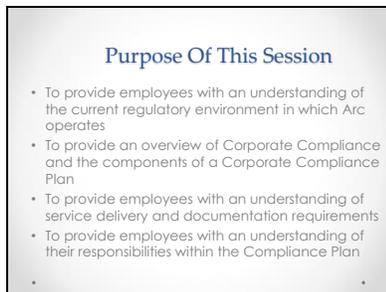


Slide 1



Slide 2



Introduction and review the objectives of training.

Slide 3



The agency must comply with many federal and state laws and regulations. Here are some of the more common ones.

There are employment and labor laws. In addition, there are laws that protect individuals from discrimination the workplace.

Some laws and regulations provide direction on how the agency is governed by the Board and how the agency is managed. There are also state regulations that address the licensing of programs that we operate and the licenses and credentials of some of our staff.

Regulations exist to protect the

people we serve from abuse and mistreatment.

A person's health information is protected by privacy and confidentiality laws. There are also laws and regulations about communicable diseases such as HIV and Tuberculosis.

The agency has to comply with OSHA requirements that address workplace safety issues.

There are regulations that apply to the physical environment of our facilities, such as fire safety and construction.

Each program is governed by regulations that relate to the services that can be provided, eligibility requirements, who can provide services, how services are provided, reviewed and documented.

The agency must also comply with federal and state laws that pertain to billing, financial recordkeeping and reporting, and how we are reimbursed for the services that we provide.

Slide 4



Laws and Regulations

- To comply with the laws and regulations, the Agency develops:
 - >Policies,
 - >Procedures, and
 - >Practices

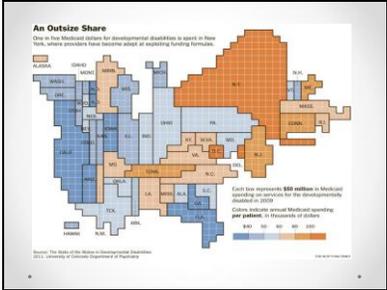
So that we are assured we are complying with all of the laws and regulations, the agency develops policies and procedures and standards of practice. In most cases, these are written documents.

In some instances, we have standard operating practices that guide what we do.

Our job as an agency is to make sure that we comply with all applicable laws and regulations, set policies and procedures and guidelines for employees to follow, and to make sure that we are

following our policies, procedures and standards of practice.

Slide 5



Slide 6

New York's Medicaid Program

- New York State's Medicaid program (annually):
 - Costs \$52+ billion
 - Provides health care to 4 million recipients through 60,000 active providers; over 160 million eligibility verification and service authorization requests
 - Processes 350 million claims and payments.
- Arc of Onondaga
 - Approximately \$22 million from Medicaid annually
 - Over 1000 enrolled in over 30 programs/service areas
 - Processes 9054 claims per month (over 100,000 per yr)

Not only is that number massive on its face, but it is also remarkable in relative terms. NY's program costs about as much as California's and Texas' programs combined

- New York : \$45 billion (4 million recipients)
- California : \$30 billion (6.3 million recipients)
- 3) Texas : \$15 billion (2.6 million recipients)

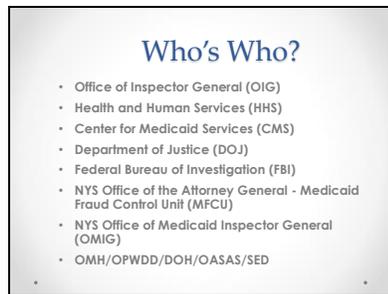
NYS Medicaid Budget FY 2008-09
\$46.3 billion

\$6 billion – OMRDD

Arc – 85-90% Medicaid
dollars
approximately 8000
claims/month

VOLUME OF CLAIMS

Slide 7



There are several federal and state agencies responsible for the investigation and prevention of fraud and abuse.

At the federal level, the Inspector General's office is responsible for the overall detection and investigation of fraud, abuse and waste.

The Department of Health and Human Services is a federal agency responsible for oversight of all health and human services programs.

The Center for Medicare and Medicaid Services is the federal agency responsible for the Medicaid program and all of its services.

The Department of Justice is a federal law enforcement agency responsible for enforcement and prosecution.

The Federal Bureau of Investigation may also assist in the investigation of any crimes.

At the state level, a special unit, Medicaid Fraud Control, operates under the Office of the Attorney General and is responsible for the investigation and prosecution of Medicaid fraud.

Recently, NY State created the Office of Medicaid Inspector General to provide a more targeted focus on Medicaid fraud, waste and abuse.

And finally, we have the oversight agencies for the different programs, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Department of Health, Office of Alcoholism and Substance Abuse, and the State Education Department. These agencies are responsible for assuring that the provider agency complies with all applicable laws and regulations.

Slide 8

NY State
Office of the Medicaid Inspector General
(OMIG)

- ❖ Created in 2005, is the first OMIG in nation at the State level
- ❖ "To coordinate the Medicaid fraud, waste and abuse control activities of...DOH, OMH, OPWDD, OASAS, OCFS, SED"

The NY Office of Medicaid Inspector General is the first Office of Medicaid Inspector General in the nation. Its purpose is to coordinate to detect and prevent fraud, waste and abuse with the oversight agencies listed on this slide.

