# COUNTY OF YOLO

Health and Human Services Agency

# Behavioral Health Compliance Plan

Original: February 22, 2005
Revised: May 25, 2010
Revised: February, 2 2018

Health and Human Services Agency
Quality Management Program

# I. Introduction

## What Is Compliance and Why Should We Be Concerned?

Compliance refers to adherence to federal health care program requirements. The two programs of prime interest are Medicare and Medicaid. Medicaid is referred to as Medi-Cal in the State of California.

Medicare is a health insurance program for 1) people 65 years of age and older; 2) people with severe disabilities under the age of 65; and 3) people of any age with End-Stage Renal Disease. Standard Medicare covers outpatient, inpatient and partial hospitalization benefits for mental health care. Medicare will pay for mental health services provided by certain specialty providers including; psychiatrists, clinical psychologists and clinical social workers.

Medicaid is a health insurance program that provides medical and medically related services to the most vulnerable populations. In general, Medicaid provides three types of health services: 1) health insurance for low-income families and individuals with disabilities; 2) long-term institutional and or community-based care for older Americans and individuals with disabilities; and 3) supplemental co-payments coverage for low-income Medicare beneficiaries. Medicaid is a joint Federal and State program. The Medicaid benefit package is determined by each state based on broad Federal guidelines. In general, each state must cover 15 categories of "mandatory services" identified in statue, such as inpatient and outpatient services, laboratory and X-ray services, nursing facility services, and Early and Periodic Screening, Diagnosis, and Treatment (EST) for individuals under the age of 21. In addition, states have the option to cover one or more of up to 28 "Optional services" under Medicaid, such as case management, personal care services, inpatient psychiatric services for under 21, prescribed drugs and a variety of professional services. We receive payments from both programs and therefore are required by law to have a Compliance Program and to prevent fraud, waste, and abuse in our behavioral health care programs. The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs outlined above. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

<u>Who monitors fraud and abuse?</u>

1. State Department of Health Care Service (DHCS), Mental Health Services Division, Program Oversight and Compliance Branch
2. DHCS Audits and Investigations
3. U.S. Department of Health and Human Services, Office of Inspector General (OIL)
4. US Department of Justice (DOJ), Federal Bureau of Investigation (FBI)
5. State Medicaid Fraud Control Units (MFCUs)
6. US Centers for Medicaid and Medicare Services (CMS - formerly HCFA)
7. Internal Revenue Service (IRS)
8. And more….

## Definitions

1. **Applicable State Contracts** are the Mental Health Plan contract and other State contracts for federal and/or state funded behavioral health care programs (i.e. substance use disorder services) to which the requirements of the Medicaid Managed Care regulations apply.
2. **Behavioral Health Employees** means Yolo County Health and Human Services Agency (HHSA) employees that participate in the provision of behavioral health services, including administrators and management.
3. **Auditing** consists of retrospectively testing the established monitoring systems to ensure they are functioning as prescribed.
4. **Monitoring** is conducted in real-time and broad in scope to facilitate appropriate management action on an ongoing basis to document compliance with policies, procedures, laws or regulations.
5. **Fraud** is an intentional deception or misrepresentation that an individual knows or should know to be false that could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
6. **Waste** is overutilization of services, needless expenditure of funds or consumption of resources or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs caused by deficient practices, poor systems controls or bad decisions. **Waste** is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.
7. **Abuse** is provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
8. **Misconduct** is wrongful, improper, or unlawful conduct motivated by premeditated or intentional purpose or by obstinate indifference to the consequences of one's acts.

## Mission Statement

The mission of the Yolo County Health and Human Services Agency (“HHSA”) is to promote a healthy, safe, and economically stable community. HHSA’s behavioral health programs support this mission by partnering with individuals, families, and the community to foster recovery and well-being via the provision of culturally and linguistically appropriate services for the prevention and treatment of serious mental health and substance use disorder issues.

In further support of these objectives, HHSA has implemented a Behavioral Health Compliance Program (“Compliance Program”), established pursuant to federal Medicaid Managed Care Regulations and monitored by the DHCS. The implementation of the Compliance Program is evidence of the agency’s continuing effort to improve quality of care in an environment that prevents fraud, waste and abuse, promotes integrity, ethical conduct and adherence to applicable laws and professional standards.

HHSA Behavioral Health Programs have designed processes for combating fraud, waste, abuse and unethical conduct through the development of this Behavioral Health Compliance Plan ("Compliance Plan".) The Compliance Plan details HHSA's commitment to achieve and maintain compliance with all applicable state and federal standards regarding behavioral health care programs. The components of the Compliance Plan will serve as guidelines for delivering services in a manner consistent with the highest professional standards and ethical code of conduct.

The Compliance Plan addresses the following issues:

1. Conducting internal monitoring and auditing of HHSA's behavioral health care programs through the performance of periodic audits to ensure that we do not fail in our efforts to adhere to all applicable state and federal laws and regulations;

2. Implementing compliance and practice standards for HHSA's behavioral health care programs through the development of written standards and procedures;

3. Oversight of the Compliance Program, which includes designating a Behavioral Health Compliance Officer ("Compliance Officer") to monitor compliance efforts, establishment of a Behavioral Health Compliance Committee ("Compliance Committee"), management and supervisory responsibilities, and individual responsibilities;

4. Conducting appropriate training and education for HHSA behavioral health employees on how to perform their jobs in compliance with the standards of the Compliance Plan and all applicable laws, regulations, and policies;

5. Establishing mechanisms to correct behavioral health care program non-compliance and respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities;

6. Developing open lines of communication, including discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct; internal memos; informational notices, e-mail; ongoing trainings; other reasonable methods to keep behavioral health care employees updated on compliance activities, and providing clear and ethical business guidelines for behavioral health employees to follow; and

7. Enforcing disciplinary standards through well-publicized guidelines.

8. Prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified during self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements.

## Legal Mandates for Compliance Activities

***Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services***

On April 25, 2016, CMS put on display at the Federal Register the Medicaid and CHIP Managed Care Final Rule, which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. See the related blog co-authored by the CMS Administrator and CMCS Director, Medicaid Moving Forward. For questions regarding Managed care, please email ManagedCareRule@cms.hhs.gov. Current federal requirements for Program Integrity Safeguards including a Compliance Program to detect fraud, waste and abuse are included in the final rule at Title 42, Code of Federal Regulations (CFR), Part 438, Subpart H and specifically in Section 438.608.

