NEW YORK STATE OF OPPORTUNITY. | Office of the Medicaid Inspector General

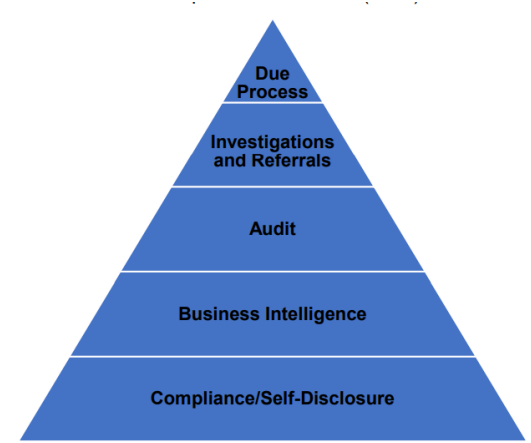
Overview of OMIG's Compliance and Self-Disclosure Programs and Processes

September 12, 2023

NYS Office of Medicaid Inspector General (OMIG)

NY Medicaid Program at a Glance

7.9 million recipients (2023)
Over $100 billion total spend ($109B projected FY24)
More than 200,000 enrolled providers
62 MCOs (17 mainstream, 45 long-term care)



OMIG Performance at a Glance (Preliminary 2022)

OMIG is the independent state agency responsible for the enhancement of Medicaid program integrity, the protection of efficient and high-quality health care service delivery, and the preservation of resources.

- Roughly 450 staff working on Medicaid program integrity functions across 7 regional locations
- Over 1,100 finalized audits
- Nearly 2,400 completed investigations (Roughly 40% generated in-house)
- Over 900 referrals, including 199 referrals to MFCU
- Over $3.4 billion in cost savings ($2.6 billion) and recoveries ($0.8 billion)

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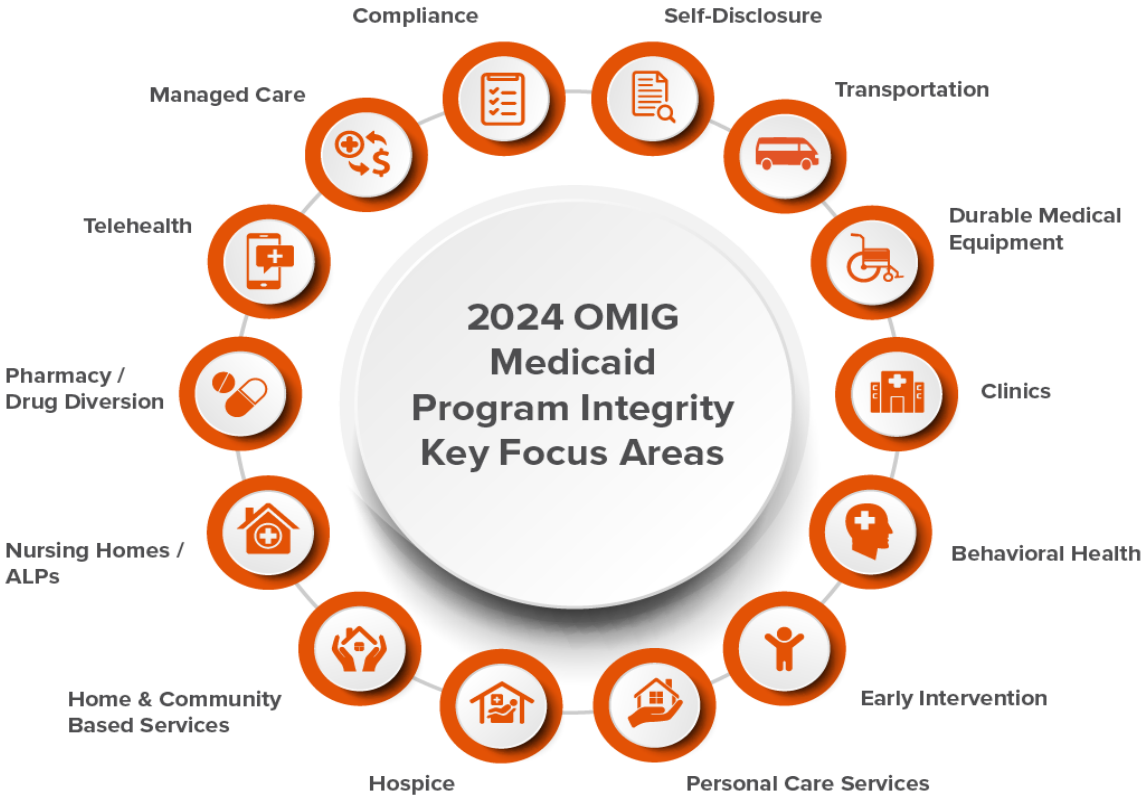
Key Focus Areas



