

Policies and Procedures Manual

Chapter 19C

Corporate Compliance Program

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Corporate Compliance Program

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I. Introduction

Astor Services' (Astor) mission is to provide essential supports, tools and high quality, comprehensive behavioral health and educational services to engage, empower and strengthen children, adults and families in all communities. Sponsored by Catholic Charities of the Archdiocese of New York, Astor is an expression of the church's concern for the poor and vulnerable. Astor's services are provided to all for whom they are appropriate without regard to race, creed, color, national origin, gender or gender identity, as well as disability.

Astor 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 Program (also occasionally called the "Corporate Compliance Plan") to comply with the provisions of the Deficit Reduction Act of 2005, NYS Office of Medicaid Inspector, Social Services Law 363-d first implemented in 2009, and the Office of Inspector General of the Department of Health and Human Services recommendations first issued in 1988. Specifically, Appendix A 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, preventing and correcting fraud, waste and abuse and non-compliance with Medicaid and associated program requirements. Astor has a record of fostering compliance in its programs spanning nearly two generations well before mandated plans and has updated and enhanced its compliance responsibilities pursuant to legal mandates as they have been enacted under State law.

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. A summary of all key elements of Astor's Compliance Plan will be available on Astor's Website, including the name of Astor's compliance officer and all methods of reporting issues or violations under this Plan.

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

Astor's Compliance Plan is reviewed and updated at least annually, and when there are significant changes to applicable federal and state laws and regulations. The processes defined within this policy are well-integrated into Astor's operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body.

According to New York State Social Services Law §363-d (2) and 18 NYCRR Part 521/363-d /363-d .3(c), as well as authorized guidance documents issued by the OMIG and/or OMH, the required elements of an "effective compliance Plan" include the following elements:

1. **Written Policies and Procedures**

Written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance Plan, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel including all Affected Individuals associated with Astor's Medicaid services and operations which describe how potential compliance problems are to be reported, investigated and resolved. "Affected Individuals" is

defined as all persons who are affected by Astor program risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. Astor also emphasizes in its Compliance Program a policy of non-intimidation and non-retaliation for good faith participation in the compliance Plan, 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 Labor Law.

2. Compliance Officer and Compliance Committee

Designate an employee to serve as compliance officer vested with responsibility for the day-to-day operation of the compliance Plan; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance Plan; designate a compliance committee to ensure that the compliance program is well-integrated into Astor's operations and supported by the highest levels of the organization through a compliance committee consisting of senior managers with defined reporting protocols. This includes that: (i) the compliance committee reports directly to the chief executive and governing body; (ii) the compliance committee charter includes duties and responsibilities for coordination with the compliance officer relating to assessments and significant actions relating to Astor's compliance duties; and (iii) that the compliance committee coordinates with the compliance officer to ensure that all Affected Individuals complete compliance training and education during orientation and annually.

3. Training and Education

Training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations, and the compliance Plan operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member as well as Affected Individuals in accordance with Astor's Compliance Training Protocols and Policies, all such training will include assessments of the effectiveness of the training as periodically evaluated.

4. Lines of Communication

Communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives, and governing body members as well as other Affected Individuals, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

5. Disciplinary Standards

Disciplinary policies to encourage good faith participation in the compliance Plan by all Affected Individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline progressive measures to ensure compliance as well as deterrent measures for violations of Astor's Compliance responsibilities such as sanctions for:

- a. failing to report suspected problems.
- b. participating in non-compliant behavior;
- c. retaliation or intimidation of Affected Individuals in relation to their compliance obligations, including the reporting of compliance violations by others, or
- d. encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced.

6. Audits and Monitoring

Auditing and monitoring policies for routine auditing and monitoring of compliance risks. This may include, but is not limited to, the following: (i) internal and external audits are documented and shared with the compliance committee and governing body; (ii) the annual compliance program reviews are shared with the chief executive, senior management, compliance committee, and governing body; (iii) monthly exclusion checks with respect to all Affected Individuals which are shared with the compliance officer and appropriate compliance personnel; (iv) measures designed and implemented to prevent, detect, and correct non-compliance with Medicaid

program requirements, including fraud, waste, and abuse most likely to occur for Astor's risk areas and organizational experience; and credentialing of providers and persons associated with providers, (Affected Individuals as appropriate) mandatory reporting, governance, and quality of care of medical assistance Plan beneficiaries.

7. Responding to Compliance Issues

A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified during self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies, and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the Office of Medicaid Inspector General; and refunding overpayments. The Compliance Officer and Compliance Committee have established and implemented procedures and systems for promptly responding to compliance issues, including any issues identified in the course of an internal or external audit. Examples include, but are not limited to: (i) Taking prompt action to investigate the conduct in question and determining if any corrective action is required; (ii) Correcting compliance problems promptly and thoroughly to reduce the potential for recurrence; (iii) Monitoring plans of correction to ensure compliance issues do not recur; (iv) Ensuring ongoing compliance with state and federal laws, rules, and regulations of the Medicaid program; and (v) Promptly reporting credible evidence that a state or federal law, rule, or regulation has been violated to the appropriate governmental entity.

Astor's implementation of these elements is described in the plan below.

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 Compliance Manual ("Compliance Manual") which is acknowledged by all employees and Affected Individuals and the Employee Handbook, the following Corporate Compliance Code of Conduct is intended to guide Agency 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, they should consult their supervisor and/or administrator.

