

**The Arc of Monroe**  
**A Chapter of NYARC, Inc.**

**CORPORATE COMPLIANCE PLAN**

Introduction:

It is the policy of The Arc of Monroe to conduct its business in compliance with applicable federal, state and local laws and regulations, and to adhere to the highest ethical standards. As an agency, The Arc is committed to and has an obligation to comply with all applicable federal and state standards.

On July 11, 2001, The Arc's Board of Directors adopted the resolution to establish a compliance program. Through this, they instructed agency management to develop and implement a compliance plan. This has included the development of policies and procedures, which explain our overall approach and guide us in its consistent implementation.

This plan provides an overview summary of the key elements of our overall compliance approach. Further details can be found within individual policies and procedures, including the responsibilities of all affected individuals in carrying out the functions of the compliance program. This plan applies to all staff, volunteers, the Board of Directors, and people with whom we do business. Each of these parties has a responsibility to follow and comply with this plan and associated policies.

This plan is reviewed annually, updated when necessary, and approved by the Board on an annual basis.

Applicability:

This plan applies to all person's 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](#)" and the Board of Directors.

Mission:

Our mission is to create an inclusive society where the people we support may live truly integrated lives and reach their full potential as part of our community.

Vision:

A progressive community that welcomes diversity, fosters meaningful relationships, and cultivates a life of fulfillment for those we support.

Core values:

- Empathy
- Camaraderie
- Ingenuity
- Integrity
- Excellence
- Perseverance

Code of conduct (from our Employee Handbook):

The Arc, in alignment with its vision of total quality and its genuine concern for people we support, believes that all have rights to safe and nurturing residences and work environments, as well as fair, ethical and legal program administration. The mission of The Arc of Monroe is to provide direct and supportive services in an effective way to individuals with intellectual and other disabilities, and their families. The Arc of Monroe has the right to add, change, revise, or remove any code of conduct, as necessary. 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. The following are examples of behaviors that are prohibited and do not support our Mission, Vision or Values:

- Violating Agency policies and procedures
- Being insubordinate, or refusing to follow a supervisor(s) reasonable direction;
- Using abusive or profane language towards individuals, co-workers or vendors;
- Sleeping while on duty
- Bringing unauthorized weapons of any kind onto Agency property;
- Committing any act of dishonesty, such as theft or removal of Agency property without permission;
- Committing an illegal act
- Violating all federal, state and local laws and regulations
- Discriminating against or harassing co-workers, subordinates, or people we support;
- Distributing or posting unauthorized materials on Agency premises;
- Photographing, video recording or copying confidential or proprietary information about the Agency, employees or its individuals, or photographing or video recording non-public areas of Agency property that contains or could reasonably contain confidential or proprietary information about the Agency, employees or individuals;
- Excessive unexcused absences or tardiness;
- Falsifying Agency or individual records or providing false or altered documentation;
- Falsification of claims (e.g., billing for services that were not provided, double billing the government, submitting a claim in excess of the actual fee or cost, billing for services different from or more than those that were provided)
- Fighting, threatening others or provoking such acts;
- Gaining unauthorized access to, improperly divulging, or otherwise misusing confidential Agency, employee or individuals information;
- Reporting expenses inaccurately or unauthorized or inappropriate use of an agency charge card;
- Interfering with another employee's performance, delaying or otherwise restricting operations or influencing others to do so;
- Reporting to work in a condition in which the employee is unfit to perform assigned duties or is potentially hazardous to oneself or others (e.g., alcohol or drug impairment);
- Willfully misusing, damaging, wasting or destroying Agency property.

The above list is not all-inclusive. It is intended to provide examples of behaviors that alone, or combined with others, will be cause for disciplinary action, up to and including termination of employment.

Implementation of the plan:

1. Written policies and procedures: Formal policies and procedures have been developed for the following topics:
  - a. [General corporate compliance policy for employees and volunteers, and affected individuals, such as vendors and contractors](#)
  - b. [Deficit Reduction Act](#)
  - c. [Communication of compliance activities to the Board of Directors](#)
  - d. [Responsibilities of the Board of Directors regarding corporate compliance](#)
  - e. [Corporate compliance-related training and communication](#)
  - f. Corporate Compliance training plan
  - g. [Code of conduct](#)
  - h. [Background checks](#) (including child register, clinical licensure and educational checks)
  - i. [Justice Center Criminal History Information Checks](#)
  - j. [Exclusion checks](#)
  - k. [Anti-kickback, inducement and physician arrangements](#)
  - l. [Conflict of interest – for Non-agency officers/Board and Agency Officers/Board](#)
  - m. [Staff performance, incentives and discipline](#)
  - n. [Agency-wide preventive risk assessment and annual compliance activity planning](#)
  - o. [Service delivery standards](#)
  - p. [Medical/clinical necessity](#)
  - q. [Accurate and timely documentation, and Medicaid Fraud and Abuse/Misuse](#)
  - r. [False claims](#)
  - s. [Internal monitoring and auditing](#)
  - t. [Non-compliance detection and response, and confidential communications](#)
  - u. [Management of situations reported to the Compliance Office](#)
  - v. [Compliance Investigations](#)
  - w. [Risk appetite assessment of compliance matters](#)
  - x. [Unsupported claims and repayment/financial adjustments/Voluntary disclosure and self-reporting](#)
  - y. [Response to governmental investigations](#)
  - z. [Political contributions/lobbying](#)
  - aa. [Vendor management](#)
  - bb. [New government initiatives related to corporate compliance](#)
  - cc. [Annual Compliance Program review](#)
  - dd. [Whistleblowers, Non-intimidation and Non-retaliation policy](#)
  - ee. Document management

All compliance policies are reviewed at least one each calendar year and updated as required.  
All compliance policies are available on Arcmonroe.org or the agency's intranet.

Annually, The Arc will complete the required DOH certifications, confirming that we are compliant with requirements.

Please see the Compliance Policy on Policies for more detail.

2. A staff person who is responsible for the compliance plan: The VP for Quality and Compliance is the agency's full-time compliance officer. They are responsible, with the support of the compliance committee, for oversight of compliance activities for the organization, including

developing and monitoring this plan and related policies. They report to the COO for administrative purposes, but has free and unfettered access to the CEO, the Board of directors and legal counsel at their discretion. Any issues or concerns related to their reporting to the COO would be brought immediately to the attention of the CEO.

Please see the job description for the VP for Quality and Compliance.

3. Compliance Committee: Consistent with New York state compliance requirements, The Arc has a compliance committee. This committee reports to the CEO or designee, who is the committee's chairperson. Membership includes a member of EMT, a Board member, program operations, IT, finance, HR, nursing, incidents, and clinic. It is responsible for reviewing compliance and HIPAA cases, reviewing and approving compliance policies and procedures, monitoring agency outcome metrics, and providing support to the Compliance Officer. Please see the committee's charter for details.
4. Training and education: All parties that are affected by the agency's risk areas will receive compliance training when they first join the agency and every year thereafter. This may include the following: employees, managers, contractors, agents, subcontractors, independent contractors, vendors (consistent with our "[Vendor Management Policy](#)"), students, interns, volunteers, and the Board of Directors. While there are certain core elements that everyone receives instruction on, additional specific training may vary based on individual roles and responsibilities. Core elements include (but are not limited to):
  - \*What corporate compliance is
  - \*Why we have a corporate compliance plan
  - \*Our key risk areas and our organizational experience
  - \*General Medicaid requirements
  - \*The importance of accurate coding, billing and claims submission
  - \*A list of our policies and procedures, and where to access them
  - \*Who the compliance officer is and their role
  - \*Information on the Corporate Compliance Committee and its role
  - \*Documentation and corporate compliance
  - \*How affected parties can ask questions and report potential compliance-related issues to the compliance officer – including anonymous and confidential reporting
  - \*Disciplinary standards
  - \*Auditing
  - \*How the agency responds to compliance issues and implements corrective action plans
  - \*False Claims Acts
  - \*Non-retaliation

Students and interns also receive information on corporate compliance consistent with their roles when they first start with us and annually thereafter, if they are still with us. Vendors who provide a certain level of health care service and support also receive information on our compliance plan, false claims act information and how to report compliance concerns, consistent with the [Deficit Reduction Act](#). Please see the policy on vendor management for more detail.

Board members also receive training when they first join our agency and annually thereafter. In addition to compliance basics, they also receive training on their fiduciary responsibilities,

namely putting the agency first in their roles as Board members. This training is conducted by the VP for Quality and Compliance as the compliance officer.

Everyone learns how and to whom they can report concerns.

Please see the Compliance Training Plan for more details.

5. How to contact the compliance officer/Lines of Communication: Staff, volunteers, students, interns and vendors can report concerns in a number of different ways. They can contact the VP for Quality and Compliance directly as follows:

- \*Email: [pdancer@arcmonroe.org](mailto:pdancer@arcmonroe.org),

- \*Via phone: 585-672-2234 or 585-451-5586.

