

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 health and educational services offering children the opportunity to meet life's challenges, pursue their dreams, and reach their full potential. 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 Quality & 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 postdate 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.
15. Staff and vendors/consultants will, at all times, act in a way to meet the requirements of the mandatory compliance program law and regulation.
16. Staff and vendors/consultants are expected to conduct business in a manner that supports integrity in operations.
17. Conduct contrary to these expectations will be considered a violation of the compliance program, and related policies and procedures.

III. Compliance Officer/Chief Quality & Compliance Officer

Astor Services for Children & Families has designated a Compliance Officer/Chief Quality & 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 designated 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	Phone
Yvette Bairan	Chief Quality & Compliance Officer	ybairan@astorservices.org	845-871-1097
Jennifer LaBarbera	Director of Compliance	JLaBarbera@astorservices.org	845-871-1108

A. Duties of the Compliance Officer/Chief Quality & Compliance Officer

- To 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/Chief Quality & 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/Chief Quality & 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. Compliance Team

Director of Compliance

The Director of Compliance oversees all compliance activities. The Director of Compliance works very closely with the Medicaid Compliance Analysts and provides direct supervision to some MCAs and SCC. The Director of Compliance conducts reviews, conducts analysis of compliance data and submits reports to the Chief Quality & Compliance Officer, program leadership, CQA&I, Program Oversight and the Board. She/he also reviews and updates compliance audit tools as needed. In addition, The Director of Compliance conducts monthly exclusions checks and conducts corrective actions checks and updates.

Supervising Compliance Coordinator

The Supervising Compliance Coordinator is responsible for various services as well as supervising Medicaid Compliance Analysts.

Duties of (Supervising Compliance Coordinator)

The responsibilities of the Supervising Compliance Coordinator are listed below. The Supervising Compliance Coordinator will:

- Ensure all clinical service documents meet New York State and federal criteria for billing compliance
- Conducts internal audits of all clinical service documents for assigned services or programs
- Generates reports based on audit findings
- Notifies Chief Quality & Compliance Officer, Director of Compliance AED, and program/site directors 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, Compliance Officer and Director of Compliance
- 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
- Work with the Director of Compliance and Chief Quality & Compliance Officer to ensure corrective action is taken for Medicaid errors reported at the sites
- Provides Supervision and oversight of a Medicaid Compliance Analyst

Duties of Medicaid Compliance Analyst (MCA)

Under the direct supervision of the Director of Compliance or Supervising Compliance Coordinator, the Medicaid Compliance Analysts:

- Have a primary role of reviewing charts to ensure compliance with applicable program or services 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 the Chief Quality & Compliance Officer or Director of Compliance and Associate Executive Director
- 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 Director of Clinical Outcomes, CANS & TCOM, 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 & Bronx 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 Director of Compliance based on the number of URs conducted by program and findings
- Provides support and reports on special assignments

V. Communication and Changes in Compliance Manual

The Chief Quality & 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 Quality & 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 Quality & 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.

VI. 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 or Chief Quality & 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 in a digital file 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 Quality & 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.

VII. 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 Quality & 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 Quality & 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 Quality & 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 intimidation or 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 Quality & 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 Quality & Compliance Officer through the hotline number at 1-866-293-0031. This line will be answered only by the Chief Quality & Compliance Officer (or his or her designee during vacations and other prolonged absences). This hotline number is anonymous and confidential. This line cannot trace the caller's telephone number and does not have caller id capabilities.
2. **Voice Mail or Face-To-Face Reports:** Voice mail or face-to-face reports to the Chief Quality & 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 Quality & 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 Quality & Compliance Officer and the service area Assistant Executive Director.

VIII. 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 and or vendors/consultants 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 Chief Quality & 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.

Head Start Eligibility Requirements

All Head Start employees are expected to adhere to the federal regulations and policies and standards that govern the Head Start Programs as well as the organization's Code of Conduct. Employees are responsible for reporting any potential violations and the matter will be investigated by Astor Services for Children & Families. Any violations of Head Start regulations, particularly intentional violations, including those pertaining to client eligibility and enrollment of ineligible clients are subject to potential disciplinary actions.

In the event of a violation, in order to correct or improve employee performance, Astor encourages employee counseling as an initial step especially if the violation was unintentional. However, there may be times (such as when the outcome of an investigation determines obvious intentional violations have occurred) where more severe action is appropriate. In these cases, formal disciplinary actions will range from verbal warnings to termination or revocation of contract.

The Chief Quality & Compliance Officer shall disseminate the range of disciplinary standards for improper conduct during each training session to educate personnel, board of directors 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-intimidation & 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 intimidation or retaliation for their good faith actions.

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

1. The Chief Quality & Compliance Officer will explain the Agency's Non-intimidation and Non-retaliation Policy to each caller or reporter.
2. The Chief Quality & Compliance Officer will give the reporter a means for contacting them confidentially to report any actions the reporter believes is retaliatory.
3. The Chief Quality & Compliance Officer will investigate any reports of intimidation or 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 Quality & Compliance Officer will confidentially contact reporters on a regular basis to inquire about any perceived intimidation or 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 Quality & 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 Quality & Compliance Officer and maintained in the consultant record.

All matches will be addressed by the Chief Quality & 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.

IX. 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 Quality & 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 Quality & 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.

A. Service or Program Type Auditing Practices

All Astor services where Medicaid billable services are provided, designate a Medicaid Compliance Analyst who reports either to the Director of Compliance or to a Supervising Compliance Coordinator. It is expected that the supervisor of the Medicaid Compliance Analyst inform, via written form to the Chief Quality & Compliance Officer, the frequency of audits, outcomes and corrective action plans. All audits not being conducted by the Chief Quality & Compliance Officer or the Director of Compliance follow the same Corporate Compliance Plan Guidelines for Auditing.

Following are details of the specific auditing practices broken down by service type, these audits are completed by either the Medicaid Compliance Analysts (MCA), Medicaid Compliance Coordinator (MCC) or Supervising Compliance Coordinator (SCC). These audits are conducted on varying timeframes dependent upon the service being audited.

Outpatient Clinics/Counseling Centers

There are numerous licensed locations for outpatient clinic or counseling services in the Hudson Valley and in the Bronx. Clinical, medical, and health staff provided behavioral health services at these programs. Both regions have satellites located in 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”.

Day Treatment Programs

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 MCA review occurs on three levels: current cases and discharges. For current cases, the MCA reviews a sample of cases monthly that are a portion of the total site census. This process enables the MCA 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 MCA 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 MCA making sure all documentation is signed and TPR's are signed without using the audit tool. If a case exceeds the 90 days the MCA will conduct a full audit using the audit tool.

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

Partial Hospitalization Program

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 Quality & 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.

