CORPORATE COMPLIANCE POLICY AND PROCEDURE HANDBOOK

1042 38 Street, Brooklyn, NY 11219 | 718.854.2747 | hcsny.org

GENERAL OVERVIEW/POLICY

Human Care Services ("HCS") is committed to providing services of the highest quality and to being in full compliance with federal, state, and local laws and regulations. HCS has adopted a compliance plan and Standards of Conduct to help support a culture that encourages responsible and honest conduct, transparency in its business transactions and adherence to government laws and regulations.

It is HCS' policy to facilitate the prevention of improper or illegal activities and to establish mechanisms to detect violations of laws and regulations and to investigate issues related fraud, waste, and abuse. HCS is committed to conducting its business affairs on sound ethical and moral standards and will hold all affected individuals to these same standards. ("Affected individuals" are all persons affected by the provider's risk areas including employees, chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, governing body, and corporate officers.)

All affected individuals shall acknowledge that it is their responsibility to report any instances of known or suspected non-compliance to their immediate supervisor, the chief executive, or the corporate compliance officer ("CCO") without fear of retaliation, retribution, or intimidation. Failure to report known non-compliance or making reports that are not in good faith will be grounds for disciplinary action, not limited to and including, termination of employment or contract.

HCS will measure the effectiveness of its program by monitoring the seven elements of its compliance program and by its auditing systems.

I. WRITTEN POLICIES, PROCEDURE AND STANDARDS OF CONDUCT

HCS will communicate its compliance standards through training and distribution of the compliance handbook to all the affected individuals.

The CCO will work with the compliance committee to implement and maintain an effective compliance program. The program will be consistently enforced through appropriate disciplinary action. Detected non-compliance will be addressed in an expedient manner and HCS will take immediate steps to prevent further similar violations.

The policies, rules and regulations and Standards of Conduct included or referenced in handbook herein are applicable to all affected individuals. Affected individuals can access the Compliance Policy and Procedure Handbook on the HCS website. (Employees can also access the handbook on ADP.)

APPLICABLE LAWS

Affected individuals who are involved with HCS share in the agency's responsibility for ensuring that services are documented in compliance with applicable laws, rules, and regulations. Supporting documentation must be provided for all services rendered.

Some of the laws that apply include:

Federal Laws:

The False Claims Act (31 USC Chapter 37, §§ 3729-3733) is a federal law designed to prevent and detect fraud, waste, and abuse in Federal healthcare programs, including Medicare and Medicaid. Under this

act, anyone who knowingly submits false claims to the federal government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of approximately $12,000 to $25,000 for each false claim submitted. (Penalties are updated regularly.)

Examples of false claims include, but are not limited to:

• Falsifying records.

• Submitting claims for services never performed or items never furnished.

• Double-billing for items or services.

• Using false records or statements to avoid paying the government.

• Overpayments resulting from the service provider billing for services rendered after the beneficiary's death.

• Falsifying time sheets used to bill Medicaid.

• Otherwise causing a false claim to be submitted.

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claim Act contains a "Qui Tam" or whistleblower 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.

New York State Laws:

New York's false claims laws fall into two categories, civil/administrative, and criminal laws. Some apply to recipient false claims and some apply to provider false claims. Most are specific to healthcare or Medicaid; some of the "common law" crimes apply to areas of interaction with the government.

Civil and Administrative Laws

New York State False Claims Act (State Finance Law §§187-194) This act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including programs such as Medicaid. The penalty for filing a false claim is $6,000 to $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false-claim filer may have to pay the government's legal fees.

The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the False Claims Act. Any employee who is discharged, harassed, demoted, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

Social Services Law §145-b (False Statements)- It is illegal to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use

of a false statement, deliberate concealment, or other fraudulent scheme. The State may recover three times the amount incorrectly paid. A civil penalty may be imposed of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty of up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c (Sanctions) - If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person and the family's needs are not taken into account for 6 months to five years, depending on the number of offenses.

