

## COMPLIANCE AND ETHICS PROGRAM CHARTER

### CONTENTS

I.	Purpose .....	1
	Scope and Key Source Documents .....	1
II.	Oversight of Program .....	3
	Designated Compliance Officers .....	3
	Compliance Committees .....	6
	Responsibilities of Supervisors .....	8
III.	Education .....	9
	Initial Orientation .....	9
	Reorientation .....	9
	Program-Specific Compliance Education .....	10
	Governing Body Members' Compliance Education .....	10
	Vendor/Contractor Compliance Education .....	10
IV.	Effective Lines of Communication .....	10
	Questions Welcome .....	10
	Duty to Report Compliance Issues .....	11
	Confidentiality .....	11
	Non-Retaliation/Non-Intimidation .....	11
V.	Disciplinary Standards to Encourage Good Faith Participation in the Compliance and Ethics Program .....	12
VI.	The System for Routine Monitoring and Identification of Compliance Risk Areas .....	12
	Risk Assessments .....	13
	Monitoring and Auditing Work Plans .....	14
	Credentialing .....	15
	Sanction Screening .....	15
	Conflicts of Interest .....	15

VII. The System for Promptly Responding to Compliance Issues.....	15
Investigations .....	16
Corrective Action and Responses to Suspected Violations.....	16

## Attachments

[Board of Trustees Compliance Committees Charter](#)

[Chief Compliance Officer Charter](#)

[Code of Conduct](#)

### Compliance and Ethics Program Policies & Protocols

Detecting and Preventing Fraud, Waste, and Abuse [Compliance and Ethics Program, Detecting and Preventing Fraud, Waste and Abuse, System-Wide](#)

Discipline [Compliance and Ethics Program, Discipline Policy, System Wide](#)

Employee Reviews [Compliance and Ethics Program, Employee Reviews, System-Wide](#)

Compliance and Ethics Program Files [Compliance and Ethics Program, Compliance Program Files, System-Wide](#)

Conflict of Interest and Related Party Transactions [Compliance and Ethics Program, Conflict of Interest, System-Wide](#)

Investigating Compliance Matters [Compliance and Ethics Program, Investigating Compliance Matters, System-Wide](#)

Gifts [Compliance and Ethics Program, Gifts, System-Wide](#)

Corporate Ethics Hotline [Compliance and Ethics Program, Reporting Compliance Matters; Whistleblower/Non-Retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program \(System-Wide\)](#)

Risk Assessment, Monitoring and Reviewing [Compliance and Ethics Program, Risk Assessment, Monitoring and Reviewing, System-Wide](#)

Record Retention [Compliance and Ethics Program, Record Retention & Document Destruction, System-Wide](#)

Report and Return of Overpayments [Compliance and Ethics Program, Report and Return of Overpayments, System-Wide](#)

Corrective Actions and Response to Detected Offenses [Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide](#)

Sanction Screening [Compliance and Ethics Program, Sanction Screening, System-Wide](#)

Governing Body Education [Compliance and Ethics Program, Governing Body Members Education \(System-Wide\)](#)

Vendor Compliance Education [Compliance and Ethics Program, Vendor Deficit Reduction Act Compliance Education, System-wide](#)

Compliance and Ethics Program Training & Education [Compliance and Ethics Program, Compliance and Ethics Program Training & Education, System-Wide](#)

## I. Purpose

Catholic Health Care System d/b/a ArchCare and all the entities that it sponsors<sup>1</sup> (hereinafter “ArchCare”) are committed to complying fully with applicable federal, state and local laws and regulations and federal health care program requirements.<sup>2</sup> Accordingly, ArchCare operates a Compliance and Ethics Program (the “Program”) to govern operations. An important goal of the Program is to promote understanding of and adherence to applicable laws and regulations and guidance and to make a sincere effort to prevent, detect, and correct non-compliance with government health care program requirements as well as to implement measures to prevent, detect and correct fraud, waste and abuse (FWA). The Program is designed to meet the definition of an effective program in accordance with New York Social Services Law §363-d and Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York, as well as Federal requirements for Compliance and Ethics Programs under the Medicare Program.

