RES Home Care

COMPLIANCE PLAN

RES Home Care, Inc. and affiliates have established and updated a Corporate Compliance Program for the purpose of prevention, detection, and remediation of any potential fraud, abuse, or waste involved with the provision of care and related billing or claims processing. We operate under the laws and regulations governing the Federal Medicare and the NYS Medicaid programs. A Standard of Conduct has been established and it is expected that employees, contractors, sub-contractors, agents, independent contractors and administrators abide by them. Our Corporate Compliance Program is a guide to all employees to understand the benefits of compliance and obtain a culture of compliance throughout RES. Any deviation from the above referenced laws and regulations are not condoned or tolerated, and once discovered, will be dealt with in a manner consistent with the level of non-compliance.

Employees, contractors, sub-contractors, agents, independent contractors and administrators are directed to refrain from non-compliant behavior and to report any non-compliant behavior they have witnessed, discovered, or inadvertently participated in to the agency's Compliance Officer. This plan applies to everyone listed.

SEVEN ELEMENTS OF A CORPORATE COMPLIANCE PROGRAM

The specific required elements of a Provider Compliance Program have been issued by the State government, the Office of Medicaid Inspector General (OMIG) who are charged with detecting, monitoring and preventing health care fraud and abuse.

RES has demonstrated a commitment to compliance by adopting these elements of a Medicaid Provider Compliance Program through the following actions:

- The development and distribution of a written Code of Conduct/Team Member Standards and Expectations as well as specific compliance program related policies and procedures that promote the agency's commitment to compliance and providing clear guidance regarding professional expectations and legal and ethical obligations to all employees.

- The designation of a Compliance Officer and a Compliance Committee who are charged with the responsibility of operating and monitoring the Compliance Program. At RES, the Compliance Officer is primarily responsible for the day-to-day operations of the Compliance Program and Administrators are primarily responsible for executing and enforcing the agency's policies related to compliance within each of their respective departments. An annual compliance workplan that outlines strategy for meeting the requirements, and addresses all elements will be completed by the Compliance Officer by the end of each year, for the upcoming year. A Compliance Committee will coordinate with compliance officer. The

workplan will outline the duties, responsibilities, membership, designation of a chair and frequency of committee meetings.

- The development and implementation of general compliance-related training and education programs for all employees. Ensuring that additional specialized compliance training is conducted for specific departments (that are deemed as having higher risk operations such as the coding and billing functions). Employees will be trained upon hire, and annually.

- The implementation of a 'reporting and response mechanism' to receive reports of potential non-compliance or concerns and a procedure for the Compliance Officer to address them, including anonymous reporting.

- The implementation of a process to respond to any allegations of potential non-compliance, whether intentional or not. In addition, RES will follow disciplinary policies against employees who have violated internal compliance policies, regulations, or State Health Care Program requirements.

- Systems for identifying compliance risk areas, routine auditing and monitoring, annual compliance program review, checking monthly for excluded providers, requiring contractors, agents, subcontractors and independent contractors to comply with checking monthly for excluded providers
    - The use of periodic monitoring activities and conducting internal audits to determine the rate of compliance with specific regulations and to decrease the risk of non-compliance. These particular departments and risk areas are likely to change over time as the State government change focus and as internal computer applications and processes change.

    - The implementation of a process that verifies that RES has not employed or contracted with physicians, service providers, vendors and independent contractors that are listed on the EPLS, OIG or OMIG exclusion website as excluded providers from the Federal and State health care program. This means RES cannot receive reimbursement from Medicare or Medicaid for any physicians, providers or vendors services if they are listed as OIG excluded (or OMIG excluded), and generally cannot do business with them.

- Systems for responding to compliance issues, responding promptly to compliance issues raised, investigating and correcting problems, ,ensuring compliance with state and federal laws, rules, regulations and requirements of the Medicaid program.