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NYCRR Part 521

Part 521

- Adopted on December 28, 2022
- Self-disclosure requirements became effective with adoption on December 28, 2022
- Compliance program reviews began on July 3, 2023, with a three-month look-back review period of April 1 - June 30, 2023

Compliance Program Requirements

Compliance Programs

- Definitions established
- Contractual requirements
- Written policies and procedures
- Defined responsibilities (compliance officer, etc.)
- Management-level compliance committee
- Communications and transparency requirements
- Training requirements

Compliance Programs

- Auditing and monitoring requirements
  - Auditing and monitoring risk areas
  - Responding to compliance issues
  - Provider/MMCO-generated annual compliance program review
- Report, return and explain requirements

Outcomes

- Recognizes key role providers play in program integrity efforts
- Builds on existing, long-standing provider compliance and reporting requirements
- Aligns state and federal provisions related to compliance program requirements

Compliance Program Guidance

Compliance Program Guidance

- OMIG's Compliance Program Guidance document gives general guidance to assist providers in meeting amended compliance program requirements.
- The goal of the guidance document is to share key components that must be included in every compliance program so providers can be effective partners in preventing fraud, waste, and abuse within the Medicaid program.

Definitions & Duties

Condition of Receiving Payment

Required providers shall, as a condition of receiving payment under the Medicaid program, adopt, implement, and maintain an effective compliance program that satisfies the requirements of SubPart 521-1.

Those Required to Have Effective Compliance Programs

- Providers subject to the following Articles regardless of amount paid:
  - Public Health Law Article 28 or Article 36
  - Mental Hygiene Law Article 16 or Article 31

- **(NEW)** Managed Care providers, including Managed Long-Term Care Plans (collectively, “MMCOs”)

- **(NEW)** $1,000,000 (up from $500,000) or more during a consecutive 12-month period:
  - Claimed or reasonably expected to …
  - Received or reasonably expected to …

Compliance Program Requirements

- Providers must certify to the Department of Health (DOH) upon enrollment and annually thereafter that they have met the requirements of SOS § 363-d and Part 521
- Compliance program certifications are included in the annual *Certification Statement for Provider Billing Medicaid* (Electronic Transmitter Identification Number - EITN) form submitted to DOH

Compliance Program Elements

Element 1 – Compliance Policies

- The Providers should incorporate legal and ethical obligations related to compliance program requirements into their written policies, procedures, and standards of conduct (Policies).
- The written policies should also document the implementation of each of the seven elements and outline the ongoing operation of the compliance program.

Element 2 – Compliance Officer

- Designation of a compliance officer who is vested with responsibility for the day-to-day operation of the compliance program
- **(NEW)** Designation of a compliance committee that will coordinate with the compliance officer

* See additional information in the Compliance Program Guidance on pages 9-11

Element 3 – Training

- Compliance program training and education for all affected individuals
- **(NEW)** Develop and maintain a training plan

*See additional information in the Compliance Program Guidance on pages 11-12

Element 4 – Communications

- Lines of communication to the compliance officer to report compliance issues

- Provider must ensure the confidentiality of persons reporting compliance issues

*See additional information in the Compliance Program Guidance on pages 12-13

Element 5 – Disciplinary Standards

- Disciplinary standards that address potential violations and encourage good-faith participation in the compliance program
- **(NEW)** Written policies establishing disciplinary standards are published and disseminated to all affected individuals

* See additional information in the Compliance Program Guidance on pages 13-14

Element 6 – Compliance Processes

- Systems for:
  - identifying compliance risk areas
  - routine auditing and monitoring
  - **(NEW)** annual compliance program review
  - **(NEW)** checking monthly for excluded providers
    - ✓ requiring contractors, agents, subcontractors, and independent contractors to comply with checking monthly for excluded providers

* See additional information in the Compliance Program Guidance on pages 14-15

Element 6 – Compliance Processes

- Systems for routine auditing and monitoring include the annual compliance program review which is a good method to confirm compliance program effectiveness.

We recommend using the Module and Self-Assessment Form on OMIG's website to help guide your annual compliance program review.

