Topic: Management of situations reported to the Compliance Office	**Department:** Entire agency
Original effective date: 5/17/11	**Last revision date:** 9/25/24
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Internal/Regulatory Reference(s) (all that apply): Federal sentencing guidelines 8.B.2.1(b)(7); NYS Social Security Law 636-d(2)(g); 18 NYCRR 521-1.4(h)	
Related documents/Links: Please see references within the document	

Policy: It is the policy of The Arc of Monroe that business, administrative and support functions promote personal and organizational outcomes.

Additional Information: It is critical to approach and respond to compliance concerns in a consistent way. This policy clarifies when a situation will be handled by the VP for Quality and Compliance and when it can be handled within program operations.

This policy applies to all persons who are affected by the agency's risk areas (to the degree that they are so affected) including our employees, the CEO and other senior management, managers, contractors, agents, subcontractors, independent contractors, students, interns, volunteers, vendors consistent with the "Vendor Management Policy," the Board of Directors and Board committees; hereafter referred to as "affected parties."

In general, the following situations are not handled by the compliance function:

- Allegations of abuse or neglect. If you believe that abuse or neglect is occurring, please intervene immediately to stop the abuse, ensure that the person is safe and then contact your supervisor. You can also reach out to the Incident Department for further information and guidance. The regulatory references for incident management through OPWDD are 14 NYCRR 624 and 625.
- HR issues, such as employees not getting along with each other.
- Operational issues, meaning things that have to do with how programs are organized or run.

In addition, if program staff discover something non-compliant as part of their usual operations, they may handle it internally, but are always welcome to discuss it with the VP for Quality and Compliance (VPQC). These situations are viewed as part of normal program operations. As a result, a formal compliance case will only be opened if the criteria listed below are met, even if there is a payback or financial adjustment. Anytime a program determines that a payback or financial adjustment is necessary, they are required to notify the VPQC (whether it rises to the level of a formal compliance case or not) so that the VPQC may formally report the issue to the NYS Office of Medicaid Inspector General (OMIG) through their self-disclosure process, as well as monitor, track and trend these issues organizationally as appropriate. Please cross reference the policy on "Unsupported claims, repayment/financial adjustments and voluntary self-disclosure" for further information.

Issues brought to the VPQC/Compliance Officer shall be tracked and monitored for volume, trends, disposition and resolution.

Situations that would be managed by the VPQC/Compliance Officer (including the opening of a formal compliance case) include but are not limited to the following (regardless of who or how they are discovered):

- Deliberate falsification of any agency documentation including, but not limited to: service documentation, time records, applications, fire drill records, overnight check sheets, expense/mileage sheets, etc.
    - "Deliberate" means that the person knows what they are documenting is inaccurate but they document it anyway.
    - This does not include errors in judgment, unintentional inaccurate documentation, or other mistakes made my staff.
- Fraud, meaning someone deliberately acts in a way to deceive the agency and/or the government. Please see the policy, "Accurate and timely documentation of services; and Medicaid fraud, waste and abuse" for more information.
- A program has received government money they shouldn't have gotten and refuses to pay it back.
- A HIPAA violation is believed to have occurred (please cross reference HIPAA policies and procedures for more information) including but not limited to the following:
    - It's believed that an Arc employee exceeded the HIPAA minimum necessary standard and/or sent protected health information (PHI) to someone outside The Arc who has no legal right to receive or see it.
    - It's believed that an Arc employee has deliberately accessed PHI that they are not entitled to see.
    - It's believed that an Arc employee tried to use PHI to cause harm to someone else.
    - It's determined that a breach of PHI occurred as defined in the HITECH law.
- An anonymous or confidential report via our hotline that alleges any of the above.
- Issues related to regulatory requirements unique to the field, the people we support, or the supports and services we provide
- Anytime the VPQC/Compliance Officer thinks a case should be opened.

Please see the policy, "Non-compliance detection and response" for more information.

