Compliance Plan

Victor Community Support Services

1360 East Lassen Avenue
Chico, CA

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Section 1: Introduction

Victor is a private non-profit organization dedicated to serving the most troubled children throughout California. The organization –Victor Community Support Services– has operated for approximately twenty years to provide innovative services to children and families across the state. Victor is dedicated to learning, exploring new approaches, building new services, and maintaining its commitment to treating children in the most professional, least restrictive, community-based settings possible**.**

Mission and Core Values

Our mission is to be a catalyst for sustained improvement in the lives of those we touch

Each and every action we take is evaluated against our mission. The culture we seek to create at each program ensures that we achieve our mission. At Victor, we adhere to a set of core values that direct our decision-making, policies, and standards of conduct:

- Teamwork
- Excellence
- Adaptability
- Mission Driven

Victor's Compliance Plan

Victor has clearly defined job expectations, including the manner in which services will be delivered. For many years various methods of oversight have been employed to monitor compliance issues. Some of these include: close supervision, peer audits, quality documentation workgroups, regular agency chart reviews, and participation with County led documentation reviews.

As part of its commitment to excellence, Victor has developed a Compliance Plan to ensure that all programs and employees adhere to all federal, state, and county regulations governing MediCal service delivery. The Compliance Plan is coordinated by the Agency Compliance Officer, who works in tandem with representatives from each program to comprise the Agency CQI Workgroup. The CQI workgroup is responsible for development and monitoring of compliance procedures throughout Victor programs.

1. Designation of a Compliance Officer and Compliance Workgroup

   a. Compliance Officer (Quality Assurance Manager)

   The Agency Compliance Officer duties include:

   - Responsibility for facilitating and maintaining of compliance procedures across all sites in the Agency.
   - Investigate and resolve alleged non-compliance issues.
   - Develop procedures and standards as necessary.

- Conduct compliance trainings as needed.
- Maintain the compliance reporting mechanism and closely participate in internal audits.

This person has knowledge of Medicaid/MediCal requirements and is separate from the legal department. The Compliance Officer reports to the Director of Quality, can receive confidential communications, and has the ability to conduct internal investigations. The Compliance Officer holds current certification in healthcare compliance and privacy compliance. *See Attachment C for the Compliance Officer (Quality Assurance Manager)*.

The Compliance Officer promotes new or enhanced compliance systems, the development of compliance procedures, and the implementation of pertinent trainings. This Officer demonstrates leadership to enhance the relationship with the Behavioral Health community and participates in agency statewide trainings. In general, the Compliance Officer provides oversight of the Agency Quality Assurance Team and the CQI Workgroup. The Compliance Officer is responsible for the annual report to the Executive Leadership Team and the Board of Directors.

b. Quality Assurance Team

The Quality Assurance (QA) Team, housed within the Department of Quality, is comprised of Quality Assurance Specialists who partner with the Compliance Officer in executing the Agency Compliance Plan and ensuring adherence at the site level. QA Specialists are sponsored to attend healthcare compliance academies as part of their training at point

of hire and are encouraged to obtain and/or maintain their certification. QA Specialists assist the Compliance Officer with ongoing compliance trainings (agency wide or site specific), serve as liaison to sites for all compliance matters, and conduct regular internal audits. *See Attachment C for the QA Specialist job description.*

c. CQI Workgroups

The CQI Workgroups were created as part of the Agency's continuing dedication to quality services and documentation. These groups are comprised of representatives from each program site across VCSS and the Agency QA Specialist, who acts as the chairperson. Each program site has a designated site representative at the director or supervisor level that communicates with the QA Specialist and ensures thorough and consistent communication between the individual sites and the Quality Assurance Team. Each QA Specialist is assigned specific program sites, and is responsible for bringing representatives from these sites together to monitor HIPAA and MediCal activities at the program sites.

