Independent Living Association, Inc. and ILA Case Management Services, Inc.

Corporate Compliance

Corporate compliance is about detecting, preventing and avoiding Medicaid fraud, misuse and waste.

There are many federal and state laws and regulations that govern the operation of agencies like Independent Living Association, Inc. and ILA Case Management Services, Inc. (ILA). To assure that we are in compliance with the laws and regulations the agency develops and implements written policies and procedures and standards of practice. All staff must be made aware of these laws and regulations and are required to comply with them at all times. Failure to comply with any of these policies, and procedures and standard of practice may jeopardize ILA's ability to provide services to the individuals we serve.

Some of the laws that apply :

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Increased resources for detecting fraud
- Expanded power and authority of enforcement agencies
- Creation of Health Integrity and Protection Data bank

Balanced Budget Act of 1997 (BBA)

- Agencies work together/share information
- Enhanced authority for exclusions
- Beneficiary Incentives
- 1-877-87FRAUD- hotline for reporting fraud

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

The Federal False Claim Act/New York False Claims Act (* Enacted during Civil War, revised in 1986)

Under the False Claim Act, a private citizen with knowledge of fraud against the government can file a lawsuit on behalf of the government. The suit must be sealed and served on the government, who has 60 days to decide whether or not to join in the suit. If the government joins the suit and is successful in the prosecution, the realtor or whistleblower is entitled to receive 15% - 25% of the recovery. If the government declines to join the suit, the realtor or whistleblower can proceed with the suit on its own. If the case is successfully prosecuted, the realtor or whistle shares in the government recovery with an entitlement of 25% - 30% of the recovery.

* Prohibits a person or business from submitting to the government a false or fraudulent claim to secure payment.

* Prohibits conspiring to defraud the United States by getting a false or fraudulent claim to be allowed or paid

* Prohibits 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.

Violations of the False Claims Act can result in serious penalties and recoveries of funds. The government may require a provider found to be in violation to pay back false claims at up to three times the amount of the disallowed claim. In addition the Government can impose penalties of $5,500 to $11,000 per claim that was submitted for payment, by a provider found to be in violation of the law.

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.

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 whistle blower provision. Under the law a whistleblower is provided with protection against retaliation for reporting compliance issues. This is referred to as "whistleblower protection". Any employee who is discriminated against, discharged, demoted, or harassed because of reporting unlawful practices is entitled to relief. Relief may include reinstatement, double back pay, and compensation for any special damages.

Medicaid

The NY Office of Medicaid Inspector General, created in 2005, is the first state Office of Medicaid Inspector General in the nation. Its purpose is to coordinate, to detect and prevent fraud, waste and abuse with oversight agencies such as the Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, New York State Office of Alcoholism and Substance Abuse Services, The New York State Office of Children and Family Services and the New York State Department of Education.

Medicaid is a health care program, As such; any service provided and billed to Medicaid must be medically necessary. All of ILA's programs and services are funded by Medicaid.

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.

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.

Medicaid Eligibility Requirements:

- NOD-"Notice of Decision", completed once, says "Notice of Decision" at top of page
- Physicians sigh off-"Level of care Determination" Signed annually by MD
- ISP- Must be current, within last 6 months, must name ILA as provider of Residential Habilitation and/or MSC
- Reviewed as necessary/specified

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.

WHAT DOES COPERATE COMPLIANCE MEAN TO ILA ?

AVOIDING ABUSE, WASTE and FRAUD.

Abuse: is defined as performing acts that are not consistent with acceptable business practices. The following is an example of abuse:

If an agency did not have sufficient controls or systems in place to monitor which services were provided prior to billing 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 to Medicaid for payment.

Waste: to spend carelessly and extravagantly

Fraud : is defined as an intentional act to deceive, meaning that someone intended to misrepresent, omit or hide information which resulted in payment of funds

The following 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 services 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 data sheets are filled out retroactively indicating that a consumer completed their objectives. It is also fraud when a supervisor is instructed to retroactively complete the data sheets.

- 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.

- 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.

What we can we do to protect ILA?

Training is one of the most important preventative measures. Everyone needs 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 meets the 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.

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

There are seven required element of a corporate 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

As part of ILA's Compliance Plan, we have developed a Code of Conduct. The Code addresses the following areas:

- Conflict of Interest
- Maintenance of Records
- Protection of Confidential Information
- Employee Compliance Training
- Enforcement of Compliance Standards
- False Claims Act and Whistleblower Provisions
- Internal Auditing and Monitoring
- Investigation of Compliance Issues
- Reporting of Compliance Concerns and Non-Retaliation

ILA's compliance staff:

- ILA's Compliance Officer is Richard Gruber
- ILA's Compliance Specialist is Ms. Velma Bishop-Leacock
- Both can be reached at (718) 852-2000 ext 122
- ILA's confidential 24 hour line for reporting FRAUD (718) 858-1204

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.

Investigating compliance-related issues:

- All allegations of Medicaid Fraud, Abuse and Waste go to the Corporate Compliance Officer (unless reported externally)
- Corporate Compliance Officer determines if an investigation is warranted based on facts
- Corporate Compliance Officer conducts or assigns and oversees all investigations
- All staff are required to cooperate
- Investigate reports of actual or suspected non-compliance
- Report findings
- Develop corrective action plans
- Review for effectiveness
- 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 in this document, please direct them to the Compliance Officer.