Corporate Compliance Plan

Revised January 2024

The Mental Health Association of Nassau County, Inc. (the "Agency") receives funds to operate programs that provide services to vulnerable individuals. This Corporate Compliance Plan has been developed to protect clients from abuse and to prevent fraud within the Agency. This Corporate Compliance Plan must be followed by all persons working for or in conjunction with the Agency.

This Agency will only conduct business in an ethically acceptable manner and in ways that comply in all respects with the various local, state, and federal rules, regulations, and requirements that apply to it.

In accordance with that directive, the Agency's Corporate Compliance Plan is a systematic effort to prevent, detect, and report violations of law throughout the Agency. The purpose of Corporate Compliance is to ensure that all affected individuals such as employees, Board of Directors, consultants, Business Associates, vendors and contractors of the Agency conduct themselves in conformance with ethical standards and all applicable legal requirements.

The Agency's Corporate Compliance Plan consists of seven (7) core elements:

1. Written Policies, Procedures and Standards of Conduct;
2. Assignment of a Compliance Officer/Corporate Compliance Committee;
3. Compliance Education and Training for affected individuals;
4. Free and open Communication with the Corporate Compliance Officer;
5. Discipline for failure to report suspected fraud, which may enable non-compliant behavior;
6. Routine identification of compliance risk areas, including Monitoring and Auditing; and
7. System for responding to compliance issues as they are raised, how to remedy instances of non-compliance, and with respect to financial matters, reporting non-compliance to Medicaid, Medicare or any other relevant payors, governmental agencies, and refunding overpayments when such are identified within the appropriate timeframe as required by law.

Within this Plan the following are defined as**:**

1. **Abuse-** Improper behavior intended to cause physical, psychological, or financial harm to an individual or group.
2. **Corporate Compliance Program-** Initiatives designed to detect and prevent issues of non-compliance as well as to identify areas where the Organization may be vulnerable or at risk.

3. **Fraud-** Healthcare fraud is intentional deception or misrepresentation that an individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual, to the entity or to some other party.
   a. The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from State-to-State.
   b. The most common fraudulent acts include, but are not limited to:
      1. Billing for services that were not provided.
      2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
         a. The nature of services provided;
         b. The dates on which the services and/or treatments were rendered;
         c. The medical record of services and/or treatment provided;
         d. The condition treated or diagnosis made;
         e. The charges or reimbursement for services provided;
         f. The identity of the provider or the recipient of services.
      3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.
4. **Qui tam (Whistleblower)** – An individual, internal or external to the Agency, which reports a claim of fraud or abuse on behalf of the United States Government.

<u>Element 1</u>

Written Policies, Procedures and Standards of Conduct

This Corporate Compliance Plan and all applicable compliance policies are reviewed by the Compliance/Quality Improvement Department on at least an annual basis or more often as necessary to determine if revisions are necessary. This Plan can be viewed within the Agency's "MHA Common Drive">Universal Policies and Procedures>Agency-Wide.

At the start of employment, all new hires are required to complete the Agency's "MHANC Corporate Compliance Training" within Relias as well as complete a post-test. Each employee must obtain a post-test score of at least 80% to pass the post-test exam successfully. Each employee will be given two (2) opportunities to pass the exam. If an employee does not successfully pass the exam after two (2) opportunities, he/she will be mandated to be re-trained by the Agency's Compliance Officer to ensure that the employee understands the training material and successfully passes the post-test. Relias tracks new hires' completion of the MHANC Corporate Compliance Training and post-test scores. Additionally, existing employees are required to complete the aforementioned training annually in Relias where it is tracked.

All new employees are educated on and provided with a copy of the "Employee Handbook" in Paylocity

as part of the new-hire orientation process. This Handbook contains information on all policies and procedures that must be adhered to by all employees, as well as information on detecting and preventing fraud, waste and abuse. New hires are responsible to access Paylocity in order to acknowledge their review of the "Employee Handbook".

Every employee is expected to adhere to the Agency's Code of Conduct:

Agency Code of Conduct

The purpose of the Agency's Compliance Program is to safeguard its services and to continue its tradition of strong moral, ethical, and legal standards of conduct. The Code of Conduct has been adopted in order to guide the Agency and individuals' responsibilities as a provider in accordance with law, regulation, and best practices. The Agency is committed to engaging in ethical business practices and to adhering to all Federal, State laws and regulations, interpretations thereof and the Code of Conduct.

The Code of Conduct is not meant to be all inclusive in that it can't list all possible situations that may occur. Whether or not the situation or action is described specifically within this Code of Conduct or in other Agency policies, any potential issues should be submitted to the Compliance Officer or a member of the Compliance/Quality Improvement Department as soon as it is suspected.

Every Agency staff member, Board member, volunteer, intern, temporary employee, etc. is required to understand and comply fully with the Agency's Code of Conduct. Any staff member, volunteer, intern, or temporary employee violating any provision of this Code of Conduct or other Agency policies will be subject to disciplinary action, up to and including termination of employment, business relationship, volunteer opportunity, and/or discharge from the Board of Directors in accordance with the Agency's bylaws. All Agency representatives have a duty to disclose any potential conflict of interests and/or potential ethical issues.

