Mercy Haven’s Compliance Program Plan  
As of 8.29.19

The Compliance Program is established to ensure that operations within Mercy Haven, Inc. are conducted in a manner that is ethical and adheres to state and federal laws and regulations. The Compliance Program will address such regulations, but is not limited to, those established in part 521 of Title 18 of the Code, Rules, and Regulations of the State of New York, the New York State False Claims Act and HIPAA.

1. **Compliance Officer**

The operations of the Compliance Program are the responsibility of the agency’s Compliance Officer including but not limited to the development, implementation, and monitoring of agency policies that support the requirements of the Compliance Program.

The Compliance Office works under the supervision of the Associate Executive Director, with direct access to the Executive Director and regular reporting to the Board of Directors.

It is the responsibility of the Compliance Officer to oversee that the requirements of the Compliance Program are met and to ensure that deficiencies are responded to in a timely manner if any are detected. In part, the oversight will be done through the review of audit findings and corrective action plans developed with support from the responsible departments.

The Compliance Officer conducts compliance risk assessments periodically and revises the program in light of the agency's needs and if changes are made in the laws or regulations.

**A. Investigations and Resolution of Compliance Issues**

The Compliance Officer conducts or oversee investigations including but not limited to issues of suspected Medicaid fraud, abuse, and waste, breaches of protected health information (PHI) as protected under HIPAA, actual and perceived conflicts of interest, and illegal or unethical behavior.

Based on the nature of the issue being investigated, the Compliance Office determines who will be involved with the investigative process (i.e. HR, Program Administrator, Program Director, etc...)

The investigations conducted by the Compliance Officer or designee include but are not limited the use of interviews, documentation reviews and a root cause analysis of issues.

The Compliance Officer oversees the investigation and resolution of all compliance-related issues, even if other staff are involved in the investigative process. The resolution of issues include but are not limited to the development and implementation of policies, procedures, changes to systems based on assessed risk, and the development and/or monitoring of corrective action plans to reduce compliance-related problems from occurring or reoccurring.

The results of internal audits, investigations and the status of corrective action plans are reported to the Corporate Compliance Committee, to allow for feedback and governance over the operations of the Compliance Program.
The Compliance Officer is also responsible for ensuring that identified issues are reported to the Office of the Medicaid Inspector General (OMIG) when appropriate, as outlined in the agency’s Self-Disclosure policy.

The Compliance Officer ensures that all certifications as required by OMIG are completed and forwarded accordingly. An annual self-assessment of the agency’s Compliance Program is conducted prior to the certification of the program, utilizing the OMIG Self-Assessment document and Compliance Program Review Guidance document.

The Compliance Officer ensures that any staff, Board members or non-employee agency affiliate (i.e. students, volunteers) known as Affected Individuals who request information pertaining to the agency’s Compliance Program receives it in a timely manner.

2. Corporate Compliance Committee

The Corporate Compliance Committee is established to ensure compliance and quality are achieved in the agency, its policies, programs, and departments. The committee consists of Board members, the Compliance Officer, and agency Directors. The committee is chaired by a member of the Board of Directors.

The committee is responsible for the oversight and annual review of the Code of Ethics, which includes the Conflict of Interest policy. The committee is also responsible to review the results of audits, potential situations that impact the quality of services and corresponding corrective action plans; to identify potential risk areas and vulnerabilities in agency practices and establish additional corrective action plans to prevent future issues from occurring or reoccurring.

3. Whistleblower Program

It is the expectation of Mercy Haven that all Affected Individuals play an active role in the Compliance Program through the prevention and reporting of Medicaid fraud, abuse, and waste, breaches of PHI, and illegal or unethical behavior. Participation in the Compliance Program includes but is not limited to reporting potential issues, investigating issues, self-evaluations, and audits.

The first option for staff is to report any suspected acts of misconduct to their supervisor. If they would prefer they may report any issues to the Director of Human Resources or directly to the Compliance Officer.

All individuals, including Affected Individuals and participants, may contact the Compliance Officer directly at the Main Office, by phone (631-277-8300), through direct email or through the Compliance section of the agency’s website (www.mercyhaven.org).

Those who would prefer an anonymous and confidential approach may use the 24/7 hotline service, through Lighthouse at 833-490-0007 or www.lighthouse-services.com/mercyhaven (See Whistle Blowing Program policy).