- Agency established a non-intimidation and non-retaliation policy and procedure. Staff is trained upon hire, and given a copy of the compliance plan.
- Internal Investigation policy and procedure established for responding to compliance issues. A process to refund any overpayments that RES discovers they may have received inadvertently from Medicaid (follow self-disclosure process) .
- Implementing self-disclosure policy and procedure as per the most current Self-disclosure protocols as per OMIG

- https://omig.ny.gov/news/2023/omig-announces-updates-self-disclosure-program

These commitment statements follow the recommended structure for the elements of a Provider Compliance Program from Title 18 of the Codes, Rules and Regulations of the State of NY, Part 521 'Provider Compliance Programs', effective July 2009, including changes resulting from 2020 law updates.

REPORTING & RESPONSE SYSTEM

WHERE TO GO FOR ASSISTANCE

Since many of the laws and regulations that apply to RES are complex, you may have questions or concerns. There are times when the right solution isn't always clear, but a decision will need to be made. If you:

- ✓ have a question, or
- ✓ would like to report a concern or
- ✓ report a potential circumstance of non-compliance, then

  - Discuss the question or concern with your direct supervisor (who in turn can seek assistance from the Compliance Officer, if necessary).
  - Call the Compliance Officer directly at extension 115 or phone (631)732-4794 X115.

If

- ✓ the concern deals with your direct supervisor or Department Administrator, or
- ✓ if you feel uncomfortable going to your direct supervisor or
- ✓ if your past reports to your direct supervisor remain unresolved, then

  - Submit an anonymous report using the complaint form on the RES Internal Website www.reshomecareli.com.
  - Mail an anonymous letter to the Compliance Officer's attention at RES Home Care, Inc. 1461 Lakeland Ave. Suite 12 Bohemia, NY 11716
  - Leave a message on the Compliance Officer's confidential voice mail at (631) 732-4794 X115.

Such lines of communication shall be accessible to all employees, and allow compliance issues to be reported, including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

Once a report is made, the employee making the report can decide whether they want their name to be kept confidential, as the Compliance Officer conducts the investigation. Alternatively, employees can also make a report anonymously if they wish.

The disadvantage of reporting anonymously is that the Compliance Officer can't go back to the employee if she needs additional information and can't report back to the employee on the outcome.

When making a report, you have the option of remaining anonymous. However, it will help the Compliance Officer in responding if you identify yourself. The Compliance Officer will do his/her best to keep all questions and reports confidential to protect the individual making the report.

The Compliance Officer will initiate a response to all reports made within three business days. Reports will not be responded to on a first-come, first-serve basis, rather by the nature and extent of potential non-compliance. If necessary, the Compliance Officer will seek advice from external legal counsel based on the severity of allegations.

In cases where the reporter is known, he or she will be notified of the outcome of their report, to the extent deemed appropriate, by the Compliance Officer.

If it is determined that **criminal** misconduct has occurred, the matter will immediately be referred to external legal counsel to initiate contact with the appropriate law enforcement agency. RES is committed to returning any overpayment obtained in error from Medicaid or other payor.

The Compliance Officer, along with relevant Administrators, Supervisors and Members of the Corporate Compliance Committee, are responsible for evaluating RES's training and education needs and ongoing monitoring activities to prevent the reoccurrence of any incidents of non-compliance.

MANDATORY REPORTING AND NON-INTIMIDATION/NON-RETALIATION

A key element of RES's Compliance Program is the ability of team members to express problems, concerns or opinions without fear of retaliation or reprisal. Administrators and Supervisors should maintain an environment whereby team members feel comfortable raising issues or asking questions. Management staff should also take appropriate steps to address concerns that are raised and communicate the results of corrective action whenever possible or appropriate.

Administrators, Supervisors, the President and the Compliance Officer are required to receive and respond to reports of noncompliance, and are further required to protect team members making these reports from intimidation, threats, coercion, discrimination, or any other form of retaliation.

At the same time, RES requires team members to report any suspected or known instances of fraud and abuse, perceived misconduct, including actual or potential violation of laws, regulations, and procedures, Code of Ethics, Team Member Conduct or Compliance Plan. Failure to do so can result in disciplinary action up to and including termination. Team members are protected from retaliation in any form and by anyone connected with RES for reporting issues and concerns in good faith and on a timely basis. **Every team member must understand that retaliation in response to an issue or concern will not be tolerated.** Reports of retaliation will be investigated thoroughly and addressed expeditiously with appropriate disciplinary action, up to and including termination of employment.

