

MEDICAID COMPLIANCE PROGRAM**I. INTRODUCTION**

Agencies and departments of the U.S. Government have identified a number of instances of fraud, abuse, and waste in federally funded health care programs including Medicaid. The South Colonie Central School District recognizes the seriousness of the issues raised by the government and recognizes that failure to comply with applicable laws and regulations could threaten the District's continuing participation in federal health care programs.

Accordingly, the District shall undertake an integrity program in order to continue the District's commitment to high standards of conduct, honesty, and reliability in its business practices. The purpose of this Compliance Program is to make a sincere effort to prevent, detect, and correct any fraud, abuse, or waste in the District in connection with federally funded health care programs. In order to accomplish this goal, the program strives to create a culture that promotes understanding of and adherence to applicable federal, state, and local laws and regulations. To be effective the Compliance Program should be a continuously evolving effort to meet the changing regulatory landscape.

It is the policy of the District to comply with all applicable federal and state laws and regulations pertaining to fraud, waste and abuse in accordance with the Federal Fraud Enforcement and Recovery Act of 2009, the New York State False Claims Act, and all other applicable Federal and State laws and regulations.

A. Expected Conduct

The Compliance Program describes the expected conduct of all District employees including:

Employees: all District employees including officers, administration and staff, both instructional and non-instructional.

Volunteers: those individuals working at the District on an unpaid basis.

Contractors: an entity with whom the District has a written agreement to provide health care items or services, or perform billing or coding functions.

B. Examples of Medicaid Fraud

Examples of fraud covered under this policy include, but are not limited to, such actions when they are done intentionally and knowingly:

- Billing for medical services not actually performed.
- Providing unnecessary services.
- Billing for more expensive services.
- Billing for services separately that should legitimately be one billing.

- Failing to provide medically necessary services.
- Billing more than once for the same medical service.
- Giving or accepting something of value (cash, gifts, services) in return for medical services, i.e. kickbacks.
- Falsifying cost reports.

Employees, contractors and agents who prepare, process and/or review claims should be alert for these and other errors.

C. Compliance

The District believes that an effective compliance program shall have the following basic elements:

- Written policies and procedures.
- A designated Compliance Officer and a Compliance Committee.
- Effective training and education.
- Effective lines of communication.
- Standards enforced through well-publicized disciplinary guidelines.
- Auditing and monitoring.
- Response to suspected and/or detected offences and corrective action plans.

D. Purpose of this Document

This document describes the above listed basic compliance elements as they fit within the District and details the fundamental principles, values, and operational framework for compliance within the District. It articulates the organization's commitment to compliance and the goals to which the organization strives.

E. Disclaimer

Nothing in this document shall:

- constitute a contract of or agreement for employment;
- modify or alter in any manner any employee's at-will employment status; or
- modify any rights of staff as set forth in the respective collective bargaining agreements.

Any part of this policy may be changed or amended at any time without notice to any employee.

II. WRITTEN POLICIES AND PROCEDURES

An effective compliance program should define the expected conduct of its employees through the establishment of written policies and procedures.

A. Periodic Review

To effectively manage known risks, adherence to policies and procedures should be reviewed on a periodic basis. In addition, newly identified risks should result in the promulgation of new policies and procedures or revisions to old ones as well as action plans, where necessary, to address those risks.

B. Communication

Policies and procedures, to be effective, should be clearly communicated to employees such that they are capable of integrating them into their daily operations. Methods for accomplishing this include administrative notification, posting of policies and procedures on the District's Intranet, inclusion in documents such as member handbooks, performance evaluations, newsletters, and via the provision of training.

III. OVERSIGHT AND MANAGEMENT OF THE PROGRAM**A. Compliance Committee**

The purpose of the Compliance Committee is to provide oversight of the District's regulatory compliance and business ethics with respect to the Medicaid program. The Compliance Committee members shall be appointed annually at the District organizational meeting. The Committee shall be comprised of at least one Board of Education member who is also a member of the Board of Education Audit/Finance Committee, and those staff members that are familiar with the District's accounting, business, and finance functions related to the Medicaid program. Special Education or additional school business officials shall be invited to Compliance Committee meetings as necessary. The Compliance Committee shall report to the Board of Education through the Audit/Finance Committee.