1. Astor will bill only for services actually rendered and shall seek the amount to which it is entitled.
2. Astor 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 Compliance Committee whenever possible. The 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 (E.H.R) 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 E.H.R you are allowed as the 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 program area, or speak with your direct supervisor and/or administrator.
14. The promotion of, and adherence to, the elements of the compliance program should 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 regulations.
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

Astor has designated a Deputy Director of QA/QI, Client Risk, & Compliance/Privacy Officer (hereafter known as 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
Jennifer LaBarbera	Deputy Director of QA/QI, Client Risk, & Compliance/Privacy Officer	jlabarbera@astorservices.org	845-768-2895
Amie Adams	Chief of Quality Improvement, Client	aadams@astorservices.org	845-264-8061

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A. Appointment and Duties of the Compliance Officer

The Governing body of Astor approves appointment of the Compliance Officer who will undergo training and attest to their duties and responsibilities. The Compliance Officer performance duties as set forth below will be assessed by Governance under a performance plan and evaluation process evidencing effective performance of compliance responsibilities and other duties. Duties shall include:

- Attends the Program Oversight Committee of Board meetings, prepares reports of Medicaid-related performance indicators as needed, and participates in any and all internal and external audits.
- Annually assesses the effectiveness of the agency-wide compliance plan and updates the Plan as necessary. Implements changes to the Plan and communicates those changes to staff and vendors.
- Monitors and ensures agency compliance with regulatory accrediting agencies and is the primary coordinator of the agency’s internal compliance program.
- Works closely with the Chief of Quality Improvement, Client Risk, & Compliance on the preparation of bi-monthly reports to the Board of Directors Program Oversight Committee and of annual reports to the Board of Directors.
- Responsible for maintaining orientation materials/training for new employees and their responsibilities around the Agency Corporate Compliance Plan. As needed, conducts in-person training on Compliance.
- Supervises the Compliance Analysts. Provides on-going supervision and training as needed and ensures supervisees are completing required tasks. Provides support to these positions as needed and acts as the backup for them in their absence.
- Functions as a leader in the oversight and tracking of Compliance throughout the agency. Responsibilities include developing and maintaining detailed knowledge of each program’s system for tracking and improving Compliance, regular auditing of program client charts and billing procedures to ensure Compliance, and the development and maintenance of a database used to track Medicaid-related performance indicators. Manages the agency Compliance/Privacy hotline. Responsible for investigating any reports of fraud, waste, or abuse as per the Corporate Compliance Plan and with guidance from the agency attorney.
- Chairs the Compliance Committee and is responsible for ensuring that the Committee addresses the mandate. Consults with the Committee and reports on findings. Reports directly to the CEO and the Governing body of Astor as needed throughout the course of each year. The Compliance Officer is responsible for the annual compliance assessment and certifications as required by OMIG procedures.
- Works closely with the agency billing and finance departments to maintain and improve agency-wide compliance with Federal and State laws, rules, and regulations surrounding the provision of Medicaid-funded behavioral health services. Ensures agency-wide compliance and training on the Federal and NYS False Claims Acts & Whistleblower Protection.
- Implements and performs a system-wide, comprehensive auditing program for all locations that perform Medicaid billing. This system includes coding and documentation reviews.

- Maintains comprehensive and up-to-date knowledge of any and all rules, regulations, manuals and transmittals pertaining to the Medicaid-funded programs in the agency and shares knowledge with program leadership. Uses independent judgment, in conjunction with supervision by the Chief of Quality Improvement, Client Risk, & Compliance, and program leadership, to interpret CMS and New York State rules and regulations.
- Ensures that all employees, vendors, and contractors are checked, prior to hire and every 30 days, on the OIG, OMIG, and GSA websites' Medicaid Exclusions Lists. They are also responsible for verifying and resolving any matches.
- Works collaboratively with Chief Program Officer, and service area AED's and their designees to identify compliance related strengths and weaknesses in all Medicaid-funded programs. Takes the lead in the development of corrective action when programs need to improve Compliance, and reports to the CQI Committee and Program Oversight Committee of the Board on all corrective initiatives. Works closely and provides oversight to Compliance staff by ensuring that they are abiding by the agency-wide corporate compliance plan. Provides guidance to Compliance staff and analyzes reports from reviews/audits. Strives to maintain a professional, collaborative partnership with program leadership and staff.
- Conducts aggregate analyses of Compliance related data as needed (for financial audits, program audits, Board reports, and annual reports). Uses analyses and reports to develop recommendations or intervention strategies to correct, and proactively prevent Compliance problems. Seeks legal counsel, when necessary, to assist in interpreting findings and/or Medicaid laws and regulations.
- Coordinates annual education and provision of waste, fraud and abuse materials under the Deficit Reduction Act of 2005 as required under 18 NYCRR Section 521-1.4(a)(2)(ix) and the provisions of 42 U.S.C. 1396a(a)(68). To the extent vendors and contractors qualify as Affected Individuals, the Compliance Officer and Compliance Committee shall also be responsible to ensuring training of such non-employed individuals or entities as required by law for an effective compliance training protocol.

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

Other duties assigned to the compliance officer include:

- Manages the agency's Incident Review Committee, and as such is responsible for oversight of all incident follow up at the individual incident and aggregate pattern level. They also facilitate auditing action plans developed as a result of serious incidents. Responsibilities include attendance at monthly program level quality assurance/improvement meetings throughout the agency's catchment area, chair of the Central Quality Assurance & Improvement Committee, preparation of CQA/I Committee minutes, and accurate, well-organized maintenance of documentation of all quality assurance related activities.
- Attends the agency's monthly Clinical Leadership meeting and participates in various agency meetings associated with new business initiatives. Facilitates required and/or necessary review and editing of the Agency Policy and Procedure Manual at the CQA/I and Board levels.