Slide 9

**OMIG Work Plan
HCBS Waiver Services**

"The purpose of the waiver is to decrease the risk of institutionalization by providing such services as day hab., res hab., respite and family education & training. *Any waiver service provided to a participant must be included in the participant's service plan along with the amount, frequency and duration of each service.*"

Slide 10

**OMIG Work Plan
HCBS Waiver Services (continued)**

"The OMIG will review Medicaid payments to providers to determine if services provided to individuals were in accordance with approved waiver agreements and 18 NYCRR Parts 624, 633, 635, 686 and 671."

Slide 11

**The OMIG Perspective -
Not Everything Bad is Fraud**

- Fraud is intentional breach of standard of good faith and fair dealing as understood in the community involving deception or breach of trust, for money
- *An improper payment is a payment that should not have made under program rules- we want it back (no inference of fraud, no requirement of intent)*
- An improper practice is a violation which need not be intentional (but can result in exclusion)

Definitions from OMIG office

**Supervisor's role –
False Claims Act**

- it is a crime to knowingly submit a false claim for payment

- "knowingly" – know or should have known

Slide 12

From the Medicaid Regulations

Provider agrees to:

- (a) Prepare and maintain contemporaneous records demonstrating their right to receive payment...and keep, for 6 years from date care/service furnished, all records necessary to disclose the nature & extent of the service furnished and all information regarding claims for payment by, or on behalf of, the provider...

NYCRR Title 18, Section 504.3

As a provider of Medicaid services, the agency agrees to abide by certain requirements. This slide contains some very important language from the Medicaid regulations that relate to you and the documentation of services.

(NOTE: Read the regulation.)

This regulation means that the agency, and you as an employee of the agency, must document services at the same time that the service is provided or closely afterwards, for all services that are billed to Medicaid. The agency must keep all records and information to support the claim for six years from the date the service was provided.

Slide 13

More regs...

Provider agrees:

- (e) To submit claims for payment only for services actually furnished and which were medically necessary...
- (h) That the information provided in relation to any claim for payment shall be true, accurate and complete; and
- (i) To comply with the rules, regulations and official directives of the department.

NYCRR Title 18, Section 504.3

The regulation goes on to say that the agency, and you as an employee of the agency, agrees to only submit claims for services that **were actually provided and medically necessary.**

Any information that relates to a claim for payment must be **true, accurate and complete.** In other words, you must document accurately and thoroughly and honestly.

A provider of Medicaid services must also comply with all laws, rules and regulations.

To comply with this regulation, the agency has developed policies and procedures and practices related to service delivery and documentation.

Slide 14

And even more . . .

An overpayment includes any amount not authorized to be paid under the medical assistance program, *whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake*

NYCRR Title 18, Section 518.1 (c)

As a provider of Medicaid services, the agency agrees to abide by certain requirements. This slide contains some very important language from the Medicaid regulations that relate to you and the documentation of services.

(NOTE: Read the regulation.)

This regulation means that the agency, and you as an employee of the agency, must document services at the same time that the service is provided or closely afterwards, for all services that are billed to Medicaid. The agency must keep all records and information to support the claim for six years from the date the service was provided.

Slide 15

Deficit Reduction Act of 2006

- ❖ Policies and Procedures are now a requirement for all applicable Medicaid Service providers
- ❖ Emphasis is on fraud detection and prevention
- ❖ Training and Education of Staff regarding False Claims Act
- ❖ Requirement for Protection of Whistleblowers
- ❖ Encourages State level "qui tam" actions under False Claims Act provisions
- ❖ Enforcement of State Medicaid laws and regulations is expected/required

Another very new law was passed in 2006, for implementation January 1, 2007. The Deficit Reduction Act is federal legislation that places more emphasis on fraud detection and protection. This law is expected to encourage individual states to enact "qui tam" or Whistleblower provisions for persons to report fraud and abuse. The law requires that protections are provided to Whistleblowers to prevent retaliation for reporting fraud.

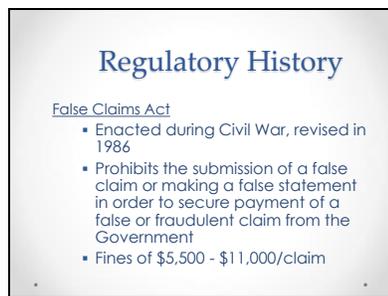
The law also requires training and education of staff in the False Claims Act and Whistleblower provisions.

As an employee, you need to be aware that there can be criminal or civil prosecution for a wide range of conduct that leads to the submission of a false claim. You also need to know that there are ways to report false claims. Should

an employee report, in good faith, knowledge of an alleged false claim, the employee is protected from retaliation or discrimination for making such a report. The agency has developed policies and procedures related to the False Claims Act and the reporting of non-compliance. We strictly prohibit any form of retaliation against an employee who reports a possible false claim.

Under this new law, we can expect more enforcement of Medicaid laws and regulations at the federal and state level.