### Scope and Key Source Documents

The Program applies to ArchCare “care members,” also known as affected individuals *i.e.*, trustees, employees, affiliated health care practitioners, and other individuals or entities affiliated or associated with ArchCare (including, but not limited to, all persons who are affected by ArchCare’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers who perform functions or services on behalf of ArchCare and all the entities it sponsors or who otherwise contribute to ArchCare’s entitlement to payment under federal and/or state health care programs).<sup>3</sup>

The Program is delineated in this Charter as well as the: 1) Board of Trustees Compliance Committee Charter, 2) Chief Compliance Officer Charter and the job descriptions of the Compliance Officers, 3) Code of Conduct, and 4) Compliance policies and procedures.

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<sup>1</sup>Carmel Richmond Healthcare and Rehabilitation Center, Ferncliff Nursing Home, Mary Manning Walsh Home, St. Teresa’s Nursing and Rehabilitation Center, San Vicente de Paúl Skilled Nursing and Rehabilitation Center, Terence Cardinal Cooke Health Care Center, Catholic Managed Long Term Care, Inc. dba ArchCare Community Life and ArchCare Senior Life, Dominican Sisters Family Health Services, Inc. dba ArchCare at Home, Family Home Health Care, Inc., and Calvary Hospital.

<sup>2</sup>“Federal health care program” means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans’ programs, and the State Children’s Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

<sup>3</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

These documents demonstrate our commitment to complying with applicable legal, regulatory and other requirements, appropriate guidance, and our contractual commitments. The Chief Compliance Officer and the Executive Compliance Steering Committee will meet periodically (*i.e.*, at least annually or more frequently as necessary) to review all Program documents and make any necessary changes.

ArchCare's written Compliance Policies and Procedures and the Code of Conduct are designed to:

- (1) articulate ArchCare's commitment to comply with all applicable federal and state standards;
- (2) describe compliance expectations as embodied in the Code of Conduct;
- (3) implement the operation of the Compliance and Ethics Program;
- (4) provide guidance on dealing with potential compliance issues;
- (5) identify how to communicate compliance issues to appropriate compliance personnel;
- (6) describe how potential compliance issues are investigated and resolved;
- (7) include a policy of non-intimidation and non-retaliation for good faith participation in the Compliance and Ethics Program, and
- (8) include all requirements listed under Section 6032 of the Deficit Reduction Act of 2005 as to maintaining and disseminating policies regarding false claims laws and whistleblower protections.

ArchCare compliance materials will be placed on the ArchCare internet as well as on its policy management software. Questions regarding interpretation of compliance policies and procedures should be directed to the ArchCare Department of Compliance.

The Compliance and Ethics Program shall be reviewed by the Chief Compliance Officer in collaboration with the Executive Compliance Committee annually in light of changes in laws and/or requirements and the Program's performance over the last year and modified to ensure that it is current with requirements and operating effectively. The Program as revised during this Annual Review will be approved by the Audit, Risk, and Compliance Committee of the Board of Trustees and changes will be communicated to all ArchCare care members in the annual reorientation and to the Board of Trustees in the Governing Body Members' Compliance Education.

All care members are expected to comply with the standards set forth in these documents.

The Compliance Department will retain records of compliance activities for ten (10) years.

## II. Oversight of Program

The Governing Bodies of the organizations sponsored by ArchCare shall oversee the design and operation of the Program across all the programs and facilities it sponsors, delegating the duties to a Committee if appropriate, but remaining knowledgeable about the content and operation of the Program and exercising reasonable oversight of the Program. For those entities governed by Boards mirroring the CHCS Board, the duties are delegated to the Compliance Committees of the CHCS Boards, but those Boards must remain knowledgeable about the content and operation of the Program and shall exercise reasonable oversight of the Program.

To fulfill its oversight duties, the Compliance Committees of the Boards shall:

- 1) approve key Program Documents,
- 2) assess Program effectiveness,
- 3) appoint the Chief Compliance Officer,
- 4) participate in FWA and Compliance training and oversee the administration of this training to operations, 5)
- 5) review quarterly summaries of compliance concerns, compliance indicators, compliance audits, and governmental audits, and
- 6) approve and/or oversee actions undertaken to resolve compliance issues, as appropriate. These duties are detailed in Catholic Health Care System Board of Trustees Compliance Committees' Charter.

