NEW YORK CITY DEPARTMENT OF EDUCATION

MEDICAID-IN-EDUCATION COMPLIANCE PLAN

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I. INTRODUCTION

The Compliance Program

The New York City Department of Education ("NYCDOE") has adopted and implemented a Medicaid-In-Education Compliance Program ("Compliance Program") to achieve compliance with federal and state laws relating to the New York State School and Preschool Supportive Health Services Program ("SSHSP").

As a condition of payment for services and to be eligible to submit claims for such, the NYCDOE must implement and maintain an effective Compliance Program, as required under New York Social Services Law § 363-d with compliance regulations codified at 18 NYCRR Part 521, as well as state guidance from the New York State Office of the Medicaid Inspector General, ("OMIG") and federal guidance, from among other entities, the U.S. Sentencing Commission Guidelines Manual, and the Centers of Medicare and Medicare Services ("CMS"). On an annual basis the NYCDOE certifies with the New York State Department of Health ("NYSDOH") that it maintains an effective Compliance Program.

The goal of the Compliance Program is to ensure that eligible services, for which NYCDOE submits claims for Medicaid reimbursement (the "Services"), are appropriately provided, properly documented, and accurately billed. The Medicaid Compliance Plan ("Compliance Plan" or "Plan") describes the NYCDOE's procedures to detect, prevent, and correct fraud and abuse in connection with the Medicaid program.

The Compliance Program applies to all persons and entities affected by the provider's risk areas and who are involved in the provision or claiming of Medicaid eligible services, including but not limited to employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers ("Affected Individuals").

The Compliance Program is the sum of all efforts designed to ensure NYCDOE's compliance with applicable laws and regulations, including:

- This Compliance Plan, which is the main written document, sets forth the NYCDOE's commitment and approach for achieving compliance with applicable laws and regulations.
- The Medicaid Billing and Claiming Code of Conduct, which can be found in this Compliance Plan.
- Medicaid-specific policies that apply to or affect the Medicaid Program.
- Policy of anti-retaliation and anti-intimidation designed to protect individuals who in good faith report suspected compliance issues.
- Related NYCDOE, NYC and NYS policies or procedures that support the Compliance Program.
- Related activities and initiatives designed to support and improve compliance and mitigate risk.

The purpose of the Medicaid Compliance Program is to:

- Support the NYCDOE's strong commitment to transparency, compliance, and appropriate conduct.
- Develop a system to encourage employees to report potential problems that may be detrimental to the NYCDOE and the community at large.
- Develop procedures that allow for a thorough investigation of alleged misconduct.
- Develop procedures for promptly and effectively conducting internal monitoring and auditing which may prevent non-compliance.
- Minimize the risk of the NYCDOE's exposure to civil damages or penalties, criminal sanctions, or administrative remedies, by implementing procedures for early detection and reporting of noncompliance in the following risk areas:
    - Billing
    - Payments
    - Ordered Services
    - Medical Necessity
    - Quality of Care
    - Governance
    - Mandatory Reporting
    - Credentialling
    - Contractor, subcontractor, agent, or independent contract oversight, and
    - Other risk areas that should reasonably be identified by the provider through "organizational experience."

The Seven Elements of an Effective Compliance Program

As required by the OMIG, the NYCDOE's Compliance Program is comprised of the following seven elements:

Element 1: Written policies, procedures, and standards of conduct that describe compliance expectations.

Element 2: Compliance Officer and Compliance Committee

Element 3: Compliance Program Training and Education

Element 4: Lines of communication

Element 5: Disciplinary Standards

Element 6: Auditing and Monitoring

Element 7: Responding to Compliance Issues

The Compliance Plan

This Compliance Plan is the main written compliance document and is intended as a guide and resource for all Affected Individuals.

As is detailed within this Compliance Plan, it is the duty of all Affected Individuals to comply with the policies as applicable to their individual areas of employment or contracts. Affected Individuals are expected to be familiar with the NYCDOE's policies, procedures, and standards of conduct. Based on your role in the organization, you may be required to be familiar with related service provisions specifically relevant to documentation and billing.