Criminal Laws

Social Services Law § 145 (Penalties) - Any person who submits false statements or deliberately conceals relevant information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law §366-b (Penalties for Fraudulent Practices) - Any person who presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law, Article 155 Larceny- The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud or other similar behavior. This law has been applied to Medicaid fraud cases.

Fourth degree grand larceny involves property valued over $1,000 and is a Class E felony. Third degree grand larceny involves property valued over $3,000 and is a Class D felony. Second degree grand larceny involves property valued over $50,000 and is a Class C felony. First degree grand larceny involves property valued over $1 million and is a Class B felony.

Penal Law, Article 175 Written False Statements- Four crimes in this article relate to filing false information or claims and have been applied to cases involving Medicaid fraud. Actions include falsifying business records, entering false information, omitting material information, altering an organization's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and intent, a person may be guilty of a Class E felony.

• Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

• Falsifying business records in the first degree includes the above offense and the intent to commit another crime or conceal its commission. It is a Class E felony.

• Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

• Offering a false instrument filing in the first degree includes the elements of the second degree offense and must include intent to defraud the state or a political subdivision.

Penal Law Article 176, Insurance Fraud- Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes:

• Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

• Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

• Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

• Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

• Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

• Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud – A person commits health care fraud when, with the intent to defraud Medicaid (or other health plans), they knowingly provide false information or omit material information for the purpose of requesting payment for a healthcare item or service and, as a result of the false information or omission, receives such payment in an amount to which they were not entitled.

New York Labor Law §740 – An employer may not take any retaliatory personnel action against an employee if the employee:

- Discloses or threatens to disclose to a supervisor or a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety.
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into a violation, of a law, rule or regulation by the employer.
- Objects to, or refuses to participate in, any activity, policy, or practice in violation of a law, rule or regulation.

New York Labor Law §741 - This law protects an employee who:

- Discloses or threatens to disclose to a supervisor, public body, news media outlet, or to a social media form available to the public at large, an activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.
- Objects to, or refuses to participate in any activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

BILLING

• Affected individuals who are involved with HCS share in the agency's responsibility for ensuring that services are documented in compliance with applicable laws, rules, and regulations. Supporting documentation must be provided for all services rendered

• Services must be accurately recorded to ensure proper billing

• Affected individuals who suspect that fraudulent or improper documentation or billing is occurring must report their suspicion to the CCO. Supervisors and managers have the responsibility of creating and fostering a work environment in which employees can do so without fear of retribution or retaliation.

• All members of the governing body agree to abide and uphold all rules and regulations governing OPWDD agencies

CONFLICTS OF INTEREST

• Affected individuals must avoid conflicts of interest. The potential for a conflict of interest exists whenever an affected individual is faced with choices between his or her responsibilities to the agency and an outside and/or personal interest, such as when an affected individual is in a position to influence a decision that may result in a personal gain for the affected individual or their relative.

Common examples of conflicts of interest include, but are not limited to:

a. Conducting personal business on agency time and/or premises.

b. Conducting agency business with a company, business, or individual with whom the affected individual doing so has a direct business or personal interest.

c. Soliciting or offering agency business or services in exchange for payment or other consideration.

d. Soliciting money, gifts, or any other personal benefits or favors of any kind from providers, contractors, merchants, business accounts, or people we serve or their families.

e. Supervising or being supervised by a family member, or involvement in the hiring, assignment, promotion, salary, or payment of a family member.

Unsolicited non-monetary gifts from people served by the Agency and their families and/or unsolicited nonmonetary gifts from business associates are acceptable. Such gifts may not exceed a value of $150.

Affected individuals shall disclose conflicts of interest of which they are aware.

The CCO is responsible for seeking resolution of any conflict of interest.

STANDARDS OF CONDUCT

- Affected Individuals observe HCS' compliance policy as expressed in its Compliance Policy and Procedures Handbook and all applicable rules, laws and regulations.