Element 7 – Monitoring

- Systems for responding to compliance issues
  - responding promptly to compliance issues when raised
  - investigating and correcting problems
  - ensuring compliance with state and federal laws, rules, regulations, and requirements of the Medicaid program

* See additional information in the Compliance Program Guidance on pages 15-16

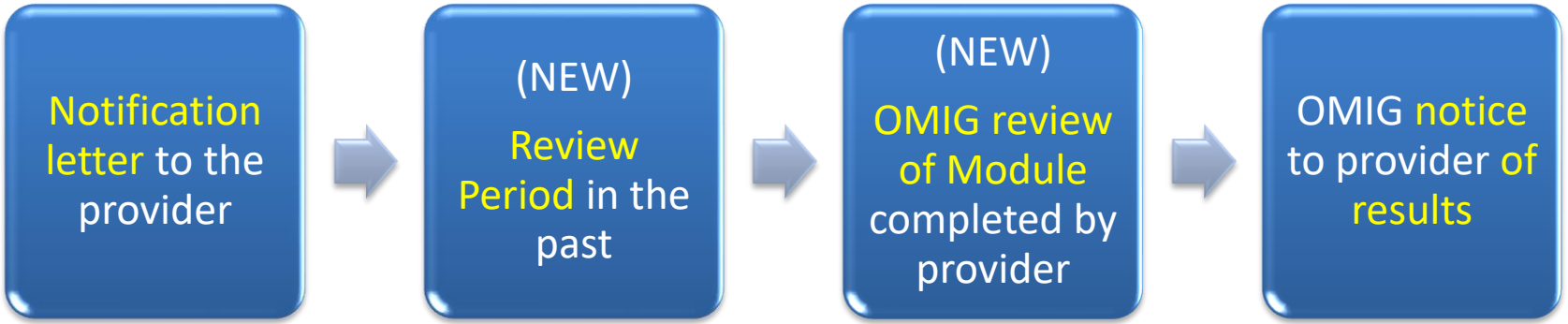
Managed Care Key Components

- **(NEW)** Incorporate fraud, waste, and abuse prevention programs into compliance programs
  - Interconnections between 521-1 and 521-2
- **(NEW)** Special Investigations Unit staffing requirements
- **(NEW)** Contractual requirements
- **(NEW)** Fraud, waste, and abuse reporting
- **(NEW)** a public awareness program

* See additional information in the Medicaid Managed Care Fraud, Waste and Abuse Prevention Program Guidance

Compliance Program Review Process

Compliance Program Review Process



Possible Sanctions & Penalties

Sanctions & Penalties

- Per SOS § 363-d(3)(c-d), if the provider does not have a satisfactory program, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, up to and including revocation of the provider's agreement to participate in the Medicaid program

Sanctions & Penalties

OMIG may impose penalties, for failure to have an effective compliance program, up to:

- $5,000 per calendar month in the first instance
- $10,000 per calendar month for subsequent instances

Plans of Correction

- Providers should identify and implement corrective actions in all areas identified by OMIG as needing improvement.
- Implementation of corrective actions may not be immediately reviewed by OMIG, but failure to implement requested corrective action could subject a provider to further sanctions associated with a future review.

Compliance Program Best Practices

Best Practices

- Utilize the Module and Self-Assessment Form on OMIG's website to guide the annual compliance program review. The Module focuses on the elements from a high-level; the Self-Assessment form focuses on each requirement under the elements.
- The compliance work plan is a key component in demonstrating that a provider has an effective compliance program.
- Disciplinary actions should be progressive
- Upon receipt of a notification letter, assemble the appropriate team and promptly begin completing the form/gathering related documentation
- Communicate early and often with OMIG throughout a review

Compliance Resources

Compliance Resources

- The Compliance Library on OMIG's website (omig.ny.gov) contains:
  - *Compliance Program Guidance*
  - *General Compliance Guidance and Resources*
  - *Compliance-Related Laws and Regulations*
- Bureau of Compliance email: compliance@omig.ny.gov

Self-Disclosure

Self- Disclosure Regulation Background

- NYS Regulation – 18NYCRR Part 521-3
  - Updates to the regulation governing OMIG's Self-Disclosure Program went into effect December 28, 2022.
  - The updates codified into NYS regulation the Federal 60-day report, return & explain requirement.
  - The updates also provided additional details regarding process.

Federal Laws

- Federal Law – Affordable Care Act (128J(d)(1)):
  - Requires a person who has received an overpayment to report and return the overpayment within 60 days of identification and to provide in writing of the reason for the overpayment.