- Primary coordinator of the agency's targeted recertification with The Office of Mental Health (OMH). Responsibilities include preparing for recertification, facilitating the on-site surveys and tracking and monitoring applicable corrective actions. Coordinates the completion of the bi-annual OMH Patient Characteristics Survey. Ensures agency compliance with OCFS regulations related to 29-I and other related OCFS regulations.
- Oversees the tracking of a variety of quality indicators for the agency and prepares reports on those indicators as needed. Coordinates incident management for the agency, supervises program response to client and family concerns and problem identification forms and tracks program progress on agency wide quality improvement projects.
- Serves as the agency's HIPAA Privacy Officer. Responsibilities include overseeing all ongoing activities related to the development, implementation, and maintenance of the agency's HIPAA Privacy policies in accordance with applicable federal and state laws. The Privacy Officer performs ongoing compliance monitoring activities, provides or ensures the delivery of privacy training and orientation to all employees, volunteers, consultants, and temporary staff, participates in the ongoing compliance monitoring of all business associate agreements, oversees and ensures the rights of patients to their protected health information when appropriate, administers the process for receiving, documenting, tracking, investigating, and taking action on potential HIPAA violations or complaints, and reports breaches annually to the Department of Health and Human Services. The Privacy Officer ensures compliance with privacy practices, promotes privacy awareness activities within the organization, works closely with the Security Officer to ensure alignment between security and privacy practices, maintains current knowledge of applicable federal and state privacy laws, and would cooperate with the Department of Health and Human Service's Office of Civil Rights in a compliance review or audit. The Privacy Officer coordinates the auditing of Authorizations to Release, accounting of disclosures and conducts HIPAA walk throughs agency-wide as applicable.
- Serves as the agency's primary coordinator of all matters of investigation, documentation, and communication around the New York State Justice Center, allegations against staff, and other serious incidents and situations needing independent investigation. Arranges for investigators and receives, reviews, and disseminates reports. Provides oversight at all levels of the agency to the completion of follow up and/or HR response to these investigation findings. Involved with Justice Center led investigations and assists programs leaders in facilitating Justice Center needs and requests.
- Works closely with Executive leadership to provide oversight of, and feedback to, the programs around restraint practices and documentation.
- Responsible for maintaining orientation materials/training for new employees and their responsibilities around HIPAA, mandated reporting of abuse and neglect and the Justice Center. As needed, conducts in-person training on HIPAA, and Mandated Reporter requirements.
- Supervises the Quality Improvement Coordinator and the Information and Risk Management Coordinator. Provides on-going supervision and training as needed and ensures supervisees are completing required tasks. Provides support to these positions as needed and acts as the backup for them in their absence.

These duties do not hinder the compliance officer's ability to carry out their primary responsibilities in any way. Responsibilities outside of compliance, are clearly delineated and separated through a single job description that separates the compliance and non-compliance elements of the job.

- A. Performance of the compliance officer is assessed annually by the Chief of Quality Improvement, Client Risk, & Compliance. The evaluation is available to the board of directors upon request from the Human Resources department.

Duties of Chief of Quality Improvement, Client Risk, & Compliance

The Chief of Quality Improvement, Client Risk, & Compliance is responsible for comprehensive oversight of quality improvement, client risk management, regulatory requirements—and Medicaid compliance in all agency programs. They supervise the QA/QI, Compliance team, and E.H.R. Conducts ongoing assessment of agency-wide client risk management. Serves on various quality improvement and oversight committees, including the Central Quality Improvement Committee, is a member of the Program Oversight Committee of the Board of Directors, and attends full Board meetings. The Chief of Quality Improvement, Client Risk, & Compliance reports to the Chief Executive Officer (CEO), participates fully in the Strategic Team, and works closely with the Chief Program Officer (CPO) and the Chief Financial Officer (CFO). They also work closely with other members of the Strategic Team, and Executive team to ensure a strong alliance between program operations and all aspects of quality improvement and compliance. They represent the agency on external workgroups and committees that are key to agency success in the evolving world of integrated healthcare. In all areas related to Compliance & Quality, they maintain awareness, through a system of auditing, oversight, and communication, of emerging areas of potential non-compliance or poor quality, and keeps both the CEO and the CPO apprised of any concerns.

IV. Compliance Team

Astor's Compliance Team

The Compliance Team will work collaboratively to ensure effective implementation of the overall Compliance Program as well as HIPAA Privacy standards. Together with the Compliance Officer, Astor had devoted resources to positions including Compliance Analyst and Utilization Reviewer.

Duties of Compliance Analyst (CA)

Under the direct supervision of the Compliance Officer, the 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 of Quality Improvement, Client Risk, & Compliance or Compliance Officer and Assistant Executive Director
- Provide support and reports on special assignments

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 applicable 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
- Submits timely reports to Program Directors, Associate Executive Director, and Compliance Officer based on the number of URs conducted by program and findings
- Provides support and reports on special assignments

V. Communication and Changes in Compliance Plan

Changes in the Compliance Program shall be initiated by the Compliance Officer, reviewed by the Compliance Committee and approved by the CEO and Governing Body. Archival versions of the Compliance Program shall be maintained for 6 years on a running basis with all changes or modifications reflecting an effective date. The Compliance Officer will distribute in writing, make available via Astor's SharePoint Folder, and/or post in conspicuous places, any modifications of, or amendments to this Compliance Plan. The Compliance Officer will also provide employees, contractors, vendors, agents of the Agency and professional staff members and Affected Individuals with written explanations of any substantial changes in these policies. If the 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.