Slide 16



Regulatory History

False Claims Act

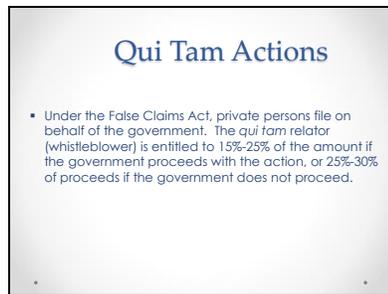
- Enacted during Civil War, revised in 1986
- Prohibits the submission of a false claim or making a false statement in order to secure payment of a false or fraudulent claim from the Government
- Fines of \$5,500 - \$11,000/claim

In addition to the laws that we just reviewed, there is another very important law that you must be familiar with. The False Claims Act, a very old law that was enacted during the Civil War to combat fraud in government contractors, prohibits persons or businesses from improperly receiving governmental funding for goods or services, and from abusing or wasting governmental funds. This very old law, updated last in 1986, prohibits anyone from submitting a false claim to obtain government funds. It also prohibits individuals or businesses from making a false statement in order to receive funds. The revision of this law in 1986 holds an agency's management staff more accountable. By the nature of their responsibilities as management, the law says they either "knew" or "should have known" about fraudulent claims or false statements.

As you can see, there are very severe fines and penalties for

submitting false claims.

Slide 17



Qui Tam Actions

- Under the False Claims Act, private persons file on behalf of the government. The *qui tam* relator (whistleblower) is entitled to 15%-25% of the amount if the government proceeds with the action, or 25%-30% of proceeds if the government does not proceed.

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a “Qui Tam” (pronounced “*kee tom*”) or whistleblower provision.

Private citizens are able to bring suits, under the False Claims Act, in the name of the government. The suit must be sealed and served on the government, which then has 60 days to decide whether to join the suit. If the government joins the suit and is successful in the prosecution, the relator or whistleblower is entitled to between 15% and 25% of the recovery. If the government declines to join the suit, the relator can proceed with the suit on its own. If the case is successfully prosecuted, the relator shares in the government’s recovery with an entitlement between 25 to 30% of the recovery.

There is a protection under this law for the relator or whistleblower that prohibits retaliation against the person who reported. This is referred to as “whistleblower protection”.

The False Claims Act prohibits

discrimination against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to relief. Such relief may include reinstatement, double back pay, and compensation for any special damages.

The agency has a procedure for reporting compliance concerns and strictly prohibits retaliation against an employee who raises a compliance concern in good-faith.

Slide 18

The False Claims Act

This statute prohibits, among other things:

- knowingly presenting or causing to be presented a false or fraudulent claim for payment to the United States;
- knowingly making or using, or causing to be made or used, a false record or statement to obtain payment on a false or fraudulent claim;
- conspiring to defraud the United States by getting a false or fraudulent claim to be allowed or paid; and
- knowingly making or using, or causing 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.

First, as an employee, you must know that it is a crime to knowingly cause a false claim to be submitted.

It is also a crime to falsify records that result in the submission of a false claim to Medicaid or Medicare.

Conspiring to defraud the government by getting a false claim paid is also considered a crime under this Act.

Just as it is a crime to submit a false claim, it is also a crime to falsify records, submit false reports or conceal information to avoid paying an obligation to the government.

In Other Words ...

- presenting a claim that the person knows or should know is false;
- presenting a claim for services not provided as claimed;
- upcoding;
- presenting claims for physician services not provided by a physician;
- violation of anti-kickback legislation;
- contracting with someone excluded from a federal health care program; and
- inducements to referrals or recipients of service

In other words, the following actions are considered fraud:

- Submitting a claim for services that a person knows is false. It can also be considered fraud if a person should have known that a claim is false. As a result, the agency must be very diligent in making sure that persons served meet eligibility criteria, that services are authorized and medically necessary, and that services are accurately and thoroughly documented before a claim is submitted for payment.

- It is also important that services are accurately coded for billing. Billing for a higher reimbursement rate than was actually provided is an example of fraud.

- There have been several cases where services that were required to be provided by a physician were provided by others and billed as provided by the physician. This is fraud.

- There are laws, called anti-kickback legislation, that prohibit anyone from soliciting or offering payment for referrals of Medicare or Medicaid recipients. Acts of this nature may be considered a felony.

- The False Claims Act prohibits the agency from employing or conducting business with an individual or entity that has been excluded for participation in federal healthcare programs.

- It is also illegal for a provider to provide inducements of money or gifts in place of money for referrals of Medicaid or Medicare recipients for service.

Common Examples

- Billing for a service that was not provided
- Billed for days the person was in hospital
- Documentation is false or inaccurate
- Billed for more service than provided
- Service is provided by unqualified staff
- Billed for service that is not authorized or medically necessary
- Billed twice for the same service

Here are some common examples of fraud:

Billing for a service that was not actually provided is fraud. This can occur when a person documents for something that they did not provide and the agency receives payment for the service. This can also occur when documentation is not completed or is inadequately completed for a service that was provided.

A provider cannot bill for services while a person is in the hospital, a nursing home or other certified residential programs such as an ICF. There are some exceptions if services were provided on the day of admission or discharge. Agencies must be very carefully in taking attendance and the recording of services that were provided.

It is considered fraud when payment is received for documentation that is false or inaccurate. The agency must assure that all services are accurately and completely documented.

In most programs, services are authorized based on a person's need. The authorization for the type, amount and frequency of services is stated in the form of a plan, such as an Individualized Service Plan (ISP), a Treatment Plan, an Individualized Educational Plan (IEP), or a prescription or order by a physician. It is considered fraud when services are billed in excess of the amount authorized.

