NEHIA/HFMA

2025 Compliance & Internal Audit Conference

Wednesday, December 3 - Friday, December 5, 2025
Mystic Marriott Hotel, Groton, CT

Panel Discussion:
Office of Medicaid Inspector General (OMIG) Compliance Program Reviews (CPRs)

Disclaimer

The information provided in this presentation is for educational and informational purposes only. It does not constitute legal, compliance, or billing advice and should not be relied upon as such. Attendees should consult their organization's policies, legal counsel, or compliance department for guidance on specific issues. The views expressed are those of the presenter(s) and not necessarily those of their employer or affiliated entities.

Panel Speakers

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Who is OMIG?

Mission: To enhance the integrity of the New York State Medicaid program by preventing, detecting, and investigating fraud, waste, and abuse.

Goal: Promote a culture of compliance and accountability across the Medicaid program.

Overview:

- An independent agency within New York State government.
- Oversees Medicaid providers, managed care plans, and contractors to ensure compliance with laws and regulations.
- Works to protect taxpayer dollars and ensure Medicaid funds are used appropriately for patient care.

Key Functions:

- Audits and reviews provider billing and documentation.
- Investigates potential fraud, waste, and abuse.
- Recovers overpayments and enforces compliance actions.
- Collaborates with state and federal agencies (e.g., DOH, OIG, Attorney General's Office).

Agenda

1. Review who must have a compliance program and what makes it effective
2. Walk through the seven elements of an effective compliance program
3. Discuss OMIG compliance program reviews and enforcement
4. Compare OIG compliance program guidance and best practices
5. Conclude with a panel discussion on OMIG reviews in practice

OMIG Compliance Program Requirement

NYS Social Services Law (SOS) § 363-d and Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) SubPart 521-1 defines those factors that require providers to have a compliance program.

If you answer **YES** to any of the following questions, you are required to have a compliance program in New York State.

1. Is your organization subject to Article 28 or Article 36 of the NYS Public Health Law (PBH)?
2. Is your organization subject to Article 16 or Article 31 of the NYS Mental Hygiene Law?
3. Notwithstanding the provisions of § 4414 of the NYS PBH, is your organization a managed care provider, as defined in SOS § 364-j, which includes managed long-term care plans?
4. Does your organization claim —and/or can be reasonably expected to claim—Medicaid services or supplies of at least $1,000,000 in any consecutive 12-month period?
5. Does your organization receive Medicaid payments—and/or can be reasonably expected to receive payments—either directly or indirectly, of at least $1,000,000 in any consecutive 12-month period? Indirect Medicaid reimbursement is any payment that you receive for the delivery of Medicaid care, services, or supplies that comes from a source other than the State of New York. For example, if you provide covered services to a Medicaid beneficiary who is enrolled in a Medicaid Managed Care Plan, the payment you receive from the Managed Care Organization is considered an indirect payment.

Source: OMIG

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.

Source: OMIG Compliance Program Guidance

Affected Individuals

The Office of Medicaid Inspector General (OMIG) defines “affected individuals” as all persons who are affected by the provider’s risk areas:

- Employees
- Chief executive and other senior administrators
- Managers
- Contractors
- Agents
- Subcontractors
- Governing body
- Corporate officers

Source: OMIG Compliance Program Guidance

Office of Medicaid Inspector General (OMIG) Compliance Program Reviews (CPRs)

OMIG CPRs

Purpose

- Ensure Medicaid providers comply with mandatory program requirements.
- Strengthen prevention, detection, and correction of fraud, waste, and abuse.

Scope

- Applies to Medicaid providers in New York State.
- Governed by NYCRR Part 521.
- Focused on Medicaid-specific risk areas.

