Frequently Asked Questions (FAQs)
NYS Mandatory Compliance Programs

The following Frequently Asked Questions ("FAQs") primarily address New York State's Social Services Law ("SSL") §363-d and the accompanying regulations at 18 NYCRR Part 521. There are a few FAQs that address questions related to the Federal Deficit Reduction Act of 2005 ("DRA"). Unless the FAQ specifically refers to the DRA, please consider the question and the response to apply to New York's law and regulation.

(Revised: 11/1/2014)

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1. WHAT IS NEW YORK'S MANDATORY COMPLIANCE PROGRAM LAW FOR MEDICAID PROVIDERS?

Chapter 442 of the Laws of 2006, which established the New York State Office of the Medicaid Inspector General (OMIG), also created a new Social Services Law § 363-d which requires that Medicaid providers develop, adopt and implement effective compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program.

Regulations found in 18 NYCRR Part 521 were effective on July 1, 2009. Those regulations provide additional direction on how the mandatory compliance program law for Medicaid providers in New York State operates.

2. WHAT IS THE PURPOSE AND INTENT OF NEW YORK'S MANDATORY COMPLIANCE LAW FOR MEDICAID PROVIDERS?

The legislature included in Social Services Law § 363-d subd. 1. a legislative finding that Medicaid

… providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences.

The purpose of directing Medicaid providers to implement a compliance program is to require providers to implement and maintain appropriate systems and processes to detect and prevent fraud, waste and abuse in the Medicaid program. This promotes program integrity in the Medicaid program and saves the Medicaid program dollars by reducing inappropriate payments and maximizing appropriate payments for covered services that are delivered to Medicaid recipients.

3. ARE NEW YORK'S MANDATORY COMPLIANCE PROVISIONS RELATED TO THE FEDERAL DEFICIT REDUCTION ACT OF 2005 ("DRA") REQUIREMENTS?

While the mandatory compliance program requirements contained in New York Social Services Law § 363-d and 18 NYCRR Part 521, and the Deficit Reduction Act (DRA) obligations found in 42 USC § 1396a (a) (68) both address program integrity, there are significant differences in which providers are subject to the requirements and the scope of provider responsibilities.

Providers required to meet both provisions typically include the DRA requirements in their more comprehensive mandatory compliance programs that are implemented to meet the requirements of the New York Social Services Law § 363-d and 18 NYCRR Part 521.

4. WHO MUST HAVE A COMPLIANCE PROGRAM?

New York's mandatory compliance program law applies to Medicaid providers subject to Public Health Law (PHL) articles 28 or 36, and Mental Hygiene Law (MHL) articles 16 or 31 [SSL §363-d subdivision 4, and 18 NYCRR §521.1 (a) and (b)]. In addition, a compliance program is required for other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or who submit claims for care, services or supplies for or on behalf of another person for which Medicaid is, or should be reasonably expected by the provider to be a substantial portion of their business operations [SSL §363-d subd. 4 and 18 NYCRR §521.1(c)].

The first group of providers (those subject to the specified articles in the PHL or the MHL) must have a compliance program under SSL § 363-d and 18 NYCRR Part 521 regardless of the amount that they bill, order or receive from New York's Medicaid program.

The second group of providers (those for which Medicaid is a "substantial portion of their business operations") are broken into three groups. All three groups have a $500,000 minimum reference point associated with them. 18 NYCRR 521.2 (b) requires a Medicaid provider to meet the mandatory compliance program obligation if the Medicaid provider:

1. is a person, provider, or affiliate that claims, orders or has claimed or has ordered or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from Medicaid;
2. is a person, provider, or affiliate that receives or has received or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from Medicaid; or
3. is a person, provider, or affiliate that submits or has submitted claims for care, services, or supplies to the Medicaid program on behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.