B. Compliance Officer

The Director of Pupil Personnel Services shall be designated as the Medicaid Compliance Officer (MCO) and shall be responsible for the day-to-day operation of the Medicaid Compliance Program. The performance of the duties and responsibilities of the MCO shall be reviewed at least annually by the Compliance Committee.

1. Duties: The MCO's primary responsibilities shall include:
 - a. Overseeing and monitoring the implementation of the Compliance Program.
 - b. Reporting on a regular basis to the Board of Education, the Superintendent and the Compliance Committee on the progress of implementation.

- c. Assisting the Board of Education, the Superintendent and the Compliance Committee in establishing methods to improve the District's efficiency and quality of services, and to reduce the District's vulnerability to fraud, abuse, and waste.
 - d. Periodically revising the Compliance Program as required by changes in the law.
 - e. Developing, coordinating and participating in an educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all individuals to whom this program is extended are knowledgeable of, and comply with, pertinent federal and state standards.
 - f. Ensuring that independent contractors and agents are aware of the requirements of the Compliance Program with respect to coding and billing, among other things.
 - g. Coordinating personnel issues with the Director of Human Resources in performing criminal background checks on individuals following an offer of employment, but prior to the individual starting work.
 - h. Assisting in coordinating internal compliance reviews and monitoring activities, including annual or periodic reviews of departments and audits.
 - i. After consultation with legal counsel, investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action.
 - j. Developing procedures and programs that encourage employees to report suspected fraud and other improprieties without fear of retaliation.
2. Authority: The MCO shall have access to all documents and information relevant to compliance activities, including but not limited to billing records, contracts, written arrangements, or agreements with others. The MCO shall seek the advice of the District's attorney as necessary to ensure compliance with all federal and state laws. The MCO shall make written and/or oral reports on compliance activities including reports on complaints received from employees, investigations, audits, and monitoring to the Compliance Committee, Board of Education, and the Superintendent on a regular basis. Reports to the Board of Education shall be at least annually or more often as necessary or advisable.

IV. TRAINING AND EDUCATION

A. Requirement

Training is required by the federal and state governments to provide employees with the knowledge and skills to carry out their responsibilities in compliance with all requirements. Proper and continuing training and education of employees at all levels is, therefore, a significant element of the District's Compliance Program. Adherence to and promotion of this program shall be a factor in evaluating the performance of employees.

B. Content

The MCO strives to ensure that training and education for all District employees, contractors, and agents shall include the dissemination of this policy.

This Policy will be distributed to District employees via the District's media sources. In addition, hard copies will be provided to new employees during the orientation process and current employees in those departments providing Medicaid health care items or services for which Medicaid payments are made.

C. Initial Education

The MCO shall strive to ensure that all new employees participate in a training session introducing them to the purpose of compliance, healthcare fraud, abuse and waste, and HIPAA privacy and security. The employee shall receive an explanation of the District's Compliance Program including a specific discussion of the laws, the rights of employees to be protected as whistleblowers (as defined in Section V., G., Non-Retaliation), and a specific discussion of the District's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. Subsequent Retraining

Periodically, but not less than annually, employees (as defined in Section I., A., Expected Conduct) should be retrained on the District's Compliance Program.

E. Post-Risk Assessment Training

In the performance of its duty to monitor compliance, the MCO may establish the need for additional training. When identifying a problem, the MCO, together with the Compliance Committee, will develop and provide specific training for the identified issue. As part of the regularly scheduled risk assessment process, risk areas will be identified. Training for these risk areas will be specific to the departments and employees involved.

F. Evolving Regulatory Training

As new laws and regulations are implemented, the MCO together with the Compliance Committee shall consult to interpret, implement and revise policies, procedures, and training.

G. Types of Training

Training and education may occur in sessions with individual employees, in mandatory inservice meetings, incorporated into special or regular departmental meetings, or in some other effective manner. Training and education may consist of live presentations, videos, question and answer sessions, written material, and/or web-based sessions.

