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

# Compliance Program Requirements 2023

March 2023

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# OMIG Background

# OMIG Mission

To enhance the integrity of the NYS 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.

# OMIG Office Locations

Regional Offices:

- ❑ Albany
- ❑ Buffalo
- ❑ Hauppauge
- ❑ New York City
- ❑ Rochester
- ❑ Syracuse
- ❑ White Plains

# Part 521

# Part 521

- Adopted on December 28, 2022
- Self-disclosure requirements became effective with adoption (12/28/22)
- Compliance/MMCO: within ninety (90) days of the effective date of the regulation (by 3/28/2023), providers/MMCOs are required to have a satisfactory compliance program in place that meets new requirements. Failure to do so may be subject to any sanction or penalty authorized by law.

# Part 521

- A copy of Part 521 is available on OMIG's website at: Laws and Regulations | Office of the Medicaid Inspector General (ny.gov)

# Compliance Program Guidance

# 18 NYCRR Part 521 Guidance Materials

- Assist providers who must adopt and implement programs designed to detect, prevent, report, and correct incidents of fraud, waste, and abuse in the Medicaid program
- Guidance materials are intended to assist the providers in understanding and implementing the statutory and regulatory requirements. In the event of a conflict between statements in the guidance and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

# 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.

# Compliance Program Guidance

- Addendum A to the guidance document identifies the changes in compliance program requirements between 18 NYCRR Part 521 (effective July 1, 2009) and SubPart 521-1 (effective December 28, 2022)

- Addendum B to the guidance document provides information related to 42 U.S.C. § 1396-a(a)(68), also known as the Deficit Reduction Act (DRA)

# Compliance Programs

# Outcomes

- Recognizes key role providers play in Program Integrity (PI) efforts
- Builds on existing, long-standing provider compliance and reporting requirements
- Aligns state and federal provisions related to 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

# Risk Areas

- A compliance program must apply to the provider's risk areas that include:
  - Billings
  - Payments
  - Medical necessity
  - Quality of care
  - Governance
  - Mandatory reporting
  - Credentialing
  - Contractor, subcontractor, agent, or independent contract oversight (NEW)
  - Other risk areas identified by provider through its organizational experience (NEW)
  - Ordered services (NEW)

# 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.

# Effective Compliance Program Means:

- A compliance program adopted and implemented by the required provider that, at a minimum, satisfies the requirements of (NEW) SubPart 521-1
- The program is designed to be compatible with the provider's characteristics, which means that it:
  - (NEW) is supported by the highest levels of the organization

# Effective Compliance Program Means:

- (NEW) is well-integrated into the company's operations;
- (NEW) promotes adherence to legal and ethical obligations
- (NEW) is reasonably designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements

# 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 …

# Affected Individuals

- (NEW) A compliance program must apply to all persons (affected individuals) who are impacted by the provider's risk areas including:

- employees
- chief executive & senior administrators
- managers
- governing body, corporate officers
- (NEW) contractors
- (NEW) agents
- (NEW) subcontractors
- (NEW) independent contractors

# 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 SubPart 521-1
- Compliance program and Deficit Reduction Act (DRA) certifications are included in the annual *Certification Statement for Provider Billing Medicaid* form submitted to DOH

# Compliance Program Elements

# Element 1

- 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 1

- (NEW) Written policies, procedures, and standards of conduct:
  - meet all requirements listed under 42 United States Code (USC) 1396-a(a)(68)
  - for MCOs & MLTCs, describe the implementation of the requirements of 18 NYCRR SubPart 521-2

* See Compliance Program Guidance Addendum B

# Element 1

- (NEW) Provider must review the written policies, procedures & standards of conduct annually to determine whether:
  - the policies, procedures & standards have been implemented
  - all affected individuals are following the policies, procedures & standards
  - the policies, procedures & standards are effective
  - any updates are required

# Element 2

- Designation of a compliance officer who is vested with responsibility for the day-to-day operation of the compliance program
- (NEW) The compliance officer develops an annual compliance workplan that outlines strategy for meeting compliance program requirements and addresses all elements

* See additional information in the Compliance Program Guidance on page 9

# Element 2

- (NEW) Designation of a compliance committee that will coordinate with the compliance officer
- (NEW) The compliance committee charter outlines the duties, responsibilities, membership, designation of a chair, and frequency of meetings

* See additional information in the Compliance Program Guidance on pages 10-11

# Element 3

- Compliance program training and education for all affected individuals

- (NEW) Develop and maintain a training plan that:
  - outlines the required subjects or topics
  - the timing and frequency of training
  - which affected individuals are required to attend
  - how attendance is tracked
  - how the effectiveness of the training is evaluated

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

# Element 4

- Lines of communication to the compliance officer that are available to:
  - all affected individuals and
  - (NEW) Medicaid recipients of service

  to report compliance issues
- Anonymous reporting method directly to the compliance officer
- 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 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

- 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 7

- 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

# MMCO

# Outcomes

- Recognizes key role MMCOs play in Program integrity (PI) efforts
- Promotes collaboration and partnership with OMIG in program integrity efforts as currently exists with fraud, waste and abuse reporting
- Builds on existing, long-standing MMCO compliance and reporting requirements
- Aligns requirements and creates consistency across both mainstream and long-term care plans

# MMCO Risk Areas

- (NEW) Compliance programs for MCOs & MLTCs must also apply to the following risk areas:
  - Compliance with contract
  - Cost reporting
  - Encounter data submission
  - Network adequacy & contracting
  - Provider & subcontractor oversight
  - Under-utilization
  - Marketing
  - Provision of medically necessary services
  - Payments & claims processing
  - Statistically-valid service verification

# Key Components

- Incorporate fraud, waste, and abuse prevention programs into compliance programs
  - Interconnections between 521-1 and 521-2
- SIU Requirements
  - Staffing
- Contractual requirements
- FWA reporting
- FWA public awareness program

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

# Self-Disclosure

# Self-Disclosure Programs

- (NEW) Providers must comply with the requirements of SubPart 521-3 (Self-Disclosure Programs) to report, return, and explain overpayments.

* See additional information in the Self-Disclosure Program Requirements Instructions & Guidelines

# Compliance Program Review Process

# Compliance Program Review Process

- Compliance Program Reviews (CPRs) involve:
  - Notification to the provider for commencement of a review
  - (NEW) A review period in the past
  - (NEW) Review of a Module completed by the provider and all records, reports, other documentation, and information submitted by the provider
  - Notice to the provider of the results of the review

# Compliance Program Review Module



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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.

# Compliance Program Review Process

- A score is calculated for each month of the review period
- The score determines whether the provider's compliance program satisfactorily met the requirements for all months of the review period
- Average score percentages:
  ≥ 60% is satisfactory
  < 60% is unsatisfactory and may result in enforcement (i.e., monetary penalties)

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

# 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, including revocation of the provider's agreement to participate in the Medicaid program
- 363-d(3)(d) specifies the amounts of the penalty

# 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 Resources

# Compliance Resources and Contact Information

- 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

# MMCO Resources and Contact information

- Guidance: Medicaid Managed Care Fraud, Waste, and Abuse Prevention Programs: https://omig.ny.gov/information-resources/medicaid-managed-care-fraud-waste-and-abuse-prevention-programs-guidance-and

- Medicaid Managed Care Fraud, Waste and Abuse Prevention Program email: bmfa.mco@omig.ny.gov

# Self-Disclosure Resources and Contact information

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

- Self-Disclosure email: selfdisclosures@omig.ny.gov

# OMIG Contact Information

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


Questions