Policies and Procedures Manual

Chapter 19C

Corporate Compliance Plan

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I. Introduction

Astor Services for Children & Families' mission is to provide behavioral and educational services in a caring environment where children and their families find strength, healing, hope and trust. Sponsored by Catholic Charities of the Archdiocese of New York, Astor Services for Children & Families is an expression of the church's concern for the poor and vulnerable. Astor services are provided to all for whom they are appropriate without regard to race, creed, national origin, or gender.

Astor Services for Children & Families is dedicated and committed to meeting high ethical standards and compliance with all applicable laws in all activities regarding the delivery of health care through its licensed and certified facilities. It is our goal that our established Compliance Program will assist the Agency in fulfilling its fundamental vision, mission, and values.

Our organization has adopted this Corporate Compliance Plan to comply with the provisions of the Deficit Reduction Act of 2005, NYS Office of Medicaid Inspector General Work Plan, Social Services Law 363-d, and the Office of Inspector General of the Department of Health and Human Services. Specifically, Appendix B to this Policy includes detailed information concerning the Federal and State False Claims Acts along with Federal and State laws protecting whistleblowers and providing for criminal and administrative penalties and sanctions in the health care arena. This Policy describes our procedures for detecting and preventing fraud, waste and abuse.

As is detailed within this Compliance Plan, it is the duty of all of our employees, contractors, vendors and agents to comply with the policies as applicable to their individual areas of employment or contracts.

This Compliance Plan also advises all of our employees, contractors, vendors and agents of the procedures to be used in reporting non-compliance with such Federal and State laws.

It is the purpose of this plan to organize our resources to resolve payment discrepancies and detect inaccurate billings as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences of any such findings.

A. Benefits to our Compliance Program

Benefits to our Compliance Program include, but are not limited to the following:

- Demonstrates to the employees and community at large our strong commitment to honesty, responsibility and appropriate conduct.
- Develops a system to encourage employees to report potential problems that may be detrimental to the client and the Agency.
- Develops procedures that allow for a thorough investigation of alleged misconduct.
- Develops procedures for promptly and effectively conducting internal monitoring and auditing which may prevent non-compliance.
- Through early detection and reporting, minimizes the risk to the Agency and, thereby, reduces our exposure to any civil damages or penalties, criminal sanctions or administrative remedies.

II. Corporate Compliance Code of Conduct

In addition to the Agency's general policies and procedures as found in documents such as the Agency Policies and Procedures Manual and the Employee Handbook, the following *Corporate Compliance Code of Conduct* is intended to guide Agency's staff. The code is not intended to prescribe a specific response to every conceivable situation, but to assist staff in determining an appropriate response as salient situations arise. Whenever a staff person has a question about an appropriate response in a given situation, (s)he should consult his/her supervisor and/or administrator.

1) Astor Services for Children & Families will bill only for services actually rendered and shall seek the amount to which it is entitled.
2) Astor Services for Children & Families does not tolerate billing practices that misrepresent the services actually rendered.
3) Supporting documentation must be present for all services rendered.
4) Astor staff shall bill private insurance and Medicaid by the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
5) All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws and contracts and Astor Policies and Procedures.
6) An accurate and timely billing and documentation structure is critical to ensure that Astor staff can effectively implement and comply with required policies and procedures.
7) Demonstrated lapses in the documentation and billing systems infrastructure should be remedied in a timely manner at the program level with input from the Medicaid Quality Improvement Team (a.k.a. Compliance Committee) whenever possible. Chief Compliance Officer must approve all proposed remedies.
8) Astor staff must never falsify documentation for the purposes of billing.
9) Never assume a service has been provided. Always verify services by referring to clinical and/or medical documentation in the electronic health record and/or hard copy record.
10) If you personally did not provide a service, never sign that the service has been provided. If the document is in the EHR you are allowed as supervisor to sign off on the document if the staff person did not sign it, but only attesting that you have reviewed the document and clinical content is appropriate. The supervisor will be expected to put an “addenda” to the record that explains why the staff person who provided the service did not sign the note.
11) Never pre or post date documentation.
12) Astor staff are not to use white-out in clinical or medical records, or erase any official documentation – always cross off; initial and then re-write.
13) Whenever in doubt if a service is being provided, check the Astor Policies and Procedures governing regulations for that service area, or your direct supervisor and/or administrator.
14) The promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers and supervisors. They, along with other employees, will be periodically trained in new compliance policies and procedures.

III. Compliance Officer

Astor Services for Children & Families has designated a Compliance Officer who oversees the development and implementation of Astor’s Compliance Program and ensures appropriate handling of instances of suspected or known illegal or unethical conduct. However, in the event that the Chief Compliance Officer is not available, we have designated an alternate contact. The following responsible individuals will receive and coordinate complaints or concerns involving the Agency’s health care operations:

Name:	Title:	Email Address:	Telephone Number:
Yvette Bairan	Chief Compliance Officer	ybairan@astorservices.org	845-871-1097
Suzanne Button	Assistant Executive Director, Quality & Clinical Outcomes	sbutton@astorservices.org	845-871-1111

A. Duties of the Compliance Officer

- Oversee and monitor the implementation of the Compliance Program;
- Maintain responsibility for day to day operation and the effectiveness of the Compliance Program;
- Establish methods such as conducting periodic audits, developing effective lines of communication on compliance issues and preparing written standards and procedures that reduce Astor's vulnerability to fraud and abuse;
- Oversee the implementation of the policies and procedures in place with respect to compliance with federal and state anti-kickback statutes, as well as the Stark physician self-referral law;
- Periodically revise the Compliance Program and make recommendations for revising the policies and procedures in light of changes in the needs of the organization or, in the law, policies, and procedures of the government;
- Develop, coordinate and participate in a training program that focuses on the components of the Compliance Program and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards; and that independent contractors, consultants and volunteers who furnish mental health services to Astor Services for Children & Families' clients are aware of the requirements of the Compliance Program;
- Ensure that the List of Excluded Individuals and Entities have been checked with respect to all employees, medical staff and independent contractors;
- Report on a regular basis to the Executive Cabinet, Board, CQI/A Committee, and Compliance Committee on the progress of implementation and activities of the Compliance Program and any investigations and corrective actions.
- Ensure that the electronic health record includes all required documentation necessary for program and Medicaid compliance.

The Compliance Officer shall have authority to review all documents and other information that are relevant to compliance activities, including, but not limited to, patient records, billing records, and records concerning the marketing efforts of the facility and the hospital's arrangements with other parties, including employees, professionals on staff, independent contractors, suppliers, agents, and hospital-based physicians, etc. This policy enables the Compliance Officer to review contracts and obligations (seeking the advice of legal counsel, where appropriate) that may contain referral and payment issues that could violate the anti-kickback statute, as well as the physician self-referral prohibition and other legal or regulatory requirements.

IV. Communication and Changes in Compliance Manual

The Chief Compliance Officer will distribute in writing, make available via Astor's public folder, and/or post in conspicuous places, any modifications of, or amendments to this Compliance Plan. The Chief Compliance Officer will also provide employees, contractors, vendors, agents of the Agency and professional staff members with written explanations of any substantial changes in these policies. If the Chief Compliance Officer determines that written materials are insufficient, in-service will be conducted (please refer to section on Education and Training below).

Employees, contractors, vendors, agents of the agency and professional staff will be provided periodic information about our Corporate Compliance Program, changes in applicable laws or ethical standards that may affect an employee's responsibilities through written memoranda, newsletters, periodic training sessions or other appropriate forms of communication, including the posting of such information on our website or secure server. Astor will also use our website to post the most recent plan and as a way to provide our contractors and vendors with the current compliance plan.

V. Education and Training

The proper education and training of employees is a significant element of an effective compliance program. As such, staff will be expected to participate in appropriate training. The Compliance Officer shall retain adequate records of its training of employees, including attendance logs and material distributed at training sessions. The training and education should be provided to all relevant levels of personnel and employees whose actions affect the accuracy of the claims submitted to public and private third-party payors, such as employees involved in the coding, billing, cost reporting and marketing processes.

A. Compliance Plan

- All current employees will be provided a copy of the Compliance Plan. The first time they receive the Plan they will be expected to sign a certification stating that they have read and understood the Plan (See Appendix C). We will expect all staff to annually certify receipt and review of the Plan through their participation in mandated annual compliance training.

  For new employees, the Compliance Plan will be provided during the orientation process and an educational session will occur at that time. All supervised personnel will be informed that strict compliance with the Compliance Plan is a condition of employment. All new employees will be expected to sign a certification stating that they understand and will comply with the Plan.

- For vendors, consultants, contractors and other agents who provide any service where Medicaid dollars are used; the Compliance Plan and any updates will be on our Astor website. If they cannot access internet or email, we will provide a hard copy.

- For clinical consultants, the Medical Director will be responsible for ensuring that the Plan is sent to all current and new clinical consultants. For new consultants it will be sent at the same time that the rules and regulations of the professional clinical staff are distributed. We will expect all consultants to annually certify receipt and review of the Plan through their participation in annual compliance training.

B. Federal and State False Claims Act and Whistleblower Protection

All Astor employees will have available to them via a PowerPoint presentation and by distribution in accordance with Section 6032 of the Deficit Reduction Act of 2005, the Federal and NYS False Claims Act and Whistleblower Protection (Please see Appendix B for a summary of the laws). These trainings are a requirement of the Compliance Plan and will be conducted by the Chief Compliance Officer. Trainings will occur in various formats:

- Computer-based training – Employees will view a PowerPoint presentation, which is located in Astor's Public Folder under Mandated Trainings in our MS Outlook software. Once they have viewed the presentation and the supervisors is aware that the staff completed the training, their name will be entered into Astor's training database as proof of compliance.

- Face-to-Face (on-site training) – Employees who do not have access to a computer or prefer on-site training will be given that opportunity; supervisors may also print a hard copy of the training material. Attendance will be taken as proof of participation.

The Human Resources Department will maintain a database that shows all employees who have completed training for the year. If any staff member is non-compliant, the supervisor will be informed and further non-compliance may result in disciplinary action.

VI. Reporting Requirements

Astor believes that it is our employees who best know where organizational policy or regulation is not being followed. Therefore, the effectiveness of our Compliance Program depends on the willingness of employees in all parts and at all levels of the organization to step forward, in good faith, with questions and concerns. The policy and procedures set forth below, as well as the available lines of communication and examples of the types of issues to be reported, will be incorporated with staff training and publicized throughout the Agency as appropriate.

We believe strongly that in all of these cases, resolution of the problem behaviors or actions will result in better care for our consumers. Therefore, each person reporting problems or concerns will be contributing positively to the overall quality of the services at Astor.

If there is suspicion of possible fraud, waste and abuse or/and other matter related to the Compliance Program, it is the responsibility of the staff who suspects such action to inform a person in senior level authority who they feel may assist in directing the issue/concern to resolution. Astor expects that the first person informed be the direct supervisor; however, if staff want to keep anonymity they can call our Hotline and/or call or email the Chief Compliance Officer. (See procedures for reporting possible non-compliance below.)

All reports of possible fraud, waste and abuse, or other matters related to Medicaid compliance must be reported to the Chief Compliance Officer who will implement the necessary steps as set forth in the Compliance Program for investigating the matter.

Examples of provider fraud or abuse

- Billing for services that were not provided.
- Documenting services that were not provided and subsequently are billed.
- Duplicate billing, which occurs when a provider knowingly bills Medicaid and also bills private insurance and/or the recipient.
- Upcoding – billing for a comprehensive visit at a higher rate, when a lower rate visit was actually provided.

- Having an unlicensed person perform services that only a licensed professional should render, and bill as if the professional provided the service.
- Billing for more time than actually provided.
- Billing for an office visit when there was none, or adding additional family members' names to bills.

Example of provider waste

- Referring the recipient for more office visits when another appointment is not necessary.

A. Policy

1) Every employee is responsible for doing his/her job in a manner that is ethical and complies with the laws and regulations that govern our work.

2) Every employee is responsible for seeking supervisory assistance if he or she has doubts or is unclear about what the right action is to stay compliant. If the employee does not believe their supervisor is correct in their advice, they can go to the service area Assistant Executive Director or directly to the Chief Compliance Officer with the question and he/she will investigate and answer the question.

3) Every employee has a duty to Astor and to our consumers to report actions or behaviors they feel violate the code of conduct, procedure, law or regulation. Any employee that fails to report misconduct or illegal behavior may be subject to disciplinary procedures up to and including, termination.

4) Astor will encourage employee questions and/or reports by:

   a) taking each report seriously;
   b) investigating each report; and where there is enough information, to determine the extent of the problem and corrective action(s) needed;
   c) making sure that employees who do report:
      - Do not suffer any retaliation by their peers or supervisors for their good faith reports or questions.
      - Have more than one way to report questionable behavior or for asking questions about compliance. This includes giving employees the option of reporting directly to their supervisor or directly to the Chief Compliance Officer.
      - Have the choice of keeping their name confidential in regard to a specific report for as long as the organization can reasonably do so.
      - Have an agreed upon method for determining the status of their report and any subsequent investigation where possible.

B. Procedures

HOW TO REPORT
Employees may report at any time to:

1) CHIEF COMPLIANCE OFFICER: Directly to the Chief Compliance Officer through the hotline number at 1-866-293-0031. This line will be answered only by the Chief Compliance Officer (or his or her designee during vacations and other prolonged absences).

2) VOICE MAIL OR FACE-TO-FACE REPORTS: Voice mail or face-to-face reports to the Chief Compliance Officer or any manager or supervisor.

3) MAIL AND EMAIL: Employees may use mail or email to report problems or concerns. Mail and email can be directed to the Chief Compliance Officer or to any manager or supervisor.

In all cases, the Assistant Executive Director will be given information regarding the possible non-compliance.

In all cases, supervisors who get employee reports will be required to discuss the report with the Chief Compliance Officer and the service area Assistant Executive Director.

VII. Enforcement and Discipline

In the event of an investigation or through monitoring and auditing it is determined that fraud, waste or abuse has occurred, or that a staff person or program is violating policies and procedures set forth in the Compliance Plan, there may need to be disciplinary action.

A. Discipline Policy and Actions

All employees are expected to report any breaches of laws, regulations, policies and standards that govern our work as well as the organization's Code of Conduct. Upon receipt of such reports, the matter will be investigated by Astor Services for Children & Families. Additionally, the Agency, through its ongoing monitoring, may determine a breach(es) may have occurred. In either instance, where a breach is confirmed, appropriate actions will be taken by the Agency.

As a result, in order to correct or improve employee performance, Astor encourages employee counseling as an initial step. However, there may be times (such as when the outcome of an investigation determines fraud has taken place) where more severe action is appropriate. In these cases, formal disciplinary actions will range from verbal warnings to termination or revocation of contract. The Compliance Officer shall disseminate the range of disciplinary standards for improper conduct during each training session to educate personnel and contractors regarding these standards. When disciplinary action other than a verbal warning is proposed, the Human Resources Office will be contacted and they will coordinate such action.

B. Non-retaliation Policy

To the extent possible, all employee reports will be handled in a manner that protects the confidentiality of the reporter if they request it. However, there may be circumstances in which confidentiality cannot be maintained. Some examples of this include situations where the problem is known to only a very few people or situations in which the government or one of our other payers or funders must be involved. In most cases, they will require the name of the individual who first brought the problem to the attention of the organization. In all cases, however, Astor is determined that the reporting employee will not suffer from any retaliation for their good faith actions.

It is the responsibility of the Chief Compliance Officer to ensure that those reporting in good faith do not suffer any retaliation for doing so. As such, the following will occur:

1) The Chief Compliance Officer will explain the Agency's Non-retaliation Policy to each caller or reporter.

2) The Chief Compliance Officer will give the reporter a means for contacting them confidentially to report any actions the reporter believes is retaliatory.
3) The Chief Compliance Officer will investigate any reports of retaliation and will make recommendations through management regarding disciplinary and other corrective actions that should take place, if there is a positive finding.

The Chief Compliance Officer will confidentially contact reporters on a regular basis to inquire about any perceived retaliation.

C. List of Excluded Individuals or Entities

To be in compliance with HIPAA and other Federal and State requirements, providers must check the OIG List of Excluded Individuals and Entities on the OIG website *http://www.oig.hhs.gov/fraud/exclusions.html* prior to hiring or contracting with individuals or entities. Persons and entities who are listed on the Federal OIG Exclusion Database must receive reinstatement through the OIG to be eligible for reimbursement through Medicaid. In addition, the NYS Office of the Medicaid Inspector General has a list of excluded individuals and entities which can be visited at http://www.omig.state.ny.us/data.html and click on the "disqualified individuals" link. We also check the System for Award Management (SAM) list for vendors and contractors who have done work with the federal government, but were excluded since then.

Astor Services for Children & Families has implemented the following policy

1) Prior to hiring an employee, the Human Resources Department will check all of the websites noted above. Printed proof of "no matches" will be filed in the employee's personnel record;
2) For current employees, vendors or contractors, we utilize a licensed software product to check all relevant websites. Any matches that show up are verified and resolved by the compliance department;
3) For any new vendors, the finance staff setting up the account will inform the Chief Compliance Officer who will then check all relevant websites;
4) For clinical consultants that do not show up on our payroll database; the Medical Director will be responsible for designating someone who can check the OIG, NYS OMIG, and SAM websites at the time of hire. Proof of such check will be provided to the Chief Compliance Officer and maintained in the consultant record.

