XIV. REGULATORY COMPLIANCE PLAN

ACMH

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Introduction

ACMH is committed to establishing and maintaining an effective compliance Plan 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 Plan and policies is to:

- Detect and correct payment and billing mistakes and fraud.
- Organize ACMH resources to resolve payment discrepancies and detect inaccurate billing.
- Make corrections/improvements quickly and efficiently to prevent compliance issues going forward.
- Create and operate a system of checks and balances to prevent recurrences.
- Develop and implement an organization-wide system to identify and address risks that includes self-evaluation and mitigation procedures.
- Maintain compliant processes to detect, track, and repay overpayments, regardless of the cause.
- Build on and expand existing management control structures so that integrity of operations is demonstrated.
- Ensure compliance Plans are compatible with a provider's characteristics.
- Create a culture of compliance by making sure the compliance Plan is implemented throughout the organization with adequate training and support.
- Demonstrate to your constituencies a commitment to integrity operations.

ACMH '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 Plan requirements. The processes defined within this policy may be modified by ACMH based upon the unique circumstances of specific plan contracts.

Relevant Statutes and Standards

New York State Social Services Law §363-d
18 NYCRR Part521 with addendums A and B
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)

Applicability

The following persons shall be subject to the provisions of part 521 and are referred to as "required providers" in the ruling. ACMH shall note which organizations and providers within their working relationships fall within these categories, and therefore should have compliance Plans comparable to that of ACMH:
(1) any person subject to the provisions of articles 28 or 36 of the Public Health Law.
(2) any person subject to the provisions of articles 16 and 31 of the Mental Hygiene Law.

(3) any managed care provider or managed long-term care plan, which shall hereinafter be collectively, unless otherwise noted, referred to as "Medicaid managed care organization" or "MMCO;" and
(4) any other person for whom the MA Plan is, or is reasonably expected by the person to be, a substantial portion of their business operations. A "substantial portion of business operations" means providers claimed or should be reasonably expected to claim at least $1,000,000 or more within a 12-month period. (Health, 2022)(OMIG, Compliance Program Guidance including appendices A & B, 2023)

Definitions

(OMIG, Compliance Program Guidance including appendices A & B, 2023)
For purposes of the compliance policy directive:

(1) *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Plan, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. [18 NYCRR Part 515.1(b)(3)

(2) "Affected Parties" refers to: all persons who are affected by the required provider's risk areas including: ACMH's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers and any person or affiliate who is involved in any way with ACMH in a way that contributes to ACMH's entitlement to payment under the Medical Assistance Plan who does not fall into the previous categories (Compliance Program Guidance including appendices A & B, 2023) .
Types of Affected Parties (OMIG, 2023):
   - Employees
   - Chief Executive
   - Senior Administrator(s)
   - Manager(s)
   - Contractor(s)
   - Agent(s)
   - Subcontractor(s)
   - Independent Contractor(s)
   - Governing Body Member(s)
   - Corporate Officer(s)

(3) *Compliance Plan* 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.

(4) *CO* means the designated OMH Medicaid Compliance Officer.

(5) An executive is any member of senior management staff regardless of specific title.

(6) Governing Body is the Governing body of Directors.

(7) *Employee* means any person responsible for complying with this policy directive.

(8) *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. 18 NYCRR 515.1(b)(7)

(9) *Intimidation* means any form of coercion or threatening behavior aimed at compelling an employee not to report actual or suspected fraudulent activity.

(10) *Insufficiency* means the failure to meet one or more of the 8 elements for compliance, or one or more of the requirements under the eight elements.

(11)*OMIG* means the NYS Office of the Medicaid Inspector General.
(12)Periodic/periodically means a regular interval which is no less than annually, but the context may require a more frequent interval.
(13)*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.
(14)*Vendors*. The term includes vendors, suppliers, consultants, other care providers, referral sources, manufacturers, payors and other third parties seeking to do, or that are currently engaged in, business with any ACMH entity.
(15)*Waste* means the overutilization, underutilization, or misuse of resources.

Effective Compliance Plan

ACMH Compliance Plan is reasonably designed, implemented, and enforced so that the Plan is generally effective in preventing, detecting, and correcting fraud, waste, abuse, and non-compliance with Medicaid Plan requirements. The ACMH Compliance Plan has been adopted and implemented and at a minimum, satisfies the compliance Plan requirements.

- Is well-integrated into ACMH's operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body.
- Promotes adherence to ACMH's legal and ethical obligations; and
- Is reasonably designed and implemented to prevent, detect, and correct non-compliance with Medicaid Plan requirements, including fraud, waste, and abuse most likely to occur for the provider's risk areas and organizational experience.

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

According to New York State Social Services Law §363-d (2) and 18 NYCRR Part 521/363-d /363-d .3(c), the required elements of an "effective compliance Plan" 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 Plan, 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 Plan; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance Plan;

(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 Plan operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member.

(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 Plan by all Affected Parties, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

- failing to report suspected problems.
- participating in non-compliant behavior; or
- 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 because of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance Plan beneficiaries.

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified during self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies, and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the Office of Medicaid Inspector General; and refunding overpayments.

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance Plan, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits, and remedial actions, and reporting to appropriate officials as provided in sections 740 and 741 of the Labor Law. There must be:

1. Policies of non-intimidation and non-retaliation.
2. Reference to reporting to appropriate officials as provided in sections 740 and 741 of the NYS Labor Law.
3. At minimum, there must be reference in the compliance plan document, or other policies or employee handbooks, to NYS Labor Law sections 740 and 741 in connection with non-intimidation and non-retaliation expectations.
4. If a policy is said to exist but is not in writing, further inquiry is necessary.

(9) In addition, 18 NYCRR § 521.3 (a) identifies ten areas that all compliance Plans must be applicable to. Required Providers' compliance Plans must have connectivity to all the below nine areas. BOC looks to see that Required Providers have considered each of these ten areas and decided of the applicability of the Seven Areas to their compliance Plan. This is neither a required nor an exhaustive list:

(1) Billings
(2) Payments
(3) ordered services.
(4) Medical necessity and quality of care
(5) Governance
(6) Mandatory reporting
(7) Credentialing
(8) contractor, subcontractor, agent, or independent contract oversight.

(9) Other risk areas that are or should with due diligence be identified by the provider.
(10) Risk area for MCO’s

The requirements as per 18 NYCRR 521.3 (a)(2) for the 10 areas are:

1) Billings
    1. Internal controls for documentation during data entry and billing
    2. Billing office internal audit results shared with compliance.
    3. Conduct root cause analysis for persistent billing denials.
    4. Conduct tracer audits for work being billed.
    5. Self-assess if number and value of adjustments is accurate.
    6. Separation of duties in billing and receipt functions.
    7. Involvement of CO in analysis of strengths and weaknesses

2) Payments
    1. Track and analyze any overpayments, underpayments, and denials.
    2. Results of accounts receivable internal audits are shared with CO.
    3. Conduct tracer audit for payments to assess accuracy of billing and resulting payments.
    4. Determine if billing and payment system weaknesses are being identified and corrected as necessary.
    5. Involvement of CO in analysis of strengths and weaknesses

3) Ordered Services
    1. Follows section 513.4 of NYCRR Section 18
    2. Document that the ordering practitioner has verified recipient's eligibility for MA
    3. Document that adequate and less expensive options have been explored
    4. Document communication with DOH regarding the request for the ordered services

4) Medical necessity and quality of care
    1. Develop compliance connectivity to quality oversight process as part of the reporting and control structures.
    2. Conduct periodic tracers of care to assess if quality requirements are being met and provide reports to the compliance function.
    3. Develop quality scorecards with resolution of outliers being reported to the compliance function.
    4. Review documentation for completeness and appropriateness of entries.
    5. Tracking and resolution of complaints from clients, patients, and family members.
    6. Reporting of statistics and responses to aberrations of medical necessity and quality issues to the CO to be used for a control test for the effectiveness of the underlying control process.

5) Governance
    1. Meaningful conflict of interest policy for Governing Body and management with reporting of unresolved conflicts.
    2. Compliance function is connected to all management and Governing Body entities within the enterprise.
    3. Include the Governing Body in compliance plan approval process and in setting compliance budget.

4. Include Governing Body in self-assessment and work plan process to include planning, tracking progress, and budgeting.
5. Governing Body oversight of the compliance Plan.
6. Frequency of compliance reports to the Governing Body.
7. Compliance training of the Governing Body and management.

6) Mandatory reporting

1. Report, repay, and explain all overpayments.
2. Required reporting of compliance issues for all Affected Parties .
3. Required reporting of compliance issues to DOH and OMIG. Testing periodically on completeness of mandatory reporting of billing, payment, quality, and contractual issues.
4. Quality control of reporting to ensure accuracy and completeness of reports being made.
5. Ensure compliance with applicable mandatory reporting obligations:
    a. annual SSL certification.
    b. annual DRA certification.
    c. SADC certification; and/or
    d. other regulatory and Plan reporting

7) Credentialing

1. Regularly check accuracy and comprehensiveness of credentialing process.
    a. Identify Affected Parties who must be credentialed.
    b. Include normal credentialing considerations like primary source verification and licenses.
2. Regularly check the excluded party lists and take appropriate action if Affected Parties are on those lists. CMS and BOC recommend checking the excluded party lists monthly.

8) Contractor, subcontractor, agent, or independent contract oversight.

1. Regularly review the Compliance Plans of contractors, subcontractors, or agents providing direct services
2. Regularly perform risk assessments for contractors, subcontractors, agents, or independent contracts

9) Other risk areas that are or should with due diligence be identified by the provider.

1. Determine if your compliance Plan covers all risk areas specific to your provider type. BOC recommends Periodic and routine self-assessments and gap analyses because at any point in time risks may change.
2. Assess affiliates' Plan integrity. Commitments that affiliates (non-employees) are making to the Required Provider will require some level of audit and investigative expertise and activity.
3. Stratify risks within the compliance Plan. BOC recommends that Required Providers rank risk areas based upon frequency, severity, impact, etc. and address the ones that create the most exposure.
4. Expand risk areas based upon compliance Plan history and its operations. As compliance issues are identified and resolved, they should be considered risks to be addressed in the future or the resolution tested to be sure that it resolved the problem needing attention. The analysis should include the other six areas discussed above.
5. For associates (non-employees) that provide Medicaid reimbursable services through the Required Provider, determine if they are independently required to have a compliance Plan and if they have met the annual certification obligation.

6. Monitor compliance with annual certification obligation for associates, if any

10) Risk areas for MCO's

Who is subject to the compliance Plan?

All Affected Parties are subject to ACMH's compliance Plan. As per Title 18 of the New York Codes of Rules and Regulations, Affected Parties include: All affected employee [all Plan staff, Executives, Governing Body members, any person or affiliate who is involved in any way with ACMH, such that the person or affiliate contributes to ACMH's entitlement to payment under Medical Assistance Plan and who is not an employee, Executive, or Governing Body member of ACMH (e.g., independent contractors, interns, students, volunteers and vendors). Individuals who are at least a 5% owner of ACMH shall be considered persons associated with the provider.

The minimum requirements for Affected Parties

The following must be met:
NYS OMIG Bureau of Compliance (BOC) considers the following information when defining all Affected Parties :
1. Individuals receiving 1099 forms are considered independent contractors. This does not necessarily include such independent contractors as landscaping and maintenance companies, or others who are not involved in delivery of or billing for Medicaid care, services, or supplies.
2. It is possible that there are no Affected Appointees and Persons Associated with the Required Provider. However, most Required Providers have at least some Affected Appointees and Persons Associated with the Required Provider.
3. Corporations, partnerships, or government entities typically maintain a control function that is above the Executive level of the organization. For the purposes of this Guidance, this control function is referred to as the Governing Body.
4. Sole proprietors are not corporations, partnerships, or government entities; therefore, BOC looks to the owner(s) of the Required Provider as the Governing Body.

All the elements in the following 8 sections as outlined with their requirements for mandatory Compliance Plans must apply to all Affected Parties. ACMH will consider each requirement's applicability to all Affected Parties.

18 NYCRR 521.3 (c):

18 NYCRR 521.3 (c)(1) states "employees and others." BOC interprets this to be "all Affected Parties," as used in 18 NYCRR 521.3 (c)(5), which is consistent with requirements found in other elements that address all affected employees, appointees, and persons associated with the Required Provider, Executives, and governing body members.

Element 1: Written Standards, Policies and Procedures

As documented by New York State Social Services Law §363-d and 18 NYCRR 521-1.4, the written policies and procedures must describe compliance expectations as embodied in ACMH's code of conduct. The code of conduct applies to all Affected Parties.

1.1 Minimum Requirements

The policies and procedures must be in writing. When changes to the written standards, policies and procedures are needed to address a new or revised law, regulation, or Plan requirement, either an existing policy will be revised, or a new policy will be drafted and added to the existing policies and procedures.

Whenever a standard, policy or procedure is drafted:

- The Policy and Procedure template will be utilized.
- Requirements and responsibilities will be outlined in the draft policy.
- Once a draft policy is created, it will be reviewed and approved by
  - ACMH Compliance Committee and,
  - Plan Leadership for the affected area(s).
- The draft policy will then be routed to the EVP/CEO for review, as needed, to ensure that there are no conflicts with other business policies and procedures.
- The CO will conduct a final review of the draft policy and make any revisions, before sending it to the Governing Body for final approval. Once revisions are completed, the CO is responsible for disseminating the policy throughout the organization utilizing multiple formats: email, webex and/or staff meetings. The policy will then be loaded onto the Shared Drive under Policy and Procedures: Regulatory Compliance.
  - Changes and/or additions to the Compliance Plan require staff attestation of receipt and understanding.
- The policies and procedures as well as the code of conduct will be available, accessible, and applicable to all affected parties.