All reports to the hotline are considered confidential and details related to the person’s identity will only be disclosed if law enforcement becomes involved.
The Compliance Officer will receive the hotline reports and determine if the report falls under the scope of the Compliance Program or if it should be investigated by the Director of Human Resources.

Based on the nature of the issue being investigated and the way in which the information was received, the Compliance Officer will determine who will be involved in the investigation of Compliance related issues.

The Director of Human Resources and the Compliance Officer are responsible for overseeing investigations related to their departments, even if other staff assists in the investigation. They are also responsible for notifying the Executive Director and Associate Executive Director that an investigation is being initiated.

If investigations determine that a corrective action plan is warranted, then the appropriate Department Director will be notified and provided with a summary of the investigation findings, in order to maintain the confidentiality of the reporter.

The Compliance Officer is designated to administer the Whistleblower policy and to report findings to the Corporate Compliance Committee and/or the Board of Directors as needed. If a call received through the Whistleblower hotline is regarding Mercy Haven’s finances, the Chair of the Board Finance Committee will also be notified immediately.

Investigation outcomes will be documented and maintained by the Compliance Officer or the Director of Human Resources.

In compliance with sections 740 and 741 of the Labor Law, Affected Individuals who report suspected misconduct will not be terminated, demoted, suspended, threatened, harassed, intimidated or in any manner retaliated against in the terms and conditions of employment/position by the agency, as a result of the report.

When questions or concerns are raised regarding compliance issues, feedback shall be provided by the Compliance Officer in a timely fashion. If questions or concerns are raised anonymously then feedback shall be provided at agency staff meetings and/or to Lighthouse for reporting back to the individual making the report.

4. **Training and Education**

All staff receives an Employee Handbook and training upon hire (within 30 days of start date), which provides initial information about the Code of Ethics and Business Conduct, Whistle Blower Program, HIPAA, billing and documentation compliance, and the Compliance Program.

Staff is also provided an opportunity to review the Compliance Program policies during their introductory period (90 days of start date).

Training occurs annually for all employees.

Mercy Haven’s Board of Directors receive initial educational material on the Compliance Program upon being appointed to the Board and then annually.
Volunteers and students are provided with training at orientation. Additional training is provided annually to those non-employee affiliates who are influential in guiding services and/or who are involved in billable services and claims.

Training formats can vary and include but are not limited to in-person training, self-study and self-study makeups. Individuals receiving training information are encouraged to contact the Compliance Officer to address any questions about the training material or the Compliance Program.

Makeup opportunities for Compliance training are made available and monitored by the Compliance Officer or designee, which include the Human Resource department and Executive Assistant. The HRIS system (in 2019) provides status reports to the Compliance Officer of those who have completed training within the scope of the Compliance Program. The Compliance Officer maintains a tracking log of other Affected Individuals to monitor the completion of Compliance related training.

Training topics may be modified based on findings from audits, investigations and Whistleblower hotline reports.

5. **Compliance Risks Identification and Monitoring**

Mercy Haven has systems in place to ensure that claims submitted for payment through Medicaid are accurate and conform to all pertinent federal, state and local laws and regulations.

All Affected Individuals working on Mercy Haven’s behalf are prohibited from knowingly presenting or causing to present claims for payment or approval which are false, fictitious or fraudulent.

A. **Internal Compliance Audits and Monitoring**

   i. **Medicaid Billing/ Claims Pre- Submission Audit Process**

   Prior to the submission of claims for Medicaid payments, a series of reviews are done to determine if all necessary requirements are met based on regulations. Requirements that are reviewed include service documentation, current Authorizations for Restorative Services and the federal and state Exclusion lists. The service documentation review is being expanded to include a quality review of the content of the billable note to ensure the content of the note matches the goals/objectives outlined in the service plan.

   If issues are found that could impact the ability to bill for services it is reported to the Program Director and the Compliance Officer to determine if the claim for services will be withheld and not submitted based on the findings.

   ii. **Medicaid Billing/ Claims Submission and Supporting Documentation**

   After billing is submitted, audits are conducted quarterly by the Compliance Officer or designee of a sample of Medicaid claims to ensure that regulatory requirements related to services and service documentation are met.

   Documentation related to the services being billed for (e.g. - restorative notes, service plans and Authorizations for Restorative Services) and documentation related to billing/claims (e.g. – billing and claims reports) are reviewed.
During the year, each Community Residences is audited at a minimum of two times. The first audit is done of all participants in the residences during the audit months. The audit timeframe is the 3 months prior to the month the audit is conducted in. For example, an audit being conducted in April will be of the billing reports and supporting documentation for the months January, February, and March.