Case Management Services

Health Homes/Case Management/Waiver

Case management services/Health Home Services in the Hudson Valley and the Bronx are audited based off of the regulations provided by CHUNNY, PHAN and CCF. There is an assigned Compliance Analyst who works with the Program Director to ensure compliance.

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 place and require that treatment plans and documentation be completed on a contemporaneous and timely basis.

Bridges to Health (B2H)

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 Quality & Compliance Officer.

QA forwards their findings to the HCI supervisor, WSP supervisors and the Director of Compliance. 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.

Residential Programs

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.

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.

Agency-Wide Audit Reporting

A report is generated for each service, which includes a summary of findings. The summary report contains a detailed synopsis of what was found for that service and includes the initial checklist from the audit. Audits and audit findings are conducted and reported once a month respectively. The reports are also shared with Program Leadership in efforts to make any corrections possible without violating any Astor, Medicaid or regulatory policy or law.

The summary report for each site is sent to the Director of Compliance who compiles an agency summary of the findings from specific audits. The Director of Compliance then presents these reports to CQA&I for feedback and once approved by that committee the completed reports are presented to Program Oversight and the Board of Directors.

The Chief Quality & Compliance Officer also reviews the reports and may emphasize any systemic problems or outstanding issues, the Chief Quality & Compliance Officer may at that time begin an investigation process to determine the root cause and takes appropriate action as set forth in the Corporate Compliance Plan.

B. Periodic Audit of Coding and Billing Practices

Procedures for auditing clinical, medical and billing records:

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;

Review of Billing Practice Against Medicaid Regulations

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 Quality & Compliance Officer or Director of Compliance 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 Quality & Compliance Officer or Director of Compliance 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 Quality & Compliance Officer will provide any resources to billing staff that may assist in understanding the Medicaid Regulations that apply to their billing practice.

C. 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 Quality & Compliance Officer and Director of Compliance. 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). Not all of these reports are utilized for all service types, this is just a general list of reports that are utilized as part of this plan. 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
6. **Service Documents Unsigned Report**—This report provides a summary of how many documents are showing up on the report, how many of each document type are unsigned, how many unsigned documents per week, how long have they been unsigned, and how many documents have been unsigned for more than 90 days. This is reported out on a weekly basis
7. **Active Clients Report**—This report will be run twice, for regular service type as well as for pre-admission services (where applicable) 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 MCA 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, MCA 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.

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 Director of Compliance and the Chief Quality & 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.

D. Methodology for Audits

The Chief Quality & Compliance Officer and Director of Compliance 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 Quality & Compliance Officer or Director of Compliance 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 Quality & Compliance Officer and Director of Compliance 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 Director of Compliance works very closely with the Medicaid Compliance Analysts. The Director of Compliance conducts analysis of compliance data and submits reports to the Chief Quality & Compliance Officer, and program leadership. She/he also reviews and updates compliance audit tools.

Timeframe

The Chief Quality & Compliance Officer or Director of Compliance 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 Quality & Compliance Officer or Director of Compliance, 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/Chief Quality & 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 Quality & 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 Quality & 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 Quality & Compliance Officer or to other staff of the program.

Policy

1. Compliance records management is the responsibility of the Chief Quality & 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 Quality & 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 Quality & Compliance Officer's password
 - All records related to information received by the Chief Quality & 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 Quality & 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 Quality & 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 Quality & 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 Quality & 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.

E. 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 Quality & Compliance Officer in the development, implementation, oversight and evaluation of the Compliance Program. The Medicaid QIT will be chaired by the Director of Compliance 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 Quality & Compliance Officer and Director of Compliance 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
- To establish and maintain 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 Quality & 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 Quality & Compliance Officer will consult with the Executive Director/CEO; the Chief Operating Officer, 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 Quality & 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.

X. 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 or intimidation or retaliation for reporting non-compliance, the Chief Quality & 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 Quality & Compliance Officer will, at a minimum, take the following actions:

1. Notify the Executive Director/CEO; Chief Financial Officer and applicable 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 Quality & Compliance Officer or Director of Compliance 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 Quality & Compliance Officer or Director of Compliance will provide to the Assistant Executive Directors 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. According to Medicaid regulations an agency has up to 6 years to make corrections but The Chief Quality & 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 Quality & 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 Director of Compliance will complete reports and provide to Chief Quality & Compliance Officer for review.
7. The Director of Compliance 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 Quality & 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 Quality & 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 (CQA&I) 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 Service Area/Lines of Business Quality Assessment and Improvement Committees (QA&I) including the Chief Quality & Compliance Officer and/or Director of Compliance. The Director of Compliance 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 Chief Quality & Compliance Officer attends CQA&I as needed.

The CQA&I Committee has the authority to require further information from and/or remedial action by a Service Area/Lines of Business QA&I 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 Director of Compliance in conjunction with The Chief Quality & 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 Quality & 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 Quality & 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 Quality & 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 Quality & 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 Quality & Compliance Officer believes the Executive Director/CEO and/or the Chief Financial Officer are involved in non-compliant activities, the Chief Quality & Compliance Officer can directly report to the Chair of the Board of Directors his/her concerns.

XI. Delivery System Reform Incentive Payment (DSRIP) program

Astor is collaborating with various Performance Provider System leads, which are agencies that have been chosen through a rigorous process by NYS Department of Health (DOH) to work with agencies like ours in transforming the healthcare delivery system. These PPS leads are implementing the Delivery System Reform Incentive Payment (DSRIP) program, which is a joint

demonstration program between the NYS DOH and the Centers for Medicare and Medicaid Services (CMS).

DOH website describes DSRIP as follows: “DSRIP is the main mechanism by which NYS will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to \$6.42 billion dollars are allocated to those program with payouts based upon achieving predefined results in system transformation, clinical management and population health”.

Astor as a collaborative partner is receiving DSRIP funds to assist PPS’s leads in meeting the expected goals, which will ultimately achieve the DSRIP’s expectation of reducing health care costs. DSRIP projects and goals include (not all): proactive management of high risk clients, integration of primary care and behavioral health services, evidenced based services/ treatment, strengthen mental health and substance abuse infrastructure systems, etc.

DSRIP Payment Guidelines

Astor will receive DSRIP payments from PPS leads after achieving various goals. It is our responsibility to ensure that DSRIP funds are used as required under Medicaid guidelines. In the event that overpayments are identified, Astor will take prompt corrective actions to refund or otherwise correct the overpayment pursuant to DSRIP or OMIG guidelines. Astor is also expected to report any findings and corrective actions implemented, to the PPS lead.

XII. Outside Legal Counsel

Outside legal counsel is available to assist the Executive Director/CEO, Board of Directors, Chief Financial Officer and Chief Quality & 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 Quality & 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 Quality & Compliance Officer and Astor Services for Children & Families.

