CCM COMMUNITY COUNSELING & MEDIATION

COMMUNITY COUNSELING & MEDIATION

CCM

Medicaid

Compliance Policy and Procedure Manual

2020

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Introduction

CCM is committed to establishing and maintaining an effective compliance program that is committed to maintaining compliance with applicable federal, state, and local laws, rules, and regulations as well as healthcare industry standards and ethical standards of business conduct. The purpose to our Compliance Program is to seek to prevent and detect violations of law and company policy.

CCM's Compliance Policies and Procedures are reviewed and updated at least annually, and when there are significant changes to applicable federal and state laws, regulations, or program requirements. The processes defined within this policy may be modified by CCM based upon the unique circumstances of specific plan contracts.

Element 1: Written policies and procedures

Creation of Compliance Policies and Procedures

When the need arises, requiring Medicaid/Medicare Compliance to develop and implement a policy and procedure to address new or revised law, regulations, or program requirements, either an existing policy will be revised, or a new policy will be drafted and addended to the existing Compliance Plan. When a new policy is drafted:

- A New Medicaid/Medicare Compliance Policy will be drafted utilizing the Medicaid/Medicare Compliance Plan formatting.
- Policy and Procedure Template, Desktop guides containing procedural details may be in place to further describe the policy activities.
- Requirements and responsibilities will be outlined in the draft policy.
- Once a draft policy is created, it will be reviewed and approved by
  - Staff Compliance Committee
  - Program Leadership for the affected area(s).
- The draft policy will then be routed to CEO for review, as needed, to ensure that there are no conflicts to other business policies and procedures.
- The Compliance Officer (CO) will conduct a final review of the draft policy and make any revisions, before issuing his/her approval. Once revisions are completed the CO is responsible to disseminate the policy throughout the organization utilizing multiple formats: email, WebEx and or staff meetings, the policy will then be loaded to the Compliance Shared Drive.
  - Changes and or additions to the Compliance Plan require staff attestation of receipt and understanding.

Maintenance and Review of Existing Policies and Procedures

Existing Compliance Policies and Procedures and the Compliance Plan are reviewed at least annually and revised if needed, or when there are legal, regulatory, or program changes that require Policy and Procedure revisions. When existing policies are updated:

- Updates are noted via track changes in the document.
- The revised document is submitted to the appropriate member or members of the Compliance Department for review and comment. Legal Counsel may be consulted for additional review and input.
- The Compliance Officer will conduct a final review of the draft policy and make any revisions before issuing his/her final approval. Once approved by the Staff Compliance Committee, the policy can be implemented as a final policy and will be loaded to the Compliance Shared Drive.

Storage and Communication of Policies and Procedures

A. Compliance Policies and Procedures, including the Compliance Plan, are maintained on CCM 'S intranet or shared drive portal which is accessible on an ongoing basis to all program employees.
B. Compliance Policies and Procedures are communicated to employees who support Medicaid/Medicare/Medicaid Managed Care business within 30 days of hire and annually thereafter. In addition to these policy communications, CCM's other foundational documents as defined below are also communicated at these same timeframes.
C. Policy changes are circulated through various mechanisms: staff meetings; compliance presentations; intranet postings, compliance alerts, etc.

Record Retention

When a new policy is created that replaces an existing policy, the obsolete policy is archived in accordance with CCM's Records Retention Schedule and CMS requirements.

Relevant Statutes and Standards

New York State Social Services Law §363-d
18 NYCRR Part521
42 USC §1396(a) (68) (Federal Deficit Reduction Act)
31 U.S.C. 3729-3733 et seq. (Federal False Claims Act)
New York State Finance Law §§187-194 (State False Claims Act)
New York State Labor Laws §§740, 741
New York State Penal Law §175 (False Written Statements)
New York State Penal Law §176 (Insurance Fraud)
New York State Penal Law §177 (Health Care Fraud)

Definitions

For purposes of this policy directive:

- *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- *Compliance Program* means a proactive and reactive system of internal controls, operating procedures and organizational policies to ensure that the rules that apply to a provider are regularly followed.
- *Compliance Officer* means the designated OMH Medicaid Compliance Officer.
- *Employee* means any person responsible for complying with this policy directive.
- *Fraud* means an intentional misrepresentation, omission or concealment calculated to deceive or knowingly presenting or causing to be presented a false record or false claim for payment.
- *Intimidation* means any form of coercion or threatening behavior aimed at compelling an employee not to report actual or suspected fraudulent activity
- *OMIG* means the NYS Office of the Medicaid Inspector General.
- *Retaliation* means harassing, threatening to take, or taking an adverse employment action against an employee for reporting actual or suspected fraudulent activity. Examples include, but are not limited to, disciplinary action, failure to promote, reassignment, denial of time off, or ignoring or shunning an employee who has reported Medicaid misconduct.
- *Vendors*. The term “Vendors” includes vendors, suppliers, consultants, other care providers, referral sources, manufacturers, payers and other third parties seeking to do, or that are currently engaged in, business with any CCM Entity.
- *Waste* means the overutilization, underutilization, or misuse of resources.

New York State Social Services Law §363-d requires providers that operate under a license issued by OMH pursuant to Article 31 of the Mental Hygiene Law, or providers which order, provide, bill or claim $500,000 from Medicaid in a 12-month period, to have an effective compliance program. An “effective compliance program” is one that satisfies all the mandatory elements in SSL §363-d as supplemented by regulations at 18 NYCRR Part 521.

The required elements include:
(1) 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 program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) designate an employee vested with responsibility for the day-to-day operation of the compliance program; 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 program;
(3) 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 program 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;
(4) 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, 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 policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

- (i) failing to report suspected problems;
- (ii) participating in non-compliant behavior; or
- (iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;
(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of 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;
(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections 740 and 741 of the Labor Law.

In addition, 18 NYCRR § 521.3 (a) identifies seven areas that all compliance programs must be applicable to:

1. Billings
2. Payments
3. Medical necessity and quality of care
4. Governance
5. Mandatory reporting
6. Credentialing
7. Other risk areas that are or should with due diligence be identified by the provider

OMH/OASAS has developed a Medicaid Compliance Program to ensure compliance with SSL §363-d and 18 NYCRR Part 521. Such program also reflects OMH and OASAS's commitment to honest and responsible conduct, decreases the likelihood of unlawful and unethical behavior at an early stage, encourages employees to report potential problems, and allows for appropriate internal investigation and corrective action. This policy directive is intended to adopt these required elements, following the recommended structure of an effective Corporate Compliance Program.

Element 2: Designate an Employee Vested with Responsibility

Compliance Oversight and Management

CCM has designated a Compliance Officer, a Board of Directors Compliance Committee (BCC) and a Staff Compliance Committee (SCC) to oversee the compliance program.