In some programs, the person providing service must meet certain educational requirements or

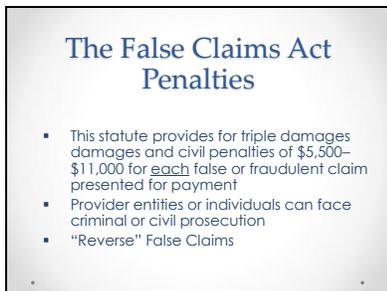
possess a current license for their profession. It is considered fraud when an unqualified or unlicensed person provides services that are billed to Medicaid or Medicare.

Billing for a services that are not authorized according to the requirements of the program, or for services that are not medically necessary, are considered fraud.

And billing twice for the same service, whether by one provider or two different providers, is considered fraud.

The agency developed policies and procedures for service provision and documentation to prevent fraud. It is up to every employee to comply with the agency's policies and procedures and standards of practices.

Slide 21



The False Claims Act Penalties

- This statute provides for triple damages and civil penalties of \$5,500-\$11,000 for each false or fraudulent claim presented for payment
- Provider entities or individuals can face criminal or civil prosecution
- "Reverse" False Claims

Violations of the False Claims Act can result in some very serious penalties and recoveries of funds. The government may require the provider to pay back false claims at up to three times the amount of the disallowed claim and can impose penalties of \$5,500 to \$11,000 per claim that was submitted for payment.

Under the False Claims Act, an agency or an individual can be criminally prosecuted. There are many cases where individual providers were criminally prosecuted. There are also specific cases where an individual, frequently an employee, faced criminal prosecution for knowingly causing a false claim to be submitted.

Slide 22

NY State False Claims Act

- Enacted in April 2007
- Intentionally modeled after Federal FCA
- Makes it illegal to submit a claim for payment to the state government that you know, or should know, is false
- Fines of up to \$12,000 per claim
- Double or triple damages

Slide 23

Fraud
"...a misrepresentation, omission, or concealment *calculated to deceive*."

Abuse
"...performing acts that are inconsistent with acceptable business practices."

We've reviewed the laws prohibiting fraud and abuse. Now let's see how they are defined.

The laws define fraud as an intentional act to deceive, meaning that some one intended to misrepresent, omit or hide information which resulted in payment of funds.

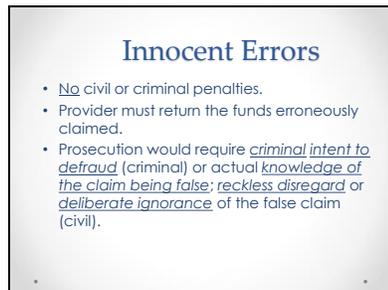
An example of fraud would be a case in which an employee documents for a service that was not provided to an individual and the agency then bills Medicaid and receives payment for a service that was not provided. The employee could be charged with Medicaid

fraud, which is a crime.

Abuse, on the other hand, is not necessarily an intentional act, but more broadly defined as performing acts that are not consistent with acceptable business practices.

Let's look at the earlier example. If an agency did not have sufficient controls or systems in place to monitor that services were provided before it billed Medicaid, the agency could be charged with abuse. Depending upon the situation, the agency could be charged with fraud if it knowingly allowed a false claim to be submitted for payment.

Slide 24



Innocent Errors

- No civil or criminal penalties.
- Provider must return the funds erroneously claimed.
- Prosecution would require *criminal intent to defraud* (criminal) or *actual knowledge of the claim being false; reckless disregard or deliberate ignorance* of the false claim (civil).

The government does acknowledge innocent errors, that we are human and mistakes can occur. In those instances, there are no civil or criminal penalties, but the provider must return any money it received in error and put measures in place so the same error does not occur again.

For the government to prosecute, there must be a criminal intent to defraud. In these cases, there are criminal penalties which may include fines, restitution and possible jail time.

There may be civil penalties in cases where an agency had knowledge of a false claim, and in cases where the agency disregarded or deliberately ignored the information about a false claim.

Slide 25

No One is Perfect!!!

Honest Mistakes and Innocent Errors Happen

- You must be able to demonstrate how your internal controls are designed to assure compliance
- Policies and Procedures relative to returning funds once errors are found
- Demonstrate that \$\$\$ has been returned in the past

For an innocent error to be considered, an agency would need to be able to demonstrate that it had adequate internal controls and practices to assure compliance and prevent fraud.

The agency must have policies and procedures that address how funds that were received in error are returned or voided.

The government is more lenient when an agency is able to demonstrate that it has returned money in the past for errors that were identified.

Slide 26

Protections and Safeguards

- Agency policies, procedures and practices
- Educated, qualified and trained staff,
- Communication between management, billing and program staff
- Internal controls
- Auditing and monitoring activities

What can we do to protect ourselves?

Training is one of the most important preventative measures. Employees need to know how to do their jobs correctly, be familiar with the agency's policies and procedures which are based on the laws and regulations, and follow the policies and procedures set by the agency.

The agency must assure that it hires and retains qualified staff. It must also assure that the credentials, education, experience and any special licensing requirements are verified and that all staff meet any minimum qualifications for the positions they hold.

In addition to developing and implementing policies and procedures, the agency expects its employees to follow them and continually do what is right.

It is important that there are open lines of communication between program staff, management, and billing or finance staff.

There must be sufficient internal controls and processes to assure that all services are authorized, medically necessary, and reviewed for effectiveness and continued need. Procedures must address the delivery and documentation of services, how services are billed, and how governmental funds are used by the agency.

The agency's management staff must also audit and monitor itself and its employees to assure that the agency complies with policies, procedures and regulations.

