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HEALTH CARE PROVIDER ENGAGEMENT FORUM

New York, NY

OCTOBER 29, 2025

AGENCY OVERVIEW

- The Office of the Medicaid Inspector General (OMIG) is an independent entity created within the New York State Department of Health to promote and protect the integrity of the Medicaid program in New York State.
- **Our mission** is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.
- In carrying out its mission, OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

GUIDING PRINCIPLES

- Maximize Medicaid Program Integrity
- Improve Awareness and Stakeholder Relationships
- Strengthen Compliance and Encourage Self Disclosures
- Promote Quality of Care
- Preserve Medicaid Resources and Access to Care

AGENDA

- Welcome and Introductions
- Overview & Milestones
- Audit protocols and updates from the Division of Medicaid Audit
- Compliance and Self-Disclosure
- OMIG Highlights
- Questions & Answers

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OVERVIEW & MILESTONES

ANNUAL REPORT AND WORK PLAN

- 2024 Annual Report

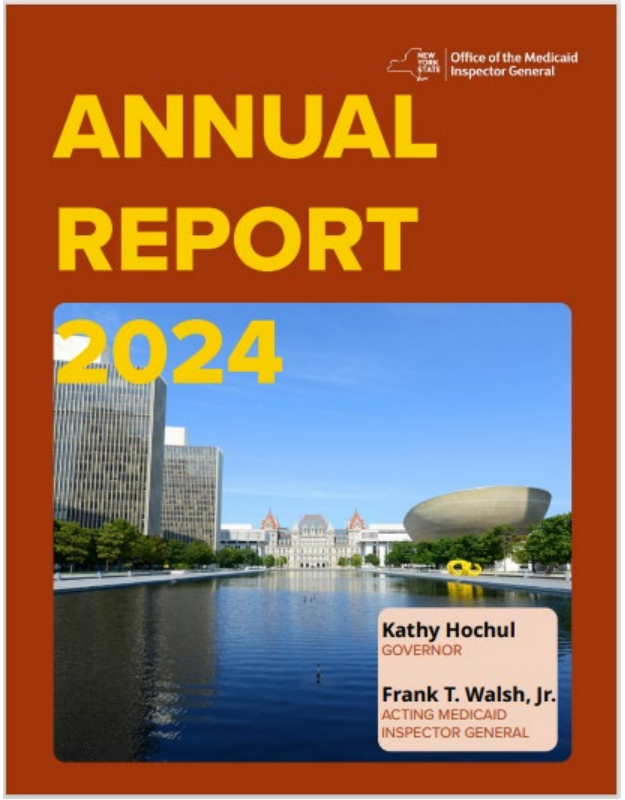
https://omig.ny.gov/information-resources/annual-reports

- 2025 Work Plan

New York State Office of the Medicaid Inspector General 2025 Work Plan | Office of the Medicaid Inspector General

KEY ACHIEVEMENTS

- Sustained education and engagement with stakeholders to de-mystify process and improve outcomes.
- Improved use of Medicaid data to identify trends and support activities.
- Reemphasized provider compliance, improving awareness and completing 83 reviews.
- Enhanced self-disclosure, facilitating provider reporting and finalizing 635 full self-disclosures, a 32% increase in cases from 2023.



KEY ACHIEVEMENTS (continued)

- Identified and referred 705 cases for enforcement, including 454 to the Attorney General's Medicaid Fraud Control Unit (MFCU).
- Completed over 2,500 audits and investigations and over $4.5 billion in cost savings and recoveries for the Medicaid program. Overall, OMIG increased its cost savings and recoveries by $468 million from 2023.
- Recognized program impacts, granting 33 providers with relief in instances when an OMIG audit could pose a financial hardship to the organization and to ensure beneficiaries' continued access to health care services.
- Strengthened due process protections during OMIG audits, investigations, and reviews, and resolved 21 hearings.
- Issued 162 Audit Summations (Positive Audit Reports) indicating that a substantial number of providers are compliant with Medicaid program requirements.

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KEY FOCUS AREAS

2025 OMIG Medicaid Program Integrity Key Focus Areas

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AUDIT PROTOCOLS

AUDIT PROTOCOLS

- To provide additional information and resources to assist the provider community, OMIG recently revised the audit protocol page (https://omig.ny.gov/audit/audit-protocols) on its website.
- The enhanced site includes information about the protocol development process, details on applicable service dates, and a protocol development planner.
- The new site also contains the following additional features:
  - Frequently Asked Questions
  - Audit Protocol Archive
  - Protocol Change Log - A summarization of updates to recently published protocols

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AUDIT PROTOCOLS - OVERVIEW

- OMIG documents that summarize audit criteria in reference to rules and regulations governing specific program areas for a retrospective period of time.
- Reflect a specified, previous period of time as OMIG audits are conducted retrospectively.
- Protocols are "…working documents for auditors, used as guidelines in their efforts to identify violations of rules and regulations" – https://www.health.ny.gov/health_care/medicaid/decisions/docs/newco_alp.pdf
- Audit protocols are not used as a basis for disallowance of audited claims. Pertinent rules and regulations established by the Department of Health and the Medicaid Program are cited in Audit Reports when a Medicaid overpayment is identified.
- Protocols are not rules imposed upon providers.