1.2 Maintenance and Review of Existing Policies and Procedures

Existing Compliance Policies and Procedures, Compliance Plan and Code of Conduct are reviewed at least annually to determine:

- If written policies, procedures, and standards of conduct have been implemented.
- Whether Affected Parties are following the policies, procedures, and standards of conduct.
- Whether such policies, procedures, and standards of conduct are effective; and
- Whether any updates are required. (OMIG, Compliance Program Review Module , 2023, pp. 5,6)

and revised if needed, or when there are legal, regulatory, or Plan changes that require Policy and Procedure revisions. When existing policies and or documents 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 CO will conduct a final review of the draft policy and make any revisions before sending it to the EVP/CEO and Governing Body for final approval. Once approved, the policy can be implemented as a final policy and will be loaded to the Shared Drive under Policy and Procedures: Regulatory Compliance and updated on all systems used to ensure availability.

1.3 Storage and Communication of Policies and Procedures

A. Compliance Policies and Procedures, including the Compliance Plan, Disciplinary Policies, and Code of Conduct, are maintained on ACMH'S intranet or shared drive which is accessible on an ongoing basis to all Plan employees, managers, interns and C-Suite. (OMIG, Compliance Program Review Module , 2023, p. 17)
B. Compliance Policies and Procedures are communicated to employees who support Medicaid/Medicare/Medicaid Managed Care business within 30 days of hire or prior to the claiming of their rendered services (whichever is earlier) and annually thereafter. When applicable, all services are reviewed and signed off by a supervisor prior to claim submission for the period before first training. In addition to these policy communications, ACMH '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.

1.4 Record Retention

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

1.5 General Standards of the Policy

Written policies and procedures articulate commitment:

The following written policies and procedures articulate ACMH's commitment and obligation to comply with all federal and state regulations that apply to ACMH's risk areas, including medical assistance (MA) related areas. These policy and procedures also describe the specific compliance expectations as they are embodied in the code of conduct.

Compliance expectations include statements that include the following:

ACMH and all affected parties are required to always act in ways to meet the requirements of the policy and procedures, compliance plan and code of conduct. ACMH expects to conduct business in a manner that supports integrity in all operations and is compliant with all applicable law.

New York State Social Services Law §363-d
18 NYCRR Part521 with addendums A and B
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)

Conduct contrary to the expectation regardless of intent is considered a violation:

ACMH has a Medicaid Code of Conduct that frames and informs these policies and ACMHs expectations. The Code of Conduct must be signed annually by all affected parties and as part of on governing bodying.

ACMH has developed and implemented Part 521/363-d Compliance Policies and Procedures to support the operation of its Compliance Plan. ACMH can identify specific written policies and procedures that support the ongoing operation of their compliance Plan.

ACMH describes the structure of the Compliance Plan throughout its policies and procedures, including the responsibilities of all Affected Parties in carrying out the functions.

Evidence of the Compliance Plan

Evidence that ACMH's compliance Plan is operational exists by:

- ACMH and all Affected Parties will act in such a way as to meet the requirements of the compliance Plan, law and regulation as demonstrated by compliance committee meeting minutes, corrective action plans, root cause analysis, trainings, compliance shared drive and disciplinary action.
- The written policies and procedures have been distributed to all Affected Parties by handing out a hard copy; sending emails to staff with instructions on how to obtain an electronic version through the shared drive/folder. Additionally, all hard copies whether original document, amendment or update require a signed receipt.
- Work product demonstrates that the written policies and procedures are operational. Examples include audit plans, meeting schedules and minutes, training sign in sheets and certificates, compliance and training logs, investigations, corrective action plans and audit. Additionally, there is a budget for the compliance function.

ACMH's written policies and procedures are in effect that provide guidance to all Affected Parties on how to deal with potential compliance issues.

All Affected Parties may receive assistance in identifying potential compliance issues, ask questions, and/or raise concerns directly to the Compliance Officer. It is expected that all Affected Parties will act in accordance with the Code of Conduct at all times, this includes the refusal to participate in unethical or illegal conduct, as well as the obligation to report any unethical or illegal conduct to the compliance Officer. Failure to do so is an act of noncompliance.

The policies and procedures, flyers and public postings all include instruction and methods about how to deal with potential compliance issues for all categories of Affected Parties.

ACMH's written policies and procedures identify how to communicate compliance issues to appropriate compliance personnel. (This cross-references with Element 4.)

1. The written policies and procedures identify the Director of Quality and Compliance as the appropriate compliance person to whom communication about compliance matters is directed.
2. While not every category of Affected Parties will choose to communicate in the same way, the Compliance Plan makes all reporting mechanisms available to all Affected Parties. Policies and

procedures, flyers and training materials identify the different methods available to Affected Parties to communicate with appropriate compliance personnel. To include anonymous fax, phone, email, interoffice mail, USPS mail, as well as direct contact through email and phone.

ACMH has established a telephone hotline that affected individuals and Medicaid recipients of service from ACMH may call to file reports anonymously. The hotline may be accessed by calling *67 1-212-274-8558 ext.250. The phone number will be blocked when entering *67 prior to dialing ensuring an anonymous call does not include a caller ID. This line is not answered and your message will be sent directly to the Compliance Officer via a computer-generated email. The Compliance Officer is responsible for overseeing the operation of the hotline, responding to complaints filed through the hotline and ensuring that all affected individuals are aware of the hotline number and understand that reports may be filed through the hotline on an anonymous basis. The Compliance Officer will also publicize the availability of the hotline through regular reminders, posters and organized compliance awareness events.

Communication methods may vary for different categories of Affected Parties under the Compliance Plan's policies and procedures. In those instances, the compliance Plan's policies and procedures should identify how each category of Affected Parties can communicate to appropriate compliance personnel.

ACMH's written policies and procedures provide guidance on how potential compliance problems are investigated and resolved. (This cross-references with Element 7.)

1. ACMH 's written policy is committed to the investigation of potential compliance problems through the steps laid out in element 7, including how to identify the appropriate investigator, and how to conduct and document the investigation.

2. ACMH's is committed to resolve confirmed compliance problems through the implementation of plans of correction; reporting results of investigations to the EVP/CEO and Governing Body; and through the monitoring of plans of correction as well as modifying or correcting any policies or practices indicated. Examples of activities for the investigation of potential compliance problems may include but are not limited to:

   a. Identification of the investigator.
   - It is permissible for investigations to be conducted by people outside of the compliance function.
   - To the extent that someone outside the compliance function is investigating, the results of the investigation will be shared with appropriate compliance personnel.
   - Results from investigations should not be filtered by someone outside of the compliance function.

   b. How the investigation will be conducted (e.g., interviews, documentation reviews, and root cause analyses).
   - Identification of investigative steps from start to finish.
   - Sufficiently detail the results of investigations and analyses to identify who the participants are and who may be encouraging, directing, facilitating, or permitting Non-Compliant Behavior.

   c. Documentation of results.

Element 2: Designation of a CO and resources

As required by New York State Social Services Law §363-d and 18 NYCRR 521.3, ACMH has designated an employee to be vested with day-to-day responsibility for the Compliance Plan. ACMH has designated a Compliance Officer (CO), a Staff Compliance Committee (SCC) and the Governing Body to oversee the Compliance Plan.

2.1 Designated Compliance Officer

18 NYCRR 521-1.4(b): The CO is the focal point for required provider's compliance program. They are responsible to ensure the Compliance plan is well integrated into ACMH's operations and are supported at the highest levels of ACMH.

Evidence that an individual has been vested with responsibility for the day-to-day operation of the Compliance Plan is seen in: Governing Body resolution/minutes evidencing appointment with appropriate authority, performance plan and evaluation evidencing responsibilities and other duties, signed letter of appointment evidencing responsibilities and other duties, executed contract evidencing responsibilities and other duties, org chart with designation to chief executive, annual work plan, quarterly written reports from CO to governing body and chief executive, meeting minutes documenting quarterly reports to chief executive, governing body and compliance committee, an analysis that determined the Co other duties did not hinder the carrying out of their primary compliance responsibilities, and/or an analysis that demonstrates the CO was able to satisfactorily perform their compliance responsibilities. (OMIG, Compliance Program Guidance including appendices A & B, 2023, pp. 9,10) Additionally, operationalism of these responsibilities are reflected in communications and planning documents.

The employee vested with responsibility for the day-to-day operation of the Compliance Plan is neither in the legal department or in the finance department to minimize any opportunity for conflict of interest. If it is not feasible for the provider to separate the compliance function, then a procedure for addressing conflicts of interest or potential risks is recommended to achieve an appropriate system of checks and balances. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 9 (6))

ACMH chief executive has designated the EVP/CEO as the direct supervisor for the CO as evidenced by the organizational chart.

The designated employee is responsible to report to the entity's chief executive; this may include results of audits and investigations; work plans; plans of action; plans of correction; and/or results of annual self-assessment of the Compliance Plan, related policies and procedures, and risk analyses.

2.2 Accountability

The compliance officer shall report directly to and be accountable to ACMH's chief executive or another senior manager whom the chief executive may designate. However, such a designation does not hinder the compliance officer in any way from carrying out their duties and having access to the chief executive and governing body. The CO is the person coordinating the implementation of the work plan, and while there are other individuals involved in completing auditing and monitoring activities identified in such a work plan the responsibility rests first with the CO.

ACMH has ensured that the compliance officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Plan based on ACMH's risk areas and organizational experience.

ACMH ensures that the compliance officer and their appropriate personnel have access to all records, documents, information, facilities, and Affected Parties that are relevant to fulfilling Compliance Plan responsibilities.

It is the responsibility of the chief executive and the governing body to act when there is continued noncompliance within the CO role and responsibilities.

Evidence of the CO reports to the Governing Body may be in the form of a written report or Governing Body meeting agendas, minutes, and excerpts that set out reports by the CO. The Governing Body has the responsibility to understand the compliance plan and the CO implementation of it. To do this the governing body receives quarterly reports in writing and in person from the CO, can call special compliance meetings, and has full unfettered access to the CO. Additionally, there is evidence that CO has direct access to the governing body.

2.3 Primary Responsibilities

- overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness.
- drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance work plan which shall outline the required provider's proposed strategy for meeting the requirements of this section for the coming year, with a specific emphasis on subdivisions (a), (d), (g), (h) of this section and, if applicable, SubPart 521-2 of this Part;
- reviewing and revising the compliance program, and, in accordance with paragraph 3 of subdivision (a) of this section, the written policies and procedures and standards of conduct, to incorporate changes based on the required provider's organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards.
- reporting directly, on a regular basis, but no less frequently than quarterly, to the required provider's governing body, chief executive, and compliance committee on the progress of adopting, implementing, and maintaining the compliance program.
- assisting the required provider in establishing methods to improve the required provider's efficiency, quality of services, and reducing the required provider's vulnerability to fraud, waste, and abuse.
- investigating and independently acting on matters related to the compliance program, including designing, and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors, and the State; and
- the compliance officer shall be responsible for coordinating the implementation of the fraud, waste, and abuse prevention program with the director and lead investigator of the MMCO's special investigation unit pursuant to SubPart 521-2 of this Part, if applicable.

2.4 Other Duties

Other duties assigned to the CO include the oversight of Quality. These duties do not hinder the compliance officer's ability to carry out their primary responsibilities in any way. The Compliance Officer's role and position as well as other responsibilities are reflected in the agency's organizational charts and delineate separate reporting lines. At ACMH QA and QI are seen as a function of risk management and therefore work with compliance. To avoid any perceived or actual conflict of interest QA, QI and Compliance activities are shared with CEO and Governing body on a quarterly basis.

2.5 Assessment

ACMH conducts ongoing performance management to ensure that compliance responsibilities are satisfactorily carried out. Evidence of this includes:

- A compliance work plan and logs, reports, and risk analyses.
- Annual self-assessment of the compliance Plan and related policies and procedures and risk analyses.
- Completion of the annual SSL and /or DRA certification(s) on OMIG's web site.
- Evidence of initial and ongoing compliance training for all Affected Parties.
- Completion of investigations, including implementation and monitoring of plans of correction for compliance issues.
- Evidence that there is an objective, regular analysis of what the CO is required to perform, and if performance is being assessed and rated. This should be.
  - reflected in the annual performance plans made by the chief executive and the governing body.
  - The CO has responsibilities other than operation of the compliance Plan, but the logs and results of compliance activities evidence that the CO has sufficient time and attention to devote to satisfactorily carrying out compliance responsibilities. The EVP/CEO and Governing body query on a quarterly basis the compliance productivity, self-assessment insufficiencies, risk management and timeliness of investigations, as it relates to CO resources to include time, other staff, consultants, and financial resources.
- If there are multiple insufficiencies in other elements, specifically 3,6, and 7, then ACMH EVP/CEO and governing body addresses that compliance responsibilities are not being carried out properly either through resource allocation and/or disciplinary action.

2.6 Access

The CO has access to and interaction with documentation relative to the ten areas to fully evaluate risk. This is evidenced through email, reports, logs, meeting minutes.

The CO may have access to documentation that includes but is not limited to the following activities. Acceptable examples of documentation relative to the ten areas:

- Overseeing and monitoring the implementation of the Medicaid Compliance Plan.
- Reporting the progress of implementing the various elements and components of the Medicaid Compliance Plan to the BCC at regularly scheduled meetings.
- Develop, revise, maintain, implement, and distribute compliance-related policies, procedures, systems, and other materials for all Affected Parties.
- Work with the certifying official (e.g., chief executive) identified on the annual SSL certification(s) to ensure accurate completion of the certification on OMIG's website.