All RES policies apply to all team members. Administrators, Supervisors and the President are not exempt from disciplinary action. On the contrary, RES expects more from individuals in supervisory or administrative positions. All individuals working within the agency on all levels are subject to disciplinary action for failing to report suspected problems, participating in non-compliant behavior, and or encouraging, directing, facilitating or permitting non-compliant behavior.
Team members may report misconduct to their supervisor, the Compliance Officer, the President, or use the Anonymous Lines of Communication.

Team members will be advised of RES's Non-Retaliation Policy at the time of employment, during Compliance training and at annual team member training. The Compliance Officer shall investigate allegations of retaliation and coordinate with Supervisors as appropriate. The Compliance Officer, President, and all RES team members ensure compliance with this policy.

MEDICAID COMPLIANCE

The Medicaid Fraud Unit in NYS requires providers to have an effective compliance program that addresses, at a minimum, the following:

- Billings
- Payments
- Medical Necessity and Quality of Care
- Governance
- Mandatory Reporting
- Credentialing (of physicians and service providers)
- Other risk areas that should, with due diligence, be identified by the provider

These areas are incorporated into the applicable section of this compliance manual. In addition, how RES monitors the effective operations of these particular topics are written in detail in RES's Handbook and Internal Policies.

RES has policies that address these topics listed below including but not limited to:

- Grievance Policy
- Human Resources: Hiring and New Service Policy, New Employee Checklists (credentialing prior to hire)
- Medical Records: New Case Checklists, required documents list
- Billing Policies
- Policies within the Team Member Handbook:
    - Team Member Standards and Expectations outlined in the Team Member Handbook
        - 302 Business Ethics and Conduct
        - 303 Team Member Conduct and work rules
        - 304 Medicaid Compliance and Documentation
    - Prevention, Detection and Remediation of Problems in the Workplace
        - 801 Exclusions
        - 802 Compliance Program and Medicaid Fraud Prevention
        - 808 Team Member/Relations/Compliant Resolution
        - 809 Mandatory Reporting and Non-Intimidation/Non-Retaliation Policy
        - 810 Anonymous Lines of Communication
        - 810.1 OMIG Self-disclosure
        - 811 Internal Investigations
        - 812 Disciplinary Action
        - 815 EVV (Electronic Visit Verification)
    - Implementing policy to contact Department of Health, or any Contract utilized for billing, for clarification, in writing, of any directive that could be a potential compliance risk for RES Home Care

MEDICAID COMPLIANCE CERTIFICATION

Instead, a provider adopting and maintaining an effective compliance program will RES Home Care will record (attest to) adopting and maintaining an effective compliance program as part of our annual Certification Statement for Provider Billing Medicaid. This annual certification shall occur on the anniversary date of RES's enrollment in Medicaid. Additionally, each year, approximately 45-60 days before the anniversary of enrollment, the NYS Department of Health (NYSDOH) sends by mail a package of information and materials, which includes the Certification of Statement for Provider Billing Medicaid Form. This Form will be completed and returned to NYSDOH by the enrollment anniversary date.

COMPLIANCE OVERSIGHT STRUCTURE

The Compliance Oversight Structure at RES consists of:

- Corporate Compliance Officer, (reports directly to the CEO of RES)
- Corporate Compliance meetings held on a quarterly basis, and
- Governance of the RES Corporate Compliance Program.
- Compliance Program Review Process (complete Module on an annual basis)

The (above) compliance-related roles have been added to existing positions at RES.

The compliance related positions oversee all aspects of RES Home Care, Inc.

- Compliance Officer.
- The Compliance meetings will include Compliance Officer, CEO, and other pertinent Administration.
- Administration is ultimately in charge of the governance of the compliance program.

These roles have been developed to ensure appropriate oversight of planning, designing, implementing, and maintaining organization-wide Compliance Programs and associated policies and procedures.