In accordance with Section XII, the annual assessment of Astor's Compliance Program will include changes in the Program as well as any required changes in compliance policies and/or standards which shall be assessed annually. Astor will undertake all efforts needed to communicate changes and incorporate such matters within its Compliance Training and Education Plan with respect to all Affected Individuals.

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 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 payers, such as employees involved in the coding, billing, cost reporting and marketing processes. In addition, compliance training will be developed and implemented with regard to other Affected Individuals in accordance with the risk assessment relating to non-employed staff.

A. Compliance Plan Training and Education

- For new employees and clinical consultants, the Compliance Plan will be provided during the orientation process and an educational session will occur at that time but no later than 30 days after hire or onset of services. All supervised personnel will be informed that strict compliance with the Compliance Plan is a condition of employment. All new employees and clinical consultants will be expected to sign a certification (see Appendix B) stating that they understand and will comply with the Plan. We will expect all staff to annually certify receipt and review of the Plan through their participation in mandated annual compliance training.
- For vendors, contractors and other agents who provide any service where Medicaid dollars or funding 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. In addition, where applicable, contracts contain termination provisions for failure to adhere to Astor's compliance program requirements. Human Resources provides Affected Individuals with compliance training materials upon start of contract and during the re-credentialing process. As applicable, alternate training may be customized to the needs of an effective compliance program with respect to vendors and contractors who do not provide services on site or directly to those served by Astor's programs.

- For members of the Board of Directors training will occur annually.

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 A for a summary of the laws). These trainings are a requirement of the Compliance Plan and will be conducted by the Compliance Officer or duly competent and experienced designees. 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 SharePoint folder. Once they have viewed the presentation and the supervisor 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 and other Affected Individuals 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.

The effectiveness of compliance and false claims training is evaluated in a quiz that is completed at the conclusion of training provided at orientation.

C. Training and Education Standards

The Human Resources Department in coordination with the Compliance Officer will develop and maintain a "Compliance Training and Education Plan" to be updated as standards change and reviewed on an annual basis. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing and frequency of the training, which affected individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated.

Compliance training and education will be documented in an annual training plan that includes:

1. Required subjects or topics to be maintained by subject area with the content of any reading, presentations or other online and/or written materials maintained for a period of 6 years.
2. Each program will include timing and frequency of training,
3. Each program will be customized to Affected Individuals by class, such as employees, governance/executive positions, and essential contractors followed by non-essential vendors who are required to attend,
4. Each program will include methods to be used to track attendance to be maintained for a period of 6 years, and
5. All programs will be assessed as to the effectiveness of the training to be periodically evaluated, including quizzes and assessments.

Compliance program training standards will include:

1. Each program will be customized for different types of Affected Individuals, including contractors, agents, subcontractors, and independent contractors (Contractors), based upon specific issues for each type, as long as all Affected Individuals meet the core training requirements of the Medicaid compliance program. Such types may include:
 - (i) Employees and related personnel to be trained within 30 days of hire or retention and annually thereafter.
 - (ii) Governance and Executive Staff to be trained annually
 - (iii) Essential Contractors to undergo training/education on compliance and waste prevention upon onset of services and annually thereafter.
 - (iv) Non-Essential Vendors to complete acknowledgements of education/training materials within 30 days of the onset of services and annually thereafter.
2. The programs relating to vendors and contractors will be coordinated with DRA-05 requirements with a dated distribution letter and/or completion acknowledgement to evidence that compliance training occurred pursuant to self-study and/or online training modules.
3. Training and education shall be provided in a form and format accessible and understandable to all affected individuals, consistent with Federal and State language and other access laws, rules or policies. Compliance training will be provided in a manner that is understandable and accessible to all Affected Individuals. For example, if Affected Individuals include people whose primary language is not English, the training will be made available in appropriate languages.
4. The training and education shall include, at a minimum, the following topics:
 - (i) the required Astor risk areas as identified by the Compliance Committee;
 - (ii) Astor's compliance program written policies and procedures;
 - (iii) the role of the compliance officer and the compliance committee;
 - (iv) how affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the compliance program;
 - (v) disciplinary standards, with an emphasis on those standards related to Astor's compliance program and prevention of fraud, waste and abuse;
 - (vi) how Astor responds to compliance issues and implements corrective action plans;
 - (vii) requirements specific to Astor's categories of service;
 - (viii) coding and billing requirements and best practices, if applicable;
 - (ix) claim development and the submission process, if applicable;

VII. Reporting Requirements

Astor believes that it is our employees and service providers who may first find instances where organizational policy or regulation is not being followed. Therefore, the effectiveness of our Compliance Program depends on the willingness of Affected Individuals in the front line of care delivery and payment in all parts and at all levels of the organization to step forward, in good faith, with questions and concerns or report issues anonymously. 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 clients. 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, 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 Compliance Officer. (See procedures for reporting possible non-compliance below.)

All reports of possible fraud, waste and abuse, or other matters related to compliance must be reported to the 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 their 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 they have doubts or are 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 Assistant Executive Director or directly to the Compliance Officer with the question and they will investigate and answer the question.
3. Every employee has a duty to Astor and to our clients 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, implementing corrective action as 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 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. **Compliance Officer:** Directly to the Compliance Officer through the hotline number at 1-866-293-0031. This line will be monitored only by the Compliance Officer (or their designee during vacations and other prolonged absences). This hotline number is anonymous and confidential.
2. **Voice Mail or Face-To-Face Reports:** Voice mail or face-to-face reports to the 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 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 Compliance Officer and the Assistant Executive Director.