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HOW ARE AUDIT PROTOCOLS DEVELOPED?

- Audit protocols are intended solely as guidance
- Audits focus on criteria listed in protocols, but additional findings may be uncovered during the course of the audit
- Protocols are not a substitute for a review of the statutory and regulatory law
- Audit Protocols can be found on OMIG's website at: https://omig.ny.gov/audit/audit-protocols

WHEN/WHY IS A NEW PROTOCOL DEVELOPED?

- New service or benefit created under state or federal policy
- Expansion of existing program areas
- Emergence of new risk areas or program vulnerabilities
- OIG/AG/OSC recommendations or compliance mandates
- Change in billing structure or provider type (e.g. shifting from institutional to community-based settings)

WHEN/WHY IS A PROTOCOL UPDATED OR DISCONTINUED?

Reasons for audit protocol update

- New regulations or regulatory revisions
- New programmatic guidance or updates
- Addition or deletion of audit finding types
- New claims processing rules or edits
- Clarification of audit finding types (e.g. revision of audit finding type name)
- Events outside of our control (e.g. COVID-19 public health emergency)
- Expiration of applicable service dates

Reason for audit protocol discontinuance

- Service or program is no longer active or reimbursed
- Scope of audit protocol has been absorbed into another audit protocol

PROTOCOL UPDATES

- Audits in progress remain bound to the regulations and guidance that were active at the time the service occurred. When existing protocols are updated, there should be little to no impact to audits in progress.
- When protocols are updated, regulations and policies are included to cover all audits already in progress through the current policy at the time of the updated.
- Providers will be informed of protocol updates through official OMIG channels, including but not limited to the agency listserv, public website, Medicaid Updates, and social media channels.
- OMIG's recently launched enhanced protocol website will contain all current audit protocols, as well as archived audit protocols. Additionally, information on new protocols in development and targeted publication dates for existing protocol updates will be contained here.

PROVIDER FEEDBACK

- Stakeholders/relevant provider associations are afforded the opportunity to provide feedback on protocols as part of OMIG's protocol development process
- Provider Associations have discretion with how they may choose to comment. Comments may indicate perceived errors, discrepancies or disagreements with audit criteria, request that additional policy be referenced, and/or request that additional information be included or modified for clarity.

AUDIT PROTOCOLS & SERVICE DATES

- The “For Service Dates” listed at the beginning of the protocol represent the timeframe in which the regulatory and policy references listed in the protocols are applicable.
- Oftentimes, the “For Service Dates” range will extend beyond six years. This is because protocols are designed to reflect long-term regulatory guidance and any relevant changes that may have occurred over an extended period.
- The broader date range ensures that the latest guidance and historical regulatory context are available in one comprehensive document.
- This date range does not represent the timeframe that each audit will cover. OMIG will continue to be bound to a six-year look-back period for audits, as required in Title 18, Sections 504.3 and 517.3
- Previous versions of protocols may not have listed “For Service Dates”. Going forward, all protocol updates will include “For Service Dates” to indicate the specific date range covered by the protocol.

PUBLIC HEALTH EMERGENCY

- During the PHE, many flexibilities or waivers to certain programmatic and billing policies were issued by federal and state agencies overseeing the Medicaid Program.
- OMIG has worked with program agencies to compile the relevant flexibilities and waivers that were issued.
- Page 2 of each set of protocols contains a chart listing all relevant guidance issued by program agencies.
- OMIG will apply these PHE flexibilities when reviewing claims and records for the period in question. Audit staff are expected to review such claims within the context of the PHE, recognizing legitimate and documented use of said flexibilities.
- Flexibilities and/or waivers generally did not apply to all regulations and policies. Audit disallowances may still apply to claims not meeting all requirements.