Compliance Officer

Peiying Ou has been appointed by the Board of Directors and/or President/CEO as the Compliance Officer. *The Compliance Officer reports directly to the President/CEO monthly and reports in person to the Board of Directors biannually.* The incumbent serves as Chair of the staff compliance committee and is responsible to direct and oversee the day to day operations of the compliance program. The Compliance Officer is primarily responsible for overseeing compliance within an organization, and ensuring compliance with laws, regulatory requirements, policies and procedures. Should the Compliance Officer become aware of a compliance issue the incumbent will inform the Board of Directors and the President/CEO within 3 business days.

The Compliance Officer will be primarily responsible for the following activities:

- Overseeing and monitoring the implementation of the Medicaid Compliance Program;
- Reporting the progress of implementing the various elements and components of the Medicaid Compliance Program to the BCC at regularly scheduled biannual meetings;

- Revising the Medicaid Compliance Program to incorporate changes in Applicable Law, CCM policies, other guidance of Federal, State, and private healthcare payers, and/or identified audit patterns and trends;
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the Medicaid Compliance Program and seeking to ensure that all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers are knowledgeable of, and comply with CCM policies and applicable laws;
- Independently investigating and acting on matters related to Medicaid compliance, including coordinating and conducting internal investigations (e.g., responding to reports of known or suspected violations of the MCP) and reviewing any resulting corrective action within all CCM Medicaid billable programs;
- Planning and overseeing periodic and scheduled internal audits of CCM 's operations [charts, billing and personnel files] in order to evaluate compliance with CCM policies and applicable law as it pertains to Medicaid;
- Maintaining a well-publicized program for reporting known or suspected violations of the MCP that encourages all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers to report suspected fraud and other improprieties without fear of retaliation;
- Working with CCM management and CCM's counsels in the preparation, development, and implementation of written guidelines on specific issues under applicable law, including matters involving unethical business practices;
- Developing and implementing an education program for all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers to enhance their understanding of applicable laws, including, without limitation, documentation, coding and billing practices with respect to requests for payments and/or reimbursements from Medicaid;
- Reviewing all documents and other information that are relevant to Medicaid compliance activities, including, but not limited to, billing records, charts, and personnel files;
- Completing NYS OMIG Annual Self-Assessment (or its most current version) as well as, a summary report of the Compliance Office which contains all reports of Medicaid non-compliance, the results of all investigations and any corrective action taken, the results or anticipation of internal audits, any Medicaid non-compliance patterns or trends identified, and an assessment of the Medicaid Compliance Program to the Medicaid Compliance Committee and Board;
- Upon completion of the NYS OMIG Self-Assessment (or its most current version) determine need for Corrective Action Plan (CAP). When a CAP is determined to be necessary the Compliance Officer is to write, implement and complete such plan prior to OMIG attestation in December of each year.

- Performing such other duties and responsibilities pertaining to Medicaid compliance as the Board, Medicaid Compliance Oversight Committee, or President/Chief Executive Officer may request.

Communications from the Compliance Officer

- The Compliance Officer will communicate key initiatives and changes, including new and revised policies and procedures and updates to the Medicaid/Medicare Compliance Plan, to all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers through various Compliance communications which may include any combination of the following: Compliance Regulatory Alerts, Compliance intranet site, training programs, verbal and written communications, and telephonic announcements.
- Medicaid/Medicare Compliance may periodically develop and post intranet-based communication (e.g., newsletters, etc.) to be accessed by all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers. Such communications may include key reporting requirements and information about the various methods available for reporting.
- Compliance Officer will distribute statutory, regulatory and sub-regulatory changes through a distribution and tracking tool. Distribution lists are maintained on an ongoing basis and are verified at least annually to ensure communications are accurately directed. Business leads are expected to communicate guidance, as applicable, to relevant CCM.
- The Compliance Officer ensures the reporting of Medicaid/Medicare/Medicaid Managed Care related compliance issues on a regular basis to the Committee, the Board of Director or the Compliance Committee of the Board of Directors, as well as to any accountable business leads as necessary.

CCM Staff Compliance Committee

The Board of Directors authorized the establishment of a Staff Compliance Committee (SCC), which is responsible for implementing and monitoring the CCM's compliance program and promoting responsible and ethical decision-making by all employees. The SCC is comprised of all Program Directors (OMH/OASAS/HUD/SAMSHA/ACS), Human Resources, Biller, Compliance support staff/consultants and is chaired by the Compliance Officer or their designee. Other personnel designated by the Compliance Officer can also be invited to specific meetings. The CEO and Compliance Officer may appoint members to the Staff Compliance Committee with varying backgrounds and experience to ensure that the Compliance Committee has the expertise to handle the full range of clinical, administrative, operational, and legal issues relevant to the Program.

The committee is held responsible for the following:

- Meet no less than quarterly.

- Attend regularly scheduled and special meetings of the SCC in their discretion.
- Request that certain CCM personnel and subject matter experts attend meetings as a guest to provide specific information to the Committee as warranted.
- Oversee the compliance program and ensures that potential issues or violations presented directly to the SCC or through a member of the management team are investigated and addressed.
- Oversight also includes (examples only) developing employee education, investigating complaints or reports, implementing internal audit recommendations when applicable to the Committee's work plans, managing audits by outside professional firms applicable to compliance matters, preparing and providing annual reports to the Board of Directors, and other functions as needed to meet the requirements of the compliance program.

The Board of Directors Compliance Committee (BCC)

The BCC is a sub-committee of the Board of Directors or may be a responsibility of the audit committee, responsible to oversee and review the policies, activities, and results related to implementation of the Medicaid Compliance Plan and receive written reports from the Compliance Officer periodically, but no less than twice a year. The Compliance Officer will also provide the BCC email updates, when needed, for issues or concerns that arise.

Executive/Employee/Intern/Volunteer Responsibility

Responsibility for the Medicaid Compliance Program includes not only the commitment of the Board of Directors and CCM management, but also the participation and commitment of all applicable Executives/ Employees/ Interns/ Volunteers. Executives/ Employees/ Interns/ Volunteers are personally responsible to read, understand, question and adhere to the most current program, employee manual and agency policies and procedures. They will also be expected to conduct themselves in a manner that complies with the highest ethical standards and is consistent with all applicable law and all CCM policies to include reporting all deviation from the articulated standards of this document. Applicable Executives/ Employees/ Interns/ Volunteers who have knowledge of actual or suspected violations of law or agency policy, operating procedures or conduct, which might reasonably constitute fraud, waste, abuse, corruption or misconduct must report what they know as soon as possible, to their supervisor and/or the Compliance Officer. Supervisors have an obligation to report known or suspected compliance issues to the Compliance Officer.