- Foster appropriate environment within the organization to promote participation in the compliance Plan by all Affected Parties.
- Establish and maintain open lines of communication within the organization so potential compliance problems may be reported promptly.
- Monitor all methods of communication, including anonymous and confidential methods
- Create and maintain appropriate documentation (e.g., logs, spreadsheets, and records) of compliance activities.
- If applicable, supervise assigned staff to ensure compliance-related duties are satisfactorily carried out.
- Report Periodically on compliance activities to the chief executive or other senior administrator and the Governing Body.
- Develop, provide, coordinate, and/or track compliance training and education for orientation and Periodic training for all Affected Parties
- Monitor results of compliance-related disciplinary actions to confirm fair and firm enforcement.
- Develop, manage, and report on the annual compliance work plan, including routine identification of compliance risk areas and trends.
- Monitor credentialing and conduct monthly checks of the federal and state exclusion lists.
- Conduct and/or oversee and review results of internal and external audits and self--evaluations of compliance risk areas, as well as the resulting evaluations of potential or actual non-compliance.
- Investigate potential and actual compliance issues, including root cause analyses.
- Ensure prompt and thorough resolution of compliance issues, including implementation of policies, procedures, systems, and necessary training of all Affected Parties to reduce the potential for recurrence.
- Monitor plans of correction to confirm problems have been resolved or new plans of correction are required.
- Report compliance issues to DOH and/or OMIG.
- Oversee self-disclosures and refunding of overpayments

2.7 Communications from the CO

The CO will communicate key initiatives and changes, including new and revised policies and procedures and updates to the Medicaid Compliance Plan, to Executives/Governing Body/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 Plans, verbal and written communications, and telephonic announcements.

Medicaid Compliance may periodically develop and post intranet-based communication (e.g., newsletters, etc.) to be accessed by employees. Such communications may include key reporting requirements and information about the various methods available for reporting.

CO 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 ACMH risk areas.

The CO ensures the reporting of Medicaid/Medicare/ Medicaid Managed Care related compliance issues on a regular basis to the Committee, or the Governing Body, as well as to any accountable business leads as necessary.

2.8 Compliance Committees

Staff Compliance Committee

The Governing Body has authorized the establishment of a Staff Compliance Committee (SCC), which is responsible for working with the CO on implementing and monitoring ACMH's Compliance Plan and promoting responsible and ethical decision-making by all affected parties. The SCC is fully integrated and representative of the different functional areas throughout the organization. The SCC is comprised of Directors in the following licensed programs that participate in Medicaid billing (OMH/DOHMH), Human Resources, Revenue Cycle Management, legal, Compliance support staff and is chaired by the CO. The SCC reports directly to the Chief Executive and the Governing body. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 10 (1)) Other personnel designated by the CO can also be invited to specific meetings. The Chief Executive and CO may appoint members to the Staff Compliance Committee with varying backgrounds and experience to ensure that the SCC has the expertise to handle the full range of clinical, administrative, operational, and legal issues relevant to the Plan.

SCC Charter

- Meet no less than quarterly.
- Members must attend regularly scheduled and special meetings of the SCC.
- Request that certain ACMH personnel and subject matter experts attend meetings as a guest to provide specific information to the Committee as warranted.
- Oversee the ongoing implementation of the compliance plan and ensure that potential issues or violations presented directly to the SCC or through a member of the management team are logged, investigated, and addressed.
- Review all audits/reviews and quality assurance activities both internally and externally to ensure corrective action while identifying patterns and trends that need to be addressed on a larger scale.
- Ensure both root cause analysis' and the OMIG Compliance Performance Review Module is completed and that the results inform the current and following years work, policy, and training.
- 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 Governing Body, and other functions as needed to meet the requirements of the compliance Plan.

Governing Body Compliance Oversight

The Governing Body are responsible to oversee and approve the policies, activities, and results related to implementation of the Medicaid Compliance Plan and receive written reports from the CO no less than quarterly in a calendar year. The Governing Body has an executive session with the CO only at least once a year to have an opportunity for confidential discussion. This can occur in person or via an audio video platform. Meeting minutes are kept separate from regular Governing body minutes in the sole custody of the Governing body President.

The CO will also provide the Governing Body email updates, when needed, for issues or concerns that arise. The Governing Body is responsible for contributing to the job evaluation of the compliance officer and ensuring that they have adequate resources to perform their job.

Governing Board Compliance Charter

- Coordinate with the compliance officer to ensure that the written policies and procedures and standards of conduct are current, accurate and complete, and that all required training topics are developed and completed.
- Ensure that the CO reports to the committee no less than quarterly on the following areas:
    a. Training
    b. Policy
    c. Regulations
    d. Internal oversight activities & corrective actions
    e. External Oversight activities & corrective actions
    f. RCM
    g. Over and under payments
- Coordinate with the compliance officer to ensure, through self-evaluation methods, that adequate communication and cooperation by Affected Parties on compliance related issues, internal or external audits, or any other function or activity required is occurring.
- ensuring that the required provider has effective systems and processes in place to identify Compliance Plan risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues; and
- ensuring that the compliance officer is allocated sufficient funding, resources, and staff to fully perform their responsibilities.
- Enacting required modifications to the Compliance Plan.

Documentation

ACMH requires that documentation exists that demonstrates the effectiveness of the compliance committees.

- Charter that outlines duties, members, chair, and frequency of meetings.
- Minutes from quarterly meetings
- Evidence of annual charter reviews including date and updates
- Org chart showing reporting structure to the chief executive and governing board (OMIG, Compliance Program Guidance including appendices A & B, 2023, pp. 10, 11)

Employee/Executives/Governing Body/Volunteer/Intern Personal Responsibility

Responsibility for the Medicaid Compliance Plan includes not only the commitment of the Governing Body and ACMH management, but also the participation and commitment of all Employees/Executives/ Governing Body/Interns/Volunteers. Employees/Executives/Governing Body/Interns/Volunteers are personally responsible to read, understand, question, and adhere to the most current Compliance Plan, HR employee manual and agency policies and procedures [available on our Shared x: drive and our web site]. 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 ACMH policies to include reporting all actual and suspected deviation from the articulated standards of this document. Individuals 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 or suspect as soon as possible, to the Compliance Officer. You may include your supervisor as part of your reporting process but know supervisors have an obligation to report known or suspected compliance issues to the CO even if it is hearsay. Failure to report known OR suspected noncompliance is a compliance violation in and of itself and that reporting failure will be investigated and remediated the act of noncompliance that it is.

Employees and Executives; upon hire, volunteers, and Governing Body members; upon acceptance and interns upon placement, are responsible to read the compliance plan and attest that they have read it and understand it. They are required to attest annually thereafter.

If at any time an employee/executive/governing body member/intern or volunteer suspects noncompliance they must report it to the compliance officer using any of the methods below. Not all methods are anonymous, if you wish to report anonymously use the US postal service with no return address or call the hotline by calling *67 1-212-274-8558 ext.250. The phone number will be blocked when entering *67 prior to dialing ensuring an anonymous call that does not include a caller ID,
fax- 212-465-0610
phone -1-212-274-8558 ext.250
US Postal Service by writing to- Compliance Officer, 254 West 31st Street, 2nd Floor, New York, NY 10001

You may also report suspected noncompliance directly to NYSDOH and NYS OMIG by
website https://omig.ny.gov/fraud/file-an-allegation
Mail: NYS OMIG Bureau of Fraud Allegations, 800 North Pearl Street, Albany, New York 12204
Fax: (518) 408-0480
The form needed to report to OMIG is attached to this policy.

2.6 Vendors/Contracted Parties

Responsibility for the Medicaid Compliance Plan includes participation and commitment of all ACMH Vendors/Contracted to include vendors and independent contractors as it relates to their intersection with Medicaid and Managed Care services. Examples of affected vendors and contracted parties includes but is not limited to:

Electronic Health Records	Billing companies	Auditors
Laboratories	1099 staff	Compliance Companies

Vendors/Contracted Parties are responsible, individually and on behalf of their designers, to read, understand, question, and adhere to the most current ACMH Medicaid Compliance Plan. 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 ACMH 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 contact the compliance officer or NYS OMIG directly. Not all methods are anonymous, if you wish to report anonymously use the US postal service

with no return address or call the hotline by calling *67 1-212-274-8558 ext.250. The phone number will be blocked when entering *67 prior to dialing ensuring an anonymous call that does not include a caller ID:

Email- mmiller@acmhnyc.org
fax- 212-465-0610
phone -1-212-274-8558 ext.250
US Postal Service by writing to- Compliance Officer, 254 West 31st Street, 2nd Floor, New York, NY 10001

You may also report suspected noncompliance directly to NYSDOH and/or NYS OMIG by going to the website https://omig.ny.gov/fraud/file-an-allegation
Mail: NYS OMIG Bureau of Fraud Allegations, 800 North Pearl Street, Albany, New York 12204
Fax: (518) 408-0480
The form needed to report to OMIG is attached to this policy.

An attestation of regulatory applicability and or compliance is required as part of contracting and annually thereafter.

Element 3: Training and Education of all affected parties

3.1 Comprehensive Compliance Training Plan

As documented by New York State Social Services Law §363-d and 18 NYCRR 521-1.4, ACMH conducts training and education on compliance issues, expectations, and the Compliance Plan for all Affected Parties . ACMH has established and implemented a comprehensive compliance training and education plan for its compliance officer and all Affected Parties.

ACMH's compliance training and education plan is maintained as part of the overall Compliance Plan and as such is reviewed and edited no less than annually. Training updates also occur as part of corrective action.

Training Subjects and Topics

(1) The training and education cover, at a minimum, the following general topics:

(i) ACMH's risk areas and organizational structure.

(ii) ACMH's written policies and procedures

- guidance on dealing with compliance issues.
- how to communicate compliance issues to appropriate compliance personnel; and
- guidance on how potential compliance problems is investigated and resolved.
- expectations related to acting in ways that support integrity in operations.
- written policies and procedures that describe compliance expectations; and
- written policies and procedures that implement the operation of the compliance Plan.

(iii) the role of the compliance officer and the compliance committees at ACMH

- training materials must identify who the designated employee and compliance committee members are.

(iv) how Affected Parties can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the compliance Plan; .

- expectations for reporting compliance issues.
- expectations for the resolution of compliance issues.

(v) disciplinary standards, with an emphasis on how the standards relate to the compliance Plan and the prevention of fraud, waste, and abuse.

- sanctions for failing to report suspected problems.
- sanctions for participating in non-compliant behavior.
- sanctions for encouraging, directing, facilitating, or permitting non-compliant behavior; and
- expectations that compliance-related disciplinary policies are fairly and firmly enforced.
- information about the non-intimidation and non-retaliation requirements

(vi) how ACMH responds to compliance issues and implements corrective action plans.
(vii) requirements specific to the Medicaid Plan, and ACMH's category or categories of service.
(viii) compliant coding and billing requirements and best practices, if applicable.
(ix) compliant claim development and the submission process,
(x) training and education frequency to include onboarding, periodic, episodic, and annual.

BOC recommends that training and education be given using a method that is reasonably expected to be understood by the individuals required to receive training. Examples of such a method include but are not limited to:

- Training and education offered in a language understandable to Affected Parties. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 11)
- Training and education should be sensitive to any reasonable accommodations of the Affected Parties. Training is customized for different affected groups, executives and governing board, staff & contractors, and vendors.

3.2 Timing, Frequency and Evaluation

Timing of Trainings

ACMH regularly communicates its Medicaid Compliance standards and policies to all affected employees and persons associated with ACMH, including Executives, Governing Body, Employees/Interns/Vendors and/or Contracted Staff/Volunteers on compliance issues, expectations, and the compliance Plan operation. Training occurs at onboarding [within 30 days of start date or prior to beginning independent work in the Medicaid service], annually, periodically throughout the year as well as episodically when circumstances warrant. Training methodologies are documented to include on-the-job supervision, classroom (in-person or remote with audio and video) instruction, self-taught manuals, electronic communication of compliance alerts and announcements via e-mail and the intranet. All training requires the taking of attendance and the issuance of certificates of completion when they score 70 or better on their posttest.

Training Evaluation

The Medicaid Compliance Plan'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 Plan by the Compliance Officer.

ACMH will at its quarterly compliance meetings review training posttests results, as well as incidents of noncompliance and their subsequent investigations to determine compliance effectiveness. The SCC is responsible to make recommendations to the CO regarding updates needed to training materials ensure that they are current, consistent with applicable law and provisions of the Medicaid Compliance Plan and incorporates the findings and results of ACMH 's ongoing evaluation, auditing, and monitoring of the Medicaid Compliance Plan. All reviews will be documented in meeting minutes.

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

Orientation for Affected Parties

Staff (Employees/Executives/Contracted Parties (1099)/Volunteers/Interns)

New Hire Orientation is provided to all new and current applicable Staff of ACMH, and will include an overview of the general provisions, practices, code of conduct and standards of the Compliance Plan as well as a review of ACMH's policies and applicable laws. In addition, there will be a discussion, and review of the applicable responsibilities of staff in complying with the provisions of the Medicaid Compliance Plan. All staff will be provided with a copy of the Compliance Plan and will be instructed on how to access the policy via electronic means through ACMH's intranet.

All newly hired applicable staff will be required to participate in the New Hire Orientation within 30 days of their start date. This is scheduled on their first day as part of onboarding. All staff must pass the Compliance posttest with a score of 70% or higher prior to participating in any Medicaid activities. Prior to the completion of training and subsequent post test score of 70 or lower the supervisor must review and sign every billable note prior to it being sent out for payment.

All applicable staff in the health care operations of ACMH will be provided with a copy of the Compliance Plan and access to the Compliance Plan via intranet.

ACMH's staff who fail to participate and complete the New Hire Orientation 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 ACMH introductory period policies.

Vendors

Vendors receive Compliance information as part of the contracting process to include a *Business Associate Agreement*, Vendor Part 521/363-d /363-d Training materials, and a vendor's attestation and are responsible to orient themselves to the compliance process. Failure to do so can result in immediate termination of the contract for cause.

The CO is responsible for ensuring vendors receive and understand compliance training material and reporting mechanisms. The CO makes themselves available for any question's vendors may have.

