

Compliance Work Plan

**Arbor Housing and Development**

**Compliance Work Plan**

**Table of Contents**

# Purpose

# Overview

# Structure

# Definitions

# Areas of Risk

# Affected Individuals

# Elements of an Effective Compliance Program

# Written Policies, Procedures, and Standards of Conduct

# Medicaid Compliance Officer & Compliance Committee

# Training and Education

# Lines of Communication

# Disciplinary Standards

# Auditing and Monitoring

# Responding to Compliance Issues

# Self-Disclosures

# Compliance Program Review

# Contacts

# Referenced Materials

1. **Purpose of the Compliance Program**

As required by the New York State Department of Health and the Office of Medicaid Inspector General or OMIG, Arbor has implemented a compliance program aimed at detecting and correcting payment and billing mistakes quickly and efficiently, identifying, assessing, and addressing risks, and imposing systemic checks and balances to prevent future recurrences of such issues.

Arbor is committed to implementing and maintaining a successful Medicaid Compliance Program and conforming with all local, state, and federal laws aimed at prohibiting fraud, waste, and abuse of healthcare resources.​

Per OMIG, “each required provider shall adopt, implement, and maintain an effective compliance program that is tailored to its specific organizational needs, depending upon its size, complexity, resources, and culture.”​

OMIG recognizes that the implementation of a compliance program may not eliminate fraud, waste, and abuse in the Medicaid program. However, a sincere effort by providers to establish an effective compliance program meeting the requirements may serve to mitigate risks associated with unlawful or improper conduct and enhance program effectiveness and efficiency.

1. **Compliance Program Overview**

Arbor Housing is committed to fostering a culture of integrity, compliance, and ethics throughout its program offerings. OMIG considers an “effective compliance program” to be one that, at a minimum, satisfies the compliance program requirements and is designed to be compatible with the provider’s characteristics. For example, the compliance program should:​

* Be well-integrated into the company’s operations. ​
* Be supported by the highest levels of the organization, including chief executives, senior management, and the governing body.​
* Promote adherence to the provider’s legal and ethical obligations.​
* Be designed and implemented to reasonably prevent, detect, and correct noncompliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur within the provider’s risk areas.​

1. **Structure**

The Medicaid Compliance Program is made up of the following components which work collectively to meet the goals and requirements of having a well-integrated and effective program:

**Medicaid Compliance Officer-** the primary contact for the daily operations of the Compliance Program; oversees all Compliance Department activities. Ensures that effective systems and processes are in place to identify compliance program risks, overpayments, and other issues, and that there are effective policies and procedures for correcting and reporting such issues.

**Behavioral Health Compliance/QA Specialist-** reports to and works closely with the Compliance Officer to ensure the delivery of an effective and efficient Medicaid Compliance

Program.

**Compliance Committee-** coordinates with the Medicaid Compliance Officer to ensure that the written policies and procedures, and standards of conduct required are current, accurate, and complete, and that the required training is completed in a timely manner.

**Board of Directors-** ensures the compliance department is completing all requirements and are responsible for steering the organization towards a sustainable future by adopting comprehensive, ethical, and legal governance and fiscal management policies, as well as ensuring the nonprofit has adequate resources to advance its mission.

1. **Definitions**

**Medicaid:** A joint federal and state program that helps cover medical costs for some people with limited income and resources. The federal government has general rules that all state Medicaid programs must follow, but each state runs its own program.

**OMIG or Office of the Medicaid Inspector General**: The independent office within the department established pursuant to Title 3 of Article 1 of the New York State Public Health Law.

**The Office of Mental Health (OMH)**: Operates psychiatric centers across the State. OMH also regulates, certifies, and oversees more than 4,500 programs, operated by local governments and nonprofit agencies.

**Compilation of the Rules and Regulations of the State of New York (NYCRR):**

This regulation governs the provision of temporary housing assistance to persons who are homeless. It sets forth the requirements with which an individual or family who applies for temporary housing must comply in order to be eligible for temporary housing assistance.

**Affected Individuals:** Any individual potentially impacted by a provider's risk areas including employees working within any Medicaid-billed program, senior executives, administrators, directors, supervisors, the Board of Directors, and any applicable vendors or contractors.

1. **Areas of Risk**

* Billings
* Payments
* Medical necessity
* Quality of care
* Governance
* Mandatory reporting
* Credentialing
* Contractor, subcontractor, agent, or independent contract oversight
* Other risk areas as identified

1. **Affected Individuals**

* Employees working within any Medicaid- billed program
* Chief Executive Officer & Executive Staff
* Directors
* Supervisors & Assistant Supervisors
* Front-line staff
* Board of Directors
* Contractors
* Subcontractors
* Independent contractors
* Agents

1. **Elements of An Effective Compliance Program-** There are seven elements to an effective compliance program:

# Written Policies, Procedures, and Standards of Conduct

The drafting, revising, approving, and communicating of written policies, procedures, and Standards of Conduct to all Affected Individuals is part of an effective compliance program. The Medicaid Compliance Officer will review all policy and procedure requirements indicated within Title 18 NYCRR SubPart 521. This includes reviewing the Office of the Medicaid Inspector General (OMIG) website as well as the NYS Office of Mental Health (OMH) website.

