services should be billed to NYS Medicaid.

Explanation of Payment (EOP)

The EOP describes how claims for services rendered to ElderServe members were reviewed. It details the adjudication of claims, describes the amounts paid or denied, and indicates the determinations made on each claim. The EOP shall include the following elements:

- Name and Address of Payor
- Toll-free Number of Payor
- Subscriber's Name and Address
- Subscriber's ID Number
- Member's Name
- Provider's Name
- Provider Tax ID Number (TIN)
- Claim Date of Service
- Type of Service
- Total Billed Charges
- Allowed Amount
- Discount Amount
- Excluded Charges
- Explanation of Excluded Charges (Denial Codes)
- Amount Applied to Deductible
- Copayment/Coinsurance Amount
- Total Member Responsibility Amount
- Total Payment made and to Whom

The EOP is arranged numerically by Member ID number. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- Paid Claim Lines: If the Paid Amount field is greater than zero (0), the claim was paid in the amount indicated.
- Denied Claim Lines: If the Not Covered field is greater than zero (0) and equal to the allowed amount, the service was denied.
- Claim processed as Capitated Service: all claims Capitated are indicated as such by a message.
- End of Claim: Each claim is summarized by a claim total.

Providers may receive a copy of an EOP upon access to our provider portal: riverspring.ppi.com

Electronic Funds Transfer (EFT)

ElderServe's EFT/Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of ElderServe claims.

EFT is the direct deposit of claim reimbursements into your bank accounts. Advantages of these programs include:

- Prompt Payment- no waiting on checks
- Reduced paperwork.
- No lost checks or mail delay.
- Savings on administrative and overhead costs.
- Simplified and organized recordkeeping.
- Improved cash flow.

For questions related to Automated Clearing House (ACH), please contact Sherese.Brock@elderservehealth.org.

Balance Billing

Reimbursement by ElderServe constitutes payment in full except for applicable cost sharing (copays, deductibles and coinsurance); these amounts will be indicated on the EOP / EOB.

For Members of ElderServe Star (HMO I-SNP) who have Medicaid as a secondary insurance, providers must bill any cost sharing applied by ElderServe directly to NYS Medicaid. If a Member of ElderServe Star does not have Medicaid insurance, a provider may collect the cost sharing applied by ElderServe directly from the Member.

Providers may not bill Members for services that are covered by ElderServe Health Plans.

Providers may not bill a Member for a non-covered service unless:
1) The provider has informed the Member in advance that the service is not covered; and
2) The Member has agreed in writing to pay for the non-covered service.

Providers agree NOT to bill Members for balances that are not their responsibility or that are the responsibility of another carrier.

Adverse Reimbursement Change

An adverse reimbursement change is one "that could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional". A health care professional under this section is one who is licensed, registered or certified under Title 8, NYS Education Law.

ElderServe shall give providers who are health care professionals 90 days prior written notice of any adverse reimbursement change. The notice will state, among other things, that the provider may, within 30 days of date of the notice, give written notice to ElderServe to terminate the contract effective upon the implementation of the adverse reimbursement change, except as follows:

- The change is required by law, regulation or applicable regulatory authority, or is required due to change in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's CPT codes, Reporting Guidelines and Conventions; and
- The change is part of the contract between ElderServe and provider or IPA and provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a health care professional relative to this provision.

Rules for Billing Medicaid Spend-down and Third Party Insurance

ElderServe assumes responsibility for billing Medicaid spend-down amounts for Members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Providers shall not bill nor collect such amounts from the Member.

CLAIM DISPUTE RESOLUTION & APPEAL

Claims Adjudication

ElderServe is dedicated to providing timely adjudication of provider claims for services rendered on behalf of our Members. All provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. Providers must use the most current and specific codes when billing ElderServe. When industry codes are updated, the provider is required to update their billing software to meet the current standards. ElderServe will not pay any claims submitted using noncompliant codes.