All matches will be addressed by the Chief Compliance Officer and appropriate staff. If the person is working for a program where Medicaid dollars are used, then HR and Executive leadership (as appropriate) will be involved in decisions about the future of the staff person.

VIII. Monitoring and Auditing

The Agency's Monitoring and Auditing Procedures will uncover activities that could potentially constitute violations of the Compliance Plan or failure to comply with federal and state law or other types of misconduct. We understand our obligation to investigate any incidents uncovered to determine:

- if a violation has, in fact, occurred;
- if disciplinary action must be taken; and
- corrective actions are put into place as required.

All issues reported to the Chief Compliance Officer will be handled in a consistent fashion so that

the integrity of the Plan is maintained, and so employees will have confidence in the workings of compliance investigations.

The Agency has a management hierarchy that is designed to deal with employee misconduct through the normal avenues of supervision. Most day-to-day issues should be handled through this hierarchy. Action from the Chief Compliance Officer is required when systemic problems give rise to misconduct and require system-wide changes to prevent misconduct from occurring in the same fashion in the future.

As part of our effort to implement an effective Compliance Program, Astor will periodically conduct routine self-audits of its operations including its billing practices, its written standards, Electronic Health Record, manual clinical and billing records, and Medicaid Audit Checklists (see below).policies and procedures to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program. (Please see Appendices D & E) for self-assessment tools.)

All Astor service areas, where Medicaid billable services are provided, are expected to designate a Medicaid Compliance Analyst, who in most cases, reports to someone in the service areas Quality Improvement and/or Administrative department. It is expected that the supervisor of the Medicaid Compliance Analyst inform, via written form to the Chief Compliance Officer, the frequency of audits, outcomes and corrective action plans. All program area audits not being conducted by the Chief Compliance Officer or the Corporate Compliance Coordinator should follow the same Corporate Compliance Plan Guidelines for Auditing. However, all service areas' are expected to have a Service Area Compliance Plan that specifically addresses monitoring and auditing for that service area. Appendix A includes all current Service Area Plans.

Procedures for auditing clinical, medical and billing records:

A. Periodic Audit of Coding and Billing Practices

A periodic audit of coding and billing practices is done to identify whether

- bills are accurately coded and accurately reflect the services provided (as documented in the Electronic Health Record and/or hard copy clinical and medical records, or other documentation);
- bills are submitted only when appropriate documentation supports the bills and only when such documentation is maintained and organized in a legible form to be available for audit and review;
- documentation is being completed in accordance with established documentation policies and procedures;
- services provided are reasonable and necessary with particular attention paid to issues of medical necessity, appropriate diagnosis codes; and any incentives for unnecessary services exist.

The above will be accomplished through the use of existing tools and systems such as;

<u>Review of billing practice against Medicaid regulations</u>
Due to changes in Medicaid regulations, rate changes and operational changes within the agency, it is important for the organization to periodically review its billing practices to ensure that it remains compliant. The Chief Compliance Officer or Corporate Compliance Coordinator will review written billing procedures and/or meet with billing staff to ensure that the Electronic Health Record has been updated with the most recent billing regulations. If billing is taking place outside of the Electronic Health Record the Chief Compliance Officer or Corporate Compliance Coordinator will conduct audits of that billing, which includes generating reports and gathering clinical documentation of services provided to ensure that

services are provided and documented as required by the regulations. She/he will also address if there has been any changes in billing practice since the last review. The Chief Compliance Officer will provide any resources to billing staff that may assist in understanding the Medicaid Regulations that apply to their billing practice.

B. Medicaid Audit Checklist and Electronic Health Record

All Astor program areas where Medicaid billing occurs will have a Medicaid Audit Checklist and/or reports from the Electronic Health Record that will be used by the program's designated Medicaid Compliance Analyst, as well as the Chief Compliance Officer and Corporate Compliance Coordinator. The Medicaid Audit Checklists will include the necessary Medicaid requirement questions associated with the particular service area. Data from the Electronic Health Record will include reports that provide information on compliance, such as missing and timeliness of treatment plans, documents requiring signatures, completion of documentation required for billing, and a whole array of other reports that gauge program compliance with documentation and expectations for documenting clinical services. The compliance staff may also go into individual clinical records to complete the Medicaid audit tool and to get further clarification on data showing up in the compliance reports.

Electronic Health Record Reports and Data

The following are reports and data that will be used to monitor program compliance with clinical, medical, and billing practices (See examples as Appendix F). Although this is not an exhaustive list it provides a concrete picture of the importance we place on compliance at our agency:

1. Failed Activities Report: This report is used to determine which services have been provided but have not "passed" through all of the system error checks, such as being marked as kept but not document completed or document not signed.

2. Failed Claims Report: This is the 2nd level of compliance check in the system before the claim goes for approval. When services show up in failed claims it usually means that the service was provided, but there isn't a treatment plan in place at the time of service. We do not submit a service for payment unless the treatment plan is in place during the time of service.

3. Treatment Plans with missing begin or end dates – This is a custom report that helps us monitor any treatment plans that got entered into the system, but whose begin or end date might have been left blank and the system did not auto-generate a date in the missing field. The begin date of a treatment plan is usually generated based on when the MD signed the treatment plan. However, there were instances that for some reason the MD did sign the plan, but the system did not auto-generate the begin date. As a result, we are closely monitoring all treatment plans.

4. Weekly Progress Note Completion Report – For certain program types we are required to complete a weekly note prior to billing. In addition to ensuring the treatment plan is in place, we also generate a weekly progress note report to determine if the required documentation for billing has been completed in those programs.

5. Transfer / Discharge Document never finished – In the system anytime a client is being discharged, referred to another Astor program, or being transferred to another program they must complete a module in the system called "transfer/discharge". Sometimes staff begin the process of entering data in the module, but never complete the process. As a result, we sometimes have unfinished transfer/discharges in the system, which impact staff ability to enter clinical documentation into the system. Therefore, we decided to

monitor via a compliance report any transfer/discharges that were not fully completed.

Medicaid Audit Checklist

While the majority of Astor programs are using the Electronic Health Record for some programs we continue to use an audit checklist (See Appendix G for examples) because the regulation and billing requirements are so complicated that even the error checks and alerts in the system are not sufficient to capture every aspect of those requirements.

Programs that use a fairly comprehensive audit checklist are (not an exhaustive list):

1. Bridges to Health Program: This program uses primarily the State Connections system to document progress notes. In addition, a large number of documents require external agency signatures, which makes it very difficult to use the Electronic Health Record. As such, we use two comprehensive audit tools, one that is used by the Medicaid Compliance Analyst and the other used by the program supervisors. Both tools help us assess compliance and can trigger that we not bill for a given client or that we repay if a bill was generated without documentation completely required.

2. Waiver Program: Although this program is using the Electronic Health Record; we also use an audit tool due to the complexity of the waiver billing. This program has admission and enrollment dates which trigger different sets of documents and billing requirements.

3. Therapeutic Foster Boarding Home – Like our Bridges to Health Program, this program also uses the State Connections electronic health record and we did not want to duplicate their entry of documentation. As a result, we decided to use only certain data entered into the system that would allow us to bill, but opted to have an audit checklist to assess documentation compliance.

The Medicaid Audit Checklist will only be revised with the approval of the Chief Compliance Officer. Revisions may occur for the following reasons:

- New Medicaid Regulations associated with the designated program area;
- To ensure clarity and consistency of the tool.

On a monthly basis, staff from different locations but similar/same service types (i.e. outpatient clinics) will discuss their needs related to the Electronic Health Record and clinical or medical documentation that may be needed to enhance the clinical or medical record.

C. Methodology for Audits

The Chief Compliance Officer and Corporate Compliance Coordinator will use various methods for monitoring and auditing. She/he will use the failed activities, failed claims, and active census from EHR. In addition, the designated Medicaid Compliance Analyst for each area will have a roster/list of Medicaid billable services which the Chief Compliance Officer or Corporate Compliance Coordinator will use to conduct audits. This is critical to ensuring a system of checks and balances and for providing further objectivity to the monitoring and auditing process.

In addition to the Chief Compliance Officer and Corporate Compliance Coordinator, every designated Medicaid Compliance Analyst will have a similar method for auditing which will include a review of the Electronic Health Record data and manual documentation similar if not identical to what is done by the corporate compliance staff. These procedures will be part

of the program areas' written Policies and Procedures on Monitoring and Auditing. The Corporate Compliance Coordinator works very closely with the Medicaid Compliance Analysts. The Corporate Compliance Coordinator conducts analysis of compliance data and submits reports to the Chief Compliance Officer, service area compliance staff and program leadership. She/he also reviews and updates compliance audit tools.

Timeframe

The Chief Compliance Officer or Corporate Compliance Coordinator will conduct audits via the Electronic Health Record and/or Medicaid Audit Checklist for every program area at least twice a year. In addition to the review of the Electronic Health Record and manual clinical and medical records, the Chief Compliance Officer or Corporate Compliance Coordinator, as noted in Section VIII – A above, will conduct audits of billed services against Medicaid Regulations. The timeframe might be altered depending on any reports of fraud, waste, or abuse that may require investigation. It can change if we get an unexpected Medicaid audit from the federal or state government. Finally, it can change depending on risk area, which will be determined through analysis of audits that have been completed or through senior management concerns about specific vulnerabilities.

Sample size

Sample size will depend on the following factors:

- The number of billable activities for a given period of time;
- Risks and vulnerabilities in any given program area;
- Number of errors from previous audits.

Record retention

As set forth in the Agency Policies and Procedures Manual, the designated Compliance Officer will develop and implement policies and procedures to assure that Astor's Privacy Officer is coordinating compliance in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended by the American Recovery and Reinvestment Act of 2009, and as otherwise amended from time to time and any and all of the requirements of any regulations promulgated thereunder (collectively, "HIPAA"). The HIPAA Privacy Officer will be responsible for ensuring that the system and electronic health information in the system is secured and compliant with HIPAA and promulgated regulations, as in effect from time to time, including, but not limited to, the federal privacy regulations as contained in 45 CFR Parts 160, and 164, the Electronic Transaction Standards (45 CFR Parts 160 and 162), the Security Standards (45 CFR Parts 160, 162 and 164), training mandates and applicable data breach notification requirements.

Through compliance activities, the Chief Compliance Officer will receive and generate hard copy, electronic records and information. Certain records will be kept for given periods of time because of law, regulation or contract obligations. Other records maintained or created will be retained or destroyed pursuant to a standard policy. Electronic Health Records will always be available and include the admission and discharge dates, as well as a history of client program activity.

This policy will help the Chief Compliance Officer manage the records of the Compliance Program in a manner that will promote the organization and integrity of the program. In addition, the policy will help protect the anonymity or confidentiality of consumers, employees or others who report problems or concerns to the Chief Compliance Officer or to other staff of the program.

Policy

1) Compliance records management is the responsibility of the Chief Compliance

Officer. For those programs that have manual records which have been used to assess compliance those records will be kept in a secure location and the confidentiality of consumers, employees and business operations and activities will be protected. Records that are no longer required to be kept under applicable federal and state law or are duplicative of other records maintained will be destroyed on a routine basis in accordance with applicable federal and state law using the standard procedures outlined below.

2) Records relating to a specific incident or report should be retained at least during the period the review or the investigation is ongoing. Otherwise, all records (with the exception of a summary of activities, findings and corrective actions) related to a specific incident that has been resolved should be destroyed on a periodic basis unless otherwise required by applicable state or federal law or the organization is advised to retain the records by corporate counsel.

3) Records relating to the Compliance Program including memoranda, meeting minutes and reports will be retained indefinitely in order to maintain a record of Compliance Program activities. These documents can be used by the organization to prove the existence of an active and effective Compliance Program.

Procedures

1) All records of the Chief Compliance Officer will be kept in secure locations. File cabinets will be locked when not in use and any electronic data or records will be protected by passwords or other security features.

2) Any information received via the hotline or any report of a potential problem and the records developed during the investigation of the potential problem will be maintained, at a minimum, until the matter is resolved.
   - All records relating to a particular incident or report will be kept together in a locked file cabinet or if in electronic form, secured through the Chief Compliance Officer's password.
   - All records related to information received by the Chief Compliance Officer or the hotline relating to an incident or potential problem (in either paper or electronic form) will be reviewed every 180 days. The Chief Compliance Officer will make the decision to destroy any records or set of records during this review only after all issues relating to a specific incident or problem have been resolved. Resolution includes the completion of any investigation or inquiry, implementation of any disciplinary actions, implementation of any corrective action and evaluation of the efficacy of the corrective action plan
   - Before destroying records of an investigation, the Chief Compliance Officer will prepare a summary of all material activities, lists of interviewees, findings and actions taken in light of findings.

3) In addition to records relating to reports, incidents or potential problems, during each review period the Chief Compliance Officer will also assess the need to retain other records (in both paper and electronic form) including correspondence, calendars, diaries, notepads, personal files, telephone message pads, chronological correspondence files and other similar materials.

4) If the Chief Compliance Officer should receive notice of any kind that an investigation is underway, she/he will take immediate steps to secure all relevant documents and/or to cease their destruction until notice that the investigation or any related litigation has concluded.

D. Medicaid Quality Improvement Team (a.k.a. Compliance Committee)

The Agency is committed to developing and operating an "effective" Compliance Program. The organization has, therefore, established the Medicaid Quality Improvement Team to assist the Chief Compliance Officer in the development, implementation, oversight and evaluation of the Compliance Program. The Medicaid QIT will be chaired by the Chief Compliance Officer and will meet quarterly.

The role of the Medicaid QIT includes, but is not limited to:

- assessing the impact of current and future Medicaid Regulations on Astor's day to day operations;
- working with the Chief Compliance Officer and Corporate Compliance Coordinator to develop any necessary changes for compliance;
- ensuring that Medicaid compliance is occurring throughout the agency;
- recommending solutions to barriers that may exist in the successful implementation of compliance activities;
- addressing issues regarding billing (private and Medicaid) that impact our ability to maximize our revenue and make recommendations on how to improve them;
- assessing the success of the Compliance Plan by reviewing compliance-related activities and recommending any needed updates to the Plan;
- addressing any compliance and billing issues that may present a risk to Astor and make recommendations on how to correct and prevent them from occurring;
- establishing and maintaining an open line of communication with the Central Quality Improvement Committee in order to ensure that recommendations and feedback are implemented in a timely manner.

The Chief Compliance Officer will inform the Medicaid QIT of any allegations and investigations of Medicaid fraud or abuse. However, prior to making a decision to share such information, the Chief Compliance Officer will consult the Assistant Executive Director of Quality & Clinical Outcomes; the Executive Director/CEO; and the Chief Financial Officer. The Medicaid QIT is expected to work with the highest level of confidentiality and members may be sought to provide information that can assist in making a determination on any pending investigations. The Chief Compliance Officer will also provide the Medicaid QIT with reports of any monitoring and auditing findings as necessary. As an advisory committee, the Medicaid QIT may provide feedback on the findings and make recommendations for corrective actions.

IX. Response and Prevention

The goal of our Compliance Program is to prevent and reduce the likelihood of improper conduct. Astor's response to information concerning possible violations of law or the requirements of the Compliance Program is an essential component of its commitment to compliance.

A. Investigations

Upon receiving a report or other reasonable indication of suspected non-compliance, the Chief Compliance Officer will initiate prompt steps to investigate the conduct in question and determine whether a material violation of applicable law or the requirements of the Program has occurred. An investigation will be conducted with one or several of the following:

- In conjunction with the programs/areas senior staff, Medicaid compliance staff, billing staff, and/or other appropriate staff who may have information about what might have occurred;
- Interviewing of individuals with potential knowledge of the matter;
- Review of the relevant documents (both manual records and Electronic Health Record);
- Engaging legal counsel, outside auditors or other experts to assist in the investigation.

Upon receipt of information concerning alleged misconduct, the Chief Compliance Officer will, at a minimum, take the following actions:

1) Notify the Executive Director/CEO; Chief Financial Officer; Assistant Executive Director, Quality & Clinical Outcomes, and service area Assistant Executive Director.
2) Ensure that the investigation is initiated as soon as reasonably possible but in any event not more than three business days following receipt of the information. The only exception is if relevant staff is on vacation or ill. The investigation shall include, as applicable, but need not be limited to:
    a) Interviews of all persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether or not a violation has occurred.
    b) Identification and review of relevant documentation including, where applicable, representative bills or claims submitted to the Medicaid Program, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.
    c) Interviews of persons who appear to play a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct, and may include, but shall not be limited to:
        - The person's understanding of the applicable laws rules and standards;
        - Identification of relevant supervisors or managers;
        - Training that the person received;
        - The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws
    d) Written transcript of interviews to be signed by the interviewer and interviewee attesting that everyone as written is correct.
    e) Preparation of a summary reports that (1) defines the nature of the alleged misconduct, (2) summarizes the investigation process, (3) identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws, (4) assesses the nature and extent of potential civil or canal liability and (5) where applicable, estimates the extent of any resulting overpayment by the government.
3) Establish a due date for summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and the appropriate disciplinary or corrective action is taken if warranted.

