Topic: Corporate Compliance	**Department:** Entire agency
Original effective date: 3/11/02	**Last revision date:** 2/19/26
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 of Monroe's (The Arc) 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 NYS Office of Medicaid Inspector General (OMIG), The US Centers for Medicare and Medicaid Services (CMS), the NYS Department of Health (DOH), the NYS Office for People with Developmental Disabilities (OPWDD), and the United States Department of Health and Human Services (for HIPAA).

The goal is to prevent and find fraud, waste, and abuse of government and other payers' money. This policy and procedure will be enforced through 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 (please refer to the False Claims Acts policy for additional information); 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").

All compliance policies and procedures are available through ArcSmart (for staff) or Arcmonroe.org (for anyone including affected parties). 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;" and
- Contractors, agents, subcontractors, independent contractors, vendors (consistent with the "Vendor Management policy (please cross-reference)), the Board of Directors/corporate officers, and Board committees, hereafter referred to as "affected parties."

Procedure	
Task:	**Responsible party:**
General Guidelines:	
1. All staff and affected parties are expected to do their work and responsibilities ethically and within state and federal 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	Staff, affected parties

	and related policies and procedures. For staff, this may result in disciplinary action up to and including termination. Please cross reference the policy, "Staff Performance, Incentives and Discipline" for additional information. For affected parties, this may result in separation from the agency.	
2.	Participation in compliance and HIPAA training is required. Please cross reference the policy on "Compliance-related Training and Communication" for further details. In addition, affected parties who are vendors should cross reference the policy, "Vendor Management."	Staff, affected parties
3.	All staff and affected parties are required to report compliance concerns. Reports can be made internally to The Arc using the agency's Compliance Hotline or to a member of agency leadership. This can be done confidentially or anonymously, which is most easily accomplished through the hotline. The hotline can be accessed by calling 585-448-3588 or by going to https://ethcomp.com/arcofmonroe 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 DOH, OPWDD, the NYS Attorney General (NYS AG), the Department of Labor (DOL), the Office of Inspector General (OIG), the US Attorney's Office, or the US Department of Health and Human Services Office of Civil Rights (OCR). Please cross reference the policy, "Non-compliance detection and response, and confidential communications" for further details.	Staff, affected parties
4.	Neither staff nor affected parties can 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 following policies for additional information: "Non-compliance detection and response, and confidential communications" and "Whistleblower, non-intimidation and non-retaliation.	All staff including coworkers, supervisors, administration and affected parties
5.	Staff who do not report known or suspected concerns or who deliberately report a false concern may receive discipline up to and including termination from employment. Affected parties who fail to report a concern or who deliberately make a false report may no longer be able to work or be affiliated with The Arc.	Staff, Affected parties, 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 The Arc's compliance practices are. These are designed to find where things are happening that should not be. Audits may include, but are not limited to:	Quality/Operations Coordinators (or comparable

*Health care regulations and laws *Medicaid and other payers *Billing and payment *Medical necessity *Seeing if staff are excluded from working with Medicaid-funded providers *Clinical licensure (where applicable) *HIPAA privacy *HITECH *Security policies (HIPAA, etc.). Please note that HIPAA Security Policies can be found on ArcSmart, the agency's intranet.	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 Compliance, Management
9. To prevent situations from happening again, we may change or update our existing processes or procedures, we may develop new ones, we may provide additional/enhanced training, or we may take disciplinary action with staff up to and including termination of employment. For "affected parties," we may take steps to terminate our relationship with them.	Management
10. If we believe we were paid for services or supports that we should not have received payment for, we will return the money.Please cross reference the policy, "Unsupported claims, 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 staff and affected parties as appropriate and/or required, 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. Acts as the agency's Compliance Officer, as required by 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, unfettered 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. Referenced annual Medicaid certification. Added discrete sections for manager and VPQC responsibilities	ICC
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
4/17/25	4/17/25	Consolidated formerly separate compliance policies for staff and affected parties into one policy; added clarifying language; added hotline contact information; added HHS reference where appropriate	ICC
2/19/26	2/19/26	Added a secondary policy reference and clarifying language, and information specific to affected parties	ICC