### Designated Compliance Officers

Catholic Health Care System shall employ a Chief Compliance Officer, appointed by the Board of Trustees who shall:

- 1) be a member of senior management,
- 2) report directly to the Boards' Compliance Committees on compliance matters while being accountable to and reporting administratively and operationally to the President & CEO, and
- 3) have direct access to senior management and legal counsel.

The Chief Compliance Officer shall have sufficient education, training, funding, resources and authority to ensure implementation of the Program. The Chief Compliance Officer shall make regular reports to the President and CEO and to the Boards' Compliance Committees. The Chief Compliance Officer's Charter is detailed in the Chief Compliance Officer Charter.

In addition, the Chief Compliance Officer shall appoint a Compliance Officer for ArchCare Senior Life, and a Compliance Officer for ArchCare at Home and Family Home Health Care, Inc., Compliance Liaison for each of the Nursing Homes. Compliance Officers/Liaisons report to the Chief Compliance Officer on compliance matters while reporting administratively and operationally to the Executive Director or equivalent of their organizations. Each Compliance Officer/Liaison has the authority to make in-person reports to the CEO or equivalent or governing body of the relevant organization, in their sole discretion, either through the Chief Compliance Officer or not. The Chief Compliance Officer as well as all the demonstrate unimpeachable integrity, good judgment, assertiveness, an approachable demeanor, and the ability to elicit the respect and trust of entity employees;

The Compliance Officers/Liaisons must act in concert with the Chief Compliance Officer and consistently with the ArchCare Compliance and Ethics Program documents and activities. The Compliance Officers'/Liaisons' duties include, but are not limited to, the following:

a. program implementation

- i. serve as the co-chair or member of the facility/program level ("local") Operational Compliance Committee and work closely with local management to set compliance direction and strategy;
- ii. prepare Compliance and Ethics Program policies and procedures for the local facility/program to supplement those of ArchCare, if necessary;
- iii. help identify and document all local compliance initiatives already in place, and recommend additional initiatives that should be pursued locally;
- iv. consult with local department heads and other appropriate persons in the development and implementation of policies and procedures and other documents necessary to ensure compliance with applicable federal, New York, and local laws, regulations, and other requirements;
- v. consult with the Chief Compliance Officer, legal counsel, and others as needed to monitor changes in statutes, regulations, and other requirements for the local facility/program and take action as necessary;
- vi. consult with the Chief Compliance Officer, systematically responding to compliance questions or concerns (raised through a hotline call or other method) within the facility/program, including coordinating the internal review of such issues and formulating appropriate corrective actions and documenting on ArchCare's hotline platform—assuring



that good faith local allegations of non-compliance are investigated and responded to promptly;

- vii. consult with the Chief Compliance Officer to coordinate the response to audits and develop corrective action plans as necessary; and
- viii. assist in the development of the facility/program annual risk assessment and work plan

b. education

- i. help ensure that all employees and others associated with the facility/program complete initial compliance orientation and annual reorientation;
- ii. in consultation with the Chief Compliance Officer, coordinate additional educational programs on key local compliance risk areas;

c. investigations

- i. in consultation with the Chief Compliance Officer and others, as appropriate,
- ii. Oversee and/or assist in the local internal investigations into suspected violations of the Code of Conduct or compliance policies and procedures or improper business practices;
- iii. Work with the appropriate management in determining obligations to report self-discovered violations;

d. discipline

- i. In consultation with Human Resources and Chief Compliance Officer, help ensure that those engaged in instances of noncompliance are appropriately disciplined;

e. auditing and monitoring

- i. Perform and oversee the performance of auditing and monitoring in accordance with the compliance work plan and establish additional local monitoring and auditing systems to identify compliance issues, as necessary;

f. quality of care

- i. Be knowledgeable about quality of care concerns and how identified deficiencies are addressed.

g. sanction screening

- i. Ensure that exclusion checks are completed for newly hired employees and others associated with the local facility/program prior to hire or association and monthly thereafter;
- h. communication and reporting
  - i. Coordinate the assembling of information for the operational compliance committee;
  - ii. Participate in the operational compliance committee or assist in participating in the operational compliance committee (in the case of nursing home compliance officers, the operational compliance committee is the Joint Nursing Home Compliance Committee)

### Compliance Committees

Each program or facility shall maintain a compliance committee (“Operational Compliance Committees”).