B. Corrective Action Plans and Implementation Reviews

Investigations

In the event the investigation identifies employee misconduct or suspected criminal activity, Astor Services for Children & Families will undertake the following steps:

1) Immediately cease the offending practice. If the conduct involves the improper submission of claims for payment, we will immediately cease all billing potentially affected by the offending practice.
2) Consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authority is warranted.
3) If applicable, calculate and repay any duplicate or improper payments made by a federal or state government program as a result of the misconduct.
4) When appropriate, handle any over payments through the administrative billing process by informing the billing staff and making appropriate adjustments via software used for billing.
5) Ensuring that any investigation and overpayment is finalized no later than 60 days after it was first identified. This ensures compliance with Federal and NYS laws.
6) We will initiate disciplinary action as noted in "Section VII – Enforcement and Discipline" of this Compliance Plan.
7) Promptly undertake appropriate training and education to prevent a recurrence of the misconduct.
8) Conduct a review of applicable Astor Policies and Procedures to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.
9) Conduct, as appropriate, follow-up monitoring an audit to ensure effective resolution of the offending practice.

Audit Findings

We will use the Electronic Health Record and Medicaid Audit Checklist as our primary tools for determining compliance. The following will be the process for reporting audit findings:

1) The Chief Compliance Officer will provide a report to Executive Director/CEO, CQI Committee, Medicaid QIT and the appropriate Assistant Executive Director, that includes charts and narrative to show increases or decreased of failed activities or claims, lack of timeliness of treatment plans and treatment plan reviews, billable units and productivity data, as well as utilization reviews;
2) The Chief Compliance Officer or Corporate Compliance Coordinator will provide to the Assistant Executive Director of each service area specific details from the Electronic Health Record and Medicaid Audit so that the appropriate staff have the opportunity to correct errors. This will provide billing staff the opportunity to make adjustments where errors in billing occurred. Errors may only be corrected as long as they are in compliance with Astor's Compliance Plan Code of Conduct and within the allowable federal and state regulations;
3) If applicable, Astor Services for Children & Families will calculate and repay any duplicate or improper payments made by a federal or state government program as a result of the non-compliance;
4) The Chief Compliance Officer will ensure that any repayment is done no later than 60 days after the audit findings;
5) When ongoing patterns of non-compliance are exhibited or the lack of compliance in an area requires a large overpayment, the Chief Compliance Officer will request that a corrective action plan be submitted to him/her which details steps the program/service area will take in preventing similar non-compliance activities from occurring in the future.
6) The Corporate Compliance Coordinator will complete reports and provide to Chief Compliance Officer for review.
7) The Corporate Compliance Coordinator will work with service area staff to ensure corrective action plans are completed and monitoring will occur based on CAP.
8) In the event that the non-compliance occurs in Astor's billing practice, the Chief Compliance Officer will create a report that explains the current practice, why it is

non-compliant and what the practice should be moving forward. Such report will be provided to the Chief Financial Officer, appropriate billing staff and Medicaid QIT.

9) Conduct, as appropriate, follow-up monitoring an audit to ensure effective resolution of non-compliance findings;
10) It will be the responsibility of the Assistant Executive Director of each service area, through prompting by the Chief Compliance Officer, to address implementation of correction action activities and/or other implemented changes that minimize risk and address non-compliance. This will be done as part of the CQI meetings.

C. Central Quality Improvement Team

The Central Quality Assessment and Improvement Committee is responsible to develop, implement and evaluate a plan for quality assessment and improvement activities throughout the Agency. The CQA&I Committee meets on a monthly basis to review reports from Program Quality Assessment and Improvement Committees including the Chief Compliance Officer and/or Corporate Compliance Coordinator. The Chief Compliance Officer is a member of this committee and will provide information not only on Medicaid QIT meetings and activities, but on findings and corrective actions from audits and investigations.

The Central Quality Assessment and Improvement Committee has the authority to require further information from and/or remedial action by a Program Quality Assessment and Improvement Committee or from the administrator responsible for the program in question, and it is authorized to institute surveillance, preventive, control measures or studies when there is reason to believe that client or personnel welfare may be in danger.

The Compliance Officer will coordinate all pertinent issues or recommendations arising from the operation of Astor's Compliance Program with the CQA&I Committee to ensure that operational policies, procedures, vendor contracts, job descriptions, and related documentation concerning Astor's programs are created and modified as needed to ensure compliance with governmental expectations and legal requirements. Such coordination will include assuring appropriate risk assessment and testing of the integration of all policies and procedures with Astor's Electronic Health Records systems as well as security assessments as required under HIPAA.

D. Reporting to the Executive Director/CEO and Board of Directors

The Chief Compliance Officer will report investigations to the Executive Director/CEO within 1 – 2 days of having received a possible fraud, waste or abuse allegation. The Executive Director/CEO along with the Assistant Executive Director, Quality & Clinical Outcomes and the Chief Compliance Officer will determine how to report it to the Board of Directors.

Through verbal reporting, the Executive Director/CEO will immediately be aware of the outcome of any investigations. However, a formal report, as noted previously, will also be provided to the Executive Director/CEO.

At least twice a year the Chief Compliance Officer will provide a report to the Board of Directors through the Performance Oversight & Monitoring Committee of the Board, which includes all investigations and their status. She/he will also provide to them the audit findings from any reviews that have taken place throughout the year, as well as corrective actions that have been implemented. The Chief Compliance Officer will provide investigation and auditing finding updates to the Board's Performance Oversight and Monitoring Committee during their bi-monthly meetings.

In the event the Chief Compliance Officer believes the Executive Director/CEO and/or the Chief Financial Officer are involved in non-compliant activities, the Chief Compliance Officer

can directly report to the Chair of the Board of Directors his/her concerns.

X. Outside Legal Counsel

Outside legal counsel is available to assist the Executive Director/CEO, Board of Directors, Chief Financial Officer and Chief Compliance Officer as needed to identify and interpret federal and state laws and regulations in the Corporate Compliance Plan.

Outside legal counsel may be notified at the discretion of the Executive Director/ CEO of incidents that have a reasonable cause to support the assertion of non-compliance at which time the Chief Compliance Officer will be responsible for facilitating an investigation. The results of the investigation will be used by legal counsel to provide legal advice to the Chief Compliance Officer and Astor Services for Children & Families.

XI. Assessing Effectiveness of Astor's Compliance Program

The Chief Compliance Officer is responsible for ensuring that the Electronic Health Records system shall conform and be adaptable to any applicable federal and state laws or federal health care program requirements. The Chief Compliance Officer is responsible for ensuring that the system protects the user and patient from potential user errors. The Chief Compliance Officer may conduct a user interface validation test of the system as necessary, with users performing representative tasks to observe, record and categorize successful, successful with issues or problems, or unsuccessful based on certain criteria that define success. To the extent practicable, the Agency will seek to use the Electronic Health Records system to achieve the meaningful use objectives and measures set forth under federal law.

Every December Astor is expected to certify to the NYS Office of the Medicaid Inspector General (OMIG) that we have an "effective compliance program" in place. In order for us to certify to our effectiveness Astor has used various tools that the OMIG has put forth to help providers in this process. We use a Self-Assessment Tool (see Appendix D), which basically addresses all of the required elements that are supposed to be in our Compliance Plan and whether we are or have implemented them throughout the agency. The assessment tool is completed yearly by the Chief Compliance Officer and Corporate Compliance Coordinator, and the findings are shared with the CQI committee. In addition, the Medicaid QIT members as a group also complete the assessment tool. The outcome of this assessment is used to update our Plan and implement new systems that address any deficiencies in our compliance program.

In July 2011, the OMIG's Bureau of Compliance published a checklist (see Appendix E) to identify for Medicaid providers documentation that OMIG may request at the time of an effectiveness review. The form is an example of the types and kind of information that the Bureau will review. Astor's uses this checklist as another way of assessing the effectiveness of the compliance program.

XII. Conclusion

The Corporate Compliance Plan has been prepared to outline the broad principles of legal and ethical business conduct embraced by Astor Services for Children & Families. It is not a complete list of legal or ethical questions you might face in the course of business. Therefore, this plan must be used together with your common sense and good judgment.

If you are in doubt or have a specific question, you should contact your supervisor or the Agency

Chief Compliance Officer.

Appendix A: Service Area Compliance Plans

Bronx Service Area

Purpose of the Plan

The purpose of this Plan is to develop a Bronx service area Medicaid Compliance Plan that fits within the scope and parameters of the Agency's Corporate Compliance Plan. This Plan is a document that ensures all programs in the Bronx area are aware of two things: the importance of compliance with Medicaid state and federal regulations, as well as regulatory agencies; and the compliance review and auditing process we use to ensure compliance. Ultimately, this Plan helps the Bronx minimize payment discrepancies, reduce billing errors, and provide systemic checks that raise the quality of service and support office operations throughout all of our programs.

Stakeholders

To ensure that Bronx programs maintain this commitment, our compliance plan reaches across several programs and agencies to various stakeholders' .These stakeholders are:

- Administrative Staff –Assistant Executive Director (AED), Directors, Program Directors;
- Clinicians- this includes anyone responsible for providing clinical care, creating and updating treatment plans, and completing documentation via the Electronic Health Record or hard copy that will be used to bill for services.
- Medical and Health Care staff – Psychiatrists, nurse practitioners, nurses, licensed practical nurse, speech therapists, occupational therapists, and physical therapists.
- Support Staff- Medicaid Compliance Coordinator, office management, and billing;
- The New York State Office of Mental Health (NYSOMH);
- New York City Department of Health and Mental Hygiene (NYCDOHMH)
- New York City Department of Education

Administration supports the direct service personnel with the information, resources and insight needed to keep their documents compliant. Clinicians create, maintain and keep important documentation that ensures the organization remains compliant and bills accurately. The support staff submits billing to receive funds from Medicaid and reviews clinician records for compliance errors. Each group of stakeholders oversees important key elements that allow the Plan to be executed effectively. Lastly, we are accountable to the NYSOMH and NYCDOHMH. These governmental entities set treatment and operational standards to ensure that all our clients receive the highest quality of care and that Astor maintains fiscal integrity.

Astor Corporate Compliance Plan

The Bronx service area Compliance Plan complements the Agency's Corporate Compliance Plan in two ways. First, Bronx programs adhere and enforce the Corporate Compliance Plan Code of Conduct. Refer to Roman Numeral II page 4 in the Agency's Corporate Compliance Plan, to review the Code of Conduct. Second, the plan was written to highlight the duties of the Director of Operations and Medicaid Compliance Coordinator (MCC) who is integral to maintaining compliance standards as set forth by the Chief Compliance Officer in the Agency plan.

Director of Operations

The responsibilities of the Director of Operations DOS are listed below. The DOS:

- Supervises the work and deliverables of the MCC
- Works with the MCC and Program Directors to ensure that corrective action plans are in place to address Medicaid errors.
- Co-develops and implements new compliance initiatives.
- Submits monthly aggregate reports on the MCC's compliance findings for all programs to the Corporate Compliance Officer and to the Chief Financial Officer.
- Receives and reviews the aggregate utilization review data from the MCC and sends a report to the Corporate Compliance Officer.
- The Director of Operations supervises the Medicaid Compliance Coordinator Supervision consists of:
- Reviewing work performance monthly.
- Evaluating audit reviews and work deliverables.
- Helping resolve any outstanding compliance-related issues or conflicts.

Supervision occurs on a consistent basis to give the MCC time to address outstanding compliance issues and to provide the Director of Operations the opportunity to continually evaluate the compliance work plan.

In addition, the Director of Operations is responsible for ensuring that all Bronx programs are in compliance with all of the aspects of the Agency Corporate Compliance Plan and the Bronx Medicaid Compliance Plan and for "closing the loop" on areas needing corrective action and ongoing monitoring. The Director of Operations reports at the monthly Program QA meetings and to the Bronx AED. The Medicaid Compliance Coordinator is responsible to address to the Corporate Compliance Officer and Corporate Compliance Coordinator on all compliance issues.

Duties of (Medicaid Compliance Coordinator) MCC

The responsibilities of the Medicaid Compliance Coordinator (MCC) are listed below. The MCC:

- Ensures all clinical service documents meet New York State and federal criteria for billing compliance;
- Conducts internal audits of all clinical service documents at the following sites that bill Medicaid.
- **DT:** Byron, Little Red School House, Tilden DT, and P.352,
- **OPC**: Tilden, Highbridge, Middle Schools (5 in total), Elementary Schools Satellites (3 in total) and 2 Foster Care Satellites

- Generates reports based on audit findings

- Notifies Chief Compliance Officer, Corporate Compliance Coordinator, AED, program/site directors and Director of Operations of non-compliance contained in the case record that need correction and could potentially cause citations during a regulatory review from a licensing agency or Medicaid;

- Sends monthly audit finding reports to Program/Site Director, Deputy Directors, and Director of Operations, Chief Compliance Officer and Corporate Compliance Coordinator.

- Tabulates aggregate Utilization Review data and send information to the Director of Administrative Services.

- Participates in Medicaid Quality Improvement Team.

- Generates weekly reports from the EHR to check for failed activities, failed claims, scheduled services with no status, weekly progress note documentation, unsigned documents, missing TPR's, and an array of other reports that assist in assessing compliance.

- The Medicaid Compliance Coordinator reports to the Director of Operations. The DO is responsible for the work the MCC does in each program. The t Medicaid Compliance Coordinator must:

- Send audit finding reports to the Director of Operations

- Submit the completed site checklists to the Director of Operations

- Work with the Director of Operations to ensure corrective action is taken for Medicaid errors reported at the sites.

Medicaid Compliance Coordinator:

To ensure that each site is given a proper review, the Bronx has a Medicaid Compliance Coordinator to cover the north and south sites. The Medicaid Compliance Coordinator is responsible for the following sites: Byron, Little Red School House, Tilden DT, P. 352 ,Tilden OPC, Highbridge OPC, Middle School Satellites (5in total), Elementary School Satellites (4in total) and 2 Foster Care Satellite.

Compliance

Chart reviews are conducted by the MCC . The MCC reviews the electronic health record or in some instances where information is kept in a hard copy (the chart) to verify that clinical documentation meets the expected compliance standards from Medicaid and regulatory entities.
Utilization reviews are to be conducted 30 days from admission and every 6 months thereafter. They are completed by someone outside of the treatment team and it is expected that at least 30% of all active Medicaid cases are reviewed based on the review period set forth by our regulators. These utilization reviews are conducted to determine if the child is receiving the appropriate level of care and if there is medical necessity that warrants their continued stay in our program.
The electronic health record also has a level of internal compliance error checks that assist us in ensuring that documentation is being completed in a timely manner and that it includes the

elements required by our regulatory bodies.
All compliance activities drive our Bronx compliance efforts, and give us valuable information to provide the highest quality of care.

Outpatient

There are two primary licensed locations for outpatient clinic services: Tilden and Shakespeare (a.k.a. Highbridge). Clinical, medical, and health staff provided behavioral health services at these locations. Our Shakespeare location also has multiple satellites within school settings where we provide clinical services.

The electronic health record has afforded us the opportunity to conduct compliance without having to travel to multiple locations. We also have an integrated clinical and billing component that allows us set-up compliance business rules, which are triggered whenever incorrect or incomplete information exist in the record.

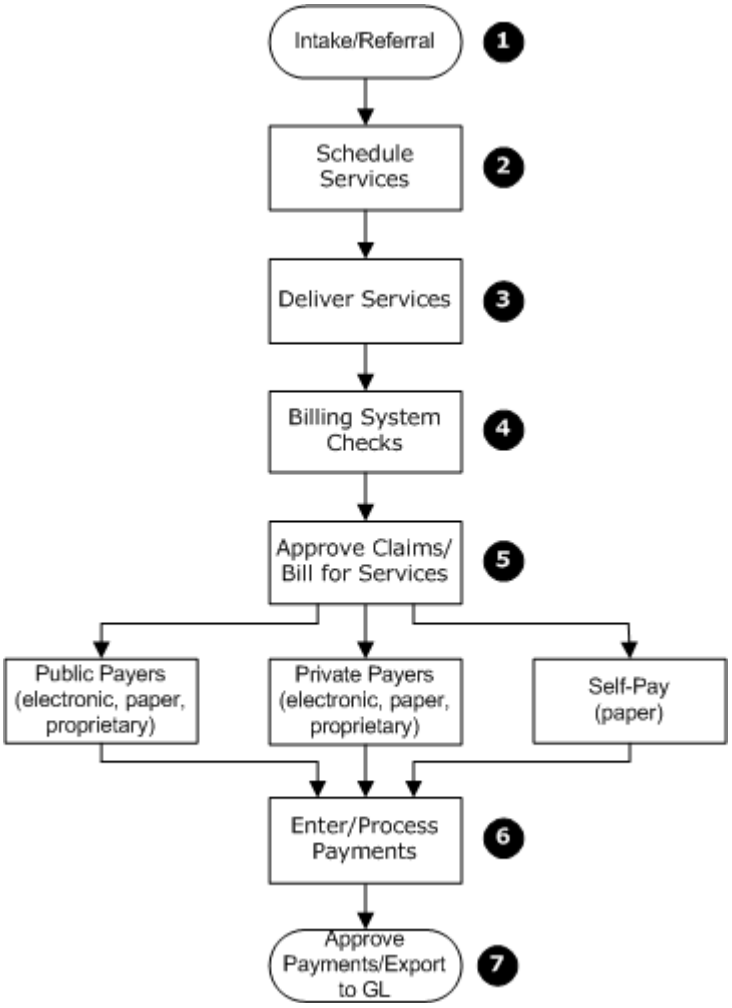
We have business rules set up so that a service that has been documented does not get billed unless an active treatment plan is in place. We also have rules that allow us to see if clients have been scheduled for services but documentation was not completed, if documentation was completed but not signed, if the client does not have a diagnosis in place, and an array of other "error checks".

