LSU HEALTH CARE SERVICES DIVISION
BATON ROUGE, LOUISIANA

POLICY NUMBER:	8516-23
CATEGORY:	Compliance
CONTENT:	Compliance Plan
APPLICABILITY:	This policy applies to employees of the Health Care Services Division Administration (HCSDA) and Lallie Kemp Medical Center (LKMC); including classified, unclassified, students, volunteers, and any other persons having an employment or vendor relationship with the agency.
EFFECTIVE DATE:	Issued: February 22, 2022 Reviewed: December 5, 2023
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Note: Approval signatures/titles are on the last page

LSU HEALTH CARE SERVICES DIVISION
COMPLIANCE POLICY

I. STATEMENT OF POICY

It is the Health Care Services Division (HCSD) Compliance Program mission to establish a culture within the organization that promotes prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payer health care program requirements, as well as the organization's ethical and business policies. The Compliance Program demonstrates HCSD's commitment to the compliance process and provides a guide to the organization's managers, employees, and third party contractors, in the efficient management and operations of the organization.

It is understood that it is the responsibility of the organization's senior officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct through the organization's policies and the application of the Compliance Program.

The Compliance Program will also serve as a central coordinating mechanism for furnishing and disseminating information and guidance on applicable federal and state statutes, regulations, and other requirements.

<u>Note:</u> Any reference herein to Health Care Services Division (HCSD) also applies and pertains to Lallie Kemp Medical Center (LKMC)

II. IMPLEMENTATION

This policy and subsequent revisions to the policy shall become effective upon approval and signature of the HCSD Chief Executive Officer or Designee.

III. HCSD COMPLIANCE STRUCTURE

The organization's Compliance Program was instituted by a formal resolution and stated commitment by the Louisiana State University Board of Supervisors. It is the responsibility of the HCSD's Chief Executive Officer (CEO) to ensure the functions of the Compliance Program are implemented. The Compliance Liaison Officer (CLO), appointed by the CEO, provides the immediate oversight of the organization wide Compliance Program. The CEO and HCSD management are ultimately responsible for ensuring the Compliance Program is active and effective. Department managers of high-risk departments work in tandem with the CLO to perform various functions of the compliance program.

The CLO and HCSD management are responsible for ensuring, that at a minimum, the facility Compliance Program includes:

A. The development and distribution of written standards of conduct, as well as written policies and procedures that promote the HCSD's commitment to compliance and that address specific areas of potential fraud.

B. The development and implementation of regular, effective education and training programs for all employees.

C. The maintenance of a process to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

D. The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated established policies.

E. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

F. The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

G. The performance of a periodic enterprise wide risk assessment to determine potential areas of weakness that needs to be formally addressed.

HCSD is a part of the LSU Health Sciences Center – New Orleans ((LSUHSC-NO). The CLO has direct access to the Chancellor of LSUHSC-NO and the Louisiana State University Board of Supervisors. This reporting structure ensures that the CLO has access to all officers who make operational decisions that affect the organization.

IV. WRITTEN COMPLIANCE POLICIES AND PROCEDURES

The Compliance Program requires the development and controlled distribution of written compliance policies that identify the specific areas of risk to the organization.

Compliance policies will include, at a minimum, the following categories:

A. Code of Conduct/Rules of Conduct

HCSD has established a Code of Conduct that is to be followed by all HCSD facilities. The Code of Conduct provides guiding standards for the

decisions and actions of personnel of HCSD. HCSD has also established Rules of Conduct for all employees that include a clearly delineated commitment to compliance by HCSD's senior management and its divisions, including affiliated providers operating under the HCSD's control, to include physicians and other health care professionals. These rules of conduct articulate the HCSD's commitment to comply with all federal and state standards, with an emphasis on preventing fraud and abuse. The rules of conduct will be regularly updated as applicable statutes, regulations and federal health care program requirements are modified.

B. Risk Areas

Departmental and organization wide policies, procedures or processes take into consideration the regulatory exposure for the various functions of the organization. Risk areas may change periodically depending on the federal and state government's focus. It is the responsibility of the CLO to monitor any changes in the federal and state government's focus or the operations of the organization that would necessitate a change in the potential risk areas for the organization.

C. Retention of Records

The organization has a record system related to the creation, distribution, retention, storage, retrieval and destruction of documents, including clinical and medical records and claims documentation, as well as all records necessary to protect the integrity of the organization's compliance process.

D. Compliance as an Element of a Performance Plan

The promotion of and the adherence to the elements of the Compliance Program should be considered in evaluating the performance of managers, supervisors, and employees. This includes the distribution of compliance related policies, adequate training of employees regarding these policies, and strict adherence to the policies. The manager or supervisor must make clear that the organization may take disciplinary action against any employee or contract service provider up to and including termination for violation of these policies depending on the regulations governing the particular entity (i.e., civil service and contractual agreements).

