

NEW YORK CITY DEPARTMENT OF EDUCATION
MEDICAID COMPLIANCE PLAN

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NEW YORK CITY DEPARTMENT OF EDUCATION

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NEW YORK CITY DEPARTMENT OF EDUCATION MEDICAID COMPLIANCE PLAN

I. INTRODUCTION

The New York City Department of Education ("DOE" or "Department") has adopted this Medicaid Compliance Plan ("Compliance Plan") to achieve compliance with federal and state laws relating to Medicaid billing for the School and Preschool Supportive Health Services Program ("SSHSP") and other programs.

This Compliance Plan applies to all DOE employees, officials, contractors, vendors and agents involved in the provision or claiming of Medicaid eligible services ("Relevant Staff"). As is detailed within this Compliance Plan, it is the duty of all Relevant Staff to comply with the policies as applicable to their individual areas of employment or contracts.

The Eight Elements of an Effective Compliance Plan

As required by the New York State Office of the Medicaid Inspector General ("OMIG"), the Department's Compliance Plan is comprised of the following core elements:

1. Written policies and procedures that describe compliance expectations;
2. A designated compliance officer and compliance committee;
3. Education and training of all affected employees and persons associated with the provider;
4. Communication lines and processes for the reporting of compliance concerns;
5. A system for responding to, investigating, correcting and reporting compliance issues as they are raised;
6. Enforcement and disciplinary policies and procedures to encourage good faith participation in the compliance plan;
7. Monitoring and auditing systems to aid in the routine identification of compliance risk areas; and
8. A policy of non-intimidation and non-retaliation against any person for good faith participation in the compliance plan;

The goal of the Compliance Plan is to ensure that eligible services for which DOE intends to submit claims for Medicaid reimbursement (the "Services") are properly documented and accurately billed. The Compliance Plan describes the Department's procedures to detect and prevent fraud and abuse in connection with the Medicaid program.

The benefits to the Medicaid Compliance Plan include, but are not limited to the following:

- Supports the DOE's strong commitment to honesty, responsibility and appropriate conduct.
- Develops a system to encourage employees to report potential problems that may be detrimental to the DOE and the community at large.
- Develops procedures that allow for a thorough investigation of alleged misconduct.
- Develops procedures for promptly and effectively conducting internal monitoring and auditing which may prevent non-compliance.

- Through early detection and reporting, minimizes the risk to the Department and, thereby, reduces the Department's exposure to any civil damages or penalties, criminal sanctions or administrative remedies.

Appendix I to this Compliance Plan includes information concerning the Federal and State False Claims Acts along with Federal and State laws protecting whistleblowers and providing for criminal and administrative penalties and sanctions in the health care arena.

II. WRITTEN POLICIES AND PROCEDURES

The Department has long had in place general policies and procedures that speak to the standards for employee and contractor conduct. Those standards are, for example, embodied in the Chancellor's Regulations related to conflicts of interest; contract terms targeting service provision and record completion and maintenance, and related service invoices that require certifications as to the validity of the service information upon which the billing is based. The policies and directives contained in this Compliance Plan are not intended to prescribe a specific response to every conceivable situation, but are intended to assist staff and contract providers in recognizing issues and determining an appropriate response as specific situations arise. Whenever a staff person has a question about an appropriate response in a given situation, (s)he should consult his/her supervisor and/or administrator or contract manager.

Medicaid Compliance Code of Conduct

- The Department will submit claims for Medicaid only for services actually rendered and shall seek the amount to which it is entitled.
- The Department does not tolerate claiming practices that misrepresent the services actually rendered.
- Supporting documentation must be prepared and properly retained for all services rendered.
- The Department will submit claims for Medicaid only where the appropriate and required documentation has been prepared.
- An accurate and timely billing and documentation structure is critical to ensure that Department staff can effectively implement and comply with required policies and procedures.
- Demonstrated lapses in the documentation and claiming systems infrastructure should be remedied in a timely manner at the program level with input from the Medicaid Compliance Committee (the "Committee") whenever possible. The Medicaid Compliance Officer must approve all proposed remedies.
- Department staff and vendors are not to falsify documentation for any purposes, including Medicaid claiming.

III. COMPLIANCE PLAN OVERSIGHT AND MANAGEMENT

Compliance Officer

The Department has designated a Medicaid Compliance Officer who is directly responsible to the Chancellor for overseeing the development, implementation, and monitoring of the Department's Medicaid Compliance Plan and ensuring appropriate handling of instances of suspected or known illegal or unethical conduct related to Medicaid claiming.