ElderServe reserves the rights to use code editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System

(HCPCS) procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For your claim to be adjudicated in the most efficient manner and for you to receive reimbursement as quickly as possible, you must submit a clean claim. Clean claims are typically adjudicated within 30 calendar days of receipt. Examples of clean claims are claims that:

- Are submitted in a timely manner;
- Pass all edits;
- Have all basic information necessary to adjudicate the claim;
- Are accurate in services rendered and coding used to request for payment;
- Are submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS- 1450 or the electronic equivalent of such claim form 59;
- Require no further information, adjustment or alteration by the provider or by a third party in order to be processed.

Dispute Resolution

For any questions regarding the status of claims, please call ElderServe Billing and Claims.
ElderServe will notify provider of any billing that it determines is inaccurate or incomplete within 30 days of original receipt, and provider shall have 7 business days from the date of such notice to resubmit such billing. Provider will be notified in writing of any claim denial and the reason for denial.

Disputes related to claims payment must be submitted to ElderServe within 60 days of the denial notice. All disputes must be in writing and include the following:

- Provider name and NPI number
- Member name and ID number
- Date(s) of Service, billing code, units and amount
- Specific item in dispute and reason
- Supporting information and copies of relevant documentation for review e.g. claim number, authorizations, medical records, etc.

ElderServe will review all disputes and supporting information and notify the provider in writing within 60 days of receipt of the dispute.

Disputes related to matters covered by ElderServe's contract with NYS DOH shall be resolved using the DOH's interpretation of the terms and provisions under the DOH Contract. Any dispute that is not resolved after 30 days from the date of either party's notice of the dispute to the other party, shall be resolved by binding arbitration in accordance with the contract between ElderServe and the provider. The NYS Commissioner of Health shall be sent written notice of all issues submitted to arbitration and copies of all decisions rendered. The Commissioner of Health is not bound by any arbitration decision rendered.

All out-of-network providers can submit written appeals with supporting documentation and Waiver of liability (WOL) to:

ElderServe Health, Inc.
Attn: Claims Appeals
80 West 225th Street
Bronx, NY 10463

A link to the WOL form is located on our Helpful Links page.

VI. MEMBER GRIEVANCES & APPEALS

ElderServe handles grievances and appeals in accordance with its policies and procedures, which are based on CMS and NYS Department of Health regulatory requirements. ElderServe offers assistance to Members and their representatives in the grievance, appeal and compliance process, and requires the cooperation of participating providers in our investigative and administrative processes.

GRIEVANCES

A grievance, or complaint, is any expression of dissatisfaction regarding the Member's care and treatment that does not involve a coverage determination such as denial or reduction in payment or service. Examples of grievances include quality of care, wait time, inappropriate provider or staff behavior.

All grievances will be resolved without disruption to the Member's Care Plan, and Members will be free from coercion, discrimination or reprisal in response to a grievance. Grievances are logged, tracked and reported, and addressed as quickly as required by the Member's condition. Every attempt will be made to resolve telephonic grievances at the time of the call. Grievances that are not resolved on the same day will be resolved following a more formal review process.

Please instruct the Member to contact ElderServe Member Services if the Member has a grievance about any issue. ElderServe will contact providers with grievances concerning their services, and expect providers' cooperation with our investigations related to such grievances.

APPEALS

Members, their representatives, or providers on Member's behalf and with Member's consent, have the right to appeal an initial adverse determination (IAD) by ElderServe that terminates, suspends or reduces an authorized service, denies or limits a requested service, denies payment for services, or if ElderServe does not provide timely service or does not make determinations within required timeframes.

ElderServe will send its IAD to the Member, which describes the right to file an internal appeal with ElderServe, the external appeal process, and in connection with a determination to reduce, suspend or terminate an authorized service, the right to request that services continue pending a decision of the appeal. A provider can ask for an appeal to be fast tracked if a delay will cause harm to the Member's health. A claims appeal cannot be fast tracked and must be submitted in writing.

ElderServe tracks appeals and processes appeals as expeditiously as the Member's health status requires, and makes appeal determinations within the required timeframes. If ElderServe upholds its adverse determination to all or part of the Member's first appeal, additional levels of appeals are available depending on the Member's plan.