These actions form the basis of our corporate compliance program.

Slide 27

What is a
Corporate Compliance Program?

- * ... a set of formal organizational systems intended to prevent, detect and respond to misconduct committed by employees and other agents.
- * An organizational commitment to make sure that we provide high quality services with the highest degree of integrity, and always act in an ethical manner.

Corporate Compliance is defined as a long term commitment by an organization to conduct business in a manner that promotes compliance with laws and regulations, that continually monitors itself for compliance, and has created systems to allow the organization to respond to changes in the regulatory environment.

Corporate Compliance is not something that we say that we are going to do, but do not end up doing effectively. Our organization needs to be committed to making sure that we provide high quality services with the highest degree of integrity, and always act in an ethical manner. The agency is committed to complying with all applicable laws and regulations.

Compliance is part of the culture of our agency.

Slide 28

Compliance

- On an organizational level:
 - Long term commitment to conduct business in ways that promote doing the right things
 - Continually monitoring that the right things are being done
 - Responding to changes and problems that are identified along the way

Slide 29

Compliance

- On a personal level:
 - Doing the right thing because it is the right thing to do
 - Doing the right thing even when no one is looking

Benefits of a Compliance Plan

- You find your 'weaknesses' before Medicaid does
- Promotes ethical conduct
- Communicates agency's commitment to regulatory compliance
- Educated staff
- Drives more efficient and effective operations
- Improves financial health of agency
- Defends the organization; may mitigate paybacks/fines
- Required by NYS OMIG

Our Compliance Plan is designed to find our weaknesses, or mistakes, before an outside reviewer or governmental agency does.

The Compliance Plan and the Code of Conduct state our commitment to complying with the laws and regulations and provide high quality services with the highest degree of honesty and integrity.

As a result of our compliance program, the training that we provide our staff, and our methods for reporting alleged wrongdoing without fear of retaliation for raising an issue, the agency expects to protect itself from "qui tam" or whistleblower lawsuits.

Because we are continually monitoring ourselves and developing corrective actions when we discover an error or the potential for an error, we are able to operate more efficiently. As a result of the reduced risk for payback or financial penalties, we are able to make sure the agency is financially healthy.

An effective compliance program has been shown to reduce penalties, payback and fines that could result from a review or audit by a governmental oversight agency.

Slide 31



7 Elements of a Compliance Plan

1. Written Policies and Procedures
2. Compliance Program Oversight
3. Training and Education
4. Effective, Confidential Communications
5. Enforcement of Compliance Standards
6. Auditing and Monitoring
7. Responding to Offenses & Developing a Corrective Action Plan

A Compliance Plan is a very important part of Corporate Compliance.

There are seven required elements.

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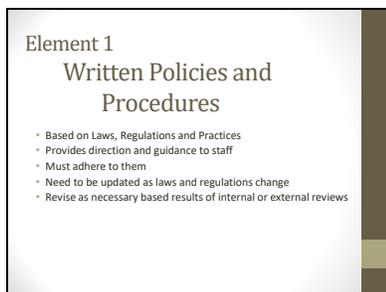


NYS Adds an Eighth Element

- Added in the New York False Claims Act
- Per Medicaid Inspector General
"New York is the only state in the union with 8 elements"

Whistleblower Provisions and Protections is the eighth element

Slide 33



Element 1
Written Policies and Procedures

- Based on Laws, Regulations and Practices
- Provides direction and guidance to staff
- Must adhere to them
- Need to be updated as laws and regulations change
- Revise as necessary based results of internal or external reviews

The first element includes written policies and procedures. These are developed from the laws and regulations and provide employees with written directions on how to perform their job responsibilities.

A Code of Conduct is part of the written documents that guide employees in their day-to-day actions and performance of their job.

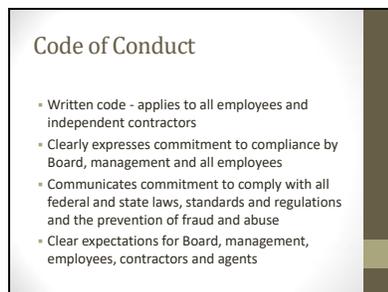
It is important that you are familiar with the agency's policies and procedures and the Code of Conduct.

Slide 34



These are examples of policies and procedures that are part of a Compliance Program.

Slide 35

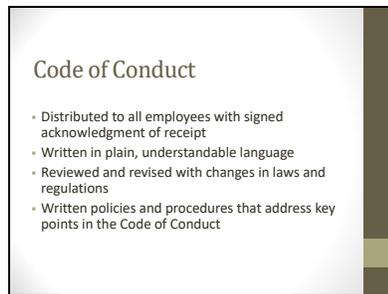


The agency's Code of Conduct is another very important part of the agency's compliance program. In addition to following the agency's policies and procedures, employees are expected to adhere to a code of conduct. The Code of Conduct was developed by _____ and approved by management and the Board of Directors.

They provide guidelines for employees to do the right thing and always act in the best interest of the people we serve and the agency. When you are faced with a situation that is not addressed by

policies and procedures or the Code of Conduct, or seems to conflict, we expect you to seek direction from a member of management.

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Code of Conduct

- Distributed to all employees with signed acknowledgment of receipt
- Written in plain, understandable language
- Reviewed and revised with changes in laws and regulations
- Written policies and procedures that address key points in the Code of Conduct

Each employee is responsible for knowing and adhering to the the Code of Conduct. You will receive a copy and sign an acknowledgement that you received a copy.