H. Amount of Training

All employees need not have the identical amount of training and education, nor should the focus of training and educational efforts be the same for all employees. Targeted training and education should be provided to employees whose actions may affect the accuracy of claims submitted to the government. The actual amount of training should reflect necessity, an analysis of risk areas, or areas of concern identified by the District or the New York State Office of Medicaid Inspector General (OMIG), and the results of periodic audits or monitoring.

I. Documentation

The MCO strives to document policies, procedures, and training provided to each employee. Appropriate documentation shall include the date and a brief description of the subject matter of the training activity or program. Documentation is important and should be retained on file.

J. Failure to Comply

Failure of employees to comply with training requirements or to attend scheduled training sessions of the District may result in disciplinary action.

K. Evaluation

There should be periodic evaluations of training and education programs to determine, and if necessary improve, the value, effectiveness, and appropriateness of any such program.

V. COMMUNICATION**A. Reason**

The District strives to ensure that open, two-way communication lines to the MCO are accessible to all employees, contractors and agents to allow compliance issues to be reported. This open communication is essential to maintaining an effective compliance program. It increases the District's ability to identify and respond to compliance issues and reduces the potential for fraud, abuse and waste. Without help from employees it may be difficult to learn of possible compliance issues and make necessary corrections.

B. Questions

At any time employees should be free to request information or education. Employees should be able to seek clarification or advice from the MCO in the event of any confusion or question regarding any element of this Program. The MCO will strive to document questions and their responses and, if appropriate, share them with other employees for informational and educational purposes.

C. Communication with Employees and Contractors

The District strives to maintain open two-way channels of communication with its employees and contractors. This communication may include information on policies, guidelines, and/or changes in the law. Communication methods can include one-on-one conversations, mailings or emails to individual members, education sessions, small-and large-group meetings and/or periodic newsletters.

D. Reporting

It is expected that all officers and employees of the District shall fulfill the public's trust and conduct themselves in an honorable manner, abiding by all District policies and regulations and by all applicable federal and state laws and regulations.

Employees who are aware of or suspect acts of fraud, abuse, waste or violations of the standards of conduct have a duty to notify the MCO of such activities, including giving the institution reasonable time to investigate and to respond to such allegations. Having knowledge of inappropriate conduct and choosing not to report it is, in itself, a violation of this policy. The District strives to establish and maintain several independent reporting paths for an employee to report fraud, waste, or abuse:

- Persons covered by this policy who suspect a violation of the Federal or State False Claims Provisions are expected to notify the MCO (to the extent he/she is not involved).
- Individuals who feel that the MCO is not responding, or that the MCO may be involved, may express their concerns to the Superintendent.
- The District will strive to investigate all allegations individuals bring forward and will make every attempt to correct those found to be true and prevent future occurrences.
- Individuals who feel that nothing is being done to address their concerns have the right to report their suspicions to the appropriate government agency including the New York State Office of the Medicaid Inspector General at 1-877-873-7283.

E. Feedback

The District strives to provide appropriate feedback regarding resolution of reported issues. Such feedback may include reports through confidential meetings or confidential communications.

F. Confidentiality

The MCO will treat all reports confidentially, to the extent possible under applicable law. However, there may be a time when an individual's identity may become known or have to be revealed if governmental authorities become involved or in response to a subpoena or other legal proceedings.

G. Non-Retaliation

The District strives to ensure that there will be no intimidation of or retaliation against any employee who in good faith reports acts or suspected acts of fraud, abuse, or waste; violations or suspected violations of the standards of conduct; or other wrongdoing or misconduct. An employee who has been subject to an adverse employment action based on his or her prior disclosure of alleged or actual wrongful conduct may contest the adverse employment action by filing a written complaint of reprisal with the MCO, or his/her designee. An adverse employment action shall be defined as discharge, suspension or demotion of an employee, or other adverse employment action affecting compensation, appointment, promotion, transfer, assignment, reassignment, reinstatement or evaluation of performance.