Employees may also report suspected noncompliance directly to NYS OMIG:

- Online: <https://omig.ny.gov/medicaid-fraud/file-allegation>
- Telephone: (877) 873-7283
- Fax: (518) 408-0480
- Mail: NYS OMIG Bureau of Fraud Allegations, 800 North Pearl Street, Albany, New York 12204

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. Additionally, the Agency, through its ongoing monitoring, may determine a breach(es) has occurred. In either instance, where a breach is confirmed, appropriate actions will be taken by the Agency.

As a result, in order to correct or improve employee performance, Astor encourages employee counseling as an initial step. However, there may be times (such as when the outcome of an investigation determines fraud has taken place) where more severe action is appropriate. In these cases, formal disciplinary actions will range from verbal warnings to termination or revocation of contract. The Compliance Officer shall disseminate the range of disciplinary standards for improper

conduct during each training session to educate personnel and contractors regarding these standards. When disciplinary action other than a verbal warning is proposed, the Human Resources Office will be contacted, and they will coordinate such action.

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. 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 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 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 Compliance Officer will explain the Agency's Non-intimidation and Non-retaliation Policy to each caller or reporter.
2. The Compliance Officer will give the reporter a means for contacting them confidentially to report any actions the reporter believes is retaliatory.
3. The 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 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 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 searchable list of excluded individuals and entities which is also checked. In addition, 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 has implemented the following policy:

1. Prior to hiring an employee or consultant, the Human Resources Department will check all of the websites noted above. Printed proof of “no matches” will be filed in the employee’s/consultant’s personnel record;
2. For current employees, consultants, vendors or contractors, we utilize a licensed software product to check all relevant websites to ensure that all relevant exclusionary information is obtained by Astor at the very least within 30 days of any posting of an exclusion. Any matches that show up are verified and resolved by the compliance department;

All matches will be addressed by the Compliance Officer and appropriate staff. If the person is working for a program where Medicaid dollars are used, then Human Resources 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 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 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 Audit Checklists (see below) as well as its policies and procedures to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.

A. Service or Program Type Auditing Practices

To satisfactorily meet the requirements of SSL 363-d and Part 521, a compliance Plan must be appropriate to the Required Provider’s characteristics (A compliance Plan that is appropriate to the Required Provider’s characteristics should “... reflect a provider’s size, complexity, resources, and culture” according to SSL 363-d subsection 1); meet all the requirements of each of the Eight Elements; apply to each of the Ten Areas; be implemented; and produce results that can be reasonably expected of an operating compliance Plan that meets the Eight Elements and applies to the Ten Areas. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 6)

All Astor’s services where Medicaid billable services are provided, designate a Compliance staff person who reports to the Compliance Officer

Audits are completed by the Compliance Analyst (CA), on varying timeframes dependent upon the service being audited.

The CA reviews charts via the designated electronic health record or paper file. The auditing staff use an Audit checklist to determine if documentation is meeting expected regulations from various oversight bodies, including but not limited to The Joint Commission, Office of Mental Health, Office of Children and Family Services, and Department of Health. All checklists have been approved by the Agency's Compliance Officer.

Charts to be audited are selected randomly up to a specific number or based on total census of the program with the goal of auditing a portion of intake clients, discharge clients and clients with ongoing treatment. Chart selection is weighted towards clients and staff who have not been audited recently.

The electronic health record has afforded the agency the opportunity to conduct compliance for most of its programs without having to travel to multiple locations. There is an integrated clinical and billing component that allows for compliance business rules, which are triggered whenever incorrect or incomplete information exists in the record.

Business rules are designed to prevent claims from being submitted for the following (but not limited) to common errors which are captured via dashboards:

- If an active treatment plan is not in place,
- 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.

Compliance and program staff are responsible for monitoring the various dashboards to ensure compliance for Medicaid billing.

The following programs/services are reviewed on a regular basis by compliance department staff:

- Mental Health Outpatient Treatment & Rehabilitative Services Programs
- Day Treatment
- Partial Hospitalization
- Health Homes
- Children and Family Treatment and Support Services
- Home and Community Based Services
- Therapeutic Foster Boarding Home

Agency-Wide Audit Reporting

A dashboard is available for each service, which includes a summary of findings from each audit. The dashboard contains a detailed synopsis of what was found in each audit as well as aggregate data over time. Audits and audit findings are conducted and reported on a regular basis. The dashboard is also available to Program Leadership in efforts to make any corrections possible without violating any Astor, Medicaid or regulatory policy or law.

The Compliance Officer compiles an agency summary of the findings from specific audits and then presents these reports to CQI for feedback. Reports are also presented to Program Oversight and the Board of Directors no less frequently than quarterly. Such reports address compliance productivity, self-assessment insufficiencies, risk management and timeliness of investigations.

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

A compliance work plan has been established to monitor the completion of various projects that are planned to be addressed throughout the fiscal year. The work plan is monitored and updated on at least an annual basis and as needed for high-risk items.

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 Compliance Officer 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 E.H.R the Compliance Officer or their designee, 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. They will also address if there have been any changes in billing practice since the last review. The Compliance Officer will provide any resources to billing staff that may assist in understanding the Medicaid Regulations that apply to their billing practice.

C. Audit Checklist and Electronic Health Record

All Astor program areas where Medicaid billing occurs will have an Audit Checklist and/or reports/dashboards from the Electronic Health Record that will be used by the program's designated Compliance Analyst or the Compliance Officer. The Audit Checklists will include the necessary Medicaid and oversight body requirement questions associated with the particular program/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 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. 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 document not 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. **Service Documents Unsigned Report**—This report provides a summary of how many of each document type are unsigned, how many unsigned documents per week, and how long have they been unsigned.