Governing Body

ACMH's Governing Body must complete Compliance Fraud, Waste, and Abuse training within 30 days of appointment and then annually thereafter. The training materials are provided to the Governing body Members in their Governing body Orientation Packet, and in advance of live training annually thereafter. The CO delivers the training together with an acknowledgment form. Upon completion of the course, the CO collects the completed acknowledgments. The acknowledgments include confirmation of Compliance awareness, completion of ACMH 's Compliance Trainings, agreement to comply with these standards, a copy of the Medicaid Compliance Plan/Code of Conduct and disclosure of any conflict of interest.

Periodic Education for affected parties

Periodic compliance training and education on compliance issues, expectations, and the compliance Plan operation must be provided to all categories of Affected Parties.

The CO oversees the development and scheduling of periodic education/training throughout the year on compliance issues, expectations, and the Compliance Plan operations for all ACMH's affected parties. The CO 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 Employees/Interns/Contracted Parties and Volunteers. These education materials may be regularly scheduled and delivered in varying modalities.

Staff (employees, executives' contractors (1099) volunteers and interns)

Staff receive periodic education as part of staff meetings, flyers, email blasts and town halls. Periodic education content is intended as reminders of compliance rules, workflows, and practices at ACMH.

Vendors

Vendors receive periodic education specific to changes in the compliance plan and or regulation. All periodic education is sent as an email and used confirm receipt functionality.

Governing Body

Governing Body receives periodic education specific to changes in the compliance plan and or regulation. All periodic education is sent as an email and used confirm receipt functionality.

Episodic Education for affected parties

Affected parties assigned to particularly sensitive positions or functions may require additional topic specific episodic 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 Plan. The need for additional training may also be determined because of new requirements promulgated under applicable law. It will be the responsibility of the CO 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:

- Handling Complaints, Grievances and Appeals
- Marketing to Medicaid/ Medicaid Managed Care beneficiaries
- Medicaid Regulatory Guidance Distribution & Validation process

- CMS Requirements for ACMH
- OIG & SAM Exclusion Screenings
- ACMH Compliance Plan Requirements

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

3.4 Training Plan documentation.

Training Attestation Form (TAF)

ACMH will document training provided to Affected Parties , including the name and job title of the individual, type of affected party, date of hire, date of training, subject matter, method of training, type of training [orientation, periodic, episodic or annual] and nature of training provided. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 12) Upon successful completion of training under the Medicaid Compliance Plan, the training instructor will ensure that each affected party/individual completes and signs a TAF. A copy of this form will be forwarded to the Compliance Officer. ACMH 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 upon request (i.e., for audits, etc.).

The TAF certifies that the affected parties who have received the training and received and reviewed the Compliance Plan agree to participate fully and ask questions when unsure. The CO will monitor the return of the TAFs from affected parties so that a copy is placed within each staff person's, companies' compliance and/or personnel file. Should an affected party fail to return TAF within the prescribed timeframe, this will be considered non-compliance with the Compliance Plan such as to require that appropriate disciplinary action is implemented.

Only distributing compliance-related policies and procedures does not qualify as compliance training and education. BOC determines that self-study plans are acceptable where compliance-related policies and procedures and/or compliance training materials are distributed so long as the Required Provider can produce evidence that individuals being trained have received, read, and understood the materials. Those required to receive training must be afforded an opportunity to ask questions and receive responses to any questions they have for training to be considered complete.

Both in training Plans and throughout the year, Affected Parties have the opportunity to ask questions and receive responses on anything covered in the training Plans or that have arisen through day-to-day operations by emailing the compliance officer directly.

Meeting Minutes

For the Governing Body meeting minutes and agendas must include reference to all compliance trainings and trainers. As well as date of training, attendee names and titles. If a subcommittee is tasked with compliance, there should be meeting minutes that indicate with the subcommittee chair reported out to the full board.

Attestations

Vendors may use attestations to indicate receipt of and review of trainings.

Element 4: Accessible Communication to and from the Compliance Officer

As documented by New York State Social Services Law §363-d and 18 NYCRR 521.3, ACMH must have open lines of communication to the CO to allow questions to be asked and compliance issues to be reported promptly. (OMIG, Compliance Program Review Module , 2023, p. 14 (1)) In an effort to keep the communication lines to the CO accessible to all ACMH provides a variety of methods that all affected parties and others, to include consumers, (OMIG, Compliance Program Review Module , 2023, p. 14(2)) may use to report potential compliance issues as soon as they are suspected and or identified. This includes a method for anonymous and confidential good faith reporting as well as information on how to report directly to NYS DOH and or OMIG.

4.1 Reporting Mechanisms

ACMH has established a telephone hotline that affected individuals and Medicaid recipients of service from ACMH may call to file reports anonymously. The hotline may be accessed by calling *67 1-212-274-8558 ext.250. The phone number will be blocked when entering *67 prior to dialing ensuring an anonymous call that does not include a caller ID.

4.2 Accessible lines of communication exist to the CO.

The following methods are available for reporting suspected compliance misconduct, which will be detailed in training materials.

a) *Who to speak with*

- If you are comfortable, you can discuss the question or concern first with the direct supervisor. Supervisors be aware, any reports of actual or suspected non-compliance during supervision, conversation or observation ARE considered by federal law to be reportable to the CO and *must be reported immediately* upon knowledge to the agency compliance officer and tracked in the compliance log.
- All affected parties are always able to speak first and directly to the agency Compliance Officer, contact NYS OMIG directly or utilize one of the anonymous or confidential reporting mechanisms listed below. All methods are included in the training and flyers.

b) *Phone Calls*

- Call the CO directly at 212-274-8558 ext 218. (THIS IS NOT ANONYMOUS).
- Call the Compliance Hotline where details can be left on the voicemail anonymously and confidentially. The hotline may be accessed by calling *67 1-212-274-8558 ext.250. The phone number will be blocked when entering *67 prior to dialing ensuring an anonymous call that does not include a caller ID. All reports via the confidential method will be kept confidential, whether so requested or not, additionally, if a caller chooses to identify him/herself, the CO will keep the caller's identity confidential and will disclose the caller's identity on a "need to know" basis. In general, once a caller chooses to disclose his/her identity, "need to know" means that further disclosure of his/her identity 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 or the matter is turned over to law enforcement.

c) *Email* CO at: Michele Miller: mmiller@acmhnyc.org [not anonymous]

d) *Hard copy* :

- Interoffice Mail send using shotgun envelope without a sender address or name.
- U.S. Postal Service by writing to: Compliance at 254 West 31st Street, 2nd Floor New York, NY 10001 . If you wish to be anonymous use the agency's return address and do not use your name.

e) *Fax:* 212-465-0610 [not anonymous if you use a personal fax machine. But you can be anonymous if you use a fax service.]

f) *Directly to OMIG/DOH:* Report the matter to DOH/OMIG based on findings specific to medical necessity, governance, quality of care, overpayment, or underpayment to Medicaid.

- Report to OMIG at 1-877-87FRAUD (1-877-873-7283) or via their website at www.omig.ny.gov;
- Report to DOH at https://www.health.ny.gov/
- 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.
- Report the matter to the NYS Attorney General's Medicaid Fraud Control Unit at 1-800-771-7755.

4.3 Anonymous reporting

ACMH provides multiple ways to communicate anonymously. Every Affected Parties has multiple methods of anonymous communication. No anonymous method will be observable by surveillance controlled by anyone other than the CO.

A person's identity, if known, will be kept confidential unless the matter is subject to disciplinary proceedings, referred to or under investigation by MFCU, OMIG or law enforcement or disclosure is required during legal proceedings. (OMIG, Compliance Program Review Module , 2023, p. 15)

Documentation

All reports received through the Compliance reporting mechanisms will be maintained by the Compliance Office. All distributions through email and US postal service will have a date and be entered into the compliance report log. Screenshots will be taken of notifications on intranet, and/or websites, along with affirmation that it was published. Posters and flyers must be dated, and lists must be kept indicating locations and updates. All notifications to vendors must also be recorded in the compliance log. Documentation must also indicate how confidentiality was maintained and that such persons were protected under the Non-retaliation or intimidation rules. Documentation evidencing ACMH made their Compliance Plan, and Code of Conduct available on their website to include posting dates is maintained by the CO. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 13)

Responding to Reports/Complaints

Upon receiving an oral or written report of known or suspected noncompliance the CO will determine if the report is in fact related to a Medicaid Compliance Plan issue, log the complaint on a Compliance Log and begin an investigation where appropriate. In cases where it is determined that the reported issue does not concern a compliance issue related to the Medicaid Compliance Plan, the CO will refer the issue to the appropriate manager and/or department. Documenting the determination, follow-up and

resolution of the issue will be required in every case referred to the manager and the CO will maintain a record of all such reports. All affected parties are expected to participate fully and cooperate with all investigations. In cases where a reported concern and/or complaint is deemed to be an actual or probable violation of the Medicaid Compliance Plan, the CO will thoroughly investigate the matter to determine:

- if the issue reported has a basis in fact,
- if a self-disclosure to NYS OMIG and or another payer is required and
- whether modifications should be made to the Medicaid Compliance Plan and/or ACMH policies, trainings, and/or procedures which may help prevent similar compliance issues in the future.

*<u>*For the full investigative process please refer to element 7 in this plan.*</u>

Element 5: Disciplinary Policies to encourage Good Faith participation.

As documented by New York State Social Services Law §363-d and 18 NYCRR 521.3, ACMH must have disciplinary procedures must be in effect to encourage good faith participation in the Compliance Plan by all Affected Parties.

It is acceptable that the expectation for fair and firm enforcement of compliance-related disciplinary actions may be included in training and education materials.

The disciplinary policies below specific to Medicaid related noncompliance are also incorporated into ACMH employee Policy and Procedures. The purpose of any disciplinary action involving applicable affected parties will be to correct any behaviors or practices that.

1) result in a violation of the Medicaid Compliance Plan,
2) jeopardize the fair, equitable and/or professional treatment of a person served,
3) compromise the integrity and accountability of ACMH's financial reporting and/or billing practices, and/or
4) place at risk the financial stability, and/or overall operations of ACMH.

5.1 Disciplinary Procedures

Affected Parties- Staff (Employees/Interns/Volunteers and/or Contracted 1099)

Employees and/or Contracted Staff 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 Human Resources in consultation with the CO and legal counsel when appropriate. In addition to possible disciplinary action mentioned elsewhere in this plan, personnel may be subject to disciplinary action for:

- Failure to perform any obligation or duty required of personnel relating to compliance with this Plan or applicable laws or regulations.
    - To include but not limited to mandatory training and post testing.
- Promoting, permitting, or facilitating conduct that is contrary to ACMH 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 Plan

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.

- Falsification of a signature
- Falsification of a date of service/time
- Backdating
- Falsification of a timecard
- 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
- Failure to report known or suspected fraud, waste and or abuse.

There are certain circumstances which may help to mitigate the severity of the disciplinary action recommended against the applicable staff, including, but not limited to (a) the prompt reporting by the applicable staff member of any violation(s) of the Medicaid Compliance Plan, (b) a positive work record including no previous history of violations under the Medicaid Compliance Plan, (c) cooperating fully as required, with the investigation and correction of the violation, and/or (d) other compelling factors reviewed with the CO and EVP/CEO.

While progressive discipline is the practice at ACMH there are some actions so egregious, they will not follow progressive discipline but in fact result in immediate termination.

Disciplinary action for any compliance violation may include, but is not limited to:

- A verbal warning and counseling, [which must be documented, and a copy placed in the individual's supervision folder]
- A written warning
- Suspension
- Termination of employment, placement and or contract
- Report to legal authorities/ OMIG/CMS and or DOHMH

The CO will complete a corrective action plan regardless of outcome to include updates to policies, practices, and trainings.

Executive Management

In cases involving a member Executive management, the CO will work directly with the Governing body President. ACMH will remove the executive from any operations related to the Compliance Plan, services rendering, billing or being paid by Medicaid or Managed Medicaid, and the deliberation of company business related to those Plans until a full investigation has been conducted by the CO and/or legal counsel. Once the investigation is concluded, if it is determined that the allegation of misconduct is indicated, the CO will inform ACMH 's Governing body President. The Governing body President is responsible to inform the executive committee and determine a disciplinary course of action. If termination is indicated the Governing Body President will engage HR in the implementation of that action. If the alleged misconduct is not substantiated by any evidence, the Governing body President will reinstate the Executive. ACMH will also comply with all reporting requirements associated with the

substantiated misconduct. The CO will complete a corrective action plan regardless of outcome to include updates to policies, practices, and trainings.

Governing Body

In cases involving a member of the Governing Body, ACMH will suspend the Trustee/Director from the Governing body and the deliberation of company business until a full investigation has been conducted by the Compliance department and/or legal counsel. Once the investigation is concluded, if it is determined that the allegation of misconduct is indicated, the Governing body President will remove the individual. If the alleged misconduct is not substantiated by any evidence, the Governing body President will reinstate the director. ACMH will also comply with all reporting requirements associated with the substantiated misconduct. ACMH will consult counsel when misconduct allegations involve Governing body members. If the misconduct involves the Governing body President, the CO will work directly with the Governing body legal committee. The CO will complete a corrective action plan regardless of outcome to include updates to policies, practices, and trainings. Disciplinary action for governing bodies may also be found in the by-laws/operating agreements.

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/ Managed Care activities until the investigation is complete. It is the responsibility of the intern's supervisor to notify the educational Institution that placed the intern of the allegation and investigation. If the intern is cleared, they may resume their normal duties, if the allegation is substantiated their placement at ACMH will be immediately terminated.

Volunteers

In cases involving volunteers the CO will contact HR. The volunteer will be removed from any Medicaid/ Managed Care activities until the investigation is complete. It is the responsibility of the volunteer 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 ACMH will be immediately terminated. It may also indicate a need for termination of the engagement with the Volunteer or institution responsible for them.