## HHSA Behavioral Health Code of Conduct

In an effort to clearly define the expectations of HHSA behavioral health employees, HHSA has developed a written *Behavioral Health Code of Conduct ("Code of Conduct")*. This document is distributed to all HHSA behavioral health employees to serve as a guideline for appropriate conduct and behavior.

1. Each behavioral health employee shall be required to sign an acknowledgement that he/she has received and read a copy of the *Code of Conduct*. This acknowledgement will be maintained in a file by the Behavioral Health Compliance Officer ("Compliance Officer".)
2. This acknowledgement form shall be re-signed after reviewing the *Code of Conduct* on an annual basis.

## HHSA Behavioral Health Compliance Plan

The Compliance Plan articulates the establishment and implementation of procedures and a system with dedicated behavioral health for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under applicable State contracts.

## HHSA Behavioral Health Compliance Committee

The Compliance Committee is a regulatory committee at the senior management level charged with overseeing the Compliance Program and its compliance with requirements under the applicable State contracts. Compliance Committee members shall be appointed by the HHSA Director.

# Statement of Policy on Behavioral Health Employee Conduct

HHSA expects that all personnel will conduct themselves in a manner consistent with the highest professional standards and the ethical codes of their profession. HHSA places great importance on its reputation for honesty and integrity. To that end, the Executive Leadership and Senior Mental Health Management Teams expect that the conduct of behavioral health employees will comply with these ideals.

All HHSA behavioral health employees are expected to be familiar with this Compliance Plan and the appropriate processes necessary to perform his or her duties, and how to obtain the requisite information pertinent to performing those duties in a manner consistent with HHSA and County requirements. Behavioral health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA or the County may be subjected to progressive disciplinary action, up to and including termination.

HHSA will adhere to all applicable federal, state and local laws and regulations in the performance of its day-to-day activities. In addition, HHSA will inform its providers and/or organizational service providers of this intention. Where uncertainty regarding federal, state, and local law and regulations exists, each behavioral health employee shall seek guidance from a knowledgeable supervisor or manager. Supervisors may contact the Compliance Officer or Management with any concerns. The Compliance Officer or Management may contact County Counsel, or other County Departments, as the situation warrants.

HHSA Behavioral Health Quality Management Program ("QM Program"), as part of the Compliance Program, will develop and implement detailed policies setting forth standards of conduct specifically applicable to the services. These policies will be communicated to all behavioral health employees, and contracted organizational service providers, as appropriate. HHSA behavioral health employees and outside service providers are expected to be familiar with the detailed policies applicable to their activities and are required to adhere to such policies.

# II. Conducting Auditing and Internal Monitoring

## Overview

As part of its Compliance Plan, HHSA conducts on-going program evaluation through auditing and monitoring processes. These processes determine if the Compliance Plan is working, whether individuals are carrying out their responsibilities in an ethical manner and that claims are being submitted appropriately.

## Procedures

1. In its oversight of the Compliance Program, the Compliance Officer, Compliance Committee and/or the QM Program will facilitate the following auditing and monitoring activities:

    a. Utilization Management Program: The QM Program operates a Utilization Management Program that is responsible for assuring that beneficiaries have appropriate access to specialty mental health services (SMHS) as required in California Code of Regulations, Title 9, §1810.440(b)(1)-(3) and the Mental Health Plan (MHP) contract. The Utilization Management Program will include:

        i. Utilization Review Committee (URC)

        The URC is responsible for providing oversight of the Authorization and Access (AAC); Peer Review (Peer Review); and Inter-Rater Reliability (IRR) subcommittees; and to provide oversight of the Inpatient Utilization, for both 5150's and TARS, and medication monitoring processes. The URC functions include monitoring trends identified and conducting chart reviews which occur within AAC, IRR, and Peer Review. An additional component of URC is to review disallowances identified from Peer Review chart audits.

        - AAC subcommittee: The AAC reviews charts for completeness and accuracy and to ensure compliance with Medi-Cal documentation requirements prior to authorizing the billing for services rendered. The charts reviewed will be those that include an initial request for services (first request for services); a request for add-on service(s) (to add services during a period in which services have already been authorized); when there's a "significant change" in the client's condition; or an annual reauthorization request.

          The chart documents reviewed by the AAC include: The Client Intake packet; Medical Necessity Form; LOCUS Form (if applicable); Client Assessment; Client Treatment Plan; and Discharge Summary (if applicable). Subcommittee participants include clinical team supervisors and/or designated team member and designated QM Program staff. The Compliance Officer may also attend.

        - Medication Monitoring: The Medication Monitoring subcommittee or an independent contractor will audit at least 20 charts of clients receiving medication services. The charts will be randomly selected from all mental health systems. This audit shall be conducted at least five times per fiscal year. Each audit of at least 20 charts shall contain at least two (2) charts per prescribing doctor.

- Peer Review: The Peer Review Subcommittee is responsible for random chart audits. Clinical staff conduct a monthly random audit of two charts to compare billing with chart documentation. This audit seeks to confirm that:
    - Bills are accurately coded and accurately reflect the services provided (as documented in the client's chart);
    - Documentation is being completed correctly and in a timely manner; and
    - Services provided meet medical necessity criteria.

b. Standards and Procedures Review: The behavioral health policies and procedures are reviewed on an ongoing basis as the Compliance Officer, Compliance Committee, or QM Program as new information and/or guidance is received. Periodically, behavioral health policies and procedures are audited by the Compliance Officer, Compliance Committee, or QM Program to determine if they remain current and effective. If any behavioral health policies and procedures is found to be inaccurate or ineffective, it will be updated as needed. All HHSA policies and procedures including revisions to same, including behavioral health policies and procedures, must be approved by the HHSA Director or designee.

c. System Level Monitoring

i. Utilizers: The Quality Improvement Committee (QIC) annually reviews data on service utilization and clients with high service utilization patterns.

