NEW YORK STATE
Office of the Medicaid Inspector General

Medicaid Managed Care Fraud, Waste and Abuse Prevention Programs

JANUARY 2023

This guidance does not constitute rulemaking by OMIG and does not have the force of law or regulation. Nothing in this guidance alters any statutory or regulatory requirement. In the event of a conflict between statements in this guidance and either statutory or regulatory requirements, the requirements of the statutes and regulations shall govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. This guidance does not encompass all the current compliance program requirements and, therefore, is not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney or a compliance consultant.

This guidance supersedes any prior guidance issued by OMIG addressing, or relating to, reporting fraud, waste and abuse and responsibilities of Special Investigations Units. OMIG may amend this guidance as necessary.

Contents

INTRODUCTION 4

Purpose 4

Background 4

Part 521-2 GUIDANCE 4

521-2.1 Scope and applicability 4

521-2.2 Definitions 4

521-2.3 MMCO duties 5

Policies and Procedures Related to Fraud, Waste and Abuse 5

Record Retention 5

Contractor and Subcontractor Responsibilities 5

521-2.4 Fraud, waste and abuse prevention program requirements 5

Compliance Programs 5

Special investigation unit (SIU) 5

MMCO Audits and Investigations 7

Reporting Cases of Fraud, Waste and Abuse 8

Reporting Reasonably Suspected Criminal Activity 9

Report, Return and Explain 9

Fraud, Waste and Abuse Detection Procedures Manual 9

Other Program Integrity Requirements 9

Fraud, Waste and Abuse Prevention Plan 10

Annual Report 10

SUMMARY/CONCLUSION 11

INTRODUCTION

Purpose

The purpose of this document is to provide guidance related to Medicaid managed care plan fraud, waste and abuse prevention programs required by 18 NYCRR SubPart 521-2.

Questions related to this guidance may be directed to bmfa.mco@omig.ny.gov and should reference "MMC FWA Guidance Question" in the subject line.

Background

Revisions to 18 NYCRR SubPart 521-2 were made following amendments to Social Services Law §§ 363-d and 364-j(39) in the State Fiscal Year 2020-2021 Enacted Budget (Chapter 56 of the Laws of 2020, Part QQ) related to (1) provider compliance programs, (2) Medicaid managed care plan fraud, waste and abuse prevention programs under the Medical Assistance (Medicaid) program, and (3) the obligation to report, return and explain Medicaid overpayments through OMIG's Self-Disclosure Program.

Part 521-2 GUIDANCE

521-2.1 Scope and applicability

All Medicaid managed care organizations, including managed long term care plans, (collectively referred to as "MMCOs") are required to adopt and implement programs designed to detect and prevent fraud, waste and abuse in the Medicaid program. SubPart 521-2 sets forth the standards for managed care fraud, waste and abuse prevention programs which is further clarified in this guidance. This guidance does not speak to the fraud and abuse prevention plan requirements under Title 10 SubPart 98-1.21and Title 11 Section 86.6. Guidance relative to Titles 10 and 11 should be directed to the Department of Health and Department of Financial Services respectively.

521-2.2 Definitions

The definitions of fraud and abuse are defined in the Medicaid Managed Care Contract and should be referenced in connection with Section 521-2.4(d) to assist in determining what is required to be reported to OMIG as it relates to cases of fraud and abuse. The definition of waste is as follows:

(1) "Waste" means the overutilization of services, or other practices that directly or indirectly, result in unnecessary cost to the Medicaid program.

521-2.3 MMCO duties

Policies and Procedures Related to Fraud, Waste and Abuse:

The regulation requires adoption and implementation of policies and procedures designed to detect and prevent fraud, waste and abuse. The MMCO's fraud, waste and abuse prevention program may be a component of a more comprehensive effort by the organization but must meet the requirements outlined in 521-2.4, which requires that the Medicaid FWA prevention program be incorporated into the Medicaid Compliance Program.

Record Retention:

In addition to the retention requirements outlined in this section of the regulation, 521-2.3 requires the MMCO and its subcontractors to provide OMIG, the department or their authorized representatives, and MFCU, all records and information requested, in the form requested, and allow access to their facilities at any time. The MMCO and its subcontractor shall permit private interviews of MMCO personnel, its subcontractors, and their personnel, as requested.

