**BOARD OF EDUCATION**
**AMITYVILLE UFSD**
**REGULAR MONTHLY MEETING – July 14, 2010**

---

**FOR ACTION**

**Agenda Item**
**3C – 13**

# Resolution to Adopt a "Medicare Compliance Plan"

**WHEREAS**, the New York State Education Department, the NYS Health Department and the NYS Office of the Medicaid Inspector General entered into the New York State School Supportive Health Services Program Compliance Agreement (the Agreement) on July 20, 2009 as part of a settlement with the Federal Government in connection with allegations of false Medicaid claims, and ,

**WHEREAS**, the Agreement requires New York State and school districts to establish a confidential disclosure mechanism that enables employees to anonymously disclose any possible improper practices or procedures, and,

**WHEREAS**, the development of written compliance procedures, though not explicitly required, is considered a "best practice," and,

**WHEREAS**, the Amityville School District has prepared a formal written "Medicaid Compliance Plan to meet the "best practice" standard, and,

**WHEREAS**, the training of all District staff and all affected vendors shall be based upon the district Medicaid Compliance Plan, and,

**WHEREAS**, the district Plan has been reviewed and approved by legal counsel, now, therefore,

**Motion made by** _____ and seconded by _____
to approve and adopt the Amityville School District Medicaid Compliance Plan.

**Superintendent/Designee:** _____

Prepared by: Dr. William Fanning
Typed by: wjf
H:\Fanning - Amityville 2008 - RESOLUTIONS - Bid Awards, etc\Resolutions for July 14, 2010 Regular Meeting\Resolution - 3C- 13 - Medicaid Compliance Plan - Adoption.doc

# AMITYVILLE UNION FREE SCHOOL DISTRICT
# MEDICAID COMPLIANCE PLAN

**I have received a copy of the Amityville Union Free School District's Medicaid Compliance Plan.**

**Staff Member's Name:** _____

**Staff Member's Signature:** _____

**Title:** _____

**Building Assignment:** _____

**Date:** _____

# AMITYVILLE UNION FREE SCHOOL DISTRICT
# MEDICAID COMPLIANCE PLAN

## PART ONE: General Descriptions

### I. Policy

1. It is the policy of Amityville Union Free School District, to comply with all applicable federal, state and local laws and regulations, both civil and criminal.

2. It is the policy of the Amityville Union Free School District to require staff to comply with the Medicaid Compliance Plan and any additional standard of conduct which may be adopted by the District.

3. The Plan summarizes the provisions of the Amityville Union Free School District Compliance Program and the requirements of the Federal Deficit Reduction Act of 2005, 42 USCs 1396(a)(68), and provides information to Amityville Union Free School District staff about important federal and state laws. The provisions, standards and requirements of the program will be reviewed with each new employee and provided to all employees.

### II. Scope

1. The Plan applies to all employees of the Amityville Union Free School District providing Medicaid health care items or services for which Medicaid payments are made.

2. The Plan applies to all contractors and agents who furnish or authorize the furnishing of Medicaid services on behalf of the Amityville Union Free School District County, or perform billing or coding functions or are involved in monitoring the care provided by the County, hereinafter referred to as "agent."

### III. Administration

1. The Plan will be implemented by administrative staff of the Amityville Union Free School District.

### IV. Procedures

1. Each employee or agent of the Amityville Union Free School District will strive to act in accordance with the provisions of any applicable federal, state and local laws, and the Medicaid Compliance Plan, and will encourage other employees or agents to act the same. The District will appoint a Medicaid Compliance Officer to oversee implementation of this Plan.

2. No employee or agent of the Amityville Union Free School District has the authority to act contrary to the provisions of any applicable laws, the Ethics Code, or the Compliance Plan or to authorize, on direct action by any other employee or agent. Any employee or agent of the Amityville Union Free School District County who has knowledge of activities that he or she believes may violate a law, rule or regulation has an obligation, after learning of such activities, to promptly report the matter to his or her immediate supervisor and/or the Medicaid Compliance Officer. Reports may be made anonymously and employees will not be penalized for reports made in good faith. Failure to report known violations, failure to detect violations due to negligence or reckless conduct and intentionally making false reports shall be grounds for disciplinary action, including termination. The appropriate form of discipline will be case-specific, and in accordance with NYS Civil Service Law, NYS Education Law and/or existing collective bargaining agreements.

3. The Amityville Union Free School District will take steps to communicate its standards and procedures to all employees and agents by disseminating information that explains in a practical manner what is required. This will include distribution of this Plan through annual, mandatory provider training.