These individuals have the appropriate access to information, employees and all individuals associated with the agencies required to complete the designated compliance responsibilities.

THE COMPLIANCE OFFICER'S RESPONSIBILITIES:

The Compliance Officer oversees the Agency's Compliance Program, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization. The position ensures the President, all departments, administrators, supervisors and employees are in compliance with the rules and regulations of regulatory agencies, including all federal and state standards, that company policies and procedures are being followed, and that behavior in the organization meets the agency's Standards of Conduct.

The Compliance Officer position exists:

- As a channel of communication to receive and direct compliance issues to appropriate resources for investigation and resolution, and
- As a final internal resource with which concerned parties may communicate after other formal channels and resources have been exhausted.

The Compliance Officer acts as staff to the CEO by monitoring and reporting results of the compliance/ethics efforts of the agency and in providing guidance for President and Administrators on matters relating to compliance. The Compliance Officer, together with the CEO, and Administrators, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.

The Compliance Officer:

- Develops, initiates, maintains, and revises policies and procedures for the general operation of the Compliance Program and its related activities to prevent illegal, unethical, or improper conduct. Manages day-to-day operation of the Program.
- Develops and periodically reviews and updates Code of Conduct/Code of Ethics to ensure continuing currency and relevance in providing guidance to management and employees.
- Collaborates with other departments (e.g., Finance, Medical Records, Human Resources & Training, Program Services, etc.) to direct compliance issues to appropriate existing channels for investigation and resolution. Consults with the agency's attorney along with the President as needed to resolve difficult legal compliance issues.
- Responds to alleged violations of rules, regulations, policies, procedures, and Code of Ethics by evaluating or recommending the initiation of investigative procedures. Develops and oversees a system for uniform handling of such violations.
- Acts as an independent review and evaluation body to ensure that compliance issues/concerns within the organization are being appropriately evaluated, investigated and resolved.
- Monitors, and as necessary, coordinates compliance activities of other departments to remain abreast of the status of all compliance activities and to identify trends.
- Identifies potential areas of compliance vulnerability and risk; develops/implements corrective action plans for resolution of problematic issues, and provides general guidance on how to avoid or deal with similar situations in the future.
- Provides reports on a regular basis, and as directed or requested, to keep the President and Administrators informed of the operation and progress of compliance efforts.
- Ensures proper reporting of violations or potential violations to duly authorized enforcement agencies as appropriate and/or required.
- Establishes and provides direction and management of the anonymous communication lines (email or phone calls to Compliance Officer, anonymous submission of a complaint or comment through the agency's website employee section (delivered directly to

Compliance Officer via email), submissions to a complaint and comment box).

- Institutes and maintains an effective compliance communication program for the organization, including promoting (a) use of the Anonymous Communication Lines; (b) heightened awareness of Code of Ethics, and (c) understanding of new and existing compliance issues and related policies and procedures.
- Works with the Human Resources Department and others as appropriate to develop an effective compliance training program, including appropriate introductory training for new employees as well as ongoing training for all employees, supervisors, and administrators.
- Monitors the performance of the Compliance Program along with the Compliance Committee and relates activities on a continuing basis, taking appropriate steps to improve its effectiveness.

DISCIPLINARY ACTIONS & SANCTIONS

After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed.

It is important to note that depending on the severity of the non-compliant behavior, progressive discipline is not required.

The purpose of this policy is to state RES's position on administering equitable and consistent discipline for unsatisfactory conduct in the workplace; unsatisfactory work performance; or violation of Agency policy. The best disciplinary measure is the one that does not have to be enforced and comes from good leadership and fair supervision at all employment levels.

RES's own best interest lies in ensuring fair and firm treatment of all team members in <u>all</u> positions and in making certain that disciplinary actions are prompt, uniform, and impartial. The main purpose of any disciplinary action is to correct the problem, prevent recurrence, and prepare the team member for satisfactory service in the future.