E. Health Information Portability & Accountability Act (HIPAA), American Recovery and Reinvestment Act (ARRA), and HIPAA Omnibus Rule

This legislation provides for a wide array of regulations impacting health care coverage and delivery. The Compliance Program focuses on the

HIPAA provisions of Privacy and Security, ensuring that patients' protected health information is protected against unauthorized use or dissemination, as well as ensuring that patients have greater control over their healthcare information.

F. Deficit Reduction Act (DRA)

The DRA gives the states a significant economic incentive to adopt laws that model the federal False Claims Act. It has also transformed the nature of compliance programs from voluntary to mandatory, requires communication of fraud abuse and prevention policies to employees and contractors, and provides for non-retaliation provisions for those who are whistleblowers.

V. DESIGNATION OF COMPLIANCE OFFICERS AND A COMPLIANCE COMMITTEE

A. Compliance Liaison Officer

HCSD has designated a Compliance Liaison Officer (CLO) for the organization wide implementation and monitoring of the Compliance Program. The CLO is not encumbered in any way in investigating potential compliance problems. The CLO has the authority to access and review all documents and other information that is relevant to compliance activities. The CLO reports compliance issues and activities to the HCSD Chief Executive Officer. The CLO may also report concerns directly to the HCSD Chief Medical Quality Officer, HCSD Chief Medical Informatics Officer, or higher, if satisfactory resolution of the issue is not obtained.

B. Department Compliance Representative

Many HCSD departments have a designated Department Compliance Representative (DCR) for the department's specific implementation and monitoring of the Compliance Program. In most instances, the DCR is the department manager. The DCR coordinates compliance measures in their department and reports any issues or concerns to the CLO. The following departments will be required to designate a Department Compliance Representative:

1. Finance
2. Cost Reporting
3. Procurement/Contracts
4. Medical Records
5. Human Resources
6. Telemedicine
7. Informatics

8. Health Care Effectiveness

VI. COMPLIANCE TRAINING AND ONGOING EDUCATION

The proper education and training of corporate officers, managers and employees, and the continual retraining of current personnel at all levels, are significant elements of an effective compliance program. Therefore, HCSD requires employees and contracted personnel to participate in training and ongoing education of significant compliance issues. Failure to meet the standards established by the organization for such training and education may result in disciplinary action, up to and including termination from employment or revocation of contracts.

A. Compliance Training

1. New Hire Orientation

All new hire employees are required to complete compliance orientation that includes specific training in compliance. New hires must complete orientation within 60 days, but preferably within 30 days of hire. The only exceptions to this requirement must come with the permission of the senior management for a postponement of the training.

2. Annual Re-orientation

All employees are required to complete mandatory re-orientation on an annual basis. Re-orientation includes compliance training.

3. Contracted employees

All individually contracted clinical employees must complete an initial orientation that includes compliance training within 45 days of the initiation of the contract. Contracted clinical employees must complete re-orientation to compliance issues on an annual basis. Contracted clinical service providers that act as an entity may review written materials to satisfy these education requirements.

B. Ongoing Training

In addition to new hire and annual re-orientation, the organization and specific departments may provide ongoing training related to compliance issues. Such training may take the form of:

1. Changes in organization policy or procedure due to special fraud alerts, or state or federal policy or changes in federal or state laws and regulations. Any significant changes in policy require the organization/department to scrutinize their policies and procedures and make changes if necessary. The department(s) affected should provide a formal training of the changes in policy/procedure, document that training through sign in sheets and copies of the materials reviewed, and store that documentation in a secure place.
2. Periodic professional education courses that may be offered or required by statute and regulation for certain facility personnel. Attendance should be documented and that documentation retained.
3. Risk areas that were identified through compliance auditing and/or performance improvement activities of the organization.

If there is an organization process/function under focus because it is a compliance risk, then ongoing training should be provided to those individuals who are involved in that process/function. Periodic or sustained monitoring should occur by the DCR to ensure policies and procedures covered in ongoing training is being uniformly applied in the department. Such monitoring efforts should be fully documented, including any Remediation measures efforts should be fully documented, including any remediation measures taken if it is determined that such policies and procedures are not being followed.

VII. EMPLOYEE/CONTRACTOR/PATIENT ACCESS TO THE COMPLIANCE PROGRAM

An open line of communication between the CLO and organization personnel is vital to the successful implementation of a Compliance Program and the reduction of any potential for fraud, abuse, and waste. Therefore, there are multiple avenues for communication that any employee, contracted entity, or patient may use to access the CLO.

