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Bureau of Compliance Identified Compliance Program Opportunities for Enhancement As of March 31, 2014

The Office of the Medicaid Inspector General's (OMIG's) Bureau of Compliance conducts compliance program reviews of New York Medicaid providers who are required to have compliance programs. If an opportunity for enhancement is identified during the course of the Bureau's review of a provider's compliance program, it is included in the Bureau's written assessment. Opportunities for enhancement are suggestions made by OMIG on how a Medicaid provider can enhance its compliance program. The identification of an opportunity for enhancement does not constitute a finding that a provider's compliance program does not meet the mandatory compliance requirements. Providers are free to implement or not implement opportunities for enhancement at their discretion.

New York State Social Services Law §363-d recognizes that there is a wide variety of provider types enrolled in the Medicaid program and that compliance programs should reflect a provider's size, complexity, resources, and culture. However, the statute requires that all compliance programs satisfy the eight elements set out in §363-d subd. 2 and 18 NYCRR 521.3(c).

The following is a list of opportunities for enhancement identified during the Bureau of Compliance's reviews of providers' compliance programs.¹ These opportunities for enhancement are being presented as examples for Medicaid providers to consider when developing, operating, and managing their compliance programs. The opportunities for enhancement could apply to all provider types.

This listing is broken down by the required compliance program element and will be updated periodically on OMIG's Web site. The information contained in parentheses following each item indicates the period during which it was added to the list. Updates have been made to some previously published items to reflect additional guidance on the same topic.

¹ The opportunities for enhancement cited have been edited, and, in some cases, combined for purposes of presentation in this format. If opportunities for enhancement are combined, the parenthetical entry reflects the period when the most recent addition was made.

Element (1) Written policies and procedures

1. Develop a compliance plan document and policies and procedures that address the eight elements of NYS Social Services Law §363-d and 18 NYCRR Part 521, as well as the Deficit Reduction Act (DRA). The DRA establishes certain requirements for providers who are paid \$5 million or more by Medicaid. Please see OMIG's home page at www.omig.ny.gov under the Compliance Tab for information on the DRA. (7/2011)
2. Develop the code of conduct to more specifically address the issues surrounding compliance under NYS Social Services Law §363-d and 18 NYCRR Part 521. (10/2011)
3. Develop written policies and procedures that centralize the process used by the compliance officer when conducting investigations. (1/2013)
4. Develop definitions for constituencies covered by the Compliance Program (e.g., employees and others) so that it is clear who is subject to the requirements of the Compliance Program, the code of conduct/code of ethics and the Compliance Plan. (12/2013)
5. Develop and document a process to address appropriate vendors as being within the scope of the provider's Compliance Program and address compliance expectations and consequences for vendors and vendors' employees in the provider's contract with its vendors. (12/2013)
6. Develop a more specific list of compliance expectations. This may include a statement that refers to the existence of the Compliance Program and that the provider will operate at all times under the highest standards for integrity in its dealings with its Medicaid business. (12/2013)
7. Update all references in compliance plan and applicable policies to contact information for compliance function (e.g., changes in telephone numbers, e-mail contact and identity of compliance officer, as may be necessary). (12/2013)
8. Identify the provider's approving authority and the adoption and revision dates on written policies and procedures that describe compliance expectations. (3/2014)
9. Develop, document, and implement a grievance policy that includes references to the corporate Compliance Plan and code of conduct policies and procedures dealing with guidance on how potential compliance problems are investigated and resolved. (3/2014)
10. Amend the handbook to include references to the corporate Compliance Plan and code of conduct policies and procedures dealing with guidance on how potential compliance problems are investigated and resolved. (3/2014)

Element (2) Designate an employee vested with responsibility

1. Develop a cost center and reasonable budget for compliance to ensure that proper resources are devoted to compliance. (7/2011)
2. Ensure that the identity and contact information of the compliance officer and compliance function are publicized in appropriate, highly visible locations and settings and is current. (3/2014)
3. If developing a management compliance committee, include a variety of disciplines on the committee. (7/2011)
4. Ensure that there is an independent reporting structure for the compliance function to the governing body and senior management. (7/2011)
5. Limit the compliance officer's duties that are unrelated to compliance to minimize the

opportunity that the compliance officer will be overextended and to maximize the opportunity that adequate resources are given to the compliance function. (10/2011)