XIII. Assessing Effectiveness of Astor’s Compliance Program

The Chief Quality & 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 Quality & Compliance Officer is responsible for ensuring that the system protects the user and patient from potential user errors. The Chief Quality & 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 Quality & Compliance Officer and Director of Compliance 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.

XIV. 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 Quality & Compliance Officer.

APPENDICES CHAPTER 19C: Policies and Procedures Manual

Appendix A

Summary of Federal & NYS False Claims Acts

I. Purpose

The purpose of this section of the employee handbook/manual and Agency Corporate Compliance Plan 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 Agency's compliance program concerning fraud prevention is fully incorporated in this employee handbook/manual. The Agency 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 Agency's obligations under Medicaid, Medicare and other publicly funded health care programs.

III. Scope

This section applies to all Agency programs, operations and employees. This section of the employee handbook/manual will provide the detail required under the DRA and related compliance mandates of State and Federal law. The Agency'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 Agency, 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 Agency.

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. Federal False Claims Act

1.) 31 USC §§3729-3733

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 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 to recover the penalties.¹

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:
 - provides or has provided any portion of the money or property requested or demanded; or
 - will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

¹ 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:

- (i) 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;
- (ii) The person fully cooperated with any governmental investigation of the violation; and
- (iii) 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.

- (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” means that a person, with respect to information:

- (a) Has actual knowledge of the information;
- (b) Acts in deliberate ignorance of the truth or falsity of the information; or
- (c) 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:

- (a) Filing a claim for payment knowing that the services were not provided or were medically unnecessary;
- (b) Submitting a claim for payment knowing that excessive charges are being billed;
- (c) Submitting a claim for payment knowing that a higher billing code which does not reflect the services provided is used;
- (d) Filing a claim knowing that the claim is for duplicate services.

The Act has been used as a basis to impose civil 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.

In addition, pursuant to 42 U.S.C. §1320a-7k(d), if a person fails to report and return an identified overpayment within 60 days of identification, the overpayment is considered an “obligation” under § 3729 and subject to the penalties provided for under the False Claims Act.

2.) **31 U.S.C. §3730 (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 §3729 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:

- (a) More than six years after the date on which the violation of the Act is committed; or
- (b) 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.

3.) **31 U.S.C. §§ 3732 and 3733**

These sections provide detailed jurisdictional and investigatory process rules regarding the False Claim process.

B. Federal Administrative Remedies for False Claims and Statements

1.) **31 U.S.C. §3801 et. seq.**

Section 3801 imposes additional civil penalties for the filing of false claims or statements with the federal government which are conducted through an administrative process. 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:
 - (provided such property or services;

- (provided any portion of the funds for the purchase of such property or services; or
 - 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:
- provided any portion of the money requested or demanded; or
 - 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 (31 U.S.C. §3802). 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 (31 U.S.C §§ 3803-3812).

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 Federal Civil and Criminal Penalties and Sanctions for False Claims

1.) 42 U.S.C. §1320a-7a (Civil)

In addition to the False Claim Act and 31 U.S.C. §3801 et. seq., the federal government may, pursuant to, impose civil monetary penalties (CMP) for improperly filed claims. Such claims include those knowingly presented that were:

- (a) For item or service that person knew or should have known were not provided as claimed, including up coding.
- (b) False or fraudulent
- (c) For service that person knew or should have known were by unqualified physician
- (d) Provided by provider excluded from federal health care program reimbursement
- (e) For service or item that person knew or should have known were unnecessary
- (f) In violation of assignment, agreement on limited charge, or provider agreement

§1320a-7a also provides for penalties for the following additional acts:

- (a) Knowingly providing false or misleading information leading to a hospital discharge
- (b) Being excluded and owning or being an officer of an entity submitting claims
- (c) Providing remuneration to influence beneficiaries

- (d) Contracting with excluded individual or entity for which reimbursement is made
- (e) Participating in kickback or improper or rebate referral remuneration
- (f) Knowingly making or using a material false record or statement for a claim
- (g) Failing to timely permit access to OIG for audit
- (h) Ordering or prescribing by provider when he/she knew or should have known she was excluded from federal health care program reimbursement
- (i) Knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a federal health care program
- (j) Knows of and fails to report and return overpayment

The CMP for the above violations may be assessed in addition to any other penalty prescribed by law. The penalties may be up to \$10,000 for each item or service with some exceptions². In addition, a violator shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.³

The Secretary may also make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a-7b (f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program. Additional CMPs for hospitals and physicians is also provided under the statute.⁴

2.) **42 U.S.C. §1320a-7**

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.

3.) **42 U.S.C. §1320a-7k(d)(2)**

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.

² \$15,000 for each person provided false or misleading hospital discharge information is give; \$10,000 per day for excluded individual ownership or officer/manager participation in billing entity; \$50,000 for participating in kickback or improper or rebate referral remuneration; \$50,000 for each material false record or statement relating to claim; \$15,000 per day for denial of audit access; and \$50,000 for each false statement, omission, or misrepresentation of a material fact in any application, etc.

³ Where violation is bribe, kickback or other improper remuneration, it is 3 times the remuneration. Where violation is for false statement, omission, or misrepresentation of a material fact in any application, it is 3 times the amounts claimed under the application contract.

⁴ Additional CMPs of up to \$2,000 per patient may be assessed against any hospital which improperly induces by payment a physician for limiting services to a Medicare or Medicaid beneficiary/recipient and \$2,000 per patient against the physician. A CMP of up to the greater of \$5,000 or 3 times the amount of home care payments paid may be assessed to a physician that falsifies a certification of need for home care.

4.) 42 U.S.C. §1320a-7b (Criminal)

Pursuant to, 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:

- (a) 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;
- (b) 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;
- (c) 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;
- (d) 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;
- (e) 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
- (f) Knowingly and willfully, for a fee, counsels or assists 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 Laws

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

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000-\$12,000 per claim plus 3 times the amount of all damages, including consequential damages, which the state or local government sustains because of

the violation.⁵ Prohibited acts under State Finance Law §189 include:

- (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 the act;
- (d) Has possession, custody, or control of property or money used, or to be used, by the state or a local 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 state or a local government and, intending to defraud the state or a local 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 state or a local government knowing that the officer or employee violates a provision of law when selling or pledging such property;
- (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 state or a local government; or
- (h) Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a local government, or conspires to do the same.

In addition, the false claim filer may have to pay the government's costs and legal fees expended to recover the damages.

Furthermore, the New York False Claim Act also allows private individuals to file civil lawsuits (Qui Tam) in state court, just as if they were state or local government parties (State Finance Law § 190). 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 (Criminal)**

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 (Criminal)**

⁵ The amount may be dropped to 2 times the damages if the court finds that the violator self-disclosed fully within 30 days of having knowledge, fully cooperated with officials and if the self-disclosure was before criminal, civil or administrative prosecution and the violator had no knowledge of investigation.