Audit Checklist

While the majority of Astor’s programs are using the Electronic Health Record for some programs we continue to use an audit checklist (See Appendix C 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

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

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

D. Methodology for Audits

Corporate compliance staff will use various methods for monitoring and auditing. They will use the various reports/dashboards generated from the E.H.R and clients are selected at random. This is critical to ensuring a system of checks and balances and for providing further objectivity to the monitoring and auditing process.

The Compliance Officer works very closely with the Compliance Analysts. The Compliance Officer conducts analysis of compliance data and submits reports to leadership. They also review and update compliance audit checklists.

Timeframe 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:

- Total census of the program
- Number of full-time staff providing billable services

Record Retention

As set forth in the Agency Policies and Procedures Manual, the designated Compliance Officer will develop and implement policies and procedures to ensure 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 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 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 clients, employees or others who report problems or concerns to the Compliance Officer or to other staff of the program.

Policy

1. Compliance records management is the responsibility of the 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 clients, 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 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 Compliance Officer's password
 - All records related to information received by the 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 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 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 Compliance Officer should receive notice of any kind that an investigation is underway, they 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. Compliance Committee

The Agency is committed to developing and operating an “effective” Compliance Program. The organization has, therefore, established the Compliance Committee to assist the Compliance Officer in the development, implementation, oversight and evaluation of the Compliance Program. The Compliance Committee will be chaired by the Compliance Officer and will have a quarterly meeting schedule. The compliance committee reports directly to the chief executive and governing body and is charged with coordinating an effective program with the compliance officer, including the regular functioning of polices under each of the elements of an effective Compliance Program as well as ensuring that all Affected Individuals complete compliance training and education during orientation and annually.

The Committee is comprised of senior managers and is chaired by the agency Compliance Officer.

When a member is unavailable to attend a Committee meeting, the member will appoint a delegate to represent the member at the meeting. A delegate has the same duties, powers and obligations as the delegating member.

The role of the Compliance Committee 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 Compliance Officer 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 Committee conducts an annual evaluation of its effectiveness which shall be reported to the Governing body prior to the annual certification of the Compliance Program to regulatory authorities. The Committee also reviews and reassess its Charter on a periodic basis.

The Compliance Officer will inform the Compliance Committee of any allegations and investigations of Medicaid fraud or abuse. However, prior to making a decision to share such information, the Compliance Officer will consult with the Chief of Quality Improvement, Client Risk, & Compliance, Chief Executive Officer; the Chief Program Officer and the Chief Financial Officer. The Compliance Committee 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 Compliance Officer will also provide the Committee with reports of any monitoring and auditing findings as necessary. As an advisory committee, the Compliance Committee 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.

All affected parties who have or **may have knowledge** of potential non-compliance are expected to participate in any investigation, and to assist in the resolution of any compliance issues. Failure to do so is an act of non-compliance and may result in disciplinary action up to and including termination of employment, placement, and our contract.

A. Investigations

Upon receiving a report or other reasonable indication of suspected non-compliance or intimidation or retaliation for reporting non-compliance, the 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, 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 paper 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 Compliance Officer will, at a minimum, take the following actions:

1. Notify the Chief Executive Officer; Chief Financial Officer, Chief of Quality Improvement, Client Risk, & Compliance 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. We may request that the written transcript of interviews to be signed by the interviewer and interviewee attesting that everything, 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 criminal 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 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 overpayments through the administrative billing process by informing billing staff and making appropriate adjustments via software used for billing. In addition, the compliance officer is responsible for ensuring that identified overpayments are reported, returned, and explained to the Medicaid Program through the OMIG Self Disclosure Program. The compliance officer will promptly initiate corrective action to prevent recurrence.
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 VIII – 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 Audit Checklist as our primary tools for determining compliance. The following will be the process for reporting audit findings:

1. The Chief of Quality Improvement, Client Risk, & Compliance or Compliance Officer will make available reports to the CEO, CQI Committee, Compliance Committee and the appropriate Assistant Executive Director, that includes data on increases or decreases in 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 Compliance Officer will provide to program leadership specific details from the Electronic Health Record and Audits 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 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 Compliance Officer will ensure that any repayment is done no later than 60 days after the audit findings and in all cases, in accordance with the Repayment and Reporting Policy as may be updated from time to time based on regulatory and statutory changes;
 5. When ongoing patterns of non-compliance are exhibited or the lack of compliance in an area requires a large overpayment, the Compliance Officer will request that a corrective action plan be submitted to them which details steps the program/service area will take in preventing similar non-compliance activities from occurring in the future.
 6. The designated compliance staff will work with service area staff to ensure corrective action plans are completed and monitoring will occur based on the corrective action plan.
 7. In the event that the non-compliance occurs in Astor's billing practice, the 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 the Compliance Committee.
 8. Conduct, as appropriate, follow-up monitoring an audit to ensure effective resolution of non-compliance findings;
 9. It will be the responsibility of the Assistant Executive Director of each area, through prompting by the 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 Improvement Committee (CQI) is responsible to develop, implement and evaluate a plan for quality assessment and improvement activities throughout the Agency. The CQI Committee meets on a monthly basis to review reports from the Quality Assessment and Improvement Committee (QA&I) for each line of business. The Compliance Officer is a member of this committee and will provide information not only on Compliance Committee meetings and activities, but on findings and corrective actions from audits and investigations.

