St. Lawrence NYSARC
Corporate Compliance Annual Report
January-December 2017

I. Introduction

St. Lawrence NYSARC's Corporate Compliance Program began in January 2007. This report is based on a review of the 2017 Corporate Compliance Work Plan, risk assessments, and audits.

II. 2017 Risk Assessments

It is our practice to conduct an agency-wide Risk Assessment every three years. The last agency-wide assessment was conducted in 2014 with completion in the first quarter 2015. In 2017 we initiated a risk assessment that was created by The Arc New York. Following are some of the findings:

Risk Area	*Identified Risk*	*Recommendation*
Human Resources ***Areas addressed include: Employee Verification and Hiring, Background Screening, Employee Training, Separation from Employment, Time and Attendance, Code of Conduct, Conflict of Interest, Department of Labor Requirements, and Satisfaction Surveys.***	1. Changes in key staff/new staff. 2. Changes in technology 3. Audit review findings 4. OPWDD citations for staff being out of date with training 5. Inadequate satisfaction surveys	1. HR office and Staff Training Department replaced staff. Duties have been reviewed and redistributed. 2. Review of application process online. Removed request for SS#, DOB, etc. (protected health information). 3. I-9 audit completed; corrections in process. 4. Review methods to make sure managers aren't the reason for non-attendance at mandatory trainings. 5. Revise the staff satisfaction survey to include more responses, less questions with N/A answers.
Financial ***Areas addressed include: Annual Independent Audit, Accounts Payable, Accounts Receivable, Purchasing, Executed Contracts & Agreements, Inventory Controls, Billing Reconciliation, CFR, Personal Allowance Accounts, and Social Security Benefits Reconciliation***	1. Personal accounts over the regulatory limit affecting Social Security 2. Contracts and Agreements not executed, not updated to reflect trends 3. Inventory controls needs to be tightened up	1. Designate staff to review and monitor accounts to assure they are not over the limit. 2. Additional audits of Personal Allowance Accounts on a routine basis. 3. Review and update contracts on a routine basis. 4. Create monitoring system for all contracts. 5. Re-inventory equipment, vehicles, etc. Maintain accurate counts.

Risk Area	Identified Risk	Recommendations
Operations ***Areas addressed include: Transportation Requirements (DOT, DMV, 19-A), Facility/Property Maintenance, Accreditations and Certifications, The Arc NY QI Metrics, and Record Retention***	1. Changes in key staff 2. Changes in regulations and policies 3. Physical plant issues: generators, roof replacements 4. Record retention: no one designated to assist with retention and destruction functions	1. Additional training of staff to keep up with regulatory changes with DOT, DMV, 19-A. 2. Look into replacing antiquated and non-functioning generators. RLL Center priority – designated as an emergency site. 3. Review and monitor maintenance schedule. 4. Re-establish document retention and destruction oversight responsibilities.
Programming/Services ***Areas addressed include: OPWDD BPC Reports (SODs, 45 day letters, POCAs), Res. Hab., DH, CH, Prevoc, MSC, Pathway, SEMP, HWR, Clinic, Nursing Services, Guardianship, Behavioral/Human Rights, and Self-Directed Services***	1. BPC: Plans of Nursing Services 2. Audits reveal no evidence of Habilitation Plan being sent to MSC w/in 30 days 3. ISPs lack specific program designation (i.e., Group DH, Supplemental GDH)	1. QA monitor Statements of Deficiencies for corrective actions. 2. Create system agency-wide to verify that Hab Plans are distributed within the correct timeline. 3. Create system agency-wide that ISPs and Plans state specific designation of service/support.
HIPAA ***Areas addressed include: Business Associate Agreements, HIPAA Privacy & Security, Document Retention, Periodic Risk Assessment***	1. BAAs up to date 2. Document retention	1. Review BAAs; create a schedule to update (i.e., every 3 years). 2. Document retention is covered under Operations.
Information Technology ***Areas addressed include: Electronic Health Records, Access Controls, Encryption, Internal Controls over Inappropriate Use, Controls against Viruses/Hacking***	1. Changing over from PrecisionCare to Therap 2. IT accessibility at all Agency Sites	1. Complete the HIPAA Privacy & Security Risk Assessment in 2018. 2. Look at all sites to make sure adequate internet capabilities exist for Therap use.
Incident Management ***Areas addressed include: Incident Reporting, Incident Investigation, Incident & Investigation Review Committee, Corrective Action Plans, Incident Management System (internal, dedicated mailbox, WSIR, IRMA)***	1. Timely completion of investigations (within 30 days) 2. Timely follow up to investigations, including corrective actions	1. Continue to monitor incidents to make sure they are thoroughly investigated within 30 days. 2. Establish a more streamlined process to ensure follow up is completed and corrective actions have been implemented.