Disciplinary action may call for any of four steps -- verbal warning, written warning, suspension with or without pay, or termination of employment -- depending on the severity of the problem and the number of occurrences. There may be circumstances when one or more steps are bypassed based on the severity of the offense.

Progressive discipline means that, with respect to most disciplinary problems, these steps will normally be followed:

1. First offense: verbal warning (with re-education, with or without probation)
2. Second offense: written warning (with re-education, with or without probation)
3. Third offense: probation, suspension or termination based on offense.
4. Fourth offense (if not already terminated): termination of employment

If more than 12 months have passed since the last disciplinary action, the process will typically start over. The supervisor will need to account for the nature of the offense prior to determining the most appropriate disciplinary action.

RES recognizes that there are certain types of team member problems that are serious enough to justify either suspension or termination of employment at the first disciplinary action in reaction to a first or second offense.

While it is impossible to list every type of behavior that may be deemed a serious offense, this Team Member Handbook acts as a guide for all team members. Team members should pay special attention to the following:

- Mandatory Reporting and Non-Intimidation/Non-Retaliation Policy
- Team Member Standards and Expectations Policies
- Medicaid Compliance and Documentation Policy

These policies include behavior that would result in disciplinary action. Offenses the agency considers serious may result in immediate suspension or termination of employment.

By using progressive discipline, we hope that most team member problems can be corrected at an early stage, benefiting both the team member and RES.

Sanctions and Penalties: If RES Home Care does not have a satisfactory program, RES may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the Medicaid program.

POCA (Plans of Corrective Action) will be identified and implemented in all areas identified by OMIG as needing improvement. Although the corrective actions may not be immediately reviewed by OMIG, failure to implement the requested corrective action could subject RES Home Care to further sanctions associated with a future review.

OIG/EPLS/OMIG EXCLUSION CHECK FOR PROVIDERS & EMPLOYEES

The OIG/OMIG has authority to exclude individuals and entities from the Federal and State Health Care Programs. The OIG/OMIG also has the authority to assess penalties to providers that violate the law by employing or contracting with an excluded individual or entity. An individual or entity is most commonly excluded for civil or criminal health care fraud and abuse. Exclusion could occur for fraud and

abuse circumstances that were not intentional however also in circumstances when it was intentional.

RES is prohibited from employing or contracting with any employee, agent or vendor who is listed by the OIG as debarred, excluded or otherwise ineligible for participation in Federal and State Health Programs. This prohibition is necessary to ensure RES receives appropriate Federal healthcare program reimbursement for items and/or services provided to patients.

Any employee, agent or vendor who is charged with criminal offenses related to health care, must be removed from direct responsibility for or involvement in any Federal and State Health Program until resolution occurs. If resolution results in conviction, debarment or exclusion of the employee, agent or vendor, the agency's Compliance Committee must immediately review the case and proceed with termination of the contract or employment.

RES shall terminate conditional employment or a conditional contract upon receiving results of the individual or organization being excluded from participation in Medicaid until which time that they are not on the list.

There is a process in place to verify that new employees and providers are not excluded from the Medicaid program. This occurs during the employment process and credentialing phase for providers.

There is a monthly process to ensure that all existing providers and employees are not excluded by OIG or OMIG.

COMPLIANCE TRAINING & EDUCATION:

RES's initial compliance training program shall:

- Highlight the importance of a Compliance Program;
- Highlight our customized Compliance Program and Manual and
- Clearly discuss employee responsibilities as they relate to compliance.

This initial training was provided to existing employees in December 2009 and still continues today. This initial compliance training has been incorporated into the New Employee Orientation process for all future employees. In addition, each new employee is required to sign an acknowledgement of receipt of the agency's manual or copies of policies outlining the compliance program.

Mandatory annual training for all employees is provided. Specialized training is provided to certain groups of departments and individuals, including Administrators and Supervisors.

Periodic compliance training and education sessions will be developed and enforced by the Compliance Officer. Attendance and participation in these education programs is a condition of continued employment. Attendance will be tracked and enforced. Failure to meet minimum prescribed requirements will result in disciplinary action, including possible termination.