ii. Staff Productivity: Clinical behavioral health employees will track productivity using a staff productivity report which tracks direct and non-direct service time. Clinical behavioral health supervisors will monitor this report.

iii. Medi-Cal Denial Reports: HHSA Fiscal staff or designee will review Medi-Cal Denial Reports at least quarterly to identify potential compliance issues.

iv. Electronic Health Record (EHR) System [Avatar] Access: Monthly the County Avatar Administrator will run a report to monitor the Avatar System User Access. This ensures that only active and authorized providers have access to the EHR.

v. Internal Claims Submission Process: On a quarterly basis, HHSA behavioral health fiscal staff audits and monitors billable services against internal behavioral health staff timesheets.

vi. Productivity Review: At least quarterly, designated fiscal staff monitors timeliness of progress notes and accuracy of billable services to ensure there are no duplicated services or incorrect services codes.

vii. Service Verification: At the conclusion of all outpatient appointments clients are provided and asked to complete a service verification form. At least annually, designated QM staff review and analyze the forms.

2. Reporting Results from Auditing and Monitoring Activities: Any compliance issues that are detected through these activities will be reported to the Compliance Officer immediately. The Compliance Officer will document all incidences of non-compliance on the Compliance Log. This information will be reported at least quarterly to the Compliance Committee. For more information on these oversight committees and their responsibilities, please refer to HHSA PP 5-4-008 *Oversight of the Behavioral Health Compliance Program*.

3. Investigation and Corrective Action: When compliance issues are reported by staff or detected via auditing/monitoring activities, the Compliance Officer will initiate an investigation. If non-compliance is evidenced, the Compliance Officer will follow a course of corrective action outlined in the Compliance Plan and HHSA PP 5-4-014 *Non-Compliance Investigation and Corrective Action*. Please refer to these documents for more information.

# III. Implementing Compliance and Practice Guidelines

As a component of the broader Compliance Program required by federal Medicaid regulations and the MHP contract between HHSA and DHCS, and other applicable State contracts, HHSA has designed processes for combating fraud, waste, abuse and unethical conduct through the development of this HHSA Behavioral Health Compliance Plan. Implementation of this Compliance Plan is accomplished through written policies and procedures, and efforts are documented through various mechanisms.

## Policies and Procedures

The purpose of the Compliance policies and procedures is to reduce the possibility of erroneous claims, misconduct, and fraudulent, wasteful and abusive activities by clearly identifying risk areas and establishing internal controls to counter those risks. These controls include practice standards regarding client care, personnel matters, and compliance with federal and state laws.

The policies and procedures serve to identify and implement these standards necessary to successful compliance. These policies and procedures will be reviewed annually to determine their continued viability and relevance.

The Compliance policies and procedures are as follows:

1. *Implementation of the Behavioral Health Compliance Program* HHSA PP 5-4-007
2. *Oversight of the Behavioral Health Compliance Program* HHSA PP 5-4-008
3. *Compliance Program Standards* HHSA PP 5-4-009
4. *Auditing and Monitoring Activities* HHSA PP 5-4-010
5. *Standards for Risk Areas and Potential Violations* HHSA PP 5-4-011
6. *Reporting Suspected Compliance Violations* HHSA PP 5-4-012
7. *Non-Compliance Investigation and Corrective Action* HHSA PP 5-4-013
8. *Disciplinary Guidelines* HHSA PP 5-4-014
9. *Compliance Training* HHSA PP 5-4-015
10. *Behavioral Health Reporting and Notification Requirements* HHSA PP 5-4-016
11. *Disclosure of Ownership, Control and Relationship Information* HHSA PP 5-4-017

To ensure successful implementation of the compliance standards, to track compliance violations, and to evidence the department's commitment to compliance, HHSA has developed the following documentation procedures:

## Behavioral Health Compliance Log

Documentation of violation investigations and results will be maintained by the Compliance Officer in the Behavioral Health Compliance Log ("Compliance Log"). On a quarterly basis, information from the Compliance Log will be summarized and system level issues will be reviewed with the Compliance Committee.

The Compliance Log contains the following materials:

a. The Behavioral Health (BH) Compliance Issue Number

b. The date or general time period in which suspected non-compliant action(s) occurred;

c. The date or general time period in which suspected non-compliant action(s) were discovered;

d. Source of the allegation (via direct or anonymous contact with the Compliance Officer, routine audit, monitoring activities, etc.);

e. Name of the behavioral health provider or employee(s) involved;

f. Name of the client(s) or chart number(s) involved;

g. Issue description with specific information regarding the nature of the allegation, including supporting reference materials, etc.;

h. In the event that the non-compliant actions require a Privacy Incident Report (PIR) be made to the State, the following information will be logged as well: State Investigation Number, Date incident was reported to the State: Submission date of the Initial PIR Form; Submission date of the Final PIR Form; Date the Investigation was closed by the State;

i. Additional Information re the incident;

j. The corrective action plan;

k. Name of the person responsible for following up, if appropriate; and

l. Final Disposition.

## Electronic Compliance Program Folder

The components of the Compliance Program are kept in an electronic folder ("efolder"), (although materials protected by attorney-client privilege will be saved separately). This efolder contains the following materials:

a. A copy of the Compliance Plan

b. A copy of the HHSA Compliance Policies and Procedures, as well as any changes or updates

c. A copy of the Compliance Officer's Duty Statement

d. The HHSA Behavioral Health Code of Conduct

e. A log of the Compliance Officer's education and training efforts

f. A log of the HHSA behavioral health employee education and training efforts

## The Compliance Committee Binder and Efolder

The Compliance Committee binder and efolder will contain the following materials:

a. Meeting Agendas; Meeting minutes indicating those present, summary of items discussed, and any future meeting items; Copies of any materials distributed.

# IV. Oversight of the Compliance Program

The successful implementation and maintenance of the Compliance Program depends on the efforts and support of all behavioral health employees including administration and management. To guide these efforts and perform day-to-day operations, HHSA has developed a Compliance Plan, appointed a Compliance Officer, convened a Compliance Committee, and is operating a comprehensive QM Program. The role and responsibilities of each are outlined herein.