- Federal Law - Title 42 of the US Code (USC) §1320a-7k(d)(1) & (2)
  - Requires a person who has received an overpayment to report, the reason for the overpayment, and to return the overpayment within 60 days of identification or by the date the corresponding cost report is due, if applicable.

NYS Laws

- NYS Public Health Law (NYS PHL) §32(18)
  - OMIG shall, in conjunction with the commissioner, develop protocols to facilitate efficient self-disclosure and collection and monitoring of overpayments. A provider's good faith self-disclosure may be considered as a mitigating factor in the determination of an administrative enforcement action.
- NYS Social Services Law (SOS) §363-d (6(a)(1)&(2)):
  - Requires a person who has received an overpayment under the medical assistance program to report and return the overpayment and to notify the Medicaid inspector general in writing of the reason for the overpayment within 60 days of identification.

Self-Disclosure Process

Benefits of Self-Disclosure

- Promotes an environment of compliance and integrity within an organization
- Enables OMIG to work with the provider on repayment terms
- Satisfies the provider's obligation to report, return and explain under Federal and State law

Common Issues Identified

- Commonly self-disclosed errors that led to a Medicaid overpayment include, but are not limited to:
  - Billing errors
  - Fraudulent behavior by employees
  - Discovery of an employee on the Excluded Provider list
  - Documentation errors
  - Changes in billing systems which caused claims to be billed incorrectly

Two Self-Disclosure Avenues

All identified Medicaid overpayments must be self-disclosed.

OMIG has developed two paths for different types of Medicaid Self-Disclosures. Medicaid entities choose the appropriate type of Self-Disclosure based on the type of overpayment identified.

- ❑**Self-Disclosure Full Statement** (existing form & process)
- ❑**Self-Disclosure Abbreviated Statement** (new as of August 2023)

Which type of self-disclosure do I have?

Determination should be based on the error or issue that occurred that caused the overpayment of Medicaid funds

- ❑ The first step is to fully investigate and identify the error that caused the overpayment.

Self-Disclosure Full Statement

- Any error that requires a Medicaid entity/Provider to create and implement a formal corrective action plan
- Actual, potential or credible allegation of fraudulent behavior by employees or others
- Discovery of an employee on the Excluded Provider list
- Non-claim-based Medicaid overpayments
- Systemic billing or claiming issues
- Overpayments that involved more than one Medicaid entity/Provider (example – Health Homes & Care Management Agencies)
- Any error with substantial monetary or program impacts
- Any instance upon direction by OMIG

Self-Disclosure Abbreviated Statement

- Routine credit balance/coordination of benefits overpayments
- Typographical human errors
- Routine Net Available Monthly Income (NAMI) adjustments
- Instances of missing or faulty authorization for services due to human error
- Inappropriate rate, procedure or fee code used due to typographical or human error
- Routine recipient enrollment issue

*** All overpaid Medicaid claims appropriate for the Abbreviated process must be voided or adjusted.**

I have IDENTIFIED an overpayment
(Investigated the issue and quantified the overpayment amount to the best of my ability)

What caused the overpayment?

- ☐ Any error that requires a formal corrective action plan
- ☐ Actual, potential or credible allegation of fraud
- ☐ Error with substantial monetary or program impacts
- ☐ Excluded or non-enrolled employee
- ☐ Non-claim based overpayment
- ☐ Systemic issue (either technology or behavior based)
- ☐ Errors that involve more than one entity (ex – Health Home & Care Management Agency)

Self-Disclosure Full Statement process

1. Complete the Self-Disclosure Full Statement & Certification Form
2. Complete the Claims Data Form or MPC Form (as applicable)
3. Determine how you intend to repay
   a. If you choose to repay the overpayment by voiding or adjusting the impacted claims, either void/adjust them prior to submitting the disclosure or identify in your Self-Disclosure Statement that you are in the process of voiding or adjusting your claims
4. Submit your completed Self-Disclosure documentation to the OMIG website's secure uplink within 60 days of identifying the overpayment
5. Cooperate with any requests received from the OMIG Self-Disclosure Unit
6. Repay according to the terms in the Determination Notice or Self-Disclosure and Compliance Agreement (if not already voided or adjusted)

- ☐ Error with minimal monetary and program impact, such as:
  - Human error
  - Credit balance
  - Coordination of benefits overpayment