ElderServe will ensure that there will be no punitive or retaliatory action taken against a provider who requests an expedited resolution or supports a Member's grievance, appeal, or service authorization request.

Filing a Grievance or Appeal on Behalf of a Member

A provider may, with the Member's written consent, file an appeal or grievance on behalf of a Member. A provider may be appointed as a Member's representative via an Appointment of Representative (AOR) Form, which can be downloaded here: (AOR) Form. When executed in accordance with the Form's instructions, the Appointment is valid for one year from the date of signature.

To file an appeal or grievance on behalf of a Member, please call ElderServe Quality Department or write to:

ElderServe Health Inc.
Attn: Quality Department
80 West 225th St.
Bronx, NY 10463

MEMBERS RIGHTS AND RESPONSIBILITIES

ElderServe Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are stated in, and governed in case of conflict herein, by the Member's Handbook and Evidence of Coverage and are outlined below. Providers will deliver care to Members in accordance with these rights and responsibilities.

Members have the right to:

- Have information provided in an accessible manner, including alternate languages and formats
- Be treated with fairness, respect, dignity and courtesy
- Be treated in clean facilities, with clean equipment and materials
- Refuse to participate in or be a patient for research purposes
- Be assured that only persons having the qualifications established by Medicare and ElderServe will provide medical services
- Receive from the Member's physician information necessary to enable the Member to give informed consent prior to the start of any procedure or treatment
- See ElderServe Participating Providers, receive covered services, and get their prescriptions filled in a timely manner.
- Privacy and to protection of their protected health information (PHI)
- Receive information about ElderServe, its network of Providers and practitioners, their covered services, and their rights and responsibilities
- Know their treatment choices and participate in decisions about their healthcare
- Use advance directives (such as living will or durable health care power of attorney)

- Make complaints about ElderServe or the care provided and feel confident it will not adversely affect the way that they are treated.
- Appeal medical or administrative decisions of ElderServe by using the appeals process
- Make recommendations about ElderServe Member's rights and responsibilities policies
- Talk openly about care needed for their health, regardless of the cost of benefit coverage, as well as the choices and risks involved. The information must be given to Members in a way they understand.
- Request unaltered copies of Member's complete medical records to be forwarded to the physician or hospital upon Member's request and payment of the cost of duplication and delivery.

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules for obtaining care
- Tell ElderServe and providers if they have any additional health insurance coverage or prescription drug coverage
- Tell their PCP and other healthcare providers that they are enrolled in ElderServe
- Show their Member ID card before receiving healthcare services
- Keep scheduled appointments
- Use emergency room services only for injury or illness that in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- Give their PCP and other healthcare providers complete and accurate information in order to care for them, and to follow the treatment plans and instructions that they and their providers agree upon
- Understand their health problems and help set and agree on treatment goals with their doctor
- Ask their PCP and other providers questions about treatment if they do not understand
- Make sure their providers know all of the drugs that they are taking, including over the counter drugs, vitamins and supplements
- Act in a way that supports and respects the care given to other patients of their provider's office, hospitals and other care facilities
- Pay their plan premiums (if applicable) and any co-payments or coinsurance they owe for the covered services they get. Members must also meet their other financial responsibilities as described in the Evidence of Coverage
- Inform ElderServe if they move
- Inform ElderServe of any questions, concerns, problems or suggestions by calling ElderServe Member Services

VII. QUALITY ASSURANCE

QUALITY IMPROVEMENT PROGRAM

The purpose of the Quality Improvement Program (QIP) is to improve the health outcomes of our entire membership, by targeting the special needs of each product population, and providing access to affordable, appropriate and timely health care and services, which are routinely measured for compliance with established standards. This objective is accomplished 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. Annually, ElderServe reviews and approves the QIP and work plan. Each element of the QIP may be reviewed and updated during the course of the year dependent on business needs and regulatory requirements.