Upon hire all Executives/ Employees/ Interns/ Volunteers are responsible to read the compliance plan and attest that they have read it and understand it. They are required to attest annually thereafter. Upon termination of employment employees must complete a Termination attestation that states they have not nor currently have any knowledge of non-

compliance with the plan by themselves or others. Report can be done through the Compliance Hotline (718-802-0666, ext. 229 or 914-704-7148), via email at ComplianceCCM@ccmnyc.org, and/or web portal at https://ccmnyc.org/about-us/ - “non-compliance report”.

Vendors/Contracted Parties

Responsibility for the Medicaid Compliance Program includes participation and commitment of all CCM Vendors/Contracted Parties as it relates to their intersection with Medicaid/Medicare/Managed Care services. Applicable Vendors/Contracted Parties are responsible, individually and on behalf of their designees to read, understand, question and adhere to the most current Medicaid Compliance Program. They will also be expected to conduct themselves in a manner that complies with the highest ethical standards and is consistent with all applicable law and all CCM policies to include reporting all actual or suspected deviation from what the articulated standards of this document are. If Vendors/Contracted Parties or their designee, suspect fraud, waste or abuse they should follow procedures for reporting concerns and/or complaints.

An attestation of regulatory applicability and or compliance is required as part of contracting and annually thereafter. Reporting can be done through the Compliance Hotline (718-802-0666, ext. 229 or 914-704-7148), via email at ComplianceCCM@ccmnyc.org, and/or web portal at https://ccmnyc.org/about-us/ - “non-compliance report”.

Compliance Expectation

Code of Conduct

CCM is committed to maintaining the highest quality services for all persons served. To this end, CCM has adopted and incorporated the Code of Conduct into all of its program operations. CCM has established written policies and procedures for documentation and billing [see program and fiscal manuals] that demonstrates our commitment to complying with all applicable federal and state statutory, regulatory, and other requirements. These policies and procedures are a critical component of CCM efforts to detect, prevent, and control fraud, waste and abuse. **CCM will review all Compliance Policies and Procedures annually and update as necessary to remain current with legal and other current developments.** These standards apply to all applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/ or Contracted Staff/ Volunteers of CCM. The code of conduct has been disseminated to ensure that CCM’s applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers promote the mission of CCM ; protect the rights of persons served; and perform in an ethical manner at all times while carrying out their job responsibilities.

Applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers will be required to carefully review the Code of Conduct/vender Attestation on an

annual basis and will be advised that any violation of these provisions may be grounds for disciplinary action, up to and including termination from employment or any contract. Applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers will be encouraged to discuss any questions about these guidelines with their immediate supervisor. Vendors and Contracted Parties are encouraged to discuss any questions with the CEO or Compliance Department.

All applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers are required to:

- Report any violations or suspected violations of the compliance program in accordance with the Whistleblower Protection – Non-Intimidation and Non-Retaliation Policy. Failing to report to the direct supervisor and/or the Compliance Officer or designee any instance of conduct of which CCM Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers know or suspect to be a violation of the Medicaid Compliance Program or should, in the ordinary course of carrying out his/her duties, known to be a violation of the Medicaid Compliance Program, which will lead to disciplinary action in accordance with Element 5 up to and including termination from employment.
- Assist with the investigation and resolution of compliance issues by cooperating with and engaging in activities including but not limited to providing requested documentation, participating in interviews, assisting with the gathering of information, implementing and monitoring corrective actions and/or internal controls, training relevant parties, implementing disciplinary action as necessary, and any other steps necessary for the appropriate and timely resolution of compliance issues. Failure to assist and cooperate with the investigation and resolution of compliance issues may lead to disciplinary action in accordance with Element 5 up to and including termination from employment.

The CCM's policies and procedures manual sets forth the degrees of disciplinary action that may be imposed on applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers for failing to comply with CCM's policies. Intentional or reckless noncompliance will subject the applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/Volunteers to more significant sanctions than unintentional noncompliance or honest mistakes. Disciplinary action will be taken on a fair and equitable basis and will be applied in an appropriate and consistent manner - all levels of employees are subject to the same disciplinary action for the commission of similar offenses.

Prohibited Activities

CCM's applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers are expected at all times to carry out their responsibilities in a highly ethical manner consistent with CCM Code of Conduct. CCM's applicable Executives/ Board of

Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers are strictly prohibited from directly and indirectly engaging or participating in any of the following activities:

- Submission of Improper Claims for Medical Care – Presenting or causing to be presented to the United States government, any other healthcare payer, individual, government agency or funding source a claim for a medical or other service that was not provided as claimed and such violations were committed either knowingly, or with reckless disregard of the truth.
- Fraudulent Statements – Making, using or causing to be made or used any false record, statement or representation of material fact for use in determining rights to any benefit or payment under any health program or service; or executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain, by means of false, fictitious or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody of, any healthcare benefit program.

Element 3: Training and Education

Purpose

CCM regularly communicates its Medicaid Compliance standards and policies to all applicable employees and persons associated with CCM, including *Executives, Board of Directors, Employees/Interns/Vendors and/or Contracted Staff/Volunteers* on compliance issues, expectations and the compliance program operation. The training must occur annually and the training methodologies should be documented to include on-the-job supervision, classroom (in-person) instruction, self-taught manuals, electronic communication of compliance alerts and announcements via e-mail and the intranet.

The Medicaid Compliance Program's education and training component includes a review of applicable law, including applicable provisions of the False Claims Act. As additional areas or matters are identified they will be added to the educational component of the compliance program by the Compliance Officer.

CCM will regularly update its training policies and programs to ensure that they are current, consistent with applicable law and provisions of the Medicaid Compliance Program and incorporates the findings and results of CCM's ongoing evaluation, auditing, and monitoring of the Medicaid Compliance Program.

The sub-sections that follow highlights the scope and range of the education and training activities implemented as part of the Medicaid Compliance Program.

Orientation Program

An orientation program will be provided to all new and current applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers of CCM, and will include an overview of the general provisions, practices, and standards of the Compliance Program as well as a review of CCM's policies and applicable laws. In addition, there will be a discussion, and review of the applicable responsibilities of Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers in complying with the provisions of the Medicaid Compliance Program. **All Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers will be provided with a copy of the policies and procedures or will be instructed on how to access the policy via electronic means through CCM's intranet or shared portal.**

All newly hired applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers will be required to participate in the Orientation program. **All Executives/ Employees/ Interns/ Volunteers must complete training within 30 days of hire** and must pass the Compliance posttest with a score of 70% or higher prior to billing for any service rendered.

