



Corporate Compliance Plan

Revised November 2022

Federation of Organizations 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. Federation of Organizations will only conduct business in an ethically acceptable manner and will comply with regulations that have been identified by the State, Local and Federal Government. Corporate Compliance is a systematic effort to prevent, detect, and report violations of law throughout the Federation of Organizations. The purpose of Corporate Compliance is to ensure that employees, consultants, Business Associates, vendors and contractors of Federation of Organizations conduct themselves in conformance with all applicable legal requirements.

This Corporate Compliance Plan is reviewed by the Compliance/Quality Management Department on at least an annual basis to determine if revisions are necessary. This Plan can be viewed on Federation of Organizations' website, www.fedoforg.org and on Federation of Organizations' Knowledge Management System (KMS).

Federation of Organizations' Corporate Compliance Plan consists of eight (8) core elements:

1. Code of Conduct/Code of Ethics;
2. Assignment of a Compliance Officer/Corporate Compliance Committee;
3. Education and Training for employees, including education/training regarding Federal and State False Claims Acts and acceptable Medicaid and Medicare documentation;
4. Communication with Corporate Compliance Officer, which includes anonymous and confidential reporting by staff of suspected fraud, waste or abuse;
5. Discipline for failure to report suspected fraud, which permits non-compliant behavior;
6. Routine identification of compliance risk areas, including Monitoring and Auditing;
7. System for responding to compliance issues as they are raised, how to correct such non-compliance, and reporting non-compliance to Medicaid, Medicare and other appropriate payers, Governmental agencies and refunding overpayments when such are identified within the appropriate timeframe as stated by law; and
8. Non-retaliation (whistleblower protection).

Element 1

This section addresses Federal, State, and local laws that the Federation of Organizations and its employees must comply with. All new employees are educated on and provided with a copy of the "Employee Handbook" in KMS and in the Alcott HR Portal 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 the Alcott HR Portal in order to acknowledge their review of the "Employee

Handbook”. In addition, staff is required to acknowledge their review of the “Employee Handbook” in the Alcott HR Portal annually.

At the start of employment, all new hires are required to review the Compliance Plan and take a pre- and post-quiz regarding its content within 30 days of hire on KMS. KMS tracks new hires’ completion of the Compliance Plan Training and quiz scores. Additionally, existing employees are required to complete the aforementioned training annually on KMS where it is tracked.

Every employee is expected to adhere to Federation of Organizations’ Code of Conduct:

Agency Code of Conduct

To function effectively, Federation of Organizations has policies and procedures to protect persons receiving services and to ensure that the rights of co-workers and the Federation of Organizations are respected. Conduct that is disruptive, unproductive, immoral, unethical or illegal will not be tolerated. Types of behavior and conduct that Federation of Organizations considers inappropriate include, but are not limited to, the following:

- Negligence or mistreatment of Federation of Organizations’ consumers or colleagues.
- Intimidating, coercing, discriminating, or sexually harassing persons receiving services or colleagues.
- Mishandling confidential information.
- Falsification of records (persons receiving services and personnel records).
- Unauthorized solicitation of gifts and/or loans from persons receiving services or colleagues.
- Accepting gifts in excess of \$50.00 from family members, contractors and vendors. It is never acceptable for a staff person to accept money as a gift from a contractor or vendor.
- All financial transactions with consumers are prohibited, including giving or receiving money or gifts (unless approved prior by Administration).
- Abandonment of position; leaving assigned work area during working hours without permission or doing work for another Organization during scheduled work hours.
- Theft.
- Unauthorized use of Federation of Organizations’ vehicles.
- Unauthorized use of Federation of Organizations’ electronic equipment and supplies (this includes computers, tablets, cell phones, etc.).
- Destruction or misuse of Federation of Organizations’ or other individuals’ property.
- Insubordination including refusal to perform assigned work duties.
- Refusal to accept changes in work assignment within job category.
- Use or possession of alcohol, narcotics or intoxicating drugs during work hours or on Federation of Organizations’ property.
- Reporting to work after using and still being under the influence of alcohol, narcotics or intoxicating drugs.
- Fighting or illegal gambling on Federation of Organizations property.
- Conduct unbecoming of a Federation of Organizations’ employee, including disregard of personal appearance, dress or hygiene.
- Signing in or out for another employee.
- Excessive absenteeism or lateness (as identified in the “Employee Handbook”).
- Failure to properly notify Supervisor of absence.
- Sleeping on the job (Staff members assigned to work in a 24-hour facility that work overnight sleep positions are exempt from this item).
- Possession of unlawful or dangerous weapons.