BEST PRACTICES

- Assemble and inform your team
- Ensure key staff involved in the audit process are available and accessible
- Understand your process for storage and retrieval of medical/billing records. Things to consider:
  - Paper and/or electronic records
  - Multiple systems or upgraded systems
  - Onsite and/or off-site storage
  - Multiple locations
  - Open vs closed cases
- Advise the audit team of bankruptcy or self-disclosure
- Communicate with the auditor(s) throughout the process

BEST PRACTICES (POST AUDIT)

- Consider adjustments to compliance program to address issues identified in OMIG audit
- Assess any self-disclosure obligations
  - Pursuant to 18 NYCRR SubPart 521-3, any person who has received an overpayment under the NYS Medicaid program is required to report, return and explain the overpayment through OMIG's Self-Disclosure Program.
  - Providers should, following an audit, exercise reasonable diligence to determine whether the practice(s) that resulted in the overpayment identified in OMIG's audit also occurred outside of the timeframe covered by this audit, and submit a self-disclosure, if appropriate.
  - Additional information and resources concerning OMIG's self-disclosure program can be found at https://omig.ny.gov/provider-resources/self-disclosure.

QUESTIONS ON POSTED PROTOCOLS

- Questions related to the audit protocols or OMIG's audit process should be directed to: audit@omig.ny.gov
- Questions related Medicaid policy cited within the protocols should be directed to the relevant oversight agency (e.g., DOH, OMH, OASAS, OPWDD, etc.)
- If a provider suspects an error or discrepancy in a protocol document, please contact: audit@omig.ny.gov
- Ensuring accurate protocol information is essential for both compliance and audit accuracy. OMIG encourages and welcomes provider feedback.

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LOST, DESTROYED OR DAMAGED RECORDS

- By enrolling in Medicaid, providers agree to have records demonstrating the right to receive payment under the Medicaid program, and to maintain those records for a period of six years from the date the care, services or supplies were furnished. Records must be produced upon request.
- This requirement encompasses all types of records including electronic records, and all types of loss, destruction, corruption or inaccessibility including, but not limited to data corruption, theft, and other issues.
- OMIG has developed a process for providers to self-disclose lost, damaged or destroyed records. Reports must be submitted to OMIG no later than 30 days after discovery.

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COMPLIANCE PROGRAM REVIEWS AND COMMON FINDINGS

18 NYCRR 521

- OMIG's Compliance Review Module is built on the requirements pursuant to Social Services Law Section 363-d (SOS § 363-d) and Title 18 NYCRR SubPart 521-1 (SubPart 521-1).
- Main objectives:
  - ✓ flexibly build upon existing provider compliance programs
  - ✓ integrate/strengthen role for compliance within management structure
  - ✓ enhance organizational awareness and training
  - ✓ improve communications/transparency
  - ✓ align state and federal compliance program requirements

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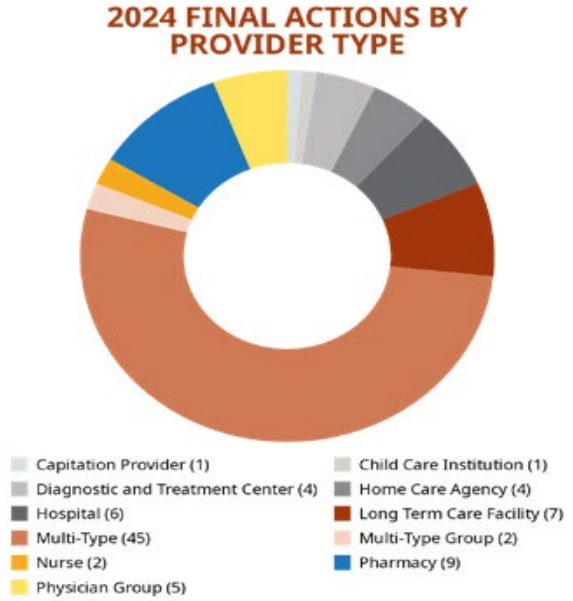
COMPLIANCE PROGRAM REVIEWS

- SubPart 521-1 is comprised of **seven elements**, which are all assessed in the Compliance Reviews:
  1. Compliance Policies
  2. Designated Compliance Officer and Compliance Committee
  3. Compliance Program Training
  4. Lines of Communications to/from the Compliance Officer
  5. Disciplinary Standards
  6. Auditing and Monitoring
  7. Responding to Compliance Issues

CPR DATA

- In 2024, OMIG initiated 86 CPRs and finalized 83.



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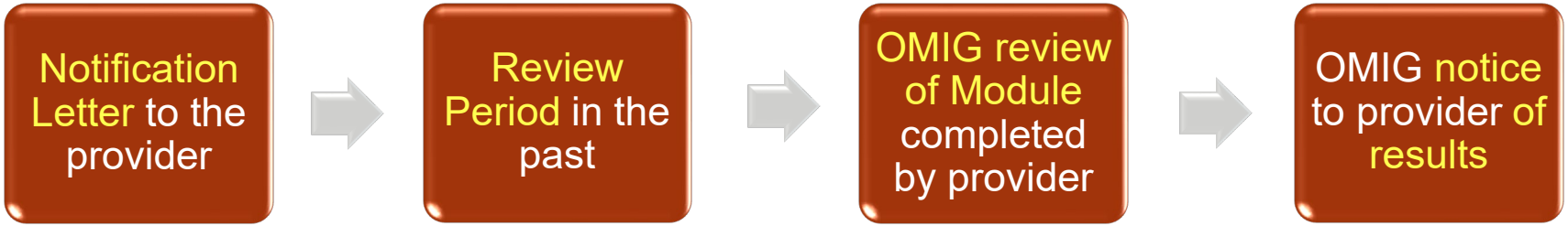
COMPLIANCE PROGRAM REVIEW PROCESS



OMIG and the provider will communicate throughout the process.