CCM's Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers who fail to participate and complete the Orientation program will be required to take supplemental training and pass the Compliance posttest within an additional 30 days. Failure to pass the second test may result in discharge in accordance with CCM introductory period policies.

Vendors/Contracted Parties

Vendors/Contracted Parties will receive Compliance information as part of the contracting process to include a *Business Associate Agreement* and a vendor's attestation and will be responsible to orient themselves to the compliance process. Vendors/Contracted Parties may be required to participate in training or testing activities as part of their contracted services. Failure to do so can result in immediate termination of the contract for cause.

Board of Directors

CCM 's Board of Directors must complete a general Compliance and Fraud, Waste, and Abuse training within 90 days of appointment and then annually thereafter. The training materials are provided to the Board Members in their Board Orientation Packet along with a posttest, and in advance of live training annually thereafter. The Compliance Officer or their designee delivers the training together with an acknowledgment form. Upon completion of the course, Compliance Officer collects the completed acknowledgments. The acknowledgments include confirmation of Compliance awareness, completion of CCM 'S Compliance Trainings, agreement to comply with these standards, and disclosure of any conflict of interest.

Continuing Education

The Compliance Officer or designee will oversee the development and scheduling of continuing education courses and refresher training programs periodically throughout the year to ensure that CCM applicable Executives/ Employees/ Interns and Volunteers keep informed of current practices and changes related to the Medicaid Compliance Program, policies and applicable law. These training sessions may be regularly scheduled for all applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers or mandated by the Compliance Officer.

The Compliance Officer or designee will also review all health care fraud alerts issued by the Office of the Inspector General, US Office of Civil Rights, U.S. Department of Health and Human Services, and other newly released guidance regarding compliance issues, and will communicate relevant information to all applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers.

Specialty and Topic-Specific Training

Applicable Executives/Board of Directors/Employees/Interns/Vendors and/or Contracted Staff/Volunteers assigned to particularly sensitive positions or functions may require additional topic specific training. Such targeted specialty and topic-specific training may be identified through the compliance hotline, and/or the ongoing audits and reviews of the Compliance Program. The need for additional training may also be determined because of new requirements promulgated under applicable law. It will be the responsibility of the Compliance Officer to identify, evaluate and implement such specialty and such topic-specific training as necessary and required.

Examples of specialized training that may be developed include, but are not limited to:

1) Handling Complaints, Grievances and Appeals
2) Marketing to Medicaid/Medicaid/Medicare/Medicaid Managed Care beneficiaries
3) Medicaid/Medicare Regulatory Guidance Distribution & Validation process
4) CMS Requirements for CCM
5) OIG & SAM Exclusion Screenings
6) CCM Compliance Program Requirements

Upon successful completion of a specialty or topic-specific training session, the training Instructor will complete, sign, and forward certification to the Compliance Officer for Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers who complete the training.

Training Acknowledgement Form

CCM will document training provided to applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers, including the name and job title of the individual, date of training, subject and nature of training provided. Upon successful completion of training under the Medicaid Compliance Program, the training instructor will ensure that each Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers completes and signs a training acknowledgement form. A copy of this form will be forwarded to the Compliance Officer. CCM is required to retain evidence of training completion (e.g., training logs, employee certifications, etc.) for a period of no less than ten (10) years, and to make this evidence available to CCM /CCS and/or CMS, upon request (i.e., for audits, etc.).

The acknowledgement certifies that the Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers who have received and reviewed the policy agrees to participate fully with the Medicaid Compliance Program. The Compliance Officer will monitor the return of the Acknowledgement forms from Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers so that a copy is placed within each staff person's individual compliance and/or personnel file. Should an Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers fail to return the policy Acknowledgement Form within the prescribed timeframe, this will be considered non-compliance with the Compliance Program such as to require that appropriate disciplinary action is implemented.

Element 4: Communication Lines to the Responsible Compliance Position

Summary

In an effort to keep the communication lines to the Compliance Officer accessible to all Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers to be reported, CCM provides a variety of methods that Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers and others may use to report potential compliance issues as they are identified. *This includes a method for anonymous and confidential good faith reporting.*

Reporting Mechanisms

The following methods are available for reporting suspected compliance misconduct, which will be detailed in training materials and on the CCM internet page.

a) **If you are comfortable, you can discuss the question or concern first with the direct supervisor**. Supervisors be aware of any reports of actual or suspected non-compliance

in the course of supervision, conversation or observation considered by federal law to be reportable to the Compliance Officer and *must be reported immediately* upon knowledge.
If an employee is uncomfortable discussing a concern with their direct supervisor, the employee should report the concern to the Compliance Officer directly or utilize one of the anonymous reporting mechanisms listed below.

b) **Call the Compliance Officer Peiying Ou directly at 718-802-0666 (ext. 229) or 914-704-7148.** (THIS IS NOT ANONYMOUS).
c) All questions and reports to the Compliance Hotline are kept confidential. The Compliance Officer will disclose questions and reports on a "need to know" basis, except as required by law. Similarly, if a caller chooses to identify him/herself, the Compliance Officer will keep the callers' identity confidential and disclose the callers' identity on a "need to know" basis. In general, "need to know" means that disclosure will be made only to the extent necessary to allow for a full investigation of reports of suspected misconduct and for the implementation of any appropriate corrective actions or disciplinary sanctions.
d) Email compliance correspondences to:
   ComplianceCCM@ccmnyc.org [not anonymous]
e) Make an anonymous online report https://ccmnyc.org/about-us/ - "non-compliance report". If you wish to be contacted regarding the outcome of the investigation please include an email address, [if you do so, the report will NOT be anonymous.]
f) Report the matter to the OMIG at 1-877-87FRAUD (1-877-873-7283) or via their website at www.omig.ny.gov;
   1. Report the matter to the Office of the Inspector General by phone at 1-800-DO-RIGHT (1-800-367-4448) or by email to inspector.general@ig.ny.gov.
   2. Report the matter to the NYS Attorney General's Medicaid Fraud Control Unit at 1-800-771-7755.

Confidentiality of Reports/Complaints

All reports received through the Compliance reporting mechanisms will be maintained by the Compliance Office. While CCM will attempt to protect the confidentiality of those applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers. Those that report via a confidential method of communication and/or request confidentiality must have reasonable expectation that their communication will be kept confidential unless required by law enforcement. In instances, where an investigation will need to be conducted confidentiality may not be withheld but the investigation will not name the identity of the person who reported the incident.

Anonymous Reports/Complaints

All anonymous reports to either the U.S. Mail, Fax, Email and web portal may have circumstances where the identity of someone making an anonymous report and/or complaint may become known or may have to be disclosed, if deemed necessary, in order to comply with applicable law.

