Topic: Corporate Compliance – Employees and Volunteers	**Department:** Entire agency
Original effective date: 3/11/02	**Last revision date:** 4/25/24
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Internal/Regulatory Reference(s) (all that apply): NYS Social Services Law 363-d; 18 NYCRR 521	
Related documents/Links: See references within the document	

Policy: It is The Arc's policy that business, administrative and support functions promote personal and organizational outcomes; and implement sound fiscal practices.

Additional Information: The Arc is committed to and has an obligation to comply with all applicable federal and state standards. This includes, but is not limited to, The US Centers for Medicare and Medicaid Services (CMS), The NYS Department of Health, and the Office for People with Developmental Disabilities (OPWDD).

The goal is to prevent and find fraud, waste, and abuse of government and other payers' money. This policy and procedure will be enforced with training and discipline. This may include discipline for not reporting a concern.

The Arc has other related policies and procedures. These include:

- The False Claims Act established under sections 3729 through 3733 of title 31, United States Code;
- Administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code; and
- State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (please cross reference our policy, "Whistleblowers, Non-intimidation, Non-retaliation").

Please cross reference as appropriate.

The NYS Office of the Medicaid Inspector General (OMIG) can impose penalties upon The Arc for failure to meet compliance requirements.

This policy applies to staff (including the CEO and all members of management), volunteers, students and interns, hereafter referred to as "staff."

Procedure	
Task:	**Responsible party:**
General Guidelines:	
1. All staff are expected to do their work and responsibilities ethically and within laws and requirements at all times. Conduct contrary to the expectations in any compliance policy or the agency's Code of Conduct shall be considered a violation of the compliance program and related policies and procedures and may result in disciplinary action up to and including termination. Please cross reference the policy, "Staff Performance, Incentives and Discipline" for additional information.	Staff
2. Participation in compliance and HIPAA training is required. Please cross reference the policy on "Compliance-related Training and Communication" for further details.	Staff
3. All staff are required to report compliance concerns. This can be done confidentially or anonymously. Reports can be made internally to The Arc	Staff

	using the agency's Compliance Hotline or to a member of agency leadership. Reports can also be made to any government agency or entity including, but not limited to: NYS OMIG, the Medicaid Fraud Control Unit (MFCU), the NYS Department of Health (DOH), OPWDD, the NYS Attorney General (NYS AG), the Department of Labor (DOL), the Office of Inspector General (OIG) or the US Attorney's Office. Please cross reference the policy Non-compliance detection and response, and confidential communications for further details.	
4.	Staff cannot be intimidated or retaliated against for any of the following: *Reporting something they believe is really happening to any appropriate parties or officials *Investigating issues *Conducting self-evaluations, audits or remedial actions Please cross reference the policy and procedure on Non-compliance detection and response, and confidential communications for additional information.	All staff including coworkers, supervisors, administration
5.	Staff who do not report concerns or who deliberately report a false concern may receive discipline up to and including termination from employment.	Management, HR
6.	Reports of harassment or retaliation will be handled primarily by HR, with the appropriate support of the compliance function.	HR
7.	Audits will be done to determine how effective its compliance practices are. These are designed to find where things are happening that should not be. Audits may include, but are not limited to: *Health care regulations and laws *Medicaid and other payers *Billing and payment *Medical necessity *Seeing if staff are excluded from working with Medicaid *Clinical licensure (where applicable) *HIPAA privacy *SHIELD requirements *Security policies (HIPAA, etc.). Please note that HIPAA Security Policies can be found on ArcSmart, the agency's intranet.	Quality Coordinators (or comparable positions), Outside auditors, Other staff as assigned
8.	The Arc will respond to any concern identified, raised or reported, regardless as to how it is reported. We will look into the situation, consistent with the concern raised, and take steps appropriate to prevent it from happening again.	VP for Quality and Comp, Management
9.	To prevent situations from happening again, we may change or update our existing processes or procedures, we may develop new ones, or we may take disciplinary action with staff up to and including termination of employment.	Management
10.	If we believe we have received money from any payer for any services or supports we've provided that we should not have gotten, we will pay it back. Please cross reference the policy Unsupported claims and repayment or financial adjustments, and voluntary self-disclosure for additional information.	VP for Quality and Compliance, Administration, Management, legal counsel where appropriate
11.	Background checks will be conducted for employees, volunteers, vendors, contractors, and members of the Board of directors as required by regulations, including checking for exclusion from participation in Medicaid-funded programs. Please cross reference the policies Background Checks and Exclusion Checks for further details.	HR, VP for Quality and Compliance (or designee)