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 (Criminal)

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 (Criminal)

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 (Criminal)

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 (Criminal)

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 (Criminal)

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 (Criminal)

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 (Administrative)

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:

- (a) Submitting, or causing to be submitted, a claim or claims for:
 - (i) unfurnished medical care, services or supplies;
 - (ii) an amount in excess of established rates or fees;
 - (iii) medical care, services or supplies provided at a frequency or in amount not medically necessary; or

(iv) 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:

(c) 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

(d) 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 – 31 U.S.C. §3730(h)

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

1.) NY False Claim Act – State Finance Law §191

Any current or former employee, contractor, or agent of any private or public employer who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment, or otherwise harmed or penalized by an employer, or a prospective employer, because of “lawful acts” done by the harmed individual or associated others in furtherance of an action brought under this article or other efforts to stop one or more violations of the State False Claims Act is entitled to all relief necessary to make the person whole, including (a) an injunction to restrain continued discrimination; (b) hiring, contracting or reinstatement to the position such person would have had but for the discrimination or to an equivalent position; (c) reinstatement of full fringe benefits and seniority rights; (d) payment of two times back pay, plus interest; and (e) compensation for any special damages sustained including litigation costs and reasonable attorneys' fees. “Lawful act” includes obtaining or transmitting to the state, a local government, a qui tam

plaintiff, or private counsel solely employed to investigate, potentially file, or file a cause of action under the False Claim Act documents, data, correspondence, electronic mail, or any other information, even though the act may violate a contract, employment term, or duty owed to the employer or contractor, so long as the possession and transmission of such documents are for the sole purpose of furthering efforts to stop one or more violations.⁶

2.) **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.

3.) **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,

⁶ Nothing in subdivision (h) is to be interpreted to prevent any law enforcement authority from bringing a civil or criminal action against any person for violating any provision of law.

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.

VI. Procedure

The Agency 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 Agency 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/Chief Quality & 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 Agency to disclose the information, such information may be disclosed at the direction of legal counsel.

The Agency will not take adverse action against an employee for reasonably requesting assistance from, or reporting potential violations of law or the Agency on policy in good faith to, a supervisor, and the Compliance Officer/Chief Quality & 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 Agency 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 B

Acknowledgement Receipt – Corporate Compliance Plan

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 C

Self-Assessment Tool

Corporate Compliance Self-Assessment Tool

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

	Requirement	Meets Requirements		Provider's Evidence of Compliance or Action Required <i>For each response – Include specific citations to the documents and text that meets the requirement</i>
		Yes	No	

Element 1: Written policies and procedures

1.1	Do you have written policies and procedures in effect that describe compliance expectations as embodied in a code of conduct or code of ethics?			
1.2	Do you have written policies and procedures in effect that implement the operation of the compliance program?			
1.3	Do you have written policies and procedures in effect that provide guidance on dealing with potential compliance issues for all of the following groups: a. employees; and b. others?			<i>"Others" for purposes of this requirement should be defined to include all those individuals that are not employees that are subject to the Compliance Program. This includes, but may not be limited to: executives, governing body members, appointees, and persons associated with the provider.</i>

Element 2: Designate an employee vested with responsibility

2.1	Has a designated employee been vested with responsibility for the day-to-day operation of the compliance program?			<i>Identify the designated employee, and include evidence to support that the person has been vested with responsibility.</i>
2.2	Are the designated employee's (referred to in 2.1) duties related solely to compliance?			<i>Include a job description for all duties of the designated employee.</i>
2.3	Are the compliance responsibilities satisfactorily carried out?			<i>Provide evidence of your assessment of whether the compliance duties are being satisfactorily carried out.</i>
2.4	Does the designated employee (referred to in 2.1) report directly to the entity's chief executive or other senior administrator?			<i>Specify the reporting relationship and provide a copy of an organizational chart. If the designated employee does not report to the chief executive, provide proof that the chief executive has designated the senior administrator to whom the employee reports.</i>
2.5	Does the designated employee (referred to in 2.1) periodically report directly to the governing body on the activities of the compliance program?			<i>Specify the reporting relationship and the frequency of the reporting.</i>

Element 3: Training and education

3.1	Is periodic training and education on compliance issues, expectations and the compliance program operation provided to all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also define the timing of the periodic training, and identify any categories of affected individuals that do not receive training and education, if any.</i>
3.2	Is compliance training part of the orientation for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also define when orientation occurs, and any categories of affected individuals that do not receive orientation, if any.</i>

Element 4: Lines of communication to the responsible compliance position

4.1	Are there written policies and procedures that identify how to communicate compliance issues to appropriate compliance personnel?			
4.2	Are there lines of communication to the designated employee referred to in item 2.1 that allow compliance issues to be reported and which are accessible to all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also Identify any categories of affected individuals that <u>do not</u> have access to the lines of communication identified.</i>
4.3	Is there a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also Identify any categories of affected individuals that <u>do not</u> have access to the lines of communication identified.</i>

Element 5: Disciplinary policies to encourage good faith participation

5.1	Do disciplinary policies exist to encourage good faith participation in the compliance program by all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also identify any categories of affected individuals not covered by the disciplinary policies.</i>
5.2	Are there policies in effect that articulate expectations for reporting compliance issues for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also identify any categories of affected individuals not covered by the policies.</i>
5.3	Are there policies in effect that articulate expectations for assisting in the resolution of compliance issues for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also identify any categories of affected individuals not covered by the policies.</i>
5.4	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also identify any categories of affected individuals not covered by the policy.</i>
5.5	Is there a policy in effect that outlines sanctions for participating in non-compliant behavior for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			<i>Also identify any categories of affected individuals not covered by the policy.</i>
5.6	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant			<i>Also identify any categories of affected individuals not covered by the policy.</i>

	behavior for all of the following categories of affected individuals: a. employees; b. executives; c. governing body members; and d. persons associated with the provider?			
5.7	Are all compliance-related disciplinary policies fairly and firmly enforced?			<i>Also list all policies in effect that support your answer and identify circumstances where compliance-related discipline was enforced.</i>

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

6.1	Do you have a system in effect for routine identification of compliance risk areas specific to your provider type?			<i>Also reference documents in which you've identified your risk areas.</i>
6.2	Do you have a system in effect for self-evaluation of the risk areas identified in 6.1, including internal audits and as appropriate external audits?			<i>Also reference any documents in which you have identified compliance work plans and/or audit plans.</i>
6.3	Do you have a system in effect for evaluation of potential or actual non-compliance as a result of audits and self-evaluations identified in 6.2?			<i>Also reference documents that outline your system for evaluating the cause of compliance problems.</i>