The Agency is committed to the following:

- To train every employee on the Agency's Code of Conduct and policies and procedures relevant to his/her duties.
- Not to tolerate any act of retaliation or retribution against an Agency staff member, volunteer, intern, temporary employee, or Board member who makes a "good faith" report of a potential compliance violation of law, regulation, standard, policy, or of this Code.
- Billing errors are identified and corrected and any overpayments due to the government are returned in the timeframe prescribed by law. Each employee is to do his/her due diligence to prevent fraud, waste, and abuse.
- Discipline those employees who commit any compliance violation(s), up to and including termination, following the Agency's disciplinary policies as set forth within the Employee Handbook.

- Employees are encouraged to create a work environment in which ethical concerns can be raised and will be addressed.
- Properly credentialed employees (in programs where applicable) with the necessary experience are employed and are provided with the necessary supervision to perform their duties.
- Qualified individuals are hired without regard to race, color, religion, sex, sexual orientation, national origin, age, marital status, military status, or disability.

- All prospective employees are routinely screened to ensure they have not been sanctioned by any regulatory agency and are eligible to perform their designated responsibilities in accordance with law, regulation, and industry practices. This includes background checks prior to hire, exclusion checks prior to hire, as well as exclusion checks monthly. This also applies to the Agency's Business Associates.
- The privacy of the Agency's employees is respected, and salary, benefits, payroll, personnel files, and information containing disciplinary documentation are treated as confidential information.
- Discrimination and unlawful harassment of any kind are not tolerated.
- Accurate and complete claims are submitted for all services provided and appropriate documentation to support these claims is maintained.
- Services are billed according to medical necessity guidelines and regulatory and legal requirements. Staff are to act responsibly and report any potential overpayments, fraud, or false claims if identified.
- Staff responsible for coding and billing functions are trained and continually educated to ensure compliance with current laws or regulations.
- The Agency establishes and builds upon internal controls to ensure the accuracy of financial statements and all other records and reports.

All Agency Employees are expected to perform the following:

- Staff are responsible for reporting any potential compliance issues/violations to his/her supervisor and subsequently the Compliance Officer must be made aware. Staff may also opt to report any potential compliance violation anonymously using the Agency's Compliance Hotline. The telephone number of such is indicated within this Corporate Compliance Plan.
- Staff are to inform management of their whereabouts, to document or record all services or transactions accurately, and to be honest and forthcoming with the Agency, regulatory agencies and internal/external auditors.
- Comply with the Agency's policies and procedures, accounting rules and internal controls.
- Be honest when working for the Agency, with the people being served, providers, suppliers, and all others with whom the Agency does business with.
- Staff shall comply with the Compliance Plan, including the Code of Conduct, and understand and follow all the rules and regulations that govern their jobs.

- Staff shall follow all Agency HIPAA Policies and Procedures and must complete training on the topic of HIPAA within 30 days of hire and annually thereafter. A post-test is also required. The training and post-test are maintained in Relias.
- Be fully committed to the Agency during working hours. An employee is prohibited from taking on any other outside job or work assignments during their working hours.
- Staff shall submit timely, accurate, complete, and truthful records of their work, including any written documentation needed to support the services provided.
- Treat fellow employees and recipients of services with respect, dignity, patience, and kindness and never discriminate against or harass anyone on the basis of race, religion, sex, age, national origin, sexual orientation or affiliation, or disability.
- Maintain confidentiality of recipient information and Agency business operations. This responsibility extends beyond employment with the Agency.
- Refrain from giving or accepting any form of gift or gratuity that might influence, or appear to influence, another person's judgment in the performance of his/her job duties.
- Avoid offering or receiving anything of value that induces another person to purchase an item or service from Agency, refer a person to this Agency, or market this Agency's products or services.
- Officers, Directors, and key employees must abide by the Agency's Conflict of Interest Policy.
- Refrain from contributing or donating this Agency's funds, products, services, or other resources to any political party or candidate.
- Abstain from misrepresenting this Agency by making dishonest statements or statements intended to mislead or misinform individuals about the quality of the Agency's services or those of a competitor.
- Refrain from using Agency property or services for personal gain or benefit, from removing or disposing of Agency materials, supplies, or equipment without proper authority.
- Respect the privacy of fellow employees and treat information on salary, benefits, payroll, personnel files, and disciplinary matters confidentially.
- Comply with Federal and State laws and regulations regarding government contracts and programs in which the Agency participates.
- Tell the truth and cooperate with any investigation of a potential compliance or other legal matter, whether investigated by an Agency representatives or government authorities.
- Act in a professional manner that includes behavior that advances every consumer's course of treatment and establishes appropriate boundaries in the employee-consumer relationship.
- Not to accept gifts or money from consumers, former consumers, and/or their family members.
- Set the tone and maintain a work environment that encourages ethical and responsible behavior and to establish an environment in which subordinates feel comfortable addressing compliance issues without fear of reprisal when serving in a supervisory role.
- Discuss the Compliance Program, including the Code of Conduct regularly and encourage questions from fellow employees when serving in a supervisory role.

Consumer Bill of Rights

The Consumer Bill of Rights provides the minimum guidelines for ensuring that an individual's right to be treated with dignity and respect within our healthcare system is taken into account in all situations.

Below are some examples of a breach of the Consumer Bill of Rights:

- Providing differential care due to race, religion, national origin, sexual orientation, etc.
- Disclosing information contained in the consumer's/resident's medical record without proper written authorization.
- Denying a consumer/resident the right to review/receive a copy or amend their medical records at their request.
- Preventing a consumer/resident from voicing a complaint about services.