All HHSA behavioral health employees are expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his or her duties and how to obtain the requisite information in order to perform those duties in a manner consistent with legal, regulatory, HHSA and County requirements. Behavioral health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA or Yolo County may be subjected to progressive disciplinary action up to and including termination.

## Compliance Officer

The Compliance Officer is empowered provide oversight to HHSA's adherence to the Compliance Plan; and is responsible for overseeing the implementation and day-to-day operations of the Compliance Program. The Compliance Officer is a main point of contact for behavioral health employees regarding compliance issues. The Compliance Officer also plays an integral role in linking behavioral health employees to information regarding the requirements of the Compliance Program and compliance training resources. The Compliance Officer as a required member of the Compliance Committee, assists with the oversight and monitoring of the Compliance Program. The Compliance Officer is embedded in the QM Program and can make reports to the HHSA Director and the Compliance Committee.

The Compliance Officer duties include but are not limited to:

1. Overseeing and monitoring the implementation of the compliance program;
2. Establishing methods, such as periodic audits, to improve the program's efficiency and quality of services, and to reduce the program's vulnerability to fraud, waste, and abuse;
3. Periodically revising the compliance program considering changes in the needs of the program or changes in the law and regulations;
4. Developing, coordinating, and participating in a compliance training program;
5. Monitoring behavioral health staff and contractors for possible exclusion from participation in federal or state health care programs or from maintaining other prohibited affiliations;
6. Collaborating with HHSA Human Resources to arrange for background checks of behavioral health staff and contractors, including fingerprint checks when applicable; and
7. Receiving and logging of reports of potential compliance issues;
8. Conducting compliance investigations and monitoring corrective action plans;
9. Reporting compliance issue to appropriate federal and/or state authorities;
10. Other appropriate duties, as assigned.

## Compliance Committee

In coordination with the functions performed by the Compliance Officer, the Compliance Committee oversees and monitors the Compliance Program in its entirety; and performs vital functions to assure compliance with state and federal regulations. In coordination with the Compliance Officer, the Compliance Committee shall meet at least quarterly and is responsible for the following compliance activities:

1. Receiving reports on compliance issues and corrective actions from the Compliance Officer;
2. Collaborating with the Compliance Officer regarding compliance violations and corrective actions;
3. Collaborating with the QM Program regarding compliance policies, procedures, and processes;
4. Reporting to the HHSA Director on compliance matters;
5. Developing and maintaining the Compliance Plan;
6. Ensuring that appropriate processes are developed for the compliance program including record-keeping system for compliance files and logs.
7. Ensuring that compliance training programs are developed and made available to behavioral health staff and that such training is documented;
8. Ensuring that an internal review and audit system is developed and implemented which will include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action.

## QM Program

The Compliance Officer and Compliance Committee work in collaboration with the QM Program to review HHSA behavioral health program policies and procedures and to detect potential and actual compliance violations. The efforts of the QM program exemplify HHSA's commitment to consumer focused, high quality, value-based, culturally competent, clinically appropriate services in a system that promotes integrity, ethical conduct, and adherence to applicable federal and state laws. The collaboration of the Compliance Officer, Compliance Committee, and QM Program ensures that the practices and standards of the Compliance Plan are fully implemented and maintained.

The QM Program encompasses Compliance, Quality Assessment, and Performance Improvement (QAPI) activities. Compliance Program activities and responsibilities include:

1. Monitoring HHSA's adherence to the State-County Mental Health Plan Contract and all other applicable state contracts in all categories, which may include: beneficiary protection, provider relations, utilization management, utilization review, Medi-Cal documentation, quality improvement, access and authorization, network adequacy, and program integrity;
2. Monitoring and assisting contract agencies' adherence to their contracts with HHSA;
3. Informing behavioral employees and contractors of compliance issues via the issuance of Information Notices;
4. Operation and oversight of the Electronic Health Record;

5. Facilitating the Utilization Review Committee; the Quality Improvement Committee; and the Access and Authorization Committee;
6. Provide training regarding clinical documentation, including assessments, medical necessity, client treatment plans, and other forms required for compliance;
7. Provide ongoing review and recommendations regarding policies, procedures, and processes to ensure compliance with current federal and state requirements.

## Management/Supervisor Responsibilities

1. Create an environment of honesty and ethics within each manager/supervisor's span of control. This can be accomplished by providing employees clear direction regarding work expectations and legal requirements.
2. Reduce opportunities for fraud, waste and abuse by implementing strong internal controls that detect and deter dishonest behavior.
3. Ensure that behavioral health employees are aware of the options available for reporting fraud, waste and abuse and other compliance issues.
4. Establish an environment free from intimidation and retaliation to encourage open communication.

## Individual Responsibility

1. Perform duties in a way that promotes the public trust and ensures proper expenditures and use of county assets and property.
2. Employees, contractors, volunteers and other designated individuals have a duty to report actual or suspected violations of law, regulations or policy including fraud, waste and abuse to appropriate authorities.
3. Cooperate with investigations of compliance issues.

# V. Standards for Risk Areas and Potential Violations

To successfully implement the Compliance Program required by federal Medicaid Managed Care regulations and the applicable State contracts, risk areas and potential violations have been identified and assessed. This policy and procedure has been developed to address these risk areas and serve to implement the standards necessary to avoid these types of violations.

Each HHSA employee is expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his/her duties and/or how to obtain the requisite information pertinent to performing his/her duties in a manner consistent with legal, regulatory, and departmental requirements.

Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA may be subjected to progressive disciplinary action up to and including termination.

## Areas of Risk

The following areas of risk have been identified as high-risk areas. Behavioral health employees and contract providers are expected to be familiar with these potential violations and work to maintain compliance with the standards surrounding each area of risk.

### 1. Coding and Billing

A routine audit helps determine if any problem areas exist and provide the ability to focus on the risk areas that are associated with those problems. There are several types of audits that occur under the Compliance Program:

a. Billing for services not rendered and/or not provided as claimed. A claim for a behavioral health service that the staff person knows or should know was not provided as claimed, or claims that cannot be substantiated as delivered. This includes presenting or causing to be presented a claim for an item or service that is based on a code that will result in a greater payment to HHSA than the code that is applicable to the service actually provided.

b. Submitting claims for equipment, medical supplies and services that are not reasonable and necessary. A claim for health equipment, medical supplies and/or mental health services that are not reasonable and necessary and are not warranted by a client's documented medical condition. This includes services that are not warranted by the client's current and documented medical condition (medical necessity).