Element 7: A system for responding to compliance issues

7.1	Do you have written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved?			
7.2	Is there a system in effect for responding to all of the following: a. compliance issues as they are raised; and b. as identified in the course of audits and self-evaluations?			<i>Also reference documents that outline your system for responding to actual or potential compliance issues.</i>
7.3	Is there a system in effect for correcting compliance problems promptly and thoroughly?			
7.4	Is there a system in effect for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?			
7.5	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?			
7.6	Is there a system in place for refunding Medicaid overpayments?			<i>Also identify examples of prior refunds of Medicaid overpayments.</i>

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

8.1	Is there a policy of non-intimidation and 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?			<i>Both Non-intimidation and Non-retaliation must be present.</i>
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Appendix D

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 E

Sample Electronic Health Record Reports and Data

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 F

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:		Dis-enrolled:		Setting:	

Q#	Previous Review Date:		
Enrollment Forms (Signed & Dated)			
1	8000 - Referral Form		Signature Date:
2	- 8000 - Waiver Type checked		
3	- 8000 - Referral Type checked		
4	- 8000 - Agency selection filled out		
5	- 8000 - Referral Source checked		
6	8002 - Understanding B2H		
7	8003 - Freedom of Choice		
8	8005 - LOC w/supporting documentation & by qualified evaluator		
9	If Client is DD, is the DDSO Letter of Eligibility present?		
10	8007 - HCI Selection		
11	8008 - Rights		
12	8009 - Notice of Decision		
8004- Application Forms			
13	Signed & dated w/in 60 days of receiving referral?		Signature Date:
14	Correct Waiver Type checked		
15	Application Type checked		
16	HCI Information completed		
17	Is decision section appropriately completed?		
8027- Contact Information List Form			
18	8027- Is the Contact Information List present?		
8011B- Discontinuance/ Reduction of Services Form			
19	Is the form filled out & present if it is applicable?		Signature Date:
Reauthorization Forms (Signed & Dated)			
20	8014 - Reauth. Form		Signature Date:
21	8003 - Freedom of Choice		
22	8005 - LOC w/supporting documentation & by qualified evaluator		
23	8008 - Rights		
24	8017-IHP		Signature Date:
25	Submitted 30 Days Prior to Reauth.?		
Disenrollment Forms (Signed & Dated)			
26	8026- Loss of Eligibility Recommendation Form (if applicable)		
27	8011A- Notice of Decision (if applicable)		
28	8030- Transition Plan (if applicable)		

Notes:

Submitted to the Supervisor by the Medicaid Compliance Analyst on:

HCI Sign & 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:

Compliance %	NA
--------------	----

	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					
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					
Strengths					
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					

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	

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

Was there documentation on the SSPs 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 WSPs in the IHP per month Consistent with progress notes?

2 contacts w/the case planner/manager per month Consistent with progress notes?

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

Were the SSPs 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 SSPs reconcile with billing reports?

Notes:

Outpatient Clinics Audit Tool

Review Date:	<input type="text"/>	Reviewer:	<input type="text"/>
Client Name:	<input type="text"/>	Admission Date:	<input type="text"/>
Client ID #:	<input type="text"/>	Discharge Date:	<input type="text"/>
Primary Clinician:	<input type="text"/>	Doctor:	<input type="text"/>
Is the Client SED?	<input type="text"/>	Is the SED form in chart?	<input type="text"/>

Q#		Previous Review Date:	<input type="text"/>
Pre-Admission & Intake			
1	Did the client have the allowed amount of pre-admission visits (including MD visits) per year at Astor? (if more than 3 occurred, please answer with a N).	<input type="text"/>	
2	Is the admission note present?	<input type="text"/>	
2a	Is the reason for referral noted?	<input type="text"/>	
2b	Are the collaterals identified in the admission note?	<input type="text"/>	
2c	Are the clinical & service-related needs & the services to meet those needs documented?	<input type="text"/>	
Forms (Health Questionnaire & CANS)			
3	Is the Health Questionnaire present & signed by appropriate staff within 30 days of admission?	<input type="text"/>	Signature Date: <input type="text"/>
4	Is the Admission CANS present, signed & completed prior to the Initial TP?	<input type="text"/>	Signature Date: <input type="text"/>
5	Was the Annual Health Questionnaire present and completed on time?	<input type="text"/>	Signature Date: <input type="text"/>
6	Was the Annual CANS present and completed on time? (due annually from the OPC admit date)	<input type="text"/>	Signature Date: <input type="text"/>
Initial Treatment Plan- Due within 30 days of admission			Due Date: <input type="text"/>
7	Was the Initial Treatment Plan completed within 30 days of the admission date? (by Clinician)	<input type="text"/>	Clinician's Date: <input type="text"/>
8	Was the TP signed on time by the MD? (IF the TP was started late by Clinician or Sup, this will be NA)	<input type="text"/>	MD Signature Date: <input type="text"/>
9	Treatment goals, objectives & related services are present & described?	<input type="text"/>	
10	Is the criteria for discharge planning present?	<input type="text"/>	
11	Is the Client/Parent signature present? (Y or NA only: If the answer is no, enter na and answer # 11a).	<input type="text"/>	
11a	If there is NO Parent/Client signature, is there a legitimate explanation of client/parent involvement?	<input type="text"/>	
Treatment Plan Review # 1- Due within 90 days of previously signed TP			Due Date: <input type="text"/>
12	Was the TPR completed on time? (by Clinician)	<input type="text"/>	Clinician's Date: <input type="text"/>
13	Was the TPR signed on time by the MD? (IF the TP was started late by Clinician or Sup, this will be NA)	<input type="text"/>	MD Signature Date: <input type="text"/>
14	Is there an assessment/update towards the goals? (changes since last review)	<input type="text"/>	
15	Is the criteria for discharge planning present?	<input type="text"/>	
16	Is the Client/Parent signature present? (Y or NA only: If the answer is no, enter na and answer # 16a).	<input type="text"/>	
16a	If there is NO Parent/Client signature, is there a legitimate explanation of client/parent involvement?	<input type="text"/>	
30	Is the criteria for discharge planning present?	<input type="text"/>	
31	Is the Client/Parent signature present? (Y or NA only: If the answer is no, enter na and answer # 31a).	<input type="text"/>	

31a	If there is NO Parent/Client signature, is there a legitimate explanation of client/parent involvement?		
Medical			
32	If the client is on Medication prescribed or changed by the Clinic, are all Medication Consents present, signed & dated?		
33	Is there a PCP consent present or a declined consent present? (If declined, answer NA to # 34)		
34	Are there quarterly PCP Letters with medication changes present? (If there are no changes, answer NA).		Dates:
35	If there were there any changes to medications since the last review...are they clearly indicated?		
Discharge			
36	Is there a discharge summary fully filled out and completed within 3 business days of the discharge date?		Signature Date:
37	If the client discharged to alternate care, was the discharge summary sent prior to the client arriving or within 2 weeks of discharge?		Signature Date:
38	Is the Discharge CANS present, signed & dated?		Signature Date:
Utilization Review			
39	Is this a UR Chart? (If N, mark # 39 as N & 40-41 as NA).		Last Review Date:
40	Was the Admission UR completed within 30 days of admission date?		
41	Were all Continued Stay UR's completed within 6 months of the previous UR date?		