Communication of the Compliance Plan

The Compliance Plan is the blueprint for NYCDOE's Medicaid Compliance Program. It is provided to all Affected Individuals with annual training to be used as a reference and ensure that Affected Individuals understand how the NYCDOE complies with Medicaid laws and regulations.

- The Compliance Plan is posted on the NYCDOE's intranet and public facing website, accessed through the Office of Medicaid Compliance webpage. Hard copies of the Compliance Plan are available upon request from the Compliance Officer.
- Affected Individuals are advised of the obligation to review the Compliance Plan and act accordingly.
- As new Affected Individuals enter the system, they will be advised of the obligation to review a copy of the Compliance Plan and other related policies and standards of conduct that may affect their position.
- All new or renewed contracts for Medicaid eligible services will include a requirement to read, understand, and comply with the Compliance Plan.

II. THE SEVEN ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

ELEMENT 1: WRITTEN POLICIES AND PROCEDURES

Policies, procedures, standards of conduct, and other related documents are the foundation for a successful and effective Compliance Program. These documents provide the Compliance Officer, executive management, employees, vendors, contractors and other Affected Individuals with an understanding of what is expected in the workplace and how to operate effectively.

The NYCDOE Compliance Plan includes specific policies and procedures intended to achieve the following goals:

- Describe the NYCDOE's commitment to comply with all applicable state and federal standards.
- Describe compliance expectations as embodied in the Compliance Plan and Medicaid Billing & Claiming Code of Conduct.

- Implement the operation of the Compliance Program.
- Provide guidance to Affected Individuals on dealing with potential compliance issues.
- Identify how to communicate compliance issues to the Compliance Officer.
- Describe how potential compliance issues are investigated and resolved by the organization.
- Include a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program.

The NYCDOE also has other policies and procedures in place that may impact the Medicaid Compliance Program, including:

- Chancellor's Regulations related to conflicts of interest, contract terms targeting service provision, record completion and maintenance.
- Mayor's Executive Order on Reporting to the NYCDOE Special Commissioner of Investigation for the NYC School District.
- NYCDOE Special Education Standard Operating Procedure Manual(s).
- HR Policies and Procedures that speak to standards for employee and contractor credentialing, eligibility and general conduct.
- Contract guidance for non-public schools, agencies, and independent contractors.

Medicaid Billing & Claiming Code of Conduct

- The NYCDOE will only submit claims for Medicaid services actually rendered, properly documented, and accurately coded.
- The NYCDOE does not tolerate claiming practices that misrepresent the services actually rendered.
- The NYCDOE submits claims for Medicaid only when the appropriate and required documentation has been prepared.
- Supporting documentation must be prepared and properly retained for all services rendered.
- An accurate and timely billing and documentation structure is required to ensure that Affected Individuals can effectively implement and comply with 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.
- All identified overpayments will be reported, returned, and explained as required by OMIG Self-Disclosure protocols.
- Affected Individuals are not to falsify documentation for any purpose, including Medicaid claiming.
- Where applicable, the NYCDOE will only produce and submit cost reports that are true, correct and complete.
- Affected Individuals will immediately report any suspected billing or documentation improprieties to the Compliance Officer.

- The NYCDOE will not retaliate against anyone for good faith reporting of suspected compliance issues.

Annual Review of Compliance Plan and Related Policies

The Compliance Plan and related policies, procedures and standards of conduct will be reviewed at least annually to determine:

- If such written policies, procedures, and standards of conduct have been implemented.
- Whether Affected Individuals are following the policies, procedures, and standards of conduct.
- Whether such policies, procedures, and standards of conduct are effective.
- Whether any updates are required.

Appendices to this Compliance Plan include the NYCDOE Policy of Non-Intimidation and Non-Retaliation and information concerning the federal and state False Claims Acts along with federal, state, and city laws protecting whistleblowers. It also includes criminal and administrative penalties and sanctions for healthcare cases.