The QA Specialists are the first point of interaction with the program sites, as well as the liaisons with the CQI workgroup members and the Agency as a whole. They are knowledgeable about their particular region/county's documentation rules/standards and contribute to the Agency's statewide development of quality compliance. Representatives from the CQI Workgroups work directly with programs to ensure quality.

The Workgroup members meet monthly, in person or remotely. Through these meetings areas of further training are identified; and information is provided to the Compliance Officer relative to areas of improvement and risk. As indicated, the CQI Workgroups establish or redesign Agency policies with approval from the Executive Leadership Team.

The Compliance Officer, with feedback from CQI Workgroup members, responds to internal issues in a timely manner. As a workgroup they investigate claims of misconduct and make recommendations to the Executive Leadership Team regarding an appropriate course of action. (Attachment B – Compliance Plan Components).

The Board of Directors oversees implementation of the Compliance Plan. The Board is composed of persons outside the Agency but knowledgeable in behavioral health issues. They routinely monitor the actions of the Compliance Officer and QA Team and make recommendations about the implementation of the compliance plan.

2. Written Policies and Procedures

a. Standards of Conduct

Victor is dedicated to quality services and compliance throughout the Agency. Our compliance record is exemplary with excellent audits and a near zero error rate in our many years of service. Victor has achieved this through responsible hiring, superior training, and careful attention to federal, state, and county regulations. We work closely with our partners in the community and maintain open channels of communication.

Each employee at time of hire is referred to the Personnel Policies and an Employee Handbook for which they sign that they have received and read. Subsequent annual revisions of these policy documents require a further signed acknowledgement. VCSS Personnel policy "Code of Conduct" communicates our commitment to conducting our activities in an ethical manner, and in compliance with all applicable state and federal status governing health care programs. This policy communicates our standards at time of hire, annually, as well as expectations and consequences for non-compliance, including the requirement of reporting any and all violations, or suspected violations, to the Compliance Officer or through the Agency's Compliance Hotline (888-881-1802). Upon hire, employees sign the Confidentiality and Code of Conduct Agreement and the Code of Conduct Certification form acknowledging receipt of the policy, that the employee has read the policy and agrees to comply with the policy. *See Attachment D for the personnel forms.*

Separately there are clearly written, definitive Policies & Procedures in hard copy and on-line for all staff to access through the Victor Employee Information Resources Center (VEIRC). These directories explain in detail the Agency's regulations regarding office administration, service provision and documentation requirements to mention a few topics. Again, available to staff, are training manuals of quality documentation standards and detailed explanations for service procedures. In addition, there is a highly developed Mental Health Service Client Database with the ability to track service delivery.

b. Written Compliance Policies and Procedures

The Federal False Claims Act was enacted during the Civil War to combat fraud against the federal government by suppliers for the war effort. In 1986 it was amended to combat the abuses in the defense contracting industry. Today the False Claims Act primarily has become the federal government's most effective and successful tool in combating waste, fraud and abuse in federal spending.

The Federal False Claims Act is composed of civil and criminal components. Under the civil portion the federal government does not have to prove intent but only that there exist claims that are not valid. The criminal component requires that willful misrepresentation be shown to exist in the submission of claims. The California State False Claims Act is similar in intent to the Federal False Claims Act. (Attachment A – False Claims Act Compliance).

There is federal and state Whistleblower protection to guard against any retaliation against those who disclose non-compliance information to a government or law enforcement entity. Employers are prevented from discriminating in any way against such whistleblowers. Individuals who initiate compliance lawsuits can be awarded from 15% to 33% of the money recovered in the action.

The provision of mental health care services to segments of the population has become a large investment of the federal government. To monitor and protect that investment, Victor compliance programs/compliance members have become vital to the process of service delivery. The duties and responsibilities of the Compliance

Officer include: maintaining/overseeing compliance activities; communication with and training of staff as needed; and acting as a liaison within the Agency regarding federal/state/county requirements. Further, the Compliance Officer maintains and disseminates a database of interventions, compliance feedback, updates and standards.