- HCS does background checks to ensure that all affected individuals have not been sanctioned by any regulatory agency.
- HCS maintains supporting documentation for all services rendered.
- HCS records services accurately to ensure proper billing.
- HCS bills only for services it has provided.
- HCS follows established financial and accounting principles and practices.
- All affected individuals who suspect that fraudulent or improper documentation or billing is occurring must report such suspicion to the Corporate Compliance Officer (or their immediate supervisor or manager).
- Supervisors and managers have the responsibility of fostering a work environment in which employees can report suspicions or violations of non-compliance without fear of intimidation or retaliation.
- Affected individuals must avoid conflicts of interest. Conflicts of interest can occur when an affected individual is faced with a choice between his/her responsibility to HCS and an outside or personal interest. Conflicts of interest include, but are not limited to, conducting agency business with a company, business or person with whom the affected individual has a direct business or personal interest; soliciting or offering agency business or services in exchange for payment or other consideration.
- Affected individuals are responsible for reporting to the corporate compliance officer (or their immediate supervisor or manger) any suspicions or actual knowledge they have regarding non-compliance.
- Affected individuals are responsible for cooperating in investigations of allegation of non-compliance.
- Affected individuals who fail to report suspicions or actual knowledge of non-compliance or who do not cooperate with investigations can be subject to disciplinary action up to and including termination of employment or contract.

ESTABLISHING AND REVISING CORPORATE COMPLIANCE POLICY AND PROCEDURES

HCS will review its corporate policy and procedures at least on a yearly basis, and more often as necessary. The following can trigger earlier review and revision of HCS' policy:

- Change in pertinent law and regulations
- Review of audits, risk assessments, and related corrective actions
- Issues raised during training
- Recommendations made by the compliance committee following discussion at the quarterly meeting
- Recommendations made by the compliance officer based on issues raised by supervisors, employees, and all other affected individuals

When it is determined that change in policy is appropriate, the compliance officer or his/her designee shall draft policy and procedure to address the desired change. Thereafter, it will be submitted to the governing body for approval.

II. CORPORATE COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

CORPORATE ROLE OF THE COMPLIANCE OFFICER

The chief executive and governing body of HCS designate the CCO.

The CCO has the primary responsibility for developing, implementing, monitoring, and evaluating the effectiveness of the compliance program. The CCO has direct lines of communication to the chief executive, the governing body, the compliance committee, and HCS' legal counsel.

The CCO's primary responsibilities include:

- Implementing, overseeing, and maintaining the compliance program and Standards of Conduct.
- Annually reviewing the Standards of Conduct and the compliance program and revising as necessary.
- Evaluating the effectiveness of the compliance program and Standards of Conduct.
- Developing, implementing, and monitoring the compliance work plan.
- Reporting, at least quarterly, to the governing body, chief executive, and the compliance committee on the implementation of the compliance program.
- Assisting senior leadership to reduce incidents of fraud, abuse, and waste.
- Developing a training program that seeks to ensure that all affected individuals are knowledgeable of and comply with HCS' compliance program, Standards of Conduct, and all pertinent government regulations.
- Ensuring that excluded individuals are not retained by HCS.
- Directing audits and monitoring program effectiveness, investigating matters that relate to compliance-related issues, and implementing corrective actions.
- Developing policies that encourage reporting suspected fraud without fear of retaliation or intimidation.
- Ensuring that all affected individuals are aware of HCS' compliance program.

ROLE AND RESPONSIBILITIES OF THE COMPLIANCE COMMITTEE

The compliance committee is appointed by the president of the governing body and chief executive. The committee assists the CCO with the implementation of the compliance program and reports directly to the chief executive and governing body.

The committee will meet not less than quarterly. Meeting minutes will be maintained by the CCO.