Employees are expected to familiarize themselves with the Consumer Bill of Rights and should seek guidance if they are uncertain about how to make sure that consumers'/residents' rights are upheld during the provision of services.

Non-Retaliation; Whistleblower Protection

Good Faith Reporting

An internal whistleblower is an employee, former employee, or member of the Agency, who reports misconduct, in this case, health insurance fraud, to those that have the power to take corrective action.

An external whistleblower is any private party outside of the Agency that may report fraud to outside persons or entities on behalf of the United States Government.

Any person may bring a qui tam action (a person who brings a suit on behalf of the Government). The False Claims Act provides protection to any person who brings a qui tam action on behalf of the Government and who may be, as a result, terminated, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of whistleblowing. Remedies include reinstatement of one's employment with comparable seniority, two (2) times the amount of any back-pay, interest on back-pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

No employee will be subject to any punishment or reprisal for good faith reporting of compliance concerns to their supervisor or to the Compliance Officer. The Agency takes all reports of known or suspected violations seriously. Good faith reporting is considered loyal and professional, and no employee will be subjected to retaliation. However, reports of non-compliance, which are known to be

false when they are made, will not be tolerated and will be subject to corrective action, up to and including termination.

Board of Directors

It is the intent of the Board of Directors that the Agency operates within the highest moral and ethical standards. It is expected that all employees of the Agency will conduct themselves in a professionally competent manner that provides the highest example for persons receiving services, other agencies, employees, and the community.

The Agency and its employees recognize that persons with disabilities and other service recipients will always be treated with dignity and respect. Services are individualized based upon preferences and desired outcomes. The Code of Conduct is important as the Agency recognizes that through its services, an impact is made on the lives of the people served. The Agency acknowledges that some of the individuals that participate in its programs and services are vulnerable individuals who trust that their experience with the Agency will influence the quality of their lives. Therefore, staff must always conduct themselves in a professional and moral manner.

The Board of Directors is selected to represent diversity in the Agency's community, values, and beliefs. The Board of Directors is responsible for establishing the governing policies and demonstrating exceptional leadership for the Agency. This is attained by attending meetings, representing the Agency within the community, remaining current on issues of concern to the Agency and its mission, and monitoring the operations of the Agency.

The Board of Directors understands and acknowledges the importance and purpose of Corporate Compliance and this Plan. The Board of Directors receives annual "MHANC Board Corporate Compliance Training and compliance issues are discussed during monthly Board Meetings as necessary. In addition, a member of the Board attends all quarterly Corporate Compliance Committee meetings and receives the minutes of such meetings. The Board of Directors also has access to the Agency's Corporate Compliance Plan, the annual Compliance Program Self-Assessment and the annual Compliance Work Plan designed to address the Agency' risk areas. In addition, the Board of Directors receives all meeting minutes of the Corporate Compliance Committee on a quarterly basis.

The Agency maintains its status as a state of the art mental health organization by always providing quality services. The Agency's values its reputation and works closely with other stakeholders, such as funding sources, employers, family members, other service organizations and their staff, and the communities in which it is located. Education is provided to stakeholders on the stigma of mental illness and substance abuse and other issues concerning the people served.

The Agency maintains a financial solvency by properly allocating funds, developing annual budgets, and continuously providing quality services at the most competitive rate. The Agency's financial practices

are governed by specific policies covering the way in which funds are collected, distributed and allocated.

The Agency shall make the following commitments to persons receiving services:

- Provide persons receiving services with professional care in a non-discriminatory manner.
- Respect the constitutional rights of all persons.
- Take reasonable measures to protect the health, safety, and emotional well-being of all persons.
- Recognize that everyone has the right to participate in and make informed consent decisions about their services and treatment. In addition, individuals have the right to refuse any service provided by the Agency.
- Have the right to present a grievance and such grievance will be addressed according to the "Grievance Procedure for Consumers/Residents".
- Have reasonable access to view and amend their Agency's records in accordance with HIPAA and the Agency's HIPAA Policies and Procedures.
- Have full protection of their rights as defined by the Mental Hygiene Law.
- Have the right to utilize the Agency's services as a means of achieving individual goals within the program and service structure.

As an employee of the Agency, I will:

- Perform my designated job duties, responsibilities, and functions.
- Do my best to ensure that the Agency meets the needs of the individuals' receiving services.
- Respect the human rights, integrity, and dignity of all individuals.
- Do my best to create and maintain an environment of loyalty, trust, and mutual respect.
- Strive to communicate with individuals in a professional, positive, enthusiastic, and courteous manner.
- Support the decisions of Administration.
- Respect the confidentiality of persons receiving services.
- Not become intimately involved with a person receiving services by the Agency
- Report any unethical behavior of and by another employee to Administration.
- Abide by the Agency's HIPAA Policies and Procedures.
- Be loyal to the Agency and refrain from any behavior or action that might damage the reputation of the Agency.
- Carefully consider the public perception of personal and professional actions, and the effect that actions could potentially have on the Agency's reputation in the community.
- Not participate in, condone, or be associated with dishonesty, fraud, or deception.

Financial Practices

- All financial practices of the Agency shall be handled in accordance with the applicable Federal, State, and local laws.

- All financial matters shall be conducted within the standards of commonly accepted, sound financial management practices.