Vendors

In cases involving a vendor, ACMH will halt all contracted activities until such time as an investigation can be completed. ACMH will retain legal counsel for all allegations involving vendors. If the vendor is cleared, they may resume their normal activities, if the allegation is substantiated their contract with ACMH will be immediately terminated for cause.

The EVP/CEO and/or Chief Financial Officer will be responsible for reviewing and approving any remedial or disciplinary action recommended and implemented against applicable affected parties to correct violations of the Medicaid Compliance Plan.

Notification of Disciplinary Standards

ACMH' disciplinary standards and the procedures for taking such actions as outlined above shall be published and disseminated to all Affected Parties and shall be incorporated into ACMH's training plan and orientation. These standards are incorporated into the Employee handbook.

Excluded Provider Screening [OIG, GSA & OMIG]

New staff

ACMH screens all prospective staff against state and federal exclusion lists before extending a conditional offer of employment/placement/contract. ACMH confirms the identity of all potential staff before performing the exclusion checks. If a prospective individual or 1099 contractor is identified as being an excluded provider. A conditional offer of employment/placement cannot be extended to any individual identified as being an excluded provider on any state or federal exclusion list.

Databases are:

- NYS Office of the Medicaid Inspector General Exclusion List [OMIG]
- Health & Human Services Office of the Inspector General's List of Excluded Individuals and Entities [OIG/GSA]

Current staff

ACMH checks all staff against state and federal exclusions lists monthly. If an individual is identified as an excluded provider (i.e., they are not a recurring match), the CO takes appropriate action to ensure that the individual is not providing services for which ACMH obtains reimbursement from federal health insurance Plans either directly or indirectly. ***Being placed on any of the 3 exclusions lists is a terminable offense.***

Vendors

ACMH checks all vendors against the state and federal exclusions lists prior to contracting and monthly thereafter. Vendors that provide rotating employees to provide services at ACMH are required to submit an attestation indicating that the vendor has completed the requisite exclusion screenings on the employees assigned to ACMH. The ACMH boilerplate contract, which is used for nearly all contracts for goods and services, contains language requiring compliance with exclusion screening procedures. ACMH will not make employment or contract offers to an individual or business that is verified to be excluded from participation in federal health insurance Plans.

If a vendor or one of their employees is identified as an excluded provider (i.e., they are not a recurring match), ACMH will terminate the contract for cause.

5.2 Expectations for reporting compliance issues

All affected parties are responsible for promptly reporting known or suspected violations of the Medicaid Compliance Plan whether committed by that affected party or by someone else, to the Compliance Officer. *Supervisors should be aware that reports of actual or suspected noncompliance made to them during supervision, conversation or observation are considered by federal law to be reportable to the CO and must be reported immediately upon knowledge.* These reports can be made directly using any of the reporting options available.

ACMH maintains the confidentiality of all reports it receives to the extent that applicable law requires such confidentiality. ACMH will also make every effort to maintain, within the limits of the law, the

confidentiality of the identity of any individual who reports possible misconduct. **Failure to report suspected or actual non-compliance is subject to disciplinary action up to and including termination.**

5.3 Investigation & resolution

Expectations

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

Sanctions

If an affected party fails to report suspected noncompliance, participates in non-compliant behavior, and/or encourages, directs, facilitates, permits or knowing turns a blind eye to non-compliant behavior they will be subject to disciplinary actions up to and including termination. (See 5.1)

Enforcement

ACMH implements fair and firm enforcement of compliance-related disciplinary actions across all affected parties. No one affected party group or individual will receive special treatment. Known relationships between affected parties and any investigator, CO or ACMH decision maker will be disclosed and managed by another entity. It is ACMH's policy to hire external investigators when a **conflict has been established that cannot be resolved internally.**

5.4 Documentation

Disciplinary policies and procedures are published and disseminated on ACMH intranet, in HR employee handbook and in all contracts all of which require a signed attestation of receipt, understanding and acknowledgement that the affected party has the responsibility to ask questions when they are unclear. (OMIG, Compliance Program Review Module , 2023, p. 17)

All disciplinary action taken is documents in HR and reflects equity across affected parties for similar acts of noncompliance. (OMIG, Compliance Program Review Module , 2023, p. 17)

Governing body by-laws and or operating agreements identify disciplinary standards and related procedures.

Contracts include disciplinary standards and related procedures for affected vendors and 1099 contractors. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 14)

Element 6: Auditing & Monitoring

As required by New York State Social Services Law §363-d and 18 NYCRR 521, ACMH has a system of routine auditing and monitoring of compliance risk areas and non-compliance. Evidence of the outcome of the system's operation includes but is not limited to:

- call/report logs that track activity.
- work plans; documentation and reports of audits and/or investigations.
- SCC and BCC meeting minutes
- Supervisory notes

- Executive staff meeting minutes
- Annual compliance plan review
- plans of correction; or
- documentation of refunded overpayments and/or self-disclosures.

Documentation evidence identification, investigation, resolution, and prevention activities taken as part of noncompliance. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 14)

6.1 Identification

ACMH has a system for routine identification of compliance risk areas. The goal of ACMH's compliance Plan is to prevent, detect, and correct non-compliance with Medicaid requirements, including fraud, waste, and abuse as it relates to ACMH's identified risk areas and experience. To accomplish this ACMH has implemented the following:

Code of Conduct

ACMH is committed to maintaining the highest quality services for all people served. To this end, ACMH has adopted and incorporated the Code of Conduct into all its operations. ACMH has established written policies and procedures for documentation and billing [see Plan 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 ACMH efforts to detect, prevent, and control fraud, waste, and abuse. **ACMH 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 affected parties of ACMH.

The code of conduct has been disseminated to ensure that ACMH's affected parties promote the mission of ACMH; protect the rights of persons served, and always perform in an ethical manner while carrying out their job responsibilities.

Affected parties are required to carefully review the Code of Conduct/vender Attestation on an annual basis and are advised that any violation of these provisions are grounds for disciplinary action, up to and including termination from employment or any contract. Affected parties are encouraged to discuss any questions about these guidelines with their immediate supervisor or the compliance officer. Vendors and Contracted Parties are encouraged to discuss any questions with the Compliance Department.

Failure by any affected party to comply with applicable compliance regulation or ACMH's policies and procedures will subject the those who ignore or fail to detect misconduct or who have knowledge of the conduct and fail to correct it, to disciplinary action up to and including termination from employment. The ACMH's policies and procedures manual set forth the degrees of disciplinary action that may be imposed for failing to comply with ACMH's policies. Intentional or reckless noncompliance will subject the affected party 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

ACMH's affected parties are always expected to carry out their responsibilities in a highly ethical manner consistent with the ACMH Code of Conduct. ACMH's affected parties 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 Plan or service; or executing or attempting to execute a scheme or artifice to defraud any healthcare benefit Plan, 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 Plan.
- Failure to Report Violations to CO– Failing to report to the CO or designee any instance of conduct of which ACMH employee knows or suspects to be a violation of the Medicaid Compliance Plan or should, in the ordinary course of carrying out his/her duties, known to be a violation of the Medicaid Compliance Plan.

6.2 Self-evaluation

ACMH has established and implemented an effective system for the routine monitoring and identification of compliance risks. The system includes internal monitoring and audits and, as appropriate, external audits, to evaluate compliance with the requirements, as well as the overall effectiveness of the required provider's Compliance Plan.

The system covers self-evaluation of the identified risk areas. Evidence of a system may include but is not limited to:

- Monthly review of NYS OMIG Compliance Review Module (March 2023) inclusive of identifies risk areas.
- documented results of self-evaluations.
- a written expectation for internal and/or external audits of the identified risk areas.
- documented results of internal and/or external audits.
- a compliance work plan that identifies self-evaluation or auditing of identified risk areas; or
- documented results of work plan activities.

Audits and Monitoring

Internal Audits

ACMH conducts monthly audits to identify risk in the following 9 areas.

1. Billings
2. Payments
3. Ordered services; [Treatment Planning]
4. Medical necessity and quality of care

5. Governance
6. Mandatory reporting
7. Credentialing
8. Contractor, subcontractor, agent, or independent contract oversight.
9. Other risk areas that are identified as part of monitoring.

Each month depending on the focus of the audit a sample is selected, audit conducted, report and corrective action plan (CAP) written. All reports and CAPs are submitted each month to the CO and presented quarterly to the SCC.

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 with specific rules and policies that have been identified by Medicaid, the OIG, or the Fiscal Intermediary as high-risk areas. Any overpayments discovered because of our auditing activities shall be promptly refunded to the applicable payer with appropriate documentation and an explanation of the reason for the refund.

Staff, and/or contractors conducting audits must have the knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and are independent from the functions being reviewed. (OMIG, Compliance Program Review Module , 2023, p. 19(2)(i))

External Audits

In addition to the internal reviews and audits, ACMH '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 Plan, such findings will be reported to the CO, SCC, Chief Executive, and Governing. The findings will also be entered into the compliance log and reviewed as part of the SCC and BCC meetings.

Auditing the Compliance Plan

The CO is responsible for ensuring a comprehensive audit and review of the Compliance Plan is completed annually and a review ongoing thereafter using the NYS OMIG Compliance Program Module (March 2023). The scope of this audit will focus on ACMH's plans and operations, specifically those with substantive exposure to government enforcement actions. The audit will address ACMH's compliance with laws governing billing, coding, claim development and submission, and reimbursement. Additionally, there will be an evaluation of the extent to which ACMH's affected parties have implemented and complied with the Medicaid Compliance Plan. An audit summary report, including findings, results and recommendations will be reviewed by the CO and SCC and submitted to the Chief Executive and Governing Body.

Reviews of the compliance plan will include onsite visits, interviews with affected parties, review of records, surveys, or any other comparable method the CO deems appropriate, provided that such methods do not compromise the independence or integrity of the review. (OMIG, Compliance Program Review Module , 2023, p. 19(2)(ii))

Monitoring

The Co is responsible to ensure that policies, systems, and workflows are in place to ensure ongoing monitoring of exclusion lists checks, staff credentials, mandated trainings, governance, and contractor compliance as part of management by assigned areas such as Human Resources, Purchasing, Finance, and or other administrative or central services.

Response to Audits & Monitoring

The CO is responsible for developing corrective action in those areas where audits and monitoring activities indicate violations, inconsistencies, or deviations from the compliance standards covered in the Medicaid Compliance Plan. The CO will seek to remedy any instances of non-compliance immediately and will work with program leadership to ensure implementation of corrective actions without delay. If more than one department is involved in the implementation of a corrective action, the CO will facilitate root cause analysis meetings between the Affected Parties and/or affected departments to ensure that the corrective action is implemented correctly and thoroughly.

At the meetings, each department will show evidence that the department has implemented the needed corrective actions properly and thoroughly. Each department's evidence will serve as a check of the other departments' implementation of the needed corrective actions which will reduce the likelihood that the issue will recur. And, once each department is satisfied that the actions have been properly implemented, the departments will jointly design and run a test to ensure that the issue has been adequately corrected. All corrective action plan development and implementation will be part SCC meetings.

The EVP/CEO and Governing Body will be informed of any actions implemented in response to either an internal or external audit or monitoring review. The CO is responsible for overseeing such responses and plans of correction are following ACMH's policies. The CO is responsible for ensuring all corrective actions are audits post implementation to ensure continued compliance.

Overpayments

Suspected overpayments must be reported immediately to the Compliance Officer. The CO must ensure that each genuine instance of overpayment is recorded in the compliance log. The CO must coordinate the return of the monies to Medicaid. Additionally, via investigation, the CO must determine the root cause of the overpayment, how widespread the overpayment issue is and if there is a genuine issue of purposeful intent to commit fraud. Such audits and investigations must include a look back period (up to the 6-year records retention period) prior to the audit period, and a look ahead period beyond the audit period up to the time of implementation of corrective actions plan to resolve the issue.

The CO is responsible to ensure the identified overpayments are reported, returned, and explained to the Medicaid Program through the OMIG Self Disclosure Program. (OMIG, Compliance Program Guidance including appendices A & B, 2023, p. 16) (OMIG, Compliance Program Review Module , 2023, p. 19) The CO will promptly initiate corrective action to prevent recurrence.

Inventory/Schedule of Audits

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

6.3 Documentation

All audits regardless of auditor must include dates completed and any compliance issues identified and be tracked on the compliance log. All meetings must have minutes that articulate items discussed and actions agreed to as well as a list of attendees, and date.

The CO is responsible for maintaining distribution lists of all documents shared with affected parties. Additionally, the compliance log is to be maintained by CO and shared with the SCC and BCC every quarter. The compliance log also services as the primary document for the annual review, root cause analysis and updates.

Annual Meeting

Annually the SCC is responsible for identifying patterns and trends and conducting a root cause analysis to identify any additional risk areas to be monitored, audited and or trained on in the upcoming year. The SCC and CO are also responsible for conducting and documenting updates to work plans, policies, and procedures as well as recommendations for training updates.

The purpose of the annual review is to (1) consider the overall effectiveness of the Medicaid Compliance Plan; (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 ACMH policies as it relates to the Medicaid Compliance Plan.

Element 7 – System for Responding to Compliance Issues

As documented by New York State Social Services Law §363-d and 18 NYCRR 521.3, ACMH has a system in place for responding to compliance issues when they are reported. Violations of the Medicaid Compliance Plan can potentially jeopardize and place at risk the operations, reputation, financial and legal status of ACMH. Consequently, upon reports of known or suspected violations of the Medicaid Compliance Plan or other reasonable indications of violations of the Compliance Plan, the CO will promptly investigate the conduct in question to determine whether a violation of the Medicaid Compliance Plan has occurred. If such a violation has occurred, corrective action will be implemented, and disciplinary action taken that is appropriate to the materiality of the violation. All affected parties are required to participate willingly and fully with all investigations.

7.2 Investigations

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 CO, internal or retained legal counsel, fiscal, contracted parties to include forensic accountants, and/or compliance auditors or any appropriate federal, state, or local government agency to include the NYS Office of Medicaid Inspector General (OMIG).