Audit Tool

We continue to use an audit tool to check for compliance components that may not be getting captured by our electronic health record or are not easily accessed via compliance data and reporting. The audit tool is used in conjunction with various EHR reports.

Centralized Billing

In an effort to enhance the Bronx's capacity to standardize billing processes and protocol, the Bronx has centralized their for the outpatient clinics, the clinic satellites. Now with CareLogic the process has changed the workflow that you can find below:



Day Treatment Billing Review

Day Treatment billing is based on attendance days for each child enrolled in the program and on supervisory review of clinical documentation. Attendance is taken twice each day by both Astor and the Department of Education staff to ensure attendance is accurate. In supervision, each supervisor, using a compliance monitoring checklist, reviews the weekly note for each child, and matches it to the weekly attendance record for that child and ensures that the treatment plan is current and has the required signatures. The supervisor signs the compliance monitoring check list. All check lists are then reviewed by the Program Director who certifies compliance and "authorizes" billing for that week via an attendance certification letter that is sent to the primary biller who then bills for all clients that were not excluded. Collaterals are sent to the primary biller on a monthly basis.

Day Treatment can bill for a full day half day, brief day and/or a collateral visit. The type of billing depends on the length of time the child was in the program on any given day (full day half day, brief day). The electronic health record is set-up to be able to bill these 3 levels of attendance once the staff has entered into the system the data required. Collateral billing is done via the electronic health record once the staff completes the required documentation

Chart Review Auditing

The MCC review occurs on three levels: current cases and discharges. For current cases, the MCC reviews a sample of cases monthly that are a portion of the total site census. This process enables the MCC to cycle through all the charts at a site in a 12 month period. For example, one of our Day Treatment sites has 96 children, and each child has a case record. The MCC must look at seven (7) cases a month to review all the charts in a year. Discharge records are reviewed depending on when the last compliance audit took place. If a case was discharged within 90 days of the last audit, an informal audit will be conducted. An informal audit consists of the MCC making sure all documentation is signed and TPR's are signed without using the audit tool. If a case exceeds the 90 days the MCC will conduct a full audit using the audit tool.

The MCC reviews the chart via the electronic health record. To determine if the clinical documents are meeting expected Medicaid regulations, the Bronx Medicaid coordinator use a Medicaid Audit Checklist of information that is required but not easily accessible or captured via the electronic health record.

Reporting

A report is generated for each site, which includes a summary of findings. The summary report contains a detailed synopsis of what was found at the site and includes the initial checklist from the audit.

The summary report for each site is sent to the Chief Compliance Officer, Corporate Compliance Coordinator, AED, Program/Site Director, Deputy Directors and Director of Operations. All of the data from the summary reports are compiled across the sites by the Director of Operations and sent to the CFO and Chief Compliance Officer.

The Chief Compliance Officer reviews the report to identify trends and patterns. If there are systemic problems or outstanding issues, the Chief Compliance Officer begins the investigation process to determine the root cause and takes appropriate action as set forth in the Corporate Compliance Plan.

Reports are reviewed on a monthly basis among top management staff at Tilden during QA or a specified time determined by the Director of Operations or the Assistant Executive Director. Information from the report is used to determine if there are any systemic or program changes that need to be implemented that can make the overall billing and clinical documentation process more effective and efficient. The Program/Site Director, Director of Operations , and the Deputy Directors review the corrective action plan and monitor the process closely to see if the plan works well or needs to be modified.

Audits and audit findings are conducted and reported once a month respectively.

Out Patient Clinic tracking:

1) The OPC short tool must be filled out and completed for each audit

2) Each week the following reports will need to be run;
    - **Service Documents Unsigned Report-** MCC will report out how many documents are showing up on the report, how of each document type are unsigned, how many unsigned documents per week and how long have they been unsigned, and how many documents have been unsigned for more than 90 days. MCC will report this out on a weekly basis.
    - **Activities: No Status Report-** MCC will report how many scheduled visits for the week without status and how many status visits have been on the list for more than 2

days. Visits that have no status for longer than 2 days, it should be addressed with the supervisor/provider so that it can be rectified.

- **Failed Activities Report-** MCC will report out each week the specific activity that has an error, report if no errors occurred, type of error, # of errors happening each week, # of failed days (how long has this note had an issue) and also tracking if the note is over 90 days and older, which means it cannot be billed. If notes are near the 90 day mark the MCC should email or make the supervisor and provider aware of the issue.

- **Failed Claims Report-** MCC will report the type of failed activity, the specific error, the amount to be billed for those error types (ex: service documents not found=$4,000), the total # of claims with issues for the week (ex: 50 issues=$20,000), # of service days that the error has been on chart, and tracking if the note is 90 days or older, which means it cannot be billed (unbillable services.) Example:

How the service has has an error?	1-30 days	31-44 days	45-59 days	60-75 days	76-89 days	90 days or over
No active Treatment Plan	10	12	1	7	3	5
No Diagnosis	2	0	1	0	0	0

- **Active Clients Report-** This report will be run twice, once for OPC and once for OPC-Pre and this report should be run at least once per month. The goal is to make sure that the active client list is updated/correct and matches the data the MCC is reviewing. If a client is found on the active client list who has been discharged but did not have the proper transfer/discharge summary, MCC must track how many of these he/she finds. If upon investigating the active client list, it appears that there are active clients on the list who have in fact been discharged, an email needs to be sent to the supervisor to remove the client from the active list by completing the proper transfer/discharge summary.

Data from the reports will be reported out on the OPC EHR data spreadsheet to Corporate Compliance Coordinator on a weekly basis. MCC will also errors/notes that appear on this report should be addressed with the supervisor/provider.

Day Treatment Clinic Tracking

1) The Day Treatment short tool must be filled and completed for each audit
2) Each week the following reports will need to be run:
   - **Active Client Report-** This report will be run twice, once for Day Treatment and once for Day Treatment Pre-Admission, MCC will report out how many active clients are on the active client list for that reporting week. How many clients on an active list are missing ex: If there are 55 clients on the active list but only 40 notes are present on the weekly progress note report. If a client is found on the active client list who has been discharged but did not have the proper transfer/discharge summary, MCC must track how many of these he/she finds. If upon investigating the active client list, it appears that there are active clients on the list who have in fact been discharged, an email needs to be sent to the supervisor to remove the client from the active list by completing the proper transfer/discharge summary
   - **Service Documents Unsigned Report-** MCC will report out how many documents are showing up on the report, how of each document type are unsigned, how many unsigned documents per week and how long have they been unsigned, and how many documents have been unsigned for more than 90 days. MCC will report this out on a weekly basis.

- **Failed Activities Report-** MCC will report out each week the specific activity that has an error, report if no errors occurred, type of error, # of errors happening each week, # of failed days (how long has this note had an issue) and also tracking if the note is over 90 days and older, which means it cannot be billed. If notes are near the 90 day mark the MCC should email or make the supervisor and provider aware of the issue.
- **Failed Claims Report**- MCC will report the type of failed activity, the specific error, the amount to be billed for those error types (ex: service documents not found=$4,000), the total # of claims with issues for the week (ex: 50 issues=$20,000), # of service days that the error has been on chart, and tracking if the note is 90 days or older, which means it cannot be billed (unbillable services.) Example:

How the service has has an error?	1-30 days	31-44 days	45-59 days	60-75 days	76-89 days	90 days or over
No active Treatment Plan	10	12	1	7	3	5
No Diagnosis	2	0	1	0	0	0

Response

Once the Program Director receives their summary report, if there are outstanding errors and these problems can be corrected without violating any Astor, Medicaid or regulatory policy or law, then it is the responsibility of the Medicaid Compliance Coordinator to ensure that the Program Director corrects these problems. The Program/Site Director has fifteen (15) days to make corrections. At the end of this period, the Program Director contacts the MCC to state that the corrections are complete. The MCC must return to the charts to verify that the corrections are adequate. In the event a Program Director is non-responsive, the Director of Operations and the Deputy Director contact the Program Director to ensure the Program Director makes the corrections.

Communication & Changes in Service Area Compliance Plan

To assure that all stakeholders are aware of the Plan we will employ different communication strategies. The strategies consist of the following:

- Annual Review-An initial review of the Bronx Compliance Plan beginning with the Program QA in the fall of 2013 and annual review thereafter.
- Disseminate Plan via email to Astor stakeholder's i.e. administrative staff, clinicians and support staff.
- All Astor stakeholders sign a copy of the Compliance Plan for the Bronx and return it to Director of Operations and Corporate Compliance Officer.

To communicate changes to the plan, Astor at Bronx will:

- Disseminate document via email to all Agency stakeholders' i.e. administrative staff, clinicians and support staff.
- Inform Program Directors of plan changes and request that they notify staff.

- Make the Plan available via shared or public folder.

In addition, we recognize that communication is dynamic within our organization. The MCC may communicate changes to the Compliance Plan or it may come from the Director of Operations. The DO will communicate any changes at monthly QA meetings. In the event, communication comes from the MCC it will be by email and/or face-to-face.

Also, any new personnel, vendors or partners will receive the Compliance Plan during orientation or the procurement process. With the Plan, they will receive training about the importance of the Plan and the regulations they must follow.

Conclusion

The Astor Bronx service area uses this Compliance Plan to ensure that all Bronx staff is aware of the need for compliance and its importance in our day to day activities. The Medicaid Compliance Coordinator works in collaboration with the Corporate Compliance Coordinator and Chief Compliance Officer, so that any corrective actions that stem from our reviews and reports are within the expectations of the overall Astor Corporate Compliance Plan.

Utilization Review for Bronx programs OPC and Day Treatment

Purpose: To insure that the Bronx programs meet the regulatory requirement of utilization reviews in 25% of all active case records.

Staff: Compliance Coordinator, Deputy Director for Bronx OPC programs, Deputy Director for Bronx Day Treatment programs, Highbridge Program Director, Highbridge Clinic Supervisor, Lawrence F. Hickey Center Clinical Director, Tilden Day Treatment Program Director, Byron Day Treatment Program Director, P. 352x Adolescent Day Treatment Site Director

Highbridge and Tilden OPC's:

1) Compliance Coordinator will, on a weekly basis, forward Highbridge and Tilden OPC "Admission Report" to the Deputy Director of the Bronx OPCs. Compliance Coordinator will, at the same time, forward the report of due Continued Stay Reviews (CSR) obtained from the "Bronx UR List" on the 'U' drive of the Astor server.

2) The Deputy Director has 5 business days to complete Admission Criteria Review (ACR) and Continued Stay Review (CSR) utilization reviews in Carelogic on identified clients.

3) Once step #2 is completed, the Deputy Director forwards the outcomes of the UR process to the Compliance Coordinator, identifying by name the clients for whom ACR and CSR were performed, and which clients were discharged and/or are currently in the discharge process.

4) The Compliance Coordinator records the names of clients with completed UR's on a tracking spreadsheet (which will calculate the due date of the next CSR), and saves the spreadsheet on the 'U' drive of the Astor Server in the Compliance Folder (CACPM Storage), in a subfolder labeled "Bronx UR List." At any time, the "Bronx UR List" can be retrieved to identify clients with UR's.

5) Compliance Coordinator runs "Active Client List" on weekly basis to determine census and make UR threshold calculation.

Highbridge School Satellite Programs:

1) Compliance Coordinator will, on a weekly basis, forward Highbridge School Satellite "Admission Report" to the Program Director of the Highbridge Clinic. Compliance Coordinator will, at the same time, forward the report of due Continued Stay Reviews (CSR) obtained from the "Bronx UR List" on the 'U' drive of the Astor server.

2) The Highbridge Program Director will delegate and oversee UR completion process to the Highbridge OPC Clinical Supervisor, who has 5 business days to complete Admission Criteria Review (ACR) and Continued Stay Review (CSR) utilization reviews in Carelogic on identified clients.

3) Once step #2 is completed, the Highbridge Program Director forwards the outcomes of the UR process to the Compliance Coordinator, identifying by name the clients for whom ACR and CSR were performed, and which clients were discharged and/or are currently in the discharge process.

4) The Compliance Coordinator records the names of clients with completed UR's on tracking spreadsheet (which will calculate the due date of the next CSR), and saves the spreadsheet on the 'U' drive of the Astor Server in the Compliance Folder (CACPM Storage), in a subfolder labeled "Bronx UR List." At any time, the "Bronx UR List" can be retrieved to identify clients with UR's.

5) Compliance Coordinator runs "Active Client List" on weekly basis to determine census and make UR threshold calculation.

Persons Responsible for Completion of the Utilization Reviews

-Deputy Director for Bronx OPC Programs is responsible for completing Utilization Reviews for Tilden OPC and Highbridge OPC.

-The Highbridge Program Director & Highbridge Clinical Supervisor is responsible for completing Utilization Reviews for all Highbridge Satellite Schools & Foster Care Satellites.

Bronx Day Treatment

In the Bronx Day Treatment Programs, Utilization Reviews are completed within 30 days of a client's admission if they are to be added to the program's Utilization Review List and every 6 months thereafter, occurring in January and July. *Although the regulations state that we are to complete utilization reviews on 25% of active cases, the Bronx Day Treatment programs aim to complete 30 -35% due to program attrition.*

Intake Coordinators and/or Program/Site/Clinical Directors notify the Compliance Coordinator of new admissions. If the sites do not have 25% of their total census on the Utilization Review List the Compliance Coordinator adds the following information to The Bronx Day Treatment Utilization Review List located on the Bronx Server (*Folder Name "CACPM Storage", in the "Bronx UR List" subfolder*).

- Client Name
- Admission Number
- Admission Date
- Date of Completion for the Admission/Continued Stay Reviews

The Compliance Coordinator obtains a monthly census of the sites to determine if programs are

in compliance with the required amount of Utilization Reviews. This information is sent to all Program/Site/Clinical Directors and the Deputy Director for review.

Persons Responsible for Completion of the Utilization Reviews:

- Tilden's Program Director is responsible for the completion of Lawrence F. Hickey Center.
- P. 352x's Site Director is responsible for the completion of Tilden Day Treatment.
- Lawrence F. Hickey Center's Clinical Director is responsible for the completion of P. 352x.
- Byron's Program Director and Team Leaders are responsible for completing the Utilization Reviews for Byron for which they are not a member of the treatment team.

HUDSON VALLEY PROGRAMS

Purpose & Goal of the Plan
The purpose of this plan is to develop a Medicaid compliance plan that works in conjunction with the agency Corporate Compliance Plan. Specifically the Hudson Valley Community Based Behavioral Health and Prevention Services has its own compliance plan to review charts to ensure proper documentation exists for all sessions/services that are billed to Medicaid and other entities. This plan will ensure that the Hudson Valley programs reduce errors in billing and raise the quality of service.

Astor Corporate Compliance Plan
The billing and auditing procedures of the Hudson Valley programs that have been established are specific to its programs needs and is in keeping with the Agency's Corporate Compliance Plan. Staff of this service area are to abide by the Agency's Corporate Compliance Code of Conduct. The Electronic Health Record will be used to generate reports which will assist the service area in monitoring compliance. In addition, any compliance areas that are not being addressed by the EHR will have a mechanism of getting reviewed either the compliance staff or through the QA process. Any systematic or ongoing issues related to compliance that are reflected in the monitoring of the data in the EHR will be presented at the Quality Improvement meetings and corrective actions will be expected.

Communication and Changes in Plan
Communication of this plan and changes that may occur are done via the monthly Hudson Valley Quality Assurance and Improvement meeting. The members of this meeting are comprised of the Associate Executive Director, the Coordinator of Quality & Clinical Outcomes and Program Directors of this service area. Information is then disseminated to line staff. Any changes to the Plan are to be approved by the Chief Compliance Officer and final versions will be included in the agency's Corporate Compliance Plan as an attachment.

Duties of the Hudson Valley Coordinator of Quality & Clinical Outcomes
The duties of the Coordinator of Quality & Clinical Outcomes in relation to the Medicaid Compliance Analysts and Utilization Reviewer consist of, but are not limited to:

- Providing direct supervision including but not limited to reviewing work performance and helping to resolve any issues or conflicts.
- Receiving monthly aggregate reports from the Medicaid Compliance Analysts.
- Receiving monthly UR reports that include Admission, Continued Stay and Discharge URs completed as well as UR percentages for all programs.
- Communicating on a regular basis with the Associate Executive Director on compliance

findings and corrective actions.

- Participates in Medicaid Quality Improvement Team.

Duties of Medicaid Compliance Analyst (MCA)
Under the direct supervision of the Coordinator of Quality & Clinical Outcomes, the Medicaid Compliance Analysts:

- Have a primary role of reviewing charts to ensure compliance with OMH and OCFS regulations.
- Submit timely reports based on findings.
- Notify Program Director of non-compliance contained in a case record that need correction and could potentially lead to pay backs.
- Look for trends of non-compliance which may lead to further training needs.
- Send monthly reports to Coordinator of Quality & Clinical Outcomes, Associate Executive Director, Chief Compliance Officer and Corporate Compliance Coordinator.
- Provide support and reports on special assignments.
- Participate in Medicaid Quality Improvement Team.