As a member of Agency's administrative team, I will:

- Do my best to see that the Agency is operated in a manner that upholds the Agency's integrity, adherence to its policies and procedures, and merits the trust and support of the community.
- Take my responsibilities as a leader seriously, conduct myself in a manner that is professional and appropriate, and avoid all potential conflicts of interest.
- Make myself available to employees and provide supervision and guidance.
- Represent the Agency internally and externally in a professional manner.
- Treat others with dignity and respect.
- Administration shall take no actions that could benefit them personally at the expense of the Agency
- Strive for personal growth to improve my effectiveness as a Manager/Supervisor.

Element 2

Assignment of a Compliance Officer/Corporate Compliance Committee

Corporate Compliance Officer

Lisa Weiss, LMSW, CHC, CHPC is the assigned Corporate Compliance Officer, Director of Compliance/Quality Improvement, and HIPAA Privacy Officer for the Agency She can be contacted via telephone at (516) 489-2322, extension 1234 and via email at lweiss@mhanc.org. Her office is located at 16 Main Street, Hempstead, NY 11550. The Corporate Compliance Officer is responsible for overseeing the Compliance Program at the Agency. She will ensure that the Agency is meeting all requirements of an effective compliance program by completing an annual Compliance Self-Assessment and Compliance Work Plan. In addition, she will receive all compliance concerns and is responsible for responding to these concerns in a professional and timely manner. She will report such concerns to the Executive Director and to the Corporate Compliance Committee. The Board of Directors will also be made aware. The Corporate Compliance Officer is expected to act as a liaison between consultants and Governmental agencies in the event of an audit or investigation. The Corporate Compliance Officer, in conjunction with the Compliance/Quality Improvement Department, is responsible for assessing program risk areas, trending, assisting in the implementation of corrective action plans, investigating non-compliance, and assisting with determining when Medicaid and/or Medicare overpayments may have occurred, communicate these concerns, and assist in the decision-making towards resolution of the issue.

Corporate Compliance Committee

The Corporate Compliance Committee will meet on a quarterly basis or more often if necessary and is chaired by the Compliance Officer. Committee members include, but are not limited to, the Executive Director, a Board Member, the Director of Community Living Programs, the Director of Clinical Services, the Director of Peer Services, the Director of Financial Management, the Director of Care Coordination, the Director of Veteran's Services, the Agency's Compliance/Quality Improvement Specialist, the Director of Human Resources, and the Acting Chief Financial Officer. The Committee is responsible for ensuring that the Agency is conducting business in an ethical and responsible manner. The Committee will review the results of internal and external audits, investigations or claims of fraud and abuse, any reported overpayments and make recommendations and initiate education and training efforts to address compliance issues and concerns. The Committee is also responsible for updating employees on current compliance issues.

Element 3

Compliance Education and Training for Affected Individuals

False Claims

I. Introduction

The Agency is committed to assisting individuals and families to meet their needs through participation in the Agency's services and to grow by empowering them to help themselves to become active participants in their goal attainment. The Agency is committed to ensuring that it operates under the highest ethical and moral standards and that its activities comply with applicable Federal and State laws.
The Agency focuses on the prevention of abuse and fraud in Federal and State Health Care Plans by protecting against non-compliance, accidental or deliberate. The Agency seeks to promote full compliance with all applicable legal duties in order to foster and ensure ethical conduct and to provide guidance and education to all employees regarding their conduct. As the Agency is reimbursed by Medicaid/Medicare for the services that it provides in applicable programs, staff must comply with all compliance regulations. The Agency intends to detect non-compliance if it occurs, to discipline those involved in such non-compliance, to remedy the effects of non-compliance and to prevent future non-compliance. All employees are educated about compliance requirements in the healthcare industry as it relates to guidance by the Center of Medicare and Medicaid Services (CMS), the United States Department of Health and Human Services Office of Inspector General (HHS-OIG), the Office of Civil Rights (OCR), and the New York State Office of the Medicaid Inspector General (NYS OMIG).

II. Compliance Standards and Procedures

Numerous Federal and State laws and regulations define and establish obligations for the health care industry with which the Agency must comply. Any Agency employee who violates these laws and/or

regulations risks individual criminal prosecution and penalties, civil actions for damages and penalties and subjects the Agency to these same risks and penalties. Any employee who violates these laws may be subject to immediate termination of his/her employment.

III. Discussion of Applicable Legal Standards

Below are some major Federal and State statutes specifically applicable to health care providers, which are not all inclusive. They are designed to effectively combat all Federal Health Care Program fraud. Any employee who is uncertain about applicable laws should always consult with the Compliance Officer.

New York State False Claims Act (modeled on the Federal False Claims Act) - Signed into law April 2007

Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; and (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government is liable to the U.S. Government for a civil penalty of not less than $6,000 and not more than $12,000, The court may assess not more than two (2) times the amount of damages sustained because of the act of the person.

This means that the person has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, and acts in reckless disregard of the truth or falsity of the information.

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal Government that he/she ***knows or should know*** is false. It was signed into law to comply with the Deficit Reduction Act (signed into law in February 2006).

Civil Monetary Penalties Act

The Agency's employees shall not knowingly present a claim to any Federal Health Care Program or Health Care Benefit Program for an item or service the person ***knows or should have known***, was not provided, was fraudulent, or was *not medically necessary*.