Duties of the Medicaid Compliance Officer include but are not limited to:

- Overseeing and monitoring the development and implementation of the Medicaid Compliance Plan;
- Maintaining the effectiveness of the Medicaid Compliance Plan;
- Establishing methods such as conducting periodic reviews of the Department's compliance with the current Corrective Action Plans and the State Plan Amendment, developing effective lines of communication on compliance issues and preparing written standards and procedures that reduce the Department's exposure to fraud and abuse;
- Periodically revising the Medicaid Compliance Plan to reflect changes in the needs of the organization, the law or policies and procedures of the government;
- Developing, coordinating and implementing a training and education program that focuses on the components of the Medicaid Compliance Plan and seeking to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards and that contractors, independent service providers, consultants and others who furnish school health services to the Department's students are aware of the requirements of the Compliance Plan;
- Providing guidance to management, program personnel and appropriate departments relative to compliance matters;
- Developing procedures for checking the status of all Relevant Staff against applicable government exclusion lists.
- Reporting on a regular basis to the Chancellor/designee and the Committee on the implementation of the Compliance Plan, any investigations and necessary corrective actions;
- Conducting an annual assessment of the success and effectiveness of the Compliance Plan by reviewing internal and external audits, reviews, investigations, reports, and the Compliance Officer's personal experiences with the functioning of the Compliance Plan, and submit a summary of the assessment to the Chancellor/designee and the Compliance Committee;
- Consulting, as necessary, with the New York State Office of Medicaid Inspector General, the New York State Department of Health Medicaid Compliance Officer, the

City's Special Commissioner of Investigation, internal and external investigative and auditing offices, and outside law enforcement agencies.

Compliance Committee

In fulfilling its commitment to develop and operate an "effective" Compliance Plan, the Department has established the Medicaid Compliance Committee, the members of which are high-level managers representing operational and programmatic offices. Subject to reorganization and changes in job titles or functions, the Committee will consist of representatives from the following divisions:

- Division of Financial Operations
- Office of Legal Services
- Office of the Auditor General
- Division of Human Resources
- Division of Capital Budgeting and Financial Planning
- Division of Students with Disabilities and English Language Learners
- Division of School Support Services

In addition to addressing the matters identified below, the Compliance Officer will keep the Committee informed of matters that the Compliance Officer is responsible for investigating and referring for disciplinary action or review by an external agency.

The Compliance Officer will schedule and chair Committee meetings which will be held on a quarterly basis. The Compliance Officer may request that the Committee convene outside its regular schedule if a situation arises that necessitates disclosure to and/or consultation with the Committee. In addition, the Compliance Officer may convene *ad hoc* or special subcommittees or task forces to deal with specific topics. All activities of these subcommittees shall be reported to the Committee at its full meetings.

The role of the Committee includes, but is not limited to:

- Assessing the impact of current and future Medicaid Regulations on the Department's day to day operations;
- Working with the Medicaid Compliance Officer to develop any necessary changes for compliance;
- Ensuring that Medicaid compliance is occurring throughout the Department;
- Recommending solutions to barriers that may exist in the successful implementation of compliance activities;
- Addressing issues regarding Medicaid claiming that impact the Department's ability to maximize revenue and make recommendations on how to improve them;
- Assessing the success of the Compliance Plan by reviewing compliance-related activities and recommending any needed updates to the Plan.
- Encouraging a culture of compliance throughout the Department of Education

IV. EDUCATION AND TRAINING

Proper education and training is a significant element of an effective compliance plan. It is the responsibility of all Relevant Staff to be familiar with the Compliance Plan.

Communication of Compliance Plan

- All current DOE employees and officials involved in the provision or claiming of Medicaid eligible services will be advised of the obligation to review the Compliance Plan and act accordingly. As new employees enter the system, they will be advised of the obligation to review a copy of the Compliance Plan and other policies and standards of conduct that may affect their position.
- All contractors, vendors and agents who are involved in the provision or claiming of Medicaid eligible services will be advised that the Compliance Plan and any updates will be posted on the Department's website. All applicable contracts will require a certification that the Compliance Plan has been shared with employees providing SSHSP services to the Department and that these employees will be made available for training by the Department.

