Community Counseling and Mediation (CCM)

Compliance Policy and Procedure Manual

2024-2025

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Introduction

Community Counseling and Mediation (CCM) is committed to establishing and maintaining an effective compliance program designed to ensure adherence to applicable federal, state, and local laws, rules, and regulations, as well as the highest standards of healthcare industry practices and ethical business conduct. Our Compliance Program is built upon the principles of integrity, accountability, and transparency, and is integral to our mission of delivering high-quality, compliant services to the communities we serve.

The primary purpose of our Compliance Program is to prevent, detect, and address violations of law, regulations, and organizational policies while fostering a culture of compliance throughout the organization. The program provides a framework for identifying risks, establishing internal controls, and addressing compliance issues effectively and promptly. It also ensures that all affected individuals, including employees, contractors, and governing body members, understand and fulfill their responsibilities in supporting compliance efforts.

To ensure ongoing relevance and effectiveness, CCM reviews and updates its Compliance Policies and Procedures at least annually and whenever there are significant changes to applicable federal or state laws, regulations, or program requirements, including those outlined by the New York State Office of the Medicaid Inspector General (OMIG). Updates are also made to reflect lessons learned from compliance activities, such as internal audits, investigations, and regulatory reviews. This manual represents the most current requirements and processes, which may be adjusted based on the unique circumstances of specific Medicaid program contracts or as directed by applicable regulatory authorities.

This document provides detailed guidance for implementing our Compliance Program, including roles and responsibilities, processes for issue reporting and investigation, anti-retaliation protections, training requirements, and ongoing monitoring and auditing protocols. Through these efforts, CCM remains dedicated to ethical operations, regulatory compliance, and the continuous improvement of our services and organizational integrity.

Overview of Compliance Program Requirements

In compliance with **New York State Social Services Law (SSL) §363-d** and **18 NYCRR Part 521**, CCM has established a comprehensive compliance program that incorporates key components necessary for maintaining compliance with Medicaid regulations. This program reflects our commitment to federal and state laws, ensures organizational integrity, and fosters a culture of accountability and ethical behavior.

Definitions and Compliance Program Overview

Definitions

- **Abuse**: Provider practices inconsistent with sound fiscal, business, or medical practices, resulting in unnecessary costs to the Medicaid program or reimbursement for services

that are not medically necessary or fail to meet professionally recognized healthcare standards.

- **Compliance Program**: A proactive and reactive system of internal controls, operating procedures, and organizational policies ensuring adherence to applicable laws, regulations, and program requirements.
- **Affected Individuals**: All persons impacted by the provider's risk areas, including employees, senior administrators, managers, contractors, agents, subcontractors, independent contractors, governing body members, and corporate officers.
- **Compliance Officer (CO)**: The designated official responsible for the day-to-day operation of the compliance program.
- **Employee**: Any person responsible for adhering to this policy directive.
- **Fraud**: Intentional misrepresentation, omission, or concealment intended to deceive or cause the submission of false claims or records for payment.
- **Intimidation**: Coercion or threats aimed at discouraging the reporting of actual or suspected fraudulent activities.
- **Office of the Medicaid Inspector General (OMIG)**: The New York State office is responsible for ensuring Medicaid program integrity.
- **Retaliation**: Adverse employment actions, such as disciplinary measures, failure to promote, or harassment, taken against an individual for reporting compliance issues.
- **Vendors**: Entities, including suppliers, consultants, referral sources, manufacturers, payers, or third parties conducting business with the provider.
- **Waste**: Overutilization, underutilization, or misuse of resources.

Key Components of the Compliance Program

Commitment to Compliance

CCM is committed to full compliance with all applicable federal and state laws, as well as Medicaid program requirements. The Compliance Program embodies this commitment through the establishment of comprehensive standards of conduct, clear guidance for identifying and reporting compliance issues, and robust anti-retaliation policies. By adhering to these principles, CCM fosters a culture of accountability, transparency, and ethical behavior across all operations.

Compliance Officer

The Compliance Program is led by a designated Compliance Officer who has primary responsibility for its implementation and management. The Compliance Officer:

- Reports directly to senior management and periodically to the governing body, ensuring independence and authority.
- Is provided with sufficient resources, authority, and support to execute compliance responsibilities effectively.
- Oversees all aspects of the compliance program, including training, auditing, and issue resolution.

Compliance Committee

A Compliance Committee is established to support the Compliance Officer in coordinating and overseeing compliance activities. The committee:

- Is composed of representatives from key operational areas, such as billing, clinical services, and administration.
- Has clearly documented responsibilities, including policy review, risk assessment, and monitoring of corrective actions.
- Meets at least quarterly, with minutes recorded to document discussions and decisions.

Training and Education

Regular training is a cornerstone of the Compliance Program, ensuring that all employees understand their roles and responsibilities in maintaining compliance. Training activities include:

- Annual compliance training for all employees, executives, governing body members, and contractors.
- Specialized training tailored to staff involved in high-risk areas, such as billing, coding, and Medicaid program requirements.
- Inclusion of compliance training in new employee orientation to establish awareness from the outset.

Effective Communication

Maintaining open lines of communication is critical to the success of the Compliance Program. CCM ensures:

- The availability of confidential and anonymous reporting mechanisms, such as a hotline or dedicated email, for reporting compliance concerns.
- All reports are handled confidentially to the extent permitted by law.
- Individuals who report issues in good faith are protected from retaliation through strict enforcement of anti-retaliation policies.

Disciplinary Standards

To reinforce accountability, the Compliance Program includes clear and consistent disciplinary measures for non-compliance. These measures:

- Articulate expectations for reporting compliance concerns and participating in corrective actions.
- Define sanctions for failing to report suspected issues, participating in non-compliant behavior, or facilitating non-compliance.
- Are applied fairly and consistently across all levels of the organization.

Auditing and Monitoring

Auditing and monitoring activities are integral to identifying and mitigating compliance risks. The Compliance Program ensures:

- Routine internal and external audits focused on high-risk areas such as billing, credentialing, and governance.
- Comprehensive reviews of audit findings, with corrective actions implemented to address identified risks.
- Ongoing evaluation of compliance activities to identify trends and opportunities for improvement.

Response to Compliance Issues

Prompt and effective response to compliance issues is essential for maintaining program integrity. The Compliance Program establishes procedures to:

- Investigate and resolve compliance concerns as they arise.
- Document all aspects of the investigation, including findings, corrective actions, and outcomes.
- Implement measures to prevent recurrence, such as policy updates or additional training.

Integration with Core Values

The compliance program reflects CCM's dedication to ethical business conduct, regulatory adherence, and continuous improvement. By incorporating robust standards, effective training, and responsive procedures, the program ensures a proactive approach to compliance risks while promoting transparency and accountability across the organization.

Areas of Focus for Compliance Programs

Under **18 NYCRR § 521.3(a)**, compliance programs must address seven key areas:

1. **Billings**: Accuracy and compliance with Medicaid billing requirements.
2. **Payments**: Proper receipt and handling of Medicaid payments.
3. **Medical Necessity and Quality of Care**: Ensuring services meet established medical standards.
4. **Governance**: Oversight and accountability within the organization.
5. **Mandatory Reporting**: Timely reporting of compliance issues and overpayments.
6. **Credentialing**: Verification of qualifications for providers and associated personnel.

7. **Other Risk Areas**: Identification and management of additional risks relevant to the provider's operations.