   Medi-Cal: HHSA operates under a federal waiver implementing Medi-Cal SMHS with medical necessity standards defined in the California Code of Regulations, Chapter 11, Title 9, Sections 1820.205 (psychiatric inpatient hospital services), 1830.205 (non-hospital SMHS) and 1830.210 (SMHS for children under 21 years of age). All persons served in mental health must meet the state guidelines for medical necessity.

c. Double billing which results in duplicate payment. Double billing occurs when a person bills for the same item or service more than once or another party billed the Federal health care program for an item or service also billed by HHSA. Although duplicate billing can occur due to simple error, the knowing submission of duplicate claims, which may be

evidenced by systematic or repeated double billing, can create liability under criminal, civil and/or administrative law.

d. Billing for non-covered services as if covered. Submitting a claim using a covered service code when the actual service was a non-covered service. "Necessary" does not always constitute "covered".

e. Knowing misuse of provider identification numbers which results in improper billing. A provider has not yet been issued a provider number so uses another provider's number. Staff need to bill using the correct provider number, even if that means delaying billing until the provider receives the correct provider number.

f. Unbundling (billing for each component of the service instead of billing or using an all-inclusive code). Unbundling is the practice of a provider billing for multiple components of a service that must be included in a single fee. For example, if a client receives Day Treatment services and medication services are included as part of that service, then medication services cannot be billed separately.

g. Failure to properly use coding modifiers. A modifier, as defined by the federal Current Procedural Terminology (CPT) manual 4th edition; the Healthcare Common Procedure Coding System (HCPCS) code; and/or CSI coding manual, provides the means by which a provider can indicate a service or procedure that has been performed.

h. Clustering. Clustering is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period of time (in reality, this overcharges some clients while undercharging others).

i. Up-Coding. Up-coding the level of service provided. Up-coding is billing for a more expensive service than the one actually performed.

j. Claim from an Excluded Provider. A claim for a behavioral health service or other item or service furnished during a period that the provider who furnished the services was excluded from the program under which the claim was made.

### 2. Reasonable and Necessary Services

Claims are to be submitted only for services that staff finds to be reasonable and necessary. Medi-Cal will only pay for services that meet the definition of medical necessity. Staff will be required to document and support the appropriateness of services that have been provided to a client in his/her chart.

### 3. Service Documentation

Timely, accurate and complete documentation is important to clinical client care and an important component of compliance. This documentation also serves as verification that this service was delivered and the claim is accurate as submitted.

One of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation is necessary to determine medical necessity and the appropriate behavioral health treatment for the client and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

For claiming purposes, the client chart is used to validate a) the site of the service; b) the appropriateness of the service provided; c) the accuracy of the claims; and d) the identity of the service delivery staff member.

a. Documentation also assures that the:

   i. Documentation for each encounter includes the reason for the encounter; any relevant history; assessment of clinical impression or diagnosis; plan of care; and date and identity of the provider.

   ii. Diagnostic codes used for claims submission are supported by documentation and the client chart.

   iii. Appropriate health risk factors are identified. The client's progress; his or her response to, and any changes in, treatment; and any revision in diagnosis are documented.

   iv. Documentation includes all necessary components including date; service code; duration of service; location; and signature with title.

   v. Service plans and progress notes are written within time guidelines and meets documentation standards including measurable objectives, signatures and dates.

   vi. Documentation also provides the record for when the case is involved in litigation and provides a means of communication for other providers involved with the case.

b. Timely documentation of progress notes is also essential. HHSA has implemented the following standard regarding documentation of progress notes:

   i. Progress notes should be written on the same day as the service delivery.

   ii. A progress note shall be documented as Late Entry if it is written up to a maximum of five working days after the service delivery. Late Entry progress notes will only be accepted in unusual circumstances.

### 4. Signature Requirements

Signatures are required to provide a minimum level of assurance that the provider is qualified to deliver the level of service being billed. All entries in the client record must include the date of the service, the signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable; and the date the documentation was entered in the client record. The Center for Medicare and Medicaid Services (CMS) accepts a signature other than the provider's personal signature (i.e., electronic equivalent), if the county can satisfy the carrier that proper safeguards are established.

Such safeguards include the following:

   a. Dictated notes are signed by the clinician/doctor dictating the note. Charts/notes requiring a co-signature are hand signed by the supervising clinician and/or other authorized staff as related to their scope of practice standards.

   b. Written guidelines to staff provided in MIS training shall be followed regarding security and logon into clinician workstations.

### 5. Improper Inducements, Kickbacks, and Self-Referrals

Remuneration for referrals is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to federal programs, and result in unfair competition.

Remuneration for referrals can also affect the quality of client care by encouraging staff to order services based on profit rather than the client's best medical interests.

Potential risk factors in this area include:

a. Client referrals to a HHSA employee's private practice;

b. Financial arrangements with outside entities to whom the practice may refer federal reimbursement related behavioral health business (for example, Health Foundation);

c. Joint ventures with entities supplying goods or services to the provider or its clients (for example, medical equipment referrals);

d. Consulting contracts or medical directorships;

e. Office and equipment leases with entities to which the provider refers;

f. Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit;

g. Waiving co-insurance or deductible amounts without a good faith determination that the client is in financial need or failing to make reasonable efforts to collect the cost-sharing amounts:

   i. Inappropriate Emergency Department or Crisis care;
   ii. "Gain sharing" arrangements;
   iii. Physician third-party billing;
   iv. Non-participating physician billing limitations;
   v. "Professional courtesy" billing;
   vi. Rental of physician office space to suppliers; and
   vii. Others.

## 6. Record Retention

Standards and procedures are required regarding the retention of behavioral health compliance, business, and client health records, including electronic records. This system shall address the creation, distribution, retention and destruction of documents. The guidelines shall include:

a. The length of time that HHSA's behavioral health records are to be retained.

b. Management of the chart including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption and/or damage.

c. The destruction of the charts after the legal period of retention has expired.