Mandated Annual Training

- As a result of the Compliance Agreement between New York State and the Centers for Medicare and Medicaid, New York State is required to conduct annual training for all Medicaid-In-Education "relevant employees" of local school districts, counties, 4201 schools as well as independent contractors that bill Medicaid (directly or indirectly) under the SSHSP.
- All Relevant Staff will attend the mandated training provided by the New York State Department of Education on an annual basis.
- All new Relevant Staff will be required to complete the NYSED compliance training as soon as possible after assuming duties through employment or contract.

Targeted Training

- The Compliance Officer may develop, oversee and/or provide in-service training on an as needed basis in order to address identified risk areas or new developments. These training programs may be carried out through the Compliance Office or other Department divisions.

Records of training and education activities related to Medicaid compliance will be maintained under the direction of the Compliance Officer.

Failure of the Department to achieve compliance with NYSED annual training requirements is a serious matter and may impede its ability to submit Medicaid claims for reimbursement. Failure of Relevant Staff to comply with training requirements or to attend scheduled training sessions may result in disciplinary action.

V. COMMUNICATION OF COMPLIANCE CONCERNS

The Department's employees are in a position to know where policies and regulations are not being followed. Therefore, the effectiveness of the Compliance Plan depends on the willingness of employees at all levels of the organization to step forward, in good faith, with questions and concerns.

NYCDOE employees, service providers, administrators and senior leadership are encouraged to discuss any billing or compliance concerns with the Compliance Officer, either formally or informally. Formal and informal communication channels are intended to encourage an "open door" policy.

Although individuals are encouraged to contact the Compliance Officer directly to report concerns, potential compliance concerns may be reported anonymously by calling the toll free **Medicaid Compliance Hotline (877-393-5432)** or by submitting a written report to the Compliance Officer on an anonymous basis.

Reporting Medicaid Fraud or Abuse

The prompt reporting of compliance concerns is critical to the success of the Compliance Plan.

Examples of non-compliance may include

- Claiming or verifying attendance for services that were not provided.
- Duplicate billing, which occurs when a contractor or an independent provider bills Medicaid while also submitting an invoice for payment to the Department.
- Claiming for services at a higher rate, when a lower rate service was actually provided (e.g., billing for a one-to-one service session when in fact a group session was provided).
- Submitting claims where applicable provider requirements have not been satisfied.
- Certifying attendance for a complete session where a complete session was not provided.
- Evidence of intentional false or altered documents

The Department will encourage employee questions and/or reports by:

- Taking each report seriously;
- Investigating each report; and where there is enough information, determining the extent of the problem and taking any necessary corrective action;
- Ensuring that employees who do report:
 1. Do not suffer retaliation by their peers or supervisors for their good faith reports or questions.
 2. Have the choice of keeping their name confidential in regard to a specific report for as long as the Department can reasonably do so.

How To Report Compliance Issues and Concerns

All occurrences of possible fraud and abuse or other compliance issues related to Medicaid must be reported. The Department encourages individuals to contact the DOE Compliance Officer either formally or informally.

Calls may also be made anonymously, although the DOE encourages employees to provide their name and contact information to aid in the effective investigation of reports.

Every attempt will be made to preserve the confidentiality of reports of non-compliance. All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases, disclosures will be on a "need to know" basis only.

Employees may report using one of the following options:

Reporting to the NYC DOE Medicaid Compliance Officer:

Dina Karagiorgos
NYC DOE Medicaid Compliance Officer – CONFIDENTIAL
52 Chambers Street, Room 305
New York, NY 10007

Phone: 212-374-6713

E-mail: Medicaid@schools.nyc.gov

Reporting anonymously through the NYCDOE Confidential Toll Free Compliance Hotline

877-393-5432

Reporting to the New York City Special Commission of Investigation for the New York City School District

The Special Commissioner of Investigation for the New York City School District
80 Maiden Lane, 20th Floor
New York, NY 10038

Phone: 212-510-1500 or Toll Free 877-888-8355

Fax: 212-510-1550

Reporting to the New York State Office of the Medicaid Inspector General (OMIG)

Phone: 877-873-7283

Website: www.omig.state.ny.us

Reporting to the New York State Medicaid Compliance Officer

Carol Booth
New York State SSHSP Compliance Officer
Room 2482 Corning Tower
Albany, NY 12237

Phone: 518-473-3234
E-mail: clk04@health.state.ny.us

VI. RESPONSE AND PREVENTION

Mayor's Executive Order No. 11 on Reporting to the Special Commissioner

The goal of our Compliance Plan is to prevent and reduce the likelihood of improper conduct. The Department's response to information concerning possible violations of law or the requirements of the Compliance Plan is an essential component of its commitment to compliance.