Commitment to an Effective Compliance Program

CCM has adopted a Medicaid Compliance Program consistent with SSL §363-d and 18 NYCRR Part 521 to promote honest and responsible conduct, detect and address non-compliance, and foster a culture of accountability. The program decreases the likelihood of unlawful or unethical behavior by encouraging employees to report potential issues and allowing the organization to take appropriate corrective actions. This program reflects a commitment to providing high-quality, ethical services while adhering to state and federal regulations.

ELEMENT 1: Written Policies and Procedures

Development and Maintenance of Compliance Policies and Procedures

Creation of New Compliance Policies and Procedures
To ensure adherence to federal, state, and program requirements, CCM develops and updates compliance policies and procedures in response to new or revised laws, regulations, or program directives. When a new policy is required, the organization may modify an existing policy or create one from scratch. The process includes:

1. **Drafting:**
    - A new Medicaid/Medicare Compliance Policy will be drafted using the organization's Compliance Plan formatting and Policy and Procedure Template.
    - Desktop guides with detailed procedural instructions may accompany the policy to provide additional clarity.
2. **Defining Requirements:**
    - The draft policy will outline key requirements, roles, and responsibilities to ensure clarity and effective implementation.
3. **Review and Approval:**
    - Program leadership responsible for the relevant area(s) will review and approve the draft policy.
    - If necessary, the draft will be routed to the CEO to ensure consistency with other organizational policies and procedures.
    - The Compliance Officer (CO) will conduct a final review, incorporate revisions if needed, and grant final approval.
4. **Dissemination and Acknowledgment:**
    - The approved policy will be distributed through email, staff meetings, and supervision discussions and uploaded to the ***Compliance Program Shared Drive***.
    - Staff will be required to acknowledge receipt and understanding through attestation.

Maintenance and Updating of Existing Policies and Procedures
CCM is committed to ensuring compliance with regulatory requirements by maintaining and regularly reviewing existing policies. Policies are reviewed annually or as needed due to changes in laws, regulations, or program requirements. The process includes:

1. **Documenting Changes:**
    - Updates will be tracked to maintain transparency and accountability.
2. **Legal Consultation:**
    - Legal counsel will be consulted for additional validation and input, as necessary.
3. **Final Review and Approval:**
    - The Compliance Officer will conduct a final review, make necessary updates, and approve the revised policy.
4. **Implementation and Accessibility:**
    - The updated policy will be implemented and made accessible to staff via the Compliance Program Shared Drive.

This structured approach ensures that all compliance policies are clear, up-to-date, and effectively communicated across the organization.

Storage and Communication of Policies and Procedures

All Compliance Policies and Procedures, including the Compliance Plan, are stored on the organization's intranet or shared drive, ensuring they are accessible to all employees at any time. New policies and updates are communicated to employees supporting Medicaid, Medicare, and Medicaid Managed Care services within 30 days of hire and annually thereafter. Communication methods include staff meetings, compliance trainings, supervision sessions, compliance presentations, intranet postings, and compliance alerts. Foundational documents, such as the Code of Conduct, are shared during these timeframes to reinforce compliance awareness and understanding.

Record Retention

When a new policy replaces an existing one, the obsolete policy is archived in accordance with the organization's Records Retention Schedule and CMS requirements. Retention ensures historical compliance data is maintained for regulatory reviews and organizational audits.

Relevant Statutes and Standards

CCM ensures compliance with the following statutes and standards:

- **New York State Social Services Law §363-d**: Requirements for provider compliance programs.
- **18 NYCRR Part 521**: Fraud, waste, and abuse prevention regulations.
- **42 USC §1396(a)(68)**: Federal Deficit Reduction Act provisions for compliance policies.
- **31 U.S.C. §§3729-3733 (Federal False Claims Act)**: Regulations against submitting fraudulent claims.

- **New York State Finance Law §§187-194 (State False Claims Act)**: Requirements for whistleblower protections and actions against fraud.
- **New York State Labor Laws §§740, 741**: Whistleblower protection statutes.
- **New York State Penal Law §175**: Penalties for false written statements.
- **New York State Penal Law §176**: Insurance fraud regulations.
- **New York State Penal Law §177**: Health care fraud provisions.

By adhering to these standards and maintaining robust written policies and procedures, CCM ensures compliance with all applicable laws and regulatory requirements, fostering a culture of integrity and accountability.

ELEMENT 2: Compliance Officer and Compliance Committee

Compliance Oversight and Management

CCM has designated a Compliance Officer (CO) to oversee the implementation and management of the compliance program. This position is integral to ensuring adherence to federal and state laws, Medicaid program requirements, and organizational policies. The Compliance Officer serves as the primary point of accountability for compliance-related activities and ensures the effectiveness of the compliance program across the organization.

Compliance Officer

The Compliance Officer is appointed by the Board of Directors and/or President/CEO and reports directly to the President/CEO on a monthly basis. The CO also provides in-person reports to the Board of Directors at least twice annually. In the event of a significant compliance issue, the Compliance Officer is responsible for notifying the President/CEO and the Board of Directors within three (3) business days. This reporting structure ensures that the Compliance Officer maintains independence and has direct access to organizational leadership to address compliance concerns.

The Compliance Officer's primary responsibilities include, but are not limited to:

1. **Program Oversight**:
    - Oversee and monitor the implementation of the Medicaid Compliance Program (MCP) to ensure alignment with regulatory requirements and organizational policies.
    - Revise the MCP as needed to incorporate changes in applicable laws, policies, and identified audit patterns or trends.
2. **Reporting and Accountability**:
    - Provide regular updates on the progress of the compliance program to the Board of Directors and Medicaid Compliance Committee (MCC) during biannual meetings.
    - Prepare and submit a summary report containing information about compliance investigations, corrective actions, audit results, and program assessments.

3. **Education and Training**:
    - Develop, coordinate, and deliver a comprehensive education and training program for all affected individuals, emphasizing the elements of the Medicaid Compliance Program.
    - Ensure that training covers essential topics, including documentation, coding, billing practices, and applicable laws, to enhance understanding and compliance.
4. **Investigation and Corrective Action**:
    - Independently investigate reports of known or suspected compliance violations and oversee the implementation of corrective actions.
    - Coordinate internal investigations and review outcomes to ensure resolution of compliance issues across all Medicaid billable programs.
5. **Auditing and Monitoring**:
    - Plan and oversee periodic internal audits, including reviews of billing records, charts, and personnel files, to evaluate compliance with organizational policies and applicable laws.
    - Use audit findings to identify compliance risks and recommend corrective actions to prevent recurrence.
6. **Reporting Mechanisms and Non-Retaliation**:
    - Maintain a well-publicized and accessible program for reporting suspected compliance violations, including anonymous and confidential mechanisms.
    - Encourage affected individuals to report issues without fear of retaliation, fostering a culture of transparency and trust.
7. **Policy Development and Guidance**:
    - Collaborate with organizational leadership and legal counsel to develop and implement written guidelines addressing specific compliance issues, including unethical business practices.
8. **Self-Assessment and Corrective Action**:
    - Complete the NYS OMIG Annual Self-Assessment and prepare a corresponding summary report for the Board and Medicaid Compliance Committee.
    - If any deficiencies are identified, a Corrective Action Plan (CAP) must be developed, implemented, and completed before submitting the OMIG attestation.
9. **Documentation and Record Review**:
    - Review documents relevant to compliance activities, such as billing records, clinical charts, and personnel files, to identify and address potential risks.
10. **Additional Responsibilities**:
    - Perform other duties as requested by the Board, Medicaid Compliance Oversight Committee, or President/CEO to support compliance efforts and maintain program integrity.