**Standards of Conduct**

The Standards of Conduct describes compliance expectations and serves as the foundational document that outlines Arbor's commitment to conducting business in a professional manner while fostering a culture of integrity, compliance, and ethics. The Standards of Conduct document should be shared with and adopted by all affected individuals.

# Medicaid Compliance Officer & Compliance Committee

The Medicaid Compliance Officer is responsible for the day‐to-day workings of the Medicaid Compliance Program. The Compliance Officer oversees and monitors the adoption, implementation, and maintenance of the compliance program, as well as evaluates its effectiveness. It is the Compliance Officer's responsibility to ensure that the compliance program is well-integrated into the agency's operations and supported by the highest levels of the organization.

The Compliance Officer reports directly to the CFO for day-to-day supervision. Any compliance-related issues regarding potential overpayments or self-disclosures are brought to the Compliance Committee for discussion and review. The CFO is not solely responsible for the oversight of the Medicaid Compliance Officer in these instances.

The Compliance Committee is a multi-disciplinary committee comprised of various members of senior management, program directors, and the compliance program staff. The Compliance Committee coordinates with the Medicaid Compliance Officer to ensure that the written policies and procedures, and standards of conduct are current, accurate, and complete and that required training is completed in accordance with requirements for all Affected Individuals.

Compliance Committee meetings are held at minimum on a quarterly basis and are documented utilizing agendas and meeting minutes.

The Compliance Committee Charter shall be reviewed and updated as needed annually.

# Training and Education

All Affected Individuals must be trained to ensure that they are aware of the expectations and standards of the Medicaid Compliance program pursuant to. Training needs to effectively communicate the requirements of the compliance program and the company's

Standards of Conduct. Annual trainings should be established to update employees on

program changes and new developments.

Compliance program training must be documented and updated as needed in an annual

training plan that outlines:

* Required subjects and topics.
* Timing and frequency of training.
* Affected Individuals that are required to attend.
* How attendance is tracked.
* The effectiveness of the training.

# Lines of Communication

Creating an effective compliance program includes establishing open lines of communication which ensures confidentiality for all Affected Individuals enabling the reporting of any suspected instances of fraud, waste, or abuse. These lines of communication include the Arbor Medicaid Compliance Hotline phone line and the online anonymous reporting form, both of which can be found on the agency website. Both lines of communication are tested on a quarterly basis to ensure that any complaints or concerns are being captured.

# Disciplinary Standards

Disciplinary policies that encourage good-faith participation in the compliance program for all Affected Individuals are documented in written policies and include:

* Expectations for reporting compliance issues.
* Expectations for assisting in the investigation and resolution of compliance issues.
* Sanctions for failing to report suspected problems.
* Sanctions for participating in non-compliant behavior.
* Sanctions for encouraging, directing, facilitating, or permitting non-compliance behavior.

# Auditing and Monitoring

# Routine auditing and monitoring of Medicaid-billed programs is completed in order to detect, prevent, and correct instances of fraud, waste, and abuse within identified risk areas. This process is outlined in the annual Audit Plan.

# Monthly exclusion checks are completed in partnership with the Human Resources department. This check is completed every 30 days and results are stored in the Compliance folder on the agency One Drive.

# Responding to Compliance Issues

# Arbor has established policies and procedures around promptly responding to any compliance issues identified or reported and correcting any problems in accordance with State and Federal laws, rules, regulations, and requirements of OMIG.​ When compliance issues are identified, prompt action must be taken to document, investigate, and determine what, if any corrective action is necessary and then promptly implement the appropriate corrective measures and any disciplinary action that might be required. This action may include partnering with the Human Resources Department to ensure all appropriate actions are taken.

# If a compliance issue is discovered that results in overpayment or an instance where billing was not appropriate, a Self-Disclosure must be initiated.

1. **Self-Disclosures**

Medicaid enrolled providers have an obligation and are required to report, return, and explain any identified overpayments within 60 days of identification to OMIG via OMIG's Self-Disclosure process.

The CEO, CFO, and Program Director are immediately notified when a critical compliance error warranting a Self-Disclosure is identified. The Board of Directors will receive quarterly reports on issues of non-compliance that require Self-Disclosures.

1. **Compliance Program Reviews**

Compliance Program reviews shall be completed on an annual basis with results being submitted to the Compliance Committee for review. A final report shall also be submitted to the Board of Director's portal.

1. **Contacts**

* Medicaid Compliance Officer- Stephanie Lapp: 607-742-3504
* Behavioral Health Compliance/QA Specialist- Karen Ballos: 607-329-7746
* Medicaid Compliance Hotline: 607-654-7487 ext. 2031
* OMIG Fraud, Waste, and Abuse Hotline: 1-877-87-FRAUD

1. **Referenced Material**

* https://omig.ny.gov/compliance/compliance​
* https://omig.ny.gov/medicaid-fraud/about-medicaid-fraud-waste-and-abuse​
* SOS § 363-d "Laws of New York": [http://public.leginfo.state.ny.us](http://public.leginfo.state.ny.us/)​
* NYCRR SubPart 521-1: <https://omig.ny.gov/information-resources/laws-and-regulations>​