HIT Security Risk Assessment: Completed by Daniela Austin, IT Manager/Security Officer. The purpose of this risk assessment is to identify conditions where Electronic Protected Health Information (EPHI) could be disclosed without proper authorization, improperly modified, or made unavailable when needed. This information is then used to make risk management decisions on what reasonable and appropriate safeguards are needed to reduce risk to an acceptable level. Some areas identified as medium risks are outlined below:

People and Processes

Risk	Recommended Control Measures
Information involved in electronic messaging is compromised	**Protect information – IT is in the process of organizing backlog of devices and new devices (phones, iPads, tablets).**
Systems & data are exposed to malicious software and/or unauthorized use	**Policies & procedures are implemented that address the prevention, detection, and removal of malicious code in the computer operating environment. This covers all computers and devices.**
The change management process in place does not adequately protect the environment from disruptive changes in production	**Equipment is inventoried and tracked. Formal procedures to assure staff do not move equipment or do not radically change the environment without notifying IT.**

Technology

Risk	Recommended Control Measures
Unauthorized parties gain physical access to facilities due to insufficient physical entry/exit controls	**Camera surveillance and card access. A facility security plan that protects the facility with appropriate entry/exit controls to ensure that only authorized personnel are allowed access. Removal of equipment from the facility be restricted to authorized individuals, and repairs and/or modifications of physical components are documented and monitored.**

III. Compliance Helpline and Log

The Compliance Helpline continues to be a vehicle for confidential communication of any potential compliance issues. A Corporate Compliance Log is maintained which documents all potential non-compliance issues, actions taken and outcomes. Issues documented on this Log include Helpline reports as well as issues which are identified or reported to Supervisors, Administrators or the Executive Director. *There were several issues in 2017 that required investigation: (1) a staff member worked for more than one agency at the same time in 2016-2017. A self-disclosure was not required since services were delivered, but documentation errors resulted in voids in Group DH and Supplemental Group DH in the amount of $5,055.23. (2) A potential conflict of interest. (3) It was discovered that the agency was not billing full units of Prevoc when individuals were participating in Supplemental DH activities. After investigation, rebilling of $275,823.85 for 2015, 2016, and 2017 Prevocational services occurred.*

IV. Compliance Issues and Assistance

The Compliance Plan mandates an annual evaluation of the Compliance Program. *Again this year we utilized the NYS OMIG Provider Self-Assessment Tool. The tool was reviewed by the Executive Director and the Chief Operating Officer.*