The Department is bound by Mayor's Executive Order No. 11, which mandates that all Department employees have an "affirmative obligation to report, directly and without undue delay, to the [Special] Commissioner, any and all information concerning conduct which they know or should reasonably know may involve corrupt or other criminal activity. . . and shall proceed in accordance with the [Special] Commissioner's directions."

Therefore, upon receiving a report or other reasonable indication of suspected non-compliance, the Medicaid Compliance Officer will inform the Special Commissioner of such allegation. That external agency will determine whether and how the allegation should be investigated to determine if a material violation of applicable law or the requirements of the Plan has occurred. If the Special Commissioner determines that the allegation should be investigated by the Department, the Medicaid Compliance Officer will arrange for an investigation to be conducted, either by the Compliance Officer or another office within the Department. Assistance from the Department's internal Office of Special Investigations, Office of Auditor General, or Office of Legal Services may be requested. All Department staff will be directed to cooperate fully with the Compliance Officer.

Reporting Process

Upon receipt of information concerning alleged misconduct, the Medicaid Compliance Officer will, at a minimum, take the following actions:

1. Complete a Compliance Report Intake Form.
2. Notify the Special Commissioner and, depending on the nature of the allegation, the Chancellor/Designee.
3. If the Special Commissioner refers the allegation back to the Department, the Compliance Officer will so advise the Compliance Committee and ensure that the

investigation is initiated as soon as reasonably possible. The investigation shall include, as applicable, but need not be limited to:

- i. Interviews of all persons who may have knowledge of the alleged conduct;
 - ii. Identification and review of relevant documentation including, where applicable, Medicaid claims submitted, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude;
 - iii. Subject to collective bargaining guidelines, interviews of persons who appear to play a role in the suspected activity or conduct.
 - iv. Preparation of a summary report that (1) defines the nature of the alleged misconduct, (2) summarizes the investigation process, (3) identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws
4. Ensure that the investigation is completed in a reasonable and timely fashion and that appropriate disciplinary or corrective action is taken;
 5. The results of the investigation will be reported to the Chancellor/designee and Medicaid Compliance Committee;
 6. Referrals for further action, including disciplinary action and/or review by a law enforcement agency may be made upon consultation with legal counsel.

Responses to Incidents of Non-compliance

In the event the investigation identifies inappropriate Medicaid billing practices, the Department will:

1. Immediately cease the offending practice and all billing potentially affected by the offending practice.
2. If applicable, calculate and repay any duplicate or improper payments.
3. When appropriate, handle any overpayments through the administrative billing process by informing the billing staff and making appropriate adjustments via software used for billing.
4. Undertake appropriate training and education to prevent a recurrence of the misconduct.
5. Conduct a review of applicable Department procedures to determine whether new or revised policies and procedures are needed to minimize future risk of noncompliance.
6. Conduct, as appropriate, follow up monitoring to ensure effective resolution of the offending practice.

At least annually the Medicaid Compliance Officer will provide a report to the Chancellor which includes all investigations and their status. The Medicaid Compliance Officer will also provide the audit findings from any reviews that have taken place throughout the year, as well as corrective actions that have been implemented.

VII. ENFORCEMENT AND DISCIPLINE

If, through investigation, monitoring and/or auditing, it is determined that fraud or abuse has occurred, or that a staff person or program is violating policies and procedures set forth in the Compliance Plan, there may need to be disciplinary action.

Discipline and Corrective Actions

In order to make the Compliance Plan effective, the Compliance Officer, with the approval of the Committee, will have authority to impose corrective action upon a finding of misconduct by an employee, contractor, independent provider or agent in accordance with the provisions of New York law and any applicable collective bargaining agreements.

Plans of correction and discipline will depend on the nature, frequency and severity of the non-compliance and may include but are not limited to:

- A requirement to undergo training;
- A period of required supervision or approval of documentation before bills can be issued;
- Expanded auditing, internal or external, for some period of time until compliance improves;
- In sufficiently egregious cases, discipline or termination of a contract where applicable.

The Department may also make a referral to the Office of the Medicaid Inspector General or other external enforcement agency.