The Compliance Officer plays a pivotal role in promoting accountability, minimizing compliance risks, and ensuring that CCM operates ethically and in full compliance with applicable regulations. Through diligent oversight and proactive management, the Compliance Officer supports the organization's commitment to maintaining a robust and effective compliance program.

Empowerment and Authority

The Compliance Officer is vested with the authority to:

- Access all necessary resources, records, and personnel to carry out compliance responsibilities.
- Act independently to investigate and address compliance issues.
- Provide candid, unfiltered reports to leadership and governing bodies.

The Compliance Officer's independence, authority, and direct reporting relationship with senior leadership and the governing body ensure that compliance issues are identified and addressed promptly and effectively.

Communication of Key Initiatives and Updates

The Compliance Officer is responsible for ensuring that all affected individuals are informed of compliance initiatives, policy updates, and regulatory changes. Key updates to the Medicaid/Medicare Compliance Plan, new or revised policies and procedures, and other compliance-related communications are disseminated through multiple channels. These may include, but are not limited to, emails, memos, training sessions, staff meetings, onboarding programs, and compliance-specific communications such as Regulatory Alerts, postings on the compliance intranet site, verbal and written announcements, and telephonic or virtual notifications.

Intranet-Based Communications

To promote ongoing compliance awareness, the Compliance Officer may periodically develop and post intranet-based materials, such as newsletters or alerts, accessible to all applicable affected individuals. These communications may include:

- Key reporting requirements.
- Information on available reporting methods, including anonymous and confidential channels.
- Updates on regulatory changes and best practices in compliance.

Distribution and Tracking of Regulatory Changes

The Compliance Officer oversees the prompt dissemination of statutory, regulatory, and sub-regulatory updates through a structured tracking and distribution system. This system includes a comprehensive distribution list, which is reviewed and validated at least annually for accuracy. Business leads are tasked with sharing relevant updates with their respective teams to ensure operational alignment with compliance requirements.

Reporting to Leadership

The Compliance Officer provides regular reports to the President and CEO, detailing compliance-related activities, emerging risks, and resolution of identified issues. These reports ensure that executive leadership is informed of the organization's compliance posture and any significant developments related to Medicaid/Medicare/Medicaid Managed Care programs.

Responsibilities of Chief Executive, Employees, Senior Administrators, Managers, Interns, and Volunteers

Responsibility for the Medicaid Compliance Program

Responsibility for the Medicaid Compliance Program is shared by the Board of Directors, management, and all affected individuals, including the Chief Executive Officer, employees, senior administrators, managers, interns, and volunteers. Each individual is personally accountable for understanding and adhering to the compliance program, employee manual, and agency policies and procedures. They must conduct themselves in a manner consistent with the highest ethical standards, applicable laws, and all organizational policies. Additionally, all deviations from these standards, whether observed or suspected, must be reported promptly.

Expectations for Reporting Compliance Issues

Chief Executives, employees, senior administrators, managers, interns, and volunteers are required to report any actual or suspected violations of law, agency policy, or operating procedures, including potential instances of fraud, waste, abuse, corruption, or misconduct. Reports should be made as soon as possible to the individual's supervisor or directly to the Compliance Officer. If a report is made to a supervisor, that supervisor has a duty to notify the Compliance Officer immediately to ensure timely investigation and resolution.

Reports can be submitted through any of the following methods:

- **Compliance Hotline**: TBD
- **Email**: amorales@ccmnyc.org
- **Web Portal**: www.ccmnyc.org

Compliance Plan Attestation

Upon hire, all affected individuals, including Chief Executives, employees, senior administrators, managers, interns, and volunteers, are required to:

1. Read and acknowledge the compliance plan.
2. Attest that they have reviewed and understood the compliance program.

This attestation must be renewed annually to reinforce awareness and accountability. Additionally, individuals must complete a **Termination Attestation** upon the conclusion of their employment or service, confirming that they do not have, nor are aware of, any knowledge of non-compliance with the compliance plan by themselves or others.

Commitment to Ethical Standards

All affected individuals must uphold the ethical standards established by CCM. These include acting with integrity, accountability, and transparency in all professional activities. Failure to adhere to these expectations, or failure to report known compliance issues, may result in disciplinary action, including termination of employment or service, as appropriate.

Compliance Expectation

Code of Conduct

CCM is committed to delivering the highest quality services to all individuals served while upholding the principles of integrity, accountability, and compliance. To support this mission, CCM has adopted a comprehensive Code of Conduct that is integrated into all program operations and serves as a cornerstone of the Compliance Program. This Code of Conduct, along with written policies and procedures for documentation, billing, and other operational activities, demonstrates our commitment to adhering to all applicable federal and state statutory, regulatory, and program requirements. These policies and procedures are essential tools in detecting, preventing, and mitigating fraud, waste, and abuse.

The Compliance Policies and Procedures, including the Code of Conduct, are reviewed annually and updated as necessary to remain aligned with legal and regulatory developments. These standards apply to all affected individuals, including employees, contractors, agents, subcontractors, independent contractors, governing body members, and corporate officers. The Code of Conduct has been disseminated to ensure all individuals understand and uphold CCM's mission, protect the rights of those served, and perform their duties ethically and responsibly.

Annual Review and Acknowledgment

All affected individuals are required to review the Code of Conduct and complete an attestation on an annual basis, acknowledging their understanding and agreement to comply. Violations of the Code of Conduct or related policies may result in disciplinary action, up to and including termination of employment or contracts. Affected individuals are encouraged to discuss any questions about the Code of Conduct with their immediate supervisor, while contractors, agents, subcontractors, independent contractors, governing body members, and corporate officers may consult the CEO or Compliance Department for clarification.

Compliance Responsibilities of Affected Individuals

All affected individuals are required to:

1. **Report Violations**:
   Report any known or suspected violations of the Compliance Program in accordance with the Whistleblower Protection – Non-Intimidation and Non-Retaliation Policy. Failure to report such violations to a direct supervisor, the Compliance Officer, or a designee will

result in disciplinary action in accordance with Element 5, up to and including termination of employment or contracts.

2. **Assist with Investigations**:
   Actively participate in the investigation and resolution of compliance issues. Responsibilities include providing requested documentation, participating in interviews, assisting in information gathering, and supporting the implementation and monitoring of corrective actions. Failure to cooperate with compliance investigations may result in disciplinary action in accordance with Element 5, up to and including termination.

Disciplinary Actions

The policies and procedures manual outlines the degrees of disciplinary action that may be applied to affected individuals for failing to adhere to compliance policies. Disciplinary actions are implemented in a fair and equitable manner across all levels of the organization. Intentional or reckless non-compliance will result in more severe sanctions than unintentional violations or honest mistakes. Disciplinary actions may include, but are not limited to, verbal warnings, written warnings, suspension, termination, and other measures deemed appropriate. Consistency and fairness in disciplinary actions ensure that all individuals are held to the same standards for similar violations.

CCM is committed to fostering an environment where all affected individuals actively contribute to compliance efforts and uphold ethical standards. Through the Code of Conduct and supporting policies, we aim to create a culture of integrity that benefits all stakeholders and ensures alignment with applicable laws and regulations.