The Code of Conduct is written in clear manner so that you are able to understand the agency's expectations and the way that we conduct business.

It will be revised when there are changes in the laws or regulations. There are written policies and procedures that relate to the key points in the Code of Conduct.

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Element 2
Compliance Oversight

- Compliance Officer and Compliance Committee
- Board and Management Staff
- Effective methods to report compliance-related issues

Compliance oversight is the second required element of a Compliance Plan. Typically, the Compliance Officer, is responsible for the Corporate Compliance Program. The Compliance Officer works with a compliance committee consisting of representation from agency programs and the Board of Directors to assure the agency has an effective compliance program.

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Compliance Officer Duties

- > Developing and implementing policies and procedures (P&P).
- > Overseeing and monitoring the implementation of the compliance plan on a regular basis.
- > Directing agency internal audits established to monitor effectiveness of compliance standards.
- > Providing guidance to management, medical/clinical personnel and individual departments regarding P&P and governmental laws, rules and regulations
- > Investigating compliance-related issues

This Compliance Officer reports directly to the Executive Director and the Board of Directors. The Compliance Plan identifies the Compliance Officer's duties, which basically include the overall responsibility for developing and implementing policies and procedures relating to compliance with regulations, overseeing and monitoring of the compliance plan, assuring communication of the compliance, directing the agency's internal audits, maintaining a reporting system for questions and complaints about compliance and investigating complaints or possible violations of compliance.

Slide 39

Element 3
Training and Education

- Mandatory and Regular
- Includes
 - Content of Agency's compliance plan
 - Overview and importance of compliance
 - Department specific risk areas
 - Summary of fraud and abuse laws
 - How to report non-compliance
 - Confidentiality and non-retaliation for reporting

Another very important element is education and training. The training in compliance starts with the Board of Directors and continues with all levels of the organization. This is required training for new employees and will be held on a regular basis to provide refreshers to existing employees. Additional training or department-specific training should occur as risks are identified. The training reviews fraud and abuse laws, includes the content of the compliance plan, and outlines the process for reporting non-compliance.

Slide 40

Element 4
Effective, Confidential
Communications

- "Open Door" Policy to raise issues with Management
- Methods to report actual or suspected non-compliance confidentially or anonymously
- Non-retaliation for reporting actual or suspected non-compliance
- Compliance Hotline – 476-7441 x1310

A method for effective confidential communication is essential to a Compliance Plan. Employees, business and other interested parties must have a means to ask questions, seek clarification, or report suspected instances of noncompliance with regulations, policies, and procedures without fear of retaliation or job threat. The Compliance Plan identifies the means through which an employee may ask questions or report issues. These means are addressed in the agency's Compliance Plan and Code of Conduct.

NOTE: The agency may wish to expand upon its reporting process here.

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Element 5
Enforcement of
Compliance Standards

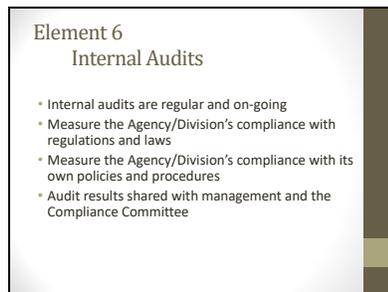
- Clear guidance for staff
- Supervision and monitoring
- Disciplinary action for non-compliance with laws, regulations, policies, procedures and practices
- Disciplinary action for failing to report actual or suspected non-compliance

The agency must enforce its standards, policies and procedures. The agency's policy for performance management and disciplinary action addresses what will happen when someone does not follow the agency's standards, policies, and procedures.

Failure to report actual or suspected non-compliance or violations of the agency's Compliance Plan may also result in disciplinary action.

The enforcement of compliance standards is important responsibility of the agency's management staff.

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Element 6
Internal Audits

- Internal audits are regular and on-going
- Measure the Agency/Division's compliance with regulations and laws
- Measure the Agency/Division's compliance with its own policies and procedures
- Audit results shared with management and the Compliance Committee

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Internal Auditing and Monitoring

Objective: Close gap between service delivery and billing

- Assure authorization for service (NOD, MD order, signed, effective service/treatment plans)
- Process to assure documentation to support claims
- Staff meet qualifications
- Develop system that promotes adherence and reports shortcomings back to programs
- Identify systemic and process problems
- Internalize findings
- Train
- Re-evaluate



The sixth element identifies systems and processes by which an agency will audit and monitor itself to assure it is complying with all laws and regulations.

One of the primary objectives of internal auditing is to close the gap between service delivery and documentation. These measures listed on this slide are part of an effective internal auditing and monitoring process.

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Element 7
Follow-up and Corrective Actions

- Investigate reports of actual or suspected non-compliance
- Report findings
- Develop corrective action plans
- Review for effectiveness

The last element details how the agency will respond when there is a finding either through a complaint, an internal audit or an audit by its oversight agencies. A plan of correction is developed, reviewed by the compliance officer and committee and monitored for completeness and effectiveness.

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**SERVICE PLANNING,
DELIVERY AND
DOCUMENTATION**

Next, we will review some regulations and requirements of service delivery and documentation of services.

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Keep in Mind...