## 7. Auditing and Monitoring Activities

The Compliance Officer, in conjunction with the Compliance Committee and the QM Program, will conduct routine audits of client charts, service utilization and cost data, and Medi-Cal Denial reports to assess the level of compliance to the above standards.

For more information on these activities of these groups and the auditing and monitoring activities, please see HHSA PP 5-4-008 *Oversight of the Behavioral Health Compliance Program* and HHSA PP 5-4-010 *Auditing and Monitoring Activities*.

# VI. Conducting Appropriate Training and Education

Compliance education and training is an important component of the Compliance Program. All HHSA behavioral health employees are expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his or her duties and how to obtain the requisite information in order to perform those duties in a manner consistent with legal, regulatory, HHSA and County requirements. The Compliance education and training seeks to assist behavioral health employees with this expectation and is mandatory. Behavioral Health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA or the County may be subjected to progressive disciplinary action up to and including termination.

1. The Compliance Officer shall be responsible for developing, implementing, evaluating, and maintaining a compliance-training program for the Compliance Program for behavioral health employees. The Compliance Officer may consult with or obtain assistance from HHSA Human Resources, the Compliance Committee, the QM Program, or other available resources, as needed.

2. Participation in Compliance Trainings shall be tracked via sign-in sheets; via online software applications, or via the Compliance Training log maintained by the Compliance Officer. This log provides information on the date of the training, names of attendees, type and topics of training, location of the training, trainer's name(s), duration of the training.

3. Annual Training: Annually, behavioral health employees will be expected to attend a compliance training in person or online, if available. New behavioral health employees are trained as soon as practicable after their start date and all behavioral health employees receive refresher training on an annual basis, or as appropriate. Training topics may include, but are not be limited to:

    a. The elements of an effective compliance program.

    b. The false claims act and non-retaliation provisions.

    c. Appropriate behaviors in the work place.

    d. How to report an alleged compliance violation.

4. Ongoing Trainings: Periodically, the completion of additional trainings may be necessary to reduce audit exceptions and/or risk to HHSA. For example, an audit or monitoring tool may expose an area of weakness within the HHSA behavioral health programs and a training will be conducted to reduce future risk in that area.

5. Training Efficiency: Surveys, testing, or email vignettes may be used to measure the effectiveness of the training sessions.

6. Ongoing Communication: To regularly communicate new compliance information and to assure that behavioral health employees receive the most recent information, the Compliance Officer, Compliance Committee or the QM Program will utilize the following communication mechanisms:

    a. Internal Memos;

    b. Informational notices,

c. E-mail;
d. Ongoing trainings;
e. Other reasonable methods.

7. Training for the Compliance Officer: HHSA will dedicate resources to provide ongoing training for the Compliance Officer. Trainings may include but are not limited to attendance at topically relevant training conferences, organizational meetings regarding compliance, and/or webinars.

# VII. Identifying and Responding to Detected Offenses and Developing Corrective Action Initiatives

Upon receipt of a report or reasonable indications of suspected non-compliance, including reported fraud, waste, abuse, misconduct or other violations, the Compliance Officer will investigate the allegations to determine whether a violation of applicable law or the requirements of the Compliance Program has occurred. If so, a corrective action plan will be developed to correct and mitigate the compliance issue. This includes reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste and abuse.

Each behavioral health employee is expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his/her duties, and/or how to obtain the requisite information pertinent to performing his/her duties, in a manner consistent with legal, regulatory, and departmental requirements. Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA or the County may be subjected to progressive disciplinary action up to and including termination.

## 1. Investigations

a. The Compliance Officer may initiate an investigation of an alleged compliance violation based on information from one of several sources:
   i. Employee reports via the Compliance Officer, or a supervisor;
   ii. Fraud hotline complaints;
   iii. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations;
   iv. Routine audits and self-assessments;
   v. Monitoring activities that may detect such warning indicators as the number and/or types of claim rejections, challenges to medical necessity, and/or high volumes of unusual charge or payment adjustment transactions;
   vi. State chart disallowances;
   vii. Any other sources of information that become available.

b. The Compliance Officer will log the investigation in the Compliance Log and report the incident to the Compliance Committee.

c. The investigation may include staff interviews, review of relevant compliance documents, and regulations and/or the assistance of external experts, auditors, etc.

## 2. Corrective Action

If an investigation yields valid evidence of non-compliance, the Compliance Officer, in coordination with the Compliance Committee, will develop a plan of correction to address the violation. As determined by the type of violation, the corrective action may include:

a. Development of internal changes in policies, procedures, and/or the Compliance Program;
b. Re-training of staff;
c. Internal discipline of staff;
d. The prompt return of any overpayments;
e. Suspension of payments to any provider for which there is a credible allegation of fraud.
f. Reporting of the incident to the DHCS and any other appropriate state or federal agency;
g. Referral to law enforcement authorities if appropriate; and/or

h. Other corrective actions as deemed necessary.

## 3. Feedback to Staff

As appropriate, the Compliance Officer, in coordination with the Compliance Committee or the QM Program Supervisor, will notify appropriate staff of the results of the investigation and inform them of the corrective actions needed. The Compliance Officer will document this notification in the Compliance Log.

## 4. Follow-Up

Subsequent investigations may be conducted to determine if corrective action has been followed by the appropriate staff member(s). If the subsequent investigation indicates that corrective action was not taken or the magnitude of the non-compliance issue cannot be remedied through a plan of correction, staff may be subject to disciplinary action and/or the case may be sent to the Federal Office of the Inspector General (OIG) to be reviewed for possible civil and criminal action. Please see *Disciplinary Guidelines* HHSA PP 5-4-014.

## 5. Documentation

Documentation of violation investigations and results will be maintained by the Compliance Officer in the Compliance Log. Information from the Compliance Log will be summarized, and system level issues will be reviewed with the Compliance Committee. on a quarterly basis.