OMIG CPRs

Focus Areas

Reviews provider adherence to the **7 Required Elements of a Compliance Program**:

- Written policies & procedures
- Designated compliance officer & committee
- Training & education
- Effective lines of communication
- Disciplinary standards
- Auditing & monitoring
- Prompt response & corrective action

Enforcement & Liability Risks

Non-compliance may result in:

- Sanctions and monetary penalties (up to $5,000 per month, increasing to $10,000 for repeat violations)
- Withholding or recoupment of Medicaid payments
- Exclusion from the Medicaid program
- Referral for further investigation or prosecution

OMIG CPRs

- OMIG periodically reviews providers' compliance programs to see if they have adopted, implemented, and maintained an "effective compliance program" in line with 18 NYCRR Part 521 and New York Social Services Law § 363-d.
- A "Review Period" is defined (not exceeding 12 months for newly-initiated reviews beginning July 1, 2025 onward) during which OMIG evaluates whether the compliance program met requirements each month.
- The provider must submit a "Module" plus supporting documentation; OMIG may ask follow-up questions or request additional materials.
- OMIG scores performance month by month; average scores > 60% are considered "satisfactory." Below that threshold may lead to being judged "unsatisfactory."
- After review, OMIG issues a written compliance program assessment reporting whether the provider's program was satisfactory and may include recommendations or required corrective actions.

I. Written Policies, Procedures, and Standards of Conduct

Providers must include compliance obligations in written policies, procedures, and standards of conduct. These policies should describe how the compliance program operates, be reviewed annually, and updated as needed. Policies must protect confidentiality and prohibit retaliation for reporting issues—including by Medicaid recipients. Citing relevant laws and Medicaid regulations is sufficient, except for 42 U.S.C. 1396a(a)(68), which requires detailed content.

Evidence of Written Policies in Effect

1. Detailed compliance policies with implementation/revision dates.
2. Policies apply to all “Affected Individuals” (e.g., staff, contractors, leadership).
3. Annual review and updates documented.
4. Policies distributed to all relevant parties.
5. Supporting work products (e.g., training, investigations, actions taken).
6. DRA compliance shown through written policies and employee handbook (if applicable).

II. Compliance Officer and Compliance Committee

Providers must show their compliance program is embedded in operations and backed by leadership. This includes appointing a dedicated compliance officer responsible for day-to-day program activities.

Compliance Officer Responsibilities

1. Reports to the CEO or senior designee and has access to the governing body.
2. Provides quarterly updates on compliance program progress.
3. May be external but must lead the compliance work plan and coordinate implementation.
4. Duties must be assessed to ensure they don't hinder compliance responsibilities.
5. Must have adequate staff and resources to fulfill the role.
6. Should not report to legal or finance to maintain independence – if unavoidable, conflict mitigation procedures are recommended.

OMIG considers providers' documented efforts to hire and retain staff when assessing compliance programs.

MMCO compliance officers implement SubPart 521-2. If an SIU is required, the SIU Director manages fraud, waste, and abuse efforts, while the compliance officer coordinates with them as needed.

II. Compliance Officer and Compliance Committee Cont'd

Compliance Committee Expectations

Providers must show their compliance program is supported by leadership through an active committee of senior managers:

1. Reports directly to the CEO and governing body.
2. Charter outlines coordination duties with the compliance officer.
3. Ensures all Affected Individuals complete orientation and annual training.

The compliance committee should include senior managers from diverse areas such as operations, finance, HR, legal, and clinical services to provide broad organizational insight.

MMCOs must also establish a board-level regulatory compliance committee to oversee the compliance program, as required by their contract with the department.

III. Compliance Program Training and Education

Providers must implement and maintain an effective compliance training program for all Affected Individuals, documented in an annual training plan that outlines:

1. Required topics
2. Training schedule and frequency
3. Who must attend
4. How attendance is tracked
5. How training effectiveness is evaluated

Orientation training should occur within 30 days of the start date. Providers should periodically evaluate training effectiveness.

Compliance training may be tailored for different types of Affected Individuals, including contractors, as long as all meet core Medicaid requirements. Training must be understandable and accessible, including in appropriate languages. Simply distributing written policies does not qualify as effective training; providers must show individuals received and applied the material.

Self-study programs are acceptable if supported by evidence, such as acknowledgements or dated distribution letters.