6. Include the compliance officer in quality assurance meetings, as opposed to merely receiving reports/memoranda. (10/2011)
7. Assess the non-compliance duties and reporting structure(s) of the compliance officer regularly to ensure that conflicts do not exist between compliance and non-compliance duties. (3/2014)
8. Engage the governing board through training, regular reports from the compliance function, and progress reports on work plan issues. This will improve the compliance culture and ensure a “tone from the top” that supports compliance and becomes evident to management, employees, staff, and contractors. (10/2011)
9. Ensure that the annual certifying person is a member of senior management who oversees the compliance officer’s function. The certifying person and the compliance officer listed on the certification should be different persons. (10/2011)
10. Develop progress reports with due dates for assignments and responsible parties for delivery of milestones on the compliance work plan. (10/2011)
11. Develop the compliance officer’s job description so that compliance functions are specific and match the compliance plan’s references to the compliance officer’s duties. (1/2013)
12. Make the compliance officer’s reporting structure to the governing board clear so that the compliance officer reports to the governing board on more than just specific instances of non-compliance and formalize the “periodic” reporting to the governing board in the compliance plan and other compliance related documents. (3/2014)
13. Clearly define the compliance program-related responsibilities of both the Medicaid compliance officer and other staff involved with the compliance function. (1/2013)
14. Offer additional compliance training to the compliance officer as a way of changing the perception that the compliance officer is a clerical position. The compliance officer should be able to make decisions about compliance issues whether they are reported or discovered as a result of risk assessment. (7/2013)
15. Redefine the organization chart to reflect a reporting relationship by the compliance officer to the governing board, board committee, or governing board member who sits on the compliance committee. (12/2013)
16. The organization chart, compliance plan, compliance-related policies and procedures and compliance officer’s job description should be consistent in the reporting relationships and the duties and responsibilities. (12/2013)
17. For compliance programs where there are multiple compliance personnel, develop and document the responsibilities at each compliance position and the reporting structures to ensure that compliance issues are reported within the compliance function for appropriate action. (12/2013)
18. Develop policies and procedures that ensure periodic reporting by the compliance officer to the governing board. (12/2013)

Element (3) Training and education

1. Establish employee pre-training benchmarks and compare with post-training to identify an individual’s future educational opportunities. (7/2011)
2. Provide training materials that refer to both the New York State-required compliance elements

and the federal Deficit Reduction Act of 2005's compliance elements, where applicable. (7/2011)

3. Include definitions of fraud, waste, and abuse for individuals completing compliance training to identify suspicious and noncompliant behavior. This highlights differences for employees and makes identification of fraud, waste, and abuse more likely. (7/2011)
4. Establish an oversight and tracking system for education so that all constituencies required to undergo training are tracked for meeting the training obligation, as well as measurement of training testing. (7/2011)
5. Be sensitive to language used in compliance education materials and hotline notices. For example, "We hope that you never have to call the fraud and abuse hotline ..." gives the impression that management does not want constituents to use the hotline. (7/2011)
6. Implement training for employees, persons associated with the provider, executives, members of the governing body, contracted staff, and non-employed medical staff that outline the expected roles that each constituency is expected to play in the compliance function. (10/2011)
7. Consider utilizing the compliance officer to conduct compliance education and training. This assists constituencies in identifying the compliance officer. (10/2011)
8. Develop a training syllabus for compliance. (1/2013)
9. Maintain a distinction between compliance training and quality training. They should be related and connected, but do not sacrifice one for the other. (1/2013)
10. Include compliance training with education on disciplinary policies specifically addressing consequences for participating in noncompliant behavior; or encouraging, directing, facilitating, or actively or passively permitting noncompliant behavior, while emphasizing non-intimidation and non-retaliation for good faith participation in the compliance program. (7/2011)
11. Include information regarding non-intimidation and non-retaliation in training and education program materials. (7/2011)
12. Include the chief executive officer/administrator as a compliance speaker in the training so that he/she is well-versed in how the compliance program works. This provides a visible support for the compliance officer and the program. This can demonstrate a strong "tone from the top" support for compliance. (7/2013)
13. Add language in the provider's policies and procedures to reflect that training is given at the time of orientation for new relevant employees, appointees, and associates, as well as other constituencies. (7/2013)
14. Expand the training program to include more than just the billing and payment issues and document those changes in the compliance plan. (7/2013)
15. Revise the compliance plan or appropriate policies and procedures to define who "affected persons" are in relation to training and education requirements. (12/2013)
16. Amend the corporate compliance plan to include how often the training is required for all groups required to receive compliance training (annual is recommended). (3/2014)
17. Align the training requirements in the corporate compliance program/plan with actual practice. (12/2013)
18. After compliance training, implement a testing tool that measures the effectiveness of the training and trainer to improve the content and presentation method on the compliance program. (3/2014)

