Mercy Haven's Compliance Program Plan

As of 5.25.23

The Compliance Program is established to ensure that operations within Mercy Haven, Inc. are conducted in a manner that are 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 SubPart 521-1 of Title 18 of the Code, Rules, and Regulations of the State of New York, the Health Insurance Portability and Accountability Act (HIPPA) and the Federal Deficit Reduction Act; focused on preventing and detecting any fraud, abuse, waste, and misconduct in the Agency.

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 Officer works under the supervision of the 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 promptly 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 a compliance risk assessment 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 oversees 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 to 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 includes but are not limited to the modification or development and implementation of policies, procedures, changes to systems based on the assessed risk, and the development and/or monitoring of corrective action plans to reduce compliance-related problems from occurring or reoccurring.

A description of the investigative process, interview notes and other documentation, and the findings of investigations will be maintained in a secure location by the Compliance Officer and reported on the Compliance Log.

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 ensures that all certifications as required by OMIG are completed and forwarded accordingly. 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. Self-Disclosures include a detailed description of the circumstances that led to the overpayment and the corrective actions taken to prevent a recurrence of the error or matter.

In addition to the Self-Disclosure policy described above, if there is credible evidence that a State or Federal law, rule or regulation has been violated, the Compliance Officer or designee shall promptly report such violations to the appropriate government entity, where reporting is required by law, rule, or regulation. The Compliance Officer will receive copies of any reports submitted to a government entity if they are not the submitter of the report.

The Compliance Officer ensures that any staff, Board members, or non-employee agency affiliate (i.e. students, volunteers), all 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 regulatory 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 reviews the results of audits, potential situations that impact the quality of services, and corresponding corrective action plans; identifying potential risk areas and vulnerabilities in agency practices and establishing additional corrective action plans to prevent future issues from occurring or reoccurring, as needed. The charter for the committee will be reviewed annually, updated as needed, and reported to the full Board.

3. Whistleblower Program

Mercy Haven expects 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 protected health information (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, by phone (631-277-8300), through email at Jmoran@mercyhaven.com, or the Compliance section of the agency's website (www.mercyhaven.org).

Those who would prefer a confidential or anonymous 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 of compliance issues are considered confidential, and details related to the person's identity will be maintained unless the matter is subject to a disciplinary proceeding, referred to or under investigation by MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the Agency's policy for non-intimidation and non-retaliation.

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 how 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 an investigation determines that a corrective action plan is warranted, then the appropriate Department Director will be notified to complete a corrective action plan. A summary of the investigation findings will be provided, to maintain the confidentiality of the reporter.

The Compliance Officer is designated to administer the Whistleblower policy and to report findings to the Executive Director, 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's Finance Committee will also be notified immediately.

Investigation outcomes will be documented and maintained by the Compliance Officer or the Director of Human Resources. Documentation surrounding compliance-related investigations will include a description of the investigative process, interview notes and other documentation, and the findings of investigations, which will be maintained in a secure location by the Compliance Officer and reported on the Compliance Log.

Affected Individuals who report suspected misconduct including reporting instances of intimidation and retaliation, and those individuals involved in the investigation and resolution of the 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, Deficit Reduction Act requirements including the Whistleblower Program and False Claims Act, 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 on the Compliance Program and related laws and regulations as described above occurs annually for all employees.

Mercy Haven's Board of Directors receives initial educational material on the Compliance Program and related laws and regulations upon being appointed to the Board and then annually.

Volunteers and students are also 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 self-study 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. Training completion is monitored by the Compliance Officer or designee, which includes the Human Resources department and Executive Assistant.

Training effectiveness for in-person training is monitored through the completion of tests before and after the training (pre-test, post-test). The effectiveness of self-study training is monitored through the completion of a test after the training is complete.

Training topics may be modified based on findings from audits, investigations, changes in regulations, training test outcomes, 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. *Monthly Pre-billing Audits (Medicaid Billing/ Claims Pre- Submission Audit Process)*
Before the submission of claims for Medicaid payments, a series of reviews are done to determine if all requirements are met based on regulations. Requirements that are reviewed

include service documentation, current Physician Authorizations for Restorative Services (CRs), and the federal and state Exclusion lists. The service documentation review also includes 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 claims for services will be withheld and not submitted based on the findings.

Additional reviews were implemented as a result of the COVID emergency and will continue indefinitely. They are as follows:

Authorizations

- A tracking grid of all authorizations was created and maintained in the CO's file to improve oversight.
- A tracking grid of the service providers signing off on the PA was also created.
- All new providers were checked against the Exclusion Lists and their license is verified.
- A review of the type of provider signing off on the PA was also completed to meet regulations.