4. The Amityville Union Free School District will take steps to achieve compliance with its standards by utilizing monitoring and auditing systems reasonably designed to detect misconduct by its employees and agents and by having in place and publicizing a reporting system whereby employees and other agents can report misconduct within the Amityville Union Free School District without fear of retribution.

5. After a suspected Medicaid related violation has been reported, the Amityville Union Free School District will take reasonable steps to respond appropriately and to prevent further similar violations, including any necessary modifications to its program to prevent and detect violations of law.

6. The Plan is designed to provide all employees of the Amityville Union Free School District with information about relevant federal and state laws whose intent is to prevent and detect waste, fraud and abuse in federal health care programs such as Medicare and Medicaid. Individuals who, in good faith, report suspected non-complaint behavior are protected by both federal and state law.

7. This Plan is intended to communicate all current procedures regarding compliance.

8. All contractors and agents who furnish, or authorize the furnishing of, Medicaid services on behalf of the Amityville Union Free School District, or perform billing or coding functions or are involved in monitoring the care provided by the Amityville Union Free School District are required to communicate the essence of this Plan and its related procedures to their employees, and are responsible for ensuring that their employees understand and comply with the Plan..

## V. Distribution

The Plan and related Procedures will be distributed to Amityville Union Free School District employees via the Amityville Union Free School District's web page. In addition, hard copies will be provided to new employees during the orientation process, and to current employees in those departments that are currently responsible for managing or processing Medicaid health care items or services for which Medicaid payments are made. All such employees will be required to sign a statement of certification that they have been informed of the Amityville Union Free School District Plan and related Procedures. The Plan and Procedures will be distributed to all agents of the Amityville Union Free School District who provide Medicaid health care items or services for which Medicaid claims are made by the Amityville Union Free School District. Such agents will have signed a contract to waive their ability to claim Medicaid reimbursement.

# PART TWO: Federal and State Laws

## FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

## I. Federal Laws

### False Claims Act (31 USC §§3729-3733)

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

(a) 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 . .

## II. New York State Laws

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some laws 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

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

The NY 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 penalty for filing a false claim is generally $6,000 - $12,000 per claim and the recoverable damages are generally between two and three times the value of the amount falsely received. In addition, the false claim filer may be required 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 a lawsuit eventually results in the awarding of payments to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit, or 15-25% if the government did participate in the suit.

**Social Services Law §145-b False Statements**

It is a violation to knowingly obtain, or attempt to obtain, payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

**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 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, 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**

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

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.

**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.

- Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
- Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
- Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
- 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 as follows:

**§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.

**§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.

**§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.

**§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 can involve six crimes as follows:

- Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
- Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

- Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

- Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

- Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

- 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:

a. 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.

b. Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony

e. 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 comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

**NY False 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 comparable seniority as the *qui tam* relator would have

had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

**New York Labor Law §740**

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

**New York Labor Law §741**

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

# M3.0 Medicaid Provider Agreement.

PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND
THE SERVICE PROVIDERS UNDER CONTRACT WITH THE SCHOOL DISTRICT
WHICH IS ENROLLED IN THE NEW YORK STATE MEDICAID
SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)

Based upon a request by the school district to participate in the New York State Medicaid SSHP Program under Title XIX of the Social Security Act.

_____
(Organization/Contracted Provider's Name

Will hereinafter be called the (outside contracted) Provider, agrees as follows to:

A)

1) Keep any record necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medicaid Assistance.

2) On request, furnish the New York States Department of Health, or its designee and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A)(1), and any information regarding any Medicaid claims reassigned by the Provider.

3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B.

B) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1974, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and/or marital status.

C) Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York State Social Service Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York.

(Outside Contract) Providers Authorized Signature: _____

Address: _____

City: _____State: _____Zip:_____

Please list the School District(s) under contract with on the back of this form.
STATEMENT OF REASSIGNMENT

_____
Name of the Outside Contracted Provider

By this reassignment the above-named outside contracted provider of services agrees:

1. to reassign all Medicaid reimbursements to your school district that you contracted with for providing medical services billed under the School Supportive Health Services Program (SSHSP).

2. to accept as payment in full the contracted reimbursement rates for covered services.

3. to comply with all the rules and policies as described in your contract with the school district.

4. to agree not to bill Medicaid directly for any services that the school district will bill For under the SSHSP program.

NOTE: Nothing in this "Agreement of Reassignment" would prohibit a Medicaid Practitioner from claiming reimbursement for Medicaid eligible services rendered Outside of the scope of the School Supportive Health Services Program (SSHSP).

_____ _____

(Date) (Outside Contract Service Provider's Signature)

_____

School District (under contract with): List additional ones on back of this form.