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**Compliance Program Review Module**

**GENERAL INFORMATION:**

This Compliance Program Review Module (Module) pertains to the requirement, pursuant to Social Services Law Section 363-d (SOS § 363-d) and Title 18 NYCRR SubPart 521-1 (SubPart 521-1), that certain providers adopt and implement an effective compliance program. All terms and acronyms contained within this Module, unless otherwise noted, shall have the same meaning as defined in Title 18 NYCRR Parts 504, 515, and 521.

“Appropriate Compliance Personnel” includes the compliance officer and compliance staff who report directly to the compliance officer.

“MMCO” refers to any managed care provider or managed long-term care plan.

**INSTRUCTIONS FOR SUBMISSION:**

When OMIG conducts a compliance program review, the provider will receive a Notification of Review (Notification) letter from OMIG informing the provider of the review. The Notification letter instructs the provider to respond by completing this Module and providing supporting documentation. **The provider’s responses to questions in this Module should be for the time period identified as the Review Period in the Notification letter.**

**Please note:** Do not send the completed Module to OMIG unless specifically requested by OMIG to do so.

Complete the Module electronically using Microsoft Word and inserting the response in the appropriate field for each question. The provider is encouraged to provide the best representation of their compliance program and include annotations or additional information, as necessary. The provider must include sufficient documentation in order to indicate “Yes,” they met the requirement during the Review Period.

A table has been provided at the end of this Module that must be completed to itemize the documentation submitted in response to the Module questions. Where supporting documentation is requested, it should be provided in the following manner:

1. in a Microsoft Word document or in a searchable Adobe PDF document (searchable electronic format). Electronic file names should reflect the document name (e.g., Compliance Manual, Code of Conduct, Training Plan, Ethics Policy, Job Description, etc.);
2. **if multiple versions of a document were in effect during the Review Period, submit all such versions for review and provide the effective dates for each document**; and
3. if the same document can be used to answer multiple questions, submit it only once. **Do not submit multiple copies of the same document**.
4. If the provider does not have the requested documentation, please indicate on the provider’s Documentation page what documentation the provider does not have.

When responding to a Notification letter, submit the following documentation to compliancereview@omig.ny.gov:

1. completed Module in Microsoft Word format,
2. copy of the Notification letter, and
3. all requested documentation in searchable electronic format.

**FOR FURTHER INFORMATION OR QUESTIONS, CONTACT:**

OMIG’s Bureau of Compliance at compliancereview@omig.ny.gov or 518-408-0401.

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**COMPLIANCE PROGRAM REVIEW MODULE**

The following information should match information from the Notification Letter or Reasonable Notice.

**Provider Name**: Click or tap here to enter text.

**FEIN:** Click or tap here to enter number.

**Review Period**: 00/00/0000 – 00/00/0000

[ ] Yes [ ] No We acknowledge that all Provider IDs listed in the Notification Letter or Reasonable Notice are enrolled in the Medicaid program under the same Federal Employer Identification Number (FEIN) and are covered by the same compliance program.

If No: ·Identify those Provider IDs that are not enrolled in the Medicaid program under the

same FEIN or are not covered by the same compliance program:

Click or tap here to enter number(s).

·Explain: Click or tap here to enter text.

·Contact the Bureau of Compliance for direction on completing this Module at

compliancereview@omig.ny.gov or 518-408-0401.

**Provider’s Contact Information**

**Person Completing the Module**: Click or tap here to enter text.

**Title**: Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Email**: Click or tap here to enter text.

**Compliance Officer** (if different from person completing the Module): Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Email**: Click or tap here to enter text.

**Affected Individuals:**

18 NYCRR § 521-1.2 defines Affected Individuals as all persons who are affected by the provider’s risk areas, including the provider’s employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, governing body, and corporate officers.

18 NYCRR § 521-1.3(d) identifies risk areas to which the compliance program shall apply.

Indicate the provider’s type(s) of Affected Individuals in the following table. Click on the box next to each type to insert an X in the box to indicate Yes or No.

| **Yes** | **No** | **Types of Affected Individuals** |
| --- | --- | --- |
| [ ]  | [ ]  | Employee(s) |
| [ ]  | [ ]  | Chief Executive |
| [ ]  | [ ]  | Senior Administrator(s) |
| [ ]  | [ ]  | Manager(s) |
| [ ]  | [ ]  | Contractor(s) |
| [ ]  | [ ]  | Agent(s) |
| [ ]  | [ ]  | Subcontractor(s) |
| [ ]  | [ ]  | Independent Contractor(s) |
| [ ]  | [ ]  | Governing Body Member(s) |
| [ ]  | [ ]  | Corporate Officer(s) |

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| --- |
| **ELEMENT 1: Written policies, procedures, and standards of conduct (collectively, Policies)** |
| **18 NYCRR § 521-1.4(a)**(a) Written policies and procedures.(1) General. Required providers shall have written policies, procedures, and standards of conduct. The required provider shall establish a process for drafting, revising, and approving the written policies and procedures required by this subdivision. The written policies and procedures described in this subdivision must be available, accessible, and applicable to all affected individuals.(2) The written policies and procedures shall:(i) articulate the required provider’s commitment and obligation to comply with all applicable federal and state standards. The required provider shall identify governing laws, and regulations that are applicable to the provider’s risk areas, including any MA program policies and procedures, as specified in subdivision (d) of section 521-1.3 of this SubPart or category of service.(ii) describe compliance expectations as embodied in standards of conduct. The standards of conduct shall serve as a foundational document which describes the required provider’s fundamental principles and values, and commitment to conduct its business in an ethical manner.(iii) document the implementation of each of the subdivisions under this section and outline the ongoing operation of the compliance program. Policies and procedures shall describe, at a minimum, the structure of the compliance program, including the responsibilities of all affected individuals in carrying out the functions of the compliance program.(iv) provide guidance to affected individuals on dealing with potential compliance issues. Such guidance shall, at a minimum:(*a*) assist affected individuals in identifying potential compliance issues, questions and concerns, set forth expectations for reporting compliance issues, and explain how to report such issues, questions, and concerns to the compliance officer; and(*b*) establish the expectation that all affected individuals will act in accordance with the standards of conduct, that they must refuse to participate in unethical or illegal conduct, and that they must report any unethical or illegal conduct to the compliance officer.(v) identify the methods and procedures for communicating compliance issues to the appropriate compliance personnel.(vi) describe how potential compliance issues are investigated and resolved by the required provider and the procedures for documenting the investigation and the resolution or outcome.(vii) include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to:(*a)* reporting potential compliance issues to appropriate personnel;(*b*) participating in investigation of potential compliance issues;(*c*) self-evaluations;(*d*) audits(*e*) remedial actions(*f*) reporting instances of intimidation or retaliation; and (*g*) reporting potential fraud, waste or abuse to the appropriate State or Federal entities.(viii) Disciplinary standards. Include a written statement setting forth the required provider’s policy regarding affected individuals who fail to comply with the written policies and procedures, standards of conduct, or State and Federal laws, rules and regulations.(*a*) Such statement shall establish standards for escalating disciplinary actions that must be taken in response to non-compliance, with intentional or reckless behavior being subject to more significant sanctions. Sanctions may include oral or written warnings, suspension, and/or termination.(*b*) The written policies and procedures shall also outline the procedures for taking disciplinary action and sanctioning individuals. Disciplinary procedures shall conform with collective bargaining agreements when applicable.(ix) Additionally, notwithstanding the requirement under 42 U.S.C. 1396a(a)(68), which applies to entities that receive or make annual payments of at least $5,000,000 annually, all required providers shall comply with the provisions of 42 U.S.C. 1396a(a)(68) (United States Code, 2006 edition, Title 42, Chapter 7, SubChapter XIX, Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2006-title42/pdf/USCODE-2006-title42-chap7-subchapXIX-sec1396a.pdf>. A copy of which is available for copying and inspection at the Office of the Medicaid Inspector General, 800 North Pearl Street, 2nd Floor, Albany, NY 12204).(x) for MMCOs, describe the MMCO’s implementation, where applicable, of the requirements of SubPart 521-2 of this Part.(3) The required provider shall review the written policies and procedures, and standards of conduct required by this subdivision at least annually to determine:(i) if such written policies, procedures, and standards of conduct have been implemented;(ii) whether affected individuals are following the policies, procedures, and standards of conduct;(iii) whether such policies, procedures, and standards of conduct are effective; and(iv) whether any updates are required. |
| **1-1** | **18 NYCRR § 521-1.4(a)(1) and (2)**Did the provider have written Policies in effect during the Review Period that complied with all requirements of 18 NYCRR § 521-1.4(a)(1) and (a)(2) and were applicable to all Affected Individuals?Yes \_\_\_\_No \_\_\_\_\_ | Provide a copy, as “Attachment 1-1a,” of such written Policies, including a record of implementation and revision dates, and evidence they were applicable to all Affected Individuals. |
| Provide a copy, as “Attachment 1-1b,” of the employee handbook, if applicable, that meets the requirements of 18 NYCRR § 521-1.4(a)(2)(ix), including a record of implementation and revision dates, and evidence to which categories of Affected Individuals such employee manual was applicable. |
| Please mark which months during the Review Period the written Policies that complied with all requirements of 18 NYCRR § 521-1.4(a) were in effect in the following chart:

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| **1-2** | **18 NYCRR § 521-1.4(a)(3)**Did the provider complete an annual review of its written Policies required by 18 NYCRR § 521-1.4?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide as “Attachment 1-2,” a copy of the annual review. |
| **ELEMENT 2: Compliance Officer and Compliance Committee** |
| **18 NYCRR § 521-1.4(b)**(b) Compliance officer. The required provider shall designate an individual to serve as its compliance officer. The compliance officer is the focal point for the required provider’s compliance program and is responsible for the day-to-day operation of the compliance program. The required provider’s designation of a compliance officer shall meet the following requirements:(1) The compliance officer’s primary responsibilities shall include:(i) overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness;(ii) drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance work plan which shall outline the required provider’s proposed strategy for meeting the requirements of this section for the coming year, with a specific emphasis on subdivisions (a), (d), (g), (h) of this section and, if applicable, SubPart 521-2 of this Part;(iii) reviewing and revising the compliance program, and, in accordance with paragraph 3 of subdivision (a) of this section, the written policies and procedures and standards of conduct, to incorporate changes based on the required provider’s organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards; (iv) reporting directly, on a regular basis, but no less frequently than quarterly, to the required provider’s governing body, chief executive, and compliance committee on the progress of adopting, implementing, and maintaining the compliance program;(v) assisting the required provider in establishing methods to improve the required provider’s efficiency, quality of services, and reducing the required provider’s vulnerability to fraud, waste and abuse; (vi) investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors, and the State; and(vii) the compliance officer shall be responsible for coordinating the implementation of the fraud, waste, and abuse prevention program with the director and lead investigator of the MMCO’s special investigation unit pursuant to SubPart 521-2 of this Part, if applicable.(2) The compliance officer shall report directly and be accountable to the required provider’s chief executive or another senior manager whom the chief executive may designate for reporting purposes provided, however, such designation does not hinder the compliance officer in carrying out their duties and having access to the chief executive and governing body.(3) The responsibilities in paragraph (1) of this subdivision may be the compliance officer’s sole duties or, depending on the size, complexity, resources, and culture of the required provider and the complexity of the tasks, the compliance officer may be assigned other duties, provided that such other duties do not hinder the compliance officer in carrying out their primary responsibilities under this SubPart.(4) The required provider shall ensure that the compliance officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program based on the required provider’s risk areas and organizational experience.(5) The required provider shall ensure that the compliance officer and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their compliance program responsibilities. |
| **2-1** | **18 NYCRR § 521-1.4(b) and (b)(1)**Did the provider have a designated compliance officer for the entire Review Period who was responsible for carrying out the day-to-day activities of the compliance program and whose responsibilities as the compliance officer met all the requirements of 18 NYCRR § 521-1.4(b)(1)?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 2-1a,”1. a summary identifying the individual(s) who was the designated compliance officer during the Review Period, including their from and to service dates as the compliance officer;
2. Examples of documentation the Provider may use to demonstrate that it had a designated compliance officer include, but are not limited to, the following:
	1. dated performance plan and performance evaluation for the compliance officer evidencing compliance responsibilities and other duties;
	2. dated governing body resolution/meeting minutes evidencing appointment of the compliance officer including appropriate compliance responsibilities and other duties;
	3. compliance officer’s dated and signed letter of appointment evidencing compliance responsibilities and other duties; or
	4. compliance officer’s dated and executed contract evidencing compliance responsibilities and other duties, if applicable; and
3. any other dated documentation evidencing the designation of the compliance officer including appropriate compliance responsibilities and other duties.
 |
| If yes, provide, as “Attachment 2-1b,” a copy of the annual compliance work plan(s) that was in effect during the entire Review Period. |
| If yes, provide, as “Attachment 2-1c,” a copy of documentation evidencing quarterly reports from the compliance officer to the governing body, chief executive, and compliance committee during the entire Review Period. Documentation may include, but is not limited to:1. dated written quarterly reports,
2. dated meeting minutes, or
3. any other dated documentation evidencing quarterly reports from the compliance officer.
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|  | Please mark which months during the Review Period the provider had a designated compliance officer as required in 18 NYCRR § 521-1.4(b) and whose responsibilities met all of the requirements of 18 NYCRR § 521-1.4(b)(1):

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| **2-2** | **18 NYCRR § 521-1.4(b)(2)**Did the compliance officer report directly and were they accountable to the provider’s chief executive or another senior manager as designated by the provider’s chief executive during the entire Review Period?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide documentation, as “Attachment 2-2,” evidencing that the compliance officer reported directly and was accountable to the provider’s chief executive or another senior manager as designated by the provider’s chief executive during the entire Review Period which may include, but is not limited to:1. the compliance officer’s appointment letter;
2. a designation from the chief executive that the compliance officer will report to another senior manager, if applicable; or
3. any other dated documentation evidencing the compliance officer reported directly to and was accountable to the chief executive.
 |
| Please mark which months during the Review Period the compliance officer reported directly and was accountable to the chief executive or another senior manager as designated by the provider’s chief executive:

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| **2-3** | **18 NYCRR § 521-1.4(b)(3)**If the compliance officer had other duties, did the provider complete an assessment to determine whether the other duties hindered the compliance officer in carrying out their primary responsibilities?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (The compliance officer did not have other duties.) | If yes, provide, as “Attachment 2-3,”:1. a copy of such assessment, or other documentation, evidencing the provider determined whether the other duties hindered the compliance officer in carrying out their primary responsibilities during the Review Period; and
2. any additional explanation, if needed.
 |
| **2-4** | **18 NYCRR § 521-1.4 (b)(4)**Did the provider complete an assessment to determine that the compliance officer was allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program based on the provider’s risk areas and organizational experience?Yes \_\_\_\_No \_\_\_\_\_ | Provide, as “Attachment 2-4,” a copy of such assessment, or any other documentation, evidencing the provider determined the compliance officer was allocated sufficient staff and resources during the Review Period. |
| **2-5** | **18 NYCRR § 521-1.4 (b)(5)**Did the compliance officer and Appropriate Compliance Personnel have access to all:1. records and documents,
2. information,
3. facilities, and
4. Affected Individuals

that were relevant to carrying out their compliance program responsibilities during the entire Review Period?Yes \_\_\_\_No \_\_\_\_\_ | Provide, as “attachment 2-5,” documentation evidencing that the compliance officer and Appropriate Compliance Personnel had access to all records, documents, information, facilities, and Affected Individuals that were relevant to their compliance responsibilities during the entire Review Period which may include, but is not limited to:1. confirmation from the compliance officer or chief executive,
2. a compliance work plan evidencing such access, or
3. any other dated documentation evidencing such access.
 |
| Please mark which months during the Review Period the compliance officer and Appropriate Compliance Personnel had access to all records, documents, information, facilities, and Affected Individuals that were relevant to carrying out their compliance program duties:

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| **18 NYCRR § 521-1.4(c)**(c) Compliance committee. The required provider shall designate a compliance committee which shall be responsible for coordinating with the compliance officer to ensure that the required provider is conducting its business in an ethical and responsible manner, consistent with its compliance program. The required provider shall outline the duties and responsibilities, membership, designation of a chair and frequency of meetings in a compliance committee charter. The required provider’s designation of a compliance committee shall meet the following requirements:(1) The compliance committee’s responsibilities shall include:(i) coordinating with the compliance officer to ensure that the written policies and procedures, and standards of conduct required by subdivision (a) of this section are current, accurate and complete, and that the training topics required by subdivision (d) of this section are timely completed;(ii) coordinating with the compliance officer to ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or any other function or activity required by this SubPart;(iii) advocating for the allocation of sufficient funding, resources and staff for the compliance officer to fully perform their responsibilities;(iv) ensuring that the required provider has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues; and(v) advocating for adoption and implementation of required modifications to the compliance program.(2) Membership in the committee shall, at a minimum, be comprised of senior managers. The compliance committee shall meet no less frequently than quarterly and shall, no less frequently than annually, review and update the compliance committee charter.(3) The compliance committee shall report directly and be accountable to the required provider’s chief executive and governing body. |
| **2-6** | **18 NYCRR § 521-1.4(c)**Did the provider have a designated compliance committee for the entire Review Period that meets the requirements of 18 NYCRR § 521-1.4(c)?Yes \_\_\_\_No \_\_\_\_\_ | If yes provide, as “Attachment 2-6a,” documentation evidencing the provider had a designed compliance committee which may include, but is not limited to:1. a summary identifying compliance committee members and designated chair during the Review Period, including their names, titles, and from/to service dates, and
2. any other dated documentation evidencing the provider had a designated compliance committee comprised of senior managers for the entire Review Period.
 |
| If yes provide, as “Attachment 2-6b,” a copy of a dated compliance committee charter along with copies of dated annual compliance committee charter reviews, or any other documentation evidencing annual compliance committee charter reviews. |
| If yes provide, as “Attachment 2-6c,” documentation evidencing:1. the reporting structure between the compliance committee and the organization’s chief executive and governing body, and
2. the compliance committee met at least quarterly during the Review Period.

Such evidence may include, but is not limited to:1. organizational chart showing the reporting structure between the compliance committee and the organization’s chief executive and governing body,
2. quarterly reports from the compliance committee to the organization’s chief executive and governing body; and
3. copies of minutes from all compliance committee meetings during the Review Period.
 |
| Please mark which months during the Review Period that the provider had a designated compliance committee that met all the requirements of 18 NYCRR § 521-1.4(c):

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| **ELEMENT 3: Compliance Program Training and Education** |
| **18 NYCRR § 521-1.4(d)**(d) Training and education. The required provider shall establish and implement an effective compliance training and education program for its compliance officer and all affected individuals. The required provider’s compliance training and education program shall meet the following requirements:(1) The training and education shall include, at a minimum, the following topics:(i) the required provider’s risk areas and organizational experience;(ii) the required provider’s written policies and procedures identified in subdivision (a) of this section;(iii) the role of the compliance officer and the compliance committee;(iv) how affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the compliance program;(v) disciplinary standards, with an emphasis on those standards related to the required provider’s compliance program and prevention of fraud, waste and abuse;(vi) how the required provider responds to compliance issues and implements corrective action plans;(vii) requirements specific to the MA program and the required provider’s category or categories of service;(viii) coding and billing requirements and best practices, if applicable;(ix) claim development and the submission process, if applicable; and(x) for MMCOs only, the fraud, waste and abuse prevention program, as specified in SubPart 521-2 of this Part, and any applicable terms of the MMCO’s contract with the department to participate as an MMCO.(2) The compliance officer and all affected individuals shall complete the compliance training program required by this subdivision no less frequently than annually. The training and education required by this subdivision shall be made a part of the orientation of new compliance officers and affected individuals and shall occur promptly upon hiring.(3) Training and education shall be provided in a form and format accessible and understandable to all affected individuals, consistent with Federal and State language and other access laws, rules or policies.(4) The required provider shall develop and maintain a training plan. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing and frequency of the training, which affected individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated. |
| **3-1** | **18 NYCRR § 521-1.4(d)(1), (3), and (4)**Did the provider have an effective compliance training and education program for all Affected Individuals which met all the requirements of 18 NYCRR § 521-1.4(d)(1), (3), and (4) during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide a copy, as “Attachment 3-1” of:1. a dated compliance program training and education plan(s), and
2. documentation evidencing what steps the provider took to ensure its compliance program training and education was provided in a form and format accessible and understandable to all Affected Individuals.
 |
| Please mark which months during the Review Period that the provider had an effective compliance training and education plan that met the requirements of 18 NYCRR § 521-1.4(d)(1), (3), and (4) for all Affected Individuals:

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| **3-2** | **18 NYCRR § 521-1.4(d)(2)**Did all Affected Individuals complete compliance program training, either annually or as part of orientation, during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | If yes, Provide, as “Attachment 3-2,” documentation evidencing all Affected Individuals completed compliance program training, either annually or as part of orientation during the Review Period which may include, but is not limited to:1. a list of all Affected Individuals that completed, and did not complete, such training during the Review Period, including:
	1. name of Affected Individual;
	2. type of Affected Individual (i.e., employee, chief executive, senior administrator, manager, contractor, agent, subcontractor, independent contractor, governing body member, corporate officer);
	3. type of compliance program training(s) completed (i.e., annual, orientation, or both);
	4. how such training was provided;
	5. date(s) of completion; and
	6. date of hire for those who completed orientation training;
2. dated governing body meeting minutes and agendas that included such training and who attended, if applicable;
3. dated attendance logs showing when such training occurred and who attended, if applicable;
4. dated attestations signed by Affected Individuals that they completed and understood such training, if applicable;
5. dated compliance training distribution letters to Contractors;
6. any other documentation evidencing all Affected Individuals completed compliance program training during the Review Period; and
7. any additional explanation, if needed.
 |
| **ELEMENT 4: Lines of Communication** |
| **18 NYCRR § 521-1.4(e)**(e) Lines of communication. The required provider shall establish and implement effective lines of communication which ensure confidentiality for the required provider’s affected individuals. In designing its lines of communication, the required provider shall meet the following requirements:(1) The lines of communication shall be accessible to all affected individuals and allow for questions regarding compliance issues to be asked and for compliance issues to be reported.(2) The required provider shall publicize the lines of communication to the compliance officer and such lines of communication must be made available to all affected individuals and all MA recipients of service from the required provider.(3) The required provider shall have a method for anonymous reporting of potential fraud, waste and abuse, and compliance issues directly to the compliance officer.(4) The required provider must ensure that the confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the required provider’s policy for non-intimidation and non-retaliation.(5) If applicable, the required provider shall make available on its website, information concerning its compliance program, including its standards of conduct. |
| **4-1** | **18 NYCRR § 521-1.4(e)(1), (2), (4), and (5)**Did the provider have lines of communication in effect for the Review Period that met the requirements of 18 NYCRR § 521-1.4(e)?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 4-1,” documentation evidencing the provider met the requirement which may include, but is not limited to:* 1. a list of lines of communication that were in effect during the Review Period, including:
1. description or identification of lines of communication,
2. effective dates for the lines of communication,
	1. to whom the lines of communication went or who had access to reports coming through the lines of communication,
	2. categories of individuals (i.e., Affected Individuals or Medicaid recipients of services) who had access to utilize such lines of communication;
3. dated distribution letter to all Affected Individuals and/or Medicaid recipients of service from the provider;
4. screenshot of notification on an intranet and affirmation that such information was published on the intranet during the entire Review Period;
5. screenshot of notification on a public website and affirmation that such information was published on the public website during the Review Period;
6. compliance posters that identified communication methods and an affirmation of where and when they were posted that made them accessible to all;
7. copy of dated notifications to contractors, agents, and independent contractors; and
8. any other evidence lines of communication to the compliance officer were publicized during the Review Period to all Affected Individuals and all Medicaid recipients of service from the provider.
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| Please mark which months during the Review Period that the provider had lines of communication in effect that met the requirements of 18 NYCRR § 521-1.4(e):

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| **4-2** | **18 NYCRR § 521-1.4(e)(3)**Did the provider have a method(s) for anonymous reporting of potential fraud, waste, abuse, and compliance issues directly to the compliance officer that was in effect for the entire Review Period?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 4-2,” evidence of method(s) for anonymous reporting of potential fraud, waste, abuse, and compliance issues directly to the compliance officer that was in effect for the entire Review Period. Such evidence may include, but is not limited to:* 1. a list of method(s) for anonymous reporting to the compliance officer, including a description and effective dates for such methods;
	2. compliance posters that identified method(s) for anonymous reporting to the compliance officer, and a description of where and when they were posted, if applicable; and
	3. any other evidence of method(s) for anonymous reporting to the compliance officer.
 |
| Please mark which months during the Review Period that the provider had method(s) for anonymous reporting of potential fraud, waste, abuse, and compliance issues directly to the compliance officer:

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| **4-3** | **18 NYCRR § 521-1.4(e)(4) and (5)**Did the provider:1. maintain the confidentiality of persons reporting compliance issues, and
2. ensure the availability of information concerning its compliance program on its website

during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 4-3a,” evidence of how the provider maintained the confidentiality of persons reporting compliance issues during the Review Period. Such evidence may include, but is not limited to:1. a summary of compliance issues reported during the Review Period, including a description of how such reports were documented, stored, and shared within the organization; a list of persons with whom they were shared and their titles; and a description of how the provider ensured persons reporting compliance issues were protected under the provider’s policy for non-intimidation and non-retaliation;
2. if there were no reports of compliance issues during the Review Period, provide a copy of written Policies that included an expectation to maintain the confidentiality of persons reporting compliance issues, and the provider’s policy for non-intimidation and non-retaliation; or
3. any other evidence of how the provider maintained the confidentiality of persons reporting compliance issues and how they were protected under the provider’s policy for non-intimidation and non-retaliation.
 |
| If yes, provide, as “Attachment 4-3b,” evidence of how the provider made information about its compliance program, including its standards of conduct, available on its website for the Review Period.  |
| Please mark which months during the Review Period that the provider maintained the confidentiality of persons reporting compliance issues and ensured the availability of information concerning its compliance program on its website:

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| **ELEMENT 5: Disciplinary Standards** |
| **18 NYCRR § 521-1.4(f)**(f) Disciplinary standards. The required provider shall establish disciplinary standards and shall implement procedures for the enforcement of such standards to address potential violations and encourage good faith participation in the compliance program by all affected individuals. In developing and enforcing its disciplinary standards, the required provider shall meet the following requirements:(1) The written policies and procedures establishing, pursuant to subdivision (a) of this section, the required provider’s disciplinary standards and the procedures for taking such actions shall be published and disseminated to all affected individuals and shall be incorporated into the required provider’s training plan as set forth in subdivision (d) of this section.(2) The required provider shall enforce its disciplinary standards fairly and consistently, and the same disciplinary action should apply to all levels of personnel. |
| **5-1** | **18 NYCRR § 521-1.4(f)(1)**Did the provider publish and disseminate the written Policies that established the provider’s disciplinary standards and the procedures for taking such actions to all Affected Individuals?Yes \_\_\_\_No \_\_\_\_\_ | Provide as “Attachment 5-1,” evidence of how the provider published and disseminated the written Policies that established the provider’s disciplinary standards and the procedures for taking such actions to all Affected Individuals during the Review Period. Such evidence may include, but is not limited to:1. dated memos documenting such written Policies were distributed to all Affected Individuals;
2. dated governing body bylaws/operating agreement that identified disciplinary standards and related procedures for governing body members, if applicable;
3. contracts for Contractors that included disciplinary standards and related procedures, if applicable; and
4. any other evidence of how the provider published and disseminated such written Policies to all Affected Individuals.
 |
| Please mark which months during the Review Period that the provider published and disseminated the written Policies that established the provider’s disciplinary standards and the procedures for taking such actions to all Affected Individuals during the Review Period:

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| **5-2** | **18 NYCRR § 521-1.4(f)(2)**Did the provider enforce its disciplinary standards fairly and consistently with the same disciplinary action applied to all levels of personnel during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | Provide, as “Attachment 5-2,” evidence of how the provider enforced its disciplinary standards fairly and consistently with the same disciplinary action applied to all levels of personnel during the Review Period. Such evidence may include, but is not limited to:1. a list of all disciplinary actions taken during the Review Period, including:
	1. name and title of all Affected Individuals disciplined,
	2. dates of disciplinary actions,
	3. reason(s) for disciplinary actions, and
	4. explanation of how the disciplinary actions were determined; or
2. any other evidence of how the provider enforced its disciplinary standards fairly and consistently during the Review Period, and
3. any additional explanation, if needed.
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| Please mark which months during the Review Period that the provider enforced its disciplinary standards fairly and consistently with the same disciplinary action applied to all levels of personnel during the Review Period:

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| **ELEMENT 6: Auditing and Monitoring** |
| **18 NYCRR § 521-1.4(g)**(g) Auditing and monitoring. The required provider shall establish and implement an effective system for the routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the organization’s compliance with the requirements of the MA program and the overall effectiveness of the required provider’s compliance program. In developing its auditing and monitoring program the required provider shall meet the following requirements:(1) Auditing. Required providers shall perform routine audits by internal or external auditors who have expertise in state and federal MA program requirements and applicable laws, rules and regulations, or have expertise in the subject area of the audit. Audits or investigations conducted by state or federal governmental entities are not considered external audits for purposes of this paragraph. The audits required by this paragraph shall meet the following requirements:(i) Internal and external compliance audits shall focus on the risk areas [specifically, risk areas 1-10] identified in section 521-1.3 of this SubPart.(ii) The results of all internal or external audits, or audits conducted by the State or Federal government of the required provider, shall be reviewed for risk areas that can be included in updates to the required provider’s compliance program and compliance work plan.(iii) The design, implementation, and results of any internal or external audits shall be documented, and the results shared with the compliance committee and the governing body.(iv) Any MA program overpayments identified shall be reported, returned and explained in accordance with the provisions of SubPart 521-3 of this Part and the required provider shall promptly take corrective action to prevent recurrence.(2) Annual compliance program review. The required provider shall develop and undertake a process for reviewing, at least annually, whether the requirements of this SubPart have been met. The purpose of such reviews shall be to determine the effectiveness of its compliance program, and whether any revision or corrective action is required.(i) The reviews may be carried out by the compliance officer, compliance committee, external auditors, or other staff designated by the required provider, provided however, that such other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and are independent from the functions being reviewed.(ii) The reviews should include on-site visits, interviews with affected individuals, review of records, surveys, or any other comparable method the required provider deems appropriate, provided that such method does not compromise the independence or integrity of the review.(iii) The required provider shall document the design, implementation and results of its effectiveness review, and any corrective action implemented.(iv) The results of annual compliance program reviews shall be shared with the chief executive, senior management, compliance committee and the governing body.(3) Excluded providers. In accordance with the requirements of section 515.5 of this Title, required providers shall confirm the identity and determine the exclusion status of affected individuals. In addition, MMCOs shall confirm the identity and determine the exclusion status of any other persons identified in its contract with the department to participate as an MMCO, including its participating providers and its subcontractors.(i) In determining the exclusion status of a person required providers shall review the following State and Federal databases at least every thirty (30) days:(*a*) New York State Office of the Medicaid Inspector General Exclusion List;(*b*) Health and Human Services Office of Inspector General’s List of Excluded Individuals and Entities; and(*c*) for MMCOs only, any other list or database required by the contract between the MMCO and the department to participate as an MMCO.(ii) Required providers shall require contractors to comply with the provisions of this paragraph. In addition, MMCOs shall require their participating providers and subcontractors to comply, where applicable, with the provisions of this paragraph.(4) The required provider shall promptly share the results of the activities required by this subdivision with the compliance officer and appropriate compliance personnel. |
| **6-1** | **18 NYCRR § 521-1.4(g)(1)**Did the provider perform audits during the Review Period which met the requirements of 18 NYCRR § 521-1.4(g)(1)(i)?Yes \_\_\_\_No \_\_\_\_\_ | Provide, as “Attachment 6-1” documentation evidencing the provider met the requirement which may include, but is not limited to:1. summary of auditing and monitoring results, dates completed, and any compliance issues identified;
2. dated meeting minutes that documented discussion of such activities, if applicable; and
3. any other evidence of how the provider performed audits that focused on risk areas identified in 18 NYCRR § 521-1.3(d) during the Review Period.
4. any additional explanation, if needed.
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| **6-2** | **18 NYCRR § 521-1.4(g)(1)(ii) and (iii)**Did the provider:1. review the results of all internal and external audits for risk areas that can be included in updates to the compliance program and work plan during the Review Period;
2. document the design, implementation, and results of any such audits; and
3. share internal and external audit results with the compliance committee, and governing body?

Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 6-2a,” documentation evidencing the provider reviewed the results of all internal and external audits for risk area that can be included in updates to the compliance program and work plan during the Review Period which may include, but is not limited to:1. summary of all internal and external audit results, dates completed, and any risk areas identified;
2. updates to compliance work plan(s);
3. any other evidence the provider reviewed audit results and included new risk areas in updates to the compliance program and work plan;
4. and
5. any additional explanation, if needed.
 |
| If yes, provide, as “Attachment 6-2b,” documentation evidencing the design and implementation of any internal and external audits during the Review Period. |
| If yes, provide, as “Attachment 6-2c,” documentation evidencing the provider shared internal and external audit results with the compliance committee and governing body which includes, but is not limited to:1. dated transmittal memos to the compliance committee and governing body,
2. dated compliance committee and governing body meeting minutes discussing audit results,
3. dated audit reports to the compliance committee and governing body including audit results, and
4. any other evidence the provider’s internal and external audit results were shared during the Review Period with the compliance committee and governing body.
 |
| **6-3** | **18 NYCRR § 521-1.4(g)(1)(iv)**Were all identified Medicaid program overpayments reported, returned, and explained during the Review Period in accordance with 18 NYCRR SubPart 521-3; and, if applicable, did the provider promptly take corrective action to prevent recurrence?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (No overpayments were identified.)**Note 1:** Repayment of an overpayment identified via an OMIG audit or investigation does not evidence that this requirement is met.**Note 2:** Do not submit claim details. | If yes, provide, as “Attachment 6-3a,” evidence of all overpayments identified, including related voided and adjusted claims, which may include, but is not limited to, a summary of any overpayments identified, including voided and adjusted claims, that includes:1. how the overpayments were identified;
2. dates of service for overpayments identified;
3. the dollar value of overpayments identified;
4. date such overpayments were identified;
5. reason(s) for such overpayments;
6. whether such overpayments were reported, returned, and explained through the self-disclosure process as required by SOS § 363-d(6) and (7), and 18 NYCRR SubPart 521-3;
7. description of how, when, and to whom the provider reported, returned, and explained such overpayments;
8. any other evidence the provider reported, returned, and explained Medicaid program overpayments during the Review Period in accordance with 18 NYCRR SubPart 521-3;
9. any evidence of corrective actions taken to prevent the overpayments from recurring; and
10. any additional explanation, if needed.
 |
| If No, provide as “Attachment 6-3b,” an explanation why there were identified Medicaid program overpayments that were not reported, returned, or explained in accordance with 18 NYCRR SubPart 521-3. |
| **6-4** | **18 NYCRR § 521-1.4(g)(2)**Did the provider conduct an annual review of the compliance program, that complied with 18 NYCRR § 521-1.4(g)(2), during the Review Period to determine whether the requirements of SubPart 521-1 were met?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 6-4” documentation evidencing the requirement was met which may include, but is not limited to:1. a report on the annual review of the compliance program, including date completed;
2. meeting agendas/minutes that showed discussion of the compliance program review, including who was in attendance, if applicable;
3. summary of updates or modifications to the compliance program as a result of the annual review, including implementation dates, if applicable;
4. the design, implementation, and results of the annual compliance program effectiveness review, and any corrective action implemented, during the Review Period;
5. evidence that the results of the annual compliance program review were shared with the chief executive, senior management, compliance committee, and governing body; and
6. any other evidence the provider conducted an annual review of the compliance program and shared the results with the chief executive, senior management, compliance committee, and governing body during the Review Period;
7. any documentation to evidence that other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and are independent from the functions being reviewed; and
8. any additional explanation, if needed.
 |
| **6-5** | **18 NYCRR** **§ 521-1.4(g)(3)**Did the provider’s auditing and monitoring activities, that included checking the exclusion status of its Affected Individuals at least every 30 days, meet all the requirements of 18 NYCRR § 521-1.4(g)(3)?Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide as “Attachment 6-5,” documentation evidencing the requirement was met which may include, but is not limited to:1. a summary of all exclusion check reports, including databases checked and dates performed for the entire Review Period;
2. meeting minutes that documented discussion of such activities;
3. any evidence the provider’s auditing and monitoring activities included checking the exclusion status of its Affected Individuals for the entire Review Period;
4. a copy of all contracts with Contractors that were in effect during the Review Period evidencing contractors were required to comply with 18 NYCRR § 521-1.4(g)(3);
5. other documentation evidencing contractors were required to comply with 18 NYCRR § 521-1.4(g)(3);
6. for MMCOs, a copy of the MMCO’s standard contract with its participating providers and all contracts with subcontractors that were in effect during the Review Period; and
7. any additional explanation, if needed.
 |
| **6-6** | **18 NYCRR § 521-1.4(g)(4)**Did the provider share the results of its auditing and monitoring activities required by 18 NYCRR § 521-1.4(g) with the:1. compliance officer, and
2. Appropriate Compliance Personnel.

Yes \_\_\_\_No \_\_\_\_\_ | If yes, provide, as “Attachment 6-6” documentation evidencing the requirement was met which may include, but is not limited to:1. a list, including name and title, of the compliance officer and Appropriate Compliance Personnel;
2. report cover pages that identified distribution to the compliance officer and Appropriate Compliance Personnel;
3. meeting minutes that documented discussion of such activities, including who was in attendance; and
4. any other evidence that the provider shared the results of auditing and monitoring activities with the compliance officer and Appropriate Compliance Personnel.
 |
|  **ELEMENT 7: Responding to Compliance Issues** |
| **18 NYCRR § 521-1.4(h)**(h) Responding to compliance issues. The required provider shall establish and implement procedures and systems for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of the internal auditing and monitoring conducted pursuant to subdivision (g) of this section, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with State and Federal laws, rules and regulations, and requirements of the MA program. In developing its system for responding to compliance program issues, the required provider shall meet the following requirements:(1) Upon the detection of potential compliance risks and compliance issues, whether through reports received, or as a result of the auditing and monitoring conducted pursuant to subdivision (g) of this section, the required provider shall take prompt action to investigate the conduct in question and determine what, if any, corrective action is required, and likewise promptly implement such corrective action.(2) The required provider shall document its investigation of the compliance issue which shall include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that the required provider completed a thorough investigation of the issue. Where appropriate, the required provider may retain outside experts, auditors, or counsel to assist with the investigation.(3) The required provider shall document any disciplinary action taken and the corrective action implemented.(4) If the required provider identifies credible evidence or credibly believes that a State or Federal law, rule or regulation has been violated, the required provider shall promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The compliance officer shall receive copies of any reports submitted to governmental entities. |
| **7-1** | **18 NYCRR 521-1.4(h)**If potential compliance issues were detected during the Review Period, did the Provider comply with the requirements of 18 NYCRR 521-1.4(h)?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (No potential compliance issues were detected during the Review Period.) | If yes, provide, as “Attachment 7-1,” documentation evidencing the requirement was met which may include, but is not limited to:1. summary of all potential compliance issues during the Review Period, including date(s) and description;
2. summary of all investigations of potential compliance issues, including date(s), description, and results of such investigations;
3. summary of all plans of correction that were promptly implemented during the Review Period to resolve identified compliance issues, including implementation date(s) and description of plan(s) of correction;
4. any other evidence the provider took prompt action to investigate potential compliance issues during the Review Period, to determine what, if any, corrective action was required;
5. summary explaining how it was determined that no corrective action was required, if applicable;
6. a copy of any documentation of investigations of compliance issues during the Review Period evidencing the requirement was met;
7. a copy of any documentation evidencing the provider documented any disciplinary action taken and the corrective action implemented;
8. dated reports containing credible evidence of violations of state or federal law, rule, or regulation;
9. copy of transmittals of such reports to the appropriate government entity;
10. copy of transmittals of such reports to the compliance officer;
11. any other evidence the provider promptly reported credible evidence of violations of state or federal law, rule, or regulation during the Review Period and the compliance officer received copies of such reports; and
12. any additional explanation, if needed.
 |
| **7-2** | **18 NYCRR** **§ 521-1.4(h)(1)**If the provider had an OMIG audit or investigation, that was finalized during the Review Period and resulted in overpayments, did the provider comply with the requirements of 18 NYCRR § 521-1.4(h)(1)?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (There were no OMIG audits or investigations that were finalized during the Review Period.) | If yes, provide, as “Attachment 7-2,” a copy of the following:1. a summary that includes:
2. OMIG audit or investigation number and final report date;
3. a description of any related internal audits or investigations of the reason(s) for the identified overpayments;
4. a description of related plans of correction, including implementation dates; and
5. any other evidence the provider took prompt action to investigate the reason for identified overpayments in an OMIG audit or investigation to determine what, if any, corrective action was required and promptly implemented such corrective action; and
6. a summary of all internal audits or investigations to identify any additional overpayments that includes the following information:
7. OMIG audit or investigation number and final report date;
8. date internal audit or investigation was conducted;
9. description of any related internal audit or investigation conducted;
10. results of root cause analysis, if applicable;
11. whether the provider included a look-back period (up to the six-year records retention period);
12. whether the provider included a look-ahead beyond the OMIG audit period up to the time of implementation of a plan(s) of correction;
13. the amount of any overpayments identified;
14. evidence of any related OMIG self-disclosure or Self-Disclosure and Compliance Agreement; and
15. a description of related plans of correction, including implementation dates; and
16. any other evidence the provider conducted internal audits or investigations that were meant to identify any additional overpayments caused by circumstances identified in an OMIG final report issued during the Review Period; and
17. any additional explanation, if needed.
 |
| **7-3** | **18 NYCRR § 521-1.4(h)(1)**If the provider had a Self-Disclosure and Compliance Agreement with OMIG during the Review Period that included plans of correction to resolve the reasons for the overpayments and prevent recurrence, did the provider implement such plans of correction?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (The provider had no Self-Disclosure and Compliance Agreements with OMIG during the Review Period that included plans of correction.) | If yes, provide documentation as “Attachment 7-3,” that the plans of correction were implemented:1. copy of the Self-Disclosure and Compliance Agreement,
2. summary that includes:
	1. OMIG self-disclosure number and final report date,
	2. description of such plans of correction, and
	3. implementation dates, and
	4. any other evidence the provider implemented plans of correction as indicated in the Self-Disclosure and Compliance Agreement with OMIG, and
3. any additional explanation, if needed.
 |
| **MEDICAID MANAGED CARE FRAUD, WASTE AND ABUSE PREVENTION PROGRAM REQUIREMENTS**This section includes questions specific to MMCOs. If you are not an MMCO, you do not need to answer the following questions. |
| **18 NYCRR § 521-2.4(a)**(a) Compliance program. The MMCO shall adopt, implement and maintain a compliance program that satisfies the requirements of SubPart 521-1 of this Part. The MMCO shall be responsible for ensuring that the requirements of its fraud, waste and abuse prevention program are incorporated into its compliance program. Specifically, the MMCO shall:(1) incorporate into the written policies and procedures required by subdivision (a) of section 521-1.4 of this Part, the MMCO’s policies and procedures for preventing, detecting and investigating fraudulent, wasteful or abusive activities by its participating providers, non-participating providers, contractors, agents, subcontractors, independent contractors, and any other person the MMCO or its subcontractors pay for ordering, providing, furnishing or arranging for a service to a MA program recipient. The MMCO shall also incorporate any other policies and procedures related to its obligations under this SubPart;(2) require its designated compliance officer, as required by subdivision (b) of section 521-1.4 of this Part, to be responsible, except where noted, for implementing the requirements of this SubPart, and shall be responsible for coordinating with the MMCO’s SIU director, where applicable;(3) include, as part of the training required by subdivision (d) of section 521-1.4 of this Part, training of all personnel involved in identifying and evaluating instances of potential fraud, waste and abuse; and(4) include, as part of its auditing and monitoring activities as required by subdivision (g) of section 521-1.4 of this Part, the requirements of subdivision (c) of this section. |
| **8-1** | **18 NYCRR § 521-2.4(a)**Did the MMCO ensure that the requirements of its fraud, waste, and abuse prevention program were incorporated into its compliance program?Yes \_\_\_\_No \_\_\_\_\_ | Provide a copy, as “Attachment 8-1a,” of such written Policies that described the MMCO’s implementation, where applicable, as required by 18 NYCRR SubPart 521-2, including a record of implementation and revision dates. |
| Provide documentation, as “Attachment 8-1b,” that evidences the compliance officer was responsible, except where noted, for implementing the requirements of SubPart 521-2 and was responsible for coordinating with the MMCO’s SIU director, where applicable. |
| Please mark which months during the Review Period the fraud, waste, and abuse prevention program that complied with all requirements of 18 NYCRR § 521-2.4(a) was in effect in the following chart:

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| **18 NYCRR § 521-2.4(b)**(b) Special investigation unit (SIU). 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 SIU to identify risk and to detect and investigate cases of potential fraud, waste and abuse, report such cases to OMIG, and electively report potential fraud to MFCU, in accordance with the provisions of this SubPart and the terms of the MMCO’s contract with the department to participate as an MMCO. The SIU must be separate and distinct from any other unit or function of the MMCO. In establishing its SIU, the MMCO shall meet the following requirements:(1) Staffing requirements. The MMCO shall dedicate sufficient staff and resources to the SIU to effectively detect and prevent fraud, waste and abuse in the New York State MA program.(i) The MMCO shall employ at least one full-time lead investigator and one SIU director who shall be based in the State of New York and be responsible for communicating and coordinating with OMIG or MFCU with respect to:(a) conducting fraud, waste and abuse investigations;(b) making fraud, waste and abuse referrals;(c) preparing investigatory reports;(d) investigating and remediating conflicts of interest;(e) identifying and recovering overpayments;(f) conducting provider terminations, education or re-education, and other related actions;(g) implementing the fraud, waste and abuse prevention program required by this SubPart;(h) participating in any meetings required by OMIG; and(i) participating in any meetings required by MFCU(ii) The MMCO shall employ at least one (1) full-time investigator per sixty thousand (60,000) enrollees, except in the case of an MLTCP, which shall employ at least one (1) full-time investigator per six thousand (6,000) enrollees. The MMCO shall employ investigators dedicated to servicing a particular county when that county on its own meets the designated investigator-to-enrollee ratio required by this paragraph. An MMCO may propose for OMIG’s consideration alternative minimum staffing levels, provided the MMCO demonstrates to OMIG’s satisfaction that its proposal would be no less effective than those required by this subparagraph and that the requirements of this SubPart can be fully met. The MMCO must apply for and receive written approval from OMIG of any alternative staffing levels prior to the implementation of any alternative minimum staffing levels. The approval or denial of any alternative staffing level proposal is at the discretion of the Medicaid Inspector General or their designee, and such approval may be rescinded by the Medicaid Inspector General or their designee with ninety 90 days’ notice.(iii) In addition to investigators, the MMCO shall also employ or utilize existing employees who are certified coders, clinicians, data analysts, or pharmacists to support the work of the SIU.(2) SIU investigator qualifications. Persons employed by the SIU as investigators shall be qualified by education or experience, which shall include:(i) 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;(ii) an associate’s or bachelor’s degree in criminal justice or a related field; or(iii) employment as an investigator in the MMCO’s SIU on or before the effective date of this SubPart.(3) SIU work plan. No less frequently than annually, the SIU shall prepare a work plan outlining the activities that it plans to complete in the coming year. The SIU shall consider the MMCO’s risk areas, as specified in SubPart 521-1 of this Part, and organizational experience in developing the work plan. The SIU work plan may be a standalone document, or a component of its larger compliance work plan required by SubPart 521-1 of this Part.(4) Delegation. The MMCO may delegate all or part of the functions of the SIU under this subdivision, provided, however, that it shall be no defense to enforcement of this SubPart that a subcontractor failed to provide effective service enabling the MMCO to comply with its obligations. The MMCO is ultimately responsible for meeting the requirements of this SubPart.(i) The MMCO shall require that the subcontractor to whom it delegates the SIU function comply with all the requirements of this subdivision, and any other relevant requirements under this SubPart. The MMCO shall also require that the subcontractor cooperate fully with OMIG in any examination of the implementation of the fraud, waste and abuse prevention program required by this SubPart and provide any and all assistance requested by OMIG, the department, MFCU and any other law enforcement agency or any prosecutorial agency in the investigation of fraud, waste and abuse, and the prosecution of fraud and abuse and related crimes.(ii) The MMCO shall review any contract for SIU functions to determine if it delegates any management authority. An MMCO shall not enter into any agreement delegating management authority except pursuant to a management contract which complies with the requirements of subdivisions (h) through (s) of section 98-1.11 of Title 10 and section 98-1.18 of Title 10.(iii) If the MMCO enters into a management contract for all or part of its SIU function, the management contract shall be submitted to the department and OMIG, and included as part of the fraud, waste and abuse prevention plan required by subdivision (i) of this section. |
| **8-2** | **18 NYCRR § 521-2.4(b)**If the MMCO was required to have an SIU during the Review Period, did the MMCO’s SIU meet all the requirements in 18 NYCRR § 521-2.4(b)?Yes \_\_\_\_No \_\_\_\_N/A \_\_\_\_ (The MMCO was not required to have an SIU during the Review Period.) | Provide documentation, as “Attachment 8-2a,” evidencing what its enrolled population was during the Review Period, including monthly totals by county. |
| Provide documentation, as “Attachment 8-2b,” evidencing the SIU was separate and distinct from any other unit or function of the MMCO. |
| Provider documentation, as “Attachment 8-2c,” evidencing the MMCO dedicated sufficient staff and resources to the SIU, including:* identification of full-time lead investigator(s) including to/from service dates, county assignments, and qualifications;
* identification of the SIU director and to/from service dates;
* whether the lead investigators and SIU director were based in the State of New York;
* whether the lead investigators and SIU director were responsible for communicating and coordinating with OMIG or MFCU as required in 18 NYCRR § 521-2.4(b)(1)(i); and
* identification of full-time investigator(s) including to/from service dates, county assignments, and qualifications;
* identification of any certified coders, clinicians, data analysts or pharmacists that support the work of the SIU.
 |
| Provide documentation, as “Attachment 8-2d,” evidencing, if applicable:1. showing that the MMCO received written approval from OMIG of any alternative SIU staffing levels,
2. when the approved alternative SIU staffing levels were implemented, and
3. when OMIG rescinded such approval, if applicable.
 |
| Provide, as “Attachment 8-2e,” an explanation of whether the annual SIU work plan was a component of the annual compliance work plan required by 18 NYCRR § 521-1.4(b)(1)(ii). If it was not, provide a copy of the annual SIU work plan(s) that was in effect during the entire Review Period, |
| Please mark which months during the Review Period the MMCO was required to have an SIU in effect in the following chart:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [ ] None | [ ] Jan | [ ] Feb | [ ] Mar | [ ] Apr | [ ] May | [ ] Jun | [ ] Jul | [ ] Aug | [ ] Sep | [ ] Oct | [ ] Nov | [ ] Dec |