The President & CEO and Chief Compliance Officer shall jointly appoint the membership of these committees, each of which shall have representation from each of the ArchCare-sponsored entities within the particular line of business and shall meet at least quarterly to enable oversight of the Program as applied to the particular line of business. Each of these committees will be co-chaired by the Compliance Officer of that line of business and the Chief Compliance Officer.

To provide strategic direction for the Program, ArchCare shall also operate an Executive Compliance Steering Committee, which shall be co-chaired by the President & CEO and the Chief Compliance Officer; other members are the Chief Medical Officer, Chief Human Resources Officer, the Chief Financial Officer, the VP of Residential and Home Care Services, and other members upon appointment by the President & CEO and Chief Compliance Officer covering areas related to Quality, Audit and other operational managers. The Executive Compliance Steering Committee will receive reports on the Program from each of the Compliance Committees from the Chief Compliance Officer or the Compliance Officer of the relevant line of business, at the discretion of the Executive Compliance Steering Committee.

The **Operational Compliance Committees’** duties may include, but are not limited to:

- a. developing strategies to promote compliance and the detection of any potential violations;
- b. reviewing and approving compliance and FWA education, and ensuring that education is effective and appropriately completed;
- c. assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan;

- d. assisting in the creation, implementation and monitoring of effective corrective actions;
- e. developing innovative ways to implement appropriate corrective and preventative action;
- f. reviewing effectiveness of the system of internal controls designed to ensure compliance with federal health care program regulations in daily operations;
- g. supporting the Compliance Officer's/Liaison's needs for sufficient staff and resources to carry out his/her duties;
- h. coordinating with the compliance officer that the relevant entity has appropriate, current, accurate and complete compliance policies and procedures ensuring that the sponsor has a system for care members and, as applicable, first tier, downstream, and related entities to ask compliance questions and report potential instances of federal health care program noncompliance and potential FWA confidentially and anonymously (if desired) without fear of retaliation or intimidation;
- i. ensuring that the relevant entity has a method for the individuals it serves to report potential FWA;
- j. reviewing and addressing reports of monitoring and auditing of areas in which the sponsor is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness;
- k. coordinating with the Compliance Officer to ensure that all affected individuals complete compliance training and education during orientation and annually;
- l. coordinating with the compliance officer to ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or any other relevant function or activity;
- m. ensuring that the required provider has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues;

2. enacting required modifications to the compliance program;

- a. providing regular and ad hoc reports on the status of compliance with recommendations; and
- b. direct reporting and accountability to the President and CEO.

The **Executive Compliance Steering Committee's** duties may include, but are not limited to:

1. directing management to adopt strategies to promote compliance and the detection of any potential violations;
2. reviewing and approving compliance and FWA education, and ensuring that education is effective and appropriately completed;
3. approving compliance risk assessments and compliance monitoring and auditing work plans for submission to the appropriate governing body(ies.);
4. approving the Code of Conduct and Program policies and procedures;
5. approving an annual program assessment;
6. reviewing and approving corrective actions submitted in operational compliance committees' reports;
7. taking other actions to increase the effectiveness of the system of internal controls designed to ensure compliance with federal health care program regulations in daily operations;
8. adjusting compliance staff and resources, if necessary;
9. ensuring that the compliance officer is allocated sufficient funding, resources and staff to fully perform their responsibilities;
10. ensuring that the organization has a system for care members and, as applicable, first tier, downstream, and related entities to ask compliance questions and report potential instances of federal health care program noncompliance and potential FWA confidentially and anonymously (if desired) without fear of retaliation or intimidation;
11. ensuring that the organization has a method for the individuals it serves to report potential FWA;
12. reviewing and approving reports of monitoring and auditing of areas in which entities in the organization are at risk for program noncompliance or potential FWA and approving corrective action plans and ensure that the plans are implemented and monitored for effectiveness; and
13. approving regular and ad hoc reports from the operational compliance committees on the status of compliance for submission to the appropriate governing body(ies.)