OMIG will issue written requests for records or other information needed. The requests will be delivered via email to the MMCO Government Liaison, Compliance Officer, SIU Director and/or other designee. The requests will include submission instructions and identify a due date.

Contractor and Subcontractor Responsibilities:

MMCOs shall specify within their contracts with contractors, agents, subcontractors, independent contractors, and participating providers that they are subject to audit, investigation, or review under the MMCO's fraud, waste and abuse prevention program.

OMIG may request the MMCO to provide a copy of their contract to demonstrate compliance with this requirement.

521-2.4 Fraud, waste and abuse prevention program requirements

Compliance Programs:

The MMCO is responsible for ensuring that the requirements of its fraud, waste and abuse prevention program are incorporated into its compliance program. OMIG's Compliance Program Guidance relative to 521-1 will serve as the primary guidance to compliance program requirements.

Special Investigation Unit:

If the MMCO has an enrolled population of one thousand (1,000) or more persons in the aggregate in any given year, the MMCO shall establish a full-time Special Investigation Unit (SIU) to identify risk and to detect and investigate cases of potential fraud, waste and abuse. If the total enrollment during any month of the calendar year is 1,000 or more, the requirement to establish a full-time SIU is prompted and shall remain in effect for the duration of that calendar year.

To assist MMCO's in determining the number of enrollees, plans may reference the New York State Department of Health (DOH) Medicaid Managed Care Enrollment Reports. The reports can be found here:
https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

SIU Staffing Requirements

MMCO's should monitor their enrollment levels to determine when the SIU staffing requirements may be triggered. MMCOs may consider the Medicaid Managed Care Enrollment Reports to assist them with monitoring enrollment. Staffing will only be prompted when the thresholds outlined in 521-2.4(1) are met and not at intermediate points.

The MMCO is required to explain how the MMCO determined the SIU staff and resources dedicated to the SIU were sufficient. OMIG recommends that the MMCO consider how it determines sufficient staffing levels for commercial lines on business and take an equitable approach to dedicating staffing and resources to the Medicaid line of business.

One full-time lead investigator and one SIU director are required to be based in the State of New York and be responsible for communicating and coordinating with OMIG or MFCU on reports of fraud, waste and abuse. An in-state presence enhances the efficiency of the SIU to conduct any necessary fieldwork and more readily obtain/access records needed for the MMCO to determine if an allegation is potentially fraudulent, wasteful, or abusive, thereby requiring referral to OMIG.

In recognition of the different business models and activities conducted by the SIUs, OMIG is allowing the MMCOs flexibility to determine any proposed alternate staffing levels that are as effective as the regulatorily-defined staffing requirements. It is the responsibility of the MMCO to demonstrate and communicate this determination. Requests for exceptions to this the regulatorily-defined requirement must be submitted to: bmfa.mco@omig.ny.gov

SIU Investigator Qualifications

SIU investigators must have:

(1) a minimum of five years in the healthcare field working in fraud, waste and abuse investigations and audits, (or) five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies, (or) seven years of professional investigation experience involving economic or insurance related matters; (and)
(2) an associate's or bachelor's degree in criminal justice or a related field; (or) employment as an investigator in the MMCO's SIU on or before the effective date of this SubPart.

The MMCO will need to make available upon request employment information, including the date of employment and assignment date to SIU, for any investigator who cannot demonstrate in a resume or other documentation that they meet the credentials required of investigators to be in compliance with the requirements of SubPart.

SIU Work Plan

The SIU shall prepare a work plan no less frequently than annually. In developing this plan, the SIU shall consider the MMCO's risk areas, as well as current trends related to fraud, waste and abuse. Consideration of risk areas and FWA trends will help ensure that the MMCO is conducting audits and investigations appropriate to preventing and detecting fraud, waste and abusive practices.

The work plan shall at a minimum identity provider name and/or provider types to be audited or investigated and include the intended scope and review period of the planned audit or investigation along with the rationale for conducting the planned audit or investigation.

Delegation

The MMCO may delegate all or part of the functions of the SIU. If the MMCO decides to delegate management authority, such contract shall be subject to review and approval by the Department of Health.

If the MMCO delegates all or part of its SIU function, the contract shall be submitted to OMIG for informational purposes only. The submission to OMIG does not constitute approval of the contract.