FRONT LINE MEDICAID FRAUD & ABUSE PREVENTION

Medicaid Compliance and Documentation:

RES enforces and complies with the strictest regulations regarding potential Medicaid Fraud.

All RES employees are required to document each session accurately and completely. The session note must reflect:

- Correct type of service delivered (SC, ILST, PBIS, HCSS, CIC, SDP, etc.)
- The team member's name who delivered the service
- actual time/date of the face-to-face session

The body of the case note must include:

- Actual activities of session (activities must reflect the goal plan, list interventions used by staff, and the success of these interventions- Ex. did participant need prompting? how much assistance did they need to complete the task?)
- Where the service took place (Each case note must include location of session. Ex: Met participant at his apartment in Medford, NY. Conducted part of session in the community. Ended session at the participant's SDP in Bohemia, NY.)

All employees are expected to do the following:

- **DO NOT** share any of your passwords with anyone- including a supervisor. If this occurs, you are expected to change your password as soon as possible.
- **DO NOT** document anything you have not actually done or observed
- Bill only for service hours that actually occurred **FACE to FACE** with the participant.
- Whenever possible, call in and out from participant's home at the beginning and end of the session
- Enter notes only for services that were actually performed
- Understand how many hours are approved for your particular service and ensure your session does not run longer than the approved hours. Contact a supervisor immediately whenever this may occur due to coverage issues or emergencies.

- Understand that the falsification of any reports, records or documentation is a serious offense.
- Comply with the rules, regulations and official directives
- Ask your supervisor for direction in a timely manner when unsure
- DO NOT cut and paste notes from a previous session. All notes are expected to be original.

Procedure for reporting Medicaid Fraud

- Follow Mandatory Reporting Procedures
- Contact Compliance Officer
- Contact President and Billing
- Follow Non-Retaliation Policy when a team member files a report
- Self-disclosure (when applicable)

COMPLIANCE MONITORING & AUDITING

RES recognizes the importance of performing regular, periodic compliance audits.

Compliance monitoring and auditing procedures will be implemented that are designed primarily to determine the accuracy and validity of the billing and coding submitted to Federal, state and private health care programs and detect other instances of potential misconduct by employees and service providers.

Random samplings of records drawn from a cross-section of departments will be conducted on an annual basis. Specific monitoring and auditing plans will be included in the annual compliance work plan. It will include periodic tests of claims submitted to Medicaid. It reviews the accuracy of the work of billing, employee credentialing and medical records personnel. For quality of care/medical necessity reviews, claims review will also include care provided by clinical supervisors and clinical staff.

This provides a system for routine identification of compliance risk areas which is required by OMIG. OMIG requires a mandatory evaluation of four areas on a regular basis: (1) credentialing of providers (2) mandatory reporting (3) governance and quality of care (4) Internal and external audits, to evaluate the overall effectiveness of the compliance program.

The Compliance meetings will discuss and address compliance topics, as well as lay out audit schedules for the upcoming year.

ANNUAL COMPLIANCE WORK PLAN

The Compliance Officer is responsible for developing an annual compliance work plan and submits during the Executive Meeting (compliance committee) for feedback. This work plan describes the areas that will be reviewed, whether it will be reviewed by internal or external resources, and describes whether it is a policy review, claims review and/or document review, and in which quarter of the year it will be completed.

Any changes to this work plan should be discussed at the Compliance Committee meetings. The work plan should also be shared with the CEO during the first meeting of the said year.

BILLING & CLAIM SUBMISSION PROCESS

When claiming payment for RES professional services, RES has an obligation to its clients and the state government to exercise diligence, care and integrity with respect to billing and claims submission. The right to bill the Medicaid program, conferred through the award of a provider number, carries a responsibility that may not be abused.

RES is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout the agency, have responsibility for entering charges and session types. Each of these individuals is expected to monitor compliance with applicable billing rules.