The CO will receive copies of all such investigations. Results from the investigations will not be filtered by someone outside of the compliance function.

Staff

- Notify EVP/CEO, SCC, and Governing Body.

- If the alleged non-compliance involves egregious activities by staff, Volunteers, interns, or contracted parties those individuals should be removed from contact with any Medicaid Plans/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	Reversals	Insurance contracts
Responses		Client insurance information

  - Contracts

Vendors	Employees	Payers

- The CO 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 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.
- Investigation must include interviews with staff and clients where appropriate. Witnesses must be present at the interviews and interviewees are entitled to representation.
- The investigative process and outcomes must be documented in an excel workbook that can be submitted in a self-disclosure to the regulatory Medicaid upon request. The investigative process must be transparent and without influence either internal or external to the provider organization.

Vendors

- Upon learning of suspected non-compliance, it is important to stop all payments to vendors related to any of the activities/parties/or services. This should be done immediately as part of the notification to the vendor of suspected noncompliance to include inclusion in an exclusion list.
- Notify executive staff and the Governing body.
- If the alleged non-compliance involves egregious activities by the vendor will be suspended from providing any services to Plans that bill or serve Medicaid individuals.
- The compliance Officer in conjunction with legal counsel will conduct the investigation to include:
    - Review of financial records
    - Review of service provision/delivery
    - Interview with Plan staff
    - Interviews with vendor
- Upon determination of noncompliance the CO will notify the Chief Executive and Governing body of the outcome. Any or some of the following actions may be taken:
    - Termination of contract
    - Revision of contract and service delivery
    - Refund to OMIG
    - Refund by Vendor to Agency
    - Reversal of over payment
    - Self-disclosure to OMIG

- Resumption of services

Governing Body

- Upon learning of suspected non-compliance by a member of the Governing Body any payments, invoicing, billing, and/or business practices suspected of being noncompliant will be suspended immediately pending results of a full investigation.
- Additionally.
  - Notify the Chief Executive
  - Notify the highest-ranking Governing body member not suspected of noncompliance. If this cannot be determined the full Governing body will be notified at once.
  - Engage Legal Counsel
  - Suspend the Governing body member (s) pending investigation.
- The CO in conjunction with legal counsel will conduct the investigation to include but not limited to:
  - Review of financial records
  - Review of service provision/delivery
  - Interview with Plan staff
  - Interviews with Governing body Members
- Upon determination of noncompliance the CO will notify the Chief Executive and Governing body of the outcome. Any or some of the following actions may be taken:
  - Termination of the Governing body members tenure
  - Refund to OMIG
  - Reversal of over payment
  - Self-disclosure to OMIG
  - Resumption of Governing Body Member tenure

7.3 Responsiveness

ACMH mandates that known or suspected noncompliance must be addressed promptly and thoroughly to include determining what corrective action is needed, prevention of recurrence, the reporting of credible evidence that a state or federal rules or regulation has been violated to the governing body and the returning of over payments.

7.4 Reduction of recurrence.

ACMH has an expectation that the Compliance Plan and activities are designed to reduce the potential for recurrence. Evidence of root cause analyses associated with compliance problems are followed by the implementation of new compliance policies and procedures or control systems that attempt to prevent the recurrence of compliance problems.

Once an investigation has identified a compliance problem and the investigation, root cause analysis and corrective action plan have been completed the CO will:

- Revise all policies and procedures to reflect CAP recommendations to prevent recurrence of noncompliance.

- Retrain identified individuals.
- Develop and implement episodic training throughout Medicaid Plans
- Schedule and perform audit of noncompliant activities 90 days post CAP implementation.
- Develop and submit report to Executives and Govern Governing body on activities and findings.

7.5 External Reporting

ACMH has a system in effect for identifying and reporting compliance issues to the NYS Department of Health or the NYS Office of Medicaid Inspector General. Once an overpayment of ***any amount*** has been identified ACMH they will report to NYS OMIG within 60 days of identification of the overpayment. The CO will go to the NYS OMIG website for self-disclosures and commence submission of the self-disclosure form online.

https://www.omig.ny.gov/self-disclosure

Once an overpayment has been identified the compliance officer will commence repayment.

- Under $5,000.00
  1. The CO will notify the biller of the need to perform a reversal in the next billing cycle.
     - Submit a spread sheet listing all claims that need to be reversed.
  2. The biller will send documentation of the reversals to the CO once it is complete.
  3. The CO will document all reversals in the compliance log.
  4. The compliance Officer will include all reversals in compliance reporting.
  5. The CO will submit the self-disclosure form via OMIG web portal.
  6. Once contacted by OMIG the CO will assist in any way with the completion of the self-disclosure process and eventual recoupment by OMIG of overpayments.
  7. The CO will document the self-disclosure and recoupment in the compliance log.
  8. The compliance Officer will include all self-disclosures and recoupment in reporting.
- $5,000.00 and Above
  1. No reversals should be performed, and CO may start at step 5.
- Penalty for non-repayment
  1. There shall be a monetary penalty for any provider or any person who fails to report return and explain an identified overpayment received from the Medicaid Plan.
  2. Once OMIG has completed its review and verified the amount of the overpayment OMIG shall notify ACMH of the amounts of the overpayment and interest if applicable, and such notification shall contain instructions for remitting payment.
  3. Interest may be waived in the sole discretion of OMIG.
  4. ACMH shall remit the full amount of the overpayment and interest within fifteen (15) days of the date of OMIG's notification of the determination of the amount of the overpayment, and interest unless ACMH has been approved by OMIG to repay the overpayment through installments.
  5. IF ACMH has been approved to repay the overpayment and interest through installment payments, OMIG's notification of the amount of the overpayment shall also include an SDCA which the compliance officer or other designated signer at ACMH shall execute and return to OMIG within the timeframe specified.

Element 8: Non-Intimidation and Non-Retaliation

As documented by New York State Social Services Law §363-d and 18 NYCRR 521.3, ACMH must create, maintain, and enforce a policy of non-intimidation and non-retaliation. In accordance with New York State Labor Laws §§ 740, 741, ACMH does not discharge, suspend, demote, or otherwise retaliate against an employee because the employee discloses an unlawful activity, policy or practice that presents a danger to public health or safety to a supervisor or to a government body. Following these laws and regulations fosters the good faith participation of employees in the compliance Plan, meaning that employees feel comfortable reporting possible violations accurately and in a timely matter because they do not fear grave repercussions.

8.1 Policy of non-intimidation and non-retaliation

ACMH ‘s policy for non-intimidation and non-retaliation for good faith participation in the Compliance Plan, includes: a) reporting potential issues; b) investigating issues; c) self-evaluations; d) audits; e) remedial actions, and f) reporting instances of intimidation or retaliation to appropriate officials as provided in sections 740 and 741 of the NYS Labor Law, and g) reporting potential fraud, waste, or abuse to the appropriate State or Federal Entities.

The ACMH's Compliance Plan follows the Federal False Claims Act's qui tam provision, also referred to as the “whistleblower” provision as well as NYS Labor Laws 740 and 741 on non-intimidation and non-retaliation to protect individuals from intimidation and retaliation and maintains confidentiality in respect to all concerns raised. All affected parties may not be intimidated or retaliated against for good faith participation in the compliance Plan, including but not limited to:

- Reporting potential issues
- Investigating issues
- Self-evaluations
- Audits
- Remedial actions
- Reporting to appropriate officials as provided in sections NYS Labor Law 740 and 741 in connection with non-intimidation and non- retaliation expectations.

To engage in any intimidation and retaliation activities including but not limited to harassment, blackmail, theft of property, and termination. Any individual(s) who engages in such retribution, intimidation, retaliation, or harassment is subject to discipline, in accordance with his or her level of intimidation or retaliation, up to and including termination/removal. For contractors and vendors, such actions may lead to the termination of the contract under which their services are provided to ACMH.

ACMH management will ensure that there is no intimidation or retaliation taken against an affected party for reporting what an affected party reasonably believed to be a violation of the Medicaid Compliance Plan. However, in those circumstances where ACMH has reasonably concluded that the affected party knowingly fabricated, distorted, exaggerated, or minimized a report of a violation to either damage another individual, to protect himself/herself or others, or if the report contains admissions of personal wrongdoing, ACMH 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.

9.0 Records, Documentation, and Billing

Privacy and Confidentiality

ACMH 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, ACMH has specific guidelines for responding to requests for information [see Plan policies and procedures].

Accuracy of Records

ACMH expects its affected parties to maintain and administer records with accuracy, reliability, and honesty always and in all circumstances. Specifically, ACMH's affected parties are required to make every effort to ensure the accuracy of their own work and report inaccuracies in any ACMH record of which they are aware or suspect. Affected parties are prohibited from creating any documentation in the records of ACMH that to the best of their knowledge is incomplete, inaccurate and/or fraudulent.

Records Retention

ACMH administers a records management plan to ensure that its records are maintained and stored in accordance with various records retention standards and requirements documented in ACMH Records Retention and Destruction Policy. Among other records, which are part of the records management Plan, ACMH 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

ACMH expects that all affected parties 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 ACMH policies. Specifically, ACMH requires its applicable affected parties to:

- Bill only for healthcare services provided and seek only the amount to which ACMH is entitled. ACMH will not tolerate billing by ACMH that misrepresents the healthcare services provided.
- Prepare supporting documentation for all healthcare services provided to Persons Served. ACMH 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 ACMH 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, ACMH will direct those issues to the Compliance Officer.

- Applicable staff participation in training on ACMH policies and applicable law regarding those activities for which ACMH is responsible with respect to coding, billing, and documentation.

APPENDICIES

Appendix 1-

Self-Disclosure Plan PART 521-3:

521-3.1 Scope and applicability.

(a) Scope.

(1) Social Services Law section 363-d(7)(e) of the Social Services Law requires persons who have received an overpayment under the MA Plan to report, return and explain the overpayment to the department and the Office of Medicaid Inspector General ("OMIG").

(2) A person satisfies their obligation to report, return and explain by making a disclosure through OMIG's Self -Disclosure Plan, complying with the requirements as specified in section 521-3.4 of this SubPart, and returning the overpayment and interest to the department in accordance with the provisions of section 521-3.5 of this SubPart.

(b) Applicability. This SubPart applies to persons who have received an overpayment under the MA Plan.

(c) Related requirements. 42 U.S.C. § 1320a-7k(d) requires persons who have received an overpayment from the MA Plan to report, return and explain the overpayment to the Federal Department of Health and Human Services, the State, or appropriate fiscal intermediary.

521-3.2 Definitions.

(a) For purposes of this SubPart, the terms defined in Parts 504 and 515 of this Title, and SubPart 521-1 of this Part, except as otherwise noted, shall apply.

(b) In addition, for the purposes of this SubPart, the following terms have the following meanings:

(1) "Managed long-term care plan " means an entity that has received a certificate of authority pursuant to section 4403-f of the Public Health Law to provide or arrange for health and long-term care services on a capitated basis for a population which the plan is authorized to enroll.

(2) "MMCO" means:

i. a managed care provider as defined in in subdivision 1 of section 364-j of the Social Services Law; and
ii. a managed long-term care plan.

(3) "Overpayment" has the same meaning as used in subdivision (c) of section 518.1 of this Title.

(4) "Person " means:

i. a provider as defined in section 504.1 of this Title.
ii. an MMCO, and any subcontractors or network providers of an MMCO; and
iii. does not include MA Plan recipients.

(5) "Self-Disclosure and Compliance Agreement " or "SDCA" means the stipulation of settlement between OMIG and a person who agrees to repay the MA Plan the amount of the overpayment and interest in

accordance with the provisions of section 518.4 of this Title through installment payments and/or agrees to implement corrective action to prevent recurrence of the conduct giving rise to the overpayment.

521-3.3 Reporting and returning overpayments.

(a) General. Any person who has received an overpayment under the MA Plan, directly or indirectly, shall report, return, and explain the overpayment by submission of a Self-Disclosure Statement to OMIG's Self -Disclosure Plan pursuant to section 521-3.4 of this SubPart.

(b) Deadline for reporting and returning overpayments.

(1) If a person has received an overpayment under the MA Plan, the person shall report and return the overpayment and interest if applicable to the department, and explain the reasons for the overpayment to OMIG by the later of:

(i) the date which is sixty (60) days after the date on which the overpayment was identified; or

(ii) the date any corresponding cost report is due, if applicable.

(2) Pursuant to paragraph (b) of subdivision 6 of section 363-d of the Social Services Law, a person has identified an overpayment when that person has or should have through the exercise of reasonable diligence, determined that they have received an overpayment and quantified the amount of the overpayment.

(3) Where a person fails to exercise reasonable diligence, and the person in fact received an overpayment, they shall be subject to any enforcement action authorized by section 521-3.7 of this SubPart and any applicable provisions of federal and state law, including but not limited to Article XIII of the New York State Finance Law.

(4) Pursuant to paragraph (c) of subdivision 6 of section 363-d of the Social Services Law, the deadline for reporting, returning, and explaining an overpayment shall be tolled when OMIG acknowledges receipt of a submission of a Self-Disclosure Statement to its Self-Disclosure Plan pursuant to section 521-3.4 of this SubPart, and shall remain tolled until such time:

(i) that an SDCA, in accordance with subdivision (e) of section 521-3.4 of this SubPart, is executed by both the person reporting, returning, and explaining the overpayment and OMIG, if applicable.

(ii) the person withdraws from the Self-Disclosure Plan.

(iii) the person repays the full amount of the overpayment along with any interest due, as determined by OMIG after review of a person's disclosure, in accordance with the provisions of section 521-3.5 of this SubPart; or

(iv) OMIG terminates, pursuant to subdivision (f) of section 521-3.4 of this SubPart, the person's participation in the Self-Disclosure Plan.