Responding to Reports/Complaints

Upon receiving an oral or written report of a known or suspected compliance the Compliance Officer will log the complaint on a Compliance Log and begin an investigation. The Compliance Officer will complete a Response Form for each report and/or complaints received and implement the following actions as appropriate. In cases where it is determined that the reported issue does not concern a compliance issue related to the Medicaid Compliance Program, the Compliance Officer will refer the issue to the appropriate manager. Documenting the determination, follow-up and resolution of the issue will be required in every case referred to the manager and the Compliance Officer will maintain a record of all such reports. In cases where a reported concern and/or complaint is deemed to be an actual or probable violation of the Medicaid Compliance Program, the Compliance Officer will thoroughly investigate the matter to determine:

(a) if the issue reported has a basis in fact,

(b) if a self-disclosure to NYS OMIG is required and

(c) whether modifications should be made to the Medicaid Compliance Program and/or CCM policies which may help prevent similar compliance issues in the future.

Element 5: Disciplinary Policies to Encourage Good Faith Participation

Summary

CCM has developed disciplinary policies to encourage good faith participation in the compliance program. The purpose of any disciplinary action involving applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers will be to correct any behaviors or practices that 1) result in a violation of the Medicaid Compliance Program, 2) jeopardize the fair, equitable and/or professional treatment of a person served, 3) compromise the integrity and accountability of CCM's financial reporting and/or billing practices, and/or 4) place at risk the financial stability, and/or overall operations of CCM.

Disciplinary Procedures

CCM is dedicated to fairly, consistently, and firmly enforcing the compliance program in place. Applicable Executives/ Board of Directors/ Employees/ Interns/ Vendors and/or Contracted Staff/ Volunteers who engage in fraud, waste or abuse, or other misconduct are subject to disciplinary action. Any disciplinary action imposed related to compliance violations will be carried out by the Compliance Officer in consultation with the Department of Human

Resources. CCM will only institute disciplinary action after an appropriate investigation of the alleged violations.

In addition to possible disciplinary action mentioned elsewhere in this Manual, personnel may be subject to disciplinary action for:

- Failure to perform any obligation or duty required of personnel relating to compliance with this Manual or applicable laws or regulations;
  - To include but not limited to mandatory training and post testing
- Encouraging, directing, facilitating or permitting conduct that is contrary to CCM compliance program, policies, applicable laws or regulations, or payer requirements; and/or
- Failure of supervisory or management personnel to enforce compliance-related requirements or detect non-compliance with applicable policies and legal requirements and the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems or implement appropriate corrective actions.
- Failure to report any violations or suspected violations of the compliance program
- Failure to assist with the investigation and resolution of compliance issues
- Falsification of a signature
- Falsification of a date of service/time
- Backdating
- Falsification of a time card
- The creation of fictitious clients and or services
- Threatening another staff/intern in misrepresentation of service delivery
- Colluding with other staff/intern in the misrepresentation of service delivery

There are certain circumstances which may help to mitigate the severity of the disciplinary action recommended by the Compliance Officer against the applicable Executives/ Board of Directors/ Employees/ Interns/ Volunteers and/or Contracted Staff, including, but not limited to:

- The severity of the violation;
- Whether the violation was committed intentionally, recklessly, or negligently;
- Whether the individual has committed other violations in the past, and whether those violations are similar to the one at hand;
- Whether the individual has been previously disciplined, and what the sanction for the given action was;
- Whether the individual self-reported their misconduct or violation promptly;
- Whether the individual attempted to hide the misconduct;
- Whether the individual cooperated fully with the investigation and correction of the violation;
- Other compelling factors reviewed with the Compliance Officer and Human Resources.

Executives/Employees

In cases involving executives or employees, disciplinary action for any compliance violation may include, but is not limited to:

- Counseling, [which must be documented]
- Written warning placed in personnel's personnel file, and/or
- Suspension with or without pay, and/or
- Termination of employment.

Board of Directors

In cases involving Board of Directors, CCM will remove the Director from company business until a full investigation has been conducted. If the allegation of misconduct is indicated, CCM Board President will inform the director of their permanent removal. CCM will also comply with any and all reporting requirements associated with the substantiated misconduct. CCM will consult counsel when misconduct allegations involve Board members.

Interns

In cases involving Interns, the Intern's supervisor will be notified immediately of any allegations and the intern will be removed from any Medicaid/Medicare and Managed Care activities until the investigation is complete. It is the responsibility of the intern's supervisor to notify the Educational Institution the allegation and the investigation. If the intern is cleared, they may resume their normal duties. If the allegation is substantiated, their placement at CCM will be immediately terminated.

Volunteers

In cases involving Volunteers, the Compliance Officer will contact CCM personnel responsible for the management of the volunteer placement. The Volunteer will be removed from any Medicaid/Medicare and Managed Care activities until the investigation is complete. It is the responsibility of the volunteer's supervisor to notify the referring agency, when applicable, of the allegation and investigation. If the volunteer is cleared, they may resume their normal duties. If the allegation is substantiated, their placement at CCM will be immediately terminated. It may also indicate a need for termination of the engagement with the Volunteer or institution responsible for them.

Contracted Parties

In cases involving Vendors and or Contracted Parties, CCM will halt all contracted activities until such time as an investigation can be completed. CCM will retain legal counsel for all allegations involving Vendors and or Contracted Parties. If the Vendor/Contracted Party is cleared, they may resume their normal activities. If the allegation is substantiated, their contract with CCM will be immediately terminated for cause.

Responsible Party

The President/Chief Executive Officer and/or Human Resources will be responsible for reviewing and approving any remedial or disciplinary action recommended and implemented against applicable Executives/ Board of Directors/ Employees/ Interns/ Volunteers/ Vendors and Contracted Parties to correct violations of the Medicaid Compliance Program.

Human Resources

Human Resources is responsible for overseeing all hearings conducted and disciplinary actions implemented in matters relating to the Medicaid Compliance Program and will seek to ensure that they are consistent with CCM policies and applicable law. The Compliance Officer will report on all Human Resources actions relating to the Medicaid Compliance Program to the Senior Management, Department Directors, as well as any external bodies requiring a plan of corrective action.

Excluded Provider Screening

New Employees

CCM screens all prospective employees against state and federal exclusion lists before extending a conditional offer of employment. Facilities are instructed to contact the Human Resources immediately if a prospective employee is identified as being an excluded provider. A conditional offer of employment cannot be extended to any individual identified as being an excluded provider on any state or federal exclusion list.