Billing Issues and Risk Areas

The following are some specific risk areas for which the Agency's employees will receive training and supervision:

- Billing for items or services not actually rendered.
- Billing for medically unnecessary services. Federal Health Care Programs will not pay for services that they do not believe are medically necessary and they may also make a determination after remitting payment to the Agency to recover monies after conducting an audit.
- Duplicate billing.
- Insufficient documentation to evidence that services were performed and were medically necessary and that warrants reimbursement from any Federal Health Care Program.
- Billing for services which were provided by unqualified or unlicensed clinical personnel (in programs where applicable).
- Service Plans/Service Plan Reviews that are not completed within the appropriate timeframes, without measurable objectives or methods, and that are not signed or agreed upon by the consumer/resident receiving the services and other appropriate parties.

Medical Necessity - Medicaid/Medicare Criteria

The only health interventions that will meet Medicaid/Medicare's (including Managed Care Organizations' [MCOs]) criteria for medical necessity are those that are recommended by a treating physician or other appropriately licensed medical professional within applicable programs. The health intervention must serve the purpose of treating a medical condition (also inclusive of psychiatric conditions), must provide the most appropriate level of service, and be known to be effective as well as cost-effective.

Intervention must be utilized with the intention of restoring the individual to the best possible functioning level. The individual must carry a reimbursable diagnosis, must exhibit current symptoms, and must not yet be functioning at his/her highest level within applicable programs. All services provided must correlate to the appropriate diagnosis.

Medical necessity is based on each consumer's/resident's Assessment, which provides information for service planning and level of need in each functional area. Assessments should clearly summarize recommendations for treatment, considering the consumers'/residents' diagnoses, their functioning level and their readiness to work on such issues.

All services provided must correspond to a Service Plan. Consumers'/residents' signatures must be indicated on their Plan, demonstrating their agreement and understanding of the Plan, or there must be documentation present within consumers'/residents' records that evidence their review, collaboration and approval of their Plan. Consumers/residents must be active participants in their treatment. In the case of the Agency's Personalized Recovery-Oriented Services (PROS) program, a medical doctor's signature (psychiatrist) must also be present on the Plan. All Plans must indicate short-term goals, objectives and methods that are measurable.

Services must be delivered at the appropriate level of care and must be individualized to each consumer/resident serviced. Appropriate referrals, transfers, and discharges must be documented demonstrating good faith efforts to place consumers/residents where appropriate for their level of functioning. Services should be in the least restrictive setting that is available and safe. In addition, it must be evident that a consumer/resident is benefiting from the services being provided.

Progress notes must correlate to the current Service Plan objectives and specify which objective the progress note is correlating to. In addition, progress notes should indicate the specific services that were rendered, the interventions that were provided, the date and time of the service provided, the individual rendering the service, the setting, the duration of the service rendered, as well as indicate the consumer's/resident's progress.

Compliance Training and Education

All existing Agency employees shall receive training and education with regards to the Agency's Compliance Program and to HIPAA. In addition, all employees have access to the Compliance Plan as well as the Agency's HIPAA Policies to ensure compliance with the aforementioned standards. All new hires are required to take the following Compliance and HIPAA trainings in Relias within 30 days of hire:

(1) MHANC Corporate Compliance Training and Post-Test
(2) Application of HIPAA in Behavioral Health and Evaluation
(3) Security Awareness Training – Level II and Evaluation

All existing employees must also take the aforementioned trainings in Relias on an annual basis as per the Agency's training schedule. All Supervisors are required to ensure that their staff complies with the training and education requirements. All employees will receive copies of any changes in these policies as they occur.

The Board of Directors are also mandated to complete the MHANC Corporate Compliance Training on an annual basis within Relias.

Should an employee have any questions or concerns regarding the Agency's Compliance Plan or any of the Compliance or HIPAA trainings, he/she should direct questions to Lisa Weiss, LMSW, CHC, CHPC at (516) 489-2322, extension 1234 or via email at lweiss@mhanc.org.

Element 4

Communication with Corporate Compliance Officer; Anonymous and Confidential Reporting

Communication is the key to effective compliance. Communication flows in both directions between the Compliance Officer and employees of the Agency It is important that each employee is knowledgeable on how to report suspected incidences of fraud and abuse or other potential compliance violations.

All staff are responsible for reporting any potential compliance violations. Reports shall be made to staffs' direct supervisor who will then in turn be responsible for reporting any misconduct or non-compliance to their superiors (each program's structure determines the staff hierarchy). Staff shall report to their Program Supervisor, Program Manager, Director, and/or Executive Director until the report reaches the Compliance Officer. A report may be made directly to the Compliance Officer should staff not be comfortable reporting it to their immediate supervisor. The Compliance Officer is then responsible for informing all appropriate parties regarding any potential non-compliance.

In addition, the Agency provides all staff with an anonymous and confidential toll-free 24-hour supervised Compliance Hotline telephone number, which is manned by an external software company, NAVEX Global, Inc. The Compliance Hotline telephone number is indicated below:

Compliance Hotline #: 1-(877) 813-8406

All staff are trained and educated related to appropriately contacting the Compliance Hotline when they complete the "MHANC Corporate Compliance Training" at hire and annually (flyers are also posted throughout Agency sites). Should a call be made to the Compliance Hotline, the Agency's Compliance Officer will be notified by NAVEX Global, Inc. via email. The Agency's Compliance Officer and the Corporate Compliance Committee are responsible for appropriately investigating all Compliance Hotline calls and for following up until there is an appropriate resolution. The Compliance Officer also maintains Compliance Hotline reports quarterly.

