Center for Disability Services

CELEBRATING 80+ YEARS IN SERVICE

Where people get better at life™

Corporate Compliance Plan

2025

Our Mission

To enable and empower people, primarily those with disabilities, to lead healthy and enriched lives.

Our Vision

To be the model for helping people get better at life, through innovation and service excellence for those we serve, in unison with staff and partners who share our passion.

Pursuant to New York State law, the Center for Disability Services, UCPA of Tri-Counties and St. Margaret's Center, are required to have an effective compliance program. Corporate compliance ensures that the organizations, and their affiliates, are operating in accordance with applicable laws, rules and regulations, and their own policies and procedures.

Although the compliance program is a multi-faceted effort that touches every area of the Center for Disability Services and affiliates, there is a heavy emphasis on detecting and correcting payment and billing mistakes, and fraud. An effective compliance program creates a control structure to reduce the potential for fraud, waste, and abuse through self-correction and/or self-reporting of errors. Accordingly, a core purpose of the program is to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences.

Federal and state agencies, including, but not limited to, the New York State Office of Medicaid Inspector General ("OMIG"), New York State Attorney General, Office of Inspector General ("OIG"), and Centers for Medicare and Medicaid Services, and their contractors, continue to perform audits and reviews to detect Medicare and Medicaid fraud, waste and abuse. These audits and reviews frequently focus on:

- Billing for services not rendered;
- Billing for medically unnecessary services;
- Misrepresenting services rendered;
- Duplicative billing;
- Failing to return an overpayment to the government; and
- Submitting bills to Medicare or Medicaid that are the responsibility of another payor.

There are significant penalties associated with such false claims. The state can seek a civil penalty of between $6,000 and $12,000 per false claim, plus three times the amount of damages the state sustains. The federal government can seek recovery of three times the amount of the false claim(s), plus an additional penalty of $5,000 to $10,000 per claim with three times damager. Obviously, such penalties could have a significant financial impact – particularly for programs with daily billings units.

Having an effective compliance program can help to mitigate these risks. Internal audits and reviews are conducted as a proactive means of monitoring compliance in areas of actual or potential risk. The internal audit plan (attached) is based on OMIG and OIG Annual Work Plans, program size, and internal risk assessments, among other factors. Audits and reviews focus on the effectiveness of the compliance program, and compliance with agency policies and procedures, billing requirements, and conditions of payment and participation in Medicare and Medicaid programs.

I. Written Policies and Procedures

Task	Description	Schedule
Review and revise as needed Compliance related policies and Standards of Conduct	Policies and procedures that describe compliance expectations, implement the operation of the compliance program.	1st and 2nd Quarter 2025
Review and revise as needed HIPAA related policies	Policies and procedures that describe HIPAA expectations and requirements to safeguard individual's information including reporting requirements in the event of a breach.	3rd and 4th Quarter 2025
Deficit Reduction Act (DRA) language added to the Employee Handbook	Regulation requires DRA language added to employee handbook. 1. the laws described above, 2. the rights of employees to be protected as whistleblowers, and 3. the entity's policies and procedures for detecting and preventing fraud, waste, and abuse (i.e., the Required Provider's compliance program).	1st Quarter 2025

II. Compliance Officer and Compliance Committee

Task	Description	Schedule
Designated Compliance Officer	Designated as employee responsible for development and implementation of compliance program	On-going
Meeting with CEO/ President	Compliance Officer of Compliance will have "dotted line" to CEO and will meet regularly with the CEO to discuss compliance related issues and concerns	Quarterly
Meeting with Board	Compliance Officer of Compliance will have "dotted line" to the board to discuss compliance related matters	Annually
Compliance Committee membership	Review compliance membership to ensure it meets criteria	1st Quarter 2024
Compliance Committee	Review compliance plan status, audit reports, external audit status, changes in regulations/ standards by regulators	Quarterly

III. Compliance Program Training and Education

Task	Description	Schedule
Training Plan	Complete Annual Training plan for training and education on Compliance	Annually
Compliance orientation	Review of Compliance Program for new hires	On-going
Compliance and HIPAA annual training	Annual trainings on Compliance Program and HIPAA	On-going
Remedial training	Complete remedial retraining with divisions and departments as needed	On-going
Board Member training	Annual training and education for directors required under New York Social Services Law	Annually

IV. Lines of Communication

Task	Description	Schedule
Respond to calls into Compliance Line	Established a compliance line for reporting concerns	On-going
Respond to compliance related complaints	Concerns reported by management, staff, and others	On-going
Track all compliance related concerns	Documentation identifying how the various lines of communication to the compliance officer	On-going
Review and revise "Compliance" page on CFDS website	Review and/or add content for compliance program, hotline, contact information, etc.	1st Quarter 2024

V. Disciplinary Standards

Task	Description	Schedule
Expectations and sanctions for non-compliance	Written policy and procedures for non-compliance and tracking of all non-compliance to demonstrate consistent practices	On-going

VI. Auditing and Monitoring

Task	Description	Schedule
Risk Assessment	Risk analysis performed to identify any risk areas	Annually
Audit Schedule	Internal and external compliance audits focus on required risk areas	See attached schedule

Exclusion Screening	Checking the exclusion status of all affected individuals	Monthly
Self-Assessment	Conducting annual review of the compliance program to determine its effectiveness, and whether any revision or corrective action is required	Annually

VII. Responding to Compliance Issues

Task	Description	Schedule
Compliance Investigations	Taking prompt action to investigate the conduct in question and determining if any corrective action is required	On-going
Plans of Corrective actions	Monitoring plans of correction to ensure compliance issues do not recur	On-going
Reporting Requirements	Promptly reporting credible evidence that a state or federal law, rule, or regulation has been violated to the appropriate governmental entity	As needed
Self-Disclosures	Reporting and returning overpayments in accordance with Medicaid self-disclosure program requirements	As needed

Reviewed by:	Date:
Compliance Committee	12/10/2024
Board Audit Finance Committee	

Plan written by Sarah Quist 12/10/2024