ELEMENT 2: COMPLIANCE OFFICER and COMPLIANCE COMMITTEE

An effective Compliance Program requires the involvement and leadership of responsible and accountable individuals.

Medicaid Compliance Officer

The DOE has designated a Medicaid Compliance Officer ("Compliance Officer") who is directly responsible to the Chancellor/designee for overseeing the development, implementation, and monitoring of the Compliance Program and ensuring appropriate handling of instances of suspected or known illegal or unethical conduct related to Medicaid claiming.

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

- Overseeing and monitoring the adoption, implementation and maintenance of the Compliance Program and evaluating its effectiveness.
- Drafting, implementing, and updating a compliance work plan that outlines NYCDOE's proposed strategies for the coming year.
- Conducting an annual review of the Compliance Program, including written policies and procedures, and revising as needed to incorporate any changes in law.
- Developing, coordinating, and implementing a training and education program.
- Reporting directly to the Chancellor/designee and Compliance Committee on a quarterly basis on the status of the Compliance Program.

- Providing guidance to management, program personnel, and appropriate departments to establish methods to improve the efficiency and quality of the Compliance Program and to reduce vulnerability to fraud, waste, and abuse.
- Investigating, documenting, and reporting matters related to the Compliance Program.
- Pursuing any resulting corrective action with all internal departments, contractors, and the State.
- Conducting an annual assessment of the effectiveness of the Compliance Program by reviewing internal and external audits, reviews, investigations, reports, and the NYCDOE's organizational experience with the functioning of the Compliance Plan and submitting a summary of the assessment to the Compliance Committee and Chancellor/Designee.
- Consulting, as necessary, with the OMIG, the NYSDOH, the NYC Special Commissioner of Investigation ("SCI"), internal and external investigative and auditing offices, and outside law enforcement agencies.

Compliance Committee

The NYCDOE has established a Compliance Committee composed of the Compliance Officer, other senior management, and other key personnel of the NYCDOE (the "Compliance Committee" or "Committee"). The Compliance Committee operates in accordance with a written committee charter setting forth its membership, roles, and responsibilities.

Subject to reorganization and changes in job titles or functions, the Committee consists of representatives from the following divisions:

- Office of Medicaid Operations
- Division of Financial Operations
- Office of General Counsel
- Office of the Auditor General
- Division of Human Resources
- Office of Revenue Operations
- Division of Inclusive and Accessible Learning ("DIAL") – Special Education Office
- District 75

The Compliance Officer schedules and chairs Committee meetings which are held at least quarterly. 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 are reported to the Committee at its full meetings.

Duties and Responsibilities of the Compliance Committee:

- Coordinating with the Compliance Officer to ensure that written policies and procedures and standards of conduct are current, accurate and complete and that training topics are timely completed.
- Coordinating with the Compliance Officer to ensure communication and cooperation on compliance issues.
- Advocating for the allocation of sufficient funding, resources, and staff for the Compliance Officer.
- Coordinating with the Compliance Officer to ensure that the NYCDOE has effective systems and processes in place to identify Compliance Program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues.
- Reporting on a quarterly basis, to the Chancellor or designee regarding Compliance Program activities undertaken in coordination with the Compliance Officer and assisting the Compliance Officer with the annual Compliance Program Effectiveness Self-Assessment process.
- Assessing the success of the Compliance Program by reviewing compliance- related activities and recommending any needed updates.
- Encouraging a culture of compliance throughout the Department of Education.

ELEMENT 3: COMPLIANCE PROGRAM TRAINING AND EDUCATION

The NYCDOE will maintain a compliance training program. The Compliance Officer will be responsible for the training and education on the NYCDOE Compliance Program for all Affected Individuals annually. The training provides Affected Individuals with information regarding compliance issues, expectations, and the operation of the Compliance Program.