Policy on Non-Intimidation or Retaliation

To the extent possible, all employee reports will be handled in a manner that protects the confidentiality of the reporter if requested. However, there may be circumstances in which confidentiality cannot be maintained. Some examples of this include situations where the problem is known to only a very few people or where the funding source must be involved. In all cases, however, the Department is determined that the reporting employee will not suffer from retaliation for his/her good faith actions.

It is the responsibility of the Department to ensure that those reporting in good faith do not suffer retaliation for doing so. Employees who believe that they have been retaliated against because they have reported a possible instance of misconduct or fraud should contact the Medicaid Compliance Officer. The Compliance Officer will investigate all good faith complaints of fraud or direct them to the appropriate entity for investigation and/or follow up.

For additional information please review Appendix I: Memo on "Federal, State and City False Claims Acts Pertaining to Medicaid School based Services and Whistleblower Protections for Individuals Reporting Violations of the Acts"

Policy on Screening for Excluded Individuals and Entities

The Department is committed to maintaining high quality care and service as well as integrity in its financial and business operations. Therefore, the Department will conduct appropriate screening of key providers, employees, officials, contractors, vendors and agents ("Screened

Persons”) to ensure that they have not been sanctioned by a federal or state law enforcement, regulatory or licensing Agency. It is the policy of the Department to ensure that no Medicaid reimbursement is sought for services furnished to the SSHSP program by an individual or entity excluded from participation in federally sponsored health care programs such as Medicare or Medicaid (“Ineligible Person”).

1. Screening databases:

The Department will conduct exclusion checks to verify that Screened Persons have not been excluded from federal healthcare programs. An exclusion check is a search of the following databases (“Exclusion Lists”) to determine whether the individual or entity’s name appears on any list:

- General Services Administration (GSA), list of parties excluded from federal programs. The URL address is <https://www.epls.gov>
- Department of Health and Human Services Office of the Inspector General (HHS OIG) cumulative sanction report. The URL address is <http://exclusions.oig.hhs.gov/search.html>.
- New York State Office of the Medicaid Inspector General (NYSOMIG) list of restricted, terminated or excluded individuals or entities. The URL address is <http://www.omig.ny.gov/data/content/view/72/52/>

2. Screening at time of hire:

The Department will conduct screening reviews of all applicants recommended for hire as part of the DHR pre-employment screening process in order to determine whether they are an Ineligible Person.

3. Screening at time of Initial Contract:

Contracts with related service contractors will contain a certification that the entity has performed its own exclusion screening against the Exclusion Lists and neither the entity, nor any individuals are Ineligible Persons. Such certification must include a requirement that the entity or individual will notify the Department of any change in the exclusion or ineligibility of any Screened Persons.

4. Monthly Screening:

As required by the New York State Office of the Medicaid Inspector General, the Department shall, on a monthly basis, review the updated List of Excluded individuals on the three Exclusion Lists and compare it to the current list of active service providers in order to verify that all existing employees have not been excluded from federal programs since the last review.

The Medicaid Compliance Officer will be notified of any matches found during any of the above screening processes and will conduct additional verifications as necessary.

5. Action:

If the Department has actual notice that a Screened Person is an Ineligible Person or is proposed for exclusion during his, her or its employment or contract term, the Department shall take all appropriate actions to ensure that the responsibilities of the Screened Person have not and shall not adversely affect the quality of care rendered to any beneficiary, or the accuracy of any claims submitted retrospectively or prospectively to any Federally funded health care program. This may include suspension, termination, termination of the contract, reporting, disclosure or other actions necessary to ensure compliance with exclusion mandates.

6. Duty To Disclose:

The Department requires all Screened Persons to disclose immediately to his or her supervisor, Medicaid Compliance Officer, or other individual as designated in the relevant contract, any debarment, exclusion, suspension, or other event that makes that person or entity an Ineligible Person. All Screened Persons shall disclose if he/she/it is an Ineligible Person at the time of the initial hiring, credentialing, or contracting process, or at any point in the future. Failure to do so may result in disciplinary action or contract termination.

7. Exclusion Screening Records:

The Compliance Officer will maintain the results of all exclusion screenings and any associated documents.

VIII. MONITORING AND AUDITING

As part of our effort to implement an effective Compliance Plan, the Department will periodically conduct routine self-audits and/or reviews of its operations including its claiming practices and its written standards, policies and procedures to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Plan. The periodic audits/reviews will be designed to assess whether the Department's claims are supported by accurate documentation conforming to the requirements of the Corrective Action Plans and Medicaid claiming guidelines and whether information in the data systems upon which the Department relies is valid and controls are working as intended.