### Responsibilities of Supervisors

Each ArchCare supervisor is responsible for:

1. promoting compliance standards, policies, and procedures within their departments;
2. ensuring that all ArchCare care members within their departments complete ArchCare compliance training;
3. enforcing this Compliance Charter, the Code of Conduct, applicable ArchCare policies and procedures, and applicable laws, regulations, and guidance;
4. reporting to a Compliance Officer any reports or reasonable indication of violations of applicable law or regulation, the Code of Conduct or ArchCare policies;
5. in coordination with a Compliance Officer/Liaison, initiating and/or implementing corrective or disciplinary action in the event of violation of the Compliance Plan, the Code of Conduct, ArchCare policies, procedures and applicable laws and regulations; and
6. taking all measures reasonably necessary to ensure compliance with the Program, federal health care program requirements and any applicable laws, regulations, and guidance.

### III. Education

#### Initial Orientation

Within 30 days of hire, ArchCare's mandatory orientation for all new care members, including a Compliance Officer, Chief Executive Officer, senior administration, managers, employees (including temporary employees) and volunteers will provide an overview of FWA laws; a summary of the standards of conduct; an explanation of the elements of the ArchCare Program, including the complaint and reporting process; a summary of HIPAA privacy and security requirements; and will highlight ArchCare's commitment to integrity in its business operations and the relationship of compliance to ArchCare's mission. Embedded in such orientation is an Employee Certification of Understanding, acknowledging an employee's understanding of their compliance responsibilities. The training will be aligned with the Training Plan for each year.

#### Reorientation

Each year, all ArchCare care members, including the Compliance Officer, Chief Executive Officer, senior administration, managers, employees (including temporary employees) and volunteers, must complete reorientation, which reinforces the initial orientation they received by providing an overview of FWA laws; a summary of the standards of the standards of conduct; an explanation of the elements of the ArchCare Program, including the complaint and reporting process; a summary of HIPAA privacy and security requirements; and will highlight ArchCare's commitment to integrity in its business operations and the relationship of compliance to ArchCare's mission. Embedded in the reorientation is a Compliance attestation acknowledging that they have reported any

compliance issues of which they are aware. Completing such training annually is a condition of continuing employment by or affiliation with ArchCare. The training will be aligned with the yearly Training Plan.

#### Program-Specific Compliance Education

As necessary, the ArchCare Compliance Department may develop or have developed program-specific compliance education addressing regulatory requirements for that particular program. Such compliance education will be described in that program's -- PACE, Nursing Homes, Hospice or Home Care—compliance work plan. The training will be aligned with the Training Plan.

#### Governing Body Members' Compliance Education

Each member of the governing body of an ArchCare-sponsored entity will receive general compliance and FWA education, and an overview of board responsibility as to the Program within 30 days of their initial appointment and annually thereafter. In addition, the board members receive annual and ad hoc training throughout their tenure on the board. The training will be aligned with the yearly Training Plan.

#### Vendor/Contractor Compliance Education

Designated contractors (those that have been designated as affected individuals by the Compliance Department) are required to acknowledge receipt of and compliance with ArchCare's policies and procedures to prevent and detect FWA, including providing compliance training to their employees and the overview of federal and state laws pertaining to the filing of false claims. The training will be aligned with the yearly Training Plan.

### IV. Effective Lines of Communication

ArchCare has established and implemented effective lines of communication, ensuring confidentiality, between the Compliance Officers, members of the Compliance Committees and care members, managers and the governing body. The lines of communication are accessible to all care members and Medicaid recipients, allow compliance issues to be reported as they are identified and include methods for anonymous and confidential good faith reporting of potential compliance issues.

#### Questions Welcome

At any time, any ArchCare care member, trustee, affiliated medical staff member, or vendor may seek clarification or advice from a Compliance Officer or the Department of Compliance with regard to this Program or any policy or procedure related to this Program.