Procedure	
	Responsible party:
1. Affected parties are required to immediately report if they believe that anything listed in this policy is occurring. Please cross reference the policy, "Non-compliance detection and response, and confidential communications" for more information on how to report.	Affected parties
2. If the VPQC receives a reported concern that is not related to compliance, they will forward it to the appropriate department (i.e., HR or operational concerns)	VPQC/Designee
3. Formal compliance cases (meeting the above criteria) are documented on a standard form and include notification to the agency's Executive Management Team and the Compliance Committee.	VPQC/Designee

4. A case file is opened and all related documentation is archived with that file in an electronic format. Any original (i.e., hand-signed) documents will be properly labeled and maintained for a period of 6 years from the date the situation officially closed.	VPQC/Designee
5. All compliance cases are reviewed by the agency's Compliance Committee, which is responsible for providing feedback on the case and has the sole authority to formally close it.	VPQC/Designee
6. Closed case files are archived for a period of at least 6 years from the date of closure.	VPQC/Designee
Manager Responsibility:	
1. Managers have a responsibility to understand the requirements of this policy and their role in it.	Managers
2. Managers are required to do their due diligence in assessing and responding appropriately to situations discovered in their program areas.	Managers
3. Managers are also required to report to the VP for Quality and Compliance anything that may meet the criteria to do so, as indicated above.	Managers
VP for Quality and Compliance:	
1. The VP for Quality and Compliance acts as the agency's Compliance Officer, as required by NYS law.	VPQC/Designee
2. The VP for Quality and Compliance has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VPQC/Designee
3. The VPQC acts as a resource for agency staff, managers, and leadership, providing support around the classification of situations.	VPQC/Designee
4. If a situation meets the criteria for a formal compliance case, the VPQC will formally open a compliance case.	VPQC/Designee
5. This case will be documented on a standard form, the "Corporate Compliance Documentation Form"	VPQC/Designee
6. An investigation will be initiated consistent with the "Compliance Investigations Policy" (please cross-reference for more information)	VPQC/Designee
7. The VPQC will ensure that the case is brought to the attention of the Compliance Committee chairperson to be added to the agenda for committee review	VPQC/Designee
8. The VPQC has primary responsibility for ensuring that the executive management team is notified and kept informed of formal compliance cases	VPQC/Designee

Document revision record:

Revision Date	Release Date	Reason for change	Approver
New	6/1/11	Approved by the internal compliance committee on 5/23/11	ICC
6/6/12	6/6/12	Reasons for changes not documented	P Dancer
10/24/14	10/24/14	Reasons for changes not documented	P Dancer
7/29/15	7/29/15	Reasons for changes not documented	P Dancer
9/2/16	9/2/16	Reasons for changes not documented	P Dancer
4/28/17	4/28/17	Reasons for changes not documented	P Dancer
11/9/18	11/9/18	Reasons for changes not documented	P Dancer
11/26/19	11/26/19	Transitioned to new procedural format	P Dancer
12/30/20	12/30/20	Took out references to non-reportable cases. Clarified investigative procedures when it's clear something happened.	P Dancer
1/29/21	1/29/21	Stated clearly that this policy applies to HIPAA as well	P Dancer
8/18/21	9/8/21	Fleshed out some details, reformatted the procedure, and added discrete sections for managers and the VPQC; added that all paybacks must be reported to the VPQC	ICC
7/18/22	7/18/22	Specified that the VPQC may direct that programs cannot investigate a situation; Typos corrected	ICC
7/21/22	8/8/22	Defined "staff" for the purposes of this policy	ICC
3/15/23	3/15/23	Added affected parties definition and corrected references throughout; separated this policy from that of investigations; referenced investigations policy; reformatted information in the policy and procedure	ICC
4/28/23	4/28/23	Took out reference to $10,000 threshold to always notify the Compliance Officer (no longer applies); included that internally-discovered can be discussed with the VPQC; reframed the reporting of all overpayments to align with other policies; added reference to "designee"	ICC
9/13/23	9/13/23	Updated references to self-disclosure to reflect new requirements; added reference to original hand-signed document retention; added a criterion to cover other types of compliance issue for opening a formal case	ICC
9/25/24	9/25/24	Added minor clarifying language and removed redundant language	ICC