Mandated Annual Training

- Affected Individuals are required to complete training annually and are expected to become familiar with the Compliance Plan provided with the training.
- All new Affected Individuals are required to complete the mandated annual compliance training as soon as possible after assuming duties through employment or contract.
- Training is provided in a webinar format easily accessible to Affected Individuals.

The training and education program may include, but is not limited to, the following topics:

- Written policies and procedures identified in the Compliance Plan.
- How to access and use the Compliance Plan as a guide for questions regarding the Compliance Program.
- The role of the Compliance Officer and the Compliance Committee.
- How Affected Individuals can ask questions and report potential compliance-related issues to the Compliance Officer and senior management, including the obligation of Affected

Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports.

- How individuals who make good faith reports regarding suspected fraud and abuse will be protected from intimidation and retaliation.
- Disciplinary standards, with an emphasis on those standards related to the Compliance Program and prevention of fraud, waste, and abuse.
- Compliance risk areas based on organizational experience such as billing and claiming, documentation, medical necessity and quality of care, governance, credentialling, and other areas identified by the Department.
- How the NYCDOE monitors and identifies compliance risk areas.
- How the NYCDOE responds to compliance issues and implements corrective action plans.

Periodic Education and Training

In addition to the mandated annual training, the Compliance Officer may provide in-service training to applicable individuals on an as-needed basis to address identified risk areas or new developments. These training programs may be carried out through the Compliance Office or other NYCDOE divisions.

Compliance education opportunities may also be made available throughout the year as needed. These may take place in more casual formats such as departmental orientations or staff meetings. Compliance education may also be included in departmental/programmatic policies and guidance, and documentation guidance for SESIS and EasyTrac users.

Additional mandated training may be imposed at any time at the discretion of NYSED, OMIG, NYSDOH, etc. The NYCDOE will make every effort to satisfy these requirements.

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

ELEMENT 4: COMMUNICATION OF COMPLIANCE CONCERNS

The effectiveness of the Compliance Program depends on the willingness of Affected Individuals to step forward, in good faith, with questions and concerns regarding potential improper, unethical, or illegal conduct. Affected Individuals who suspect or have knowledge of misconduct, including any activity, policy or practice of Medicaid fraud, waste, or abuse have an obligation to report these compliance concerns. Questions about compliance issues should be directed to the Compliance Officer.

Identifying Potential Fraud or Abuse

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

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 NYCDOE.
- 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.
- Failing to assign and report billing codes that are clearly and consistently supported by documentation in the health record.
- Cutting and pasting or copying forward or cloning substantial portions of a prior note and not making updates pertinent to the current date of service.
- Failing to produce cost reports or other Medicaid-related financial statements that are true, correct, complete, and prepared in accordance with regulatory requirements.

The NYCDOE encourages questions and/or reports by:

- Taking each report seriously.
- Ensuring investigation of each report; and where there is enough information, determining the extent of the problem and taking any necessary corrective action.
- Ensuring that Affected Individuals who report an issue:
  (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 regarding a specific report for as long as the NYCDOE 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 NYCDOE encourages individuals to contact the Compliance Officer.

Reports of possible fraud may be made anonymously, although the NYCDOE 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.

Employees may report using one of the following options:

Reporting to the NYCDOE Medicaid Compliance Officer:

Dina Karagiorgos
NYCDOE Medicaid Compliance Officer – CONFIDENTIAL
100 Gold Street
New York, NY 10038 Phone: 212-374-0274

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 Commissioner of Investigation for the New York City School District

The NYCDOE is bound by Mayor's Executive Order No. 11, which mandates that all NYCDOE 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 fraud, corruption or other criminal activity, the Compliance Officer will inform SCI of such allegation. That external agency will determine whether and how the allegation should be investigated. If SCI determines that the allegation should be investigated by the NYCDOE, the Compliance Officer will arrange for an investigation to be conducted, either by the Compliance Officer or another office within the NYCDOE. Assistance from the NYCDOE's internal Office of Special Investigations, Office of Auditor General, or Office of Legal Services may be requested. All NYCDOE staff is expected to cooperate fully with the Compliance Officer.