Upon staff reporting suspected incidences of fraud and abuse or any other potential compliance violation, an investigation will commence within 24 hours by the Compliance/Quality Improvement Department, which consists of the Compliance Officer and a Compliance/Quality Improvement Specialist. The Corporate Compliance Committee may assist as well. In addition, all follow-up, including, but not limited to, disciplinary action will be taken and documented if a compliance violation is proven.

Element 5

Discipline for Failure to Report Suspected Fraud; Permitting Non-Compliant Behavior

Any employee suspected of violating the law or committing fraud, or who receives a report of a possible violation or fraud, shall be responsible for immediately reporting it to his/her immediate supervisor. However, if an employee is uncomfortable with speaking to his/her supervisor or feels that his/her supervisor may be involved in suspected fraud, he/she may make a report directly to the Compliance Officer. As indicated above, staff may also contact the Compliance Hotline via telephone. Failure to report illegal, unethical, or activities of non-compliance will result in appropriate corrective and disciplinary action.

Once the information reaches the Compliance Officer, the information will be reported to the members of the Corporate Compliance Committee. It will be determined whether an internal investigation is warranted. If so, an investigation will commence within 24 hours to be conducted by the Compliance/Quality Improvement Department and will continue until the matter is closed. The The Corporate Compliance Committee will receive the results of the investigation. Employees' identities will be kept confidential to the extent permitted by law, unless doing so prevents the Compliance/Quality Improvement Department from fully and effectively investigating the violation which was reported. Once the investigation is complete, the Corporate Compliance Committee will determine any necessary follow-up and/or disciplinary action in conjunction with the Human Resources Department. All disciplinary action will be documented within employees' personnel files. The level of disciplinary action to be taken is dependent upon the offense, i.e., probation/suspension. The Agency has adopted a Policy of progressive discipline, which can be reviewed in the Employee Handbook.

In certain cases, an employee may be placed on disciplinary probation instead of being suspended. Probation is the final resolution attempt made to correct marginal performance or conduct problems. Failure to achieve the specified results within the probation period will result in termination. When progress reviews are satisfactory, the employee will be removed from probation on or before the end of the probation period.

The Agency recognizes that there are certain types of employee infractions (fraud) that are serious enough to justify either probation/suspension or, in extreme situations, termination of employment, without following the progressive disciplinary steps. Please Note: Employees who are suspected of committing compliance violations will be suspended with pay during the time in which a compliance investigation is occurring. Although employees are employed at-will and can resign or be terminated at any time without cause, the following conduct may result in immediate termination:

- Falsification of Documents
- Unethical Conduct
- Fraud or Dishonesty

Element 6

Routine Identification of Compliance Risk Areas; Monitoring and Auditing

The Agency has a Monitoring and Auditing Program. The OIG identifies internal monitoring and auditing among the fundamental components of an effective Compliance Program. At a minimum, annual audits will be conducted to determine whether: (1) The Agency's policies and procedures are current and complete and (2) The Agency's claims submission practices comply with applicable requirements (that bills are accurately coded and accurately reflect the services provided, documentation is being completed correctly, that services provided are reasonable and necessary, and if any incentives for unnecessary services exist). The Agency's finance policies and procedures will be audited on an annual basis, at a minimum, by appropriate outside financial auditors.

Compliance Program Audit

The Compliance/Quality Improvement Department will conduct a review of the Agency's Compliance Program on an annual basis, at a minimum, to evaluate its effectiveness, and to identify problems or weaknesses in its design and/or implementation. The review will include an examination of whether the Compliance Program's various elements have been satisfied. In addition, self-assessments of the Compliance Program are conducted on an annual basis as well as the creation of an annual Compliance Work Plan.

Client Records and Documentation

Monitoring of documentation assists the programs in verifying that billing requirements have been met (as applicable) or State regulations are met and ensures that the Agency's largest risk areas are assessed. Monitoring also assists in safeguarding the Agency by confirming that all services documented were rendered, that services provided are medically necessary, and that documentation is sufficient in evidencing that services were performed by qualified and licensed staff (if applicable).

The Agency's programs are required to follow the Agency's "Monitoring and Auditing Policy". Programs are required to conduct either full chart reviews or review designated Characteristics of Interest of consumers'/residents' documentation utilizing their programs' "Monitoring Tool" for a percentage of randomly selected client case records. This information is submitted to the Compliance/Quality Improvement Department for review. Monitoring of documentation must occur monthly.

The Compliance/Quality Improvement Department will hold conference calls with Program Managers/Team Leaders, and Directors to discuss the documentation deficiencies (error rates) that were identified. The attendees of the call will determine appropriate corrective actions in order to rectify the

areas that require improvement, as applicable. Upon completion of the call, the Program Managers/Team Leaders, or an appropriate designee, are responsible to submit a plan of corrective action to the Compliance/Quality Improvement Department for review and approval. This will ensure that similar issues are prevented from occurring in the future.

Additionally, the Program Directors are responsible to spot check case records for new admissions as a way to monitor that the corrective action(s) are taking place and to determine if additional staff training and education, support, and oversight are needed. The Program Managers/Program Supervisors will monitor to ensure that the corrective action(s) are being overseen and that they are being implemented and enforced accordingly. The Compliance/Quality Improvement Department will follow up with the programs to ensure that their benchmarks for documentation compliance are being met.