12. Annually, via the Certification Statement for Provider Billing Medicaid Form, the CEO or designee will, with the support and information provided by the VP for Quality and Compliance, attest that we are compliant with NYS compliance law.	CEO, VP for Quality and Compliance
Manager Responsibilities:	
1. Managers have a responsibility to act as role models and establish the tone and expectation within their programs and teams for compliance with laws, rules and regulations.	Managers
2. Managers are obligated to understand their roles and fulfill their responsibilities related to compliance. They are expected to have a solid understanding of the compliance requirements of their programs, and to establish the procedures necessary to ensure such compliance and the effective operation of their programs. This includes requirements related to billing and submission of claims for reimbursement through Medicaid or other payers.	Managers
3. Managers are expected to report any compliance concerns they are aware of immediately, and to actively support any efforts to audit, assess or investigate compliance (or lack thereof) with any laws, rules, regulations, policies or procedures (whether internal or external).	Managers
VP for Quality and Compliance:	
1. The VP for Quality and Compliance acts as the agency's Compliance Officer, as required in NYS law.	VP for Quality and Compliance
2. Has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VP for Quality and Compliance
3. Acts as a resource for agency staff, management, leadership and the Board for issues related to corporate compliance.	VP for Quality and Compliance
4. Reports to the COO and has direct access to the CEO, Board of Directors and legal counsel.	VP for Quality and Compliance

Document revision record:

Revision Date	Release Date	Reason for change	Approver
10/27/05	10/27/05	Specific reasons for changes not documented	P Dancer
1/8/07	1/8/07	Specific reasons for changes not documented	P Dancer
5/29/08	5/29/08	Removed "health and human services" as a descriptor of our agency; Fleshed out regulatory bases for requirements	
8/6/10	8/6/10	Specific reasons for changes not documented	P Dancer
5/21/12	5/21/12	Revised to reflect change from OMRDD to OPWDD; Revised to reflect intellectual and developmental disabilities	P Dancer
3/20/13	3/20/13	Added formal policy to the top of the document	P Dancer
4/24/17	4/24/17	Included DOH as regulatory agency	P Dancer
11/9/18	11/9/18	Simplified the language	P Dancer
10/11/19	10/11/19	Moved to new procedural format	P Dancer
4/21/21	4/30/21	Stated clearly that reports can be made to any government entity. Added specific penalties related to non-compliance.	ICC

		Referenced annual Medicaid certification. Added discrete sections for manager and VPQC responsibilities	
3/29/22	4/6/22	Removed reference to specific OMIG penalties and corrected reporting structure for the VPQC	ICC
7/21/22	8/8/22	Added that conduct contrary to the compliance plan is a violation of the compliance plan	ICC
2/17/23	3/15/23	Added “and obligated” in first line of additional information; clearly stated whom this policy applies to; added links to cross-referenced documents	ICC
4/25/24	4/25/24	Added specific reference to disciplinary actions for non-compliance, spelled out acronyms, included reference to our hotline, added HIPAA privacy as an area for potential audit, and specified managers’ responsibility to understand requirements for Medicaid and other billing	ICC

Topic: Corporate Compliance – Affected Parties	**Department:** Entire agency
Original effective date: 3/11/02	**Last revision date:** 9/25/24
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Internal/Regulatory Reference(s) (all that apply): NYS Social Services Law 363-d; 18 NYCRR 521	
Related documents/Links: See references within document	

Policy: It is The Arc's policy that business, administrative and support functions promote personal and organizational outcomes; and implement sound fiscal practices.

Additional Information: The Arc is committed to and has an obligation to comply with all applicable federal and state standards. This includes, but is not limited to, The US Centers for Medicare and Medicaid Services (CMS), The NYS Department of Health, and the Office for People with Developmental Disabilities (OPWDD).

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The Arc has other related policies and procedures. These include:

- The False Claims Act established under sections 3729 through 3733 of title 31, United States Code;
- Administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code; and
- State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws. Please cross reference our policy, "Whistleblowers, Non-intimidation and Non-retaliation."

Please cross reference as appropriate. All compliance policies and procedures are available through Arcmonroe.org.

The NYS Office of the Medicaid Inspector General (OMIG) can impose penalties upon The Arc for failure to meet compliance requirements.

This policy applies to contractors, agents, subcontractors, independent contractors, vendors consistent with the "Vendor Management Policy," the Board of directors/corporate officers, and Board committees hereafter referred to as "affected parties."