Duties of the Utilization Reviewer (UR)
Under the direct supervision of the Coordinator of Quality & Clinical Outcomes, the Utilization Reviewer:

- Has a primary role of analyzing client records to determine legitimacy of admission, treatment and length of stay to ensure that the Hudson Valley Programs are in compliance with all regulatory and Medicaid billing requirements.
- Participates in program team/staff meetings (as appropriate) to address findings and concerns regarding medical necessity based on URs.
- Maintains a systematic and effective tracking system to ensure that a minimum number of records are receiving utilization reviews (URs).
- Submits timely reports to Program Directors, Associate Executive Director and Coordinator of Quality & Clinical Outcomes based on the number of URs conducted by program and findings.
- Provides support and reports on special assignments.

Audited Hudson Valley Programs

Outpatient Counseling Centers (OPCs)
Astor Counseling Centers provide services to children and adolescents (ages 2-21), and their families

through outpatient counseling, psychiatric services and case management throughout Dutchess and Ulster Counties.

Day Treatment

Astor's School Age Day Treatment Program (SADT) is an intensive, highly structured, school-based treatment program. An interdisciplinary team of trained professionals provides mental health and educational services to emotionally disturbed children ages 5 to 12. The program utilizes a holistic approach for developing the social, emotional, and educational needs of our children through a nurturing and supportive environment.

Preschool Day Treatment provides educational and therapeutic services for children with emotional disturbances and/or behavioral problems who require participation in a structured day program in order to enable the child to return to a less-restrictive pre-school setting.

Intensive Case Management (ICM)/Supportive Case Management (SCM)

Case management services are those services which will assist children and adolescents (age 5-17) with serious mental illness to obtain needed medical, social, psychosocial, educational, financial, vocational and other services. Children and adolescents with various diagnoses whose emotional disability disrupts their ability to function without intensive intervention by the mental health care system. These children and adolescents will demonstrate serious deficits in functioning in the educational, social, vocational and interpersonal spheres of their lives. A major goal of this population is to avoid unnecessary institutionalization and hospitalization.

Waiver

The goal of the Waiver program is to serve seriously emotionally disturbed (SED) children in their family and community, in the least restrictive environment. The target population is SED children and adolescents between the ages of 5 and 17; at imminent risk for institutional placement at an RTF level of care or intermediate psychiatric hospitalization (RCPC). The family must be able to provide a viable and supportive environment for community based care.

Bridges to Health (B2H)

Bridges to Health is a program for children in foster care with complex medical, developmental or mental health conditions. Services begin while the child is in foster care and can continue after the child leaves care. The goal is to keep the child in the community by offering services and support for the child and their caregiver, which could help to avoid institutionalization or hospitalization.

Partial Hospitalization (PHP)

The Astor adolescent Partial Hospitalization Program offers an intensive treatment program designed to keep adolescents in the community and prevent inpatient hospitalization. The PHP program uses intensive group, individual and family therapy to stabilize the adolescents' symptoms and avoid inpatient admission.

Home Based Crisis Intervention (HBCI)

This program is an intensive in-home treatment of children & youth who are at imminent risk of psychiatric hospitalization. HBCI provides intensive individual and family therapy in the home as well as parent counseling. Families receive a minimum of 2 home visits per week and the therapist is on call to the family 24/7 for crises.

Therapeutic Foster Boarding Home (TFBH)

This program provides mental health services/treatment for SED children within a family therapeutic environment with specially trained professional foster parents. Also, the program provides related services to the children's families to help prevent the need to place the child in a more restrictive treatment setting and to work toward the child returning to the natural family or successfully moving into independent living. Target populations are residents of Dutchess County or the greater Mid-

Hudson region between the ages of 5-17 and who are at risk of placement into a more restrictive setting.

Auditing

New B2H Staff:
New staff's paperwork will be monitored closely by their supervisor for the first two months until the supervisor feels that they are trained and compliant in all areas.

Existing B2H Staff:
The B2H audit tool is broken up into two sections, fiscal findings and compliance findings.

The supervisors will review six charts per month from their staff's caseload using the compliance portion of the audit tool. The supervisor will forward their findings to the Health Care Integrator (HCI) and Waiver Service Provider (WSP) supervisor, if applicable with a due date for corrections to be completed.

MCA reviews charts using the fiscal portion of the audit tool. The MCA generates a report (a list of the claims that have been submitted to Medicaid and posted to accounts receivable) from Accumedics within one week after the billing process has taken place. If the MCA does not have access to Accumedics they will receive a monthly report from the billing department. The MCA then uses the report to reconcile all B2H billing from the previous month. QA also reviews each staff's charts on a rotating basis and/or upon request from a Supervisor or the Program Director. The MCA uses an audit checklist to follow specific requirements to ensure charts are compliant. All checklists have been approved by the Agency's Chief Compliance Officer.

QA forwards their findings to the HCI supervisor, WSP supervisors (if applicable) and the Coordinator of Quality and Clinical Outcomes. The HCI supervisor and WSP supervisors then forward the tool to the HCI/WSP with a due date for corrections. All charts reviewed, due dates and a date verifying that the corrections were made are recorded in the B2H Shared Folder. The HCI then brings the charts and audit tools to their next supervision where they review that the corrections have all been completed.

OPCs
The MCA generates a report (a list of the claims that have been submitted to Medicaid and posted to accounts receivable) from the Electronic Health Record (EHR) for each OPC within one month after the billing process has taken place. The MCA then takes the report and pulls random data in order to audit each clinic solely on the EHR system. As advised by the Chief Compliance Officer larger clinics have 5% of their Medicaid caseload audited each month, while smaller clinics have 10% of their Medicaid caseload audited each month. The MCA uses an audit checklist to follow specific requirements to ensure charts are compliant. The checklist is forwarded to the clinic supervisor and deputy director with the submit date recorded on each sheet and must be returned to supervisor from staff within 7 days, signed off that all corrections have been made. All checklists have been approved by the Agency's Chief Compliance Officer.

The MCA will also be expected to monitor compliance by reviewing the following reports are providing data on those reports to the MCA supervisor, Corporate Compliance Coordinator, and Chief Compliance Officer:

1. Failed Activities: MCA will generate this report on a weekly basis and aggregate data on a monthly basis on types of failed activities and number of days an activity has been "failing".
2. Failed Claims: MCA will generate this reports on a weekly basis and aggregate data monthly on the types of failed, number of days claims have failed, and any claims of 90 days for which we are unable to bill.
3. The MCA will also generate other data such as the "No Status " and "service history reports"

that will assist in assessing compliance.

PHP
The MCA generates a report (a list of claims that have been submitted to Medicaid and posted to accounts receivable) within one month after the billing process has taken place. The MCA then takes the report and audits 100% of the Medicaid clients. The MCA uses an audit checklist to follow specific requirements to ensure charts are compliant. All checklists have been approved by the Agency's Chief Compliance Officer. The MCA also runs Failed Activities reports in the EHR on a weekly basis and addresses findings with program supervisor in order to ensure compliance for Medicaid billing.

Day Treatment
The Medicaid Compliance Analyst conducts reviews by generating reports from the EHR on failed activities and failed claims. In addition, he/she generate custom reports on a variety of compliance items, including the timely completion of treatment plans, documents that have not been signed, and the required weekly progress notes. For those Medicaid and regulation requirements that may not be getting captured via the EHR, the MCA uses an audit tool to capture the data and reports on all EHR and audit findings to the Program Director and HV leadership staff.
In instances where the weekly progress note is not completed, this is one of the tools used to monitor billing submission, the MCA informs the billing staff that the claim should not be billed until the document has been completed. In addition, when a treatment plan is found not to be active during any given day that the child is the program, the MCA informs billing that the client's daily rate cannot be billed due to this non-compliance.

Other Non OPC Programs
The MCA runs failed activities and failed claims reports in the EHR on a weekly basis and addresses findings with staff as well as program supervisors in order to ensure compliance for Medicaid billing. MCA also maintains records of staff's failed activities and claims to hold staff accountable for chart compliance. Although these programs may not be billing on a fee for service basis, their regulatory requirements are in lace and require that treatment plans and documentation be completed on a contemporaneous and timely basis.

Overpayments
According to Medicaid regulations an agency has up to 6 years to make corrections. But, in the event that it is discovered that voids or adjustments need to be made, they must be made within 60 days from the date of discovery. Should this come about the Medicaid Compliance Analyst or other member of QA will submit their findings via an audit checklist to the billing department who will either void/adjust the claim immediately or should further questions arise, will do additional research and then process the void/adjustment. The voids or adjustments need to be communicated to the Chief Compliance Officer who will monitor them. In addition, the Chief Compliance Officer will assess the need for a self-disclosure instead of voiding the claims.

In the absence of QA
In the event that any member of QA is unavailable to audit a particular program then someone from the program who is not directly linked to the chart should take over as QA. They should audit a minimum of two charts per month and report their findings directly to the Program Director. The Program Director will then report on these findings in their monthly QA report which gets communicated to the Associate Executive Director via the monthly Hudson Valley Quality Assurance and Improvement meeting.

Findings will also be reported to the Compliance Coordinator and then they will conduct their own reviews consistent with the Agency Corporate Compliance Plan and the Service Area Plan.

RESIDENTIAL PROGRAMS

Purpose of the Plan

Astor's Residential Services, specifically the Residential Treatment Facility (RTF) and Residential Treatment Center/Hard to Place (RTC) both receive funding from Medicaid in the form of per diem reimbursement for care days. Both of these programs use the following plan, based on the Corporate Compliance Plan of Astor Services for Children & Families, to assure that they are in compliance with state and Federal Medicaid regulations. The RTF program is certified by NYS Office of Mental Health; the RTC Program is certified by NYS Office of Children and Family Services.

The plan lays out in detail for each program responsibilities and expectations for compliance, establishes a specific routine for oversight of service delivery and determines a process for review of compliance data. All of the procedures established are in keeping with the Corporate Compliance Plan and seek to fulfill the compliance mission on the individual program level as outlined in that Plan.

Astor Corporate Compliance Plan

The auditing procedures of the Residential Services that have been established are specific to its programs needs and is in keeping with the Agency's Corporate Compliance Plan. Staff of this service area are to abide by the Agency's Corporate Compliance Code of Conduct.

The plan was written to highlight the duties of the Quality Support Team Leader (QSTL) and the Medicaid Compliance Analysts (MCA), who are integral to maintaining compliance standards as set forth by the Chief Compliance Officer in the Agency plan.

Duties of the Quality Support Team Leader

The QSTL supervises and coordinates staff in service areas that provide both administrative support and indirect care to the residential treatment program. These services include management of quality assurance, compliance and medical records.

The QSTL directly supervises the MCA

The QSTL will be responsible for:

- reviewing MCA reports for areas that need to be addressed
- identifying any trends that need immediate attention
- communicate trends that need immediate attention to the appropriate Residential Treatment Team Leader (RTTL)
- communication with AED

The QSTL / MCA will report on these reviews at the program's monthly QA meeting.

Duties of Medicaid Compliance Analyst (MCA)

Under the direct supervision of the QSTL, a MCA will be assigned the responsibility of checking on a monthly basis a representative sample of a program's records to assure that:

- services are being delivered in accordance with the treatment plan
- services are delivered in a timely manner by appropriate personnel
- services are recorded in the Electronic Health Record (EHR) in a timely manner
- services are in compliance with OMH and OCFS regulations

A written record of these reviews will be given to the QSTL and appropriate RTTL. The MCA will work the QSTL to ensure corrective action is taken for Medicaid errors reported.

The MCA will also:

- Participate in Medicaid Quality Improvement Team
- Send reports to the Agency's Chief Compliance Officer

The name of each program's MCA will be posted in a common space in the program and this individual will be reachable through office phone and e-mail. Concerns brought to the attention of the program MCA will be accorded the same treatment that concerns brought to the attention of the corporate MCA receives.

Compliance

The Residential Programs have two levels of compliance review: chart review audits (clinical, health, and case record), and utilization reviews.

Chart review audits are done by the MCA. The MCA reviews any documents that are in manual or hard copy as well as the EHR to verify that our documentation meets the documentation and treatment standards of state and federal regulators.

Utilization reviews are periodic reviews of the current caseload to determine necessity of treatment and stay in the program. These reviews help us to determine if a child benefits from our treatment model and if their current setting meets their needs.

Chart Reviews

Each of the residential programs has a checklist pertinent to the Medicaid requirements for that program and only captures data that we are unable to monitor through EHR reports or through the system errors checks. In each program the individual with the responsibilities of the MCA will develop a schedule to review certain records of that program each month.

The MCA will be responsible for reviewing ½ of all RTC and ½ of all RTF charts each month using EHR generated compliance reports and the Medicaid compliance checklist developed for this program; any new admissions in the past 30 days will also be reviewed. Charts will be reviewed for timely delivery and recording of all services and reports and for accurate recording of care days and bed days for billing purposes. In the RTC care day information will be checked with the billing department by the residential program intake coordinator to assure accuracy. In the RTF bed days, bed reservation compliance, days out of program, review of hospital stays and appropriate requests for extensions of hospital stays will be checked with the billing department by the RTF transition coordinators to assure accuracy.

Reports that will be used to monitor compliance include, but not limited to:

1. Failed Activities, which provides a list of documents that have been completed in the EHR, but for whom missing components of the documenting are preventing it from being complete.
2. Failed Claims, which provides a list of services that have been provided, but for which a treatment plan was not in place during the time of service.
3. Service history report, which shows if the milieu of services are being completed and document appropriate in the EHR via the schedule of service portion of the system.
4. Unsigned Service Documents which shows the number of documents that were started, but have not been fully signed by everyone who is scheduled to sign them.

There will also be a variety of treatment plan reports and service document reports which will help us assess compliance with timeliness of treatment plans and appropriate documentation of services.

Reporting

The MCA will give a written summation of these reviews and any relevant reports generated from

the EHR to the Compliance Officer, the Chief Financial Officer, and to the QSTL or an individual appointed by the AED for residential services; this summation will include the number of charts reviewed and any problems noted. The MCA will be responsible for bringing the results to the monthly QA meeting.

The MCA will give a written report of all results, as outlined above, to the responsible RTTL and QSTL who will share the information at the monthly QA meeting as outlined above. The MCA will also notify individuals bearing responsibility for any problems identified and ask them to correct the issue, if possible, within a week's time.

The MCA will report on the compliance of the audit findings via the audit tool on a monthly basis to the Chief Compliance Officer, the QSTL, and Compliance Coordinator. The MCA will also provide data on findings from EHR generated reports, including the number of late treatment plans, services which have been provided and documentation is incomplete, and services that have documents in the system, but whose schedule of service is blank

Response
The QSTL will also be responsible in conjunction with the appropriate supervisor or RTTL for addressing any remediation that may be necessary and for developing a timetable for the correction(s) to be made. All corrective actions undertaken must be reported to the Compliance Officer and Chief Financial Officer.

The MCA directly notifies the responsible employee, as well as their RTTL and QSTL, regarding any compliance issues that the MCA has identified. If corrective actions are not made after a week's time the RTTL will follow up with the responsible individual to make sure the correction occurs. If for any reason corrections are still not received after the second week the supervising RTTL, in conjunction with the AED, will be responsible for devising any corrective measures that must be taken and for assuring that the necessary follow up occurs. Corrective actions will be followed up on at the next QA meeting.

RTF Utilization Review

The RTF utilization review program is in place to monitor the appropriateness of continued stay and to identify the over- or under-utilization of services. This is accomplished through meetings of the Utilization Review Committee (URC) and completion of Psychiatric Utilization Review Screening Reports.

The URC must be composed of at least three professional staff members, including two physicians. However, one of these physicians can appoint a designee (must be a professional staff member per Reg 584.10). The URC must include a physician who is knowledgeable in the diagnosis and treatment of mental illness. Those serving on the URC may not be directly involved in the care of a resident whose status is being reviewed. Specifically, any URC meeting attendees from the child's treatment team (i.e., psychiatrist, clinical coordinators, transition coordinators and social workers who are invited to URC meetings to provide updates on the status of each child's treatment) must be excluded from the committee's deliberations.

Each resident shall have an Admissions Review no later than 30 days after admission. This is documented with a Psychiatric Utilization Review Screening Report (side A), which is completed by a designee of the MD serving on the URC. The designee must not be directly involved in the child's treatment. Three members of the URC, including at least one MD, will then review this form and sign it to indicate approval or rejection of what has been recommended. They may not be directly involved in the child's treatment. These forms will be kept in the client's record.

Subsequent Continued Stay Reviews will be done every 90 days thereafter. These are

documented with a Psychiatric Utilization Review Screening Report (side B). A designee of the MD serving on the URC will complete a Psychiatric Utilization Review Screening Report for each child. The designee must not be directly involved in the child's treatment. The completed forms will be reviewed at the URC meeting by the committee members. Three committee member signatures are needed on the form (the MD, the MD designee and another professional) to indicate approval or rejection of what has been recommended. Committee members must not be directly involved in the child's treatment.

In addition, the designee of the MD will log the outcomes of all initial and continued stay reviews in each client's record on a form titled, "Patient Record Notation UR Documentation."
These forms will be maintained in a file by the RTF administrative assistant.