It is the responsibility of the Compliance Officer to review internal audit reports and develop appropriate action at the Agency level. This officer establishes and facilitates a statewide Victor CQI Workgroup to identify priorities, risk areas and appropriate standards and procedures.

The CQI Workgroup Members conduct regular internal audits and participate in developing standards and procedures for individual sites within the Agency. Annually the Compliance Officer assesses the elements of the code of conduct and evaluates the completeness of compliance standards and procedures. As needed the Compliance Officer communicates pertinent issues to the Director of Quality, Regional Directors, Chief Operating Officer and Chief Executive Officer.

At hiring, new employees receive training in quality documentation procedures and compliance issues in general, including the False Claims Act. Recertification in these areas is either annually or biannually as required. There is ongoing monitoring/auditing of compliance practices as staff receives regular, individual supervision. Regular team meetings and all-staff meetings reinforce sound tenets of

compliance and best practices. For new employees, the CQI supervisor and clinical supervisor collaborate on training and work to address any issues new staff is facing. The clinical supervisor will document this in the employee's evaluation.

Employees who have demonstrated an area of need regarding compliance issues receive supervision and coaching in identified remedial areas. Each situation is evaluated on a case by case basis. Repeated situations or failure to comply with Agency expectations can be cause for disciplinary action as discussed later in this document. *See Attachment A for Personnel Policy—Discipline*.

The Compliance Officer works closely with the Human Resources department to assure that hiring practices reflect the need for qualified, eligible staff. Prospective employees are subjected to applicable background/state license checks and are expected (if hired) to comply with the Agency standard of ethical conduct. VCSS Personnel Policy Exclusion Screening and Licensure Checks communicates our commitment to conducting an initial exclusion check on applicants/new independent contractors recommended for hire, the Victor Board of Directors, including officers, directors and board members. Additionally, we conduct ongoing exclusion screenings of all current employees, prescribing practitioners, contractors, officers, directors and board members. (Attachment A – Exclusion Screening and Licensure Checks). Management, as well, creates an atmosphere of diligence to compliance issues and develops procedures and standards that ensure that expectations are clearly stated and enforced. Issues of non-compliance are addressed seriously and in a

timely manner. Above all, management sets an example of compliant, professional behavior in the performance of their duties.

As the result of careful planning and attention to compliance issues there are well defined Agency policies regarding expected employee behavior. Copies of these are at each site and implemented by the executive leadership. There are written compliance standards and procedures pertaining to documentation quality and action in the event of a suspected non-compliance claim.

c. Retention of Records and Information Systems

All client records are stored and maintained in a locked file room in locked metal file cabinets. Charts are checked out according to systems regarding file check out. When charting is completed, the chart is immediately returned to the cabinet or locked storage closet. At the end of the day, the office manager or designee secures the client file cabinets and the file room.

The file room is not accessible to the general public. Charts are monitored by the office administrative staff person. That person and the mental health staff are the only people who have access to the records. During the time the chart is in the mental health staff person's possession, he/she is responsible to see that the chart is not left unattended. It is imperative that all files be returned to the file room following use of the file.

Any request for client records or confidentiality issues is reviewed by the Clinical Supervisor and/or Executive Director. Closed charts are

retained and secured for the appropriate amount of time after their final audit. *See Attachment A for Agency CQI Policies regarding chart security, subject Medical Records Security Requirements.*

d. Compliance as an Element of Performance Plan

All staff are expected to demonstrate knowledge of compliance procedures pursuant to their role along with the code of conduct. Employees who do not demonstrate such ability are not to be considered for promotion and are referred for corrective procedures. It is a requirement of any scheduled performance evaluation that the staff be proficient in appropriate service procedures and compliance issues.

In accordance to the Agency's Retaliation and Whistleblower policy, staff that report compliance violations are not penalized. In fact, staff is encouraged to report non-compliance with or without suggestions for alternative action. (Attachment A – Retaliation and Whistleblower policies).