Any District employee who makes a report of wrongful conduct without any good faith basis may be subject to termination or other disciplinary action.

H. Documentation

The MCO will maintain a record of reports received, detailing violations of this Program, the standards of conduct, or relevant laws or regulations. The MCO will periodically furnish a summary of such reports to the Board of Education, the Superintendent and the Compliance Committee.

VI. ENFORCEMENT THROUGH DISCIPLINE**A. General Statement of Policy**

The District encourages good faith participation in the compliance program by all employees including reporting compliance issues and assisting in their resolution. Appropriate disciplinary action will be taken promptly against any employee or contractor, determined to have violated any applicable Federal, State or local law or regulation, or this policy.

All employees are expected to abide by the Code of Ethics as set forth in Appendix B. Any violations of the Code of Ethics shall subject employees to discipline as set forth herein.

The District shall ensure that any disciplinary action follows the District's existing disciplinary policies and procedures, including any provisions of the Civil Service Law and collective bargaining agreements. Discipline should be fairly and firmly enforced.

Employees shall be disciplined for the following reasons, including but not limited to:

- Committing, authorizing, or directing an illegal act.
- Failing to report suspected problems.
- Participating in non-compliant behavior.

- Encouraging, directing, facilitating, or permitting non-compliant behavior.
- Failing to perform any obligation or duty required of employees relating to compliance with this Program or applicable laws or regulations.
- Failure of employees to detect non-compliance with applicable policies and legal requirements and this Program, where reasonable diligence on the part of the employee would have led to the discovery of any violations or problems.
- Failing to exercise proper compliance oversight or tolerating illegal conduct, if acting as a supervisor of another employee of the District.
- Failing to report illegal business conduct of which he or she directly knows or observes.
- Discouraging another employee from reporting a violation of law or of this policy.
- Improperly disclosing the identity of a person who reports a violation of this Code.
- Retaliating or condoning retaliation against any employee or contractor who reports such a violation.

B. Employees

Employees suspected of participating in fraudulent activity may be suspended without pay during the course of the investigation, in accordance with the Civil Service Law and applicable collective bargaining agreements.

Employees found to have participated in fraudulent activity will be subject to disciplinary action up to and including termination from employment and probable criminal prosecution and civil action.

Employees found to have knowledge of fraudulent activity and who knowingly failed to report the activity will be subject to disciplinary action up to and including termination from employment.

C. Contractors and Outside Agencies

The relationship of individuals or entities associated with the District found to have participated in fraudulent activity as defined by this policy will be subject to review, with the possible consequence of modification or termination of the relationship. If such action is warranted, the MCO and the Superintendent in consultation with the Board of Education shall be consulted prior to the action being taken.

Criminal or civil action may be taken against such individuals or entities.

VII. AUDITING, MONITORING AND SCREENING

The District strives to ensure that the District's Compliance Program is effective. An important element of this effort is identifying and correcting any deficiencies in the District's business processes. Identification efforts should include built-in monitoring systems, and

periodic small reviews conducted by members of the Compliance Committee, as well as larger, more formal reviews and/or audits conducted by the Internal Auditor. The MCO strives to work closely with Internal Audit, but remain a separate and distinct department.

The MCO strives to encourage the design of monitoring systems that are incorporated into day-to-day processing systems. Built-in monitoring systems can include the evaluation of a small sample of orders and/or claims at the end of each month to ensure proper documentation, coding, billing and reimbursement.

In keeping with this goal, the District shall devote such resources as are reasonably necessary to ensure that reviews are performed by persons with appropriate knowledge and experience. Reviews include both reimbursement related reviews and screening. If these reviews identify an issue that calls for further assessment, either a concurrent or a retroactive assessment may be employed with the assistance of the Internal Auditor as necessary.

A. Reimbursement Related Reviews

The District, under the direction of the MCO, strives to conduct periodic reimbursement related reviews and audits. By way of example, these reviews might include claims submitted to Medicaid as well as the claims development and submission process. They might include the work of coders, billers, as well as risk areas identified by the OMIG, or fiscal intermediaries. Reviews and audits might also cover the District's relationship with third party contractors and compliance with laws governing kickback arrangements.