(5) For an overpayment made by an MMCO to the person under the MA Plan. A person who reports, returns, and explains an overpayment to an MMCO, in accordance with the provisions of subdivision (f) of section 521-2.4 of this Part shall be considered to have satisfied the requirements of subdivision 6 of

section 363-d of the Social Services Law, provided that the overpayment is reported and returned to the MMCO by the deadline specified in paragraph (1) of this subdivision.

521-3.4 Self-Disclosure Plan.

(a) General. Pursuant to subdivision 7 of section 363-d of the Social Services Law, the OMIG's Self - Disclosure Plan is the process by which persons who have identified an overpayment under the MA Plan report, return and explain overpayments to the MA Plan. Persons required to report, return, and explain overpayments pursuant to section 521-3.3 of this SubPart shall submit information regarding the overpayment to OMIG and make repayment in the form and manner set forth in this section.

(b) Self-Disclosure Plan - General Provisions.

(1) Eligibility. A person is eligible to participate in the Self-Disclosure Plan if:

(i) the person is not currently under audit, investigation, or review by OMIG. If the person is under audit, investigation, or review, but the overpayment being disclosed does not relate to the existing audit, investigation, or review the person shall be eligible to participate. For purposes of this paragraph, an audit, investigation, or review includes, but is not limited to, Parts 515, 516, 517, 518 and 521 of this Title.

(ii) the person is disclosing an overpayment and related conduct that OMIG has not identified at the time of the disclosure.

(iii) the overpayment and related conduct are reported by the deadline specified in paragraph (1) of subdivision (b) of section 521-3.3 of this SubPart; and

(iv) the person is not currently a party to or the subject of any criminal investigation, related to their participation in the MA Plan, being conducted by the MFCU or an agency of the United State Government or any political subdivision thereof.

(2) For persons eligible to participate in the Self-Disclosure Plan, pursuant to paragraph (1) of this subdivision, OMIG, in its sole discretion, after a written request from an eligible person participating in the Self-Disclosure Plan, may:

(i) waive the imposition of interest on the amount of the overpayment, in whole or in part.

(ii) permit repayment through installments pursuant to an SDCA.

(iii) in accordance with the provisions of subdivision 18 of section 32 of the Public Health Law, consider the person's reporting and returning overpayments as a mitigating factor in the determination of an administrative enforcement action; and

(iv) for persons subject to the provisions of SubPart 521-1 of this Part and in accordance with section 363-d of the Social Services Law, consider the person's reporting and returning overpayments as a factor in determining whether the person has adopted and implemented an effective compliance Plan.

(3) Regardless of eligibility, if the person has determined that they have received an overpayment pursuant to section 521-3.3 of this SubPart, the person shall submit a Self- Disclosure Statement pursuant to subdivision (c) of this section.

(4) If OMIG determines that a person is ineligible, it shall notify the person of this determination in writing, in accordance with the requirements of subdivision (a) of section 521-3.6 of this SubPart.

(c) Self-Disclosure Statement.

As a condition of participation in the Self-Disclosure Plan, the person shall apply by the submission of a self-disclosure statement, cooperate, and furnish any information requested, including any additional data, documentation, or information requested by the OMIG needed to confirm the overpayment. A self-disclosure submission related to a Medicaid program overpayment requires completion of either a Self-Disclosure Full Statement (including a Claims Data File of affected Medicaid claims or Mixed Payer Calculation form for Excluded providers) or a completed Self-Disclosure Abbreviated Statement. Determination of which form to be completed should be based on the error identified.

(1) Self-Disclosure Full Statement

Self-Disclosure Full Statement examples include but are not limited to:

- An error that requires a Provider to create and implement a formal corrective action plan;
- Actual, potential or credible allegations of fraudulent behavior by employees or others;
- Discovery of an employee on the Excluded Provider list;
- Documentation errors that resulted in overpayments;
- Systemic billing or claiming issues;
- Overpayments that resulted from software or billing system updates;
- Overpayments that involved more than one Medicaid entity/Provider (example- Health Homes & Care Management Agencies
- Any error with substantial monetary or program impacts;
- Any instance upon direction by OMIG

(A) To participate in a Self-Disclosure Full Statement, a person shall submit a statement which shall contain the following information:

(i) An estimate of the amount of the overpayment. The person shall calculate the estimated overpayment and provide information to OMIG which supports the calculated overpayment amount. OMIG has the sole discretion to approve the methodology used for the calculation and to determine the overpayment amount and interest if applicable.

(ii) A detailed explanation of the reason the person received the overpayment, which shall, at a minimum include:

a. a description and explanation of the circumstances that gave rise to the overpayment.
b. how the circumstances giving rise to the overpayment were discovered.
c. Identification of any rule, policy, regulation or statute that was violated
d. Identification of the individuals involved in the error and discovery of the error
e. The type of Medicaid program affected
f. the date the overpayment was identified.

g. how the person calculated the amount of the overpayment.
h. the date(s) the overpayment(s) were received; and
i. the action taken to correct the error which caused the overpayment.

(iii) the person's contact information.

(iv) data file, in the form and format specified by OMIG.

(v) whether the person is requesting to repay through installment payments.

(vi) whether the person is requesting a waiver of any applicable interest.

(vii) the person's agreement to return the full amount of the overpayment and interest if applicable, as determined by OMIG; and

(viii) any other data, documentation, or information OMIG shall require through the issuance of guidance or in response to its review of the submission.

(B) The Self-Disclosure Statement shall be signed by the person's compliance officer, where the person is a required provider pursuant to SubPart 521-1 of this Part. Where the person is not a required provider pursuant to SubPart 521-1 of this Part, the Self-Disclosure Statement may be signed by one of the following, the person's chief executive officer, chief operating officer, a senior manager of the person, or the person, where the person is a sole practitioner.

(C) A person requesting to repay through installment payments may be required to furnish OMIG with financial records and other documentation in support of the request. OMIG shall approve or reject a person's request based on a review of the person's financial documentation, participation in the MA Plan, and any other factors OMIG identifies.

(D) If OMIG determines that no overpayment was made, it shall notify the person in writing of the determination.

(E) A person who has received and disclosed an overpayment or has received notice of the overpayment amount due, and interest if applicable, pursuant to section 521-3.5 of this SubPart is required to return the overpayment and interest if applicable, in accordance with section 521-3.3 of this SubPart.

(2). Self-Disclosure Abbreviated Statement

Self-Disclosure Abbreviated Statement examples include but are not limited to:

- Routine credit balance/coordination of benefits overpayments;
- Typographical human errors;
- Instance of missing or faulty authorization for services due to human error;
- Instance of missing or insufficient support documentation due to human error;
- Inappropriate rate, procedure or fee code used due to typographical or human error;
- Routine recipient enrollment issue

(A) Disclosures using the Self-Disclosure Abbreviated Statement must include:

a. Provider Federal Employer Identification Number (FEIN)
b. Provider Name

c. Contact Name, title, phone number and email
d. Overpayment Identification Period
e. TCN(s) of voided or adjusted claim(s)
f. Overpayment reason for each voided or adjusted claim
g. Total amount voided or adjusted during the identification period

(d) Review of Accepted Self-Disclosures.

(1) OMIG shall acknowledge receipt and review the Self-Disclosure Statement and consider any written requests made pursuant to paragraph (2) of subdivision (b) of this section and shall complete a preliminary review within twenty (20) days of the submission. The deadline to report, return and explain shall be done, in accordance with the provisions of subdivision (b) of section 521-3.3 of this SubPart, from the date the submission was acknowledged by OMIG until completion of OMIG's preliminary review. Upon completion of its preliminary review, OMIG shall notify the person, in accordance with the notice provisions of subdivision (a) of section 521-3.6 of this SubPart, and either accept the submission or return the submission as incomplete and identify the information and data needed to complete the submission. Only a submission that is acknowledged and accepted shall continue to toll the deadline to report, return and explain, in accordance with the provisions of subdivision (b) of section 521-3.3 of this SubPart, from the date the submission was acknowledged by OMIG. OMIG's acceptance of the person's submission of a Self -Disclosure Statement is conditioned upon the person's cooperation with OMIG under the Self-Disclosure Plan, including any request for additional information or data under paragraph (2) of this subdivision.

(2) OMIG may, at any time, request additional information or data from the person who submitted the Self-Disclosure Statement. Such requests will be made in writing in accordance with subdivision (a) of section 521-3.6 of this SubPart. The person shall respond with such information and data within fifteen (15) days of the date of OMIG's notice.

(i) OMIG may extend the period to respond for good cause. Any request by the person to extend the period to respond shall be made in writing to OMIG and any approval or denial of the extension request shall be made by OMIG, in writing, in accordance with the provisions of subdivision (a) of section 521-3.6 of this SubPart.

(ii) Failure by the person to respond within fifteen (15) days or by any extended deadline will result in the submission being deemed not accepted and returned to the person as incomplete, and any tolling of the deadline to report, return and explain shall be terminated. OMIG will notify the person in writing, in accordance with the provisions of subdivision (a) of section 521-3.6 of this SubPart, that the submission has not been accepted, and the notice shall include the date on which the submission was deemed not accepted and the tolling of the deadline to report, return and explain was terminated.

(3) Once OMIG has accepted the submission of a self-disclosure statement and determined that the submission is complete, OMIG will review and verify the amount of the overpayment and issue a notification, in accordance with subdivision (a) of section 521-3.6 of this SubPart, to the person of the overpayment amount due, including interest if applicable, and instructions for repayment.

(e) Self-Disclosure and Compliance Agreement.

(1) The SDCA is a binding contract between the person and OMIG. A person may be eligible for an SDCA based on the conduct being disclosed and/or where the person has requested to repay the determined overpayment amount through installments. The overpayment amount shall include interest unless interest is waived, at the sole discretion of OMIG.

(2) The SDCA shall include, at a minimum, the following terms, and conditions:

(i) Agreement by the person to repay the amount of the overpayment and interest if applicable, as determined by OMIG, which is the subject of the disclosure.

(ii) If approved by OMIG for installment payments, agreement to make all installments payments on time, and in accordance with the repayment schedule.

(iii) Identification of, and agreement by the person to implement any corrective actions to prevent the issues which caused the person to receive an overpayment from the MA Plan from recurring.

(3) The person shall execute and return the SDCA, which must be received by OMIG within fifteen (15) days of the person receiving said agreement from OMIG, or such other timeframe as OMIG may permit, provided that such period shall not be less than fifteen (15) days.

(4) If the person fails to execute and return the SDCA to OMIG within the timeframe specified in paragraph (3) of this subdivision the person's participation in the Self-Disclosure Plan shall be terminated. Notice of such termination shall be provided in accordance with paragraph (2) of subdivision (f) of this section.

(5) OMIG shall have the authority to enter an SDCA with a person making a Self- Disclosure, in its sole discretion.

(f) Termination of participation.

(1) In accordance with subparagraph (4) of subdivision 7 of section 363-d of the Social Services Law a person's participation in the Self -Disclosure Plan shall be immediately terminated if:

(i) Providing false material information in any disclosure documents

(ii) Failure to cooperate in validating the overpayment amount disclosed

(iii) Intentional omission of material information from any disclosure documents, including the failure to submit a completed Self-Disclosure Full Statement when directed

(iv) Failure to pay the overpayment amount and interest as agreed

(v) Failure to execute the SDCA

(vi) Violation of the provisions detailed in the SDCA

(2) If OMIG terminates a person's participation in the Self -Disclosure Plan it shall issue a notice to the person within five (5) business days of its determination. The notice shall be mailed to the person's designated payment address or correspondence address, or address provided on the Self-Disclosure Statement submitted pursuant to subdivision (c) of this section. The notice shall contain:

i. the reason for the termination and the legal authority for the action taken.
ii. the effective date of the termination.
iii. the overpayment amount and interest due.
iv. the due date of the overpayment amount and interest.
v. the date on which the tolling of the return of the overpayment amount ends.
vi. notification that the overpayment and interest amount may be recovered in accordance with Part 518 of this Title; and
vii. notification that failure to return the overpayment and interest amount by the due date may result in monetary penalties pursuant to section 145-b(4) of the Social Services Law and Part 516 of this Title, and any other sanction or penalty authorized by law.

521-3.5 Returning the overpayment.

(a) Once OMIG has completed its review and verified the amount of the overpayment OMIG shall notify the person of the amount of the overpayment and interest if applicable, and such notification shall contain instructions for remitting payment to the department. Interest may be waived in the sole discretion of OMIG.

(1) The notification will be issued in accordance with the provisions of subdivision (a) of section 521-3.6 of this SubPart.

(2) The person shall remit the full amount of the overpayment and interest within fifteen (15) days of the date of OMIG's notification of the determination of the amount of the overpayment, and interest, unless the person has been approved by OMIG to repay the overpayment through installments.

(3) Where a person has been approved to repay the overpayment and interest through installment payments, OMIG's notification of the amount of the overpayment shall also include an SDCA which the person shall execute and return to OMIG within the timeframe specified in paragraph (3) of subdivision (e) of section 521-3.4 of this SubPart.

(i) In order to remain eligible to participate in OMIG's Self -Disclosure Plan the person must comply with all the terms of the SDCA, including the schedule of repayments.

(4) Notwithstanding any provision tolling the deadline to report, return and explain, in no event shall the person be required to repay the full amount of the overpayment and interest prior to the expiration of the deadline to report, return and explain, as set forth in paragraph (1) of subdivision (b) of section 521-3.3 of this SubPart.

(b) The full amount of any overpayment shall become immediately due and payable, with interest, if:

(1) the person fails to remit payment, either for the full amount of the overpayment or any scheduled installment payment pursuant to the terms of an SDCA, or

(2) participation in the Self-Disclosure Plan is terminated in accordance with the provisions of subdivision (f) of section 521-3.4 of this SubPart.

(c) Where the person is required to pay interest, interest shall accrue on the amount of the overpayment as determined by OMIG, in whole or in part, in accordance with the provisions of section 518.4 of this Title.

(d) OMIG may recover the overpayment in accordance with Part 518 of this Title or by any other mechanism authorized by law.