SIU Contract submissions made to OMIG pursuant to this SubPart must be submitted via email to: bmfa.mco@omig.ny.gov or via OMIG's MCO Reporting Unit shared mailbox on the NYS Health Commerce System (HCS) at https://commerce.health.state.ny.us. All electronic files must be submitted in a file format that is searchable. The subject line of the email should read "SIU Contract." When submitting contracts to DOH, in accordance with this SubPart, MMCOs should follow DOH instructions and guidance.

MMCO Audits and Investigations:

The MMCO shall audit, investigate, or review cases of fraud, waste or abuse specific to its participation in the Medicaid program, and the risk areas identified by the SIU in its Work Plan. These audits, investigations, and reviews shall be conducted in accordance with the regulatory requirements and contracts between the MMCO and DOH. If applicable, the SIU will be primarily responsible for performing this work or collaborating and overseeing the individuals performing these activities. The SIU will also coordinate with the MMCO's compliance officer.

521-2.4(c)(2) requires the audits, investigations and reviews involve at least one percent (1%) or more of the aggregate of Medicaid claims. "Aggregate" means total number of Medicaid claims paid.

Audits, investigations, and/or reviews shall include pre/post-payment review of Medicaid claims, medical records, orders, and any other supporting documentation to substantiate claim submissions. Examples of audits, investigations, and/or reviews that are acceptable include but are not limited to:

1. SIU – Investigations into allegations of fraud, waste or abuse identified through data analysis or referrals received;
2. Vendor investigations into fraud, waste or abuse including, Pharmacy Benefit Managers, dental benefits, mental health or substance abuse services; and

3. Either the MMCO or subcontractor audits of Medicaid claims through data analysis typically to capture issues like duplicate claims, third party liability, retroactive disenrollment, modifier misuse, or Diagnostic Related Grouping (DRG) overpayments.

Questions may be directed to mmcreporting@omig.ny.gov

Reporting Cases of Fraud, Waste and Abuse:

The MMCO and its subcontractors shall report all cases of potential fraud, waste and abuse to OMIG.

> "Potential" means having or showing the capacity to become or develop into fraud, waste or abuse in the future. The MMCO must take reasonable steps to establish the potential for fraud, waste, or abuse prior to reporting. This may be done by reviewing data and/or medical records or conducting other investigative activities to determine the allegation or complaint is potentially substantiated.

The following information is required to be in reports of potential fraud, waste and abuse:

OMIG developed a "Medicaid Managed Care Organizations Potential Fraud, Waste and Abuse Referral" form, accessible through the HCS MCO Reports to DOH/OMIG Uploads Application, which includes fields for all information required to be reported. This form must be utilized when making reports pursuant with this SubPart.

A summary of the investigation is also required when reporting these cases. OMIG developed a "Managed Care Plan Investigative Summary Report," accessible through the HCS MCO Reports to DOH/OMIG Uploads Application which includes fields for all information required to be reported and is an approved form that MMCOs may utilize.

If a MMCO has its own investigative summary report that it would like to attach to OMIG's referral form, the MMCO may submit a written request and sample report to bmfa.mco@omig.ny.gov seeking OMIG's review and approval. The request should clearly describe or identify how the MMCO's investigative report form includes all the information outlined in OMIG's Investigative Summary Report. The subject line of the email should indicate "Approval Request of Investigative Summary Report." MMCO investigative summary reports shall not be considered acceptable unless and until written approval from OMIG is received.

521-2.4(d)(5)(iii) requires a report of the specific MA program statutes, rules, regulations, and/or policies violated. If the complaint alleges violation of a MMCO policy, a copy of the policy must be included with the referral.

521-2.4(d)(10) requires copies of the investigation file and related material to be submitted as part of all referrals. The investigative file is any and all information maintained in the MMCO SIU's records relative to the matter reported.

The reports shall be reviewed and signed by an executive officer of the MMCO responsible for the operations of the SIU. A report is considered "signed" by a unique signature either by hand or electronic.

All reports pursuant to this SubPart must be submitted via email to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting Unit shared mailbox or the Upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All

electronic files attached to the report must be submitted in a file format that is searchable. The subject line of the email should read “Report of Potential Fraud, Waste, or Abuse.”

Reporting Reasonably Suspected Criminal Activity:

Reporting criminal activity relates to the commission of a crime which is different from the standard reporting obligations related to potential fraud, waste and abuse. Therefore, in reporting suspected criminal activity, OMIG’s Medicaid Managed Care, Potential Fraud, Waste and Abuse Referral form should not be utilized.