## Duty to Report Compliance Issues

ArchCare is committed to the timely identification and resolution of all compliance issues. Care members who are aware of or suspect acts of FWA, or violations of the code of conduct or ArchCare policies are required to report them. Several independent reporting paths are available:

- Affected individuals may report to their supervisor or managers. Supervisors and managers will refer the report to the Compliance Officer of their program as soon as the report is made.
- Affected individuals may report directly to the ArchCare Department of Compliance, to the Compliance Officer of their program or to the Chief Compliance Officer.
- ArchCare has contracted with an independent company to operate the Compliance & Corporate Ethics Hotline at 800-443-0463 and [www.archcare.ethicspoint.com](http://www.archcare.ethicspoint.com). The Hotline is available 24 hours a day, seven days a week. Individuals may use this line anonymously. New care members are given a wallet-sized card with information on how to access the hotline during their orientation.

## Confidentiality

If you choose to report via the Compliance & Corporate Ethics Hotline and leave your name, your identity will remain confidential, whether requested or not, unless the matter is turned over to law enforcement (e.g., in response to a subpoena or other legal proceeding) or if in the process of the investigation the identity of the reporter cannot be kept anonymous.

## Non-Retaliation/Non-Intimidation

Individuals reporting suspected violations in good faith will be protected from any intimidation, harassment, discrimination, retaliation or adverse employment consequences. Acts of retaliation or intimidation should be immediately reported to a Compliance Officer or to the Compliance & Corporate Ethics Hotline and, if substantiated, the individuals responsible will be appropriately disciplined.

All care members are expected and required to participate in and comply with the Compliance and Ethics Program, including the reporting of any potential misconduct, illegal conduct or other compliance-related concerns. Retaliation or intimidation in any form against an individual who in good faith reports possible misconduct or illegal conduct or for other good faith participation in the Compliance and Ethics Program is strictly prohibited and is itself a violation of the Compliance and Ethics Program. Acts of retaliation or intimidation should be immediately reported to the Chief Compliance Officer and, if substantiated, will be disciplined appropriately.

## V. Disciplinary Standards to Encourage Good Faith Participation in the Compliance and Ethics Program

ArchCare has established well-publicized disciplinary standards to encourage good faith participation in the Program by all affected individuals.

Care members will be subject to disciplinary action if they fail to comply with any applicable laws, rules, regulations, or any aspect of the Program. This includes, but is not limited to, disciplinary actions for:

- (1) failure to report suspected problems;
- (2) participating in non-compliant behavior;
- (3) encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior;
- (4) refusal to cooperate in the investigation of a potential violation;
- (5) refusal to assist in the resolution of compliance issues; or
- (6) retaliation against, or intimidation of, an individual for his or her good faith participation in the Program.

## VI. The System for Routine Monitoring and Identification of Compliance Risk Areas

ArchCare has established a system for the routine identification and assessment of compliance risk areas relevant to its operations. This process includes internal, and as appropriate, external reviews, audits, and other practices to evaluate ArchCare's compliance with federal health care program requirements (e.g., the Medicare and Medicaid Programs) and the overall effectiveness of the Compliance and Ethics Program.

Monitoring and auditing provide early identification of program or operational weaknesses and substantially reduce exposure to regulatory risk and government-related lawsuits. Each of the ArchCare operational compliance committees (nursing homes, PACE, hospice and home care) will annually develop a risk assessment. Using the results of the risk assessment, each of the operational compliance committees will develop an annual compliance monitoring and auditing work plan. These work plans will be approved by the Management Compliance Steering Committee and the Compliance Committee of the Board of Trustees. Results of the ongoing monitoring and auditing reviews shall be provided to the Compliance Committee of the Board of Trustees. The components of the risk assessments and work plans are provided in more detail below:



## Risk Assessments

The annual compliance monitoring and auditing work plans will be created based on a compliance risk assessment. A risk is an event that, if it were to occur, would have a material consequence on an organization's ability to achieve objectives. A compliance risk assessment is the identification, measurement, and prioritization of compliance risks. Compliance means adhering to a standard, policy, or law. Compliance risk is the likelihood an applicable law or regulation may be violated. The compliance risk assessment's focus is solely on the risks affecting the organization as a result of its healthcare operations (e.g., HIPAA, billing and coding processes, etc.) as opposed to those risks that exist in any business (e.g., financial fraud, emergency preparedness, etc.) Conducting a compliance risk assessment enables compliance resources to be used most efficiently and effectively.