The second audit of each Community Residence is done in the 4th quarter and consists of a sample of charts (around 50% of the charts in each community residence) of the billing and supporting documentation for the 3 months prior to the audit month.

Any errors or issues found will be reported to the appropriate Director (i.e. Finance or Residential) who assists in investigating the error, determining the cause, and developing a corrective action plan.

All information regarding the error is reported to the Compliance Officer, who works with Senior Management and the Corporate Compliance Committee to determine if a Self-Disclosure to OMIG is required.

iii. Supportive Housing Documentation

Documentation is required in the Supportive Housing program to meet the regulatory requirements of several oversight agencies (i.e. OMH, Homeless Housing Assistance Corporation and the Town of Islip).

A sample of charts is reviewed using the Compliance audit tool and/or a monitoring tool used by the oversight agency responsible for the program in which the participant is involved.

Findings are provided to the Senior Administrator of the program and the Program Director for the development of a corrective action plan for the specific finding and to use as a basis for systemic change across all program documentation.

iv. Environmental Audits

Based on the nature of Mercy Haven’s services, environmental audits are conducted as they relate to the services provided by the agency and could potentially become a health and safety issue.

Community Residence Administrators and Supportive Housing staff conduct monthly environmental audits using a tool created by the Compliance Officer.

The maintenance department also conducts monthly audits of Mercy Haven’s properties to identify maintenance issues that need to be addressed.

Additional environmental audits are conducted by the Compliance Officer or designee to ensure all environmental issues are continuously being addressed by staff. Issues are reported to program Administrators for corrective action.

v. HIPAA Compliance

Audits are conducted on a quarterly basis by the Compliance Officer or designee in order to determine the level of risk of HIPAA non-compliance.
All information regarding the error including any corrective action plans is reported to the Compliance Officer if not the auditor, who reports the information to the Corporate Compliance Committee.

If it is determined that a breach of PHI has occurred that compromises the security or privacy of the protected health information and poses a significant risk of financial, reputational or other harm to the participant, then required notification to will occur without unreasonable delay.

vi. **Additional Audits**

Audits and audit tools are continuously restructured and revised to have a focus based on assessed risks; determined by the frequency, severity, and impact of the assessed risk areas.

Audits and audit tools are also structured based on best practices and guidance documents provide by OMIG and other regulatory agencies to ensure that all components of Mercy Haven billing, services and documentation are comprehensively reviewed.

Currently, additional audits on the audit schedule include a review of staff timesheets in comparison to the dates of service delivery, and security levels and access to PHI in the electronic health record, PrecisionCare.

vii. **Exclusion Lists Review**

All potential and current employees, contractors, vendors, service providers, students or volunteers who are involved (directly or indirectly) in generating a claim to bill for services or being paid by federal funds including Medicaid, are reviewed to ensure they are not excluded from participating in the Medicaid program. Additionally, all Affected Individuals who are influential in dictating agency practices and policies (i.e. Board members) are reviewed.

The Exclusion lists are reviewed prior to hire/ contract agreement by the Human Resources department or designee.

The three Exclusion lists are also checked monthly prior to the submission of Medicaid billing by the Compliance Officer.

**B. External Audits**

Annually external audits are conducted of the agency’s financial operations by an accounting firm. Findings are reported to the Finance Committee for review and reported to the Board. Findings related to overpayments are also reported to the Compliance Officer, and if necessary, a consultation with outside counsel is obtained.

Additional audits of the agency’s programs and financial operations are conducted periodically by state and federal oversight agencies as deemed necessary (i.e. - OMH, OMIG, HUD, HHAC, and Islip CDA). Findings of these audits and related corrective action plans are reported to the Corporate Compliance Committee, by the responsible Director.
C. Risk Assessment

During the 4th qtr. of each year several components of the Compliance Program are reviewed in order to prepare for the following year. The following documents are reviewed and or developed:

The OMIG Self-Assessment and Compliance Program Review Guidance documents are reviewed during this time to determine any areas not previously addressed that create potential risks and/or modifications that need to be made.

A new audit schedule is developed based on a review of the current year's audits and corrective action plans; to determine if any items need to be added or removed based on assessed risk.

The current Compliance Program Plan is reviewed to determine if any changes need to be made to the Plan and/or corresponding policies.