A. Avenues of Communication

1. Compliance Access Line (CAL)

A telephone compliance access line is available to all employees, contracted services, medical staff members, and patients to report any concerns or receive clarification on compliance issues. The individual(s) contacting the compliance access line may do so anonymously or confidentially and the individual will be protected against any retaliation as a result of reports of compliance issues whether or not he/she chooses to remain anonymous. The compliance access line is answered at the HCSD level. The

compliance access line phone number and the CLO's phone number will be posted throughout the organization for easy access to all employees and contracted services.

2. Direct Contact with the CLO

The CLO will be available by telephone, e-mail, regular mail, or appointment. Those contacting the CLO will always have the option of anonymity or confidentiality.

3. LSU Ethics, Integrity, and Misconduct Helpline (EthicsPoint)

An online reporting website is available to those who wish to contact the LSU System to report a compliance or ethics issue. The LSU Systems Office, Department of Internal Audit, maintains the site. The CLO has the ability to sign into the site to review and document any compliance concerns reported through EthicsPoint.

B. Documentation of Contacts

Contacts initiating access to the Compliance Program between employees, contracted service providers, and others, and the Compliance Program (either the compliance access line or the CLO) will be documented. Such documentation will be kept in a secure area and will be kept as a confidential document. Only the CLO has the authority to give other organization employees clearance to review the data in any specific case.

C. Limited Confidentiality

When someone contacts the Compliance Program, it must be made explicitly clear that every effort will be made to ensure the anonymity or confidentiality of the individual if it is requested. However, the individual must understand that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Such understanding should be documented in the record after limited confidentiality is explained.

In addition, civil service regulations provide that employees facing disciplinary action have the right to face their accuser. Therefore, limited confidentiality applies in cases related to classified civil service positions.

VIII. ENFORCING STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The Compliance Program will only be as effective as the enforcement of the policies and procedures in the Compliance Plan. Each employee and contractor will be held strictly accountable for adherence to these policies and procedures. To ensure that all such individuals understand what is expected of them, and to ensure that disciplinary action is consistent and uniform, HCSD has established a Code of Conduct

The Code of Conduct is disseminated to all employees and contractors. Employees will receive a copy of the Code of Conduct and will be required to sign an attestation of its receipt. The original attestation of the Code of Conduct will be placed in the employee's permanent file. The employee or contracted service provider will be disciplined according to the guidelines applicable to the individual (i.e. civil service regulations or contractual agreements).

Any significant changes to the Code of Conduct will require a written or electronic attestation indicating that the employee has received that information.

Managers and supervisors will be required to enforce the Code of Conduct or be faced with possible disciplinary action for failure to fulfill their managerial duties.

As part of the hiring or contracting process, the facility will conduct a reasonable and prudent background investigation, including reference checks, disclosure of any criminal conviction on the employment application, and a check to determine if the prospective employee has been excluded from participation in federally funded healthcare programs or is on the state of Louisiana exclusion list. Any current employee or contractor who cannot pass this background check at any time during their employment may be subject to possible termination of employment or contract.

IX. REVIEWING AND MONITORING

To ensure the organization is meeting the compliance standards established, a systematic, consistent reviewing and monitoring process has been established.
This process includes:

A. Department Monitoring

Each department noted in Section V. of this document will be responsible for monitoring compliance issues through the Department Compliance Representative. Areas for monitoring will be decided upon by the individual department, with guidance from the CLO. Each department will use the information of the department monitoring to correct any

operational deficiencies and educate department employees about the execution of compliance oriented policies and procedures. This information shall be presented to the CLO and HCSD management on a predetermined schedule, including documentation of the performance improvement steps taken to resolve any deficiencies and the education of employees.

B. Organizational Reviews

The CLO may conduct independent reviews of key compliance risk areas as needed. Factors such as perceived problem areas in high-risk departments, and focus areas of the OIG Work Plan will be considered when determining the need for such reviews.

Results of the review will be reviewed with the Department Manager and the DCR. Any deficiencies that may be found in the review may require a corrective action plan within fifteen (15) days of the receipt of the review results.

Executive Staff will review results of the review as well as the corrective action plan.

C. Special Alerts and Changes in Federal, State, or Fiscal Intermediary Policy

Federal, state, and fiscal intermediary policies and statutes are constantly changing and therefore it is vital for the facility to keep abreast of any such changes so that the facility remains in compliance. Therefore, it is the responsibility of the CLO to disseminate any such information to the affected departments and to evaluate the changes to determine whether the change necessitates any immediate action by the organization.