The Compliance Log contains the following materials:

a. The Behavioral Health (BH) Compliance Issue Number

b. The date or general time period in which suspected non-compliant action(s) occurred;

c. The date or general time period in which suspected non-compliant action(s) were discovered;

d. Source of the allegation (via direct or anonymous contact with the Compliance Officer, routine audit, monitoring activities, etc.);

e. Name of the behavioral health provider or employee(s) involved;

f. Name of the client(s) or chart number(s) involved;

g. Issue description with specific information regarding the nature of the allegation, including supporting reference materials, etc.;

h. In the event that the non-compliant actions require a Privacy Incident Report (PIR) be made to the State, the following information will be logged as well: State Investigation Number, Date incident was reported to the State: Submission date of the Initial PIR Form; Submission date of the Final PIR Form; Date the Investigation was closed by the State;

i. Additional Information re the incident;

j. The corrective action plan;

k. Name of the person responsible for following up, if appropriate; and

l. Final Disposition.

6. **Notification to DHCS When HHSA Receives Notification About Changes in a Beneficiary's Eligibility or a Network Provider's Eligibility**

   a. If HHSA becomes aware of changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including changes in the beneficiary's residence or the death of the beneficiary, the MHP will immediately contact the HHSA Service Centers Branch to correct the Medi-Cal Eligibility Data System (MEDS).

   b. If HHSA becomes aware of changes in a network provider's circumstances that may affect the provider's eligibility to participate in the Medi-Cal SMHS program, including the termination of the provider agreement, HHSA will discontinue the provider's certification to participate in the Medi-Cal specialty mental health services program and transmit the change to the appropriate entity within DHCS. If any overpayments were made to the provider, HHSA will promptly return any overpayments. If fraud, waste or abuse is suspected HHSA will utilize the procedures described above.

7. **Disclosures of Ownership, Control and Relationship Information**

   a. Disclosure of 5% or More Ownership Interest:

      i. HHSA will collect the disclosure of ownership, control, and relationship information from its providers and managing employees, including agents and managing agents. *Agent* means any person who has been delegated the authority to obligate or act on behalf of a provider.

         - The Compliance Officer will ensure that all providers and managing employees complete the Disclosure of Ownership and Control Interest Statement required by DHCS for Medi-Cal providers. The Compliance Officer will verify disclosure of ownership, control and relationship information from individual providers, agents, and managing employees.

         - The Compliance Officer is responsible to monitor and obtain the required information from their contracted providers, regardless of for-profit or non-profit status.

         - Medicaid managed care entities must disclose certain information related to persons who have an ownership or control interest in the managed care entity. Since Yolo County is a political subdivision of the State of California, there are no persons who meet such definition and therefore there is no information to disclose.

         - In the event that, in the future, any person obtains an interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by the MHP, and that interest equals at least 5% of MHP's property or assets, then the MHP will make the disclosures set forth in subsection ii., below.

      ii. All organizational and network providers subcontracting with HHSA to furnish SMHS are required to submit the disclosures below to HHSA regarding the providers' (disclosing entities') ownership and control. The providers are required to submit updated disclosures to HHSA upon submitting the provider application, before entering into or renewing contracts with HHSA, within 35 days after any change in the provider's ownership, annually and upon request during the provider certification and re-certification process.

- Disclosures to be Provided:
    - The name and address of any person (individual or corporation) with an ownership or control interest in the organizational or network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
    - Date of birth and Social Security Number (in the case of an individual);
    - Other tax identification number (in the case of a corporation with an ownership or control interest in the provider with a 5 percent or more interest);
    - Whether the person (individual or corporation) with an ownership or control interest in the provider is related to another person with ownership or control interest in the same or any other organizational or network provider of HHSA as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the with a 5 percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling;
    - The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and
    - The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

iii. Disclosures Related to Business Transactions - Providers must submit disclosures and updated disclosures to the HHSA or DHCS including information regarding certain business transactions within 35 days, upon request. The following information must be disclosed:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

iv. For each HHSA organizational or network provider, HHSA must provide DHCS with all disclosures before entering into a contract with the provider and annually thereafter and upon request from DHCS during the provider certification or re-certification process.

b. Disclosures Related to Persons Convicted of Crimes

i. HHSA will require providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints. This requirement will be enforced through contracts with all providers and monitored by the Compliance Officer.

ii. HHSA will terminate the provider certification and Medi-Cal enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required in CFR, title 42, section 455.416.

iii. HHSA will deny or terminate provider certification Medi-Cal enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's

involvement with the Medicare, Medicaid, or title XXI program in the last 10 years.

iv. HHSA will submit the following disclosures to the DHCS regarding the Contractor's management:

- The identity of any person who is a managing employee of HHSA or a provider who has been convicted of a crime related to federal health care programs.
- The identity of any person who is an agent of HHSA or a provider who has been convicted of a crime related to federal health care programs.

v. HHSA shall supply the disclosures before entering into the MHP contract and at any time upon DHCS' request.

vi. HHSA will require organizational and network providers to submit the same disclosures to HSSA regarding the network providers' owners, persons with controlling interest, agents, and managing employees' criminal convictions. Providers must supply the disclosures before entering into the contract and at any time upon HHSA or DHCS' request. These requirements will be monitored by the Compliance Officer.

# VIII. Developing Open Lines of Communication / Reporting Suspected Compliance Violations

HHSA has developed a system for behavioral health employees to report suspected compliance violations directly to the Compliance Officer ("Compliance Officer"), allowing for easy, direct access to a source to receive behavioral health employee concerns. This process creates an open-door policy for reporting possible misconduct to the Compliance Officer and evidences the commitment of HHSA to successfully implement and monitor the Compliance Plan.

All HHSA behavioral health employees are expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his or her duties and how to obtain the requisite information in order to perform those duties in a manner consistent with legal, regulatory, HHSA and County requirements. Behavioral Health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA or the County may be subjected to progressive disciplinary action up to and including termination.

1. **Open Communication**

   HHSA is committed to the success of the compliance process. An important component of the Compliance Program is to provide staff with open lines of communication for reporting suspected fraudulent activity, as well as to provide access to compliance information when needed.

   To ensure this standard, HHSA has determined that the Compliance Officer may be contacted directly by staff to report activity that may violate the ethical and legal standards and practices of the Compliance Program. Staff is also encouraged to seek guidance from the Compliance Officer if they are unsure about whether they are following the compliance policies and procedures correctly, if they need additional training, or if they have specific concerns or questions about the Compliance Program.