Upon the completion of monitoring of documentation, it may be necessary for the Compliance/Quality Improvement Department or program staff to conduct a more detailed audit by reviewing a larger sample of consumer/resident records to determine the reasons such deficiencies are occurring and to assist in determining where additional corrective actions are necessary.

Excluded Individuals

The Agency will not knowingly employ any individual that has been excluded from Medicaid. The Human Resources Department, using Valenz Health's portal, shall conduct exclusion checks for all newly hired employees as well as conduct monthly checks thereafter of all current employees to determine if the employee has been excluded from Medicaid. Each new employee will be asked to indicate any Medicaid-related fraud, arrests, sanctions, or convictions that he/she has been involved with and/or has received. Employment will be determined based upon this information. In addition, the Human Resources Department will conduct exclusion checks for all new Business Associates prior to commencement of a business relationship as well as monthly. Documentation is maintained within the Human Resources Department as evidence that these exclusion checks have taken place.

Element 7

System for Responding to Compliance Issues; Corrective Action; Refunding Overpayments

Once a report of suspected non-compliance is made, an investigation will commence within 24 hours. Employees' identities will be kept confidential to the extent permitted by law, unless doing so prevents the Corporate Compliance Committee from fully and effectively investigating the violation which was reported. Once the investigation is complete, the Corporate Compliance Committee will determine the course of follow-up necessary and/or disciplinary action to be taken. All disciplinary actions will be documented in employees' personnel files.

Investigations

The purpose of an investigation is to: (1) Determine how the potential problem was discovered; (2) How the problem occurred; (3) Review relevant policies and procedures; (4) Identify and interview employees; (5) Analyze past claims history (if applicable); and (6) Determine a course of corrective action. An investigation will also assist in reviewing and revising the Agency's policies and procedures and will assist in determining where further staff training is necessary.

Conducting an Investigation

- The Compliance/Quality Improvement Department and the Corporate Compliance Committee will immediately review the Agency's established policy and procedure that has allegedly been violated.
- A decision will be made as to if employee interviews are necessary in order to continue the investigation. If so, it will be determined which members of the Committee will interview employees.
- It will be determined which relevant documents need to be reviewed, by whom, and in what timeframe.
- A decision will be made as to if outside counsel and/or auditors need to be utilized to assist in the investigation.

All efforts will be made to observe the following timeframes with regards to the investigation of violations:

- The initial preliminary investigation will begin within 24 hours of receiving a report of an alleged violation.
- The initial preliminary investigation will be completed within five (5) business days of receiving the report to the extent possible.
- Results of the initial preliminary investigation are shared with the Executive Director who will inform the Board of Directors and other applicable Corporate Compliance Committee members.
- At the end of the investigation, the Corporate Compliance Committee will reconvene. The investigation will be presented by the Corporate Compliance Officer and a course of action will be decided upon by the Committee.
- If the investigation continues beyond the initial preliminary investigation, a final investigation should be completed no later than two (2) weeks after the report is made. A full explanation of the delay in the investigation must be documented in the investigation report.

Other Considerations

In the event that an employee is found to have violated any part of the Corporate Compliance Plan, Agency policy, or Code of Conduct, the employee will be subjected to corrective action. The corrective action will take into consideration the nature, severity, and frequency of the violation(s).

The Corporate Compliance Committee will also take action to correct the violation. Committee members will consider if the violation requires or warrants a report to the Government and/or a referral to law enforcement authorities as well as determine if the violation resulted in overpayments or other billing issues, which need to be corrected.

Once the investigation is completed, the Corporate Compliance Committee will review details of the allegation and/or violation and identify and implement measures to prevent future occurrences. The investigation will be documented, including corrective actions warranted and taken, and whether future review is required to assure that the issue is not reoccurring.

Conflicts of Interest

All Directors, Officers, and Key Employees shall follow the Agency's "Conflict of Interest Policy". The purpose of the Conflict of Interest Policy is to protect the interests of the Agency and any affiliates in situations in which there is a determined conflict of interest between the private interests and the official responsibilities of a Director, Officer, or key employee of the Agency, including when the Agency and/or any affiliate is contemplating entering into a transaction or arrangement that might benefit the private financial interest of a Director, Officer, or key employee.

The Agency desires to obtain the services, as Officers, Directors, and key employees who have knowledge, contacts, or interest in fields of relevance to the Agency. It is expected that many of these individuals will on occasion have business or personal interests which may give rise to a conflict of interest. It should be emphasized that conflicts of interest are not inherently illegal nor are they a reflection upon the integrity of the individual involved. In fact, the failure to consider engaging in activities that might give rise to a conflict of interest may mean that the Agency could not engage in activities that could be highly beneficial to it.