Prior to each URC meeting, Clinical Coordinators will complete an "RTF Utilization Services" chart which outlines the services that each child is receiving. These charts will be reviewed by the committee.

The URC will meet at least quarterly and additionally as needed. Written minutes of each meeting will be completed and submitted to the Program Director. The minutes will include:

- The time period covered in the review
- Date and time of the meeting
- List of attendees and absentees, including the chairperson
- Comment on each child's appropriateness for RTF level of care
- List of hospitalizations (child's name, dates, hospital name)
- List of hospital discharges (child's name, dates, hospital name)
- Program admissions and discharges (child's name and dates)
- Old and new business (e.g., obstacles to discharge and identification of systemic issues impacting admissions and discharge-related community-based services.)

If an alternative determination is made by the URC, the child's psychiatrist must be notified and must review the case. He/she can provide additional information for consideration of the URC. The URC will notify the program director of final decisions.

URC minutes are reviewed in monthly program QA meetings. If the URC identifies problems areas that compromise quality of care being delivered, the URC must make recommendations and conduct follow-up as needed.

Communication & Changes in Service Area Compliance Plan

The purpose and scope of this plan will be disseminated to all RTTLs and appropriate supervisors in each program. Each program will have access to a written copy of the plan as it applies to that program. It will be the responsibility of the AED and the QSTL to ascertain that the plan is fully understood and that all appropriate staff are aware of the importance of complying with state and federal Medicaid regulations. Any changes in the plan will be broadcast in the same manner.

Conclusion

Astor Residential Services uses this Compliance Plan to ensure that all Residence staff are aware of the need for compliance and its importance in the day to day activities. The QSTL works in collaboration with the Chief Compliance Officer, so that any corrective actions that stem from our reviews and reports are within the expectations of the overall Astor Corporate Compliance Plan.

Appendix B – Federal & New York State Fraud and Abuse Laws & Whistleblower Provisions

I. PURPOSE

The purpose of this section of the employee handbook/manual is to fully comply with certain requirements set forth in the federal Deficit Reduction Act of 2005 (the "DRA"), and sections 6031 and 6032 of the DRA in particular, with regard to educating employees about federal false claims laws, whistleblower protections and the Corporation's policies and procedures for detecting and preventing fraud, waste, and abuse ("fraud prevention"). Under the DRA, the Corporation must provide a discussion of applicable State and Federal law relating to civil and criminal false claims/penalties along with a whistleblower protections and the corporation's own policies relating to fraud prevention. Sections II through VI of this Part of the handbook provides the discussion mandated by DRA in this regard.

II. POLICY

The policy set forth in the Corporation's compliance program concerning fraud prevention is fully incorporated in this employee handbook/manual. The Corporation has adopted a Compliance Manual which is distributed to all employees providing a summary of the corporate compliance program, including specific provisions which provide notice of how employees may report and cooperate in the identification and prevention of fraud, waste and abuse. Employees are expected to adhere to the requirements included in the Compliance Manual with regard to the Corporation's obligations under Medicaid, Medicare and other publicly funded health care programs.

III. SCOPE

This section applies to all Corporation programs, operations and employees. This section which will also be in our employee handbook/manual will provide the detail required under the DRA and related compliance mandates of State and Federal law. The Corporation's policies for detecting and preventing fraud, waste and abuse also apply to contractors, subcontractors and agents and their employees, particularly those which or who, on behalf of the Corporation, furnish, or otherwise authorize the furnishing of Medicaid or Medicare health care items or services, perform billing or coding functions, or are involved in monitoring the health care provided by the Corporation.

IV. FALSE CLAIMS

False claims laws seek to prevent fraud, waste, and abuse in government programs. They permit the government to bring civil lawsuits to recover damages and penalties against providers that submit false claims. These laws often permit private persons, including current or former employees of such providers, to bring so-called "whistleblower" actions against the providers on the government's behalf.

A. <u>False Claims and Penalties</u>

The Federal False Claims Act ("Act"; 31 USC §§3729-3733) imposes civil liability upon any person (individual or entity) for knowingly making a false claim to the United States government ("Government"). Specifically, the Act sets forth seven circumstances for which civil liability will be imposed for false claims. These seven circumstances are:

Specifically, the Act sets forth seven circumstances for which civil liability will be imposed for false claims (31 USC §3729[a]). These seven circumstances are when a person:

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

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

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

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

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

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

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

The civil monetary penalty that can be imposed for a false claim under the Act is not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461), **PLUS** three times the amount of damages which the Government sustained because of the false claim, **PLUS** the costs of a civil action.

A Court may impose a lesser penalty of not less than two times the amount of damages sustained by the Government where the Court finds the following:

1. The person committing the violation furnished governmental officials responsible for investigating false claims with all information known to the person about the violation within thirty (30) days after the date on which the person first obtained the information;

2. The person fully cooperated with any governmental investigation of the violation; and

3. At the time the person furnished the Government with the information about the violation, no criminal prosecution, civil action, or administrative action had been commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.

The Act defines the terms “Claim”, “Knowing” and “Knowingly”, “obligation”, and “material” as follows:

“Claim”:

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

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

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

interest, and if the United States Government--

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

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

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

"Knowing" and "Knowingly":

That a person, with respect to information:

1. has actual knowledge of the information;

2. acts in deliberate ignorance of the truth or falsity of the information; or

3. acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

"Obligation" means:

an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment. (see discussion below regarding potential liability under 42 USC §1320a-7k(d)(2))

"Material" means:

having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

In essence, civil monetary penalties may be imposed upon a person for making a false claim to the Government where the individual knows the information in the claim is false, or acts in deliberate ignorance of the truth or falsity of the information in the claim or acts in reckless disregard of the truth or falsity of the information in the claim. Civil monetary penalties are imposed even where there is no specific intent to defraud the Government.

The Act applies to claims submitted under Medicare, Medicaid, other federal health care programs and other state health care programs funded, in whole or in part, by the federal government. Examples of false claims include, but are not limited to:

1. Filing a claim for payment knowing that the services were not provided or were medically unnecessary;

2. Submitting a claim for payment knowing that excessive charges are being billed;

3. Submitting a claim for payment knowing that a higher billing code which does not reflect the services provided is used;

4. Filing a claim knowing that the claim is for duplicate services.

The Act has been used as a basis to impose civil monetary penalties upon persons in situations involving egregious substandard quality of care, that is, the resident's condition is so bad that the services billed for could not have been provided.

Lastly, pursuant to 42 U.S.C. §1320a-7k(d)(2) enacted as §6402 of the Patient Protection and Affordable Care Act (PPACA), Congress added new provisions to the false claims act requirements and imposed upon providers the obligation to **report, explain and repay** overpayments within calendar 60 days of identification. Those that fail to properly disclose, explain and repay the overpayment in a timely manner may be subject to liability under the False Claims Act.

Under the revised PPACA standard, an "obligation" under 42 U.S.C 3729(a)(1)(G) is referenced as creating a liability when a person "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government". Liability under section 3729(a)(1) is "subject to" section 3729(a)(2), which provides that damages are reduced if the person violating the section "furnished… all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information".

Civil Actions Under the Act – Qui Tam

Enforcement of the Act is the responsibility of the United States Attorney General. However, private individuals have the ability to bring a civil action for a violation of the Act. These private actions are known as "Qui Tam" actions.

Qui Tam actions are brought by private individuals in the name of the Government. When the complaint in an action brought by a private individual is filed with the Court, it remains under seal for a period of sixty days and cannot to be served upon the defendants named therein until ordered by the Court. Under seal means that the action remains confidential and is not subject to disclosure. The private individual must serve a copy of the complaint and written disclosures of substantially all material evidence and information the individual possesses on the Government. Within sixty days of the Government's receipt of the complaint and written disclosures, the Government shall either intervene and proceed with the action, in which case, the action shall be conducted by the Government, or notify the Court that it declines to take over the action, in which case, the private individual bringing the action shall have the right to proceed with the action.

If the Government elects to proceed with the action brought by a private individual, the private individual shall receive at least 15% but not more than 25% of the proceeds of the action or settlement of the claim, depending upon the extent to which the private individual contributed to the prosecution of the action. If the Government does not proceed with the action, and the private individual is successful in the action or settles the action, the private individual is entitled to an amount not less than 25% and not more than 30% of the proceeds of the action or settlement which shall be paid out of the proceeds of the action or settlement. In addition, the private individual is entitled to receive an amount for reasonable expenses necessarily incurred in the action plus reasonable attorneys' fees and costs. On the other hand, if the private individual is unsuccessful in prosecuting the action, the Court, upon a finding that the action was clearly frivolous, clearly vexatious or brought primarily for purposes of harassment, may award the defendant in the action its reasonable attorneys' fees and expenses. If the private individual in the action is a person who planned or initiated the violation of the Act, the Court, where appropriate, may reduce the amount of the award to the private individual. Moreover, if such private individual is convicted of a crime arising from his or

her role in the violation, the person will not receive any share of the proceeds of the action.

A civil action under the Act may not be brought:

1. More than six years after the date on which the violation of the Act is committed; or

2. More than three years after the date when facts material to the right of action are known or reasonably should have been known by an official of the Government charged with responsibility to act in the circumstances but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

B. 31 U.S.C. §3801 Et. Seq.

31 U.S.C. §3801 imposes additional civil penalties for the filing of false claims or statements with the federal government. The term "Claim" is defined as:

Any request, demand or submission - -

(A) made to [the Government] for property, services or money (including money representing grants, loans, insurance or benefits);

(B) made to a recipient of property, services or money from [the Government] or to a party to a contract with [the Government] - -

(i) for property or services if the United States - -

(I) provided such property or services;

(II) provided any portion of the funds for the purchase of such property or services; or

(III) will reimburse such recipient or party for the purchase of such property or services; or

(ii) for the payment of money (including money representing grants, loans, insurance or benefits), if the United States –

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

(II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(C) made to [the Government] which has the effect of decreasing an obligation to pay or account for property, services or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1986.

The term "Statement" is defined as:

Any representation, certification, affirmation, document, record or accounting or bookkeeping entry made - -

(A) with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(B) with respect to (including relating to eligibility for - -

(i) A contract with, or a bid or proposal for a contract with; or

(ii) A grant, loan or benefit from,

an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan or benefit, or if the Government will reimburse such State, political subdivision or party for any portion of the money or property under such contract or for such grant, loan or benefit, except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1986.

Specifically, civil monetary penalties under 31 U.S.C. §3801 et. seq. will be imposed against:

1. Any person (individual or entity) who makes, presents, or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know:

   (A) is false, fictitious or fraudulent;

   (B) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;

   (C) includes or is supported by any written statement that:

      (i) omits a material fact;

      (ii) is false, fictitious or fraudulent as a result of such omission; and

      (iii) is a statement in which the person making, presenting or submitting such statement has a duty to include such material facts; or

   (D) Is for payment for the provision of property or services which the person has not provided as claimed; or

2. Any person who makes, presents or submits, or causes to be made, presented or submitted, a written statement that:

   (A) The person knows or has reason to know:

      (i) asserts a material fact which is false, fictitious or fraudulent; or

      (ii) is false, fictitious or fraudulent as a result of such omission;

   (B) in the case of a statement described in clause (ii) of subparagraph (A) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and

(C) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement.

The term "knows or has reason to know" means that:

A person, with respect to a claim or statement - -

(A) has actual knowledge that the claim or statement is false, fictitious or fraudulent; or

(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(C) acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required.

Civil monetary penalties under 31 U.S.C. §3801 et. seq. are not more than $5,000 for each false claim or statement. Also, in lieu of damages sustained by the federal government, an assessment of not more than twice the amount of such claim(s) may be imposed. An individual or entity against whom civil monetary penalties are sought under 31 U.S.C. §3801 et. seq. is entitled to notice, an opportunity for a hearing and judicial review.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

C. Additional Civil and Criminal Penalties and Exclusions For False Claims

Civil

In addition to the Act and 31 U.S.C. §3801 et. seq., the federal government may, pursuant to 42 U.S.C. §1320a-7a, impose civil monetary penalties for false claims. Such additional civil monetary penalties may be up to but not exceed $10,000 for each item or service which is the subject of a false claim.

In addition to civil monetary penalties, the federal government may, pursuant to 42 U.S.C. §1320a-7, exclude an individual or entity from participation in federal and state health care programs (including Medicare and Medicaid) for certain false claims or actions. Generally, exclusion is mandatory in cases where the individual is convicted of a felony relating to health care fraud, otherwise, exclusion is permissive, that is, subject to the discretion of the Government.

Furthermore, pursuant to 42 U.S.C. §1320a-7k(d)(2) (enacted as §6402 of the Patient Protection and Affordable Care Act), providers are obligated to **report, explain and repay** overpayments within calendar 60 days of identification. Those that fail to properly disclose, explain and repay the overpayment in a timely manner may be subject to liability under the New York and Federal False Claims Act.

Criminal

Pursuant to 42 U.S.C. §1320a-7b, criminal sanctions may be imposed against an individual or entity for making or causing to be made false statements or representations. Specifically, criminal sanctions will be imposed against an individual or entity who:

1. Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program;

2. At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefits or payments;

3. Having knowledge of the occurrence of any event affecting (1) his/her initial or continued right to any such benefit, or (2) the initial or continued right to any such benefit or payment of any other individual in whose behalf he/she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;

4. Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;

5. Presents or causes to be presented a claim for a physician's service for which payment may be made under a federal health care program and knows that the individual who furnishes the services was not licensed as a physician; or

6. For a fee knowingly and willfully counsels or assistants an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under [Medicaid] if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

In addition, criminal sanctions will be imposed against any individual or entity who knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution, facility or entity in order that such institution, facility or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled facility, facility, intermediate care facility for the mentally retarded, home health agency, or other entity for which certification is required under Medicare or a state health care program or with respect to information required to be provided under 42 U.S.C. §1320a-3a (disclosure requirements for other providers under Medicare Part B).

D. New York State False Claims Laws

1. NY False Claims Act (State Finance Law §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000-$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit or 15-25% if the government did participate in

the suit.

2. Social Services Law, Section 366-b

Section 366-b of the Social Services Law makes it a Class A misdemeanor for any person who, with intent to defraud, does any of the following:

a. presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise;

b. knowingly submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled for furnishing services or merchandise; or

c. knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under the Medicaid program.

3. Article 177 of the Penal Law

Article 177 of the Penal Law became effective November 1, 2006. Article 177 of the Penal Law establishes the crime of health care fraud. The crime of health care fraud in the fifth degree is a Class A misdemeanor and a person is guilty of this crime when:

With intent to defraud a health plan, [includes the State Medicaid program], he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for a health care item or service and, as a result of such information or omission, he or she or another person receives payment in an amount that he, she or such other person is not entitled to under the circumstances.

Health care fraud in the fourth degree is a Class E felony. A person is guilty of health care fraud in the fourth degree when the person commits the crime of health care fraud in the fifth degree on one or more occasions and the payment or portion of payment wrongfully received from a single health plan [including Medicaid] in a period of not more than one year, exceeds $3,000 in the aggregate.

Health care fraud in the third degree is a Class D felony. Health care fraud in the third degree is committed where the wrongful payments exceed $10,000 in the aggregate in a one-year period. Health care fraud in the second degree is a Class C felony and is committed where the wrongful payments exceed $50,000 in the aggregate in a one-year period. Health care fraud in the first degree is a Class B felony and is committed where the wrongful payments exceed more than $1,000,000 in the aggregate one year period.

Article 177 of the Penal Law provides for an affirmative defense for individuals serving as a clerk, bookkeeper, or other employee of a health care provider who, without personal benefit, was merely executing the orders of his or her employer or a superior employee generally authorized to direct his or her activities. The affirmative defense is not available to any employee charged with the active management and control, in an executive capacity, of the affairs of the corporation.

4. Social Services Law §145-b, False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false

statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

5. Social Services Law §145-c, Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five years for 4 or more offenses.

6. Social Services Law §145, Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

7. Penal Law Article 155, Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

8. Penal Law Article 175, False Written Statements

Four crimes are set forth relating to filing false information or claims and have been applied in Medicaid fraud cases:

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

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

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

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

9. Penal Law Article 176, Insurance Fraud

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

a. Insurance fraud in the 5th degree involves intentionally filing a health insurance

claim knowing that it is false. It is a Class A misdemeanor.

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

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

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

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

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

10. 18 NYCRR Section 515.2

It is an unacceptable practice under the Medicaid program for an individual or entity to submit false claims or false statements to Medicaid. False claims include:

Submitting, or causing to be submitted, a claim or claims for:

(A) unfurnished medical care, services or supplies;

(B) an amount in excess of established rates or fees;

(C) medical care, services or supplies provided at a frequency or in amount not medically necessary; or

(D) amount substantially in excess of the customary charges or costs to the general public; or

b. Inducing, or seeking to induce, any person to submit a false claim.

False statements are:

a. Making, or causing to be made, any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment; or

b. Inducing or seeking to induce the making of any false, fictitious or fraudulent statement or misrepresentation of a material fact.

Individuals who have engaged in unacceptable practices under the Medicaid program are subject to one or more of the following sanctions:

a. Exclusion from the program for a reasonable time;

b. Censure;

c. Conditional or limited participation, such as requiring pre-audit or prior authorization of claims for all medical care, services or supplies, prior authorization of specific

medical care, services or supplies, or other similar conditions or limitations.