It is the responsibility of the Department Manager to ensure that any current practices that violate the changes in policy are immediately addressed; make any necessary changes in the organization/department policies and procedures; educate all affected employees and contracted personnel; and monitor the department to ensure that the necessary changes are consistently implemented.

X. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

A. Violations and Investigations

Violations of an organization's compliance program, failures to comply with applicable federal or state law, and other types of misconduct

threaten an organization's status as a reliable, honest and trustworthy provider capable of participating in federal and state health care programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the organization. Consequently, upon reports or reasonable indications of suspected noncompliance, it is vital that the CLO or other management officials initiate prompt steps to investigate the conduct in question to determine whether or not a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem.

Upon discovery of a violation, or a report of a violation to the Compliance Department, the CLO or her designee will begin an investigation using the **Compliance Investigation Worksheet,** or a document that has the components of that worksheet. The worksheet provides a format for the systematic investigation of any reported violations, including resolving any actual violations. The investigation of a potential violation should begin no later than five (5) business days from the time of the report barring any unforeseen circumstances, but every effort will be made to begin the investigation immediately upon receipt.

In an internal compliance investigation, the CLO will coordinate, and in many cases conduct the investigation. If any additional personnel are needed to conduct the investigation, the CLO has the authority to appoint such individuals. The investigation may include interviews of employees and contracted services, as well as review of relevant documents. If the violation is in an area beyond the scope of organization employees and the CLO, outside counsel, auditors, or health care experts may be brought in to assist in the investigation.

If an investigation of an alleged violation is undertaken and the CLO believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those subjects may be removed from their current work activity until the investigation is completed, according to the policies of HCSD, including civil services regulations. In addition, the CLO will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

All investigations will be conducted in such a manner as to protect the identity of the individual who brought the violation to the attention of the Compliance Program, unless the individual waives that right. Any individual who brings compliance issues to the attention of the Compliance Program will be protected from retaliation by senior management, their supervisor, and other facility employees.

The CLO will follow any open investigation until the alleged violation is proven false, or the violation is found to be true and resolved. All records concerning the investigation will be maintained for seven (7) years in a secured file.

B. Corrective Action

If an investigation shows that there are areas that are in need of corrective action, the CLO ensures that the appropriate departments and/or individuals develop a plan of correction and successfully implement that plan.

1. System or department deficiency

Any system or departmental corrective action plan must designate the planned corrective action, the date that the corrective action will be implemented, who is responsible for implementing and monitoring the corrective action, and the final evaluation of the effectiveness of the corrective action plan. Any educational efforts should also be documented. If warranted, the corrective action will be added to the ongoing auditing processes of the department(s) involved and/or the facility wide audit process.

2. Individual Performance Deficiency

If the compliance deficiency is related to poor individual performance, the individual's supervisor is responsible for recommending a course of action to correct the deficiency, which may include disciplinary action up to and including termination. All employees and contracted service providers will be required to adhere to compliance policies and procedures, as noted in their job description or contract. All employees and contracted service providers will have access to the facility wide and departmental Compliance Plans and their related policies and procedures so that there is no question as to what is expected of them from a compliance standpoint.

C. Reporting

If the CLO, Compliance Committee, or management official discovers credible evidence of misconduct from any source, and, after a reasonable inquiry has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the facility should promptly report the existence of misconduct to the HCSD Chief Executive Officer. The Chief Executive Officer, or designee, will in turn report to the appropriate governmental authority within a reasonable period, but no more than sixty

(60) days after determining that there is credible evidence of a violation. If the CLO does not believe that the reported matter has been handled satisfactorily, the CLO may contact the HCSD Chief Medical Quality Officer, the HCSD Chief Medical Informatics Officer, on through to the LSU Board of Supervisors.

If an overpayment has occurred because of the violation, the organization will make prompt identification and restitution of any overpayment to the affected payer.

XI. MEASURING COMPLIANCE PROGRAM EFFECTIVENESS

The Compliance Program measures its effectiveness in a variety of ways. LSU's Office of Internal Audit periodically performs an independent review of the effectiveness of the compliance program. The HCSD compliance program also periodically issue surveys designed to determine the effectiveness of compliance components. In addition, the biennial compliance risk assessment measures the effectiveness of controls in high-risk areas. Any findings discovered in these methods shall be reported to the HCSD leadership.

XII. EXCEPTION

The HCSD CEO or designee may waive, suspend, change, or otherwise deviate from any provision of this policy deemed necessary to meet the needs of the agency as long as it does not violate the intent of this policy; state and/or federal laws; Civil Service Rules and Regulations; LSU Policies/Memoranda; or any other governing body regulations.

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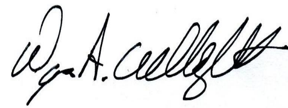

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