OMIG Provider Engagement Session June 25, 2025

Panelists include:

- Frank Walsh, MIG
- Erin Ives, First Deputy MIG
- Michael D'Allaird, Deputy MIG for Audit
- Amanda Susser, Assistant MIG for Compliance and Self-Disclosure

Agenda:

I. Overview

- Independent agency created in 2006, they simply enforce, but they do set the rules for compliance and self-disclosure
- Mission to enhance the integrity of the State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the program and recover improperly expended Medicaid funds
- In 2023 –
    - Oversight of over 725 million Medicaid claims
    - 3,666 allegations of Medicaid waste, fraud, and abuse
    - Nearly 25% provider compliance with 218 published "Positive Audit Reports"
    - Completed 2,022 investigations, finalized 891 audits, including 218 positive reports, made 655 referrals, including 241 referrals to MFCU
    - Achieved over $4 billion in cost savings (recoveries $0.9 billion)
- Miniscule people in the program intentionally trying to remove money from the program
- Guiding principles are maximizing Medicaid program integrity, improving awareness and stakeholder relationships, strengthening compliance and encouraging self disclosures, promoting quality of care, and preserving Medicaid resources and access to care
- Pharmacy is an area of particular focus with the 2023 Medicaid transition to fee-for-service

II. Audit protocols and updates from the Division of Medicaid Audit

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

Process of developing audit protocols process:

- New protocols are developed when a new service or benefit is created under state or federal policy, an expansion of existing program areas, emergence of new risk areas or program vulnerabilities, recommendations or compliance mandates from OIG/AG/OSC, or a change in billing structure or provider type
- Providers are updated on protocol updates through official OMIG channels, including the agency listserv, public website, Medicaid Updates, and social media channels
- Last week they released a change log link to identify when changes are being made to protocols and includes an archive of past changes
- OMIG recommends that providers ensure key staff involved in the audit process are available and accessible and understand your process for storage and retrieval of medical/billings records – things to consider include:
    - Paper and/or electronic records
    - Multiple systems or upgraded systems
    - Onsite and/or off-site storage
    - Multiple locations
    - Open vs closed cases
- Division of Medicaid Audit (DMA) activities currently include:
    - Recently published protocols and new FFS audits commencing
        - Diagnostic and Treatment Centers
        - Hospital Outpatient
        - OPWDD Community Habilitation Services
        - OMH Mental Health Outpatient Treatment and Rehabilitative Services

- System Match and Recovery audits

III. Compliance and Self-Disclosure

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 include:

- 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

They are looking at 7 main elements for providers including:

- Compliance Policies
- Designated Compliance Officer and Compliance Committee
- Compliance Program Training
- Lines of Communication to/from the Compliance Officer
- Disciplinary Standards
- Audit and Monitoring Standards
- Responding to Compliance Issues

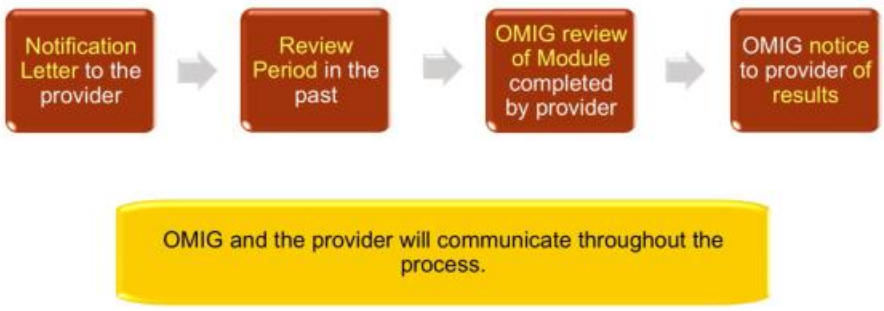
Compliance Program Reviews began July 3, 2023. There are three lookback periods currently under review:

- April 1 – June 30, 2023
- July 1 – September 30, 2023
- October 1 – December 31, 2023

OMIG plans to move to a 12-month review period beginning July 1, 2025

Review activity: 118 reviews completed, 208 reviews actively in progress

Compliance program review process:



All Medicaid entities are required to self-disclose Medicaid overpayments. The below graphic shows self-disclosures by Medicaid enrolled providers, Medicaid Managed Care Organizations (overpaid capitation payment), and other entities:

IV. OMIG Highlights

Since June 2024, OMIG has hosted more than 30 sessions (webinars, forums, etc) reaching out to more than 4,500 providers, associations, and other stakeholders. They have also enhanced communications through website upgrades, listserv announcements and increased subscribers, and social media presence enhancements. OMIG encourages providers to reach out with recommendations, needs for further guidance, etc.

V. Questions & Answers

1) Barclay & Damon has seen a few circumstances where a provider has appeared for a hearing, but OMIG has said to their counsel that they should provide the letter or documentation from OMIG to their counsel.
    a. OMIG responded that when there's a valid notice of appearance, OMIG copies counsel on all communication, but any HIPPA information may need to be transmitted specifically between the provider and counsel.
2) Harter Secrest and Emery has a provider in the final process of the audit stage, the final audit report has been issued, and they want to communicate with OMIG's Counsel to decide if they want a hearing, but no one has responded to their calls. He thinks there should be an available line of communication for situations such as this when a provider's counsel would like guidance or further discussion.
3) Local radiology practice: There was an annual submission that had to go to OMIG from providers, but he heard that that is no longer happening and would like to confirm
    a. OMIG responded that the updated compliance program review process has taken place of that.

4) Non-Emergency Medical Transportation company: There are no checks and balances for Medical Answering Service (MAS) and a hospital they deal with doesn't know how the Medicaid system works, she is very frustrated. While she agrees overpayments should be self-disclosed and returned by providers, her company is missing $16,000 because their GPS tracking doesn't always work in rural areas. She doesn't understand how extrapolation can be applied to small clerical errors.
    a. OMIG responded that they look for flexibilities where they can and they are happy to hear about problems people are facing/where misunderstandings are so they can make improvements.
5) Catholic Health: She heard in a recent presentation with HANYs that OMIG is finding people are not in compliance in relation to the Deficit Reduction Act (DRA) and is curious if they can share more.
    a. OMIG responded that some providers are not citing the DRA in their policies and procedures or that the reference in that information is not in their training. They are trying to promote some education and looking internally to determine if there are flexibilities if providers are getting the message out.
6) Healthcare Worker Bonus audit: Auditors seem to be handling them slightly differently and she asked if there are any updates?
    a. OMIG has opened 380 audits across provider types and they are working their way through, but they still have at least two-thirds to go.
7) Does use of an administrative offset require a self-disclosure?
    a. They aren't sure but they will look into this
8) Is there a minimum amount for self-disclosures?
    a. There is not, providers must return all overpayments of any amount
9) Is there follow-up with providers after abbreviated self-disclosure and what is the data being used for?
    a. OMIG will reach out if more information is needed, though that is likely not needed
    b. Data collected is simply for identifying trends
10) Providers must submit a Certification Statement for Provider Billing Medicaid (ETIN) to the Department of Health, OMIG eliminated this requirement through them as it was repetitive
11) Health homes continue to undergo audits and managed care clerical errors are resulting in hundreds of thousands of dollars in fines. She encourages OMIG to consider not using extrapolation for clerical errors as this creates inequities across the audit process, is unfair to providers, and threatens the sustainability of the health home model.
    a. OMIG said they will take her comment for consideration