Access. Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, e-mail and the contents of computers and electronic storage devices. Auditors and reviews shall at all times bear in mind confidentiality requirements.

Action. The MCO will be notified of the results of all audits performed by the internal auditor, external auditor, or government auditors that identify potential compliance issues. Further action, if any, by the MCO with respect to any deviation or discrepancy revealed by an audit will be responded to in accordance with the Section entitled Responding to Offenses and Developing Corrective Actions.

Documents. All audits shall be thoroughly documented. Such documents shall be maintained in the permanent files of the Office of the MCO and adequately secured.

B. Screening

The District strives to conduct a reasonable level of screening to ensure that it does not employ or contract with ineligible persons.

New Employees and Applicants. The District shall conduct a reasonable background investigation of all new employees or applicants for employment. This investigation is of primary importance for those employees who will have discretionary authority to

make decisions that may materially impact the Medicaid claim development and submission process. The purpose of the background investigation is to determine whether any such employee or applicant has been convicted of a criminal offense related to healthcare, or listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation.

Providers. A similar reasonable background investigation shall be undertaken for providers who do or will possess an individual Medicaid provider number. Such providers also are periodically screened.

Contractors. Contractors shall be periodically screened to determine whether they have been disbarred or excluded by a federal agency.

Prohibition. It is the goal of the District not to hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicaid claim development and submission process if such prospect or employee has been convicted of a crime related to healthcare or has been excluded or debarred. The District also strives not to contract with any person or entity that has been so convicted, excluded, or debarred, and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. The District strives to make reasonable and prudent efforts not to submit any claims for service ordered or furnished by any person or entity, excluded from participation.

VIII. RESPONDING TO OFFENSES AND DEVELOPING CORRECTIVE ACTIONS

Violations of the District's compliance program, failures to comply with applicable Federal and State law, and other types of misconduct threaten the District's status as a reliable, honest, and trustworthy agency, capable of participating in Federal healthcare programs. The District strives to ensure that all allegations of failure to comply are promptly and thoroughly investigated and that there is a prompt and appropriate response to all government inquiries.

A. Confidential Disclosure Policy

The District shall establish a confidential disclosure mechanism enabling employees to disclose anonymously any practices or bill procedures, deemed by the employee to be inappropriate, to the State's Compliance Officer. The District shall make the confidential disclosure mechanism known to each employee as part of his or her training. The District shall, as part of the confidential disclosure program, require the internal review of any such credible disclosure and ensure that proper follow-up is conducted.

The District shall include in its annual compliance report to the Medicaid Compliance Officer a summary of communications concerning inappropriate billings or any other inappropriate conduct under the confidential disclosure program, and the results of any internal review and follow-up of such disclosures.

The Confidential Disclosure Policy required will consist of the following:

1. An employee of this District, who believes that any practice or billing procedure related to Medicaid reimbursement of School or Pre-School Supportive Health Services is inappropriate, may send information concerning such practice or billing procedure to the State Compliance Officer by U.S. Mail, courier service, e-mail or facsimile transmission. Disclosures may be made anonymously. An employee's verbal communication or any such allegation will not be sufficient to require any further action to be initiated under the Confidential Disclosure Policy procedures set forth below.
2. The Compliance Officer will send any disclosures to the relevant state agency and to the implicated local school district, if any. If the Compliance Officer is aware of the employee's identity, he/she will not reveal it to any other person without the employee's written consent, provided by U.S. Mail, courier service, e-mail or facsimile transmission.
3. The relevant state agencies and local school district shall undertake a review of the practice described in the employee's disclosure without attempting to uncover the identity of the complaining employee and shall determine:
 - a. whether the employee's allegations are credible,
 - b. whether any federal or state statute, regulation, or policy pertaining to any practice or billing procedure related to Medicaid reimbursement of School or Pre-School Supportive Health Services has been violated, and
 - c. whether any such violation is systemic or was limited to one or a small number of cases.
4. The relevant state agencies and local school districts shall address any violation found during the review, whether systemic or limited in a manner designed to avoid a similar violation in the future and to remedy the effect of the violation in the cases in which it was found to have occurred. If the review determines the violation was systemic, the relevant state agencies and local school district shall take all steps necessary to identify the cases in which the violation occurred and then to remedy the effect of the violation in those cases.
5. Within ninety (90) days of receiving notice from the Compliance Officer of the information provided by an employee, the relevant state agencies and local school district shall:
 - a. complete the review of such allegations and any remedial plan required as a result of such review, and
 - b. provide to the Compliance Officer a written description of the review, the remedial plan and all actions taken pursuant to such plan.