In addition, the Department of Health may require the repayment of overpayments determined to have been made as a result of the unacceptable practice.

V. WHISTLEBLOWER PROTECTION

A. Federal False Claims Act

Any employee, contractor, or agent shall be entitled to all necessary "relief" if discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the person furtherance of efforts to stop a violation(s) of the False Claim Act including a civil action under the Act whether brought by the Government or a private individual, including investigation for, initiation of, testimony for, or assistance in any such action maybe because of such actions. Any employee who has been discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment because of such lawful acts shall be entitled to "relief" necessary to make the employee whole, including, reinstatement with the same seniority status such employee would have had but for the discrimination, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

B. State Laws

Article 20-C of the New York Labor Law prohibits retaliatory action by employers. Section 740 of Article 20-C applies to all employers. Section 741 of Article 20-C applies to health care employers, including, but not limited to, providers licensed under Article 28 (i.e., hospitals, homes and diagnostic and treatment centers) and Article 36 (i.e., long term home health care programs, certified home health care agencies, and licensed home care service agencies) of the Public Health Law. In addition, the New York False Claim Act provides additional protection to employees.

1. Labor Law Section 740

Under Section 740 an employer is prohibited from taking any retaliatory personnel action (discharge, suspension, demotion or other adverse employment action taken against an employee in terms and conditions of employment) against an employee because the employee does any of the following:

a. discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety or which constitutes health care fraud;

b. provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by the employer; or

c. objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

With respect to disclosures to a public body only, protection against retaliatory personnel actions is unavailable unless the employee has first brought the activity,

policy or practice in violation of law, rule or regulation, to the attention of a supervisor of the employer and afforded the employer a reasonable opportunity to correct the activity, policy or practice.

An employee who has been subject to a retaliatory personnel action may institute a civil action for the following relief within one year after the alleged retaliatory personnel action was taken:

a. An injunction to restrain continued violation of Section 740;

b. Reinstatement of the employee to the same position held before the retaliatory personnel action, or to an equivalent position;

c. Reinstatement of full fringe benefits and seniority rights;

d. Compensation for lost wages, benefits and other remuneration; and

e. Payment by the employer of reasonable costs, disbursements and attorneys' fees.

If the Court determines that a civil action under Section 740 was without basis in law or fact, the Court, in its discretion, may award reasonable attorneys' fees and court costs and disbursements to the employer.

2. Labor Law Section 741

Under Section 741, an employer is prohibited from taking retaliatory action (discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in terms and conditions of employment) against an employee because the employee does any of the following:

a. discloses or threatens to disclose to a supervisor, or to a public body an activity, policy or practice of the employer or agent that the employee, in good faith, reasonable believes constitutes improper quality of patient care ("improper quality of patient care" means any practice, procedure, action or failure to act of an employer which violates any law, rule, regulation or declaratory ruling adopted pursuant to law, where such violation relates to matters which may present a substantial and specific danger to public health or safety or a significant threat to the health of a specific patient); or

b. objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care.

The protections under Section 741 are not available to an employee unless the employee has brought the improper quality of patient care to the attention of a supervisor and has afforded the employer a reasonable opportunity to correct such activity, policy or practice. However, the inapplicability of Section 741 for failure to provide an employer an opportunity to correct does not apply to disclosures or threatened disclosures to a supervisor or public body where the improper quality of patient care presents an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

An employee may bring a civil action under Section 740 for the relief identified in Section 740. However, instead of the one-year period in which to bring such action, a health care employee may bring such action within two years after the alleged retaliatory personnel action was taken. In addition to the specific relief identified in Section 740, if the Court determines that a health care employer acted in bad faith in a retaliatory action under Section 741, the Court may assess a civil penalty of an amount not to exceed $10,000 against the health care employer which is to be paid to the Improving Quality of Patient Care Fund established under the State Finance Law.

3. NY False Claim Act (State Finance Law §191)

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

VI. PROCEDURE

The Corporation takes compliance with the FCA seriously. Any employee who becomes aware of a violation or potential violation of such laws, or any fraudulent or potentially fraudulent conduct for that matter, is expected to report the same immediately. Employees, including management, contractors, and agents, should review, understand, and follow the procedures detailed in the Corporate Compliance Manual.

The Corporation encourages employees to initially report compliance concerns to their immediate supervisors, when appropriate, but they may, in the alternative, report directly to the Compliance Officer in person or by telephone at: 845-871-1097.

Any information that employees provide in good faith to their supervisors or the Compliance Officer will be kept in confidence to the extent feasible and legal. In the event of a government investigation or lawsuit, or if the need otherwise arises for the Corporation to disclose the information, such information may be disclosed at the direction of legal counsel.

The Corporation will not take adverse action against an employee for reasonably requesting assistance from, or reporting potential violations of law or the Corporation policy in good faith to, a supervisor, and the Compliance Officer or government authorities. By reporting his or her own misconduct, however, an employee will not insulate himself or herself from potential disciplinary action for such a violation. Employees should report concerns about possible retaliation or harassment to the Compliance Officer.

The Corporation does not condone and will not tolerate abuse of the reporting process. Any employee who makes an intentionally false statement, or makes a report of alleged misconduct in bad faith, shall be subject to appropriate disciplinary action.

Appendix C – Acknowledgement Receipt

Acknowledgment of Receipt
Astor Services for Children & Families Corporate Compliance Plan

Name of Employee, Organization, or vendor: _____

SSN, Employee ID (if Astor staff), or Tax ID: _____

This is to certify that _____ (organization/person name) has received and understands my/our responsibility to ensuring compliance with Astor Services for Children & Families' Corporate Compliance Plan.

_____ _____
Signature of Employee/Vendor / Organization Date

Appendix D: Corporate Compliance Self-Assessment Tool

Name of Medicaid Provider:
Medicaid Provider IDS(s) #:
Federal Employee Identification Number (FEIN) associated with Medicaid billings:
Person Completing Assessment:
Title of Person Completing Assessment:
Date Assessment Completed:

	Description	**Provider Yes**	**Provider No**	**Provider's Evidence of Compliance or action required** ***Include specific citations to the documents and text that supports any "Yes" response***	**OMIG Yes**	**OMIG No**	**Bureau of Compliance Conclusions Based upon Responses from Provider**
	Element 1: Written policies and procedures						
	Do you have written policies and procedures that describe compliance expectations in a code of conduct or code of ethics?						
	Have you implemented the operation of the compliance program?						
	Do you have written policies and procedures that provide guidance to *employees* on dealing with potential compliance issues?						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required ***Include specific citations to the documents and text that supports any "Yes" response***	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Do you have written policies and procedures that provide guidance to *others* on dealing with potential compliance issues?			*Please define "others" as it relates to this Element.*			
	Do you have written policies and procedures that provide guidance on how to communicate compliance issues to appropriate compliance personnel?						
	Do you have written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved?						

Element 2: Designate an employee vested with responsibility

	Has a designated employee been vested with responsibility for the day-to-day operation of the compliance program?						
	Are the designated employee's (referred to in 2.1) duties related solely to compliance? *If the answer to 2.2 is "Yes" indicate "NA" in 2.3 and continue on to 2.4. If the answer to 2.2 is "No" answer*						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required ***Include specific citations to the documents and text that supports any "Yes" response***	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	2.3.						
	If the designated employee's (referred to in 2.1) compliance duties are combined with other duties, are the compliance responsibilities satisfactorily carried out?			*Provide details on what the designated employee's other duties are and how you assess if the compliance duties are being satisfactorily carried out.*			
	Does the designated employee (referred to in 2.1) report directly to the entity's chief executive or other senior administrator?			*Specify the reporting relationship.*			
	Does the designated employee (referred to in 2.1) periodically report directly to the governing body on the activities of the compliance program?			*Specify the reporting relationship, the basis for the reporting relationship and the frequency of the reporting.*			

Element 3: Training and education

	Is training and education provided to *all affected employees* on compliance issues, expectations and the compliance program operation?			*Please define affected employees used for purposes of training in this Element.*			
	Is training and education provided to *all affected persons associated with the provider* on compliance issues, expectations and the compliance program operation?			*Please define "affected persons associated with the provider" used for purposes of training in this Element.*			
	Is training and education						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	provided to *all executives* on compliance issues, expectations and the compliance program operation?						
	Is training and education provided to *all governing body members* on compliance issues, expectations and the compliance program operation?						
	Does the compliance training occur periodically?			*Please define the timing of the periodic training and the audience for the periodic training.*			
	Is compliance training part of the orientation for *new employees*?						
	Is compliance training part of the orientation for *appointees or associates*?						
	Is compliance training part of the orientation for *executives?*						
	Is compliance training part of the orientation for *governing body members*?						

Element 4: Communication lines to the responsible compliance position

	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to *all employees* to						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	allow compliance issues to be reported?						
	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to *all persons associated with the provider* to allow compliance issues to be reported?						
	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to *all executives* to allow compliance issues to be reported?						
	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to *all governing body members* to allow compliance issues to be reported?						
	Is there a method in place for *anonymous* good faith reporting of potential compliance issues as they are identified for each group noted in items 4.1 through 4.4?						
	Is there a method in place for *confidential* good faith reporting of potential compliance issues as they are identified for each						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	group noted in items 4.1 through 4.4?						

Element 5: Disciplinary policies to encourage good faith participation

	Do disciplinary policies exist to encourage good faith participation in the compliance program by all affected individuals? *For purposes of Element 5, "affected individuals" shall mean those persons who are required to receive training and education under Element 3 above.*						
	Are there policies in effect that articulate expectations for reporting compliance issues for all affected individuals?						
	Are there policies in effect that articulate expectations for assisting in the resolution of compliance issues for all affected individuals?						
	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all affected individuals?						
	Is there a policy in effect that outlines sanctions for participating in non-compliant behavior for all affected individuals?						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals?						
	Are all compliance-related disciplinary policies fairly and firmly enforced?						

Element 6: A system for routine identification of compliance risk areas

	Do you have a system in place for routine identification of compliance risk areas specific to your provider type?						
	Do you have a system in place for self-evaluation of the risk areas identified in 6.1, including internal audits and as appropriate external audits?						
	Do you have a system in place for evaluation of potential or actual non-compliance as a result of self-evaluations and audits identified in 6.2?						

Element 7: A system for responding to compliance issues

	Is there a system in place for responding to compliance issues as they are raised?						
	Is there a system in place for investigating potential compliance problems?						
	Is there a system in place for						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	responding to compliance problems as identified in the course of self-evaluations and audits?						
	Is there a system in place for correcting compliance problems (as referred to in 7.3) promptly and thoroughly?						
	Is there a system in place for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?						
	Is there a system in place for identifying and reporting compliance issues to the NYS Department of Health or the NYS Office of Medicaid Inspector General?						
	Is there a system in place for refunding Medicaid overpayments?						

Element 8: A policy of non-intimidation and non-retaliation

	Is there a policy of *non-intimidation* for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in Sections 740 and 741 of the New York State						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Labor Law?						
	Is there a policy of *non-retaliation* for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law?						

INSTRUCTIONS FOR THIS SECTION OF THE ASSESSMENT FORM:

In Column E below:
1. Summarize examples of 2 instances of how your Compliance Program made an impact on each of the 7 following areas; and
2. Explain how your organization used its compliance program to positively impact each instance cited.

Please attach a copy of any documentation that provides sufficient detail to support your summary and your explanation of its positive impact. Your summary should include references to the document name, page and section of text that supports the examples given.

18 NYCRR §521.3(a) requires compliance programs to be applicable to the areas listed below.

	Description	Provider Yes	Provider No	Column E	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Is your compliance program applicable to:						
	Medicaid billings?						
	Medicaid payments?						
	the medical necessity and "quality of care" of the services provided to enrollees of the Medicaid program?						
	governance of the provider, particularly as related to the Medicaid program?						
	mandatory reporting requirements as related to the Medicaid program?						
	credentialing for those who are providing covered services under the Medicaid program?						
	other risk areas that are or should with due diligence be identified by the provider?						

Appendix E– Effectiveness Checklist

Effectiveness Review Tool Documentation Review Checklist

Sample	**Documentation requested for each sample and/or Area**	**Comments**
Employee Records	1. Copy of **xx** employee records confirming the employee received the code of conduct. 2. Copy of **xx** employee records confirming the employee received initial compliance training. 3. Copy of **xx** employee records confirming the employee received annual compliance training.	
Educational Training	1. Copy of Education Training material utilized for compliance training upon hire and annually. 2. Copy of any additional compliance related training that has occurred outside of the training done upon hire and annually. 3. Copy of the participant's sign in sheet. 4. Copy of the pretest and posttest results.	
Compliance Logs and Investigations	Copy of **xx** compliance hotline calls/logs including, but not limited to how the complaint was: • Received • Recorded • Investigated • Resolved • Further action taken	
Employee Disciplinary Records	Copy of **xx** employee disciplinary or termination records to include, but not limited to: • Date of incident • Nature of the allegation • Steps taken • Information revealed during investigation • Findings • Outcome and resolution • Corrective action plan, if warranted	

Compliance Risk Areas/ Internal Audits	Copy of **xx** internal audits documentation to include, but not limited to: • Who Initiated audit (organization vs. outside agency) • Scope and Method • Findings • Recommendations • Corrective action plan • Continued follow up plan, if warranted • If the issue involved an overpayment, when was it reported, explained and repaid to OMIG	
External Audits	Copy of **xx** external audits documentation to include, but not limited to: • Who Initiated audit (organization vs. outside agency) • Scope and Method • Findings • Recommendations • Corrective action plan • Continued follow up plan, if warranted • If the issue involved an overpayment, when was it reported, explained and repaid to OMIG	
Reports of Intimidation and Retaliation	Copy of **xx** reports of intimidation and retaliation to include, but not limited to: • Date of incident • Nature of the allegation • Steps taken • Information revealed during investigation • Findings • Outcome and resolution	
Quality of Care Complaints / Mandatory Reporting	Copy of **xx** quality of care investigations/ reports to include, but not limited to: • Date of incident • Nature of the allegation • Steps taken • Information revealed during Investigation • Findings • Outcome and resolution • If the issue involved an overpayment, when was it reported, explained and repaid to OMIG	

Appendix F– Electronic Health Record Sample Reports

Failed Activities

Error	Client	Staff (On Claim)	Program	Service Date	Activity	Begin Time	End Time	Duration	**Failed Days**
Service Documentation not found	Test, Test	Thor	OPC (OPC)	8/5/2014	MedMgmt	12:30 PM	1:00 PM	30	62
Service Documentation not found	Test, Test	Thor	OPC (OPC)	10/7/2014	MedMgmt	1:00 PM	1:30 PM	30	63
Service Documentation not found	Test, Test	Thor	OPC (OPC)	10/10/2014	IndividuXL	11:15 AM	12:00 PM	45	41
Service Documentation not found	Test, Test	Thor	OPC (OPC)	10/15/2014	Individu	5:30 PM	6:15 PM	45	39
Service Documentation not found	Love, Love	Batman	OPC (OPC)	10/16/2014	Individu	6:00 PM	6:45 PM	45	48
Service Documentation not found	Love, Love	Batman	OPC (OPC)	10/23/2014	Individu	5:45 PM	6:30 PM	45	47
Service Documentation not found	Love, Love	Batman	OPC (OPC)	10/27/2014	Collateral	5:00 PM	5:30 PM	30	43
Service Documentation not found	Love, Love	Batman	OPC (OPC)	10/27/2014	Individu	1:15 PM	2:00 PM	45	41
Service Documentation not found	Hello, Hello	Joker	OPC (OPC)	10/27/2014	FamThe	7:30 PM	8:15 PM	45	43
Service Documentation not found	Hello, Hello	Joker	OPC (OPC)	10/27/2014	Individu	11:30 AM	12:15 PM	45	41
Service Documentation not found	Hello, Hello	Joker	OPC (OPC)	10/27/2014	Individu	9:45 AM	10:30 AM	45	41
Service Documentation not found	Up, Down	Hulk	OPC (OPC)	10/27/2014	Individu	10:30 AM	11:15 AM	45	41

Service History

Client	Service Date	Begin Time	End Time	Minutes	Activity	Procedure	Units	Staff	Program	Billing Status
Account, Test (110793)	3/12/2014	2:00 PM	2:45 PM	45	FamThe	90847	1	Minnie Mouse	OPC	Billed
Account, Test (110793)	3/20/2014	10:00 AM	11:00 AM	60	FamThe	90847	1	Minnie Mouse	OPC	Billed
Account, Account (115868)	9/19/2014	3:30 PM	4:00 PM	30	MedMgmt	99214	1	Donald Duck	OPC	Billed
Test2, Test2 (123507)	7/29/2014	4:00 PM	4:45 PM	45	Individu	90834	1	Donald Duck	OPC	Billed
Test2, Test2 (123507)	8/22/2014	4:00 PM	4:45 PM	45	FamThe	90847	1	Donald Duck	OPC	Billed
Test2, Test2 (123507)	9/12/2014	4:00 PM	4:45 PM	45	Individu	90834	1	Roger Rabbit	OPC	Billed
Berroa, Nygel (128767)	1/9/2014	6:15 PM	7:00 PM	45	Individu	90834	1	Roger Rabbit	OPC	Billed
Sand, Man (12345)	1/23/2014	7:15 PM	8:00 PM	45	Individu	90834	1	Roger Rabbit	OPC	Billed
Test3, Test3 (116690)	3/13/2014	4:00 PM	4:45 PM	45	FamThe	90847	1	Minnie Mouse	OPC	Not billed
Test3, Test3 (116690)	4/17/2014	4:00 PM	4:45 PM	45	Individu	90834	1	Minnie Mouse	OPC	Not billed
Test3, Test3 (11669)	6/5/2014	4:30 PM	5:15 PM	45	Individu	90834	1	Minnie Mouse	OPC	Billed

Appendix G– Sample Medicaid Audit Checklist

Bridges to Health Audit Tools

Review Period:		**Client Name:**		**DOB:**	
Review Date:		**Referral Date:**		**CIN#:**	
Reviewer Name:		**Enrollment Date:**		**Gender:**	
Medical Consenter:		**LDSS/DJJOY:**		**Waiver Type:**	
HCI:		**Disenrolled:**		**Setting:**	

Enrollment Forms (signed & dated)		Y, N, NA
8000 - Referral Form	**Date Signed:**	
- 8000 - Waiver Type checked		
- 8000 - Referral Type checked		
- 8000 - Agency selection filled out		
- 8000 - Referral Source checked		
8002 - Understanding B2H		
8003 - Freedom of Choice		
8005 - LOC w/supporting documentation & by qualified evaluator		
8007 - HCI Selection		
8008 - Rights		
8009 - Notice of Decision		
8004 Application		
Signed & dated w/in 60 days of receiving referral	**Date Signed:**	
Correct Waiver Type checked		
Application Type checked		
HCIA Information completed		
Is decision section appropriately completed?		