PLEASE NOTE: If a person or entity meets the requirements set out in this FAQ, they must have a compliance program that conforms to the mandatory compliance program requirements as set out in SSL §363-d and 18 NYCRR Part 521. It is possible that a person or entity meets these requirements and may not be required to be enrolled in NYS's Medicaid program. For example, persons, providers, or affiliates that **indirectly** receive in excess of $500,000 from the NYS Medicaid program during any consecutive 12-month period must conform to the mandatory compliance program obligation.

5. IN MULTIPLE PROVIDER SYSTEMS, WHO IS RESPONSIBLE FOR DEVELOPING PROVIDER COMPLIANCE PROGRAMS?

Each required provider must develop, adopt and implement an effective compliance program that is appropriate to its characteristics. Affiliated providers may operate under the umbrella compliance program of its parent organization, as long as the compliance program addresses the core requirements as set out in the law and the regulation and is specific enough to address the structure, operations and risk areas of each affiliate. For example, there may be an enterprise-wide compliance program for a multiple provider health system, but the compliance program may have specific terms that seek to address individual provider types within the system. This customization will enable the enterprise's compliance program to be flexible enough to address specific compliance issues that may be more likely to arise within a particular constituent provider type than in other provider types within the enterprise.

6. IS THERE AN EQUIVALENT "MULTIPLE PROVIDER SYSTEM" APPROACH FOR NON-PUBLIC EARLY INTERVENTION (EI), PRE-SCHOOL AND SCHOOL-AGE SPECIAL EDUCATION PROGRAMS?

The OMIG has had several discussions with non-public providers of EI and special education services including §4410 and "853" schools and with county officials and school districts. Given the nature of the referral and billing relationship between/with counties, districts and these types of providers, to avoid unnecessary duplication of effort and costs to contracted providers of services, the OMIG supports an approach where the county/district incorporates (covers) early intervention, pre-school, and school-age special education providers under the county's or district's compliance program (including, for example, the sharing of resources – such as a toll-free hot line). In such cases, the OMIG would expect an appropriate written agreement detailing the respective responsibilities of the parties. Such agreements may include, be incorporated in, or be ancillary to, the contract for the provision of such services executed by the county/district and provider which includes provision for Medicaid payments and reimbursement including statements of reassignment, record maintenance, quality assurance review and liability of providers for failure to support the county/district relative to special services and programs paid by or reimbursed through Medicaid.

Notwithstanding the other compliance-related functions performed by the county and/or district, the OMIG assumes that early intervention, preschool and school age special education providers will ensure an internal compliance presence by designating an employee who has an understanding of the culture and operations of the provider, to address issues raised by provider staff and to coordinate those compliance initiatives handled by the provider in satisfaction of Part 521 requirements governing compliance officers.

7. DO ALL PROVIDERS COVERED BY THE LAW, REGARDLESS OF SIZE, HAVE TO MEET THE SAME REQUIREMENTS?

The law and the regulation contain a set of minimum core requirements that are applicable to all providers, regardless of size. However, the law also recognizes that compliance programs should reflect the provider's size, complexity, resources, and culture, as the compliance program meets the set of minimum core requirements.

8. WHAT MUST A COMPLIANCE PROGRAM APPLY TO?

18 NYCRR §521.3(a) provides that compliance programs shall be applicable to:

1. billings;
2. payments;
3. medical necessity and quality of care;
4. governance;
5. mandatory reporting;
6. credentialing; and
7. other risk areas that are or should, with due diligence, be identified by the Medicaid provider.

The application of compliance programs to Medicaid providers' operations other than just billing and payments should not be underestimated. For example, when medically unnecessary care is provided or the quality of patient care does not meet established standards, waste and abuse in the Medicaid program may be impacted.

9. AT A MINIMUM, WHAT MUST A COMPLIANCE PROGRAM CONTAIN?

Social Services Law §363-d subd. 2 and 18 NYCRR §521.3(c) set out the following eight core elements that shall be included in all compliance programs:

1. written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;
2. designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program;

   Please Note: Due to the high potential for a conflict of interest to exist, related to the billing and payment function for Medicaid providers, OMIG discourages a reporting structure where the compliance officer reports to the chief financial officer. Although no specific New York law or regulation addresses this, some concerns exist with a structure where the compliance officer reports to the Medicaid provider's general counsel.