3. Auditing and Monitoring

a. Auditing

The Compliance Officer and the QA Specialists perform periodic internal audits of critical operation areas in sites throughout the Agency. These audits focus on general compliance and county-specific requirements. Reports generated from these audits are shared with the CQI Workgroup, Executive Leadership Team, Chief Operating Officer and Chief Executive Officer.

These internal audits are performed annually at a minimum, more frequently if needed. Based on the results of these audits, sites determine the effectiveness of their compliance programs, and make the necessary adjustments to trainings and/or policies and procedures. (Attachment B – MediCal Compliance Claim Review Process).

b. Monitoring

Any recommendations or corrective actions for sites or employees are monitored by the QA Team in partnership with the site Executive Director or designee until resolution is reached. Focus areas include Code of Conduct and service requirements/regulations. Incidents are shared with the CQI Workgroup and the Compliance Officer. Violation issues are addressed as needed. (Attachment B - Compliance Plan Adherence and Auditing Protocol).

c. Risk Areas

Areas of focus for auditing programs include, but are not limited to the following:

- Incomplete or missing service documentation
- Missing authorization documentation
- Misrepresentation in documentation
- Discrepancy in number of services
- Missing Clinical documentation
- Missing signatures

The Compliance Officer has a responsibility to evaluate programs based on above listed circumstances as well as to determine if

required deadlines for corrective action have been met. Special attention is paid to claim rejections or unusual patterns of service. When appropriate, auditing forms and instructions are developed to assist the audit process.

4. Responding to Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities

a. Responding to Offenses and Developing Corrective Action

The Agency has as a personnel policy to discipline employees who violate Agency rules, are dishonest or disloyal, or who do not perform satisfactorily *(Attachment A).* Although not a requirement, Agency protocol typically involves notifying the employee of the deficiency, arranging for a meeting with the staff and his/her supervisor or, if necessary, meeting with the Executive Director. *See Attachment A for Agency Personnel Policy-Discipline.*

When an issue of suspected non-compliance is identified, the on-site Compliance Workgroup member and the Compliance Officer are notified. Thereafter, the following occurs:

- It is determined who shall review the claim and determine the method of investigation.
- A timeline is established for when the incident review will take place.
- The specific elements of the complaint are evaluated.
- Based on the severity of the issue, appropriate disciplinary action may be taken.

- An action plan is developed to avoid future non-compliance, clarify expectations, and possibly incorporate additional training(s), as appropriate.

Records of this and any compliance issues are kept at the site and additionally by the Compliance Officer. These are compiled for a summary of the year's activity on an annual basis.

b. Reporting to the Government

Recent health care reform imposes upon Victor an affirmative legal duty to identify and return overpayments obtained through false, inaccurate, or improper claims. Specifically, the Patient Protection and Affordable Care Act of 2010 requires Victor to identify overpayments and self-report within 60 days of identifying an overpayment. Overpayments retained after the 60 day discovery period are subject to False Claims Act liability. Therefore, Victor diligently identifies, investigates, or reviews suspected overpayments to promptly resolve any questions and identify the appropriate party to report the overpayment – the local county, California Department of Health Care Services, or the Office of Inspector General and Centers for Medicare and Medicaid Services.

Breach notifications of unsecured protected health information are promptly communicated to affected individuals per Health Information Technology for Economic and Clinical Health (HITECH). Victor also provides reporting to the Department of Health and Human Services of privacy breaches that occur, according to the timeframes set forth in

the HITECH Act. Reporting to DBH for services provided as a contract provider.

5. Required Trainings and Education

a. Formal Training Programs

Newly hired staff participates in a New Hire Orientation that acquaints them with Agency protocols and compliance requirements. There is training regarding HIPAA, Code of Conduct and the Federal False Claims Act and regular recertification thereafter. After each segment training, staff sign attesting to completion. In addition, there is adjunct county and compliance training with respective re-certifications (see Attachment A – Required Employee Training). Staff is closely monitored for the first 180 days of employment. During this time areas of need are identified and training implemented when needed. Following this initiation period there are annual or bi-annual re-certifications depending on the subject matter, as stated in the Agency Required Employee Training. Trainings are also available on-line in an e-training format. Completion of training is closely monitored and records are kept in each personnel file. Relias is the primary online training platform for the Agency.