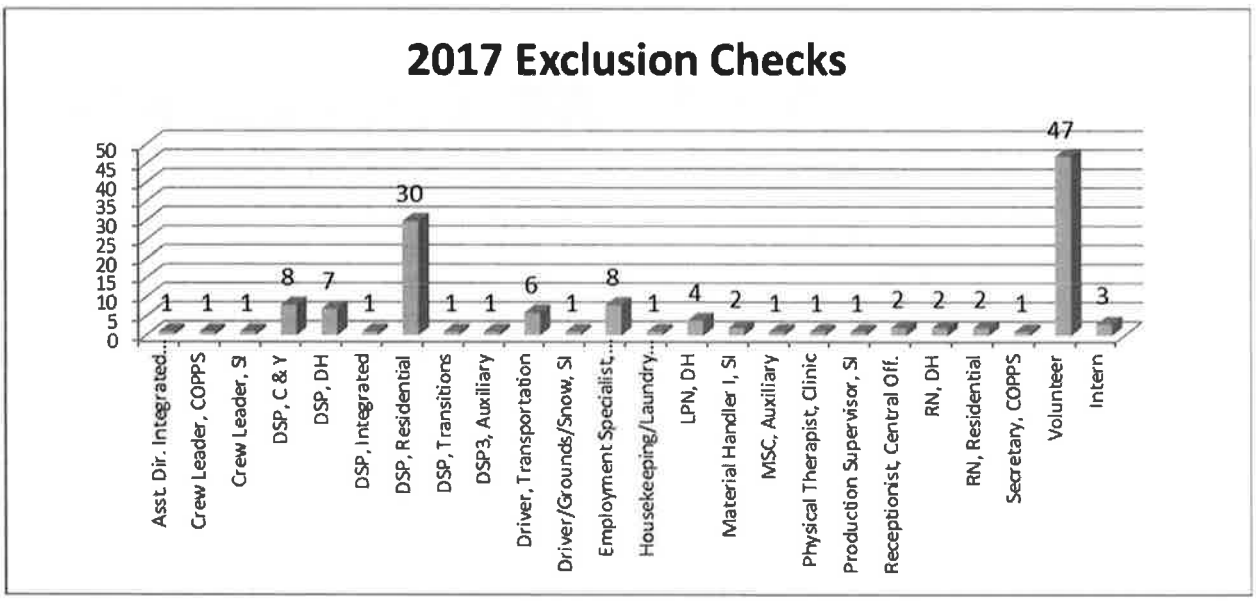
Each year we are required to electronically process two certifications to the NYS OMIG:

- *Certification that we have an effective compliance program*
- *Certification that we are in compliance with Deficit Reduction Law requirements as it relates to the False Claims Act*

These certifications were completed and filed by Howie Ganter on December 19, 2017.

V. Exclusion Checks

We are required to conduct Exclusion Checks before hire and monthly for all staff. Additionally, monthly checks are required for appropriate vendors and affiliates as well as any physicians who care for individuals in our programs. *For 2016, 179 exclusion checks were completed. For 2017, 133 checks were completed for staff, volunteers, and interns:*