The overall QIP provides a framework for the evaluation of the delivery of health care and services to Members. This framework is based upon the philosophy of continuous quality improvement and includes:

A. Development of Quality Improvement initiatives that address specific populations
B. Quality measurement and evaluation
C. Committee reporting
D. Investigation and resolution of grievances and appeals
E. Corrective action implementation and evaluation
F. Communication with and education of our Members and providers
G. Ongoing monitoring of claims and other available data to identify opportunities to improve care
H. Evaluation of Member satisfaction
I. Evaluation of the program effectiveness
J. Monitoring effectiveness of corrective action plans and making recommendations for negative trends identified

MODELS OF CARE

ElderServe's Models of Care (MOC) outline the goals and objectives for the targeted populations, and the care management processes that enable coordinated care for ElderServe Members. ElderServe identifies, supports, and engages our most vulnerable Members at any point in the healthcare continuum to assist them in achieving an improved health status. ElderServe provides services using a person-centered (Member-centered) approach. ElderServe's objectives for serving Members with complex and special needs include, but are not limited to:

- Promotion of preventive health services and management of chronic diseases through disease management programs that encourage the use of services to decrease the morbidity and mortality rate in Members;

- Identification of Member needs and barriers to care by conducting comprehensive assessments;
- Coordination of transitions of care for Members to assist in navigating the complex healthcare system and accessing providers and public and private community-based resources;
- Improvement of access to primary and specialty care for Members with complex health conditions so they receive appropriate services;
- Consultation with appropriate specialized healthcare personnel when needed;
- Ensuring that Members' socioeconomic barriers are addressed;
- Completion of a population assessment to identify the needs of the population and subpopulations, so that Care Management processes and resources can be updated to address Member needs.

The MOC effectiveness is evaluated by ElderServe through objective, measureable and population-specific quality indicators. Indicator data are collected and analyzed; interventions are implemented for goal attainment; and reports are generated. ElderServe has established performance outcomes and benchmarks for each metric based on evidenced-based practice from current literature, standards and guidelines. Through root cause analysis, interventions are identified and implemented for each indicator that fall below the desired value.

ElderServe encourages provider involvement in the implementation of our Models of Care through participation and communication with our Care Team. To reach our Care Team, please contact ElderServe Member Services.

CLINICAL PRACTICE GUIDELINES

ElderServe Health Pans believes that the Member's physicians, who know them well, are best suited to determine the best course of treatment in most cases. When needed, we reference nationally recognized evidence based Clinical Practice Guidelines (CPGs) and protocols, and guidelines of the NYS Department of Health.

Our Medical Director promotes CPGs and collaborates with the Members' physicians to ensure delivery of age-appropriate, evidence-based care to Members.

We encourage any participating physician to contact us with any concerns regarding any Member. We specifically chose not to have a voicemail function in our phone system to ensure that concerns are handled by an appropriate individual in a timely manner.

CLINICAL PRACTICE GUIDELINE REVIEW AND AVAILABILITY

ElderServe Health maintains a set of nationally recognized, evidence-based Clinical Practice Guidelines (CPGs) that support clinical decision-making, care management, and quality improvement activities. These guidelines are reviewed **annually** by the Medical Director and/or Designee and updated as needed. Each guideline remains in effect until it is revised, replaced, or retired following the annual review process documented in the Plan's policy governance system.

The Plan ensures that Clinical Practice Guidelines are readily accessible to providers and that they are available to members and potential members upon request. Providers may obtain copies of the current guidelines by contacting Provider Relations. Members and potential enrollees may request copies by contacting Member Services. Guidelines may be provided electronically or by mail.

MEDICAL RECORD DOCUMENTATION, REVIEW & RETENTION

All providers rendering healthcare services to ElderServe Members must maintain a Member health record in compliance with National Committee for Quality Assurance (NCQA) Guidelines for Medical Records Review. Providers shall maintain compliance with professional standards and safeguard the confidentiality of records.

Medical Record Documentation Criteria:

- Include Member demographic information, family history, occupational history
- Date all entries, and identify the author and professional title.
- Document changes to a medical record entry.
- Identify all providers participating in care and services furnished.
- Include up-to-date problem list with chronic conditions and significant illnesses.
- Describe presenting complaints, diagnoses and treatment plan.
- Include current medications, dosages, allergies, and adverse reactions.
- Document Member medical history, risk factors, and health behaviors.
- Information on advance directives.
- Reflect all clinical decisions, services provided, supports tools, and follow-up care.