Special training is provided to supervisors to assist with their identification of compliance issues and focusing on encouraging employees to report non-compliance matters per Agency policy. Proper handling of complaints is emphasized and delineated.

b. Informal Ongoing Compliance Training

Regular supervision of all staff provides the primary setting for ongoing compliance training. Employees are encouraged to discuss current treatment issues and seek resolution early in the process. Client Satisfaction Surveys are randomly distributed for completion to seek feedback from consumers regarding alignment between documented service delivery and consumer satisfaction. *See Attachment E for the Agency Client Satisfaction Survey.*

Careful auditing of client charts provides another opportunity to address compliance matters on an ongoing basis. Designated on site staff, with assistance and oversight of the QA Team, review documentation and make recommendations as needed. Appropriate training is arranged if indicated.

6. Enforcement of Disciplinary Standards Through Publicized Guidelines and Policies

a. Consistent Enforcement of Disciplinary Policies

All disciplinary actions are handled on an individual basis. The Personnel Policies manual details the possible range of actions available to enforce Agency policies. Depending on the issue, corrective action may involve additional training, reduced responsibility, reassignment, increased supervision, demotion/transfer, suspension, or termination.

Employees are expected to report actual or suspected cases of non-compliance. There is no retribution or backlash to persons legitimately

filing reports of non-compliance. (Attachment A – False Claims Act Compliance).

b. Employment and/or Contracting with Ineligible Persons

Prospective employees undergo a systematic interview process as the first round of possible employment. If the person is found to be suitable, a background check is performed consisting of Department of Justice fingerprinting clearance, exclusion screening and licensure checks through a third-party vendor (Provider Trust) and the on-line EDEX check of open/closed Workers Compensation claims. The prospect receives a physical exam including TB and drug tests as a requirement prior to employment. Once employed, health care providers are required to register for a National Provider Identifier (NPI), through the National Plan and Provider Enumeration System. *See Attachment A for Agency policies regarding employee hiring – Criminal Record Clearance and Clinical Licensing Standards.*

Employees are required to regularly show proof of a valid driver's license and auto insurance policy. They are required to report any convictions for driving under the influence.

The Agency shall not employ, contract with, or conduct business with individuals or entities excluded from participation in a federally sponsored health care program, such as Medicare, Medicaid, and MediCal.

7. Developing Effective Lines of Communication

a. System for Reporting Non-compliance

Employees who wish to report acts of non-compliance can do so to supervisors, managers, the Compliance Officer, or members of the CQI Workgroup. If they wish, they can do this in person, by phone (including Agency established toll free number), in hand-written correspondence, or by e-mail. If the reporting party wishes to be anonymous he/she can submit a written correspondence to the Office Services Manager's mailbox locally or mail to the Agency corporate address. The person can use an on-line reporting form or generate one that would include: date of occurrence, date of report, program, detailed description of incident, person(s) involved, and the reporter's name (optional). *See Agency Non Compliance Report form on page 23 and federal reporting information on page 24.*

All reports of actual or suspected non-compliance are given to the Compliance Officer regardless of the manner of the report. Even if another person was the immediate recipient of the report, the Compliance Officer receives the report as well. By the end of each fiscal year, a summary report of all incidents and outcomes is given to the Board of Directors and Chief Executive Officer.

b. Communication and Access to the Compliance Officer

In the role of Quality Assurance Manager for the organization, the Compliance Officer is easily accessible by all employees. A job description is written, published and accessible in the Victor Employee

Information Resources Center (VEIRC). Specific duties include answering routine questions regarding compliance and ethical issues, and acting as consulting resource to all Directors and staff regarding compliance matters. Detailed contact information is available to all sites within the Agency.