A description of the suspected criminal activity with all relevant information shall be reported to OMIG at bmfa.mco@omig.ny.gov and MFCU at MFCUReferrals@ag.ny.gov. The subject line of the email must flag the email as “Report of Reasonably Suspected Criminal Activity.”

Report, Return and Explain:

OMIG’s Self-Disclosure Guidance relative to 521-3 should serve as the primary guidance to report, return and explain overpayments identified.

To comply with section 521-2.4(f) of this regulation and 363-d of the Social Services Law, the MMCO shall develop a process for providers to report, return and explain any identified overpayments within 60 days of identification. In accordance with section 521-2(h), the procedure for providers to self-disclose must be published on the MMCO’s website.

Any reported self-disclosures an MMCO receives from a provider must be reported on the MMCO’s Medicaid Managed Care Operating Report and monthly Provider Investigative Report, conforming with the requirements for each report.

Fraud, Waste and Abuse Detection Procedures Manual

The MMCO shall develop a fraud, waste and abuse detection procedures manual for use by officers, directors, managers, personnel, and subcontractors performing claims underwriting, member services, utilization management, complaint, investigative and/or SIU services.

The fraud, waste and abuse detection procedures manual is incorporated into the MMCO’s compliance program, the procedures manual must be reviewed and updated at least annually pursuant with 521-1.4(a)(3). Training on the fraud, waste and abuse detection procedures manual may also be incorporated into the training and education requirements 521-1.4(d)(1)(ii). [See OMIG’s Compliance Program Guidance related to 521-1 requirements.]

Other Program Integrity Requirements

The MMCO shall develop a fraud, waste and abuse public awareness program focused on the cost and frequency of MA program fraud, and the methods by which the MMCO’s enrollees, providers, and other contractors, agents, subcontractors, or independent contractors can prevent it. The MMCO shall make information regarding the public awareness program available on its website.

A summary of the MMCOs fraud and abuse prevention activities for the past year, including their public awareness campaign is required to be included in the "Annual SIU Report for Managed Care Organizations" pursuant to the Department of Health Guidance and Instructions (12/08) accessible through the HCS MCO Reports to DOH/OMIG Uploads Application.

Fraud, Waste and Abuse Prevention Plan

The MMCO shall develop a fraud, waste and abuse prevention plan. 521-2.4(a) states, "The MMCO shall be responsible for ensuring that the requirements of its fraud, waste and abuse prevention program are incorporated into its compliance program."

The Department of Health Guidance and Instructions (12/08) for their "Annual SIU Report for Managed Care Organizations" requires MMCOs to provide updates, summaries of activities and any changes related to the requirements of to the 10 NYCRR 98-1.21. SubPart 521-2.4(i)(4) states, "A fraud and abuse prevention plan developed in accordance with the provisions of section 98-1.21 of Title 10 or section 86.6 of Title 11 will satisfy the requirements of this subdivision, provided that the MMCO includes any additional information required by this subdivision." Since the DOH instructions only require an update on the past year's activities and information, the DOH Annual SIU Report for Managed Care Organizations will not fully satisfy the requirements of this SubPart.

MMCOs must submit a fraud, waste and abuse prevention plan which includes all information required in 521-2.4(i)(3). The report should be presented with headings related to each subsection (521-2.4(i)(3)(i)-(x)) so that the report clearly identifies all information required to be reported is included.

The fraud, waste and abuse prevention plan shall be submitted to OMIG within ninety (90) calendar days of the effective date of this SubPart and within ninety (90) calendar days of signing a new contract with the Department of Health. The MMCO shall review and update such plan no less frequently than annually.

All reports pursuant to this SubPart must be submitted via email to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting Unit shared mailbox or the Upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All electronic files attached to the report must be submitted in a file format that is searchable. The subject line of the email should read "Fraud, Waste and Abuse Prevention Plan."

Annual Report

OMIG developed a Managed Care Plan Annual Report form, accessible through the HCS MCO Reports to DOH/OMIG Uploads Application, which includes fields for all information required to be reported.

Managed Care Plan Annual Reports must be submitted between February 1 and February 28 each year via email to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting Unit shared mailbox or the Upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All electronic files attached to the report must be submitted in a file format that is searchable. The subject line of the email should read "MMCO Annual Report." The first Annual Report will be required to be submitted in February 2024.