Element (4) Communication lines to the responsible compliance position

1. Ensure that the compliance function is supported in the organizational structure:
 - a. Organizational chart includes appropriate reporting structure between the compliance function, the governing board, and senior management.
 - b. Consider that various organizational constituencies interact with the provider in different ways and that not every communication method is effective for all constituencies. This includes ensuring that appropriate anonymous methods are readily available.
 - c. Include compliance as a standing agenda item for governing board meetings or appropriate board committee meetings. This can include attendance by the compliance officer to explain current compliance issues and/or a report from the compliance officer. (7/2011)
2. Use of drop boxes to enhance access for anonymous reporters. (7/2011)
3. Include compliance function contact information in patient registration materials. (7/2011)
4. Expand the publication of the compliance officer's contact information. This could include using a photograph of the compliance officer to assist in identification, publicizing the lines of communication in provider publications, and providing examples of the types of issues to be reported to the compliance function. (10/2011)
5. Publicize and include in the compliance education materials, all of the compliance officer's contact information (i.e., address, telephone number, e-mail, and other methods of contact, if any). (1/2013)
6. Revise language used to report compliance matters so that it is positive in approach rather than negative. (1/2013)
7. Include the governing board in the list of individuals entitled to anonymity. (1/2013)
8. Implement a back-up plan to allow for compliance issues to be communicated when the compliance officer is not available. (1/2013)
9. Clarify language regarding "confidential and anonymous" reporting of potential compliance issues. (1/2013)
10. Add language in provider's policies and procedures to itemize all of the methods for reporting compliance issues. (7/2013)
11. Dedicate a specific telephone number as a hotline for compliance issues, rather than using an all-issues hotline. (7/2013)
12. Improve access to contact information by hanging posters; making the information more obvious on both the provider's Web site and the intranet; publicize the hot line more prominently; and expand access to contact information to public areas, break rooms, and administrative offices. (3/2014)
13. Emphasize in the training that reports of potential compliance issues go directly to the compliance officer. (7/2013)
14. Use a compliance-dedicated and secure method for use in confidential and anonymous communication to the compliance function. (7/2013)
15. Utilize the provider's Internet Web site to publish compliance expectations and reporting information. (8/2013)
16. For the voice mail announcement on a phone line used for reporting compliance issues, confirm that the telephone number called is a compliance function number, as well as the number for

- the compliance officer. (12/2013)
17. Include various communication methods on the provider's front page of their Internet site to maximize compliance program visibility. (12/2013)
 18. To encourage reporting, confirm in the compliance plan and supporting policies and procedures that the compliance function respects request for confidentiality and anonymity in any good-faith reporting of potential compliance issues. (12/2013)
 19. Publicize how to anonymously report compliance issues. (12/2013)
 20. Include specific language in the compliance plan and applicable policies and procedures that supervisors or senior staff must report to the compliance function all compliance-related issues they receive and that they will respect requests for confidentiality or anonymity. (12/2013)
 21. Implement a system to periodically test the functionality and operation of all identified lines of communication to the compliance function. (3/2014)
 22. If a compliance drop box is used as a communication method, it should be controlled by the compliance function with the ability to ensure that there is a process to check that all insertions are seen by the compliance officer and not screened by a non-compliance functionary. (3/2014)

Element (5) Disciplinary policies to encourage good-faith participation

1. Ensure the existence of disciplinary policies that support and encourage good-faith reporting and participation in the compliance program, and that these are included in the employee handbook or other appropriate publication(s). (7/2011)
2. Ensure that policies reflect appropriate disciplinary consequences (potentially up to and including dismissal) for participating in noncompliant behavior, or encouraging directing, facilitating, or actively or passively permitting noncompliant behavior. (7/2011)
3. Implement disciplinary policies that articulate expectations for assisting in the resolution of compliance issues for affected individuals. (1/2013)
4. Include in the compliance plan specific language addressing disciplinary policies that support good-faith participation in the compliance program. (12/2013)
5. Ensure consistent representations in the compliance plan and the policies and procedures that address the specific disciplinary requirements for Element #5. (12/2013)
6. Include in disciplinary policies and procedures language that administration, staff, governing body members, and all affected individuals have an obligation to report compliance failures. (3/2014)

Element (6) A system for routine identification of compliance risk areas

1. Utilize OMIG's Web site for self-disclosure reporting process, checking the posted exclusion list, and other compliance tools. (7/2011)
2. Ensure that policies and procedures are in place to address appropriate action against excluded parties, including checks with vendors to ensure that excluded parties are not involved in Medicaid services through the vendor. (7/2011)
3. Use certified CPT coder(s) to enhance the effectiveness of billing compliance. (7/2011)
4. Conduct compliance exit interviews for departing employees, staff, management, governing board members, and contractors to assist in identification of risk areas. (7/2011)