Prohibited Activities

CCM requires all affected individuals to perform their responsibilities with the highest level of ethics and integrity, as outlined in the Code of Conduct. Any actions inconsistent with these standards undermine the organization's mission, violate legal and regulatory requirements, and jeopardize the trust of those we serve. The following activities are strictly prohibited, whether directly or indirectly, by any affected individual:

Submission of Improper Claims for Medical Care

Affected individuals are prohibited from presenting, or causing to be presented, any claim for medical or other services that was not provided as claimed. This includes submitting claims to the federal government, state government, healthcare payers, individuals, or other funding sources with knowledge, or reckless disregard, of their inaccuracy or falsity. Examples of prohibited conduct include:

- Billing for services not rendered.
- Falsifying documentation to support a claim.
- Misrepresenting the level, duration, or necessity of services provided.

Fraudulent Statements

The creation, use, or dissemination of false records, statements, or representations for the purpose of determining rights to any benefit or payment under a health program or service is strictly prohibited. Affected individuals are also prohibited from devising or executing schemes to defraud any healthcare benefit program or obtaining funds or property under false pretenses. Examples include:

- Submitting false information to secure reimbursement for ineligible services.
- Fabricating or altering patient records to justify claims.
- Providing misleading information during audits or investigations.

CCM enforces a zero-tolerance policy for these and similar activities. Violations of these prohibitions are considered serious compliance breaches and will result in disciplinary action, up to and including termination of employment or contracts. In cases where illegal activity is identified, violations may also be reported to the appropriate regulatory or law enforcement authorities for further action.

Compliance Committee

Purpose

The Compliance Committee is a critical component of CCM's Compliance Program, established to support the Compliance Officer in ensuring effective coordination and oversight of compliance activities. The committee plays a pivotal role in promoting a culture of integrity, accountability, and adherence to regulatory requirements throughout the organization.

Composition

The Compliance Committee is composed of representatives from key operational areas, ensuring comprehensive expertise and oversight across the organization. Members are selected to reflect the diverse functions of CCM, enabling the committee to address compliance issues effectively and collaboratively. The committee includes representatives from:

- **Billing and Revenue Cycle Management**: To address financial compliance and reimbursement practices.
- **Clinical Services**: To ensure compliance with medical necessity, quality of care, and documentation standards.
- **Administration and Operations**: To oversee organizational governance, risk management, and mandatory reporting.

Additional members, such as legal counsel or IT specialists, may be invited to participate based on the specific needs of the compliance agenda.

Responsibilities

The Compliance Committee has clearly documented responsibilities to ensure the success of the Compliance Program. Key responsibilities include:

- **Policy Review**: Regularly review and provide input on compliance policies and procedures to ensure alignment with current laws, regulations, and program requirements.
- **Risk Assessment**: Identify and evaluate compliance risk areas specific to the organization, including billing, quality of care, and credentialing.
- **Corrective Action Monitoring**: Oversee the implementation and effectiveness of corrective actions resulting from audits, investigations, or compliance concerns.
- **Program Evaluation**: Assist in evaluating the effectiveness of the Compliance Program, making recommendations for enhancements as needed.
- **Education and Awareness**: Support the development and dissemination of compliance-related training and resources for staff and contractors.

Meeting Schedule and Documentation

The Compliance Committee meets at least quarterly to ensure timely review and response to compliance matters. Additional meetings may be convened as needed to address urgent issues. During each meeting:

- **Agenda**: A structured agenda is prepared in advance, highlighting key discussion points, action items, and updates on ongoing compliance activities.
- **Minutes**: Detailed minutes are recorded to document discussions, decisions, and follow-up actions. These minutes are reviewed and approved at the subsequent meeting and maintained as part of the compliance records.
- **Reporting**: Key findings and recommendations from committee meetings are reported to the Compliance Officer, executive leadership, and the governing body as appropriate.

Accountability and Authority

The Compliance Committee operates under the direction of the Compliance Officer and supports the oversight responsibilities of the governing body. The committee has the authority to:

- Recommend changes to compliance policies or practices.
- Escalate significant compliance concerns to the Compliance Officer, CEO, or Board of Directors.
- Advocate for necessary resources to strengthen the Compliance Program, including staffing, training, or technology investments.

ELEMENT 3: Compliance Program Training and Education

Purpose

CCM regularly communicates its Medicaid Compliance standards and policies to all affected individuals to ensure understanding of compliance issues, expectations, and the operation of the compliance program. Annual training is mandatory, and a variety of methodologies are

utilized to deliver this training, including on-the-job supervision, in-person instruction, self-paced manuals, and electronic communication through compliance alerts and announcements via email and intranet postings.

The Medicaid Compliance Program's education and training component includes an in-depth review of applicable laws, including the provisions of the False Claims Act, and addresses additional compliance issues as they are identified. The Compliance Officer is responsible for updating the educational component as new areas of concern emerge. Training policies and programs are reviewed regularly to ensure they remain current, align with applicable laws, reflect findings from ongoing program evaluations, and incorporate results from auditing and monitoring activities.

The following subsections outline the comprehensive scope of education and training activities implemented as part of the Medicaid Compliance Program.

Orientation Program

Overview

An orientation program is provided to all new and current affected individuals. This program includes 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. Additionally, affected individuals are educated on their specific responsibilities in maintaining compliance with Medicaid program requirements.

Delivery

Affected individuals will receive access to policies and procedures in one of the following ways:

- Distribution of physical copies during orientation.
- Instructions on how to access policies and procedures via the intranet or shared portal.

Participation Requirements

- **New Hires**: All newly hired affected individuals, including Chief Executives, employees, senior administrators, managers, interns, and volunteers, must complete the orientation program within 30 days of hire.
- **Testing**: Participants must pass a compliance posttest with a score of 70% or higher before being allowed to bill for any services rendered.
- **Remedial Training**: Individuals who fail to complete the orientation program or pass the test will be required to participate in supplemental training and retake the posttest within an additional 30 days. Failure to pass the second test may result in termination in accordance with CCM's introductory period policies.

Contractors, Agents, Subcontractors, and Independent Contractors

Compliance Information

All contractors, agents, subcontractors, independent contractors, and corporate officers are provided with compliance information during the contracting process. This includes:

- A Business Associate Agreement.
- A compliance attestation form.

Responsibilities

These individuals are responsible for orienting themselves to the compliance process. They may also be required to participate in compliance training or testing activities as part of their contracted services. Failure to fulfill these requirements can result in immediate termination of the contract for cause.

Board of Directors

Initial and Annual Training

The Board of Directors must complete a general Compliance and Fraud, Waste, and Abuse training program within 90 days of their appointment and annually thereafter.

Training Delivery

- **Orientation**: Initial training materials are included in the Board Orientation Packet, along with a compliance posttest.
- **Annual Training**: Live training sessions are conducted by the Compliance Officer or their designee, with materials provided in advance.

Acknowledgment and Attestation

Upon completing the training, Board Members must submit an acknowledgment form that confirms:

1. Awareness of compliance policies and standards.
2. Completion of required compliance training.
3. Agreement to adhere to compliance standards.
4. Disclosure of any conflicts of interest.

These acknowledgments are collected and maintained by the Compliance Officer as part of the organization's compliance records.