3. training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations, and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive, and governing body member;

4. communication lines to the responsible compliance position (as described in "2," above) that are accessible to all employees, persons associated with the provider, executives, and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;
5. disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assisting in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; or (3) encouraging, directing, facilitating, or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;
6. a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and, as appropriate, external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits;
7. a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments; and
8. a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections 740 and 741 of the labor law.

10. WILL OMIG PROVIDE GUIDELINES OR MODEL COMPLIANCE PLANS ON ITS WEB SITE TO ASSIST PROVIDERS?

On May 11, 2012, OMIG published the Compliance Program Guidance for General Hospitals. It can be accessed by clicking on this link . On May 4, 2014, OMIG published its first guidance in a series of provider specific risk areas.

OMIG is in the process of drafting additional industry-specific guidance focusing on risk areas. When those are developed, they will be available on OMIG's Web site. OMIG does not anticipate issuing model compliance plans or templates. OMIG suggests that Medicaid providers review Compliance Guidances, Medicaid Updates and Compliance Alerts among other OMIG publications and outreach methods for information on how providers can meet New York's mandatory compliance program requirements. There is a Compliance Library on OMIG's Web site which guides providers in developing and implementing an effective compliance program. Medicaid providers are encouraged to subscribe to OMIG's listserv. The listserv provides an email notification of any changes to OMIG's Web site, including changes to published compliance program related materials. The no-cost listserv subscription is accessed using this link.

11. WILL OMIG PROVIDE ASSISTANCE TO PROVIDERS UPON REQUEST?

Yes, however, OMIG's assistance to Medicaid providers is limited to educating providers on mandatory compliance program requirements and issuing general guidance. OMIG does not assist providers in developing compliance programs nor will OMIG assess providers' compliance programs upon request. OMIG's Bureau of Compliance has a dedicated e-mail box that providers can access using the Contact Bureau of Compliance form for specific compliance-related questions. A Compliance Bureau dedicated telephone number of 518-408-0401 is also available to raise specific compliance-related questions.

12. HOW WILL THE MANDATORY COMPLIANCE PROGRAM LAW IMPACT PROVIDERS?

If a Medicaid provider is required to have a compliance program meeting the requirements of Social Services Law §363-d and 18 NYCRR Part 521, OMIG has the authority to determine, at any time, if a provider has implemented and is operating a compliance program that satisfactorily meets the requirements of SSL §363-d. Annually during December each year, at the time of enrollment in the Medicaid program, and as part of the New York State Department of Health’s revalidation of a Medicaid provider’s enrollment,

required providers must certify that they have a compliance program that meets the requirements of the mandatory compliance program law.

13. WHAT ARE THE POSSIBLE CONSEQUENCES FOR FAILING TO ADOPT AND IMPLEMENT AN EFFECTIVE COMPLIANCE PROGRAM?

As of October 1, 2009, the OMIG is authorized to impose sanctions or penalties, against required providers who fail to develop, adopt, and implement an effective compliance program. Providers may also face revocation by the Department of Health of the provider's agreement to participate in the Medicaid program. [SSL §363-d subd. 3(b)]

14. IS THERE AN EXCEPTION TO THE MANDATORY COMPLIANCE LAW?

The mandatory compliance program law provides that "a compliance program that is accepted by the United States Department of Health and Human Services Office of Inspector General (U.S. HHS-OIG) and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provision of this law" [SSL §363-d subd. 3(a)].

15. WHERE CAN I GET INFORMATION ON THE CERTIFICATION OBLIGATION UNDER THE MANDATORY COMPLIANCE LAW?

The *Compliance Tab* on OMIG's Web site includes a section on Certification. There is information set out there and in the FAQs which are a link on the form, **Certification of Compliance with the Social Services Law § 363-d and 18 NYCRR Part 521.**