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

Online Complaint Form - The Special Commissioner of Investigation of the New York City School System

Reporting to the OMIG
Phone: 877-87-FRAUD

OMIG Website

Reporting fraud to OMIG

Policy on Non-Intimidation or Retaliation

Affected Individuals have protection from retaliation for their good faith actions in filing a report of misconduct or fraud. If any Affected Individuals believe that they have been retaliated against because they have reported a possible instance of misconduct or fraud, they should contact the Compliance Officer or SCI. All claims of retaliation will be referred to SCI for appropriate action.

Appendices to this Compliance Plan include the NYCDOE Policy on Non-Intimidation and Non-Retaliation and laws protecting whistleblowers and a summary of the federal and state False Claims Acts and federal, state, and local laws protecting whistleblowers. It also includes criminal and administrative penalties and sanctions for healthcare cases.

ELEMENT 5: DISCIPLINARY STANDARDS

Affected Individuals who, after investigation, monitoring, or auditing, are determined to have failed to report fraud, waste, and abuse, and/or engaged in fraud or other misconduct, including retaliation, are subject to appropriate disciplinary action in accordance with provisions of federal, New York State, and NYC laws, regulations, and applicable contracts.

Discipline and Corrective Actions

The Compliance Officer, with the approval of the Committee, may impose corrective action upon a finding of misconduct by an Affected Individual, subject to 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 claims will be submitted for services rendered by a particular provider.
- Expanded monitoring/ auditing, internal or external, for some period until compliance improves.
- In sufficiently egregious cases, referral for disciplinary action, referral to the applicable licensing board in the case of clinicians, termination of employment, or termination of a contract where applicable.
- A referral to the OMIG or other external enforcement agency.

Enforcement

Disciplinary standards shall be enforced fairly and consistently across all levels of the organization. The types of discipline imposed will be commensurate with the severity of the violation, and will escalate in disciplinary severity, ranging from verbal or written warnings to termination of employment, contract, or affiliation, as appropriate.

ELEMENT 6: AUDITING AND MONITORING

As part of our effort to implement an effective Compliance Program, the NYCDOE periodically conducts 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 Program. The periodic audits/reviews will be designed to assess whether the NYCDOE'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 NYCDOE 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 Affected Individuals.
- Reviews of provider records that support claims for reimbursement.
- Review of written materials and documentation prepared by the NYCDOE.

Audit/Review Findings

The NYCDOE has established the following process for reporting audit/review findings:

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

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

Policy on Screening for Excluded Individuals and Entities

The NYCDOE is committed to maintaining high quality care and service as well as integrity in its financial and business operations. Therefore, the NYCDOE conducts 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 NYCDOE that Medicaid reimbursement will not be 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 NYCDOE conducts 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 of the following lists:
   - Department of Health and Human Services Office of the Inspector General (HHS OIG) cumulative sanction report.
   - New York State Office of the Medicaid Inspector General (NYSOMIG) list of restricted, terminated or excluded individuals or entities.

2. Screening at time of hire:

   The NYCDOE will conduct screening reviews of all newly hired NYCDOE Affected Individuals at or about the time of hire to determine if 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 who will provide services to NYCDOE students are Ineligible Persons. Such certification must include a requirement that the entity or individual will notify the NYCDOE of any change in the exclusion or ineligibility of any Screened Persons.

4. Monthly Screening:

   NYCDOE Screening: On a monthly basis, the Compliance Officer screens individual NYCDOE service providers and contract entity names against the Exclusion Lists identified to verify that these providers have not been excluded from federal programs since the last review.

   Contractor Screening: All contract entities are expected to conduct monthly screenings of their Affected Individuals and report any adverse findings to the Compliance Officer. The 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 NYCDOE has actual notice that a Screened Person is an Ineligible Person during their employment or contract term, the NYCDOE will take appropriate actions to ensure that no claims are submitted on behalf of such Ineligible Person during the period of ineligibility. If the reason for ineligibility impacts the provision of care, additional steps may be taken. This may include suspension, termination, termination of the contract, reporting, disclosure, or other actions necessary to ensure compliance with exclusion mandates.