A Risk Assessment/Strategic Plan is developed based on the above; to outline areas of risk being addressed throughout the next year. The Risk Assessment/Strategic Plan includes both new items to be addressed and those that have been monitored in the past but are assessed as still posing a level of risk.

i. Ongoing Review of Compliance Regulations and Risk Areas

The following are reviewed/attended/completed by the Compliance Officer or designee when available and used to guide changes and updates to the Agency's Compliance Program:

- Review of OMIG's Work Plan
- Medicaid Updates
- Compliance Alerts
- Compliance Webinars
- Corrective Action Plans
- Meetings held by the ACL and other provider groups

6. Disciplinary Action

Affected Individuals will, at all times, act in a way to meet the requirements of the mandatory Compliance Program and corresponding laws and regulations.

If it is determined that an Affected Individual has failed to meet the requirements of the mandatory Compliance Program in which they failed to report suspected problems; participated in non-compliant behavior; failed to assist in the resolution of suspected compliance issues; or encouraged, directed, facilitated or permitted non-compliant behavior, as it relates to billing, payments, or protected health information, they will face disciplinary action and/or possible termination of their relationship with the Mercy Haven.

7. Seven Compliance Areas
In addition to the activities described above, the Compliance Officer has direct or indirect involvement in the following seven compliance areas.

- Billings;
- Payments;
- Medical necessity and quality of care;
- Governance;
- Mandatory reporting;
- Credentialing;
- Other risk areas that should with due diligence be identified by the Agency.

A. Billing
The Compliance Officer conducts a root cause analysis for persistent billing denials. All billing denials are reported to the Compliance Officer by the Accountant.

Pre-billing audits are done by the Compliance Officer of billing logs and then reviewed again and compared to the claims reports submitted by the finance department during quarterly audits.

The Compliance Officer also reviews the service documentation that supports billing during quarterly audits.

B. Payments
The Compliance Officer works with the Finance department to track and analyze any overpayments, underpayments, and denials.

Billing logs and claims reports are compared during quarterly audits for accuracy.

Void/adjustment requests are submitted by the Compliance Officer to the Accountant for processing. Once completed, details of the void/adjustment are provided back to the Compliance Officer for review, including details of the amount submitted. All documentation is maintained in the Compliance Officer’s files.

C. Medical Necessity and Quality of Care
The Compliance Officer works with the Director of Behavioral Health Services on the quality control process through audits and data analysis, for the development of corrective action plans and control structures.

The Compliance Officer provides or suggests training to improve service delivery.

The Compliance Officer is provided with the resolution of complaints made by participants and family members to ensure quality and completeness.

The Compliance Officer attends meetings or receives reports in order to provide quality improvement recommendations. These meetings can include Outcome and Quality Management, Incident Review, Admissions, and Utilization Review.

D. Governance
The Compliance Officer oversees the development and implementation of the Conflict of Interest policy as referenced in the Code of Ethics and Compliance Program policies; with support from the Corporate Compliance Committee.

The Compliance Officer provides training to the entire Board and management.

The Compliance Officer provides reports pertaining to the Compliance Program and quality initiatives (with the support of the Director of Behavioral Health Services) to the Corporate Compliance Committee and the entire Board.

The Compliance Officer provides self-assessments and policies related to the Compliance Program to the Corporate Compliance Committee.

E. Mandated Reporting
As part of the Compliance Program, it is the expectation and requirement that all compliance issues are reported internally and externally, as previously described.

The Compliance Officer works with the AED to ensure the annual SSL certification is completed on time after a thorough review of the Compliance Program to ensure effectiveness.

F. Credentialing
An annual audit is done by the Compliance Officer to ensure staff meets the QMHSP requirements and/or a supervisor is signing off on documentation they have prepared. The HR department determines if they meet the requirements for a QMHSP prior to hiring.

The Exclusion lists are reviewed upon hire by the HR Generalist and monthly by the Compliance Officer prior to billing, of all Affected individuals and those indirectly involved in services (i.e. Physicians signing CR Authorizations).

G. Other Risk Areas That Are or Should With Due Diligence Be Identified
Risks are continuously assessed and a level of risk is determined based on, frequency, severity, and impact of the risk areas.

High to medium level risk areas are used as the focus of audits and audit tools. Medium to low-level risks, or areas that are being assessed for risk are included in a Compliance Work/Development plan.

Identified compliance issues remain a part of internal audit tools and/or a part of the annual compliance schedule to determine if the risk remains in the future and/or to assess the validity of their resolution.