In the event the relevant state agencies and local school district determine the employee's allegations are not credible, the written response shall describe the basis for such determination. The written document shall identify the individual(s) at the relevant state agencies and local school district who was (were) responsible for approving the review, the remedial plan and all actions taken pursuant to such plan, including the person's name, job title, telephone number, mailing address, e-mail address, and fax number.

6. If the Compliance Officer is not satisfied with the review, the remedial plan, or the actions taken pursuant to such plan, he/she may discuss the matter with the relevant state agencies and local school district to resolve these concerns. In addition, the Compliance Officer may, if he/she considers it necessary to assure the State's compliance with the Compliance Agreement, request that the Audit Unit of DOH's Division of Administration undertake an audit to determine:
 - a. whether a violation occurred,
 - b. whether any such violation has been remedied, and
 - c. whether the remedial action is sufficient to prevent similar violations in the future.
7. In the event the employee's identity becomes known to a relevant state agency or local school district or to an employee of such agency or district, no adverse employment action of any type shall be taken against such employee because he/she provided information to the Compliance Officer or to a person conducting a review of the disclosure.
8. The relevant state agencies and the local school districts shall include in every training any of them provides pursuant to the Compliance Agreement:
 - a. a description of the Confidential Disclosure Policy procedures described above,
 - b. the name, mailing address, e-mail address, and fax number of the Compliance Officer, and
 - c. and assurance that no adverse employment action of any type will be taken against an employee because he/she provided information to the Compliance Officer or to a person conducting a review concerning alleged inappropriate practices or billing procedures related to Medicaid reimbursement of School or Preschool Supportive Health Services.

B. Investigations

The District strives to ensure that all issues reported to the MCO are promptly and thoroughly investigated.

The goals of an internal investigation include:

- Discovering facts and circumstances related to allegations of legal or regulatory non-compliance.
- Discovering all relevant facts, including those that are both incriminating and non-incriminating.
- Assessing the significance of the facts discovered to determine whether the conduct was illegal or legal but in violation of the District's policies or procedures.
- Recommend both disciplinary actions and corrective actions.

Great care must be taken in dealing with suspected dishonest or fraudulent activities to avoid the following:

- Incorrect accusations.
- Alerting suspected individuals that an investigation is underway.
- Treating employees unfairly.
- Making statements that could lead to claims of false accusations or other offenses.

Individuals who knowingly make false accusations may be subject to disciplinary action.

1. Compliance Officer Investigation. When there is reasonable indication of a violation of applicable laws or regulations, the MCO strives to ensure that it maintains primary responsibility for conducting the investigation. If the potential for uncovering illegal conduct or significant liability exposure exists, the internal investigation should be conducted at the direction of the school district's attorney and should be protected pursuant to attorney-client privilege.

In undertaking investigations, the MCO may consult with appropriate administration. The MCO may also utilize the school district attorney, outside accountants and auditors, or other consultants or experts for assistance or advice, as is deemed appropriate.

An investigation by the MCO shall be preliminary to the initiation of disciplinary proceedings.

If there is reasonable cause to believe a violation exists, the MCO shall notify the Superintendent who shall initiate a formal complaint against the employee. The adjudication of such complaint shall proceed in accordance with the laws and regulations applicable to such employee.

All participants in a fraud investigation shall keep the details and results of the investigation confidential. Investigation results will not be disclosed or

discussed with anyone other than those who have a legitimate need to know, in order to protect the reputations of persons suspected of fraudulent activity but subsequently found innocent of wrongdoing and to protect the District from potential civil liability.