- \*Via correspondence or in person at:

- The Arc of Monroe

- 2060 Brighton-Henrietta Town Line Road

- Rochester, NY 14623

The agency also has established a compliance hotline, hosted by an outside company. Anyone can access this via a web-based portal or a local number, as listed below. Posters are also present throughout the agency.

The Hotline contact information is:

- \*Phone: 585-448-3588

- \*URL: <https://ethcomp.com/arcofmonroe>

Reports can be made anonymously and/or confidentially using this hotline. The company then notifies the VP for Quality and Compliance that there is a new report in the system. While reporters may share their name, they are not required to and there is no way for The Arc to determine who made the report if they choose to remain anonymous. The system does allow for anonymous/confidential dialogue between the compliance officer and the reporter.

In addition to the above, staff can also report via email, phone, face-to-face, or written statement to any:

- \*Member of Executive Management Team (EMT – the CEO, COO, CFO, CHRO)

- \*Agency Vice President

- \*Agency Sr. Director

- \*Agency Director

All staff are trained on how to report concerns when they are first hired and every year after that, including how and to whom they may report. It is also made clear that they can report anonymously or confidentially.

Please see the policy, “[Non-compliance Detection and Response, and Confidential Communications.](#)”

1. Disciplinary standards: The Arc has established policies and procedures to respond if/when staff engage in illegal behavior, misconduct, or have other performance issues. When this relates to a compliance issue, the VP for Quality and Compliance will consult with HR as appropriate to

ensure fair and consistent application of disciplinary actions for similar offenses. Discipline for not following agency policy, engaging in misconduct or doing something illegal can range from retraining or counseling up to and including termination, depending on the seriousness or circumstances of the situation, patterns of poor work behavior, and other performance issues. Final employment decisions rest with HR.

Please see our compliance policy, "[Staff Performance, Incentives and Disciplinary Actions](#)."

Please note that for non-employees who engage in behavior that is illegal or contrary to The Arc of Monroe's Compliance Program, steps will be taken to address the behavior up to and including separation from the agency.

2. Auditing and monitoring: Audits are conducted to assess our compliance with requirements and internal procedure. The scope of audits is based on how many people we support in the program: programs with fewer people will receive fewer audits than those with more. This is to make sure that we are being fair and balanced in our auditing, and not auditing some programs more than we need to. Most corporate compliance audits are done by the VP for Quality and Compliance. Audits may also be assigned to other qualified staff as necessary.

Some audits are routine and occur on a regular basis (such as monthly, bi-monthly or quarterly). At other times, we may audit very specific functions or areas less frequently (such as annually or biennially). These may be triggered by a concern or complaint, a question, audit trends, or information that other providers have had issues with this. Examples include but are not limited to the emergence of a recurrent trend or theme around an issue or topic; a single area consistently not met during subsequent audits; etc.

Through the audit process, we can identify if there are individual or systemic issues that we need to assess further, respond to, correct and/or prevent from recurring. Audit results may be shared with program management, members of the EMT, and the compliance committee at the discretion of the auditor, management and/or the VP for Quality and Compliance. Anytime it's determined that we received funds to which we are not entitled, we will pay that money back.

Please refer to the "[Audit Plan](#)" policy for further details.

Outside government agencies may also initiate audits of our programs, services, systems, and/or procedures. This may include, but is not limited to: NYS OMIG, MFCU, DOH, or OPWDD. We will provide them with timely access to our facilities and records. We will do the same if they come in to do investigations or for anything else within their statutory authority (e.g., things they are permitted, by law, to do).

In the 4<sup>th</sup> quarter of each year, we conduct what we term a preventive risk assessment, to look to identify areas of compliance focus for the upcoming year. To do so, we talk to agency leaders, look at our own internal data and trends, review information from The Arc of New York, OPWDD, OMIG, DOH, or any other state or federal governmental resource. The intent of these discussions and reviews is to identify upcoming or emergent areas of risk that we should focus on formally in the following year. These are prioritized based on potential likelihood and impact, and from there specific compliance tasks are identified and built into a work plan.

Please see policy, [“Preventive Risk Assessment”](#) for more details.

No less than annually, we complete a Compliance Program Review. This includes completion of the Compliance Program Review Module issued by the NYS OMIG, site visits and interviews with a sampling of affected individuals. Please refer to the policy, [“Conducting the Annual Compliance Program Review”](#) for more details. The preventive risk assessment described above also factors into the annual Compliance Program Review.

Exclusion checks are completed initially upon joining the agency and every 30 days for employees, Board members and vendors. This process includes checking the following for possible exclusion:

- \*NYS Medicaid Exclusion
- \*OIG exclusion list
- \*Federal System for Award Management (SAM) exclusion list
- \*Federal Specially Designed Nationals exclusion list
- \*State Medicaid exclusion lists where available

Please see the [Exclusion Check policy](#) for more details.