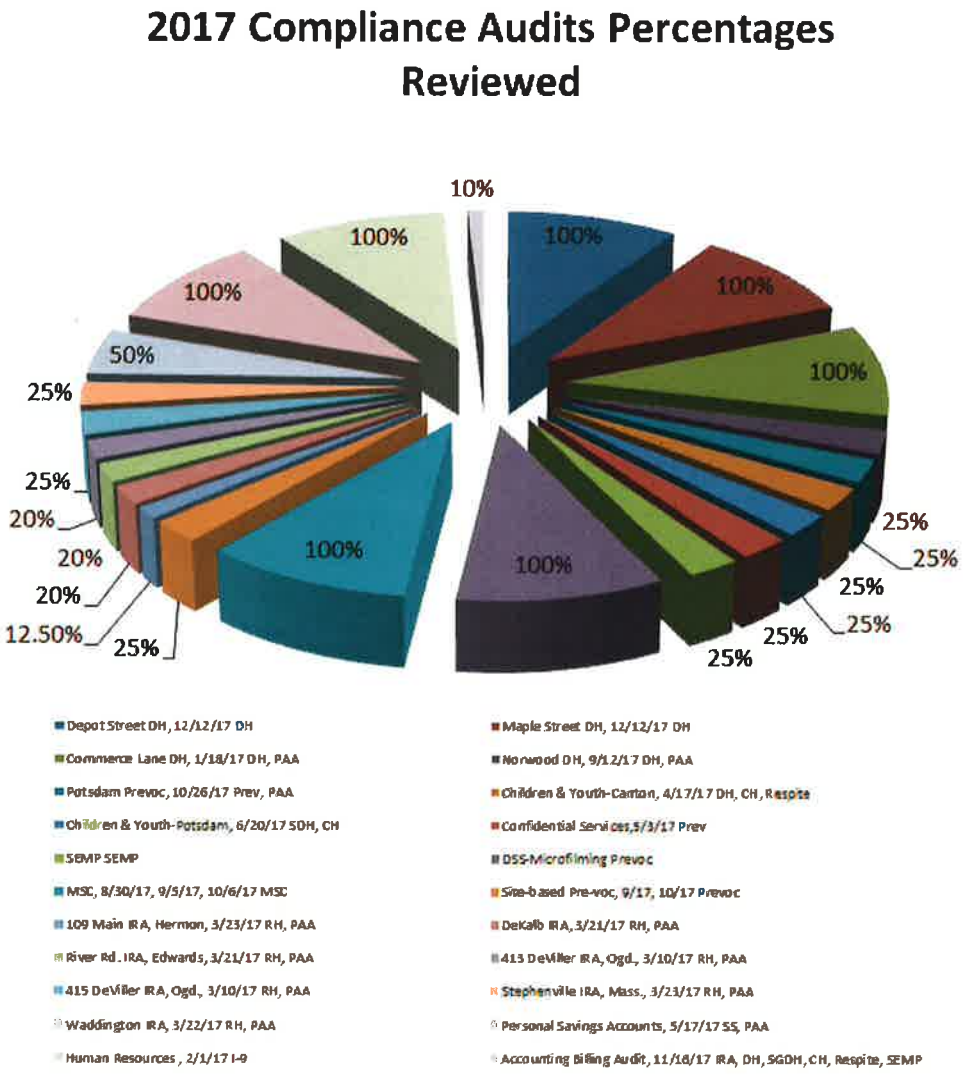


VI. Training

Mandatory annual compliance training was a self-study for 2017. The information was distributed with a return date of November 15, 2017. Mandatory initial Corporate Compliance Training is done monthly as part of new employee orientation, including DSRIP 101, HIPAA, HIPAA Privacy & Security, and Compliance. Regulatory trends, risk areas and audit trends as well as any hot topics are presented quarterly at Management Meetings.

VII. Auditing and Monitoring

An Audit Schedule is drafted each year to include routine audits of all waiver services bi-annually. For 2017, the following 23 compliance audits were completed:



The 100% audits were conducted at small Day Habs, MSCs, I-9s, and Personal Allowance Accounts.

A summary of results of all internal audits including those audits done outside of Compliance (Finance, Quality Assurance and Human Resources) is reported to the Corporate Compliance Committee. This is reported to the Committee in the first quarter of the year and will remain on the agenda for spring 2018.

VIII. Medicaid Claim Adjustments

Since the summer of 2007, we have been utilizing a system for any Medicaid claim adjustments which requires review by the Program Director, Executive Director and CFO/Comptroller. These Claim Adjustments are maintained on file in the Business Office.

To alleviate processing delays, the claim void/adjustment form was revised. The program completes the form upon discovery of an error. The form includes space for a description of the adjustment. Once this is completed, the form is signed by the CFO or Designee. The billing person provides the Compliance Officer with a quarterly report from the billing software which is scrutinized for trends or systemic issues. The totals are then shared with the Corporate Compliance Committee.

IX. Policy Development

The most recent version of the Compliance Plan is posted on the St. Lawrence NYSARC public drive.

- *Josie Clary was designated at the Privacy Officer. Periodic reminders regarding HIPAA and EPHI have been sent to all staff.*

X. Corporate Compliance Committee

The Corporate Compliance Committee met four times in 2017. March, July, September, and December. Agenda items included the following: Status of implementation of the Compliance Plan, potential compliance violations and investigations, audit reports, risk areas and plans for risk reduction, and evaluation of the compliance program.

XI. 2018 Corporate Compliance Goals

Specific objectives and goals for the upcoming year are identified on the 2018 Corporate Compliance Work Plan. Goals for the upcoming year include:

- Completion of HIPAA Security Rule Toolkit Survey.
- Attempt to revive momentum of Records Management System.
- Review Business Associate Agreements.
- Continue monitoring the Compliance Helpline and follow up with investigation of any potential issues.
- Complete monthly Exclusion Checks and monthly license verifications.
- Continue routine audits as per 2018 Corporate Compliance Audit Schedule as well as other focused audits.
- Make identified Compliance Policy Edits and Revisions.
- Complete annual Compliance Risk Assessment and incorporate recommendations into the 2018 Work Plan.

Respectfully submitted,
Josie Clary, Associate Director of Compliance
February 8, 2018