Medical records must be maintained for a period of ten (10) years after the last visit date, updated from time to time by applicable regulatory agencies. Providers shall make medical records available upon request by ElderServe, CMS, NYS DOH, or any regulatory body with jurisdiction over Medicare or Medicaid programs.

VIII. COMPLIANCE

ElderServe COMPLIANCE PROGRAM

ElderServe is committed to providing high quality and caring services pursuant to the highest ethical, business, and legal standards, including Federal and State health care program requirements, which apply to our interactions with everyone. This includes our Members, the community, providers, government entities, and entities from whom reimbursement for services is sought and received, who must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid any appearance of impropriety.

To this end, ElderServe maintains a vigorous Compliance Program and provides training to our workforce, Members, and providers on compliance with fraud, waste and abuse (FWA) laws and the reporting of any compliance concerns to ElderServe. Such concerns will be reviewed, and corrective action will be instituted as to any problematic practices in accordance with ElderServe policies and procedures.

FRAUD, WASTE & ABUSE

In accordance with applicable laws, rules and regulations, ElderServe reports cases of potential FWA to regulatory and law enforcement authorities as required by law and contract. ElderServe expects our provider community and First Tier, Downstream and Related Entities (FDRs) to bring any alleged inappropriate activity to our attention.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises, some benefit or payment for which no entitlement would otherwise exist.

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program. Abuse involves payment for items or services for which there is no legal entitlement, and provider has not knowingly or intentionally misrepresented facts to obtain payment.

Providers may report potential FWA anonymously by contacting us below:

Mail: ElderServe Health, Inc.
Attn: Compliance Officer
80 West 225th Street
Bronx, NY 10463

Phone: 1-855-265-6106

E-mail: Reportfraud@elderservehealth.org

ElderServe Health has a strict non-retaliation and non-intimidation policy against anyone who in good faith reports suspected FWA or other compliance issue.

FALSE CLAIMS ACT, ANTI-KICKBACK STATUTE, PHYSICIAN SELF-REFERRAL LAW

Important Federal fraud and abuse laws that apply to providers include the False Claims Act (FCA), the Anti-Kickback Statute (AKS), and the Physician Self-Referral Law (Stark law). Government agencies, including the Department of Justice, Department of Health & Human Services, Office of Inspector General (OIG), and Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws, violations of which could result in criminal penalties, civil fines, exclusion from the Federal health care programs, and/or loss of licensure. Below is a brief summary of each law.

False Claims Act (FCA)

The False Claims Act is a federal law [31 U.S.C. § 3279(a)] that requires ElderServe to provide FCA education to our contractors and agents, including providers. In addition, NYS False Claims Act (NYS Finance Law §§187-194) requires Medicaid providers to develop and implement compliance programs aimed at detecting FWA in the Medicaid program, and to ensure that their personnel are familiar with the requirements below.

Neither ElderServe nor our providers may submit false or fraudulent claims to the Federal and state government. Both federal and state FCAs apply when a company or person:

- Knowingly presents (or causes to be presented) to the government a false or fraudulent claim for payment
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the government
- Conspires with others to get a false or fraudulent claim paid by the government
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

"Knowingly" includes acting with actual knowledge, deliberate ignorance or reckless disregard of the facts. Simply presenting a false claim is a violation, even if the claim has not been paid and no money has been expended.

Criminal penalties for submitting false claims may include imprisonment and/or fines of “treble damages” (damages equal to three times the amount of the false claims), and exclusion from participating in federal and state programs.

Whistleblower provisions of the state and federal FCA shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates in anyway, whistle-blower protection might entitle the employee to file a charge with a government agency, sue the employer or both.

For additional information on the federal and state FCA, as well as other NYS laws that apply to the submission of false claims and the making of false statements, please click on the link to the False Claims Act Summary and Policy on the Helpful Links page.