Notes:

Submitted to the Supervisor by the Medicaid Compliance Analyst on:

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

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

HCI Signature:

Date:

Overall Compliance % (does not include UR)	
Medicaid Compliance %	
MD/Nursing Compliance %	

Day Treatment Audit Tool

Review Date:		Reviewer:	
Client Name:		Primary Clinician:	
Admission # :		Primary Doctor:	
Admission Date:		Site/Location:	
Dates Reviewed:		Discharge Date:	

Q#			Date of last review:
Pre- Admission & Intake			
1	Did the Client enroll within the first three visits?		
2	Is the Screening & Admission note present? (Day Treatment Screening & Admission Note)		
2a	Is the reason for referral noted?		
2b	Identification of Collaterals present?		
2c	Did the Client enroll within 1 month of the referral date?		
Treatment Plan (Admission)- Due within 30 days of Admission			
3	Completed on time by the Clinician? (IF the TP was started late by Clinician, # 4 will be NA)		Clinician's Date: <input style="width: 50px;" type="text"/>
4	Was the TP signed on time by the MD?		MD's Date: <input style="width: 50px;" type="text"/>
5	Treatment Goals & Objectives are present & described?		
6	Is there a plan to support the client outside of the program?		
7	Is the criteria for discharge planning present?		
8	Is the Parent or Client signature on the TP? (Y or NA only: If the answer is no, enter na and answer # 8a).		
8a	If there is NO Parent/Client signature, is there a legitimate explanation of parent involvement?		
9	If the Parent signature is missing.. Is it because the document was rejected?		
9a	If the document was rejected, was the rejection due to grammar, content or both? (Please write in answer)		
Treatment Plan Review # 1- Due within 90 days of the previous Treatment Plan			
10	Was the TP completed on time by the Clinician? (IF the TP was started late by clinician, # 11 will be NA)		Clinician's Date: <input style="width: 50px;" type="text"/>
11	Was the TP signed on time by the MD?		MD's Date: <input style="width: 50px;" type="text"/>
12	Is there an assessment/update towards the goals? (changes since last review)		
13	Adjustment of goals, time periods & intervention strategies are present?		
14	Does the TPR include input from all staff involved in the treatment of the Client, the Client & Collaterals?		
15	Is the criteria for discharge planning present?		
16	Is the Parent or Client signature on the TP? (Y or NA only: If the answer is no, enter na and answer # 16a).		
16a	If there is NO Parent/Client signature, is there a legitimate explanation of parent involvement?		
17	If the Parent signature is missing.. Is it because the document was rejected?		
17a	If the document was rejected, was the rejection due to grammar, content or both? (Please write in answer)		
Speech Therapy			
42	Is there an IEP on record that includes ST? (Y OR NA ONLY: If there is no ST for, enter NA for # 42-44).		
43	Is the Referral present and signed/dated by: Physician; Physician Assistant; NP?		
44	Were session notes completed/signed within 5 business days of the session?		
IEP			
45	Is the IEP for the current school year present?		

Consent to Treat			
46	Is the consent to treat present, fully filled out signed & dated by all?		
HIPPA			
47	Is the Notice of Privacy Practices and/or the Patient Acknowledgement present & fully filled out?		
Medical			
48	Is there a medication consent for EACH medication prescribed?		
48a	Is each consent for medication signed & dated by the caretaker & a witness?		
49	Was a letter sent to the PCP with a detailed Medication list for the Client?		
50	Reports of all mental/physical exams, assessments present? (Health Questionnaire, Hosp., immunizations, etc.)		
51	Since the last review, if there were there any changes to medications...are they clearly indicated?		
Utilization Review			Last Review Date:
52	Is this a UR Chart? If yes, continue to next question...(If no, mark all as NA).		
53	Was the UR done within 30 days of admission?		
54	Was the Continued Stay Review done on time? (every 6 months)		

Notes:

Submitted to supervisor by Medicaid Compliance Analyst on: _____
 Primary Clinician: Sign and return to SUPERVISOR within one week of the date that this audit was received.
 I certify that I reviewed this audit and made all updates and edits (as appropriate by law).
Signature: _____ **Date:** _____

Overall Compliance %	
MEDICAID Compliance %	
MD Compliance %	

Appendix G

Utilization Review (UR) Policy

VII. Purpose

Astor has developed a Utilization Review Plan in order to systematically monitor and evaluate the use of available agency resources, and the appropriateness of the care and treatment provided to clients. The plan has both an individual and an organizational focus.

VIII. Responsibility

Board of Directors

The Board of Directors has overall responsibility for the use of agency resources and for the appropriateness of the care and treatment provided to the agency's clients. The Board fulfills this responsibility through setting and approving policies and creating strategic plans, approving the organizational structure of the agency, and acting on reports received from administration.

Executive Director and Executive Cabinet

The Executive Director is responsible for operating the agency in accord with established policy, regulation, and standards; safeguarding the agency resources; assuring the appropriateness and quality of services provided; and providing the Board with meaningful reports and information on a regular basis. The Executive Director fulfills these responsibilities in collaboration with other senior staff who make up the Executive Cabinet.

Director of Clinical Outcomes, CANS & TCOM

Director of Clinical Outcomes, CANS & TCOM supervises the Utilization Review system associated with agency OMH programs. Duties include direct supervision of Utilization Reviewer(s) and clinical interns, collaboration with the UR staff on resolving clinical quality concerns, and integration of patterns noted with the CQI, Compliance and Risk Management Teams.

Program Administration and Professional Staff

Program-specific utilization review procedures apply to various programs and services. These procedures provide program leaders with vehicles to monitor the appropriateness of the match between individual client needs and the level of service being provided. Program leaders are also responsible for monitoring the utilization of resources within their areas of responsibility.

On an annual basis, the leadership of each program prepares a program report. These individual reports are incorporated into the annual report prepared by the Executive Director, and they discuss the appropriateness of the utilization of services and resources.

Quality Assessment and Improvement (QA&I) Committees

The results of utilization review procedures are included in service type QA&I Committee meetings and are reported to the Central QA&I Committee. The Utilization Reviewer is a professional position which reports to the Director of Clinical Outcomes, CANS & TCOM. The Utilization Reviewer provides data to the Director of Compliance who also reports analysis of utilization review findings to the Central QA&I Committee.

IX. Confidentiality

Information obtained through the utilization review process is considered confidential and must be handled in accord with the agency's policies and procedures (*see Chapter 3, Client Rights*).