- Conviction of a crime or felony while employed at Federation of Organizations.
- Violation of smoking policy.
- Solicitation or distribution of literature or items in violation of Federation of Organizations' policies.
- Violation of safety rules in the performance of responsibilities.
- Unacceptable job performance.

Should any of the aforementioned codes not be followed, disciplinary actions to be imposed will vary dependent upon the offense (please see section on Discipline).

Code of Ethics

Federation of Organizations accepts the role as a leader in the field of mental health, medical health, case management, substance abuse and rehabilitation by continuously improving its services. It is the Agency's goal to provide an example for other Human Service Organizations by establishing and maintaining a high standard of performance, professionalism and ethical practice.

A Code of Ethics is an explicit statement of the values, principles, and rules of a profession or Federation of Organizations that regulate the conduct of its members and employees. Federation of Organizations' Code of Ethics sets forth values, ethical principles and standards to which the staff aspire and by which their actions can be judged. Federation of Organizations' Code of Ethics is a central guide and reference for employees in support of day-to-day decision-making. It is meant to clarify the standards of professional conduct. The Agency's Code of Ethics is an open disclosure of how Federation of Organizations operates. The Agency's Code of Ethics provides employees with visible guidelines for their behavior as well as holds individuals accountable for misconduct, and provides a basis for disciplining employees when necessary.

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

Federation of Organizations 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 Ethics is important as Federation of Organizations recognizes that through its services, an impact is made on the lives of the people served. Federation of Organizations acknowledges that some of the individuals that participate in its programs and services are vulnerable individuals who trust that their experience with Federation of Organizations will influence the quality of their lives. Therefore, staff must conduct themselves in a professional and moral manner at all times.

The Board of Directors is selected to represent diversity in Federation of Organizations' 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 monthly written updates regarding compliance activities that take place within the Agency. The Board of Directors also receives a copy of

the Corporate Compliance Plan, the annual Compliance Program Self-Assessment and the annual Compliance Work Plan designed to address Federation of Organizations' risk areas. In addition, the Board of Directors receives all meeting minutes of the Corporate Compliance Committee on a quarterly basis. Lastly, the Board of Directors is educated annually on Corporate Responsibility and Corporate Compliance and receives regular updates on billing irregularities, audits, corrective action, and disciplinary action for non-compliance, compliance concerns and status of compliance training.

Federation of Organizations maintains its status as a state of the art mental health, medical health, substance abuse and rehabilitation organization by providing quality services at all times. Federation of Organizations' 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.

Federation of Organizations maintains a financial solvency by properly allocating funds, developing annual budgets, and continuously providing quality services at the most competitive rate. Federation of Organizations' financial practices are governed by specific policies covering the way in which funds are collected, distributed and allocated.

Federation of Organizations 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 each individual 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 Clients".
- Have reasonable access to view and amend their Federation of Organizations' 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 Federation of Organizations, I will:

- Perform my designated job duties, responsibilities and functions.
- Do my best to ensure that Federation of Organizations meets the needs of the persons 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 Federation of Organizations.
- Report any unethical behavior of and by another employee to Administration.
- Abide by the Federation of Organizations' HIPAA Policies and Procedures.

- Be loyal to Federation of Organizations and refrain from any behavior or action that might damage the reputation of the Agency.
- Carefully consider the public perception of my personal and professional actions, and the effect that my actions could potentially have on Federation of Organizations' reputation in the community.
- Not borrow money or personal items from persons receiving services.
- Not misuse personal information or protected health information of persons receiving services and co-workers for my personal gain.
- Not participate in, condone, or be associated with dishonesty, fraud, or deception.

Financial Practices

- All financial practices of Federation of Organizations 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 Federation of Organizations' Administrative team, I will:

- Do my best to see that Federation of Organizations 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 Federation of Organizations internally and externally in a professional manner.
- Treat others with dignity and respect.
- Take no actions that could benefit me personally at the expense of Federation of Organizations.
- Strive for personal growth to improve my effectiveness as a Manager/Supervisor.

Element 2

Corporate Compliance Officer

Diane Kyrkostas, LMSW is the assigned Corporate Compliance Officer, Director of Compliance/Quality Management, and Privacy Officer for Federation of Organizations. She can be contacted via telephone at (631) 447-6460, extension 3156 and via email at Dkyrkostas@fedoforg.org. Her office is located at 3390 Route 112, Building A, Medford, NY 11763. The Corporate Compliance Officer is responsible for overseeing the Compliance Program at Federation of Organizations. 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 Chief Executive Officer and to the Chief Operating Officer/Deputy Chief Operating Officers as well as the Corporate Compliance Committee. The Board of Directors will also be made aware by one of the aforementioned parties. 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 Management 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 Corporate Compliance Officer. Committee members include, but are not limited to, the Chief Executive Officer, Chief Operating Officer, Deputy Chief Operating Officers (as applicable), Chief Medical Officer, Chief Financial Officer and Director of Human Resources. Program Directors will be asked to attend when appropriate. Committee members will review all investigations or claims of fraud and abuse, make recommendations and initiate education and training efforts to address these issues and concerns. The Committee will be responsible for updating employees on current compliance issues.