The CQI Committee has the authority to require further information from and/or remedial action by a QA&I Committee or from the administrator responsible for the line of business/program in question, and it is authorized to institute surveillance, preventive, control measures or studies when there is reason to believe that client or personnel welfare may be in danger.

The Compliance Officer will coordinate all pertinent issues or recommendations arising from the operation of Astor's Compliance Program with the CQI 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 Chief Executive Officer (CEO) and Board of Directors

The Chief of Quality Improvement, Client Risk, & Compliance will report investigations to the CEO within 1 - 2 days of having received a possible fraud, waste or abuse allegation. The CEO along with the Chief of Quality Improvement, Client Risk, & Compliance will determine how to report it to the Board of Directors.

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

At least twice a year the 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. They 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 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 Compliance Officer believes the CEO and/or the CFO are involved in non-compliant activities, the Compliance Officer can directly report to the Chair of the Board of Directors their concerns.

XI. Outside Legal Counsel

Outside legal counsel is available to assist the CEO, Board of Directors, CFO, Chief of Quality Improvement, Client Risk & Compliance and the 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 CEO of incidents that have a reasonable cause to support the assertion of non-compliance at which time the 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 Compliance Officer and Astor.

XII. Assessing Effectiveness of Astor's Compliance Program

The 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 Compliance Officer is responsible for ensuring that the system protects the user and client from potential user errors. The 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.

Annually Astor submits a Certification Statement for Provider Billing Medicaid, which counts as our attestation of having an "effective compliance program" in place. In order for us to certify to our effectiveness Astor uses a tool that the OMIG has put forth to help providers in this process. The Self-Assessment Tool, provided by the OMIG addresses all of the required elements that are expected 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 Compliance Officer and the findings are shared with the CQI committee and the compliance committee. The outcome of this assessment is used to implement new systems that address any deficiencies in our compliance program.

The annual review will also assess all compliance program written policies and procedures, and standards of conduct required annually to determine:

- (i) if such written policies, procedures, and standards of conduct have been implemented;
- (ii) whether affected individuals are following the policies, procedures, and standards of conduct;
- (iii) whether such policies, procedures, and standards of conduct are effective; and

(iv) whether any updates are required.

XIII. Conclusion

The Corporate Compliance Plan has been prepared to outline the broad principles of legal and ethical business conduct embraced by Astor. 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 Compliance Officer.

APPENDICES CHAPTER 19C: Policies and Procedures Manual

- Appendix A: Summary of Federal & NYS False Claims Acts
- Appendix B: Acknowledgment Receipt – Corporate Compliance Plan
- Appendix C: Sample Audit Checklist
- Appendix D: Utilization Review (UR) Policy

Appendix A

Summary of Federal & NYS False Claims Acts

I. Purpose

The purpose of this section of the employee handbook and Agency Corporate Compliance Plan is to fully comply with certain requirements set forth in the federal Deficit Reduction Act of 2005 (the "DRA"), 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. 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 Plan 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 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 (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
- (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

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.

- (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 they knew or should have known they were 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.

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) their 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 they have applied for or is receiving such

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 client 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 client 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.

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

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

D. New York State 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;

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.

- (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 they are 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)

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], they 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, them or another person receives payment in an amount that them 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 the employee reasonably believes in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;
- (b) Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice; or
- (c) Objects to, or refuses to participate in any such activity, policy or practice.

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:

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.

- (a) an injunction to restrain continued violation of this section;
- (b) the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof;
- (c) the reinstatement of full fringe benefits and seniority rights;
- (d) the compensation for lost wages, benefits and other remuneration;
- (e) the payment by the employer of reasonable costs, disbursements, and attorney's fees;
- (f) a civil penalty of an amount not to exceed ten thousand dollars; and/or
- (g) the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

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.

The term "Employee" under Section 740 has been expanded to mean "an individual who performs services for and under the control and direction of an employer for wages or other remuneration, including former employees, or natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers". As such, Section 740 includes:

1. Current Employees of the Agency
2. Former Employees of the Agency, and
3. Persons employed by contractors of the Agency

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, to a news media outlet, or to a social media forum available to the public at large an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of client care or improper quality of workplace safety. ("improper quality of client 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 client); 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 client care or improper quality of workplace safety.

The protections under Section 741 are not available to an employee unless the employee has brought the improper quality of client 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 client care presents an imminent threat to public health or safety or to the health of a specific client and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

For purposes of Section 741, an "Employee" means any person who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration.

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 False Claims Act and Labor Laws 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 all training and materials provided under the Compliance Plan.

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 in person or by telephone at: 845-768-2895.

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 or government authorities. By reporting their own misconduct, however, an employee will not insulate themselves 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