5. Include the compliance officer in quality assurance, risk management, and utilization management committee meetings, as appropriate. (7/2011)
6. Prepare an annual compliance work plan that identifies risk areas based upon self-identified weak areas, regulatory advisories, regulatory actions, and outside assessments, among others. (7/2011)
7. Assess the effectiveness of the provider's compliance program annually using a self-assessment tool as part of the process that is used to meet the annual certification requirement for the provider's compliance program. (7/2011)
8. Develop a process to test the provider's employees, contractors, grantees, and other organizations providing services or billings through the provider for potential violation of the federal False Claims Act or New York's Fraud Enforcement and Recovery Act. (10/2011)
9. Develop a system to analyze, trend, and evaluate Medicaid claim denials with the goal of preventing and addressing potential billing errors and inaccurate claim submission. (10/2011)
10. Incorporate routine documentation checks by someone outside of the compliance function for the compliance officer's non-compliance program-related data entry when the compliance officer has duties other than compliance. (7/2013)
11. Consider adding specific information to provider's compliance program outlining how to identify risk areas. (7/2013)
12. Review 18 NYCRR §504.9 and OMIG's Webinar #6 to understand the requirements for a service bureau. Consider adding questions addressed in Webinar #6 to provider's risk assessment when evaluating its biller. (7/2013)
13. Establish a list of the risk areas as part of the compliance program. This will focus efforts on areas where weaknesses in the compliance program are most likely to exist, and it will assist in the application of resources. (7/2013)
14. Add language to the compliance program that specifically addresses the evaluation of risk areas, as identified in provider's self assessments. (7/2013)
15. Document provider's self-evaluation efforts to include all compliance risk areas specified under 18 NYCRR 521.3(a). (7/2013)
16. Check the appropriate exclusions lists at intervals recommended by OMIG and OIG/CMS. (7/2013)
17. Use a self-evaluation tool on an annual basis such as the compliance program assessment form available on the OMIG Web site that includes the requirements of NYS Social Services Law section 363-d and the seven areas that compliance programs should apply to that are set out in 18 NYCRR section 521.3(a). (3/2014)
18. Check the list of excluded and debarred individuals on a monthly basis. (12/2013)

Element (7) A system for responding to compliance issues

1. Create a policy and procedure to address the Patient Protection and Affordable Care Act's (ACA) overpayment recovery obligations, specifically addressing the report, repay, and explain obligations when a provider receives an overpayment. (7/2011)
2. Establish timelines and milestones for deliverables in the compliance plan, with progress monitored and reported to senior management and the governing board. (10/2011)
3. Consider expanding the system for exclusions checks of employees and leased employees. This should include performing the search more frequently than annually (i.e., monthly), and also

- checking medical staff or others who may order services. (10/2011)
4. Consider giving the compliance officer access to external audit reports. (1/2013)
 5. Consider expanding the reporting obligation to specifically include both the New York State Department of Health and the New York State Office of the Medicaid Inspector General. (1/2013)
 6. Document the procedures used to respond to compliance areas and to correct compliance issues as necessary to reduce the potential for recurrence. (1/2013)
 7. Document clearly in the Medicaid compliance program the specific steps taken to refund overpayments. (1/2013)
 8. Consider adding language to the compliance program that specifically addresses the evaluation of risk areas and that commits the provider to promptly and thoroughly implement resolutions which will also prevent the recurrence of risk areas as identified in self assessments. (7/2013)
 9. Incorporate a formalized log of compliance-related issues into the system that identifies and responds to compliance issues so there is a summary reference of issues raised and the compliance function can track the progression of resolution. (12/2013)
 10. For a large, multiple-location provider, include in the system a clear process for how local, regional, or enterprise compliance issues will be addressed (for example, all local and regional compliance issues will be responded to at the enterprise level, or compliance issues will be responded to at the location where they occur). (3/2014)
 11. The system to respond to compliance issues should operate regardless of how the compliance issues are identified. (3/2014)

Element (8) A policy of non-intimidation and non-retaliation

1. Include in all compliance literature language setting out non-intimidation and non-retaliation expectations. (7/2011)
2. Include in the Compliance Plan applicable policies and procedures, and training material references to reporting cases of intimidation and retaliation to officials as provided in New York State Labor Law Sections 740 and 741. (12/2013)
3. For multi-state providers, ensure that the appropriate references are made to New York law, for New York operations, rather than the law of the state where it has other operations. (3/2014)