Element 3

Education and Training for Employees

False Claims

I. Introduction

Federation of Organizations 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. Federation of Organizations is committed to ensuring that it operates under the highest ethical and moral standards and that all its activities comply with applicable Federal and State laws.

Federation of Organizations focuses on the prevention of abuse and fraud in Federal and State Health Care Plans by protecting against non-compliance; accidental or deliberate. Federation of Organizations seeks to promote full compliance with all legal duties applicable, to foster and ensure ethical conduct and to provide guidance and education to each employee of the Agency regarding his/her conduct. As Federation of Organizations is paid by the State for Medicaid/Medicare services provided, staff must comply with stringent regulations. Federation of Organizations 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 will be educated about compliance requirements in the health care industry as it relates to guidance provided by the Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services Office of Inspector General (HHS-OIG) 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 Federation of Organizations must comply. Any Federation of Organizations' employee who violates these laws and/or regulations risks individual criminal prosecution and penalties, civil actions for damages and penalties and subjects Federation of Organizations to these same risks and penalties. Any employee who violates these laws may be subject to immediate termination of his/her employment.

A. 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 Corporate Compliance Officer.

1. 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 \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that 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).

2. Civil Monetary Penalties Act

Federation of Organizations' 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*.

B. Billing Issues and Risk Areas

The following are some specific risk areas for which Federation of Organizations' 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 to Federation of Organizations 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).

- Treatment Plans/Treatment 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 client receiving the services and other appropriate parties.

1. 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. 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.

The intervention is 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. All services provided must correlate to the appropriate diagnosis.

(a) Medical necessity is based on each client's Assessment, which provides information for treatment planning (service planning) and level of need in each functional area. Assessments should clearly summarize recommendations for treatment, taking into account the clients' diagnoses, their functioning level and their readiness to work on such issues.

(b) All services provided must correlate to an individualized Treatment Plan (or Service Plan). Clients' signatures must be indicated on their Plan, demonstrating their agreement and understanding of the Plan, or there must be documentation present within clients' records that evidence their review, collaboration and approval of their Plan. Clients must be active participants in their treatment. In the case of outpatient mental health clinics, 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. Please Note: The Part 822 OASAS Regulations no longer call for the staff to draft written Treatment/Recovery Plans, neither at clients' admission or on an ongoing basis. The Regulations call for staff to document clients' treatment/recovery planning process within progress notes.

(c) Services must be delivered at the appropriate level of care and must be individualized to each client serviced. Appropriate referrals, transfers, and discharges must be documented demonstrating good faith efforts to place clients 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 client is benefitting from the services being provided.

(d) Progress notes must correlate to the current Treatment 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 client's progress.

III. Training and Education

All existing Federation of Organizations' employees shall receive training and education with regards to the Agency's Compliance Program. In addition, all employees have access to the Compliance Plan in order to ensure compliance with the aforementioned standards. All new Federation of Organizations' employees will be required to review the Agency's Compliance Plan and take a pre- and post-training quiz regarding its contents on KMS within 30 days of their hire. KMS will track new hires' attendance and quiz scores. In addition, all new hires are required to take the following Compliance trainings on KMS within 30 days of hire:

- (1) HIPAA for Covered Entities with Assessment;
- (2) HIPAA Confidentiality & Security of PHI Policy with Quiz; and
- (3) Individual Authorization Policy (no quiz).

All existing employees must also take the aforementioned trainings on KMS on an annual basis as per the Agency's training schedule. In addition, the following Compliance Trainings are assigned to all employees annually: (1) Culture of Compliance with Quiz and (2) New York State False Claims Act with Quiz. 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. Should an employee have any questions or concerns regarding the Agency's Compliance Plan or any of the Compliance trainings, he/she should direct questions to Diane Kyrkostas, LMSW at (631) 447-6460, extension 3156.

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 Corporate Compliance Officer and employees of Federation of Organizations. It is important that each employee is knowledgeable in how to report suspected incidences of fraud and abuse.