X. Conflict of Interest

Professional staff do not conduct utilization reviews on cases for which they have direct casework or treatment responsibilities. Utilization reviews are conducted by qualified staff not in the team or program for which the utilization review is being conducted.

XI. Criteria

Utilization review criteria are established for each program. These criteria address questions of the under use, the overuse, or the inefficient use of resources, both currently and in the past.

Any criteria determined takes into account requirements by law or regulatory agency. With this in mind, criterion are established for admission, continued stay, and discharge planning.

A. Admission and Continued Stay Criteria

1. Residential Treatment Center (RTC-HTP)

A child ages 5-11 may be approved for admission or continued stay in Astor's Residential Center if documentation exists to substantiate a current diagnosis or diagnostic impression of a mental disorder as described in the current DSM or ICD manuals.

Excluded from treatment are individuals whose primary diagnosis/presenting problems are those of alcohol/substance abuse or mental retardation/ developmental disability.

In addition to a diagnosis or diagnostic impression, documentation must exist to substantiate that at least one of the following conditions related to the disorder is present and that improvement could be expected to occur with this level of treatment.

- (a) Destructive behavior toward self, others, and property.
- (b) Severe functional impairment and, as a result of which, client is unable to care for self.
- (c) Exhibited behavior that cannot be managed at a less restrictive level of care.
- (d) Inadequate response to outpatient care.
- (e) Need to continue this level of care as initiated by another facility or agency.
- (f) Legally mandated admission.

2. Residential Treatment Facility (RTF)

Children are eligible for admission if at a minimum they meet each of the following criteria:

- (a) Have a serious and persistent psychopathology as evidenced by one or more of the following:
 - Severe thought disorder
 - Severe affective disorder
 - Moderate thought disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills
 - Moderate affective disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills
 - Severe conduct disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills
 - Severe personality disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills
 - Any combination of the above

- (b) Intelligence quotient equal to or greater than 51.
- (c) At least 5 years of age but not yet 12.
- (d) Presentation of no likelihood of serious harm to others as defined in section 584.4(a)(8) of NYS-OMH regulations.

Any additional admission criteria must relate to observable characteristics of the child. Such criteria may include age and gender.

3. Therapeutic Foster Care

Child/youth ages 5-17 may be approved for admission if documentation exists to support:

- (a) A diagnosis of a mental disorder using current diagnostic manual (DSM or ICD).
- (b) Substantial problems in social functioning due to a serious emotional disturbance within the past year.
- (c) Serious problems in family relationships, peer/social interaction, or school performance.
- (d) Serious persistent symptoms of cognitive, affective, and personality disorders.
- (e) A level of service needs which requires multi-agency intervention and involvement.

4. Community-Based Outpatient Clinics

A child age 0-18 may be approved for admission or continued stay at this level of care if documentation exists to substantiate a current diagnosis or diagnostic impression of a mental disorder using the nomenclature of the current diagnostic manuals (DSM or ICD).

Excluded from treatment are individuals whose primary diagnosis/presenting problems are those of mental retardation or developmental disability.

In addition to a diagnosis or diagnostic impression, initial assessment will indicate that:

- (a) The client (child or parent) would benefit from this level of care.
- (b) Aside from crisis services, the client can be expected to maintain, improve his/her emotional well-being, or prevent deterioration of emotional well-being as indicated by attendance (measurable) at scheduled appointments.
- (c) Client continues to maintain him/herself in the community with an adequate support system.

5. Day Treatment

A child ages 3-13, or an adolescent, may be approved for admission or continued stay in an age-appropriate program at this level of care if documentation exists to substantiate a current diagnosis or diagnostic impression of a mental disorder using nomenclature of the current DSM or ICD Manuals and functional impairments as defined in NYCRR, Part 14, Mental Health, 587.11, 587.4, or 587.9.

In addition to the diagnosis or diagnostic impression, client may be identified as being unmanageable in a regular school setting or may be experiencing a learning disability that prevents his/her functioning in a regular school setting.

Excluded from treatment are individuals whose primary diagnosis/presenting problems are those of mental retardation or developmental disability.

6. Preventive Services – These services do not require a UR process.

B. Discharge Criteria

Discharge criteria are client-and program-specific and are related to the current level of care and the client's response.

An interdisciplinary treatment team is responsible for assessing and addressing service needs and discharge plans for the client upon admission and throughout his/her stay in the program.

XII. Utilization Review Methods

Astor uses combinations of the following methods to accomplish the identification of overuse, underuse, or inappropriate use of available resources.

A. Admission Reviews

A review of the appropriateness of service occurs within a specified time from the date of admission for treatment services. In residential programs, the review occurs within one to three days. In outpatient programs the review occurs within 30 days. These reviews are performed by a Utilization Reviewer who is outside of the program, or by program staff who are not clinically involved with the case.

The majority of children admitted to Astor programs will have also been pre-screened by external entities such as HMOs, Committees on Special Education, staff of Departments of Social Services, or staff of Departments of Mental Health. In addition to this, Astor's own intake process involves a screening for appropriateness of level of service.

The compliance monitoring of clinical records includes assessment of whether admission reviews were conducted and whether alternative levels of care were recommended. Findings from this monitoring activity are filed electronically for ongoing monitoring and evaluation. They are provided to clinical supervisors to address any issues identified in the monitoring of these cases.

B. Continued Stay Reviews

A review of the continued need for service at the current level occurs within a specified time from date of admission (in accord with the regulations). They are conducted by an independent reviewer not associated with the team or program for which utilization reviews are taking place.

The compliance monitoring of clinical records includes an assessment of whether continued stay reviews have been completed on the cases studied and whether alternative levels of care were recommended. Findings from this monitoring activity are filed electronically for ongoing monitoring and evaluation. They are provided to clinical supervisors to address any issues identified in the monitoring of these cases.

XIII. Program-specific Utilization Review Procedures

1. Residential Treatment Center (RTC)

Requirements for admissions, continued stay, and discharge plans are satisfied on the *Uniform Case Records* submitted after 30 days, 90 days, and every six months thereafter. Astor does not conduct independent Utilization Reviews for the RTC.

2. Residential Treatment Facility (RTF)

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.

- (a) The Utilization Review Committee (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 regulations). 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.
- (b) Each resident shall have an Admissions Review no later than 30 days after admission. This is documented with a Psychiatric Utilization Review Screening Report, 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. These forms are kept in the client's record.
- (c) Continued Stay Reviews will be done every 90 days after the admission UR. These are documented with a Psychiatric Utilization Review Screening Report. 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.
- (d) 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.
- (e) 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.
- (f) 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.

- (g) To ensure that all records are being monitored, the compliance analyst for this service area maintains a list of clients who have received UR's and compliance of documentation being completed.

3. Therapeutic Foster Care

Requirements regarding admissions, continued stay, and discharge plans are satisfied on the "Uniform Case Records" submitted after 30 days, 90 days, and every six months thereafter. Astor does not conduct independent Utilization Reviews for TFBH.