Continuing Education

The Compliance Officer or their designee oversees the development and scheduling of continuing education courses and refresher training programs throughout the year. These programs ensure that all applicable affected individuals, including Chief Executives, employees, senior administrators, managers, interns, and volunteers, remain informed of current practices, updates to Medicaid Compliance Program policies, and changes in applicable laws. Training sessions may be regularly scheduled for all affected individuals or mandated by the Compliance Officer in response to emerging needs.

To enhance the organization's ability to respond to new compliance challenges, the Compliance Officer or designee reviews healthcare fraud alerts, regulatory updates, and other guidance issued by authorities such as the Office of the Inspector General (OIG), the U.S. Office of Civil Rights, and the U.S. Department of Health and Human Services (HHS). Relevant updates are promptly communicated to applicable affected individuals to maintain awareness and ensure compliance with the latest standards.

Specialty and Topic-Specific Training

Some roles within the organization require additional, targeted training due to their sensitive nature or specific responsibilities. The need for specialty or topic-specific training may arise from compliance hotline reports, audit findings, or changes in legal and regulatory requirements. The Compliance Officer is responsible for identifying, evaluating, and implementing such training programs as necessary.

Examples of specialized training include, but are not limited to:

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

Upon completion of specialty or topic-specific training, the instructor will issue a signed certification of completion to the Compliance Officer. This certification confirms that the affected individual has successfully participated in and understood the training content.

Training Acknowledgment Form

To ensure proper documentation and accountability, CCM maintains records of all training activities. The documentation includes the name and job title of the attendee, the date and nature of the training, and the subject covered. Upon successful completion of training, each affected individual is required to complete and sign a Training Acknowledgment Form. This form serves as:

1. Certification that the individual has received and reviewed the training content.

2. An agreement to comply fully with the Medicaid Compliance Program and related policies.

Record Retention and Monitoring

The Compliance Officer or their designee is responsible for collecting and monitoring acknowledgment forms to ensure they are filed appropriately in each staff member's compliance or personnel file. Records of training completion, such as training logs and certifications, are retained for a minimum of six (6) years. These records are readily available for audits and inspections by regulatory bodies such as CMS.

Failure to return the acknowledgment form within the prescribed timeframe is considered non-compliance with the Medicaid Compliance Program and may result in disciplinary action. The Compliance Officer will ensure that any such instances are addressed promptly and consistently to uphold the integrity of the Compliance Program.

ELEMENT 4: Effective Lines of Communication

Summary

CCM is committed to maintaining accessible and secure communication channels for reporting compliance concerns. Affected individuals and others are encouraged to report potential compliance issues using a variety of methods, including anonymous and confidential options. These reporting mechanisms support a culture of transparency and accountability, ensuring all concerns are addressed promptly and effectively. All reports, whether anonymous or identified, are handled with the highest degree of confidentiality, consistent with applicable laws and organizational policies.

Reporting Mechanisms

CCM provides the following methods for reporting suspected compliance misconduct, which are detailed in training materials and available on the organization's website. Affected individuals may use any of these methods based on their comfort level and reporting preferences:

1. **Direct Supervisor**:
   If individuals feel comfortable, they are encouraged to first raise their questions or concerns with their direct supervisor. Supervisors are responsible for documenting and promptly reporting any suspected non-compliance identified during supervision, conversations, or observations. Such reports must be forwarded to the Compliance Officer without delay.
   For those who prefer not to discuss concerns with their direct supervisor, they are encouraged to report directly to the Compliance Officer or use one of the anonymous reporting options outlined below.

2. **Compliance Officer Contact**:

- **Phone**: Contact the Compliance Officer, Alexandra C. Morales, directly at **718-802-0666 (ext. 251)**. (Note: This method is not anonymous.)
- **Email**: Send compliance-related correspondences to **amorales@ccmnyc.org**. (Note: Emails are not anonymous.)

3. **Compliance Hotline**:
   - The hotline ensures confidentiality for all questions and reports. The Compliance Officer will disclose information on a "need-to-know" basis, except where disclosure is required by law. If a caller chooses to identify themselves, their identity will also be kept confidential, shared only as necessary to facilitate a full investigation and corrective action.
4. **Anonymous Online Reporting**:
   - Submit an anonymous report through the organization's website at **ccmnyc.org**. If you wish to receive feedback regarding the investigation, you may include an email address; however, this will render the report non-anonymous.
5. **External Reporting Options**:
   If you wish to report concerns directly to external oversight bodies, the following options are available:
   - **NYS Office of the Medicaid Inspector General (OMIG)**:
     - Phone: **1-877-87FRAUD (1-877-873-7283)**
     - Website: **www.omig.ny.gov**
   - **Office of the Inspector General (OIG)**:
     - Phone: **1-800-DO-RIGHT (1-800-367-4448)**
     - Email: **inspector.general@ig.ny.gov**
   - **NYS Attorney General's Medicaid Fraud Control Unit**:
     - Phone: **1-800-771-7755**

Confidentiality and Anonymity

CCM is committed to maintaining the confidentiality of all reports to the fullest extent permitted by law. Reports will only be disclosed on a "need-to-know" basis to facilitate investigations and implement appropriate corrective actions. Individuals submitting reports anonymously will not be required to provide identifying information. However, those seeking feedback or resolution updates may opt to include their contact information.

Reporting Expectations

All affected individuals are expected to report any suspected non-compliance promptly. Failure to report observed or suspected misconduct may result in disciplinary action in accordance with CCM's policies.

Confidentiality of Reports/Complaints

All reports received through CCM's compliance reporting mechanisms are maintained by the Compliance Office. While CCM makes every effort to protect the confidentiality of individuals reporting compliance concerns, affected individuals should have a reasonable expectation that

their identity will remain confidential unless disclosure is required by law or is necessary to facilitate an investigation. When investigations are conducted, the Compliance Office will strive to avoid disclosing the identity of the reporter unless it is critical to resolving the issue. In such cases, the investigation will be handled sensitively, and the reporter's identity will only be shared on a “need-to-know” basis.

Anonymous Reports/Complaints

Anonymous reports submitted through the mail, email, or web portal are accepted and investigated to the fullest extent possible. However, individuals submitting reports anonymously should understand that their identity may become known or may need to be disclosed if necessary to comply with applicable laws or to ensure a thorough investigation. CCM encourages transparency and openness but respects the rights of individuals to report anonymously if they so choose.

Responding to Reports/Complaints

Initial Logging and Documentation

Upon receiving a report or complaint, whether oral or written, the Compliance Officer or their designee will:

1. Log the complaint in the **Compliance Log**, documenting the date, method of reporting, and nature of the issue.
2. Complete a **Response Form** for each report, which will include details of the report, the actions taken, and the resolution.

Preliminary Review

The Compliance Officer will review the report to determine whether it pertains to the Medicaid Compliance Program. If the reported issue does not concern Medicaid compliance, the Compliance Officer will refer the matter to the appropriate manager, documenting the referral, follow-up, and resolution.

Investigation Process

For reports involving actual or potential violations of the Medicaid Compliance Program, the Compliance Officer will initiate a thorough investigation to:

1. Determine if the reported issue has a basis in fact.
2. Assess whether the issue requires **self-disclosure** to the New York State Office of the Medicaid Inspector General (OMIG).
3. Identify any necessary changes to the Medicaid Compliance Program or organizational policies to prevent similar issues in the future.

The investigation process may include:

- Reviewing relevant documentation (e.g., billing records, policies, or personnel files).
- Conducting interviews with involved parties.
- Collaborating with legal counsel or external auditors as necessary.