Anti-Kickback Statute (AKS)

Federal and state laws make it unlawful to pay any individual on the basis of the value or volume of referrals. The federal and state AKSs prohibit giving or receiving any remuneration (which includes, without limitation, money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid with Medicare or Medicaid funds.

In compliance with these laws, ElderServe does not pay incentives to any person based upon the number of members enrolled or the value of services provided, or for referrals. ElderServe does not accept any remuneration in return for referring its Members to providers. ElderServe refers Members to providers based on Members' choice or documented medical needs for the referred services and the ability of the referred provider to meet those needs. ElderServe respects and honors a Member's freedom to choose a provider.

Physician Self-Referral Law (Stark Law)

Under the Stark laws, a physician cannot refer patients to entities furnishing "designated health services" that are payable under Medicare or Medicaid, if the physician or their immediate family members have a financial interest in that entity. A prohibited financial relationship includes an ownership or investment interest and any compensation arrangement.

In compliance with the Anti-Referral laws, all contracts, leases, and other financial relationships with providers who have a referral relationship with ElderServe will be based on the fair market value of the services or items being provided, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

ElderServe will not engage in any practice that violates the Anti-Referral laws or creates an appearance of illegality or impropriety, including, but not limited to:

- Free Services. We will not provide free services or items to, or accept free services or items (except token items) from, a provider with whom a referral relationship exists.
- Fair Market Value. We will not pay or charge excessive amounts above, or amounts below, the fair market value for providing equipment, space or personnel services, to or from, a provider.
- Joint Ventures. We will not enter into joint ventures with other providers when applicable Safe Harbors or exceptions under the Anti-Referral laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.

All contracts, leases, and other financial relationship with providers with whom ElderServe has a referral relationship will be reviewed to ensure compliance with the federal and state Anti-Kickback and Stark Laws, and compliance with any applicable Safe Harbor or Exception under those laws. Violations shall be reported to the government through an established self-disclosure process.

NON-DISCRIMINATION, ADA COMPLIANCE & ACCESSIBILITY

ElderServe and its participating providers ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal and state funds outlined below.

Non-Discrimination

ElderServe and our participating providers do not differentiate or discriminate in accepting and treating patients based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Americans with Disabilities Act (ADA)

ElderServe complies with Title II of the ADA, Section 504 of the Rehabilitation Act of 1973, and applicable NYS and local laws, and ensures that ElderServe program services and activities are accessible to individuals with disabilities. ElderServe exists to serve individuals with disabilities and frailties with sensitivity and good access. We provide sensitivity training to our staff, and seek to hire persons who demonstrate sensitivity to individuals with disabilities. It is our mission to serve such individuals with compassion and respect.

Accessibility

ElderServe requires its providers to be accessible to individuals with disabilities. By contract, every provider agrees to a non-discrimination clause that in particular prohibits unlawful discrimination on the basis of disability or handicap. The ElderServe Contracts and Compliance Department reviews each provider application as part of the credentialing process to assure compliance. ElderServe will assist in securing sufficient support to ensure accessibility to services for persons with disabilities.

IX. HIPAA & HITECH

ElderServe Health, Inc. is committed to complying with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Both ElderServe and its providers are required by law to protect patient privacy rights, safeguard Members' Protected Health Information (PHI), and provide patients with access to their PHI. In addition, both covered entities and business associates are obligated to notify individuals of breaches of their PHI.

Generally, covered health plans and covered providers are not required to obtain individual Member consent or authorization for use and disclosure of PHI for treatment, payment, and health care operations. If you have questions or concerns, please contact EldeServe Provider Relations.

BREACH REPORTING

If a provider becomes aware that a breach of PHI has occurred, the provider should notify ElderServe immediately, notify the individuals whose PHI was breached, and report the breach to the federal Department of Health and Human Services (DHHS) in accordance with HITECH requirements.

Individuals should be notified in writing, and provided with basic information about the breach, including when the breach occurred and when discovered, type of PHI involved, investigation and corrective actions, and contact information for any questions.

To report a breach to ElderServe, please call ElderServe Member Services. To report a breach to DHHS, please click on the link below:
https://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html