4. Partial Hospitalization

Utilization Reviews for the Partial Hospitalization program are conducted by an independent professional staff person who is part of the Clinical & Quality Outcomes department and has no clinical communication about the case.

Clinical Documentation and Timeframes

- (a) The Utilization Reviewer completes the reviews in the Electronic Health Record using a UR form.
- (b) Admission Reviews are performed within the first 4 visits after admission.
- (c) Continued Stay Reviews are performed every two weeks after admission
- (d) As part of the UR process the following documents are reviewed:

- Previous UR findings
- CANS
- Intake Documentation
- Treatment Plans
- Progress Notes
- Discharge Summary (if necessary)

- (e) Tracking of Utilization Reviews

According to regulations UR's are to be completed for at least 25% of census. Compliance with this regulation is met through the tracking of admissions and discharges for all OMH licensed programs that require a UR.

- (f) Utilization Review Findings

The Utilization Reviewer notifies her supervisor and Program Director of the findings. Any case determined to require alternate services will be reviewed by the Program Director, primary clinician, and the psychiatrist. Ultimate decision of whether alternate care is necessary will be made by the treating psychiatrist. In the event the Psychiatrist disagrees with the Utilization Reviewers recommendations, the decision is documented in the client's record as a memo to chart.

5. Day Treatment Programs

Utilization Reviews for the Day Treatment programs are conducted by an independent professional staff person who is part of the Quality and Clinical Outcomes department and has no clinical communication about the case.

Clinical Documentation and Timeframes

- (a) The Utilization Reviewer completes the reviews in the Electronic Health Record using a UR form.
- (b) Admission Reviews are performed within 30 days after admission.
- (c) Continued Stay Reviews are performed within 7 months after admission and every 6 months thereafter.
- (d) As part of the UR process the following documents are reviewed:
 - Previous UR findings
 - CANS
 - Intake Documentation
 - Treatment Plans
 - Progress Notes
 - Discharge Summary (if necessary)
- (e) Tracking of Utilization Reviews

According to regulations UR's are to be completed for at least 25% of census. Compliance with this regulation is met through the tracking of admissions and discharges for all OMH licensed programs that require a UR.
- (f) Utilization Review Findings

The Utilization Reviewer notifies her supervisor and Program Director of the findings. Any case determined to require alternate services will be reviewed by the Program Director, primary clinician, and the psychiatrist. Ultimate decision of whether alternate care is necessary will be made by the treating psychiatrist. In the event the Psychiatrist disagrees with the Utilization Reviewers recommendations, the decision is documented in the client's record as a memo to chart.

6. Out Patient Clinic Programs

Utilization Reviews for the Out Patient Clinic programs are conducted by an independent professional staff person who is part of the Quality and Clinical Outcomes department and has no clinical communication about the case.

Clinical Documentation and Timeframes

- (a) The Utilization Reviewer completes the reviews in the Electronic Health Record using a UR form.
- (b) Admission Reviews are performed within 30 days after admission.
- (c) Continued Stay Reviews are performed within 7 months after admission and every 6 months thereafter unless the recipient is:
 - Discharged out of the program and subsequently readmitted, wherein the cycle begins again; or
 - Receiving medication therapy and medication education services only, wherein the need for continued treatment shall be reviewed every 12 months thereafter.
- (d) As part of the UR process the following documents are reviewed:

- Previous UR findings
 - CANS
 - Intake Documentation
 - Treatment Plans
 - Progress Notes
 - Discharge Summary (if necessary)
- (e) Tracking of Utilization Reviews
- According to regulations UR's are to be completed for at least 25% of census. Compliance with this regulation is met through the tracking of admissions and discharges for all OMH licensed programs that require a UR.
- (f) Utilization Review Findings
- The Utilization Reviewer notifies her supervisor and Program Director of the findings. Any case determined to require alternate services will be reviewed by the Program Director, primary clinician, and the psychiatrist. Ultimate decision of whether alternate care is necessary will be made by the treating psychiatrist. In the event the Psychiatrist disagrees with the Utilization Reviewers recommendations, the decision is documented in the client's record as a memo to chart.

XIV. Financial Reports and Statements

There are established timetables for the preparation and review of a variety of reports, forms, statements, and audits. This includes, but is not limited to, the following:

- Monthly Financial Reports—completed by 14th of the following month.
- Cash Sheet—completed by 2:00 P.M. daily.
- Cash Receipt Log—completed by 12:00 noon daily.
- Aging of Receivables and Payables—completed by the 21st day of following month.
- Bank Reconciliations—completed by the 21st day of the following month.

The completion and review of these reports requires the involvement of the staff accountant, the Finance Manager, and the Chief Financial Officer. Specific items may be subject to further review internally by program staff, the Assistant Executive Directors, the Executive Director, the COO as well as possible review by external bodies such as funding agencies, rate setting agencies, and auditors.

The Finance/Audit Committee of the Board of Directors meets monthly to review the financial reports. The quarterly meeting of the Board includes a review of the financial status of the agency.

Monthly, quarterly, and/or annual reviews may also be required by funding sources, foundations, regulatory bodies, banks, etc.

Independent Audits

Astor has engaged an independent public accounting firm to perform the audits indicated below:

- Annual Audit of Astor Services for Children & Families, including the A133 Audit
- Annual Audit of The Astor Learning Center

- CFR Reports

Other audits are conducted on a regular basis by the following:

- New York City DMHMRAS Auditors—Bronx Clinics
- Dutchess County Office of Comptroller—Dutchess County Programs
- New York City ACS Auditors—Placement programs
- USDA Audit—Food program for Head Start and Day Care
- NYS Breakfast and Lunch—Food Program for Residential

XV. Evaluation of Utilization Plan

The Utilization Review Plan is incorporated within the agency's QA&I Plan and as such is reviewed annually by the Central QA&I Committee.

XVI. Independence of Utilization Review Process & Appeal Process

Utilization Review is a fully independent process, and, as such, is not subject to oversight by program supervisors, clinicians, or program psychiatrists. If clinicians, or program supervisors, disagree with a UR finding, they must conduct an in-person review with the treating psychiatrist on the case. That meeting should include the therapist, the psychiatrist, and the site or program supervisor. Reasons for departure from accepted standards of care (e.g., admission criteria, continued stay criteria, or discharge criteria) must be reviewed in the meeting. The treating psychiatrist must determine if the UR finding should be overridden due to valid clinical criteria, and must document those criteria, and the decision to override the UR finding, in a memo to the patient's chart. Utilization Reviewer tracks whether the program is documenting when they go against the reviewers recommendations. The program leadership should inform Director of Clinical Outcomes, CANS & TCOM and Utilization Review staff of the decision that was made by the psychiatrist.