Service Plans

- A report in the EHR was reviewed monthly before billing was completed to ensure the Service Plan was completed, on time, and signed by the participant.
- The signature report was also utilized to determine which Plans were new and created during the month so they can be reviewed by the CO or designee for accuracy and quality.
- Staff were encouraged to upload any hand-signed Plans so they can be reviewed remotely and also as a backup for maintaining them.

Billable Progress Notes

- Billable progress notes were reviewed by the CO or designee before the submission of billing to ensure accuracy and quality.

**** In 2023, it is anticipated that Supportive Housing services will be eligible for Medicaid billing. At that time, additional pre-billing and quarterly audits will be added to ensure regulatory requirements are being met.***

ii. Quarterly Medicaid Billing/ Claims Submission and Supporting Documentation

CRs-
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 of January, February, and March.

The second audit of each Community Residence is done in the 4th quarter and consists of a sample of charts (between 25%- 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 and program Administrator (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 and guidance 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 findings 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 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 Facilities 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 by the Compliance Officer or designee to determine the level of risk of HIPAA non-compliance. HIPAA audits review both documentation and the environment in which PHI is stored and/or created.

Findings from audits are reported to the Compliance Officer if not the auditor. The Compliance Officer will notify the appropriate staff member who will be responsible for developing a corrective action plan, as needed.

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 will occur without unreasonable delay. Information regarding breaches of PHI will be reported to the Corporate Compliance Committee and senior management by the Compliance Officer.

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 developed 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, 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 are 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). The findings of these audits and related corrective action plans are reported to the Corporate Compliance Committee, by the responsible Director.

C. Compliance Program Review/ Risk Assessment

During the 4th qtr. of each year, several components of the Compliance Program are reviewed to assess risk, determine the effectiveness of the program, and prepare for the following year. The risk assessment includes but is not limited to a review of the Compliance Program policies, Program Plan, audit findings and corrective action plans to identify trends, and the previous Risk Assessment-Corrective Action Plan/Strategic Plan.

Documentation provided by OMIG including SubPart 521-1 regulations, guidance documents, and the Compliance Program Review Module, are also reviewed during this time to determine any areas not previously addressed that create potential risks and/or modifications that need to be made.

The current Compliance Program Plan is reviewed to determine if any changes need to be made to the Plan and/or corresponding policies. All policies are also reviewed at this time and updated as needed.

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

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.

A report on the annual Compliance Program review, including the date completed and findings from the review will be created and shared with the Executive Director, senior management, Compliance Committee, and the governing body.

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
- OMIG compliance alerts
- Compliance- related webinars
- Corrective action plans
- Meetings held by the ACL and other provider groups

6. <u>Disciplinary Action</u>

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.

Disciplinary action will be based on the nature and severity of the infraction. Disciplinary action will be fairly and firmly enforced.

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 or Director.

Pre-billing audits are done by the Compliance Officer or designee of billing logs and then reviewed again and compared to the claim's 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.

C. Medical Necessity and Quality of Care

The Compliance Officer works with the Director of Behavioral Health Services and the Director of Supportive Housing 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 and the Corporate Compliance Committee are provided with the resolution of complaints made by participants and family members to ensure the quality of care and completeness.

The Compliance Officer attends meetings or receives reports in order to provide quality improvement recommendations. These meetings can include Outcome Management/ Quality Assurance, 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 ensures that all certifications as required by OMIG are completed and forwarded accordingly. 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.

F. Credentialing

An annual audit is done by the Compliance Officer to ensure that staff meet 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).

The licenses of the physicians signing the authorization are also verified to ensure that they are active. This review also helps to determine if a "match" on the Exclusion list is accurate as additional information is often not available to verify the match.

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 the Risk Assessment Corrective Action Plan/Strategic Plan.

Identified compliance issues remain a part of internal audit tools and/or a part of the annual compliance audit schedule to determine if the risk remains in the future and/or to assess the validity of their resolution. Examples include a review of timesheets compared to billable service; to ensure staff worked on the day a service was documented as provided.

As of March 2020, some modifications have been made to the Compliance Program Plan as a result of the COVID pandemic. Please see the COVID Risk Assessment for details of the temporary modifications made to the Plan and audit schedule. Examples include the suspension of in-person documentation and environmental audits when the risk of COVID infection is high.