6. Exclusion Screening Records:

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

ELEMENT 7: RESPONDING TO COMPLIANCE ISSUES

Reporting Process

The Compliance Officer, upon a finding or receipt of information concerning alleged misconduct, whether directly or otherwise, will, at a minimum, take the following actions:

- Complete a Compliance Report Intake Form.
- Conduct a preliminary assessment relating to the reported potential violation.
- If the Compliance Officer determines that a discovered or reported matter is related to Medicaid compliance, they will notify SCI and, depending on the nature of the allegation, the Chancellor/Designee.
- If SCI refers the allegation back to the NYCDOE, the Compliance Officer may conduct the investigation or refer it to the appropriate office and will ensure that the investigation is initiated as soon as reasonably possible. The investigation shall include, as applicable, but need not be limited to:

    - Interviews of all persons who may have knowledge of the alleged conduct.
    - 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.
    - Subject to collective bargaining guidelines, interviews of persons who appear to play a role in the suspected activity or conduct.
    - 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.
    - Ensure that the investigation is completed in a reasonable and timely fashion and that appropriate disciplinary or corrective action is taken.

- The results of the investigation will be reported to the Medicaid Compliance Committee.
- 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 NYCDOE will:

1. Immediately cease the offending practice and all billing potentially affected by the offending practice.
2. If applicable, calculate and repay or recoup 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 remedial training and education (formal or informal) to ensure that Affected individuals understand and acknowledge all applicable rules, regulations, and policies and procedures, in order to prevent a recurrence of the misconduct.
5. Conduct a review of applicable NYCDOE 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.

Reporting: At least quarterly, the Compliance Officer will provide a written report to the Chancellor/Designee which includes all investigations and their status.

III. RECORD RETENTION

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

IV. NOTICE TO COMPLIANCE OFFICER

The NYCDOE notifies the Compliance Officer of any visits, audits, litigation, investigations or surveys by any federal or state agency or authority of which DOE becomes aware, and which impacts the Compliance Plan.

V. PLAN REVISIONS AND UPDATES

The Compliance Program 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 Program. 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 Compliance Committee.

VI. APPENDIX A: The NYCDOE Policy on Non-Intimidation and Non-Retaliation

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, contained herein is information 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 and/or Affected Individuals should bring their concerns to NYCDOE first so that it can redress and correct any fraudulent activity. Any employee of NYCDOE and/or Affected Individual 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.

Consistent with New York State and New York City statutes and regulations, the NYCDOE strictly prohibits intimidation and retaliation in any form against anyone who participates in good faith in the NYCDOE's Medicaid Compliance Program, including, but not limited to in the following activities:

(a) reporting or threatening to report to appropriate personnel, in accordance with applicable provisions of law (see, e.g., Labor Law 740), potential compliance issues or an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

(b) participating in investigation of potential compliance issues;

(c) participating in self-evaluations, audits;

(d) cooperating with or implementing remedial/corrective action in response to compliance deficiencies or failures;

(e) reporting to SCI or the NYC Department of Investigation instances of intimidation or retaliation; and/or

(f) reporting potential fraud, waste or abuse to the appropriate city, state or federal entities;

(g) objecting to or refusing to participate in any actual or suspected activity, policy or practice that is illegal, fraudulent, or in violation of any Laws and/or adopted policy pertaining to NYCDOE's participation in the federal Medicaid program.