Current Employees

CCM checks all employees against state and federal exclusions lists on an annual basis. In the event that a current employee is identified as an excluded provider (i.e. they are not a recurring match), CCM Human Resources works with the identified employee's program, legal counsel's Office, and the Compliance Officer to take appropriate action to ensure that the individual is not providing services for which CCM obtains reimbursement from federal health insurance programs either directly or indirectly. *Being placed on any of the 3 exclusions lists is a terminable offence.*

Vendors

New vendors are screened by CCM, in the case of direct care staff, or are required to submit an attestation indicating that the vendor has completed the requisite exclusion screenings. The CCM boilerplate contract, which is used for nearly all contracts for goods and services, contains language requiring compliance with exclusion screening procedures. CCM will not make employment or contract offers to an individual or business that is verified to be excluded from participation in federal health insurance programs.

Exit Statements

The Human Resources Department administers an exit interview program to solicit and obtain information from applicable Employees relating to their reasons for terminating employment. As part of this Compliance Program, upon termination of employment (for any reason), Human Resources will ensure that applicable Employees sign a termination of attestation form certifying that she/he has reported any known or suspected violations of the Medicaid Compliance Program. Human Resources is also responsible to document those instances when an exit interview is not possible.

A similar exit interview process will be implemented for Volunteers/Interns/Contracted Staff upon their discontinuation of providing services to CCM. In these cases, the Human Resources at CCM is responsible to conduct the exit interview, part of the exit interview must include inquiry into fraudulent activities. If none are disclosed the employee must sign an attestation to that effect. If they report noncompliance the Human Resources person is to immediately contact Compliance.

Element 6: System for Routine Identification of Compliance Risk Areas

Audits and Monitoring of the Compliance Plan

CCM will implement the necessary management systems and controls to ensure the overall integrity of the Medicaid Compliance Program and monitor all applicable activities and compliance requirements.

These auditing and monitoring activities will be designed to address compliance with laws governing DSM-5 and ICD-10 coding, [or whatever is current at the time] claim development and submission, reimbursement, cost reporting, and marketing. In addition, the auditing activities will focus on compliance in 7 high-risk areas identified by 18 NYCRR § 521.3 (a), including billings, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing and other risks areas that are or should with due diligence be identified by the provider.

Any overpayments discovered as a result of our auditing activities shall be promptly refunded to the applicable payer with appropriate documentation and an explanation of the reason for the refund.

Auditing the Compliance Program

The Compliance Officer will be responsible to ensure a comprehensive audit and review of the Compliance Program at least annually but can occur more frequently as needed. The scope of this audit will focus on CCM's programs and operations, specifically those with substantive

exposure to government enforcement actions. The audit will address CCM's compliance with laws governing billing, coding, claim development and submission, and reimbursement. Additionally, there will be an evaluation of the extent to which CCM's applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers have implemented and complied with the Medicaid Compliance Program.

This comprehensive audit will be administered principally by the Compliance Officer utilizing the NYS OMIG Compliance Program Self-Assessment Tool. An audit summary report, including findings, results and recommendations will be written by the Compliance Officer and submitted to the President/Chief Executive Director and Board of Directors.

In addition to the annual audit of the Medicaid Compliance Program, Program Directors are required to audit regularly for quality and compliance. The Quality Management staff will also be responsible for overseeing, on an ongoing basis throughout the year, inspections, compliance reviews and evaluation of activities related to the Medicaid Compliance Program and entering them into the tracking sheet. The Quality Assurance staff will report to the Compliance Officer and the result of these reviews will be shared with the SCC and senior management.

Audits by Outside Parties

In addition to the internal reviews and audits noted in Section 7.1, CCM's operations and programs are regularly subject to review, inspection and audit by outside parties. To the extent that the findings resulting from such audits relate to activities and standards covered by the Medicaid Compliance Program, such findings will be reported to the Compliance Officer and President/Chief Executive Officer, who in turn will arrange for the Board to receive a copy of such reports. The findings will also be tracked and reviewed as part of the Staff Medicaid Compliance meetings.

Inventory/Schedule of Audits

The Compliance Officer will be responsible for coordinating and maintaining a schedule of all reviews and audits which relate directly to the Medicaid Compliance Program.

Reporting Results of Compliance Plan Reviews and Audits

The results of all reviews and audits of and relating to the Medicaid Compliance Program will be provided to the Compliance Officer, President/Chief Executive Officer and Board of Directors for consideration and follow-up. The purpose of the review, by any one of these parties, will be to (1) consider the overall effectiveness of the Medicaid Compliance Program; (2) determine the need for any plan of corrective action in the operations and/or professional or business practices of the organization, and (3) consider the need for organizational change and modifications and/or additions to CCM's policies as it relates to the Medicaid Compliance Program.

If the audit outcomes are involved with fraud, waste or abuse of Medicaid, the NYS Office of Medicaid Inspector General and/or NYS Department of Health will be notified.

Follow-Up and Response to Audits & Reviews

The Compliance Officer will be responsible for implementing corrective actions in those areas where reviews and audits indicate violations, inconsistencies, or deviations from the compliance standards covered in the Medicaid Compliance Program.

The President/Chief Executive Officer and Board of Directors will be informed of any actions implemented in response to either an internal or external audit or monitoring review. The Compliance Officer along with the Quality Management staff will be responsible for overseeing such responses and plans of correction for three months. Once the three months have passed, the President/Chief Executive Officer and Board of Directors revisits the issue, and either determines that the appropriate changes have been put in place and made, continued monitoring is necessary, or a revision of the corrective action plan is necessary.

Reducing Potential Recurrence

Upon the completion of the audits, corrective actions including the implementation of policies and systems to reduce the potential for reoccurrence should also be developed and initiated. The Compliance Officer along with the Quality Management staff should conduct internal audits specific to the compliance issues six months after the completion of the corrective actions to determine if similar issues have recurred.

Element 7 - System of Responding to Violations/Non-Compliance

Summary

Violations of the Medicaid Compliance Program can potentially jeopardize and place at risk the operations, reputation, financial and legal status of CCM. Consequently, upon reports of known or suspected violations of the Medicaid Compliance Program or other reasonable indications of violations of the Compliance Program, the Compliance Officer or their designee will immediately notify President/Chief Executive Officer and/or the Compliance Committee of the Board and promptly investigate the conduct in question to determine whether a violation of the Medicaid Compliance Program has occurred. If such a violation has occurred, corrective actions will be implemented, and disciplinary action taken that is appropriate to the materiality of the violation consistent with Element 5. If there shall be any conflict of interest resulting from the participation of the Compliance Officer in any investigation, then the Compliance Committee of the Board may designate another individual or legal counsel to lead the investigation.