Resolution and Documentation

The Compliance Officer will document the findings of the investigation and the resolution of the issue, including any corrective actions taken. Corrective actions may include:

- Policy updates or revisions.
- Staff training or re-education.
- Disciplinary actions, if warranted.
- Submission of self-disclosures to OMIG, if required.

All reports, investigations, and outcomes will be maintained in the Compliance Office records and retained in accordance with CCM's document retention policies.

ELEMENT 5: Disciplinary Standards

Summary

CCM has established disciplinary policies to encourage good faith participation in the compliance program and ensure accountability. Disciplinary actions are designed to correct behaviors or practices that:

1. Violate the Medicaid Compliance Program.
2. Compromise the fair, equitable, or professional treatment of individuals served.
3. Undermine the integrity of financial reporting and billing practices.
4. Jeopardize the organization's financial stability or operations.

These policies are enforced fairly and consistently to uphold compliance standards and promote a culture of integrity and accountability.

Disciplinary Procedures

CCM is committed to enforcing the compliance program in a manner that is consistent, equitable, and firm. Affected individuals who engage in fraud, waste, abuse, or other forms of misconduct are subject to disciplinary action. All disciplinary measures will be taken following a thorough investigation of the alleged violations and in consultation with the Department of Human Resources.

Actions Subject to Disciplinary Measures

Personnel may be disciplined for:

- Failing to perform compliance-related duties or obligations outlined in the Compliance Manual or applicable laws and regulations.

- Failing to complete mandatory training or post-testing requirements.
- Encouraging, directing, facilitating, or permitting actions that violate compliance policies, laws, or payer requirements.
- Supervisors or managers failing to enforce compliance requirements, detect non-compliance, or implement corrective actions when required.
- Failing to report known or suspected compliance violations.
- Failing to assist in the investigation or resolution of compliance issues.
- Acts of falsification, including but not limited to:
    - Falsifying signatures, dates of service, or time records.
    - Backdating documents.
    - Creating fictitious clients or services.
    - Misrepresenting service delivery or colluding with others to do so.
    - Threatening or intimidating staff or interns to misrepresent service delivery.

Considerations for Disciplinary Actions

The severity of disciplinary actions will be determined based on the following factors:

- The severity and impact of the violation.
- Whether the violation was committed intentionally, recklessly, or negligently.
- The individual's history of previous violations or disciplinary actions.
- Whether the individual promptly self-reported the misconduct.
- The extent to which the individual attempted to conceal the misconduct.
- Cooperation by the individual during the investigation and resolution process.
- Any other compelling factors identified in consultation with the Compliance Officer and Human Resources

Mitigating Circumstances

The Compliance Officer may consider mitigating circumstances when determining disciplinary actions, including but not limited to:

- Prompt self-reporting of the violation.
- Cooperation with the investigation and corrective actions.
- The individual's disciplinary history and the nature of prior violations.
- Whether the violation was isolated or part of a broader pattern of misconduct.

Disciplinary Actions by Role

Chief Executives, Employees, Senior Administrators, and Managers

Disciplinary actions for compliance violations may include, but are not limited to:

- Counseling, with documented evidence in the personnel file.
- Written warnings placed in the personnel file.
- Suspension with or without pay.
- Termination of employment.

Board of Directors

In cases involving allegations against a Board member:

- The Board member will be removed from company business activities pending a full investigation.
- If the allegation is substantiated, the Board President will inform the member of their permanent removal.
- CCM will comply with all reporting requirements related to substantiated misconduct and consult legal counsel as necessary.

Interns

In cases involving interns, the intern's supervisor will be notified immediately of any allegations of non-compliance. The intern will be removed from all Medicaid/Medicare and Managed Care activities until the investigation is concluded. It is the supervisor's responsibility to notify the intern's Educational Institution about the allegation and the ongoing investigation. If the investigation clears the intern, they may resume their duties. However, if the allegation is substantiated, their placement with CCM will be terminated immediately.

Volunteers

When allegations involve volunteers, the Compliance Officer will coordinate with personnel responsible for managing volunteer placements. The volunteer will be temporarily removed from Medicaid/Medicare and Managed Care activities pending the investigation's conclusion. If applicable, the volunteer's supervisor will notify the referring agency about the investigation. Volunteers cleared of allegations may return to their normal duties. If the allegation is substantiated, their placement will be terminated immediately. In certain cases, this may also lead to the termination of CCM's engagement with the referring agency or institution responsible for the volunteer.

Contracted Parties

For allegations involving contractors, agents, subcontractors, independent contractors, governing body members, or corporate officers, all contracted activities will be suspended until the investigation is complete. Legal counsel will be engaged for all allegations involving vendors or contracted parties. If the contracted party is cleared, they may resume their activities. If the allegation is substantiated, the contract will be terminated immediately for cause.

Responsible Parties

The President/Chief Executive Officer and/or Human Resources are responsible for reviewing and approving remedial or disciplinary actions recommended by the Compliance Officer. These actions aim to correct violations of the Medicaid Compliance Program and ensure consistent application of disciplinary policies.

Human Resources

Human Resources is tasked with overseeing hearings and implementing disciplinary actions related to Medicaid Compliance Program violations. All actions are reviewed for consistency with organizational policies and applicable laws. The Compliance Officer reports outcomes of disciplinary actions to senior management, department directors, and external entities requiring a corrective action plan.

Excluded Provider Screening

New Employees

CCM screens all prospective employees against federal and state exclusion lists before extending conditional offers of employment. Facilities must notify Human Resources immediately if a prospective employee is flagged as an excluded provider. Employment offers will not be extended to individuals identified on any exclusion lists.

Current Employees

Current employees, contractors, and other relevant individuals are screened **monthly** against federal and state exclusion lists, including the **Office of Inspector General's List of Excluded Individuals/Entities (LEIE)** and the **New York State Office of the Medicaid Inspector General's Exclusion List**, in accordance with OMIG compliance requirements.

If an individual is identified as an excluded provider during these screenings, **Human Resources,** in coordination with the employee's program, legal counsel, and the Compliance Officer, will take immediate action to ensure the individual ceases any involvement in services reimbursed by federal or state healthcare programs.

Inclusion on any exclusion list constitutes a serious compliance issue and is grounds for immediate termination or other appropriate corrective actions consistent with organizational policies and legal requirements.

Contracted Parties

New contracted parties are screened to ensure compliance with exclusion requirements. For direct care staff, CCM conducts screenings, while other vendors must submit attestations confirming they have completed the necessary exclusion screenings. Contracts for goods and services include boilerplate language mandating compliance with exclusion screening procedures. Contracts will not be awarded to excluded individuals or entities.

Exit Statements

Employees

Upon termination of employment, regardless of the reason, Human Resources administers an exit interview to gather information on the reasons for termination. As part of the Medicaid Compliance Program, departing employees **must sign a termination attestation form**,

certifying they have reported any known or suspected violations of the program. If an exit interview is not possible, Human Resources documents the circumstances.

Volunteers, Interns, and Contracted Staff

A similar process applies to volunteers, interns, and contracted staff upon the discontinuation of their services. Human Resources conducts an exit interview that includes inquiries into potential fraudulent activities. If no non-compliance is disclosed, the individual must sign an attestation to that effect. If non-compliance is reported, Human Resources immediately notifies the Compliance Officer for further investigation.