SUMMARY/CONCLUSION

1. MMCOs shall adopt and implement policies and procedures designed to detect and prevent fraud, waste and abuse.

2. New requirements include but are not limited to the establishment of special investigation units (SIU), minimum staffing requirements, the obligation to prepare an SIU work plan, requirements related to delegation of the MMCO's SIU function, and minimum standards for conducting audits and investigations.

3. Questions regarding this guidance should be directed to OMIG's Managed Care Organization Reporting Unit at bmfa.mco@omig.ny.gov .

ADDENDUM A

SubPart 521-2 implements requirements related to Medicaid managed care plan fraud, waste and abuse prevention programs. Part 521 (effective 7/1/2009) was previously limited to provider compliance programs identified in Social Services Law § 363-d. The following table identifies the additional requirements included in SubPart 521-2 (effective 03/28/2023).

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. This table is a summary and, therefore, is not a substitute for a review of the statutory and regulatory law.

SubPart 521-2 (effective 03/28/2023)
SCOPE AND APPLICABILITY
Section 521-2.1(a) – (c) is added to set forth the scope of the SubPart, that it shall apply to MMCOs, and to acknowledge related regulations in 10 NYCRR § 98-1.21 and 11 NYCRR § 86.6.
DEFINITIONS
Section 521-2.2(a) is added to define certain terms including "fraud" and "abuse."
MEDICAID MANAGED CARE ORGANIZATIONS' DUTIES
Section 521-2.3(a) is added to establish the general requirement that MMCOs adopt and implement policies and procedures designed to detect and prevent fraud, waste and abuse.
Section 521-2.3(b) is added to specify the MMCO's record retention and cooperation obligations relevant to the adoption and implementation of its fraud, waste and abuse prevention program under this SubPart.
Section 521-2.3(c) is added to specify requirements relative to an MMCO's contractors, agents, subcontractors, and independent contractors with respect to its fraud, waste and abuse prevention program.
FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM REQUIREMENTS
Section 521-2.4(a) is added to specify, consistent with statutory requirements, that MMCOs, as part of their fraud, waste and abuse prevention programs, adopt, implement, and maintain an effective compliance program pursuant to SubPart 521-1, and to specify the requirements for incorporating elements of the prevention program into the compliance program.
Section 521-2.4(b) is added to specify requirements for the establishment of special investigation units (SIU), including staffing requirements, investigator qualifications, lead investigator obligations, the obligation to prepare an SIU work plan, and requirements for delegating the MMCO's SIU function to a management contractor.
Section 521-2.4(c) is added to specify audit and investigation requirements including the scope of audits to be undertaken and the general requirements for conducting such audits and investigations.
Section 521-2.4(d) is added to require MMCOs to report cases of fraud, waste and abuse to OMIG in accordance with the provisions of the MMCO's contract with DOH.
Section 521-2.4 (e) is added to clarify that MMCOs and their subcontractors shall refer reasonably suspected criminal activity to OMIG and MFCU in accordance with contractual obligations.
Section 521-2.4(f) is added to clarify that MMCOs, consistent with Federal and contractual requirements, shall have policies and procedures for providers to report, return and explain overpayments to the MMCO within sixty (60) days of identification, and that the MMCO shall report such recoveries to OMIG and DOH in accordance with the terms of the MMCO's contract with the department.

SubPart 521-2 (effective 03/28/2023)
Section 521-2.4(g) is added to require the MMCO to develop a fraud, waste and abuse procedures manual for the use of its employees.
Section 521-2.4(h) is added to specify additional program integrity obligations, including the development and publication of a fraud, waste and abuse public awareness program and the publication of the policies and procedures for providers to report, return and explain overpayments to the MMCO.
Section 521-2.4(i) is added to clarify the MMCO's obligation to prepare and file with OMIG a fraud, waste and abuse prevention plan. Section 521-2.4(j)(4) specifies that OMIG will accept a fraud and abuse prevention plan that has been prepared in accordance with the provisions of 10 NYCRR § 98-1.21 or 11 NYCRR § 86.6, provided that any additional requirements under SubPart 521-2 are included with the submission.
Section 521-2.4(j) is added to specify the deadline for submitting and the elements to include in the annual report the MMCO is required to submit to OMIG on its performance under the fraud, waste and abuse prevention program.
Section 521-2.4(k) is added to clarify an MMCO's obligation to report information required by the regulation and contract.