Any false, inaccurate or questionable claims should be reported immediately to a direct supervisor, Vice President or to the Compliance Officer. Examples of false claims include:

- Claiming reimbursement for services that have not been rendered,
- Filing duplicate claims,
- Billing for a service with a higher rate or more complex services than were actually performed,
- Including inappropriate or inaccurate costs on cost reports,
- Billing for a length of stay beyond what is necessary,
- Billing for a length of stay beyond what has been approved if applicable,
- Billing for services or items that are not necessary,
- Billing for services or items that are not approved if applicable and
- Failing to provide medically necessary services or items.
- Billing for services by an unqualified individual

There are steep fines, penalties and exclusions from OMIG and NYS associated with false claims and fraud.

COMPLIANCE PROGRAM EFFECTIVENESS

This Compliance Program shall be reviewed annually by the Compliance Committee and Corporate Compliance Officer to evaluate the effectiveness of the plan and to determine if changes and/or revisions are necessary. The annual evaluation shall be promptly submitted to the President for consideration.

There are a few methods RES will use to demonstrate the effectiveness of the compliance program.

1. That there have been reports made to the Compliance Officer (either directly, through the telephone or verbal contact or anonymous submission of RES's online report or written letter). This indicates that staff is aware of the program and the reporting systems available.
2. That there are written reports that summarize specific compliance reviews/internal audits that were conducted. Ideally, there will be reviews conducted proactively from knowledge of a high-risk area along with reviews conducted reactively by a concern reported.
3. Attendance rates for annual compliance training at 95% or above.
4. Compliance Committee meetings that demonstrate the topics addressed and actions taken.
5. That there have been refunds made to Medicaid for overpayments received in error. Subsequently, refunding of overpayments discovered as part of an internal audit is typically a routine procedure at the conclusion of the internal audit. Alternatively, if overpayments are found on a case-by-case basis, those too will be refunded timely and appropriately.

Self-Disclosure

In compliance with the requirements of SubPart 521-3, RES Home Care will report, return and explain any overpayments received by Medicaid. Policy and Procedure outline the steps to follow the most current self-disclosure requirements outlined on OMIG's website, and is included in the policy and procedure.
When an overpayment is discovered, RES must determine how widespread the overpayment issue is and if there was any intention to defraud the government. OMIG has 'self disclosure procedures' that are available to providers online that provide details on how to self-disclose any intentional and/or widespread systemic compliance issues that resulted in significant overpayments. RES can follow the self-disclosure protocols, if necessary, with the assistance from external legal counsel and the policy and procedure that is in place for self-disclosure.

EMPLOYEES ROLE & RESPONSIBILITIES

RES relies on you to ensure we continue to operate in a legal and ethical manner. Without you, the Compliance Program cannot succeed. As such, you are responsible for:

- Being honest in all your interactions with clients, co-workers, supervisors, management and other employees.

- Becoming familiar with RES's code of conduct, your specific department's policies and the regulations that relate to your job responsibilities.
- Listening to questions or complaints made by clients, family members or visitors and notify your supervisor/manager of those complaints.
- Reporting any concerns, you may have about potential non-compliant behavior to your supervisor or the Compliance Officer.
- Utilizing EVV (Electronic Visit Verification) for LHCSA staff

It is important that any concerns get resolved by the appropriate Supervisor in charge because failure to comply with applicable laws can result in civil fines or criminal penalties against RES along with termination of participation in the Medicaid program. Medicaid clients are the majority of RES's business. In some instances of intentional wrong doing, civil fines could also be assessed against individuals, not just the health care provider.

HIPAA COMPLIANCE

Health Insurance Portability and Accountability Act (HIPAA) compliance includes rules on privacy, security, breach notification, and enforcement with regard to protecting consumer healthcare information. Both Privacy and Security rules require RES and its business associates to:

1. Put safeguards in place to protect patient health information.
2. Reasonably limit uses and sharing to the minimum necessary to accomplish your intended purpose.
3. Have agreements in place with any service providers that perform covered functions or activities for you. These agreements (BAAs) are to ensure that these services providers (Business Associates) only use and disclose patient health information properly and safeguard it appropriately.
4. Have procedures in place to limit who can access patient health information, and implement a training program for you and your employees about how to protect your patient health information.