ELEMENT 6: Auditing and Monitoring

Audits and Monitoring of the Compliance Plan

CCM will implement robust management systems and controls to ensure the integrity of the Medicaid Compliance Program and adherence to all applicable compliance requirements. These systems will facilitate ongoing auditing and monitoring activities designed to identify and address compliance risks. Specifically, audits will evaluate compliance with laws governing coding standards (e.g., DSM-5 and ICD-10 or their current equivalents), claim development and submission, reimbursement, cost reporting, and marketing practices.

The auditing process will focus on seven high-risk areas as outlined in **18 NYCRR § 521.3(a)**:

1. Billings
2. Payments
3. Medical necessity and quality of care
4. Governance
5. Mandatory reporting
6. Credentialing
7. Other risk areas identified through due diligence

Any overpayments identified during these audits will be promptly refunded to the appropriate payer. Refunds will be accompanied by detailed documentation and an explanation of the overpayment.

Auditing the Compliance Program

The Compliance Officer will ensure a comprehensive audit and review of the Medicaid Compliance Program at least annually, with additional audits conducted as necessary. The annual audit will focus on high-risk areas, including compliance with laws governing billing, coding, claim development, submission, and reimbursement practices. The audit will also evaluate the degree to which affected individuals have implemented and adhered to the Medicaid Compliance Program.

The **NYS OMIG Compliance Program Self-Assessment Tool** will be used as the primary instrument for conducting the audit. The Compliance Officer will prepare an **Audit Summary Report** containing findings, results, and recommendations. This report will be submitted to the President/Chief Executive Officer and the Board of Directors for review and action.

Ongoing Monitoring by Program Directors

In addition to annual audits, Program Directors are required to conduct regular quality and compliance audits within their respective areas. These audits will assess program operations, identify potential compliance risks, and ensure adherence to organizational policies and applicable laws. Findings from these audits must be reported to the Compliance Officer and entered into the compliance tracking system.

The Q&A Director is responsible for overseeing ongoing compliance inspections, reviews, and evaluations throughout the year. Regular reporting to senior management ensures transparency and accountability in compliance monitoring.

Audits by Outside Parties

CCM is regularly subject to reviews, inspections, and audits by external parties, including regulatory agencies and third-party auditors. Findings from these external audits that pertain to Medicaid Compliance Program activities and standards will be promptly reported to the Compliance Officer and the President/Chief Executive Officer. The Board of Directors will also receive copies of these reports for review and discussion.

Findings from external audits will be integrated into the Staff Medicaid Compliance meetings and tracked as part of the organization's ongoing compliance monitoring efforts. Corrective actions based on external audit findings will be implemented promptly to address identified deficiencies and prevent recurrence.

Inventory/Schedule of Audits

The Compliance Officer is responsible for coordinating and maintaining a comprehensive schedule of all internal and external audits and reviews directly related to the Medicaid Compliance Program. This schedule will ensure that auditing activities are conducted regularly and consistently, covering all identified compliance risk areas. The inventory will include details such as the audit scope, frequency, responsible parties, and anticipated timelines for completion.

Reporting Results of Compliance Plan Reviews and Audits

The results of all compliance reviews and audits will be reported to the Compliance Officer, President/Chief Executive Officer, and Board of Directors for their review and consideration. The primary objectives of this review process are to:

1. Evaluate the overall effectiveness of the Medicaid Compliance Program.

2. Identify the need for corrective actions to address deficiencies or non-compliance in operations, professional practices, or business practices.
3. Assess the necessity of organizational changes, modifications, or additions to CCM's policies related to the Medicaid Compliance Program.

If audit outcomes reveal instances of fraud, waste, or abuse involving Medicaid, the findings will be reported promptly to the **New York State Office of Medicaid Inspector General (OMIG)** and/or the **New York State Department of Health (DOH)**, in accordance with applicable reporting requirements.

Follow-Up and Response to Audits and Reviews

The Compliance Officer is tasked with implementing corrective actions in response to violations, inconsistencies, or deviations identified during reviews and audits. Corrective actions may include updates to policies, additional training for staff, and enhancements to internal controls or operational systems.

The President/Chief Executive Officer and Board of Directors will be kept informed of all corrective actions implemented as a result of audit findings. **The Compliance Officer will oversee the corrective action process for three months**, ensuring all necessary changes are executed effectively. After this three-month period, the President/Chief Executive Officer and Board of Directors will revisit the issue to:

1. Confirm that corrective measures have resolved the issue.
2. Determine if continued monitoring is required.
3. Revise the corrective action plan if necessary.

Reducing Potential Recurrence

Upon completing audits and implementing corrective actions, steps will be taken to prevent similar issues from recurring. This process includes:

1. **Policy and System Development**: Creating or updating policies and systems to address root causes and reduce the potential for future non-compliance.
2. **Follow-Up Audits**: The Compliance Officer, in collaboration with Quality Management staff, will conduct targeted internal audits six months after the completion of corrective actions. These follow-up audits will assess whether similar compliance issues have recurred and whether corrective measures remain effective.

ELEMENT 7: Response to Compliance Issues

Summary

Violations of the Medicaid Compliance Program can jeopardize CCM's operations, reputation, financial stability, and legal standing. As such, any known or suspected violations of the Medicaid Compliance Program must be addressed promptly and thoroughly. Upon receiving a

report or reasonable indication of a potential violation, the Compliance Officer or their designee will notify the President/Chief Executive Officer immediately and initiate an investigation.

If a violation is confirmed, corrective actions will be implemented, and appropriate disciplinary measures will be taken in accordance with the materiality of the violation and the disciplinary policies outlined in **Element 5**. In cases where a conflict of interest may arise due to the Compliance Officer's involvement, the President/CEO may designate another qualified individual or legal counsel to lead the investigation.

Investigations and Corrective Action

Scope of Investigations

Investigations into known or suspected violations will be conducted by the appropriate party or parties, depending on the nature of the violation. This may include:

1. The Compliance Officer or their designee.
2. Relevant internal departments (e.g., Human Resources, Program Management).
3. External government agencies, including the **New York State Office of Medicaid Inspector General (OMIG)** or other federal, state, or local entities.

The Compliance Officer will oversee and receive copies of all investigations to ensure alignment with the Medicaid Compliance Program and organizational standards.

Responsibility for Enforcement and Corrective Actions

The enforcement of the Medicaid Compliance Program and the implementation of corrective actions will be a shared responsibility among the Compliance Officer, the President/Chief Executive Officer, Senior Management, and Program Directors. Corrective actions may include policy revisions, additional training, or system modifications to prevent recurrence of the issue.

- **Disciplinary Action for Employees**:
  If an investigation warrants disciplinary action against an employee, Human Resources will be consulted to determine and implement the appropriate disciplinary measures in accordance with the organization's disciplinary policies.
- **Disciplinary Action for Volunteers and Interns**:
  For cases involving volunteers or interns, the Volunteer Manager and/or the internship agency or educational institution will be consulted. Appropriate disciplinary measures will be determined collaboratively and implemented in compliance with the organization's policies.
- **Corrective Action for Contracted Parties**:
  If a violation involves a contracted party, corrective actions will be implemented in accordance with the terms of the contractual agreement. This may include contract suspension or termination, depending on the severity of the violation.

Notification and Reporting Requirements

If investigations identify violations involving fraud, waste, or abuse of Medicaid, CCM will notify

the **New York State Office of Medicaid Inspector General (OMIG)** and/or other relevant authorities as required by law.