Provider agrees to:

- (a) Prepare and maintain contemporaneous records demonstrating their right to receive payment... and keep, for 6 years from date care/service furnished, all records necessary to disclose the nature & extent of the service furnished and all information regarding claims for payment by, or on behalf of, the provider...

NYCRR Title 18, Section 504.3

As a provider of Medicaid services, the agency agrees to abide by certain requirements. This slide contains some very important language from the Medicaid regulations that relate to you and the documentation of services.

(NOTE: Read the regulation.)

This regulation means that the agency, and you as an employee of the agency, must document services at the same time that the service is provided or closely afterwards, for all services that are billed to Medicaid. The agency must keep all records and information to support the claim for six years from the date the service was provided.

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Keep in Mind...

Provider agrees:

- (e) To submit claims for payment only for services actually furnished and which were medically necessary...
- (h) That the information provided in relation to any claim for payment shall be true, accurate and complete; and
- (i) To comply with the rules, regulations and official directives of the department.

NYCRR Title 18, Section 504.3

The regulation goes on to say that the agency, and you as an employee of the agency, agrees to only submit claims for services that **were actually provided and medically necessary.**

Any information that relates to a claim for payment must be **true, accurate and complete.** In other words, you must document accurately and thoroughly and honestly.

A provider of Medicaid services must also comply with all laws, rules and regulations.

To comply with this regulation, the agency has developed policies and procedures and practices related to service delivery and documentation.

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MMIS Manual Requirements

Payment will not be made for medical care and services:

- > Which are medically unnecessary
- > Whose necessity is not evident from documentation in the recipient's medical record
- > Which represents abuse or overuse

Slide 49

Service Planning and Delivery

- Services must be Medically Necessary
- Services must be Authorized
 - ISP, IEP, Treatment Plan, Habilitation Plan, Service Plan, LCED, Prescription, MD order
 - Services must be reviewed as required
- Reimbursement for Services is based on documentation that supports that the services provided are specified in the ISP and the Hab Plan

First of all, services must be medically necessary. The services are usually based on a diagnosis or the individual's disability. This is determined through an evaluation by a physician or other healthcare professional. It is documented in the record. In some programs, there are also certain eligibility requirements that must be met.

Once an evaluation or a statement of the person's need for a particular service is identified, a plan of service is developed by a professional or the program's staff. The plan of service may be in the form of an Individualized Service Plan (ISP), Individualized Educational Plan (IEP), a treatment plan, a habilitation plan, a prescription, or a doctor's order. The plan or order identifies the medical necessity or need for a particular service or several types of services. The requirements vary among program types.

In order for a service to be billed to Medicaid, it must be included in the required plan, or with a written order by a physician.

Each program has specific requirements and timeframes for

the review of plans or the order for services. The review must be conducted by the required parties and usually includes involvement of the person and/or their parent, legal guardian, or advocate.

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Service Planning and Delivery

- Services must be delivered by trained and qualified staff and as specified in the service/treatment plan
- The effectiveness of the service/treatment plan must be reviewed on a frequent and regular basis
- The plan must be revised as necessary

Each service that is provided, and billed, must be included in a service plan. The services must be provided by trained and qualified staff and in accordance with the person's plan of service.

Services must be reviewed for continued need, or medical necessity, on a regular basis and in accordance with the specific program requirements. The review consists of an assessment of the effectiveness of the current services, the need to revise the existing plan, and the continued need or medical necessity of services.

A plan must be revised if it is no longer effective, or when the person's needs change.

It is important that service planning and reviews are conducted and documented in the record, as required, for the services to be reimbursed by Medicaid.

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Medical Necessity

- > Is the underlying concept under which payment decisions are made
- > Definition is controlled by the payer, not the provider
- > Must be substantiated through documentation in the record
- > Initially: determined through meeting eligibility criteria for service
- > On-going: determined through service or treatment planning, reviews, and documentation

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Medical Necessity

Medicaid only pays for medically necessary services

- Allowable services
- Based on diagnosis or disability
- Staff actions
- Goal driven
- Measurable
- Meaningful

✓ Medical necessity must be clearly documented in every plan, note and summary in your program records to someone outside your program.

Medicaid is a health care program. As such, any service provided and billed to Medicaid must be medically necessary.

Certain services are allowable under Medicaid, just as certain procedures or treatments are covered by your healthcare insurance.

For a service or treatment or intervention to be considered medically necessary, it must be based on a person's diagnosis or disability.

The staff action, intervention or support must be delivered in accordance with a plan of services or under the order of a physician and documented in the record.

Services must be meaningful and related to the person's goals and the objective of treatment or service provision. Services must be developed based on goals that are measurable so that progress can be monitored and recorded.

It is important that each plan, service note and summary of services clearly document medical necessity in the record. A good rule of thumb is that an outside reviewer be able to clearly and

easily see the documentation of medical necessity when reviewing the record.

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Common Mistakes



- Not documenting allowable services
- Not proving medical necessity
- Not supporting provision of planned services
- Allowing ineligible/inappropriate providers to provide billed services
- Implementing unauthorized or expired service/treatment plans
- Service/treatment plans lack specific interventions/ activities
- Billing without service documentation

Here are some common mistakes that providers make. These mistakes could result in disallowances of Medicaid payment or fraudulent claims. The agency's policies and procedures, standards of practice, and documentation requirement reduces the the potential for such mistakes.

(NOTE: Read the examples.)

Next, we will review general documentation requirements.