Reauthorization forms (signed & dated)		Y, N, NA
8014 - Reauth. Form	**Date Signed:**	
8003 - Freedom of Choice		
8005 - LOC w/supporting documentation & by qualified evaluator		
8008 - Rights		
8017-IHP	**Date Signed:**	
Submitted 30 Days Prior to Reauth.?		

Notes:

	Date Submitted	Y, N, NA
8017 - Prelim IHP w/in 60 days of receiving referral LDSS or DJJOY		
8017 - Initial IHP submitted w/in 30 days of enrollment		
8017 - Annual IHP 30 days prior to annual reauthorization date		

Compliance % NA

8017 - IHP - Caregiver/Emergency contact section completed (Page 9)	Prelim. IHP	Initial IHP	Revised IHP # 1	Revised IHP # 2	Revised/Annual
IHP Effective Date					
Caregiver					
Emergency Contact					
HCI					
HCIA					
Voluntary Agency Case Planner					

8017 - IHP - signed & dated by:	**Date Signed**					
LDSS/DJJOY (Pg.1)						
Medical Consenter (Pg. 9)						
HCI (Pg. 9)						
HCIA/Supervisor (Pg.9)						
Child (Pg. 9)						
Case Planner (Pg. 9)						
8017 - IHP - includes info. regarding child/MC's:						
History						
Needs						
Risk Factors						
Strenths						
Preferences						
Goals						
8017 - IHP - link between services & assessments						
8017 - IHP - Addresses through service selection/delivery a change in needs as indicated by changes in the 'Child Assessment' section						

BUDGET	Prelim	Initial	Revised IHP # 1	Revised IHP # 2	Revised/Annual
Budget - w/in recommended amount ($51,600 for 12 months) or reviewed by QMS for appropriateness					
Budget - Are service Types consistent with IHP					

Submitted to supervisor by by Medicaid Compliance Analyst on _____

HCI: Sign and return to SUPERVISOR on the following date: _____

I certify that I reviewed this audit and made all updates and edits (as appropriate by law).

HCI Signature: _____

Date: _____

Bridges to Health Services Audit Tool

CLIENT:	0			Billing Month(s):			Compliance %	NA

Was enrollment month billed:		If yes is enrollment SSF present:		For All Documents Reviewed the following items are correct:	Client Name	
					Date of Birth	
					Medicaid Number	

Health Care Integration

Serv	Units	HCI Sig	Sup Sig	Compliance	Serv	Units	HCI Sig	Sup Sig	Compliance	Serv	Units	HCI Sig	Sup Sig	Compliance
Date	Minutes	Date	Date	Y/N	Date	Minutes	Date	Date	Y/N	Date	Minutes	Date	Date	Y/N
Total Minutes	0			Y	Total Minutes	0			Y	Total Minutes	0			Y

Was there documentation on the SSFs that there were:		Do Progress Notes show documentation of contacts?	
2 face to face contacts per mo. (1 in home)		Consistent with progress notes?	
2 contacts w/other WSP's in the IHP per month		Consistent with progress notes?	
2 contacts w/the case planner/manager per month		Consistent with progress notes?	

Were the SSFs completed, signed & dated w/in 5 business days?	NA	
Were the total # of units for each month consistent with the IHP budgeted amount? Note: IHP to look at would be the one that is active for the SSF billing month		
If No, is there a Progress Note explaining underage/overage?		
If the total # of units for this review period were provided for a period of 12 months would the units be w/in the approved allocation in the IHP?		
Do the SSF's reconcile with billing reports?		

Notes:

	Prelim. IHP	Initial IHP	Revised IHP # 1	Revised IHP # 2	Revised/Annual
Effective Date:	1/0/1900	1/0/1900	1/0/1900	1/0/1900	1/0/1900
Budgeted Units:					

Family & Caregiver Support — WSP Agency Name:

Serv	Units	Service Planning	WSP Sig	Sup Sig	Compliance	Serv	Units	Service Planning	WSP Sig	Sup Sig	Compliance	Serv	Units	Service Planning	WSP Sig	Sup Sig	Compliance
Date	1/4 Hr	Units	Date	Date	Y/N	Date	1/4 Hr	Units	Date	Date	Y/N	Date	1/4 Hr	Units	Date	Date	Y/N
Total Units	0	0			Y	Total Units	0	0			Y	Total Units	0	0			Y

Were the SSFs completed, signed & dated w/in 5 business days?	NA	
Were the total # of units for each month consistent with the IHP budgeted amount? Note: IHP to look at would be the one that is active for the SSF billing month		
If No, is there a Progress Note explaining underage/overage?		
If the total # of units for this review period were provided for a period of 12 months would the units be w/in the approved allocation in the IHP?		
Do the SSF's reconcile with billing reports?		

Notes:

Outpatient Clinics Audit Tool

	Follow up needed by: ☐ Therapist	☐ MD	☐ Billing		
	Review Date:		Reviewer:		
	Client Name:		Site/Location:		
	Admission # :		Admission Date:		
	Therapist:		Doctor:		
	Case Manager:		Close Date:		
		Is client SED?		Is SED form in chart?	

Q#				
	Pre-Admission			
1	Did the client have more than (3) pre-admission visits(including MD visits) per year at Astor clinic?			
	Treatment Plan			
2	Is the parent or client signature on TP? If no, enter na and answer 2a.		(y or na only for 2)	
2a	if NO, is reason indicated?			
	Treatment Plan Reviews		Date of last compliance review:	
3	Is an assessment of the progress of goals indicated? (changes since last review)		Date on TPR:	
4	Is the parent or client signature on TP? If no, enter na and answer 4a.		(y or na only for 4)	
4a	if NO, is reason indicated?			
	Medication			
5	Is there a medication consent for EACH medication prescribed?			
6	Was a letter sent to the PCP with a detailed medication list for client?			
	Utilization Review			
7	Is this a UR Chart? If yes, continue to next question. If no, mark as n, and 8-11 as NA.			
8	Document Present? Y or N			
9	If Yes, Was UR done within 30 days of admission?			
10	Last Review Date:			
11	Continued Stay Reviews done on time? (every 6 months; for med mgmt, every 12 months?)			

Notes:

Submitted to supervisor by Medicaid Compliance Analyst on _____

Primary Therapist: Sign and return to SUPERVISOR within one week the date this audit was received.

I certify that I reviewed this audit and made all updates and edits (as appropriate by law).

Signature: _____ **Date:** _____

Week 1: OPC Failed Claims Report					
Date Range (please enter):					
Error Types	44 Days or Less	45-89 Days	**90+ Days**	# of Errors	Expected Billable Amount
No Active Treatment Plan on Service Date					
No Diagnosis Listed					
No Authorization					
No Payer Covered This Activity					
Other					
Total's: (90+ Days= unbillable)	0	0	**0**	0	$0.00

Total # of Errors (on report):		**Notes:**
Total # of Claims (on report):		
# of Services that Cannot be billed b/c treatment plan was missing	0	

Week 1: OPC Pre-Admission Failed Claims Report					
Date Range (please enter):					
Error Types	44 Days or Less	45-89 Days	**90+ Days**	# of Errors	Expected Billable Amount
No Active Treatment Plan on Service Date					
No Diagnosis Listed					
No Authorization					
No Payer Covered This Activity					
Other					
Total's: (90+ Days= unbillable)	0	0	0	0	$0.00

Total # of Errors (on report):		**Notes:**
Total # of Claims (on report):		
# of Services that Cannot be billed b/c treatment plan was missing	0	

Week 1: OPC Failed Activities Report					
Date Range (please enter):					
Error Types	30 Days or Less	31-59 Days	60-89 Days	**90+ Days**	# of Errors
Service Document Not Signed					
Service Document Not Found					
No Diagnosis					
Client Address Incomplete					
Client Birth Date is Not Set					
No Primary Staff Credential Entered					
Staff is not Active on Activity Date					
Total's: (90+ Days= unbillable)	0	0	0	**0**	0

Notes:

Week 1: OPC Pre-Admission Failed Activities Report					
Date Range (please enter):					
Error Types	30 Days or Less	31-59 Days	60-89 Days	**90+ Days**	# of Errors
Service Document Not Signed					
Service Document Not Found					
No Diagnosis					
Client Address Incomplete					
Client Birth Date is Not Set					
No Primary Staff Credential Entered					
Staff is not Active on Activity Date					
Total's: (90+ Days= unbillable)	0	0	0	**0**	0

Notes:

Week 1: OPC Service Documents Unsigned					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days**	Totals
Treatment Plan/OPC-Treatment Plan					0
Treatment Diagnosis					0
Transfer/Discharge Request					0
Memo to Chart					0
CRI-Psychopharmacology Plan					0
CRI-Contact Note with Schedule					0
CRI-OPC Session Progress Note					0
Other Notes					0
Total's	0	0	0	**0**	0

Notes:

Week 1: OPC Pre-Admission Service Documents Unsigned					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days**	Totals
Treatment Plan/OPC-Treatment Plan					0
Treatment Diagnosis					0
Transfer/Discharge Request					0
Memo to Chart					0
CRI-Psychopharmacology Plan					0
CRI-Contact Note with Schedule					0
CRI-OPC Session Progress Note					0
Other Notes					0
Total's	0	0	0	**0**	0

Notes:

Week 1: OPC No Status Report	
Date Range (please enter):	
How many Scheduled Visits for the Week are without Status? (Please enter #)	
How Many No Status Visits have been on the list longer than 2 days? (Please enter #)	
Notes:	

Week 1: OPC Pre-Admission No Status Report	
Date Range (please enter):	
How many Scheduled Visits for the Week are without Status? (Please enter #)	
How Many No Status Visits have been on the list longer than 2 days? (Please enter #)	
Notes:	

Week 1: OPC- Treatment Plan Report					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days**	Totals
OverdueTreatment Plan- 30 Day					0
Overdue Treatment Plan- 90 Day					0
Missing Treatment Plan					0
Expiring in 5 days or less					0
Total's	0	0	0	**0**	0

Notes:

No Treatment Plan Report for OPC-Pre

Day Treatment Audit Tool

	Follow up needed by: ☐ Therapist	☐ MD	☐ Billing		
	Review Date:		Reviewer:		
	Client Name:		Primary Therapist:		
	Program Location:		Doctor:		
	Admission #:		Admission Date:	Discharge Date:	

Q#			
	Pre-Admission		
1	Is the reason for referral present?		
2	Did the client have more than 3 pre-admission visits (including MD visits)?		
3	Did the client enroll within one month of the referral date?		
	Treatment Plan		
4	Is the parent or client signature on TP? If no, enter na and answer 4a.		(y or na only for # 4).
4a	If TP is not signed, does the note state that the plan was discussed with parent/guardian?		
	Treatment Plan Reviews	Date of last compliance review:	
5	Is there an assessment of the progress of goals/objectives since the last review?		Date on TPR:
6	Is the parent or client signature on TP? If no, enter na and answer 6a.		(y or na only for # 6).
6a	If TP is not signed, does the note state that the plan was discussed with parent/guardian?		
	Medication		
7	Is there a medication consent for EACH medication prescribed?		
8	Is the consent for medication signed by the caretaker?		
	Speech Therapy		
9	Is there an IEP on record that includes ST?, If there is no ST for child, enter na for 9 and 10.		(y or na only for # 9).
10	Were session notes completed within 5 business days of child attendance/collateral session?		
	Consents		
11	Is the consent to treat present?		
	Hippa		
12	Is the Accounting of Disclosures/Med Records Disclosure Tracking form present?		
13	Is the Notice of Privacy Practices present? If no, enter na and answer 13a.		(y or na only for # 13).
13a	If the Notice of Privacy Practices is not present, is there a note stating why it is not in chart?		

Notes:

Submitted to supervisor by Medicaid Compliance Analyst on: _____

Primary Therapist: Sign and return to SUPERVISOR within one week the date this audit was received.

I certify that I reviewed this audit and made all updates and edits (as appropriate by law).

Signature: _____ **Date:** _____

Week 1: Day Treatment Failed Activities Report					
Date Range (please enter):					
Error Types	30 Days or Less	31-59 Days	60-89 Days	**90+ Days**	Total # per error type
Service Document Not Signed					0
Service Document Not Found					0
No Diagnosis					0
Client Address Incomplete					0
Client Birth Date is Not Set					0
No Primary Staff Credential Entered					0
Staff is not Active on Activity Date					0
Total # of Failed Activities:	0	**0**	0	**0**	0
Notes:					

Week 1: Day Treatment Pre-Admission Failed Activities Report					
Date Range (please enter):					
Error Types	30 Days or Less	31-59 Days	60-89 Days	**90+ Days**	Total # per error type
Service Document Not Signed					0
Service Document Not Found					0
No Diagnosis					0
Client Address Incomplete					0
Client Birth Date is Not Set					0
No Primary Staff Credential Entered					0
Staff is not Active on Activity Date					0
Total # of Failed Activities:	0	**0**	0	**0**	0
Notes:					

Week 1: Day Treatment Failed Claims Report					
Date Range (please enter):					
Error Types	44 Days or Less	45-89 Days	**90+ Days**	Expected Billable Amount per Claim	Total # per error type
No Active Treatment Plan on Service Date					0
No Diagnosis Listed					0
No Authorization					0
No Payer Covered This Activity					0
Other					0
Total # of Failed Claims over 70 Days:	0	0	0	$0.00	0
Total # of Claim Errors (on report):			**Notes:**		
# of Services that cannot be billed b/c treatment plan was missing	0				

Week 1: Day Treatment Pre-Admission Failed Claims Report					
Date Range (please enter):					
Error Types	44 Days or Less	45-89 Days	**90+ Days**	Expected Billable Amount per Claim	Total # per error type
No Active Treatment Plan on Service Date					0
No Diagnosis Listed					0
No Authorization					0
No Payer Covered This Activity					0
Other					0
Total # of Failed Claims over 70 Days:	0	0	0	$0.00	0
Total # of Claim Errors (on report):			**Notes:**		
# of Services that cannot be billed b/c treatment plan was missing	0				

Week 1: Day Treatment Service Documents Unsigned					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days (Non-Billable)**	Total # per document (5-90+ Days)
Treatment Plan/Day Tx-Treatment Plan					0
Transfer/Discharge Request					0
Memo to Chart					0
CRI Group Note					0
CRI-Contact Note with Schedule					0
CRI - Coordination of Care/Collateral with schedule					0
CRI- Day Tx Session Progress Note with schedule					0
Day TX-Weekly Progress Note with schedule					0
Other Notes					0
Total # of Unsigned Documents	0	0	0	**0**	0
Notes:					

Week 1: Day Treatment Pre-Admission Service Documents Unsigned					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days (Non-Billable)**	Total # per document (5-90+ Days)
Treatment Plan/Day Tx-Treatment Plan					0
Transfer/Discharge Request					0
Memo to Chart					0
CRI Group Note					0
CRI-Contact Note with Schedule					0
CRI - Coordination of Care/Collateral with schedule					0
CRI- Day Tx Session Progress Note with schedule					0
Day TX-Weekly Progress Note with schedule					0
Other Notes					0
Total # of Unsigned Documents	0	0	0	**0**	0
Notes:					

Week 1: Day Treatment- Treatment Plan Report					
Date Range (please enter):					
Document Types	5-39 Days	40-59 Days	60-89 Days	**90+ Days (Non-Billable)**	Total # per document (5-90+ Days)
Overdue Treatment Plan- 3 month					0
Overdue Treatment Plan- 90 Day					0
Missing Treatment Plan					0
Expiring in 5 days or less					0
Total # of Treatment Plan Errors	0	0	0	**0**	0
Notes:					

No Day Treatment Pre Admission Treatment Plan Report