All staff is responsible to report any individual who is suspected of violating compliance. Reports shall be made to staffs' direct Supervisor who will then in turn be responsible for reporting any misconduct or non-compliance to the following supervisory staff: Program Supervisor, Program Manager, Associate Director, Director and/or Executive Team until the report reaches the Corporate Compliance Officer. The Corporate Compliance Officer is then responsible to inform all appropriate parties about the potential non-compliance. A report may be made directly to the Corporate Compliance Officer should staff not be comfortable reporting it to their immediate Supervisor.

In addition, Federation of Organizations will provide all staff with an anonymous and confidential toll-free 24-hour supervised hotline telephone number, which will be operated by an external Consulting Agency (**Hotline #: 1-866-580-2736**). All staff will be provided training and education related to appropriately contacting the Hotline (flyer can be located on KMS and on the Agency's website). Hotline representatives will contact the Corporate Compliance Officer immediately should there be a high risk concern related to compliance or fraud and will provide the Corporate Compliance Officer with consultation regarding the most effective manner in which to respond to the situation, if necessary. In addition, in non-imminent situations, the consulting Agency will provide the Corporate Compliance Officer a quarterly report indicating and detailing all calls made to the Hotline. These reports are electronically maintained by the Compliance/Quality Management Department.

In addition, staff may report suspected incidences of fraud and abuse via email at Contact@thecomplianceconsortium.org, which is also operated by an external Consulting Agency. This method of communication is confidential, but not anonymous.

Upon staff reporting suspected incidences of fraud and abuse, an investigation will commence within 24 hours by the Compliance/Quality Management Department. In addition, all follow-up, including, but not limited to, disciplinary action will be taken and documented.

Element 5

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

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

Once the information reaches the Corporate 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 Management Department and will continue until the matter is closed. 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 Management 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 in employees' personnel files. The level of disciplinary action to be taken is dependent upon the offense (i.e. probation/suspension). Federation of Organizations 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.

Federation of Organizations 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 without 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

Federation of Organizations has a robust 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) Federation of Organizations' policies and procedures are current and complete and (2) Federation of Organizations' 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). To this end, the Accounts Receivable Department conducts monthly claims auditing prior to submission for reimbursement. Federation of Organizations' 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 Management Department will conduct a review of Federation of Organizations' 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) 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 actually 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).

Federation of Organizations' 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 clients' documentation utilizing their programs' "Monitoring Tool" for a percentage of randomly selected client case records. This information is submitted to the Compliance/Quality Management Department for review. Monitoring of documentation must occur monthly.

The Compliance/Quality Management Department will hold conference calls with Program Managers/Team Leaders, Directors, and Associate Directors to discuss the documentation deficiencies (error rates) that were identified. The attendees of the call will determine appropriate corrective action in order to rectify the areas that require improvement, as applicable. Upon completion of the call, the

Program Managers/Team Leaders are responsible to submit a plan of corrective action to the Compliance/Quality Management Department for review and approval. This will ensure that similar issues are prevented from occurring in the future.

Additionally, the Program Managers/Team Leaders 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 Associate Directors will monitor to ensure that the corrective action(s) are being overseen by the Program Managers/Team Leaders and that they are being implemented and enforced accordingly. The Compliance/Quality Management 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 Management Department or program staff to conduct a more detailed audit by reviewing a larger sample of client records to determine the reasons such deficiencies are occurring and to assist in determining where additional corrective actions are necessary.

Excluded Individuals

Federation of Organizations will not willingly employ any individual that has been excluded from Medicaid. The Human Resources Department 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 Business Associates on a monthly basis. These exclusion checks shall be conducted on the following websites: <http://oig.hhs.gov>, <http://omig.state.ny.us> and <https://www.sam.gov>. 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. Please also refer to Federation of Organizations' policies entitled "Monitoring and Auditing Billing Systems & Claims Accuracy" and "Self-Disclosure and Self-Reporting Violations".

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 Management Department and the Corporate Compliance Committee will immediately review the Federation of Organizations' 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 in order 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 Chief Executive Officer and Chief Operating Officer/Deputy Chief Operating Officers who will inform the Board of Directors, other applicable Corporate Compliance Committee members and will confer with Federation of Organizations' external Compliance Consultant as necessary.
- 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 and the external Compliance Consultant, as necessary.
- 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/Ethics, 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.

Good Faith Reporting

No employee will be subject to any punishment or reprisal for good faith reporting of compliance concerns to their Supervisor or to the Corporate Compliance Officer. Federation of Organizations 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.

Element 8

Non-Retaliation; Whistleblower Protection

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

An external whistleblower is any private party outside of Federation of Organizations 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.

Definitions:

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.