The appearance of a conflict of interest is often as important as the reality. Accordingly, the way in which the "conflicted" individual, the Officers, the Board of Directors, and the key employees handle a disclosure of a potential conflict of interest will determine whether they have fulfilled their duties to the Agency. Therefore, the crucial steps in the Conflict of Interest Policy are: (1) Certification signed and dated indicating that the reviewer has read and understands the Policy; (2) Annex A (Initial Disclosure Form) is signed and dated and indicates any potential conflict of interest; (3) Annex B (Subsequent Disclosure of a Conflict of Interest Form) is signed and dated annually indicating any new potential conflicts of interest; (4) The Compliance Officer initially reviews any potential conflicts of interest disclosed to determine if a report must be made to the Board of Directors; (5) The Compliance Officer makes the Board of Directors aware of any potential conflict of interest; (6) The Board of Directors convenes a Board meeting where the potential conflict of interest is discussed, it is determined whether a conflict of interest exists, and determines a resolution for the conflict of interest, if applicable; (7) The conflict of interest, Board discussion, and resolution is documented within Board meeting minutes; and (8) The Compliance Officer files and tracks the receipt of all signed/dated forms and documents any conflicts

of interest and their resolution.

Privacy and Confidentiality

Privacy rules are established by the federal agency, the Office of Civil Rights (OCR of the HHS). OCR enforces the Health Insurance Portability and Accountability Act (HIPAA). It is imperative that as an Agency, processes are in place to monitor privacy to comply with HIPAA and other regulations.

The Agency has policies and practices in place to ensure that protected health information of its consumers/residents is released, disclosed, or accessed according to HIPAA law. All employees are to educate consumers/residents on the Agency's Notice of Privacy Practices to ensure that all consumers/residents are informed of how their protected information may be used, disclosed, or accessed as well as when their written authorization is required. All consumers/residents must be offered a copy of the Agency's Notice of Privacy Practices. Staff are only to disclose the minimum necessary to meet the requests of external parties requesting the Agency's disclosure of protected health information of any of its consumers/residents.

Every individual who represents the Agency is obligated to keep consumer/resident information both secure and protected. This includes part-time, full-time, relief/per diem, and temporary employees, interns, vendors, and business associates. These protections include the securing of computers and all data-based applications, files, and not discussing information in public. The Agency maintains a secure database of information, via a nationally adopted computer program which stores protected health information and identifiable information in a manner in accordance with requirements.

Policies are in place restricting access to consumer/resident charts and information both in hardcopy format and computer based. All cabinets containing protected health information within any area must be locked and only unlocked when in use to access charts by appropriate staff members.

Secure passwords (which are not shared with those in the Agency) are used to access information within computer programs and emails. Restrictions on the personnel within the Agency who have access to these passwords are very minimal and the responsibility rests within the Executive Director and Compliance Officer only. All protected health information must be encrypted when emailing to external parties. Texting protected health information is prohibited.

Transmission of protected health information is permitted by fax if the Agency staff member sending the information ensures that the intended recipient is available to receive the fax as it arrives or confirms that there is a dedicated fax machine that is monitored for transmission of this protected information. Fax cover sheets that include standard confidentiality notices are available to all staff when needed.

Prior to disclosing any protected health information, the Compliance/Quality Improvement Department will ensure that any written authorizations for the release of protected health information is valid prior to disclosing. The Compliance/Quality Improvement Department is also responsible for fulfilling record requests received by external parties.

If need be, a system is in place to address the needs of individuals who may need language interpretation or transcription services. An official language interpretation service is available to the Agency at any time. Official transcription and forms in other languages besides English will be dealt with on an individual basis; however, every attempt will be made to provide this information in the language and text of comprehension. Special consideration will be given to those individuals who may have difficulty reading, including providing for information to be read in front of family members and other care takers.

Health Information Technology for Economic and Clinical Health Act (HITECH)

The federal government implemented the Health Information Technology for Economic and Clinical Health Act (HITECH) as part of the American Recovery and Reinvestment Act in 2009 to provide the adoption of meaningful use of health information technology.

HITECH addresses privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

The Agency's assigned HIPAA Privacy Officer is Lisa Weiss, LMSW, CHC, CHPC who can be reached at: (516) 489-2322, extension 1234 or via email at: lweiss@mhanc.org.

Cybersecurity systems are in place to safeguard the electronic protected health information (ePHI) of individuals. The Agency also has protocols in place to promptly notify affected individuals of breaches as well as the federal government. A HIPAA Security Risk Assessment will be completed annually by the Agency's HIPAA Security Officer.

The Agency's assigned HIPAA Security Officer is Dominic Padmore, Program Manager of Information Technology. He can be reached at: (516) 489-2322, extension 1111 or via email at: dpadmore@mhanc.org.

Credentialing/Recredentialing

Credentialing and recredentialing records are subject to federal and state audit. Therefore, the Agency seeks to ensure the competency and qualifications of the service delivery in the provision of specialty services and programs. To achieve that goal, it is the policy of the Agency that specific credentialing and recredentialing activities will occur and be documented to ensure that employees, contractors, etc. are operating within assigned roles and scope of authority in service delivery.
In accordance with statutory and funding requirements, the Agency is responsible to ensure that providers within the Agency are appropriately qualified and competent to provide covered and authorized services. All professionals who provide clinical services within the Agency must be properly credentialed and recredentialed.

All credentialing and recredentialing documentation must be retained in the personnel file of each credentialed individual and must include:

- Initial credentialing and all subsequent recredentialing certifications;
- Any other pertinent information used in determining whether the individual met credentialing and recredentialing standards;

The aforementioned documents will be maintained by the Human Resources Department.
The Compliance Officer will periodically monitor the credentialing and recredentialing activities of the Agency to ensure compliance.

Revised January 2024
Executive Director's Approval Date: 1/23/24
Board of Directors' Approval Date: 1/22/24