 |
| **18 NYCRR § 521-2.4(c)**(c) MMCO audits and investigations. In addition to the auditing and monitoring requirements of subdivision (g) of section 521-1.4 of this Part, the MMCO shall audit, investigate, or review cases of fraud, waste or abuse specific to its participation in the MA program, and the MMCO’s risk areas as specified in SubPart 521-1 of this Part. The MMCO shall conduct such audits, investigations or reviews in accordance with the following requirements and as specified in the contract between the MMCO and the department to participate as an MMCO:(1) The MMCO’s SIU, if applicable, shall be primarily responsible for performing, or collaborating with and monitoring those individuals performing, such audits, investigations and reviews, and shall coordinate with the MMCO’s designated compliance officer.(2) Such audits, investigations and reviews must involve at least one percent (1%) or more of the aggregate of MA program claims it pays to providers and subcontractors, based on the total prior year’s claims paid by the MMCO. Such audits, investigations and reviews may review claims consistent with any lookback period established in the MMCO’s contract with the Department to participate as an MMCO.(3) Such audits, investigations and reviews must be of clinical and billing records to verify that no duplicate payments were made, appropriate services were rendered and billed, appropriate procedure codes were utilized, and accurate encounter data was reported to the department. |
| **8-3** | **18 NYCRR § 521-2.4(c)**Did the MMCO conduct audits, investigations, or reviews in accordance with the requirements in 18 NYCRR § 521-2.4(c)?Yes \_\_\_\_No \_\_\_\_\_**Note:** Do not submit claim details. | Provide documentation, as “Attachment 8-3,” evidencing the MMCO audited, investigated, or reviewed cases of fraud, waste or abuse specific to its participation in the Medicaid program, and the MMCO’s risk areas as specified in 18 NYCRR § 521-1.3(d)(11). Such documentation may include, but is not limited to:* 1. summary of audit and investigation results, dates completed, and any compliance issues identified;
	2. dated meeting minutes that documented discussion of such activities, if applicable;
	3. any other evidence of how the provider performed audits that focused on risk areas identified in 18 NYCRR § 521-1.3(d) during the Review Period;
	4. evidence that such audits, investigations and reviews involved one percent or more of the aggregate Medicaid program claims required under 18 NYCRR § 521-2.4(c)(2) of this SubPart; and
	5. any additional explanation, if needed.
 |
| **18 NYCRR § 521-2.4(d)**(d) Reporting cases of fraud, waste and abuse. The MMCO and its subcontractors shall report all cases of potential fraud, waste and abuse to OMIG. The MMCO may also report cases of potential fraud to the MFCU. In reporting such cases, the MMCO shall comply with the terms of its contract with the department to participate as an MMCO. The reports shall be reviewed and signed by an executive officer of the MMCO responsible for the operations of the SIU. In addition, the MMCO shall include the following information when reporting potential fraud, waste and abuse to OMIG:(1) Information about the subject of the report, including:(i) the name of the person or provider;(ii) the provider’s Medicaid provider ID, if applicable;(iii) the person’s or provider’s national provider ID, if applicable;(iv) the person’s or provider’s address;(v) the type of provider; and(vi) any other information requested by OMIG.(2) The source and origin of the allegation;(3) The date the allegation was first reported to the MMCO, or the MMCO first became aware of the allegation;(4) A summary of the investigation, which shall be in a form and format approved by OMIG;(5) A description of the suspected misconduct, with specific details including:(i) the category of service;(ii) a factual explanation of the allegation;(iii) the specific MA program statutes, rules, regulations, and/or policies violated; and(iv) the date(s) of the conduct.(6) The amount the MMCO paid to the person or provider during the past three (3) years or during the period of the alleged misconduct, whichever is greater;(7) All communications between the MMCO and the provider or person concerning the conduct at issue;(8) The contact information for the MMCO SIU director, lead investigator, investigator(s) and staff with knowledge of the case;(9) An estimate of the overpayment, when available; and(10) Copies of the investigation file and related material. |
| **8-4** | **18 NYCRR § 521-2.4(d)**Did the MMCO report all cases of potential fraud, waste, and abuse to OMIG in accordance with requirements in 18 NYCRR § 521-2.4(d)?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (There were no cases of potential fraud, waste, and abuse identified during the Review Period.) | Provide documentation, as “Attachment 8-4,” evidencing the MMCO reported all cases of potential fraud, waste, and abuse to OMIG during the Review Period pursuant to 18 NYCRR § 521-2.4(d). |
| **18 NYCRR § 521-2.4(e)**(e) The MMCO and its subcontractors shall immediately refer reasonably suspected criminal activity to OMIG and MFCU in accordance with the requirements specified in the MMCO’s contract with the department to participate as an MMCO. |
| **8-5** | **18 NYCRR § 521-2.4(e)**Did the MMCO and its subcontractors immediately refer reasonably suspected criminal activity to OMIG and MFCU during the Review Period?Yes \_\_\_\_No \_\_\_\_\_N/A \_\_\_\_ (There was no reasonably suspected criminal activity identified during the Review Period.) | Provide documentation, as “Attachment 8-5,” evidencing the MMCO and its subcontractors immediately referred reasonably suspected criminal activity to OMIG and MFCU during the Review Period. |
| **18 NYCRR § 521-2.4(f)**(f) Report, return and explain. The MMCO shall establish policies and procedures in accordance with the requirements of section 363-d of the Social Services Law for its participating providers and other subcontractors to report, return and explain overpayments to the MMCO within sixty (60) days of identification. The MMCO shall promptly report all recoveries, including recoveries which result from a provider or subcontractor reporting, returning and explaining an overpayment under this subdivision:(1) in its cost reports to the department, and in accordance with the instructions and directives of the department; and(2) in a monthly report to OMIG in a form and format to be determined by OMIG, or as otherwise specified in its contract with the department to participate as an MMCO. |
| **8-6** | **18 NYCRR § 521-2.4(f)**Did the MMCO promptly report all recoveries in its monthly reports to OMIG during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | Provide documentation, as “Attachment 8-6,” evidencing:1. the MMCO promptly reported all recoveries in its monthly reports to OMIG during the Review Period, and
2. if applicable, an explanation of why no report of recoveries was included in its monthly reports to OMIG.
 |
| **18 NYCRR § 521-2.4(g)**(g) 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. |
| **8-7** | **18 NYCRR § 521-2.4(g)**Did the MMCO have a fraud, waste, and abuse detection procedures manual?Yes \_\_\_\_No \_\_\_\_\_ | Provide a copy, as “Attachment 8-7,” of the MMCO’s fraud, waste, and abuse detection procedures manual. |
| **18 NYCRR § 521-2.4(h)**(h) Other program integrity requirements.(1) 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.(2) The MMCO shall make available on its website information on how and where to report, return and explain overpayments to the MMCO, in accordance with the requirements of subdivision (f) of this section. |
| **8-8** | **18 NYCRR § 521-2.4(h)**Did the MMCO have information available on its website, including:1. its fraud, waste, and abuse public awareness program, and
2. how and where to report, return, and explain overpayments to the MMCO?