Compliance committee agenda items include:

1. A review of previous meeting minutes.

2. A review of new laws, regulations, and guidelines which affect the ongoing compliance program of HCS.

3. A review of any new and/or revised policies and procedures pertaining to corporate compliance.

4. a review of ongoing monitoring/internal audit activities.

5. A review of any compliance issues that have arisen or areas of identified risk.

6. A review of approval or denial of any request to accept or extend business courtesies to potential referral sources and contractors and/or their immediate family members.

7. A review of the status of corporate compliance trainings.

8. A review of the status of Medicaid exclusion checks.

9. A review of the status of credentialing and license verification.

Responsibilities of the committee include:

- Reviewing and monitoring the effectiveness of corporate compliance training.
- Ensuring that HCS' processes identify compliance program risks, overpayments and other compliance issues and that there are effective procedures for reporting and correcting such issues.
- Working with departments to develop standards and policies to address specific risk areas.
- Coordinating with the CCO to ensure that the compliance program and Standards of Conduct are current and accurate.
- Monitoring audits to identify issues related to non-compliance.
- Ensuring the development and implementation of an annual compliance work plan.
- Advocating for sufficient funding so that the CCO can effectively perform his/her duties.
- Annually evaluating HCS' compliance program for effectiveness and making modifications as necessary.
- Developing a compliance committee charter that will outline the compliance committee's duties, membership, designation of a chairperson, and frequency of meetings.
- Reviewing the charter annually.

III. COMPLIANCE EDUCATION AND TRAINING

Effective education and training are an integral part of the compliance program. All affected individuals will receive formal training that will be readily accessible and are in alignment with all pertinent laws and regulations. Affected individuals in identified risk areas and members of the governing body will receive more detailed education related to their responsibilities. Successful completion of training is a mandatory condition for continued employment and contract. Attendance will be monitored by sign-in sheets for live training and digital sign-in modalities for online training.

The CCO is responsible for developing and monitoring the compliance education and curriculum.

Compliance education must include an explanation of the structure of the compliance program. Training will introduce the CCO and compliance committee and their respective responsibilities.

Training will address:

- The compliance program.
- The Standards of Conduct.
- The Federal False Claims Act; New York False Claims Act; Whistleblower Protections.
- Risk areas and organizational experience.
- Communication channels (including the anonymous reporting system).
- HCS' expectation that affected individuals report known or suspected fraud, waste, abuse, illegal/unethical acts and actual or suspected violations of the Standards of Conduct, HCS' compliance policy and procedure, delivery or billing of services and other compliance concerns.
- The investigative response to reported concerns and subsequent corrective actions.
- Disciplinary policy and standards.
- Non-retaliation and non-intimidation policy.

Specialized areas for education may include, but are not limited to:

- Improper or fraudulent billing for services.
- Preparation of inaccurate or incorrect cost reports or misuse of HCS funds.
- Payment or receipt of remuneration or gifts in return for referrals of service recipients or business contracts.
- Medicaid requirements and coding and billing requirements.

Comprehensive education materials will be developed to facilitate compliance sessions.

Each employee, including the chief executive and other senior administrators, will receive training within the first 90 days of employment.

IV. LINES OF COMMUNICATION

Open lines of communication between HCS management, the CCO, and affected individuals are essential to the success of the compliance program. All affected individuals must report compliance concerns, suspicions, or actual knowledge they may have regarding violations or suspected violations of HCS' policy and procedure, Standards of Conduct, and relevant rules and regulations. Failure to report a suspicion of a violation or a suspected violation of HCS' compliance policy and procedure, Standards of Conduct, and relevant laws and regulations risk disciplinary action up to and including termination of their employment.

If an affected individual witnesses or is asked to participate in activities that are potentially in violation of the HCS' compliance policy and procedure, Standards of Conduct, or relevant laws or regulations, the affected individual should contact the CCO, an immediate supervisor, a member of the management team, or a member of the compliance committee.