Procedure	
Task:	**Responsible party:**
1. All affected parties are expected to conduct work and responsibilities ethically and within laws or requirements at all times. Conduct contrary to the expectations in any compliance policy or the agency's Code of Conduct shall be considered a violation of the compliance program and related policies and procedures and may result in separation from the agency.	Affected parties
2. Participation in The Arc's compliance and HIPAA training is required, consistent with agency policy. Please cross reference the policies on Compliance-related Training and Communication and Vendor Management for further details.	Affected parties

3. All affected parties are required to report compliance concerns. This can be done confidentially or anonymously. Reports can be made internally to The Arc using the agency's Compliance Hotline or to a member of agency leadership. Reports can also be made to any government agency or entity including, but not limited to: NYS Office of Medicaid Inspector General (OMIG), the Medicaid Fraud Control Unit (MFCU), the NYS Department of Health (DOH), OPWDD, the NYS Attorney General (NYS AG), the Department of Labor (DOL), the Office of Inspector General (OIG) or the US Attorney's Office. Please cross reference the policy Non-compliance detection and response, and confidential communications for further details.	Affected parties
4. Affected parties cannot be intimidated or retaliated against for any of the following: *Reporting something they believe is really happening to any appropriate parties or officials *Investigating issues *Conducting self-evaluations, audits or remedial actions Please cross reference the policy and procedure on Non-compliance detection and response, and confidential communications for additional information.	Affected parties
5. Affected parties who do not report concerns or who deliberately report a false concern may no longer be able to work with The Arc.	Management
6. Reports of harassment or retaliation will be handled primarily by HR, with the appropriate support of the compliance function.	HR and Mgmt
7. Audits will be done to determine how effective its compliance practices are. These are designed to find where things are happening that should not be. Audits may include, but are not limited to: *Health care regulations and laws *Medicaid and other payers *Billing and payment *Medical necessity *Seeing if staff are excluded from working with Medicaid *Clinical licensure (where applicable) *HIPAA privacy *SHIELD requirements *Security policies (HIPAA, etc.). Outside parties may request copies of these by contacting the VP of IT or the VP for Quality and Compliance.	Quality/Operations Coordinators (or comparable positions), Outside auditors, Other staff as assigned
8. The Arc will respond to any concern identified, raised or reported, regardless as to how it is reported. We will look into the situation, consistent with the concern raised, and take steps appropriate to prevent it from happening again.	VP for Quality and Comp, Management
9. To prevent situations from happening again, we may change or update our existing processes or procedures, we may develop new ones, or we may take disciplinary action with affected individuals up to and including separation from the agency.	Management
10. If we believe we have received money from any payer for any services or supports we've provided that we should not have gotten, we will pay it back. Please cross reference the policy, "Unsupported claims and	VP for Quality and Compliance, Administration, Management,

repayment or financial adjustments, and voluntary self-disclosure" for additional information.	legal counsel where appropriate
11. Background checks will be conducted for employees, volunteers, vendors, contractors, and members of the Board of directors as required by regulations, including checking for exclusion from participation in Medicaid-funded programs. Please cross reference the policy Background Checks and Exclusion Checks for further details.	HR, VP for Quality and Compliance (or designee)
12. Annually, via the Certification Statement for Provider Billing Medicaid Form, the CEO or designee will, with the support and information provided by the VP for Quality and Compliance, attest that we are compliant with NYS compliance law.	CEO, VP for Quality and Compliance
Manager Responsibilities:	
1. Managers have a responsibility to act as role models and establish the tone and expectation within their programs and teams (including any vendors as defined above) for compliance with laws, rules and regulations.	Managers
2. Managers are obligated to understand their roles and fulfill their responsibilities related to compliance. They are expected to have a solid understanding of the compliance requirements of their programs, and to establish the procedures necessary to ensure such compliance and the effective operation of their programs. This includes requirements related to billing and submission of claims for reimbursement through Medicaid or other payers.	Managers
3. Managers are expected to report any compliance concerns they are aware of immediately, and to actively support any efforts to audit, assess or investigate compliance (or lack thereof) with any laws, rules, regulations, policies or procedures (whether internal or external).	Managers
VP for Quality and Compliance:	
1. The VP for Quality and Compliance acts as the agency's Compliance Officer, as required in NYS law.	VP for Quality and Compliance
2. Has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VP for Quality and Compliance
3. Acts as a resource for agency staff, management, leadership and the Board for issues related to corporate compliance.	VP for Quality and Compliance
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7/21/22	8/8/22	Added that conduct contrary to the compliance plan is a violation of the compliance plan	ICC
2/20/23	3/15/23	Added “obligation” to the first sentence in additional information; included all relevant affected parties per revised 18 NYCRR 521 not covered in employee policy; updated responsible party in procedure; added links to cross-referenced documents; specified whom the policy applies to and updated terms throughout	ICC
4/25/24	4/25/24	Added specific reference to disciplinary actions for non-compliance, spelled out acronyms, included reference to our hotline, added HIPAA privacy as an area for potential audit, and specified managers’ responsibility to understand requirements for Medicaid and other billing	ICC
9/25/24	9/25/24	Added board committees to affected parties	ICC