Yes \_\_\_\_No \_\_\_\_\_ | Provide documentation, as “Attachment 8-8,” evidencing the MMCO had information available on its website, including:1. its fraud, waste, and abuse public awareness program, and
2. how and where to report, return, and explain overpayments to the MMCO.
 |
| **18 NYCRR § 521-2.4(i)**(i) Fraud, waste and abuse prevention plan.(1) Within ninety (90) calendar days of the effective date of this SubPart or of signing a new contract with the department to begin participation as an MMCO, the MMCO shall develop a fraud, waste and abuse prevention plan and shall submit such plan to OMIG.(2) The MMCO shall review and update such plan no less frequently than annually.(3) The plan shall include:(i) a description of the MMCO’s program for preventing and detecting fraud, waste and abuse;(ii) a description, if applicable, of the organization of the SIU, including:(a) titles and job descriptions of the investigators, investigative supervisors and other staff;(b) the minimum qualifications for employment in these positions in addition to those qualifications required by this section;(c) the geographical location and assigned territory of each investigator and investigative supervisor;(d) the support staff and other physical resources, including database access available to the SIU; and(e) the supervisory and reporting structure within the SIU and between the SIU and senior management of the MMCO.(iii) If investigators employed by the unit will be responsible for investigating cases in more than one state, the plan must apportion that percentage of the investigators’ efforts that will be devoted to New York cases;(iv) the rationale, if applicable and different from the minimum staffing levels required by subdivision (b) of this section, for the level of staffing and resources of the SIU which may include, but is not limited to, objective criteria such as the number of claims received with respect to the MMCO’s participation in the New York State MA program on an annual basis, volume of potential fraud, waste and abuse for the MMCO’s New York MA claims currently being detected, other factors relating to the vulnerability of the MMCO to fraud, waste and abuse, and an assessment of optimal caseload which can be handled by an investigator on an annual basis;(v) a description of the roles, responsibilities and interaction between the MMCO’s:(a) designated compliance officer responsible for carrying out the provisions of the fraud, waste and abuse prevention program and the SIU;(b) SIU and the claims, quality, member services, utilization review, complaint procedures and underwriting functions of the MMCO for the purpose of enhancing the ability of the MMCO to detect fraud, waste and abuse and to increase the likelihood of its successful prosecution, and for the initiation of civil action when appropriate;(c) SIU and the MMCO’s legal department; and(d) SIU and OMIG, the department, MFCU, or other law enforcement agencies and prosecutors;(vi) the MMCO’s policies and procedures required by paragraph (1) of subdivision (a) of this section;(vii) the criteria the MMCO uses for the internal referral of a case to the SIU for evaluation, and the criteria the SIU utilizes for reporting cases of potential fraud, waste and abuse to the department and OMIG in accordance with subdivision (d) of this section;(viii) a description of the specific controls in place for the prevention and detection of potential fraud, waste and abuse, including a list of any automated pre-payment claims edits and a list of any automated post-payment review of claims;(ix) a description of the training required by paragraph (3) of subdivision (a) of this section;(x) the timetable for the implementation of the fraud, waste and abuse prevention plan, provided however, that the period preceding implementation shall not exceed one hundred and eighty (180) calendar days from the date the MMCO executes its contract with the department to participate as an MMCO and develops its fraud, waste and abuse prevention plan pursuant to paragraph (1) of this subdivision.(4) 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. |
| **8-9** | **18 NYCRR § 521-2.4(i)**Did the MMCO have a fraud, waste, and abuse prevention plan that met all the requirements of 18 NYCRR § 521-2.4(i) during the Review Period?Yes \_\_\_\_No \_\_\_\_\_ | Provide a copy, as “Attachment 8-9a,” of the MMCO’s fraud, waste, and abuse prevention plan(s), including implementation and revision dates, that was in effect during the Review Period. |
| Provide documentation, as “Attachment 8-9b,” evidencing the MMCO reviewed and updated its fraud, waste, and abuse prevention plan no less frequently than annually. |
| **18 NYCRR § 521-2.4(j)**(j) Annual report. The MMCO shall on or before a date specified by OMIG, which shall be no sooner than January 31 of each calendar year, file with OMIG, in a form and format approved by OMIG, anannual report for the preceding calendar year, demonstrating that it has satisfied the requirements of this SubPart. Such report shall, at a minimum, include:(1) a description of the MMCO’s experience, performance and cost effectiveness in implementing the fraud, waste and abuse prevention program;(2) the MMCO’s proposals for modifications to its fraud, waste and abuse prevention program and plan, to amend its operations, to improve performance or to remedy observed deficiencies;(3) a summary of the MMCO’s SIU staffing;(4) a summary of the activities of the MMCO’s subcontractors or vendors who perform audit, investigation or review functions for the MMCO;(5) the total number of reported cases of potential fraud, waste or abuse identified by the MMCO, its subcontractor(s) or vendor(s);(6) the MMCO’s SIU work plan for the next calendar year;(7) results of service verification reviews as specified in the MMCO’s contract with the department to participate as an MMCO; and(8) any other information or data that OMIG may require relevant to the requirements of this SubPart or related requirements under the MMCO’s contract with the department to participate as an MMCO. |
| **8-10** | **18 NYCRR § 521-2.4(j)**Did the MMCO submit an annual report to OMIG for the preceding calendar year, demonstrating that it satisfied the requirements of 18 NYCRR SubPart 521-2?Yes \_\_\_\_No \_\_\_\_\_ | Provide a copy, as “Attachment 8-10,” of the MMCO’s annual report submitted to OMIG during the Review Period. |

**PROVIDER’S DOCUMENTATION**

**Provider Name:** Click or tap here to enter text.

**Review Period:** 00/00/0000 – 00/00/0000

Please identify all documentation being submitted in the following table. Add additional rows if needed.

Where supporting documentation is requested, it should be provided in the following manner:

1. in a Microsoft Word document or in a searchable Adobe PDF document (searchable electronic format). Electronic file names should reflect the document name (e.g., Compliance Manual, Code of Conduct, Training Plan, Ethics Policy, Job Description, etc.);
2. **if multiple versions of a document were in effect during the Review Period, submit all such versions for review and provide the effective dates for each document**;
3. if the same document can be used to answer multiple questions, submit it only once. **Do not submit multiple copies of the same document**; and
4. if the provider does not have the requested documentation, please indicate what documentation the provider does not have.
5. Do not submit documentation that includes Protected Health Information (PHI) for Medicaid program recipients.
6. If a submission contains information the provider considers to be trade secrets and, therefore, pursuant to New York Public Officers Law § 87(2)(d) (exemption from public disclosure under FOIL), it is the provider’s responsibility to indicate same on each submission. If an electronic submission contains multiple attachments, the FOIL exemption indication must be included as part of each attachment subject to the exemption request.

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| **Add additional rows as needed.** |
| **Document Name****(i.e., electronic file name)** | **Related Attachment Number(s)** | **Effective Dates****(From-To) or** **Do Not Have** |
| Sample: Standards of Conduct | Attachment 1-1a | 01/01/2019 - Present |
| Sample: Compliance Training Policy | 1-1a | Do not have |
| Copy of OMIG’s Notification Letter | Not Applicable | 00/00/0000 |
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**FINAL INSTRUCTIONS:**

Submit the following documentation electronically to compliancereview@omig.ny.gov:

1. Module, in Microsoft Word format;
2. copy of the Notification of Review letter; and
3. all requested documentation, in searchable electronic format.

**If multiple versions of a document were in effect during the Review Period, submit all such versions for review and provide the effective dates for each document.** **Failure to submit all documentation in effect during the Review Period and in searchable electronic format may result in a lower score for the review.**

If the same document can be used to answer multiple questions, submit it only once, identifying all the attachment numbers for which it is being submitted in the table above. **Do not submit multiple copies of the same document.**

**FOR FURTHER INFORMATION, CONTACT:**

OMIG’s Bureau of Compliance at (518) 408-0401 or compliancereview@omig.ny.gov.