Affected individuals are responsible for cooperating in investigations of allegations of violations or suspected violations of HCS' policy and procedure, Standards of Conduct, and relevant rules, laws and regulations.

Contact can be made:

a) by mail to 1042 38 St. Brooklyn NY 11219.

b) By anonymous telephone call to 718-854-2747 ext. 141, which has no caller ID and is password protected.
c) By email at corporatecompliance@humancareservices.org.
d) In person.

Methods of communication on how to report non-compliance are made available in the compliance policy and procedure handbook, HCS' website, and posters displayed in public areas at HCS' worksite.

Upon receipt of a compliance concern, the issue will be documented by the supervisor/manager and reported to the CCO. The CCO or the designee shall record the information necessary to conduct a thorough investigation and document such investigation.

HCS will, as much as possible, protect the anonymity of the affected individual who reports a compliance concern. Confidentiality may not be able to be maintained if there are investigations by government or disclosure is required during a legal proceeding.

Concerns relating to non-compliance by the CCO should be reported to the chief executive.

POLICY OF NON-RETALIATION AND NON-INTIMIDATION

HCS will not take any retaliatory action against an affected individual who in good faith reported a compliance concern or participates in the compliance program. Any threat of retaliation or intimidation is acting against HCS' compliance policy and may result in disciplinary action, including but not limited to, termination of employment or contract.

Affected individuals who believe that have been subject to retaliation or intimidation should report the actions to the CCO who will investigate the allegation.

V. DISCIPLINE

Affected individuals, who upon investigation are found to have committed illegal or unethical acts or violated government regulations, the Standards of Conduct, or HCS' compliance policies and procedures will be subject to disciplinary action, up to and including, termination of employment or contract.

HCS will administer progressive discipline consistent with the violation. Disciplinary actions can include, but are not limited to, verbal counseling and warning, written warning, retraining, reassignment or demotion, suspension without pay, termination of employment or contract.

More significant disciplinary action may result if the non-compliance involved:

- Participation in actions that violate government laws, HCS compliance policy and procedure, or the Standards of conduct.
- Failure to follow policies that govern the prevention, detection, or reporting fraud or abuse.
- Falsification of records.
- Submission of false records.
- Failure to report a violation by a peer or subordinate.
- Failure to cooperate in an investigation.
- Retaliation/intimidation against an individual for reporting a possible violation or participating in

an investigation.

Disciplinary actions will be appropriately documented and will be considered during promotional evaluations.

The CCO will provide a report to the compliance committee and governing body regarding disciplinary actions.

Managers and supervisors will be disciplined for failure to instruct their subordinates or for failure to detect noncompliance, if reasonable diligence would have led to earlier discovery and correction of the noncompliance.

HCS will enforce disciplinary actions fairly and consistently with the same disciplinary action applied to all levels of personnel. Consideration will be given to the impact of the noncompliance and whether the affected individual voluntarily reported the issue and fully cooperated with the investigation and review.

Upon a finding that the alleged behavior involved noncompliance with government laws, HCS' compliance policy and procedures, or Standards of Conduct, HCS will take care that the noncompliant behavior ceases.

The CCO will review training materials and determine what additional training needs to be given to avoid recurrence of the unethical or illegal action. The CO will review the compliance program to determine if recommendation needs to be made to the compliance committee for additional policies and procedures relating to the unethical and illegal actions. If any corrective action was recommended, the CO will perform a post-corrective action review to determine if the corrective action effectively addressed the noncompliant behavior.

VI. MONITORING AND AUDITING

HCS conducts ongoing auditing and monitoring of its risk areas related to compliance including, but not limited to, billing, fiscal management, clinical operations, service provision, quality of care, medical necessity, compliance training and education, and effectiveness of the compliance program. HCS will analyze the results of the audits to ensure that its compliance program is effective. Audits will be conducted internally, and if necessary, externally.

On an annual basis, the CCO in conjunction with the chief executive, senior management, and the compliance committee, will determine the scope of the routine audits. Each department will identify the specific issues that should be audited.