REPORTING PROCEDURE:

Affected Individuals who believe that they have been retaliated against because they have reported or participated in an investigation of a possible instance of misconduct or fraud pertaining to NYCDOE's participation in the federal Medicaid program should contact the Medicaid Compliance Officer or SCI as follows:

NYCDOE Medicaid Compliance Officer – CONFIDENTIAL
Attention: Dina Karagiorgos
100 Gold Street
New York, NY 10038
Phone: 212-374-0274
E-mail: Medicaid@schools.nyc.gov

Anonymous & Confidential Toll-Free Compliance Hotline: 877-393-5432

The Special Commissioner of Investigation for the New York City School District (SCI)
80 Maiden Lane, 20th Floor
New York, NY 10038
Phone: 212-510-1500 or Toll Free 877-888-8355

SCI Online Complaint Form: https://nycsci.org/online-complaint-form/

Allegations of retaliation will be referred to SCI for appropriate action.

VII. APPENDIX B: Summary of Federal, New York State, and New York City Laws Related to Fraud, Waste, and Abuse in Federal Healthcare Programs as Required by the Deficit Reduction Act of 2005

WHISTLEBLOWER PROTECTION LAWS

New York State Labor Law § 740 Whistleblower Protections for Employees. Prohibits retaliatory action by employers against employees because of complaints of employer violations.

New York State Labor Law § 741 Whistleblower Protections for Healthcare Workers. Prohibits retaliatory action by healthcare employers who penalize employees because of complaints of employer violations.
New York City Administrative Code 12-113

18 NYCRR 521-1.4(a) requires inclusion of Title 42 United States Code § 1396-a(a)(68), also known as the DRA, which states:

Any entity … as a condition of receiving [Medicaid] payments, shall:

(A) establish written policies for all [affected individuals], that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

New York City Whistleblower Protection

The New York City Administrative Code § 12-113 protects NYC employees and employees of City contractors who report corruption. Any employee of a City contractor, or subcontractor of a City contractor, with a contract valued at more than $100,000 is protected under the law from retaliation by his or her employer if the employee reports wrongdoing related to the contract to the New York City Department of Investigation (DOI) or corporation counsel.

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.

NEW YORK STATE STATUTES

The New York False Claims Act and other state laws address false claims. These laws fall into two categories: 1) civil and administrative laws; and 2) 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 "common law" crimes are also applicable.

Civil and Administrative Laws

18 NYCRR 521-1.4(a) requires inclusion of Title 42 United States Code § 1396-a(a)(68), also known as the DRA, which states:

> Any entity … as a condition of receiving [Medicaid] payments, shall:
>
> (A) establish written policies for all [affected individuals], that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1320a–7b(f) of this title);
>
> (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
>
> (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

New York False Claims Act (New York State Finance Law Article XIII, §§ 187-194)

The NY False Claims Act closely resembles the federal False Claims Act. 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. It also has a provision regarding reverse false claims similar to the federal FCA. A person or entity will be liable in those instances in which the person obtains money from a state or local government to which he or she is not entitled, and then uses false statements or records in order to keep the money. There are penalties of at least $6,000 but not more than $12,000 per claim and damages of not more than two times the loss the government sustains because of the false claim. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to some limitations imposed by the State Attorney General or a local government. If the lawsuit eventually concludes with payments back to the government, the person who started the case can recover, in addition to reasonable attorneys' fees and other related expenses, a percentage of the proceeds, amounts of which are dependent upon whether the government did or did not participate in the lawsuit and the extent the person contributed to the prosecution (25% - 30% if the government did not participate in the lawsuit, 15% - 25% if the government did participate in the lawsuit and 10% or less if the court finds most of the relevant information in the case was provided by a source other than the person who filed the lawsuit).

New York Social Services Law §145-b; False Statements; Actions for Treble Damages

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 (3) times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000

per violation. If the offender engages in repeat violations within a five-year period, a penalty of up to $30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

New York Social Services Law § 145-c; Sanctions
If a person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his or her family shall not be taken into account for the purpose of determining his or her needs or that of his or her family for six (6) months after a first offense, for twelve (12) months after a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen (18) months after a third offense (or if benefits wrongfully received are in excess of $3,900), and for five (5) years for any subsequent offense.

False Claims Recoveries – Medicaid Fraud and Abuse

Criminal Laws
New York 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.