Additional audits/reviews may be conducted depending on reports of fraud, waste, or abuse or identification of risk areas as determined through regular monitoring activities. Compliance monitoring and review techniques may include but are not limited to:

- On-site visits
- Personnel interviews including departmental interviews with department heads to assist in determining the effectiveness of the Plan
- General questionnaires submitted to relevant personnel
- Reviews of provider records that support claims for reimbursement
- Review of written materials and documentation prepared by the Department

Audit/Review Findings

The following will be the process for reporting audit findings:

- The Compliance Officer will provide a report of its audit/review findings to the Chancellor/designee and the Compliance Committee.
- If applicable, the Department will calculate and repay any duplicate or improper payments made as a result of the noncompliance.
- The Compliance Officer will detail the steps that should be taken to prevent similar non-compliant activity from occurring in the future.

Follow-up monitoring will be conducted as appropriate to ensure effective resolution of noncompliance findings.

IX. RECORD RETENTION

The Compliance Officer will receive and generate both hard copy and electronic records and information.

All records related to a specific incident should be retained in accordance with State Record Retention requirements, or as otherwise required by state or federal law or pursuant to contract.

Records relating to the Compliance Plan including evidence of training, meeting minutes, implementation and modification of the Plan, memoranda, and reports will be retained as required by State Record Retention requirements or as otherwise required by law or regulation.

X. NOTICE TO COMPLIANCE OFFICER

Department shall notify the Compliance Officer of any visits, audits, litigation, investigations or surveys by any federal or state agency or authority of which Department becomes aware and which impacts the Compliance Plan.

XI. PLAN REVISIONS AND UPDATES

The Compliance Plan is an evolving program responding to changes in federal and state laws and regulations, external audits, billing, coding and documentation rules and best practices. This Compliance Plan document represents the current state of the Compliance Plan. Accordingly, the Plan will be reviewed, amended and supplemented as required but not less than annually. All changes to the Compliance Plan shall be reviewed and approved by the NYCDOE Medicaid Compliance Committee.

APPENDIX I
Federal, State and City False Claims Acts Pertaining to Medicaid School Based Services
and Whistleblower Protections for Individuals Reporting Violations of the Acts
(as required by the Deficit Reduction Act of 2005)

[See attached]



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, Chancellor

BRIAN FLEISCHER, Auditor General

DATE: OCTOBER 31, 2007

SUBJECT:

FEDERAL, STATE AND CITY FALSE CLAIM ACTS PERTAINING TO MEDICAID SCHOOL BASED SERVICES AND WHISTLEBLOWER PROTECTIONS FOR INDIVIDUALS REPORTING VIOLATIONS OF THE ACTS

TO:

- Michael Best, General Counsel, Office of the General Counsel
- Ted Brodheim, Chief Information Officer, Division of Instructional and Information Technology
- Bonnie Brown, Superintendent, D.75
- Evelyn Castro, Executive Director, Office of Early Childhood Education
- Richard J. Condon, Special Commissioner, Office of the Special Commissioner of Investigations for the New York City School District
- Vincent A. Giordano, Executive Director, Division of Financial Operations
- Eric Goldstein, Chief Executive, Office of School Support Services
- Maurice Miller, Executive Director, Office of Compliance Services
- Susan Olds, Executive Budget Director, Division of Budget Operations and Review
- David N. Ross, Executive Director, Division of Contracts and Purchasing
- David Schacher, Ethics Officer, Department of Ethics and Conflicts of Interest
- Carl Schneider, Executive Director, Division of Revenue Operations
- Linda Wernikoff, Senior Instructional Manager - Special Education, Office Special Education Initiatives
- All Integrated Service Center Executive Directors
- All Principals (by Principals' Weekly)

CC:

- Christopher D. Cerf, Deputy Chancellor, Organizational Strategy, Human Capital, and External Affairs
- Kathleen Grimm, Deputy Chancellor, Finance and Administration
- Kristen Kane, Chief Operating Officer
- Marcia V. Lyles, Deputy Chancellor, Teaching and Learning and Learning Support Organizations
- Sam Mehta, Consultant, Deputy Chancellor for Operations

FROM:

Brian Fleischer, Auditor General, Office of the Auditor General

BMF

POLICY

It is the policy of NYCDOE to comply with all applicable federal, state and local laws pertaining to fraud, waste and abuse in federal health care programs including Section 6032 of the Deficit Reduction Act of 2005. In the service of these requirements, NYCDOE disseminates information to its employees, management, and to its contractors and agents regarding federal laws and administrative remedies, as well as state and city laws related to false claims and statements. This includes "whistleblower" protections under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