See additional information in the Compliance Program Guidance on pages 7-8

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COMPLIANCE PROGRAM REVIEW BEST PRACTICES

- General Best Practices:
  - 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.
  - Submit all documentation and information that is responsive to the areas outlined in the Compliance Program Review Module.
  - Include pertinent and required compliance-related information on the provider's website.

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SELF-DISCLOSURE PROCESS

IMPACTED ENTITIES

- All Medicaid Entities are required to self-disclose Medicaid overpayments, including:
  - Medicaid-Enrolled Providers
  - Network Providers
  - Medicaid Managed Care Organizations (MMCOs) as both a Plan and as a Provider (overpaid capitation payments)
  - All other Entities involved in the billing or receipt of Medicaid funds

SELF-DISCLOSURE DATA

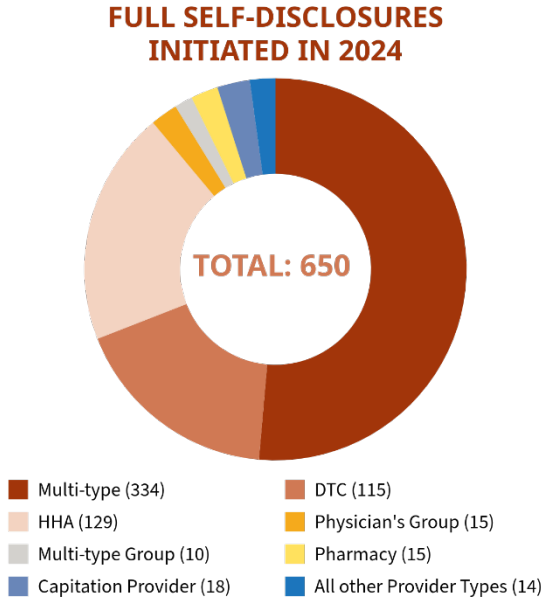
CY 2024

- 650 Full SDs initiated
- 635 Full SDs finalized
  - $25,309,288 in overpayment recoveries
- 3,827 Abbreviated SDs received
  - $21,067,584 reported returns

CY 2025

- 151 Full SDs initiated
- 141 Full SDs finalized (*as of 3/31/25*)
  - $7,554,903 in overpayment recoveries
- 968 Abbreviated SDs received (*Jan – March)*
  - $4,784,237 reported returns

(Preliminary data as of calendar year Quarter 1, 2025)



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TWO SELF-DISCLOSURE AVENUES

- All self-identified Medicaid overpayments must be self-disclosed.
- There are OMIG two paths for Medicaid Entities/Providers to satisfy their obligation to report, return, and explain self-identified Medicaid overpayments within 60 days from the date of identification:
    - **Full Self-Disclosure** (existing form & process)
    - **Abbreviated Self-Disclosure** (as of August 2023) for overpayments as a result of errors of a routine or transactional nature

❖ ***Please Note: Voiding or adjusting claims does not satisfy the obligation to report and explain identified overpayments.***

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COMMON ISSUES DISCLOSED

- 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

BENEFITS OF SELF-DISCLOSURE

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

OMIG'S COMPLIANCE PROGRAM RESOURCES

- The Compliance Library on OMIG's website (omig.ny.gov) contains:
  - *Compliance Program Guidance*
  - *Compliance Program Requirements FAQs*
  - *Compliance Program Self-Assessment Form*
  - *General Compliance Guidance and Resources*
  - *Compliance-Related Laws and Regulations*

- Bureau of Compliance email: compliance@omig.ny.gov; phone: (518) 408-0401

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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

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

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OMIG HIGHLIGHTS

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- Education and outreach
  - In 2024, more than 30 sessions (webinars, forums, etc.) reaching more than 4,500 providers, associations and other stakeholders

- Enhanced communication
  - Website upgrades
  - Listserv announcements and increased subscribers
  - Social media presence enhancements

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RESOURCES

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 X (formerly Twitter): @NYSOMIG
- Dedicated e-mail: information@omig.ny.gov

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QUESTIONS & COMMENTS

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