The Compliance Department will take the lead in creating, organizing, and overseeing the compliance risk assessment steps of risk identification, risk measurement, and risk control. The Compliance Department will identify key employees (risk assessment group) who will provide insight into the issues they face and the degree to which established controls will mitigate risk as they arise. This should include front-line staff who can provide information on how processes actually work, as opposed to how the policy and procedure state they are supposed to work. Through facilitated sessions, in a group, if possible, the following three open-ended questions should be included:

- What can go wrong?;
- Where is our organization most vulnerable?; and
- What are the issues that concern you the most?

## Risk Identification

The Compliance Department will take the first step in identifying the compliance risks to each division. These lists can be added to by the key employees. The list should include:

- Specific compliance risk areas identified in 18 N.Y.C.R.R. §521 (*i.e.*, billing; payments; ordered services; medical necessity; quality of care; governance; mandatory reporting; credentialing; contractor, subcontractor, agent or independent contract oversight, or that are identified by specific compliance protocols or through other means).<sup>4</sup>
- Issues gleaned from the OIG Work Plan and the OMIG Work Plan
- Government enforcement trends
- ArchCare's own history of government enforcement

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<sup>4</sup> For the PACE program additional risk areas are identified: cost reporting; submission encounter data to the department; network adequacy and contracting; provider and subcontractor oversight; underutilization; marketing; provision of medically necessary services; payment and claims processing and statistically valid services verification.

- Results of prior internal monitoring reviews or ongoing audits

## Risk Measurement

The purpose of the measurement step is to determine:

- The impact and extent of each risk
- The degree of vulnerability that the organization faces with respect to each risk
- The strength of the controls currently in place to mitigate each risk

For each identified risk, the risk assessment group will measure the degree of risk impact and the legal, financial and reputational impact.

When compliance risks have been identified and measured, they will be prioritized. High risk items will be those that people raise repeatedly, are hard to detect, have a high likelihood of occurrence, or will have a significant impact if they were to occur. Moderate risk items might be those that are frequently mentioned but have high or moderate detectability scores. Lower risk categories are unlikely or those that could be likely but would have a low impact upon occurrence. The high-risk items will take precedence in the development of the annual compliance monitoring and auditing work plan. Some reserve time should be built in to address urgent issues as they arise during the year. To validate the existing identified controls, the monitoring and auditing work plans should include testing some identified controls that allegedly mitigate or detect the designated compliance risks.<sup>5</sup>

## Monitoring and Auditing Work Plans

The draft monitoring and auditing work plans shall be approved by the Compliance Steering Committee. The work plan shall be submitted to the Compliance Committee of the Board, but no formal approval from the Board is required. The results of the monitoring and auditing reviews shall be provided to the Compliance Steering Committee and the Compliance Committee of the Board several times during each year. Any deficiencies notes require the submission, for the Department of Compliance's approval, of a Corrective Action Plan which shall explain how the deficiency will be addressed timely and brought to resolution. Ongoing monitoring of the progress of any corrective action plan implementation shall be monitored by the appropriate Compliance Officer. Timely updates of progress made and/or challenges to bringing deficiencies to a resolution are provided to the Compliance Steering Committee and the Compliance Committee of the Board as needed and on a periodic basis.

Note: In addition, the Program will be assessed annually using internal resources with the results reported to the Board Compliance Committees by August 1 of each year. An annual compliance work plan will include steps to address any areas of weakness indicated in the assessment. These annual internal assessments will be supplemented by periodic external assessments no less than every three (3) years.

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<sup>5</sup> Some items which on their fact present a high risk will not be scored but added to the Work Plan.

## Credentialing

All professional staff employed or engaged by ArchCare will be properly licensed (and/or certified) and registered as required by applicable law, rules and regulations. ArchCare will take steps on a regular basis to monitor and ensure such compliance.