Investigations and Corrective Action

Investigations of specific reports of known or suspected violations may be conducted by any one or more of the following departments or parties depending on the nature of the violation: the Compliance Officer or one of his/her designees, or any appropriate federal, state or local government agency to include the NYS Office of Medicaid Inspector General (OMIG). The Compliance Officer will receive copies of all such investigations. Enforcement of the Medicaid Compliance Plan and corrective action to address problem areas and violations will be the shared responsibility of the Compliance Officer, the President/Chief Executive Officer, Senior Management and appropriate Program Directors. In cases where disciplinary action involving an employee is warranted, Human Resources will be consulted. In those cases, involving Volunteers or Interns, the Volunteer Manager and Internship agency/school will be consulted. Either Human Resources or the Volunteer and/or Internship agency/school, as applicable, will determine the appropriate disciplinary action to be implemented in accordance with CCM Disciplinary Policies. In cases involving Contracted Parties, the appropriate corrective action will be implemented in accordance with the relevant contractual provisions governing the contractual agreement between CCM and the Contracted Party.

Investigative Process

- Upon learning of suspected non-compliance, it is important to stop all billing related to any of the activities/parties/or services. This should be done immediately.
- Notify executive staff and the Board of Compliance Committee.
- If the alleged non-compliance involves egregious activities by applicable Executives/ Employees/ Volunteers/ Interns / Contracted Parties, those individuals should be removed from contact with any Medicaid/Medicare/Managed Care services.
- Gather and secure all documentation related to the alleged non-compliance for review
    - Charts - paper and electronic
        - Client
            - Open
            - Closed
            - Pending
        - Employee
            - Active
            - Terminated
    - Logs
        - Billing
        - Attendance
    - Billing files
        - Invoices
        - Responses

        - Reversals
        - Insurance contracts
        - Client insurance information
    - Contracts
        - Vendors
        - Employees
        - Payers
- The Compliance Officer and/or their designee will review all documentation associated with the report of non-compliance to document if the services were billed correctly, which includes supporting documentation in the chart at the time of invoicing. This should include *at minimum* the following:
    - Verification that the employee rendering the services was employed and working at the time the service is documented as having occurred.
    - Verification that the individual alleged to have received the service was present at the time the service occurred.
    - Verification that the individual that received the service had the insurance invoiced.
    - Verification that there was an active prescription for the service in the individual's chart signed by all required parties at the time the service was being delivered. The prescription for service is defined differently for each licensed provider type but can include Treatment Plan, Plan of Care, and Individual Recovery Plan.
    - Verification that there was a note completed prior to the services invoice documenting the following; [the note may be for a single service or a group of services, in which case a weekly summary note would be appropriate].
        - What on the plan was being worked on?
        - What was the progress since the prior meeting with the provider by the individual being served?
        - What intervention was provided?
        - What was the response of the individual being served to the provided intervention?
        - What is the individuals plan till the next meeting with the provider?
        - Signature, credentials listed.
        - Date of service, start and stop time of service, and location of service delivery.
        - Modality of service delivery.
    - Verification that the duration in the note, provider credentials, modality and service location are correct for the billing code selected.
    - Verification that supervisory signatures were in place for non-licensed staff by appropriately licensed staff.

  - Verification that all add on billing codes such as; after hours, language other than English, have documentation of such occurrences.
  - Verification that MD Evaluation and Management (E&M) documentation is used to support the use of E&M coding.
  - Verification that incident to crisis, complex care and other infrequent billing codes are supported in the documentation of the service to include multiple staff either in service delivery or present.
- Investigation must include interviews with staff and clients where appropriate. Witnesses must be present at the interviews and interviewees are entitled to representation.
- The Compliance Officer will ensure that all aspects of the investigation are fully, accurately and properly documented in an ***excel workbook*** that can be submitted in a self-disclosure to the regulatory Medicaid/Medicaid/Medicare upon request. The investigative process must be transparent and without influence either internal or external to the provider organization.
- Before the investigation ends, the Compliance Officer should identify root causes of problems, desired outcomes, affected parties, applicable guidelines, and possible regulatory or financial impact and provide a complete list of findings and recommendations.

Reporting Results of Investigation

Upon completion of the investigation, the Compliance Officer should report to President/Chief Executive Officer and Board of Directors the findings and recommendations of the investigation and prompt and thorough correction of all identified compliance issues should be initiated. And the correction process will begin immediately and be completed within a reasonable time frame. Depending on the scope and severity of the identified violations, the Compliance Officer may consult with President/Chief Executive Officer and Board of Directors to determine:

- the results of the investigation and the adequacy of recommendations for corrective actions;
- the completeness, objectivity, and adequacy of recommendations for corrective actions;
- the overall effectiveness of the Medicaid Compliance Program; and/or
- further actions to be taken as necessary and appropriate, such as policy changes, operational changes, system changes, personnel changes, training/education.

If a report of potential non-compliance involved with fraud, waste or abuse of Medicaid is valid, the NYS Office of Medicaid Inspector General and/or NYS Department of Health will be notified.

Follow-Up and Response to Investigation

The Compliance Officer will be responsible for implementing corrective action in those areas where the investigation indicates violations, inconsistencies, or deviations from the compliance standards covered in the Medicaid Compliance Program.

The President/Chief Executive Officer and Board of Directors will be informed of any actions implemented in response to the investigation. The Compliance Officer along with the Quality Management staff will be responsible for overseeing such responses and plans of correction for three months. Once the three months have passed, the President/Chief Executive Officer and Board of Directors revisits the issue, and either determines that the appropriate changes have been put in place and made, continued monitoring is necessary, or a revision of the corrective action plan is necessary.

Reducing Potential Recurrence

Upon the completion of the investigation, corrective actions including the implementation of policies and systems to reduce the potential for reoccurrence should also be developed and initiated. The Compliance Officer along with the Quality Management staff should conduct internal audits specific to the compliance issues six months after the completion of the corrective actions to determine if similar issues have recurred.

Element 8: Non-Intimidation and Non-Retaliation

Summary

There is a strict prohibition of intimidation and/or retaliation against applicable Executives/ Board of Directors/ Employees/ Interns/Contracted Parties/ Volunteers who in good faith participate in CCM's compliance policy, including but not limited to: reporting potential compliance issues and/or participating and cooperating in an investigation, self-evaluations, audits, remedial actions and/or the reporting to appropriate officials as provided in sections 740 and 741 of the NYS Labor Law.

The CCM's Executives/ Employees who engage in any intimidation and/or retaliation activities including threat, harassment, blackmail, theft of property, and termination, is unacceptable. Any manager, supervisor or employee who engages in such intimidation, retribution, retaliation or harassment is subject to discipline, in accordance with his or her level of intimidation and/or retaliation up to and including termination. For Contracted Parties, such actions may lead to the termination of the contract under which their services are provided to the CCM. CCM management will ensure that there is no intimidation and/or retaliation taken against an applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties/ Volunteers for reporting what applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties/ Volunteers reasonably believed to be a violation of the Medicaid Compliance Program. However, in those circumstances where the CCM has reasonably concluded that Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties/ Volunteers knowingly fabricated, distorted, exaggerated, or minimized a report of a violation to either damage other Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties/ Volunteers, to protect

himself/herself or others, or if the report contains admissions of personal wrongdoing, CCM management may, to the extent consistent with applicable laws and pursuant to the advice of legal counsel, as necessary, implement disciplinary or corrective action against those involved.