2. Process. The MCO may conduct interviews with any District employee and with other persons; may review any District documents including but not limited to those related to the claim development and submission process, emails and the contents of computers and electronic storage devices; and may undertake other processes and methods as the MCO deems necessary.
3. Documentation. At the direction of the Board of Education, the MCO may prepare a report which
 - a. defines the nature of the situation or problem,
 - b. summarizes the investigation process,
 - c. identifies any person(s) whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicaid laws and regulations, and
 - d. if possible, estimates the nature and extent of the resulting overpayment by the government or another entity.
4. Responses. The District strives to respond promptly and appropriately to the discovery of possible criminal activity as well as the discovery of other non-compliant activity.
 - a. Possible Criminal Activity. In the event an investigation reveals or uncovers what appears to be criminal activity on the part of any employee, the following actions shall be taken:
 - i. All billing involved in the situation or problem shall be discontinued until such time as appropriate corrections are made.
 - ii. A summary of the results of the investigation shall be sent for appropriate disciplinary action to the Superintendent. Pending disciplinary action, and in accordance with the Civil Service Law and applicable collective bargaining agreements, any such employee may be removed from any position with oversight of or impact upon the claims development and submission process.
 - iii. Federal, State, and/or local agencies shall be notified as deemed appropriate by the MCO, legal counsel, the Superintendent, and/or the Board of Education.
 - b. Other Non-Compliance. In the event the investigation reveals claims development and submission problems, which does not appear to be

the result of criminal activity on the part of any employee, the following action shall be taken:

- i. If duplicate payments have been made by Medicaid or excessive payments made because of coding or other District errors or mistakes:
 - the defective practice or procedure will be corrected as soon as possible;
 - the duplicate or improper payments will be calculated and repaid to the appropriate payor or fiscal intermediary; and
 - a program of education will be undertaken with appropriate employees to prevent future similar problems.
 - ii. If no duplicate or excessive payments have been made because of District errors or mistakes:
 - the defective practice or procedure will be corrected as quickly as possible; and
 - a program of education will be undertaken with appropriate employees to prevent future similar problems.
 - iii. A summary of the results of the investigation shall be sent for appropriate disciplinary action, if any, to the Superintendent.
5. Reports by Compliance Officer. The MCO shall furnish information (bearing in mind issues of confidentiality) about such investigations to the Board of Education, the Superintendent and Compliance Committee.

C. Response to Governmental Inquiries

Federal and State agencies have available a number of investigation tools including search warrants, subpoenas, and civil investigation demands. Actions also may be brought against the District to exclude it from participating in Medicaid if the District fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of the District to cooperate with and properly respond to all governmental inquiries and investigations.

1. Process. Employees who receive a search warrant, subpoena, or other demand or request for investigation, or who are approached by a federal agency, should attempt to identify the investigator, if any. They should also immediately notify the MCO or the Superintendent. Employees should request the government representative to wait until the MCO or his or her designee arrives before conducting any interview or reviewing documents. The MCO, in consultation with the school district's attorney, is responsible for coordinating the District's response to warrants, subpoenas, inquiries, and investigations by federal and state agencies. If appropriate, the District also may provide legal counsel to employees.

2. Documents. The District's response to any warrant, subpoena, investigation, or inquiry must be complete and accurate. No employee shall alter, destroy, or mutilate any document or record or alter, delete, or download any material from any computer, word processor, disk, or tape, except in accordance with the District's records retentions policies. If a document is required to be retained, it must be preserved in its original form.

D. Remedial Efforts

The District will make diligent efforts to recover improper payments or refund misspent money or refund overpayments due to fraudulent or abusive actions by District employees or its contractors.

APPENDIX A

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS**I. FEDERAL LAWS****False Claims Act (31 U.S.C. §§ 3729-3733)**

The False Claims Act (“FCA”) provides, in pertinent part, that:

- (a) Any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to present a false or fraudulent claim; ... or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to 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 \$5,000.00 and not more than \$10,000.00, plus 3 times the amount of damages which the Government sustains because of the act of that person...