New York Social Services Law § 366-b; Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain Medicaid, for himself or others, by means of a false statement, concealment of material facts, impersonation or other fraudulent means, is guilty of a class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment a 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, is guilty of a class A misdemeanor.

New York 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. This statute has been applied to Medicaid fraud cases.

a. § 155.30 Fourth degree grand larceny involves property valued over $1,000. This is a Class E felony.

b. § 155.35 Third degree grand larceny involves property valued over $3,000. This is a Class D felony.

c. § 155.40 Second degree grand larceny involves property valued over $50,000. This is a Class C felony.

d. § 155.42 First degree grand larceny involves property valued over $1,000,000. This is a Class B felony.

New York Penal Law Article 175; False Written Statements

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

a. § 175.05 Falsifying business records in the second degree involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. This is a Class A misdemeanor.

b. § 175.10 Falsifying business records in the first degree includes the elements of § 175.05 plus the additional element of the intent to commit another crime or conceal its commission. This is a Class E felony.

c. § 175.30 Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. This is a Class A misdemeanor.

d. § 175.35 Offering a false instrument for filing in the first degree includes the elements of § 175.30 plus the additional element of the intent to defraud the state or one of its political subdivisions. This is a Class E felony.

New York Penal Law Article 176; Insurance Fraud

A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self insurer, or purported insurer, or purported self insurer, or any agent thereof.

a. § 176.10 Insurance fraud in the fifth degree.

   A person is guilty of insurance fraud in the fifth degree when he commits a fraudulent insurance act. Insurance fraud in the fifth degree is a class A misdemeanor.

b. § 176.15 Insurance fraud in the fourth degree.

   A person is guilty of insurance fraud in the fourth degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one thousand dollars.
   Insurance fraud in the fourth degree is a class E felony.

c. § 176.20 Insurance fraud in the third degree.

   A person is guilty of insurance fraud in the third degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of three thousand dollars.
   Insurance fraud in the third degree is a class D felony.

d. § 176.25 Insurance fraud in the second degree.

   A person is guilty of insurance fraud in the second degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or

withhold property with a value in excess of fifty thousand dollars.
Insurance fraud in the second degree is a class C felony.

e. § 176.30 Insurance fraud in the first degree.

   A person is guilty of insurance fraud in the first degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one million dollars.
   Insurance fraud in the first degree is a class B felony.

f. § 176.35 Aggravated insurance fraud.

   A person is guilty of aggravated insurance fraud in the fourth degree when he commits a fraudulent insurance act, and has been previously convicted within the preceding five years of any offense, an essential element of which is the commission of a fraudulent insurance act.
   Aggravated insurance fraud in the fourth degree is a class D felony.

<u>New York Penal Law Article 177; Health Care Fraud</u>
This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system, including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute. This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes five (5) crimes.

a. § 177.05 Health care fraud in the fifth degree – with intent to defraud a health plan, a person knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a Class A misdemeanor.

b. § 177.10 Health care fraud in the fourth degree – a person files such false claims on one or more occasions and the payment or portion of the payment wrongfully received from a single health plan in a period of not more than one year is over $3,000. This is a Class E felony.

c. § 177.15 Health care fraud in the third degree – a person files such false claims on one or more occasions and the payment or portion of the payment wrongfully received from a single health plan in a period of not more than one year is over $10,000. This is a Class D felony.

d. § 177.20 Health care fraud in the second degree - a person files such false claims on one or more occasions and the payment or portion of the payment wrongfully received from a single health plan in a period of not more than one year is over $50,000. This is a Class C felony.

e. § 177.25 Health care fraud in the first degree - a person files such false claims on one or more occasions and the payment or portion of the payment wrongfully received from a single health plan in a period of not more than one year is over $1,000,000. This is a Class B felony.

NEW YORK CITY LAW

New York City False Claims Act

New York City Administrative Code § 7-805. The New York City False Claims Act of 2005 (as amended in 2012) authorizes citizens to bring lawsuits on behalf of the City to recover treble damages for fraudulent claims submitted to the City. An important 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.