Records, Documentation, and Billing

Privacy and Confidentiality

CCM policies provide for maintaining the confidentiality of the records, both electronic and paper, of persons served and complying with related privacy requirements under Applicable Law [See HIPAA policies and procedures manual]. Additionally, CCM has specific guidelines for responding to requests for information [see program policies and procedures].

Accuracy of Records

CCM expects its applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers to maintain and administer records with accuracy, reliability, and honesty at all times and in all circumstances. Specifically, CCM's applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers are required to make every effort to ensure the accuracy of their own work and report inaccuracies in any CCM record of which they are aware or suspect. Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers are prohibited from creating any documentation in the records of CCM that to the best of their knowledge is incomplete, inaccurate and/or fraudulent.

Records Retention

CCM administers a records management program to ensure that its records are maintained and stored in accordance with various records retention standards and requirements documented in CCM Records Retention and Destruction Policy. Among other records, which are part of the records management program, CCM will retain various clinical, medical, administrative, and operational records, billing, claims, financial, and other records in accordance with the requirements of the MCP. At no time should an employee destroy or delete any record or part of a record without written permission from a supervisor. This is inclusive of paper and electronic documentation.

Billing and Coding

CCM expects that all applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers involved in the coding, billing, documentation and accounting for healthcare services for the purpose of billing governmental, private or individual payers will comply with all applicable law and CCM policies. Specifically, CCM requires its applicable Executives/ Board of Directors/ Employees/ Interns/ Contracted Parties and Volunteers to:

- Bill only for healthcare services actually provided and seek only the amount to which CCM is entitled. CCM will not tolerate billing by CCM that misrepresents the healthcare services actually provided.
- Prepare supporting documentation for all healthcare services provided to Persons Served. CCM will bill on the principle that if the appropriate and required documentation has not been prepared, then the healthcare services have not been provided.
- Accurately and completely code claims based on information in the record and supporting documentation of the persons served and submit any claims to the appropriate payer in accordance with applicable Law and CCM policies.
- Charge all persons served in a consistent and uniform manner except as otherwise provided herein.
- Charge government-sponsored payers at no higher rate than allowable. Any questions regarding the interpretation of this standard should be directed to the Compliance Officer.
- Offer no preferential discount to a single payer amongst payers associated with a single service. *Sliding scale is legally different than a discount. A discount must be provided to all payers equitably while a sliding scale may be provided to an individual based on DOCUMENTED income for the past 12 months and federally accepted ID*.
- Process all credit balances in a timely manner in accordance with applicable law. If an audit identifies any credit balances, CCM will direct those issues to the Compliance Officer.
- Applicable staff participation in training on CCM policies and applicable law regarding those activities for which CCM is responsible with respect to coding, billing and documentation.

Version Number	Summary of Changes	Effective Date
1.0	Initial Version	Unknown
2.0	Changes of Compliance Officer; new non-compliance report mechanism; revision of code of conduct; revision of disciplinary procedures	Approved by CCM Board of Directors on 12/13/2019, immediate effective

ATTACHMENT A

COMPLIANCE PLAN CONTACT INFORMATION

The following email address at CCM are available for applicable Employees/Interns/Contracted Staff and Volunteers to make inquiries or reports about the Compliance Program:

Compliance Officer: Peiying Ou

President/Chief Executive Officer: Emory X. Brooks

Compliance Email Address: ComplianceCCM@ccmnyc.org

Compliance Web Portal: https://ccmnyc.org/about-us/ - "Non-Compliance Report"

ATTACHMENT B

CODE OF CONDUCT

CCM is committed to compliance with all laws governing federal and state-funded health care programs and all requirements of other insurance companies.

CCM is committed to charging, billing and submitting claims for reimbursement only when professional services have been provided and documented in the manner required by laws and regulations.

Has CCM established written Medicaid Compliance Program, policies and procedures and standards that demonstrate our commitment to complying with all applicable federal and state statutory, regulatory, and other requirements. These standards apply to all Employees/ Interns of CCM and are a critical component of our efforts to detect, prevent, and control fraud, waste and abuse. CCM expects its employees to refrain from conduct that may violate the fraud and abuse laws including, but not limited to, the prohibition on submitting false, fraudulent or misleading claims to any government entity or third party payer, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply CCM with applicable program or contractual requirements.

By signing this document, I agree to abide by all components of the Code of Conduct for the duration of my tenure at CCM.

____ ____________________

Printed name date

____

Signature

CCM COMMUNITY COUNSELING & MEDIATION

ATTACHMENT C

COMPLIANCE TERMINATION ATTESTATION

I, ___________________, attest that during my tenure at CCM I did not participate in or have any knowledge of fraud, waste and abuse activity as it pertains to Medicaid, Medicaid/Medicare, and/or Managed Care. I fully attest that I understood my responsibility and agreed in writing to comply with the policies and practices set in the Medicaid Compliance Program.

I hereby attest that at no time during my full time, part time, or per diem employment, or as a volunteer and/or intern did I participate in or have knowledge of any Medicaid, Medicaid/Medicare or Managed Care non-compliance to include fraud, waste or abuse. I further attest that I understood what was required of me, and that I agreed in writing to comply with the policies and practices set forth in CCM Medicare/Medicaid Compliance Program.

Period of employment Start Date: _________________End Date:_____________________

Period as a Volunteer Start Date: __________________End Date: _____________________

Period as an Intern __Start Date: __________________End Date:______________________

Print Name: ______________________________

Signature: ___________________________________

Date: ________________

Witness Signature____

Date: _________________

ATTACHMENT D

CCM COMPLIANCE PLAN ACKNOWLEDGEMENT FORM:

I, __________________________acknowledge that I have received a copy of CCM Compliance Plan or I am aware that it is located in the shared directory. I have reviewed CCM Medicaid Compliance Program policy. I fully understand my role and responsibilities as it pertains to compliance and agree to comply with the policies and practices set. In accordance with the procedures described in the policy, I agree that I will promptly report to the Compliance Officer or designee any issues that I know or suspect to be a violation of the Compliance Program. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ASK QUESTIONS/SEEK GUIDANCE WHEN I AM UNSURE OF A COMPLIANCE MATTER.

Signature: ____

Date: ____