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Service Documentation

- Services must be documented "contemporaneously" with service delivery (at the same time or in close proximity)
- Documentation must include required elements
- Documentation must be permanent and legible (able to be read by a reviewer)

The Medicaid regulations require that services are documented in a contemporaneous manner. This means that documentation should be completed as soon as possible after you deliver the service.

Services must be documented by the person who provided the service.

There are certain required elements of documentation. Basically, the documentation must prove that a service was provided to a specific individual on a given date. The documentation must include the service that was provided and the signature and title

of the person who provided the service. In many instances, the agency has developed forms that make it easier for you to include all the required elements of documentation. It is important that you complete all forms thoroughly and accurately and that the documentation of service contains all required elements.

It is also important that the documentation is permanent and is legible. A good rule of thumb is that an outside reviewer must be able to read what you documented and identify the person who provided and documented the service.

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Arc of Onondaga
Compliance
Standards

- Documentation of plan implementation must be completed prior to the end of shift.
- Document only the services you provide
- Plans must be implemented according to identified frequency
- Documentation must include all required elements, be made in black or blue ink, be permanent and legible.
- Supervisors will complete required review of documentation in a timely manner, and monitor adherence to compliance standards.

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**Even more
Compliance Standards**

- Completion of time-sensitive job tasks must be done prior to planned leave time.
- Permanent entries cannot be altered. Late entries must be dated as such.
- Employees must not make any false entries, or create or participate in the creation of any records intended to mislead or conceal anything that is improper.

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Documentation Do's and Don'ts

DO

- Use full date (mm/dd/yy)
- Use signature and title on all entries
- Include date with your signature
- Use black or blue ink - not pencil - in records
- No use of "white out," black markers, or scribbling over....Draw a line, note error, sign/initial and date!
- Assure documentation is accurate

All of the agency's records are legal documents and as such must adhere to these elements appropriate documentation.

Any time you use a date, it must include the month, day and year.

You must sign all entries or notes that you make with your signature and title. There are instances in which we allow you to use your initials, but this is only when there is a key on the form or in the record that contains your signature.

When you sign an entry, you must include the date you signed it. Do not back date documents. The date should indicate the date you actually signed the form, note, or record.

Use ink and not pencil. Since all records are legal documents they must be permanent and completed in ink. The use of white out, black markers, or scribbling over are prohibited on agency records. When you make an error, draw a line through the error, note that it is an error and sign and date it.

You must always assure your documentation is accurate.

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Documentation Do's and Don'ts

DO

- Document service delivery promptly
- Document only for services you provided
- Only submit claims (billing) for services provided
- Obtain proper authorization for services

You must document services promptly after you deliver them or complete a task. If you forget to document or are unable to document a service promptly, you must contact your supervisor or other management staff for further direction.

Falsification of records is absolutely prohibited. If you are unsure how to document, seek direction from your supervisor or other management staff.

You must only document for services you provided, even if you saw another staff member provide the service. By putting your signature or initials on service documentation you are stating that you provided the service.

You must only submit claims for services that were provided. If you have knowledge that a service was not provided and will be billed or has been billed, you have a responsibility to report this to supervisory personnel.

The agency must have the proper authorization for services. If this is one of your job responsibilities, you must assure the agency has the proper authorization to provide the

service and thus bill for the service. This may mean that you must make sure that you have the required documents or authorization within required timeframes and/or that services are reviewed for effectiveness and medical necessity as often as required.

The agency expects that every employee will follow these requirements of documentation.

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Documentation Do's and Don'ts

Don't:

- > Document in colored ink or pencil
- > Document anything you have not actually done or observed
- > Leave labeled fields blank
- > Use initials without corresponding signature key
- > Attempt to obliterate errors
- > Alter previous documentation

Let's review some documentation don'ts:

It is important that all documentation is completed in black or blue ink, not colored ink or pencil.

You cannot document for something that you have not actually done or observed.

You must make sure that all fields or places for information on forms are completed. If you are unsure of the information needed, seek direction from a member of the management staff.

You must make sure that your signature is on a form or a signature key when you are using your initials on a document.

Do not try to cover up errors. If you made an error, make the necessary corrections in the appropriate manner.

Do not alter previous documentation. If you are not absolutely sure how to add information or make a change to a record, seek direction from a member of the management staff. Do not alter the documentation of another staff or provider.

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Your Responsibilities

- ✓ Attend required training(s)
- ✓ Read Agency's Corporate Compliance Plan
- ✓ Read and follow Code of Conduct
- ✓ Comply with laws, regulations, and Agency's policies, procedures and practices
- ✓ Provide and document services according to Service/Treatment Plans
- ✓ Report any issues, concerns or possible violations to your supervisor or the Compliance Officer

To summarize your responsibilities as an agency employee related to our compliance program, it is important that you attend required trainings, read and be familiar with the agency's Corporate Compliance Plan and the Code of Conduct.

We expect that you comply with all applicable laws, regulations, and agency policies, procedures and standards of practice.

Services must be provided according to approved treatment or service plans and documented accurately, thoroughly, and promptly after providing the service.

It is important that you report any issues, concerns or possible violations of the agency's Compliance Plan or Code of Conduct.

If you have any questions about the material covered by this presentation, please direct them to you supervisor, a member of the management staff or the Compliance Officer. ***(Agency should provide information to contact the Compliance Officer and/or hotline at this time.)***

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