Self-Disclosure Abbreviated Statement process

1. Void or adjust your claims
2. Add your voided or adjusted claims to the Self-Disclosure Abbreviated Statement spreadsheet for the appropriate 60 day aggregated period
3. Submit your completed Self-Disclosure Abbreviated Statement spreadsheet by the 5th of the month
4. Cooperate with any requests received from the OMIG Self-Disclosure Unit

Submit an Abbreviated Self-Disclosure

- ❑ Void or adjust the overpaid claim(s)
- ❑ Document the reason for the overpayment, the date the overpayment was identified, and the voided or adjusted Transaction Control Number (TCN)
- ❑ By the 5th of each month utilize the Abbreviated Statement link on OMIG's website to submit a monthly report containing the routine or transactional voided or adjusted overpayments from the previous month

Submit a Full Self-Disclosure

- ❑ Complete the Self-Disclosure Full Statement, Certification form and Claims Data or Mixed Payer Calculation spreadsheet (as applicable)
- ❑ Utilize the secure uplink on OMIG's website to submit the completed Self-Disclosure documentation
- ❑ If repaying by voids or adjustments, void or adjust the overpaid claim(s)

Matters That Should Not Be Self-Disclosed

- The overpayment is included in another separate review or audit being conducted by OMIG, the Office of the Inspector General, Attorney General, etc.
- The overpayment is included in a broader state-initiated rate adjustment, cost settlement, or other payment adjustment mechanism. For example: retroactive rate adjustments, charity care, cost reporting, etc.
- Any underpayments; these must be re-billed to eMedNY. Claims are subject to their own rules and regulations

Repayment Options

Voiding or Adjusting Overpaid Claims

Voiding or adjusting Medicaid claims is an acceptable way to **repay** Medicaid but does not satisfy a provider's obligation to **report and explain** the identified overpayment.

- **Abbreviated Process:** Overpaid Medicaid claims must be voided or adjusted prior to submitting them on the Self-Disclosure Abbreviated Statement.
- **Full Process:** Void or adjust the overpaid Medicaid claims prior to submitting the Self-Disclosure Full Statement. If this isn't possible, indicate within the Statement that voids or adjustments are in process for repayment.

Check, Money Order or Electronic Payment

- **Lump Sum Payment**: DO NOT SEND PAYMENT ALONG WITH SELF-DISCLOSURE. Once the self-disclosure is processed, you may pay by check, electronic payment or money order. A Determination Notice will be sent with instructions on lump sum repayment.

- **Extended Repayment**: A provider may request installment payments via a Self-Disclosure and Compliance Agreement (SDCA) prior to the issuance of a Determination Notice. This payment option is granted or denied at the discretion of OMIG. A provider must supply all supporting financial documentation requested by OMIG (i.e., tax returns) by the due date specified to be considered for this payment option.

Self-Disclosure Best Practices

Investigate

Fully investigate what caused the overpayment, who was involved, and what will be done to ensure it doesn't reoccur

- ❑ Determine what caused the overpayment to occur
- ❑ Identify who caused the overpayment (if identifiable)
- ❑ Identify who was involved in discovering the overpayment
- ❑ Quantify the overpayment to the best of your ability and determine an estimated overpayment amount
- ❑ Determine what corrective action needs to take place (if any) to ensure the overpayment doesn't reoccur

Determine the appropriate Self-Disclosure Process for reporting

- Use the reason the overpayment occurred to determine which of the two Self-Disclosure processes is appropriate for reporting and explaining the identified overpayment.

Visit the OMIG Website

Forms, instructions and options for secure submission can be found on OMIG's website for both the Self-Disclosure Abbreviated Process and the Self-Disclosure Full Process

https://omig.ny.gov/provider-resources/self-disclosure

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Self-Disclosure: It's the *right thing* to do

Contacts

Self-Disclosure Unit Resources and Contact Information

- Self-Disclosure web page: https://omig.ny.gov/provider-resources/self-disclosure
- Self-Disclosure dedicated email: selfdisclosures@omig.ny.gov
- Self-Disclosure dedicated phone line: 518-402-7030

Agency Contact & Resource Information

- OMIG Executive Staff: 518-473-3782
- Website: www.omig.ny.gov
- Bureau of Medicaid Fraud Allegations: bmfa@omig.ny.gov
- Medicaid Fraud Hotline: 877-873-7283
- Join our listserv
- Follow us on Twitter: @NYSOMIG
- Dedicated e-mail: information@omig.ny.gov