## Sanction Screening

ArchCare is committed to using good faith, reasonable efforts to not knowingly employ, contract with, or otherwise do business with, individuals or entities convicted of a crime related to health care or that are excluded, debarred or suspended from, or otherwise ineligible to participate in, government Health Care Programs or in Federal procurement or non-procurement programs. Prior to hiring, contracting or accepting a referral, ArchCare screens the individual or entity against the exclusion lists maintained by the U.S. Department of Health and Human Services, Office of Inspector General; the General Service Administration's System for Award Management; and the New York State Office of the Medicaid Inspector General.

ArchCare thereafter screens current staff, contractors/vendors and referring providers against each of the exclusion lists at least every month. ArchCare will require staffing agencies to perform sanction screens on the individuals provided to ArchCare.

If a potential or current staff member, referring provider or contractor/vendor is found to be excluded, ArchCare will implement corrective action, in accordance with the Program and applicable compliance policies and procedures.

## Conflicts of Interest

ArchCare requires its trustees, officers and key persons (as those terms are defined in the Conflicts of Interest and Related Party Transactions Policy) to disclose potential and actual conflicts of interest annually and whenever a conflict of interest arises, in accordance with the procedures set forth in our Conflict of Interest and Related Party Transactions Policy. ArchCare has a review and recusal process to address such reported conflicts which is overseen by the Compliance Committee of the Board. Failure to adequately disclose a potential or actual conflict of interest shall be subject to discipline up to and including termination of employment or affiliation with ArchCare.

## VII. The System for Promptly Responding to Compliance Issues

ArchCare has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with the federal health care program requirements (e.g., the Medicare and Medicaid Programs).

## Investigations

In any case where there is a report or reasonable indication of a violation of applicable laws, regulations, the Code of Conduct or policies and procedures that fall within the scope of the Department of Compliance, the Department of Compliance shall have the primary responsibility for conducting or overseeing the investigation of the alleged situation or problem.<sup>6</sup> All care members are required to cooperate in such investigations. The purpose of the investigation is to determine whether or not there is reasonable cause to believe an individual may have knowingly or inadvertently participated in violations of applicable laws, regulations, standards or policies; to facilitate corrective action; and to implement procedures necessary to ensure future compliance. If an issue that is not within the jurisdiction of the Department of Compliance is raised through one of the compliance communication channels, the Department of Compliance will refer the issue to the appropriate department and receive a report on the completed investigation. The Department of Compliance does not perform law enforcement activities and may refer all matters indicative of FWA to the appropriate government agency (e.g., the US DHHS Office of Inspector General, the NY State Office of Medicaid Inspector General, the NBI MEDIC<sup>7</sup> or other appropriate enforcement agency).

## Corrective Action and Responses to Suspected Violations

Care members are also required to assist in the resolution of compliance issues. When appropriate, corrective action plans will be created and tailored to the particular conduct and will provide a structure with time frames in order to attempt to ensure non-compliant activity does not recur. Corrective action will be implemented promptly and thoroughly and may include (but is not necessarily limited to): conducting training and education; revising or creating appropriate forms; modifying or creating new compliance policies and procedures; conducting additional internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate; refunds to appropriate payers and/or self-disclosing to appropriate government agencies (e.g., the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services, Office of Inspector General or the Centers for Medicare and Medicaid Services) or other appropriate parties as is further detailed in ArchCare's policy Responding to Compliance Reports, Investigations, and Corrective Action Protocol. Corrective action plans and other corrective actions will continue to be monitored after they are implemented to ensure that they are effective.

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<sup>6</sup> Some investigations related to managed care will be referred to the Special Investigations Unit.

<sup>7</sup> NBI MEDIC is the acronym for the National Benefit Integrity Medicare Drug Integrity Contractor. The purpose of the NBI MEDIC is to detect and prevent FWA in the Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level. Health Integrity is the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services (CMS).

## REVISION HISTORY

Date	Change/Note
4/24/2025	Review.
5/1/2024	Review and update.
5/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Compliance Program was renamed Compliance and Ethics Program 8/2022. Also, an insert after paragraph 1 allowed for an Annual Review of the Compliance and Ethics Program 8/2022.