For MMCOs, training must also include fraud, waste, and abuse prevention as required by SubPart 521-2 and contract terms.

IV. Lines of Communication

Providers must establish effective communication channels for all Affected Individuals, ensuring confidentiality for those reporting concerns. These channels may include phone, email, web portals, mail, drop boxes, and other reasonable methods.

Anonymous reporting methods must ensure the identity of the reporting person cannot be discovered. Acceptable examples include:

1. Compliance hotlines (without caller ID)
2. Online portals
3. Mailing addresses
4. Secure drop boxes

Individuals, including Medicaid recipients, who report compliance concerns should reasonably expect confidentiality, whether requested or not. They are protected under the provider's non-intimidation and non-retaliation policies.

V. Disciplinary Standards

Providers must establish and enforce disciplinary standards to address violations and promote good-faith participation in the compliance program.

Documented policies may include:

1. Expectations for reporting and assisting with compliance issues
2. Sanctions for failing to report or engaging in non-compliant behavior
3. Sanctions for enabling or encouraging non-compliance

Disciplinary actions for governing body members are typically outlined in by-laws or operating agreements.

VI. Auditing and Monitoring

Providers must show that their compliance program includes regular auditing and monitoring of risks. **This may include:**

1. Documenting internal and external audits and sharing them with the compliance committee and governing body.
2. Sharing annual compliance reviews with executive leadership, senior management, and oversight bodies.
3. Conducting monthly exclusion checks and sharing results with the compliance officer and relevant staff.
4. Preventing, Detecting & Correcting Non-Compliance

Compliance programs should be tailored to prevent, detect, and correct issues like fraud, waste, and abuse, especially in high-risk areas.
Key practices include:

1. Performing audits focused on Medicaid risk areas.
2. Reporting and returning identified Medicaid overpayments per self-disclosure requirements.
3. Reviewing the compliance program annually to assess effectiveness and need for updates.
4. Verifying exclusion status of all relevant individuals.
5. MMCOs must confirm identity and exclusion status of all contracted individuals, providers, and subcontractors—and require the same of their partners.

Providers must conduct an annual review to assess compliance with Medicaid requirements, evaluate program effectiveness, and identify needed updates. This review supports certification and OMIG assessments.

VII. Responding to Compliance Issues

The provider's compliance program should prevent, detect, and correct Medicaid non-compliance, particularly fraud, waste, and abuse, by addressing risk areas and establishing procedures to promptly resolve issues identified internally or through audits.

Examples include:

1. Promptly investigating and taking corrective action.
2. Correcting problems thoroughly to prevent recurrence.
3. Monitoring corrective action plans for effectiveness.
4. Maintaining compliance with Medicaid laws and regulations.
5. Reporting credible evidence of violations to authorities.
6. Reporting and returning overpayments per Medicaid requirements.

Office of Inspector General (OIG) General Compliance Program Guidance (GCPG)

OIG GCPG

Purpose

- Provides voluntary guidance for healthcare organizations.
- Promotes effective compliance programs to prevent fraud, waste, and abuse across the healthcare industry.

Scope

- Applies to all healthcare providers (Medicare, Medicaid, private payors).
- Not limited to Medicaid programs.
- Encourages adoption of compliance best practices industry-wide.

OIG GCPG

Focus Areas

Evaluates whether providers incorporate the **7 Elements of an Effective Compliance Program**:

1. Policies & procedures
2. Oversight (compliance officer/committee)
3. Training & education
4. Effective communication channels
5. Enforcement & discipline
6. Auditing & monitoring
7. Prompt corrective action

Enforcement & Liability Risks

- No direct penalties for lacking a compliance program.
- Absence or weakness increases exposure to liability and enforcement action.

Thank you

Scan the QR code to be brought directly to the OMIG Compliance Library.

Resources

- OMIG Compliance: https://omig.ny.gov/compliance/compliance
- OMIG Compliance Library: https://omig.ny.gov/compliance/compliance-library
- OIG GCPG: https://oig.hhs.gov/compliance/general-compliance-program-guidance/

QUESTIONS

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