NYCDOE is committed to investigating any such allegation of fraud, waste, abuse or other improper conduct. It devotes substantial resources to investigate allegations of fraud and abuse and therefore believes that all employees should bring their concerns to NYCDOE first so that it can redress and correct any fraudulent activity. Any employee of NYCDOE who reports such information may do so anonymously and will be protected against retaliation for coming forward with such information both under NYCDOE's internal compliance policies and procedures as well as federal, state and city law.

This memo serves to outline the policy and procedures followed by the NYCDOE for detecting and preventing fraud, waste and abuse, and related “whistleblower” protections pertaining to the laws addressed in this policy. The memo also provides a summary of those laws.

This memo can be found by going to:

<http://schools.nyc.gov/Administration/Offices/GeneralCounsel/AuditorGeneral/Links/default.htm>

For a summary of relevant State and federal laws, please go to:

<http://www.omig.state.ny.us/data/content/view/81/65/>

For further information on the False Claims Act, please go to:

<http://www.cms.hhs.gov/smdl/downloads/SMD032207Att1.pdf>

For a summary of New York City laws, please go to:

<http://www.nyc.gov/html/law>

PREVENTION MEASURES

- **Office of Auditor General** performs ongoing risk assessments of the fiscal and operational controls of the institution, including both school-related and ancillary service expenditures; conducts audits to test controls and identify deficiencies and beneficial practices; conducts audits and reviews of private contract vendors to test programmatic and fiscal compliance with key contract provisions; and develops and assists with implementation of recommendations and corrective actions to improve fiscal and operational processes.
- **Division of Revenue Operations** has retained a private contractor assigned to collect, image, convert to electronic data, and maintain manual records of related service delivery as well as several other student-related documents that are key to supporting claims.
- **Archive Center** has issued policies and procedures to standardize and improve controls over the archiving and storage of supporting documentation. Personnel have an on-going involvement in the implementation of corrective actions, including visitation to all Regional Operations Centers and other administrative offices to distribute copies of the New York State Document Retention Schedule and to train Department personnel on the retention rules.
- **Office of Special Education Initiatives** monitors special education service delivery through management reports and results of audit activity.
- **Division of Budget Operations and Review** monitors budgets (including reimbursable funds) of schools, regions, and central offices.

EDUCATION

NYCDOE provides the education and training that address these issues through a number of initiatives, including:

- **Department’s Ethics Officer** provides advice and counsel to all Department employees on the Conflicts of Interest Law of the City of New York and the *Chancellor’s Regulations* on conflicts of interest.
- **Integrated Service Center (ISC)** conducts training and general oversight of schools’ activity on control-related matters, compliance with procurement requirements for non-contract OTPS purchases, and accuracy and completeness of documentation. Supports in these fiscal control areas are provided by the **Network Support Teams (NST)** in coordination with the ISC.
- **Universal Pre-Kindergarten** regional and central programmatic and operational offices share responsibility for oversight of the DOE’s contracts with private Universal Pre-K program providers. Those providers are subject to on-site reviews and must submit annual budgets and disclosures of expenditures twice yearly to ISC Pre-K Contract Borough Managers.

BACKGROUND CHECKS

- **Office of Personnel Investigation** is responsible for screening all new staff hired by the NYC Department of Education to ensure the safety and well being of students and staff. State Education Laws and the Department of Education policy and practice mandate the taking of fingerprints as a prerequisite for licensure and/or employment. A criminal background check is performed on individuals following an offer of employment, but prior to the individual starting work.
- **Division of Contracts and Purchasing, Office of Policy and Vendor Performance** further strengthens the Department’s infrastructure against potential fraud and corruption for contracts projected to exceed \$1M, as well

as for selected smaller contracts. In those circumstances, all prospective vendors are subject to an extensive background check.

- **Division of Human Resources** oversees employee fingerprinting and background checks, hiring processes and qualifications.

REPORTING MECHANISMS

The Special Commissioner of Investigation for the New York City School District :

Anyone may report concerns through the 7-day / 24-hour hotline:
(212) 510-1500. Toll Free: (877) 888-TELL (8355)
Website: <http://www.nycsci.org/>
All calls are confidential. "Whistleblowers" are protected.