2. **Reporting Suspected Violations of the Compliance Program and the Behavioral Health Code of Conduct**

   Per federal regulations and HHSA requirements, behavioral health employees must report behavior that a reasonable person would, in good faith, believe to be erroneous or fraudulent. These activities may include, but are not limited to, the following:

   a. Violations of standards surrounding coding and billing; medical necessity criteria; service documentation; signature requirements; and improper inducements, kickbacks, and self-referrals. Please refer to *Standards for Risk Areas and Potential Violations* HHSA PP 5-4-011 for specific information on these standards.

   b. Violations of ethical standards as outlined in the *Code of Conduct*.

3. **Methods of Reporting Suspected Fraud or Misconduct**

   HHSA has developed simple methods for staff to report violations of the Compliance Program directly to the Compliance Officer. Reports may be made anonymously via the Compliance Hotline or in writing. Staff may also contact the Compliance Officer in person, by regular phone, mail, or via email. Whenever possible, strict confidentiality will be maintained.

4. **Non-Retaliation**

   As evidence of HHSA's commitment to this reporting process, staff will not be subject to

retaliation for reporting suspected misconduct or fraud.

5. **Confidentiality**

   The Compliance Officer will maintain the anonymity of persons reporting possible erroneous or fraudulent behavior. However, there may be certain occasions when a person's identity may become known or may need to be revealed to aid the investigation or corrective action process.

6. **Documentation of Reports of Suspected Fraud or Misconduc**t

   Documentation of violation investigations and results will be maintained by the Compliance Officer in the Compliance Log. Information from the Compliance Log will be summarized, and system level issues will be reviewed with the Compliance Committee, on a quarterly basis.

# IX. Enforcing Disciplinary Standards through Well-Publicized Guidelines

All behavioral health employees are expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his or her duties, and how to obtain the requisite information pertinent to performing his or her duties, in a manner consistent with legal, regulatory, HHSA and County requirements. Behavioral health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of HHSA may be subjected to progressive disciplinary action up to and including termination.

New behavioral health employees, and all behavioral health employees on an annual basis, are required to sign a signature page stating their understanding of the professional conduct expectations outlined in the Behavioral Health Code of Conduct.

The HHSA Behavioral Health Compliance Plan clearly outlines consistent and appropriate sanctions for compliance violations while, at the same time, is flexible enough to account for mitigating or aggravating circumstances. The range of disciplinary actions that may be taken follow the guidelines of the Yolo County Code of Ordinances Title 2, Chapter 6- Personnel Merit System and Labor Relations Memorandums of Understanding (MOUs), as they apply.

1. The HHSA disciplinary action plan for compliance issues is based on the Yolo County Code of Ordinances Title 2, Chapter 6- Personnel Merit System; any relevant County or HHSA policies and procedures; and the applicable MOU, if any, based on the status of the employee. The following Labor Relations MOUs may apply to a behavioral health employee based on their employment classification with the County.

    a. Memorandum of Understanding between County of Yolo and Yolo County Stationary Engineers, Local 39 (General Unit),
    b. Memorandum of Understanding between County of Yolo and Yolo County Supervisor and Professional Employee's Association
    c. Memorandum of Understanding between County of Yolo and Yolo County Management Association.

    Complete copies of the MOUs are available to employees on the Yolo County Human Resources webpage. If you have issues locating an MOU please contact the Compliance Officer or HHSA Human Resources, for assistance.

2. When an alleged compliance violation has been discovered, corrective action shall be taken. The Compliance Officer, in coordination with the Compliance Committee, will develop a plan of correction to address the alleged violation. As determined by the type of violation, the corrective action plan may include:

    a. Development of internal changes in policies, procedures, and/or the Compliance Program;
    b. Re-training of staff;
    c. Internal discipline of employees;
    d. The prompt return of any overpayments;
    e. Suspension of payments to any provider for which there is a credible allegation of fraud.
    f. Reporting of the incident to the State Department of Health Care Services and any other appropriate state or federal agency;
    g. Referral to law enforcement authorities if appropriate; or

h. Other corrective actions as deemed necessary.

3. The following items represent a range of areas that may constitute cause for disciplinary action of a behavioral health employee. This is not a comprehensive list and is not intended to replace the range of areas identified in Yolo County Code of Ordinances Title 2, Chapter 6- Personnel Merit System; any relevant County or HHSA policies and procedures; and any applicable MOU:

   a. Falsifying personnel records or County records or providing false information concerning employment qualifications;
   b. Incompetence;
   c. Inefficiency;
   d. Fraud;
   e. Waste;
   f. Repeatedly failing to detect or report violations;
   g. Inexcusable neglect of duty;
   h. Willfully disobeying a reasonable order or refusal to perform the job as required (insubordination).

4. Internal Disciplinary Actions: The range of disciplinary actions that HHSA can use to discipline a behavioral health employee include:

   a. written reprimand;
   b. disciplinary transfer;
   c. disciplinary suspension with pay;
   d. suspension without pay;
   e. reduction in pay;
   f. Demotion; or
   g. Discharge (termination).

5. Federal Guidelines for Compliance Violations as per the Department of Health and Human Services Office of the Inspector General (OIG)

   Employees who have been informed of non-covered services or practices, but continue to bill for them, or staff whose claims must consistently be reviewed because of repeated over-utilization, repeated late entries, or other practices of concern, could be subjected to administrative actions, as outlined by federal guidelines.

   These actions include suspension from participation in the Medi-Cal/Medicare programs and assessment of a civil monetary penalty. This penalty could be between $10,781.40 and $21,562.80 for each false or improper item or service claimed, in addition to an assessment of up to three times the amount falsely claimed. (See 31 U.S.C. 3729(a) & 28 C.F.R 85.3(a)(9).)

   Subsequent investigations may be conducted to determine if corrective action has been followed by the appropriate employees. If the subsequent investigation indicates that corrective action was not taken, responsible staff may be subject to disciplinary action and/or the case may be sent to the federal Office of the Inspector General to be reviewed for possible civil and criminal action.

   Healthcare professionals convicted of program-related crimes after December 4, 1980, will be suspended from participation in the Medi-Cal/Medicare programs.