Timely information notices regarding compliance issues are disseminated by the Compliance Officer by email. The Compliance Officer makes regular reports to the CQ Workgroup regarding trends/areas of need and/or further training required.

Non-Compliance Report Form

Date of report:_____

1. Date of occurrence:_____
   _____
   _____
   _____
   _____
2. Program and address:_____
   _____
3. Details of incident:_____
   _____
   _____
   _____
   _____
   _____
   _____
4. Person(s) involved in incident:_____
   _____
   _____
   _____
5. Reporting Person's name (optional)_____
   Contact phone # (optional)_____
   Contact e-mail (optional) _____

Report Fraud

Phone:
1-800-HHS-TIPS
(1-800-447-8477)

Fax:
1-800-223-8164

TTY:
1-800-377-4950

E-Mail:
HHSTips@oig.hhs.gov

Mail:
Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
PO Box 23489
Washington, DC 20026

Download the Contractor Code of Ethics and Business Conduct Poster (PDF)
Adobe Acrobat Reader is required to view PDF files.

Reporting Fraud

All HHS and contractor employees have a responsibility to assist in combating fraud, waste and abuse in all departmental programs. As such you are encouraged to report matters involving fraud, waste and mismanagement in any departmental program(s) to OIG. To assist you, OIG maintains a hotline which offers a confidential means for reporting vital information.

Information is for official use only (For information on confidentiality please contact the hotline and ask about our confidentiality source program).

Each caller is encouraged to assist the OIG by providing information on how they can be contacted for additional information but **caller may remain anonymous**.

To the best of your ability, please provide the following information when contacting the Hotline:

Type of complaint:

Medicare Part-A
Medicare Part-B
Child Support Enforcement
National Institute Of Health
Indian Health Service
Food And Drug Administration
Centers For Disease Control And Prevention
Substance Abuse And Mental Health Services Administration
Health Resources And Services Administration
Aid To Children And Families
All Other HHS Agencies Or Related Programs

HHS department or program being affected by your allegation of fraud waste or abuse/mismanagement:

Administration for Children and Families (ACF)
Child Support Enforcement (CSE)
Centers for Medicare & Medicaid Services (CMS)
Food and Drug Administration (FDA)

National Institutes of Health (NIH)
Office of Disease Control and Prevention (CDC)
Indian Health Service (IHS)
Office of Inspector General (OIG)
Office of the Secretary (OS)
Health Resources and Services Administration (HRSA)
Substance Abuse and Mental Health Administration (SAMSHA)
Administration on Aging (AOA)
Agency for Health Care Policy and Research
Other (please specify)

Please provide the following, if you would like your referral to be submitted anonymously please indicate in your correspondence or phone call:

Your Name
Your Street Address
Your City/County
Your State
Your Zip Code
Your email Address

Subject/Person/Business/Department that allegation is against:

Name of Subject
Title of Subject (if applicable)
Subject's Street Address
Subject's City/County
Subject's State
Subject's Zip Code

Please provide a brief summary relating to your allegation.

Attachment A - Policies

- **Code of Conduct**
- **Criminal Record Clearance**
- **Clinical Licensing Standards**
- **Discipline**
- **Exclusion Screening and Licensure Checks**
- **False Claims Act Compliance**
- **Medical Records Security Requirements**
- **Required Employee Training**
- **Retaliation**
- **Whistleblower**

Attachment B – Procedures

- **Administrative Personnel Procedure – Compliance Plan Components**
- **Administrative Personnel Procedure – Compliance Adherence and Auditing Protocol**
- **Administrative Personnel Procedure – MediCal Compliance Claim Review Process**

Attachment C – Job Descriptions

- **Director of Quality**
- **Quality Assurance Manager**
- **Quality Assurance Specialist**

Attachment D - Forms

- **Personnel Form 95b – Code of Conduct**
- **Personnel Form 08 - Confidentiality and Code of Conduct Agreement**

Attachment E

- **Client Satisfactory Survey**