Compliance Program 2023

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.

Mandatory Compliance Requirements

- Effective April 2020, for New York State (NYS) Social Services Law (SSL) §363-d, and effective December 28, 2022, for the corresponding regulations at 18 New York Codes, Rules and Regulations (NYCRR) Subpart 521-1, NYS Medicaid providers shall adopt, implement, and maintain effective compliance programs aimed at detecting fraud, waste, and abuse in the NYS Medicaid program. All NYS Medicaid providers subject to the provisions of Public Health Law (PHL) Articles 28 or 36, providers subject to the provisions of Mental Hygiene Law (MHL) Articles 16 or 31, Medicaid Managed Care (MMC) providers of Managed Long Term Care (MLTC) Plans [collectively, Medicaid Managed Care Organization (MMCOs)], and those providers for which the NYS Medicaid program "constitutes a substantial portion of business operations," are required to have an effective compliance program.
- The Office of the Medicaid Inspector General (OMIG) defines "substantial portion of business operations" as claiming or receiving $1,000,000 or more in the aggregate in a consecutive 12-month period, directly or indirectly, from the NYS Medicaid program. OMIG has the responsibility under SOS §363-d and Subpart 521- 1 to determine if compliance programs meet the requirements of the law and regulation. An "effective" compliance program is defined in Subpart 521-1 as a compliance program adopted and implemented by the required provider that, at a minimum, satisfies the requirements of Subpart 521-1 and that is designed to be compatible with the provider's characteristics.

Part 521

- NEW: SubPart 521-1
- Adopted on December 28, 2022
- Self-disclosure requirements became effective with adoption (12/28/22)

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

What is an Effective Compliance Program?

- **OMIG considers an “effective compliance program” to be a compliance program that is adopted and implemented by the provider that, at a minimum, satisfies the compliance program requirements, and that is designed to be compatible with the provider’s characteristics. Being compatible with the provider’s characteristics means that the compliance program:**
- 1. Is well-integrated into the company’s operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body;
- 2. Promotes adherence to the provider’s legal and ethical obligations; and
- 3. Is reasonably designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur for the provider’s risk areas and organizational experience.

Consequences of Not Having An Effective Compliance Program

- **A provider that is not effectively monitoring its compliance with state and federal Medicaid requirements is potentially exposed to increased operational, reputational, service, and audit risks, as well as sanctions and the repayment of identified Medicaid overpayments. These consequences may include:**
- 1. Monetary penalties up to $5,000 for each month that a provider fails to adopt, implement, and maintain an effective compliance program. For a second violation, this amount may increase to $10,000 per month.[1]
- 2. Recoupment of monies paid to the provider during the period in which it did not have a compliance program.
- 3. Termination of the provider's enrollment in the Medicaid program.
- 4. Sanctions, up to and including exclusion from participation in the Medicaid program.
- 1 See 18 NYCRR Part 516 and SOS § 363-d for more information

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)

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 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

- (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

Affected Individuals (defined)

- (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

Written Policies, Procedures, and Standards of Conduct

- 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.
- (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

Compliance Officer and Compliance Committee

- 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
- (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

Element 3
Compliance Program Training and Education

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

Element 4
Lines of Communication

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

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

Element 6
Auditing and Monitoring

Systems for:

- Identifying compliance risk areas
- Routine auditing and monitoring
- (NEW) Annual compliance program review
- (NEW) Checking monthly for excluded providers

Check requiring contractors, agents, subcontractors, and independent contractors to comply with checking monthly for excluded providers

Element 7

Responding to Compliance Issues

Our system is designed to prevent, detect and correct non-compliance with Medicaid program requirements, including fraud, waste and abuse We have implemented procedures and systems for responding to compliance issues by;

- Responding promptly to compliance issues when raised
- Investigating and correcting problems
- Ensures compliance with state and federal laws, rules, regulations, and requirements of the Medicaid program

Disciplinary Policies

Employees who are found to have violated the Code of Conduct, Company policies, or applicable laws or regulations will receive corrective action/discipline.

- Violation examples include, but are not limited to:

- failure to report,

- participating in non-compliant behavior,

- encouraging, directing, facilitating, or permitting non-compliant behavior,

- failing to detect and report a compliance violation.

- The discipline will be enforced fairly and firmly to violators at all levels of the organization.
- Corrective action/discipline should be proportional to the offense/infraction.
- HR Policy addressing Progressive Disciplinary Action provides details & guidance related to corrective action.
- All allegations and reports will be promptly and thoroughly investigated.

Self-Disclosure Programs in Response to Identifying a Compliance Issue

- (NEW) Provider will comply with the requirements of SubPart 521-3 (Self-Disclosure Programs) to report, return, and explain overpayments.
- This would be done through the OMIG Self-Disclosure Program
- Corrective Action Plans will be put in place for all audits and investigations
- https://omig.ny.gov/provider-resources/self-disclosure
- Self-Disclosure email: selfdisclosures@omig.ny.gov

Sanctions & Penalties for Failing to Maintain and Effective Compliance Program

- 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

NYS OMIG

OMIG Contact Information

- OMIG: 518-473-3782
- Website: www.omig.ny.gov
- NYMedicaid Fraud Hotline: 877-873-7283
- Dedicated e-mail: information@omig.ny.gov
- Bureau of Compliance email: compliance@omig.ny.gov
- Bureau of Medicaid Fraud Allegations: bmfa@omig.ny.gov

The Compliance Library on OMIG's website www.omig.ny.gov contains:

- Compliance Program Guidance
- General Compliance Guidance and Resources
- Compliance-Related Laws and Regulations

Reporting – Communication Lines

- Communication is always available.
- The corporate HOTLINE numbers are:
  - BrightSpring: 1-866-293-3863
  - PharMerica: 1-800-793-7741
  - You may report anonymously.
  - Reports are confidential to the extent allowed by law.
  - Either line may be used.
- A compliance officer can be reached at 502.630.7023.
- All individuals are required to report suspected misconduct or possible violations of Federal laws, state laws, or the Corporate Compliance program. No retaliation, retribution, or intimidation will be tolerated for reporting potential issues.
- Employees are encouraged to report concerns through local chain of command, though the Compliance Department and Action Line are also avenues.
- Employees may contact the Compliance Action Line with good faith concerns regarding compliance issues.

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