Acknowledgment Receipt – Corporate Compliance Plan



**Acknowledgment of Receipt
Astor Services Corporate Compliance Plan**

Name of Employee, Organization, or Vendor: _____

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

If Astor Employee, Program Name and Site: _____

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

Signature of Employee/Vendor/Organization

Date

Appendix C

Sample Audit Checklist

Mental Health Outpatient Treatment & Rehabilitative Services Audit Tool

Section	Question
General	ClientID
General	Date
General	ProgramGroup
General	Organization
General	Primary Staff
General	Prescriber/Licensed Staff
General	Nurse
General	Admission Date
General	Discharge Date
Intake	Is the admission health questionnaire completed on time & signed by appropriate staff?
Intake	On the admission HQA, if a concern was noted in part A (nutrition/pain section) was client referred in part B?
Intake	Did the client enroll in the first 3 visits (before the 4th visit)?
Intake	Is the admission note/medical necessity note present?
Intake	Is the reason for referral noted on the intake/screening & admission note?
Intake	Are the collaterals identified in the admission note?
Intake	Are the clinical & service-related needs & the services to meet those needs documented?
Intake	Is there a Consent to Treat?
Intake	Is there a Notice of Privacy Practices/Patient Acknowledgement form?
Intake	Is the admission CANS completed on time?
Assessments	Was the safety plan updated and signed by client/caregiver within 90 days of the previous safety plan?
Medical	If new meds were prescribed or there were changes to medications (including dose changes), were med consents obtained when meds were prescribed?
Medical	Is there a PCP consent present or a declined consent?
Medical	If there is a PCP consent, are the letters to the PCP present? (every 6 months-OPC)
Utilization Review	Was the admission UR completed on time?
Utilization Review	Were all continued stay UR's completed on time?
Treatment/Service Plan - Initial	Was the initial treatment plan completed on time? (by clinician/primary staff)
Treatment/Service Plan - Initial	Was the initial treatment plan signed on time? (by prescriber/licensed staff)
Treatment/Service Plan - Initial	If a need was deferred, was the reason for deferral noted?
Treatment/Service Plan - Initial	Treatment goals, objectives & related services (if applicable) are present & described?
Treatment/Service Plan - Initial	Is the clients voice represented in the treatment goals & objectives?
Treatment/Service Plan - Initial	Are treatment plan objectives measurable (observable, quantitative and include how they will be measured)?
Treatment/Service Plan - Initial	Is the criteria for discharge planning present and clearly written?
Treatment/Service Plan - Initial	If the client is receiving medication management, is it listed as an objective?
Treatment/Service Plan - Initial	Does the Treatment Plan show evidence that it was created in collaboration with the client and family?
Treatment/Service Plan - Review	Was the Treatment Plan Review completed on time? (by clinician/primary staff)
Treatment/Service Plan - Review	Was the Treatment Plan Review completed on time? (by prescriber/licensed staff)
Treatment/Service Plan - Review	If a need was deferred, was the reason for deferral noted?
Treatment/Service Plan - Review	Treatment goals, objectives & related services (if applicable) are present & described & updated since the last review?
Treatment/Service Plan - Review	Is the clients voice represented in the treatment goals & objectives?
Treatment/Service Plan - Review	Are treatment plan objectives measurable (observable, quantitative and include how they will be measured)?
Treatment/Service Plan - Review	Is the criteria for discharge planning present and clearly written?
Treatment/Service Plan - Review	If the client is receiving medication management, is it listed as an objective?
Treatment/Service Plan - Review	Does the Treatment Plan show evidence that it was created in collaboration with the client and family?
Treatment/Service Plan - Review	Does the Treatment Plan show evidence that it was created in collaboration with the client and family?
Treatment/Service Plan - Review	TPR shows an adjustment of goals, objectives, time periods & intervention strategies?
Discharge	Is the discharge summary/transfer note (day treatment only) completed on time?
Discharge	If the client was discharged to alternate care, was the discharge summary sent prior to the client arriving or w/in 2 weeks of discharge?
Progress Notes	Are the 3 most recent clinician session progress notes for the month(s) you are reviewing, completed in required time frame?
Progress Notes	On the 3 most recent clinician session progress notes are goals, objectives and interventions properly selected?
Progress Notes	Are the 3 most recent med provider progress notes for the month(s) you are reviewing, completed in required time frame?
Progress Notes	On the 3 most recent med provider progress notes is progress noted and updated from previous note?
Annual	Is the annual health questionnaire completed on time & signed by appropriate staff?
Annual	On the annual HQA, if a concern was noted in part A (nutrition/pain section) was client referred in part B?
Annual	Is the annual CANS Completed on time?
Comments	Comments

Appendix D

Utilization Review (UR) Policy

I. 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.

II. 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.

Chief Executive Officer (CEO) and Executive Cabinet

The CEO 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), 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 CEO, 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.

III. 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*).

IV. 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.

V. 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. Therapeutic Foster Care

Clients 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.

2. Mental Health Outpatient and Rehabilitative Services

A client aged 0-26 or applicable adult clients 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 intellectual or developmental disability.

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

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

3. Day Treatment

A client ages 3-13, 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 their functioning in a regular school setting.

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

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 their stay in the program.

VI. 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 Mental Health Outpatient and Rehabilitative Services 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 clients 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.

VII. Program-specific Utilization Review Procedures

1. 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.

2. 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 involvement with 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
- Clinical Assessments
- Intake Documentation
- Treatment Plans
- Progress Notes

(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 their 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.

3. 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 involvement with 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
- Clinical Assessments
- Intake Documentation
- Treatment Plans
- Progress Notes

(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 their 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.

4. **Mental Health Outpatient and Rehabilitative Services**

Utilization Reviews for the Mental Health Outpatient and Rehabilitative Services are conducted by an independent professional staff person who is part of the Quality and Clinical Outcomes department and has no clinical involvement with 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
 - Clinical Assessments
 - Intake Documentation
 - Treatment Plans
 - Progress Notes
- (e) Tracking of Utilization Reviews

UR's are to be completed for at least 10% 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 their 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.

VIII. 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 CEO, the CPO 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, 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 Mental Health Outpatient and Rehabilitative Services
- 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

IX. 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 CQI Committee.

X. 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 client's chart. Utilization Reviewer tracks whether the program is documenting when they go against the reviewer's recommendations. The program leadership should inform the Director of Clinical Outcomes, CANS & TCOM and Utilization Review staff of the decision that was made by the psychiatrist.