3. How we respond to compliance concerns: Consistent with agency policy, compliance concerns are documented in a standard form and format. Not every issue brought to the compliance office will result in the opening of a formal case. Please refer to the full policy, [“Management of situations reported to the Compliance Office”](#) for the specific criteria. For those that do meet the criteria for the opening of a formal compliance case, we will conduct an investigation consistent with our policy, [“Compliance Investigations.”](#) In response to all investigations, programs are required to respond to findings, required follow-up and recommendations, including actions they will take to prevent recurrence, as applicable. These plans to prevent may also be monitored, reviewed or audited after the fact to assess implementation and effectiveness (validation). Whether any disciplinary actions were taken is also shared with the compliance office. If, as a result of the situation, we are required to pay money back to the government consistent with the policy, [“Unsupported claims, repayment/financial adjustments and voluntary self-disclosure,”](#) the program will work with the finance office to ensure this happens.
4. The Arc of Monroe has a zero-tolerance policy for intimidation or retaliation: It is unacceptable for someone to intimidate or retaliate against staff for any of the following reasons:
  - \* Reported something, including a compliance concern, that they reasonably believe is really happening to any appropriate personnel, parties or officials
  - \* Investigated, participated in or cooperated with an agency investigation
  - \* Conducted audits, self-evaluations, or remedial actions – regardless of the findings
  - \* Reporting instances of intimidation or retaliation; or
  - \* Reporting potential fraud, waste or abuse to the appropriate state or federal entities

This applies to coworkers, managers, supervisor, leaders, volunteers, contractors, vendors or students.

Staff are trained on this when they are first hired and annually thereafter. Intimidation or retaliation that is confirmed will result in termination of employment or separation from the

agency (for volunteers, contractors, vendors, or students).

Please cross reference the policy, "[Whistleblowers, Non-intimidation and Non-retaliation](#)" for more details.

5. Routine compliance activities:

- a. Exclusions checks: There are some individual people and companies who are not allowed to work with or for an agency that receives Government money, such as Medicaid or Medicare. Because we are heavily funded through Medicaid, such people are not allowed to work with or for us. There are 3 systems we check: the Excluded Parties List System, the HHS Office of Inspector General list, and the NYS Office of Medicaid Inspector General list. We check all new staff, volunteers, contractors, vendors, and Board members when they are first hired or first join us. Every month after that, we check all employees, Board members and vendors. If we confirm that someone working for or with us in any capacity is on one of these lists (excluded), their relationship with us will be terminated. Please see #7 above for more details.
- b. Licensure checks: We will make sure that anyone who needs a license to work with us has the necessary licensure and active registration. We do this when they are first hired and every month thereafter.
- c. Audits: (See above)
- d. Technical support: The compliance officer and/or a program's quality coordinators will help people with compliance-related questions that they have. The compliance officer will track and trend question topics and report this to the compliance committee and (annually) to the full Board.
- e. Risk assessment: If we open a compliance case and we determine that something non-compliant really did happen or might have happened (the situation is confirmed), we assess it to see if it falls within our risk comfort. This helps the agency to determine whether a confirmed situation is routine (within our risk comfort) or not, as it's expected that there could be some minor things that happen periodically that don't have a significant or material impact on the agency (please cross reference the policy on "Risk Appetite" for additional information). From that, we can then focus on the things that fall outside this routine area of risk comfort and try to prevent them from recurring. This also helps us identify any emergent risks so that we can mitigate them early before they cause significant harm. Please cross reference our policy "[Risk Appetite Assessment](#)" for more information.

See #6 above for additional information on how we assess for risks.

- f. Compliance training: (See above)
- g. Contact with Board of Directors: As indicated above, the compliance officer conducts annual compliance training with the Board. In addition, they also provide in person an annual report on the prior year's compliance activities. Quarterly, they will provide a report to the Board's Executive Committee on the activities of the Compliance



Committee (see below).

Also as previously mentioned, the compliance officer has unfettered access to the Board of Directors at their discretion. At least once a year, the VP for Quality and Compliance will have a closed session with the Board, without any members of agency leadership present.

Additional contact with or reporting to the Board will occur as necessary and appropriate.

Please see the policy "[Communication of Compliance Activities to the Board of Directors](#)" for more information.

More detailed information on The Arc's compliance approach can be found in the individual policies and procedures. These can all be found at [Arcmonroe.org](http://Arcmonroe.org). Scroll to the bottom of the page and click on the link.

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