Investigative Process

1. **Immediate Actions Upon Learning of Suspected Non-Compliance**:
    - Immediately halt all billing activities related to the suspected non-compliance, including specific services, parties, or activities involved.
    - Notify the executive staff and the Compliance Officer.
    - If the suspected non-compliance involves egregious actions by affected individuals, those individuals must be removed from all Medicaid/Medicare/Managed Care-related activities pending investigation.
2. **Securing Documentation**:
   The Compliance Officer or their designee will gather and secure all documentation relevant to the investigation, including:
    - **Charts**:
        - Client records (open, closed, and pending cases).
        - Employee records (active and terminated).
    - **Logs**:
        - Billing and attendance logs.
    - **Billing Files**:
        - Invoices, responses, reversals, insurance contracts, and client insurance information.
    - **Contracts**:
        - Vendor, employee, and payer agreements.
3. **Reviewing Documentation**:
   The Compliance Officer will thoroughly review the collected documentation to determine if services were billed correctly. The review includes verifying:
    - Employee credentials and employment status during the documented service period.
    - Client presence during service delivery and insurance eligibility for invoiced services.
    - Existence of an active, signed prescription (e.g., Treatment Plan or Plan of Care) for the service during the relevant period.
    - Completeness of service documentation, including:
        - Goals addressed, progress since prior service, interventions provided, client response, treatment expectations, and necessary signatures with credentials.
        - Accurate dates, times, service locations, and modality matching the billing code.
        - Supervisory approval for services provided by non-licensed staff.
        - Supporting documentation for add-on billing codes (e.g., after-hours, language other than English).
    - Documentation supporting specific billing codes, such as MD Evaluation and Management (E&M) codes, crisis services, and complex care billing codes.

4. **Interviews**:
    - Conduct interviews with relevant staff and clients when appropriate.
    - Ensure witnesses are present during interviews, and interviewees have the right to representation.
5. **Documentation of Investigation**:
    - The Compliance Officer will log all aspects of the investigation in the corresponding spreadsheet, ensuring detailed and accurate documentation. This spreadsheet will be maintained to provide transparency and will be readily available for regulatory review or self-disclosure as required.
6. **Root Cause Analysis**:
   Before concluding the investigation, the Compliance Officer will identify:
    - Root causes of the issue.
    - Desired outcomes and affected parties.
    - Applicable guidelines and potential regulatory or financial impacts.
    - Recommendations for corrective actions.

Reporting Results of the Investigation

Upon completing the investigation, the Compliance Officer will report findings and recommendations to the President/Chief Executive Officer and Board of Directors. Corrective actions must be implemented promptly, and the correction process should be completed within a reasonable timeframe.

In consultation with executive leadership, the Compliance Officer will evaluate:

- The investigation's findings and proposed corrective actions.
- The adequacy of the corrective actions in addressing the identified issues.
- The overall effectiveness of the Medicaid Compliance Program.
- Further necessary actions, such as updates to policies, operations, systems, personnel, or training.

If fraud, waste, or abuse involving Medicaid is confirmed, the Compliance Officer will notify the **NYS Office of Medicaid Inspector General (OMIG)** and/or the **NYS Department of Health (DOH)** as required.

Follow-Up and Response to Investigation

The Compliance Officer will oversee the implementation of corrective actions to address identified violations, inconsistencies, or deviations from compliance standards.

- The President/Chief Executive Officer and Board of Directors will be informed of all corrective actions taken in response to the investigation.
- The Compliance Officer will monitor and evaluate the corrective action plan for three months to ensure its effectiveness. After this period, executive leadership will reassess the issue to determine:
    - Whether the issue has been resolved.

- Whether continued monitoring is necessary.
- Whether the corrective action plan requires revision.

Reducing Potential Recurrence

To prevent recurrence of compliance issues, the Compliance Officer will:

1. Develop and implement policies, procedures, and systems addressing the root causes of the identified problem.
2. Conduct targeted internal audits six months after completing the corrective actions to evaluate the effectiveness of the implemented changes.

ELEMENT 8: Non-Intimidation and Non-Retaliation

Summary

CCM strictly prohibits intimidation and retaliation against any affected individuals who, in good faith, participate in the Medicaid Compliance Program. This includes reporting potential compliance issues, cooperating in investigations, participating in self-evaluations or audits, implementing remedial actions, and reporting to appropriate officials as permitted under **NYS Labor Law Sections 740 and 741**.

Actions such as threats, harassment, blackmail, property theft, or termination as retaliation for good faith participation in the Compliance Program are strictly unacceptable. Any manager, supervisor, employee, or contracted party who engages in intimidation or retaliation is subject to disciplinary action, up to and including termination of employment or contract termination. CCM management ensures a safe environment for reporting violations of the Medicaid Compliance Program without fear of reprisal.

However, if an affected individual is found to have knowingly fabricated, distorted, exaggerated, or minimized a report to harm others, protect themselves or others, or if the report includes admissions of personal wrongdoing, appropriate disciplinary or corrective action may be taken in accordance with applicable laws and, where necessary, under legal counsel's advice.

Privacy and Confidentiality

CCM adheres to strict privacy and confidentiality standards to protect the records of individuals served, in compliance with applicable laws, including HIPAA. Policies and procedures governing the confidentiality of electronic and paper records are detailed in program policies, which also outline specific guidelines for responding to requests for information.

Accuracy of Records

All affected individuals are expected to maintain accurate, reliable, and honest records in every circumstance. This includes:

- Ensuring their work is accurate and reporting any inaccuracies or suspected errors.
- Avoiding the creation of documentation that is incomplete, inaccurate, or fraudulent to the best of their knowledge.
- Promptly addressing discrepancies in records in coordination with the appropriate departments or supervisors.

Records Retention

CCM administers a records management program to ensure compliance with records retention and destruction standards as outlined in the organization's **Records Retention and Destruction Policy**. Clinical, medical, administrative, operational, billing, claims, and financial records are retained in accordance with Medicaid Compliance Program requirements.

- Employees are prohibited from destroying or deleting any record, in part or whole, without written authorization from a supervisor. This applies to both paper and electronic documentation.

Billing and Coding

Affected individuals involved in coding, billing, documentation, and accounting for healthcare services must adhere to all applicable laws and organizational policies. Expectations include:

1. **Billing Integrity**:
    - Billing only for services actually provided and ensuring claims are based on complete and accurate documentation. Misrepresentation of services is strictly prohibited.
2. **Supporting Documentation**:
    - Ensuring that all healthcare services provided are documented appropriately. If required documentation is absent, the services will be considered unprovided and cannot be billed.
3. **Accurate Coding**:
    - Coding claims based on accurate and complete information from the person served's records and ensuring claims comply with applicable laws and policies.
4. **Consistent Charging Practices**:
    - Charging all persons served in a consistent and uniform manner, unless federal or state guidelines provide for exceptions (e.g., sliding scales based on documented income).
    - Charging government-sponsored payers no more than allowable rates and ensuring no preferential discounts are provided to specific payers unless consistent with applicable regulations.
5. **Credit Balances**:
    - Addressing credit balances identified during audits in a timely manner and reporting them to the Compliance Officer for resolution.
6. **Staff Training**:

- Ensuring affected individuals receive training on CCM's policies and applicable laws related to billing, coding, and documentation.

Oversight and Training

Affected individuals will participate in periodic training sessions on compliance with organizational policies and applicable laws related to coding, billing, and documentation. This ensures that all personnel understand their responsibilities and the legal standards governing their activities.