The CCO will recommend and facilitate the monitoring of identified risk areas related to compliance with laws and regulations as well as HCS' policies and procedures and Standards of Conduct. Whenever possible, the CCO will have audits conducted by employees who are not involved in the delivery of services subject to the audit.

Outside fiscal audits occur on an annual basis. Auditors' recommendations regarding corrections of non-compliant behavior are followed as applicable.

Audits may include on-site visits, personnel interviews, questionnaires to employees and contractors, and reviews of clinical records to support claims for reimbursement.

A written report of all internal audits and results will be submitted to the CCO and the respective department director. The department director will submit a plan of corrective action, if necessary, to the CCO. The CCO will determine the timeframe of a post-audit review.

The CCO will maintain the records of all auditing activities for ten years.

If non-compliance is detected during routine monitoring, the CCO will ensure that a thorough investigation is conducted.

Any correspondence received from a regulatory agency by any department of HCS will be promptly forwarded to the CCO for review and subsequently discussed with the compliance committee. The CCO will be immediately notified of any visit, audit, investigation, or survey conducted by a regulatory agency or authority. Results of these various reviews will be promptly forwarded to the CCO.

On an annual basis, the CCO will report to the compliance committee the results of audits and corrective action taken.

On an annual basis, the CCO in collaboration with the compliance committee, will review the effectiveness of its compliance program. The review will include whether all required policies and procedures have been implemented, whether affected individuals are following HCS' policies, and whether updates to any policies are required.

SELF-DISCLOSURE PROGRAM

The Self-Disclosure Program is the mechanism providers must use to self-report Medicaid Program matters that involve possible fraud, waste, abuse, or inappropriate payment of funds which they have identified through self-review, compliance programs, or internal controls. Providers are required to report, return, and explain any overpayments received by them to OMIG within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later.

Inappropriate Medicaid payments received should be self-disclosed. Examples could include, but are not limited to:

- Billing errors.
- Fraudulent behavior by employees or others.
- Discovery of an employee on the Excluded Provider list.
- Documentation errors that resulted in overpayments.
- Overpayments that resulted from changing billing systems.

For additional details regarding billing errors and the self-disclosure program, see the program specific handbook entitled HCS Self Disclosure Policy and Procedure.

VII. RESPONSE TO COMPLIANCE ISSUES

As part of the compliance program, HCS ensures that all reports of compliance concerns are immediately investigated and resolved promptly. Such investigations may be conducted by the CCO, the compliance committee, other employees, or if indicated, by an outside party. The CCO will take immediate measures to secure relevant evidence and documentation and ensure that information obtained during the investigation remains confidential, unless otherwise required by law.

The report of an investigation should include the alleged violation, description of the investigation process, copies of the interview notes, other documents that demonstrate that a thorough investigation took place, and the disciplinary action and corrective action implemented. When appropriate, outside experts or legal counsel may be retained to assist with the investigation.

The results of the investigation and remedial actions will be reported to the chief executive, governing body, and other employees, as necessary. The CCO will report to the compliance committee regarding each investigation unless conducted under attorney privilege.

If credible evidence indicates that a state or federal law, rule or regulation has been violated, the CCO will promptly notify the appropriate governmental agency.

Announcement of an impending visit by any government investigator/auditor should be immediately reported to the chief executive.

Report, return, and explain identified overpayments to the Medicaid program through the self-disclosure program. Corrective measures will be implemented to prevent such overpayments in the future.

The CO will maintain a record of investigations, including all pertinent documentation. The record will be considered confidential and will not be released without the approval of the chief executive or legal counsel.

CONCLUSION

The purpose of the compliance policy and procedures are to detect and prevent, fraud, waste, and abuse in the Medicaid program as well as to organize HCS' resources to address compliance issues as quickly and as efficiently as possible and to implement policies and procedures that will prevent future recurrences of such issues.