521-3.6 Notification.

(a) Any notification issued by OMIG to the person under this SubPart shall meet the following requirements:

(1) Notification shall be made by sending written notification to the person at:

(i) the person's designated payment address or correspondence address or address

provided on the Self-Disclosure Statement submitted pursuant to subdivision (c) of section 521-3.4 of this SubPart; or

(ii) an email address designated on the Self-Disclosure Statement if the person so designates that email address for receipt of electronic communication. It shall be the obligation of the person electing to receive notification electronically to provide and maintain a valid email address with OMIG. Proof of such email, containing a time and date stamp, shall constitute sufficient notification that the electronic communication was received by the person making such Self-Disclosure.

(2) Notwithstanding the option of a person making a Self-Disclosure under this SubPart to select electronic notification, any notice pursuant to paragraph (2) of subdivision (f) of section 521-3.4 of this SubPart shall be mailed to the person's designated payment address or correspondence address or address provided on the Self-Disclosure Statement submitted pursuant to subdivision (c) of section 521-3.4 of this SubPart.

(3) Notification mailed to the person's designated payment address or correspondence address, or address provided on the Self-Disclosure Statement submitted pursuant to subdivision (c) of section 521-3.4 of this SubPart shall be assumed to be received five (5) business days from the date on the notification.

(b) OMIG shall provide the department with information and notices upon request and in periodic reporting at least monthly concerning providers who have received notification:

(1) that they are ineligible to participate in the Self-Disclosure Plan pursuant to paragraph (4) of subdivision (b) of section 521-3.4 of this SubPart.

(2) that their Self-Disclosure is not accepted pursuant to subparagraph (ii) of paragraph (2) of subdivision (d) of section 521-3.4 of this SubPart; and

(3) of the amount of the overpayment and interest due pursuant to subdivision (a) of section 521-3.5 of this SubPart.

521-3.7 Enforcement.

(a) A person who fails to report, return, and explain an overpayment by the deadline specified in subdivision (b) of section 521-3.3 of this SubPart may be subject to monetary penalties pursuant to section 145-b(4) of the Social Services Law and Part 516 of this Title, and any other sanction or penalty authorized by law.

Disclosing Damaged, Lost or Destroyed Records

Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self=Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

(a) A submission for lost, destroyed or damaged records requires completion of a Statement of Lost or Destroyed Records form and submission of any accompanying documentation to support the report of loss or damaged records.

(b) OMIG Requires:
- A detailed explanation of the event that caused the loss, destruction, or damage of records and
- Identification of the records affected including document type, Medicaid recipients affected, dates of service; etc and
- Identification of the steps taken to report the lost, destroyed or damaged records.

(c) OMIG Response- A notification letter detailing the acceptance of the report will be issued to the provider or the provider's authorized representative.

(d) Recordkeeping- OMIG's recipt and acknowledgement of a provider's Self-Reporting Notification does not absolve the provider of its recordkeeping responsibilities. The paid claims and/or program associated with the lost/destroyed records remain available for audit, review or investigation. OMIG will evaluate whether there are mitigating circumstances for the failure to maintain these documents in conjunction with any audit, review or investigation that involves the reportedly lost/destroyed records.

Appendix 2
COMPLIANCE PLAN CONTACT INFORMATION

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

Compliance Officer: Michele Miller, LCSW, CHC Email-mmiller@acmhnyc.org

Senior Vice President/CEO: Daniel Johansson Email-djohansson@acmhnyc.org

Compliance Fax- 212-465-0610

Compliance phone -212-274-8558 ext.250*Entering *67 prior to dialing ensures an anonymous call that does not include a caller ID*

Compliance mailing address: 254 West 31st Street, 2nd Floor, New York, NY 10001

Appendix 3 CODE OF CONDUCT

Applicability

This policy applies to all Affected Parties, defined as all persons who are affected by the Agency's risk areas and includes, all employees, chief executives/senior administrators, contractors, managers, subcontractors, independent contractors, governing body, and corporate officers.

Employees and all Affected parties must not engage in or refuse to engage in any conduct that is contrary to this policy.

ACMH Commitment

ACMH is committed to providing consumers and their families with quality behavioral health and rehabilitative services. It is the policy of ACMH to comply with the letter and spirit of all applicable federal and state law and regulatory requirements consistently and fully. It is the duty of the ACMH and all affected parties to comply with all federal and state standards and conduct all business in a legal and ethical manner. This Code of Conduct is intended to comply with the requirements of the Deficit Reduction Act, the False Claims Acts and requirements outlined in NYS part 521 regulation and law.

ACMH Compliance Program Expectations

- **Billings:**
  - o All claims submitted to a payer are accurate and complete supported by appropriate documentation in the record

- **Payments:**
  - o Payments received from payers are appropriate and accurate.

- **Ordered Services:**
  - o Accurate and appropriate documentation is contained within the record regarding the individual/entity ordering the services and it follows regulation and an individual's scope of practice

- **Medical Necessity**
  - o Consumers meet the eligibility requirements for services
    - the need for admission and continued stay in the service is clearly documented
    - Evidence of progress in that the consumer is benefitting from the service

- **Quality of Care**:
  - o Quality services are provided throughout all ACMH programs and services

- **Governance:**
  - o The ACMH Board of Directors is charged with providing high level oversight of ACMH activities and performance; ensuring accountability of executive leadership and the organization.

- **Mandatory Reporting:**
  - o Duty to Report: ACMH and its affected parties must adhere to the requirement to report observed or suspected fraud, waste, or abuse

- **Credentialing:**
  o Staff providing services are appropriately credentialed. Consumers of ACMH services receive the highest level of care from qualified individuals.

- **Contractor, subcontractor, or independent contractor oversight:**
  o Contractors, subcontractors or independent contractors support and are privy to the ACMH Compliance Program.
  o ACMH maintains oversight of all persons or companies (related to ACMH Risk Areas) and ensures they are knowledgeable of the ACMH Compliance Program and expectations.

- **Clearance through Federal and State Exclusion Lists**
  o Medicaid/Medicare seeks to ensure that the medical providers participating in the program are professional, ethical and provide recipients with quality healthcare services. When it is determined that a provider should no longer be eligible to participate in the program due to unethical behavior, the individual or entity is placed on a list of excluded providers.
  o Individuals or entities (excluding client trainees) who are on the State or Federal Exclusion List are prohibited from being employed by or contracting with ACMH in any capacity.
  o Prior to hire and every 30 days thereafter, ACMH checks the OIG (Federal) and OMIG (State) exclusion Lists to ensure that ACMH affected parties are not excluded from participation in Medicaid, Medicare, or other federal health care programs.

Duty to Report

o Affected Parties are required to report any suspected fraud, waste or abuse or other improper activity as soon as they suspect or become aware of it.
o Affected Parties are required to report conduct that is observed or discovered that is contrary or inconsistent with ACMH Standards of Conduct, agency procedures, rules regulations or the law
o How to Report:

- Contact your supervisor and/or Managing Director
- Contact the ACMH Compliance Officer at 212- -274-8558 ext 218
- Report Anonymously at *67 1-212-274-8558 ext.250
- Report via email at mmiller@acmhnyc.org

Policy on Non-Retaliation/Whistleblower Provisions:

- No individual or affected other who in good faith reports any action or suspected action taken by or within ACMH that is illegal, fraudulent, or in violation of any adopted policy of ACMH shall suffer intimidation, harassment, discrimination, or other retaliation, or in the case of employees, adverse employment consequences.
- Intimidation and retaliation are also prohibited against an affected other for refusing to carry out any activity that is the subject of a report made under this policy in good faith. No employee or affected other may threaten to retaliate against another individual for filing a report.
- Prohibited retaliation includes, but is not limited to; termination, suspending, demoting, or failing to consider for promotion, harassing or reducing compensation of an employee due to the employees intended or actual filing of a report under this policy. Retaliation is prohibited even if it is determined that the alleged improper conduct was proper or did not occur, provided that the report was made in good faith.

• ACMH reserves the right to take disciplinary action on any affected individual who maliciously files a report he or she knows to be untrue.

Affected Parties' Responsibilities in the ACMH Compliance Program

- Ensure that all service documentation is accurately documented.
  - Never document a service that was not rendered
  - Never willfully misrepresent the date on which a service was provided
- Ensure that all service documentation is documented in real-time and demonstrates the unique details of the service interaction.
  - Never copy and paste information related to any consumer interaction

  Ensure prior to any claim submission that a service was rendered and accurately documented.
  - Never bill for services not rendered
- Ensure that all required documentation is maintained and accurate in support of claims made to Medicaid or other payers.
- Ensure that Medicaid is only billed as the payer of last resort.
  - Never Bill Medicaid when the individual has other primary insurance which covers the service
- Ensure consumer is eligible for services and benefits are in place prior to claim submission.
  - Never submit a false claim related to the eligibility of an individual to receive benefits
- Ensure the accuracy of all costs or cost reports filed with government agencies or private funders.
  - Never inflate or misrepresent agency costs on cost reports filed with government agencies or private funders
- Ensure medically necessary healthcare services are provided to all consumers.
  - Never intentionally deny or restrict access to medically necessary healthcare services to which the agency is responsible
- Ensure Medicaid/Medicare/Medicaid Managed Care coverage for each consumer.
  - Never bill Medicaid/Medicare for a client if the employee is aware that the client or his or her family obtained coverage fraudulently
- Ensure the accuracy of all reports submitted to a government agency.
  - Never submit inaccurate or misleading data or reports to a government agency or other funder
- Ensure all funds received from payers are used in a manner consistent with the payer's requirements.
  - Never use grant funds from government agencies in a manner inconsistent with requirements
- Ensure the appropriate use of all agency funds.
- Ensure compliance with all laws, regulations, or government contracts.

Structure of the ACMH Compliance Program

1. Written Policies and Procedures:
2. Compliance Officer and Compliance Committee:
3. Required Training and Education
4. Lines of Communication
5. Disciplinary Standards for Violation of the Compliance Program
6. Auditing and Monitoring

7. Response to Compliance Issues

Willful violation of the ACMH Compliance Policy
o Will result in immediate disciplinary action up to and including termination of employment or contract.

Federal and State Laws
NYS Social Services Law §145(b): False statements
https://codes.findlaw.com/ny/social-services-law/sos-sect-145-b.html#:~:text=%C2%A7%20145%2Db-,New%20York%20Consolidated%20Laws%2C%20Social%20Services%20Law%20%2D%20SOS%20%C2%A7%20145,statements%3B%20actions%20for%20treble%20damages&text=Welcome%20to%20FindLaw's%20Cases%20%26%20Codes,and%20the%20United%20States%20Code.
NYS Social Services Law §366-B: Penalties for Fraudulent Practices:
https://law.justia.com/codes/new-york/2022/sos/article-5/title-11/366-b/
The Deficit Reduction Act of 2005 (DRA): 18 NYCRR § 1396-a(a)(68)
https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf
Federal False Claims Act (FCA) (Title 31 United States Code § 3729- 3733):
https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf
NYS False Claims Act
https://www.cdphp.com/-/media/files/home/false_claims_act_relevant_statutes.pdf

Definitions
Fraud: Intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person

NYS Office of Medicaid Inspector General (OMIG) The Office of Medicaid Inspector General (OMIG) is an independent entity created within the NYS Department of Health to promote and protect the integrity of the Medicaid Program in NYS. OMIG conducts and coordinates investigations, detection, audit and review of Medicaid providers and recipients to ensure compliance with law and regulation.

Office of Inspector General (OIG)
Independent entity in the US Department of Justice whose mission is to promote integrity , efficiency, and accountability within the Department of Justice. Forefront of the nation's efforts to fight waste, fraud, and abuse to improve the efficiency of Medicaid, Medicare and the Department of Health and Human Services Programs.

ACMH requires the individual signing this Code of Conduct to report any known or suspected non-compliance, read and understand ACMH Compliance Plan and ask questions of the Compliance Officer when they are uncertain on how to proceed.
By signing this document, I agree to abide by all components of the Code of Conduct.

____ ____________________

Printed name Date

____

Signature

Appendix 4

ACMH COMPLIANCE PLAN ACKNOWLEDGEMENT FORM:

ACMH, Inc.
Training Attestation Form (TAF)
Compliance Plan Acknowledgement Form

I, _________________________acknowledge that I have received a copy of __paper ___ electronic and I am aware that it is located in the shared directory. I have reviewed ACMH Medicaid Compliance Plan. 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 any issues that I know or suspect to be a violation of the Compliance Plan. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ASK QUESTIONS/SEEK GUIDANCE WHEN I AM UNSURE OF A COMPLIANCE MATTER.

Signature: _______________________________________

Date: _______________________________________

Appendix 5

OMIG report form

New York State Office of the Medicaid Inspector General - Bureau of Medicaid Fraud Allegations (BMFA)

800 North Pearl Street, Albany, NY 12204

Email: BMFA@omig.ny.gov Phone: 877-873-7283 FAX: 518-408-0480

Allegation Date: _______________

YOUR INFORMATION: I would like to be considered:

CONFIDENTIAL (Your information is kept private, but your identity is known to OMIG. This allows OMIG to contact.

you to obtain additional information or clarify your allegation.)

ANONYMOUS (no personal information is provided/known to OMIG-BMFA)

Name: ____

Address: ____________________________________ City: ___________________ State: ________ ZIP: _________________

Phone: ( ) ____________________ Email: ________________________________ MEDICAID ID#:___________________

THE ALLEGATION IS AGAINST : Provider MEDICAID Recipient

Name: Provider ID/License# or MEDICAID ID# _____________________

Address: ____________________________________ City: ______________________ State: __________ ZIP:_____________

County: DOB: SS#

Phone: ( ) _________________________ Email: ____

ALLEGATION:

FIGHTING FRAUD ○ IMPROVING INTEGRITY AND QUALITY ○ SAVING TAXPAYER DOLLARS