- (b) For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information
- 1) has actual knowledge of the information;
 - 2) acts in deliberate ignorance of the truth or falsity of the information; or
 - 3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. § 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An

example of this so-called “reverse false claim” may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, 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.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims (31 U.S.C. Chapter 38. §§ 3801 - 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000.00 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK 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.

A. CIVIL AND ADMINISTRATIVE LAWS

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

The New York False Claims Act closely tracks 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. The liability for filing a false claim is not more than two times the value of the amount falsely received. 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. 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 and 15-25% if the government did participate in the suit.

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 no more than \$10,000.00 per violation. If repeat violations occur within 5 years, a penalty up to \$30,000.00 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, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over \$3,900.00), 18 months if a third and five years for 4 or more offenses.

B. CRIMINAL LAWS

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 § 366-b, Penalties for Fraudulent Practices

1. Any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain medical assistance to which he is not entitled is guilty of a Class A misdemeanor.
2. 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 is guilty of a Class A misdemeanor.

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.

1. Fourth degree grand larceny involves property valued over \$1,000.00. It is a Class E felony.
2. Third degree grand larceny involves property valued over \$3,000.00. It is a Class D felony.
3. Second degree grand larceny involves property valued over \$50,000.00. It is a Class C felony.
4. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

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:

1. § 175.05. Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
2. § 175.10. Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
3. § 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. It is a Class A misdemeanor.
4. § 175.35. Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud

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

1. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
2. Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000.00. It is a Class E felony.
3. Insurance fraud in the 3rd degree is filing a false insurance claim for over \$3,000.00. It is a Class D felony.

4. Insurance fraud in the 2nd degree is filing a false insurance claim for over \$50,000.00. It is a Class C felony.
5. Insurance fraud in the 1st degree is filing a false insurance claim for over \$1 million. It is a Class B felony.
6. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud

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

1. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
2. Health care fraud in the 4th degree is filing false claims and annually receiving over \$3,000.00 in the aggregate. It is a Class E felony.
3. Health care fraud in the 3rd degree is filing false claims and annually receiving over \$10,000.00 in the aggregate. It is a Class D felony.
4. Health care fraud in the 2nd degree is filing false claims and annually receiving over \$50,000.00 in the aggregate. It is a Class C felony.
5. Health care fraud in the 1st degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

III. 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 the same seniority as employee 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 False Claim Act (State Finance Law § 191)

The False Claim 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 the same seniority as the employee 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 \$10,000.00 on the employer.

APPENDIX B**CODE OF ETHICS****A. Introduction**

The District and its employees are committed to high standards of ethical behavior. All business decisions are made on the basis of Integrity, Compassion, Teamwork and Excellence.

B. Confidential Information

District policy prohibits employees from disclosing confidential information outside the District, either during or after employment, without authorization to do so.

C. Fraud

District policy prohibits fraud of any type or description.

D. Accounting Controls, Procedures & Records

District policy requires the maintenance of books and records that accurately and fairly reflect its business transactions. In this regard, the District's business officials shall:

1. Act with honesty and integrity in all professional relationships.
2. Provide the public with information that is accurate, complete, objective, relevant, timely and understandable.
3. Comply with rules and regulations of federal, state and local governments, and other appropriate public regulatory agencies.
4. Act in good faith, responsibly, with due care, competence and diligence, without misrepresenting material facts or allowing independent judgment to be subordinated.
5. Share knowledge and maintain skills important and relevant to District and public needs.
6. Proactively promote ethical behavior as a responsible partner among peers in the work environment.
7. Achieve responsible use of and control over all District resources for which responsible.

Employees who have evidence of fraud or other breaches of this Code are encouraged and expected to report them to their supervisor and/or Superintendent. Such reports will be

investigated in reference to applicable laws and District policy. It is unlawful and against District policy to institute reprisal or retaliation against employees for reporting such concerns.

Breaches of this code or any other unlawful acts by the District's officers, directors or employees may be subject to dismissal from employment and/or fines, imprisonment and civil litigation according to applicable laws.

Approved: December 1, 2009

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