DETECTION MEASURES

NYCDOE has implemented various billing and coding edit software packages to assist in detecting billing and coding which is not compliant with rules associated with Federal health care programs.

AUDITS

- **Office of Pupil Transportation** (OPT) oversees contract compliance of bus vendors.
- **Office of the Auditor General**: reviews programs and fiscal contract compliance with regard to pre-school programs on a real-time basis.

SUMMARY OF FEDERAL, NEW YORK STATE AND NEW YORK CITY LAWS RELATED TO FRAUD, WASTE AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

FEDERAL LAWS

False Claims Act (31 U.S.C. §§ 3729-3733)

The Federal False Claims Act (the "FCA") imposes liability on any person who submits a claim to the Federal Government that he or she knows (or should know) is false. It was designed to enhance the government's ability to identify and recover losses due to fraud by creating strong financial incentives for entities to maintain vigorous compliance programs. The penalties for violating the statute are severe and range from \$5,500 to \$11,000 for each false claim and up to three times the amount of actual damages that the government proves it sustained as a result of the prohibited conduct. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participating in Federal health care programs.

The FCA provides, in part, that:

Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; ...or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000, and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . . (31 U.S.C. § 3729)

In addition to its substantive provisions that provide a direct right of action by the government, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. § 3730(b). These private parties, known

as “*qui tam* relators,” may share in a percentage of the proceeds from an FCA action or settlement.

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.

Administrative Remedies for False Claims (31 U.S.C. §§ 3801 – 3812)

A different Federal law also provides for administrative remedies for situations in which a person or entity submits a claim if the claimant has reason to know such claims are false or are supported by a materially false statement. “Administrative remedies” means that a Federal agency responsible for enforcement conducts the investigation and proceedings, determines whether the claim is false and imposes fines and penalties, instead of prosecution of the matter in the Federal court system. The law applies to all claims made to the Federal government including Medicaid claims because Medicaid is partially funded by the Federal government. Unlike the FCA, a violation of this law occurs when a false claim is submitted, not when it is paid.

Program Fraud Civil Remedies Act (“PFCRA”):

This Federal law is similar in structure to the FCA, but provides administrative remedies against persons or entities that make or cause to be made a false claim for money, property or services to certain federal agencies, including the Department of Health and Human Services, which operates the Medicare and Medicaid programs. The PFCRA provides that any person making, presenting, submitting or causing to submit a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil monetary penalties of up to \$5,000, per false claim and up to twice the amount of the fraudulent claim. The PFCRA uses the same definition of “knows or has reason to know” as used in the FCA and explained above. Violations are investigated by the Department of Health and Human Services and enforcement actions must be approved by the Attorney General.

NY STATE LAWS

New York’s false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the “common law” crimes apply to areas of interaction with the government.

Civil and Administrative Laws

NY False Claims Act (State Finance Law, §§ 187-194)

The NY False Claims Act closely tracks the Federal FCA. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid.

The New York Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit or 15-25% if the government did participate in the suit.

Social Services Law § 145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme

or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$2,000 per violation.

Social Services Law § 145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, such person's needs are not taken into account in determining the needs of that person or his or her family for such assistance for 6 months if a first offense, 12 months if a second, 18 months if a third (or once if benefits received are over \$3,900) and five years for 4 or more offenses.

Social Services Law § 366-b Penalties for Fraudulent Practices

Applies to any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means as well as to any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services.

Criminal Laws

Penal Law Article 155 Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

Penal Law Article 175 False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions.

Penal Law Article 176 Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

Penal Law Article 177 Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes.

WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. § 3730(h))

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claims Act (State Finance Law § 191)

The False Claims Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official.

Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

New York Labor Law § 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

NEW YORK CITY

New York City False Claims Act

Signed into law on May 19, 2005 the New York City False Claims Act (Local Law 53 of 2005) authorizes citizens to bring lawsuits on behalf of the City to recover treble damages for fraudulent claims submitted to the City. An important new tool with which the City can fight fraud perpetrated against it, the statute creates a way for people to help the City recover money lost through fraud, and is patterned after the federal "Qui Tam" statute. As an incentive to bring suits, this new law allows successful citizen plaintiffs, under certain circumstances, to keep as much as 30% of funds they help recover.

The law also requires the City's Law Department and the Department of Investigation to promulgate rules governing the protocol for processing proposed civil complaints under the False Claims Act. Such rules became effective on August 8, 2005, upon publication in the City Record.