

## Bureau of Compliance Identified Compliance Program Insufficiencies As of December 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 insufficiency is identified during the course of a review of a provider's compliance program by the Bureau of Compliance, it is included in the Bureau's written assessment. Any finding of an insufficiency means a provider is not meeting a requirement of a mandatory compliance program.

Depending on the severity and extent of the insufficiency or insufficiencies, OMIG may pursue various regulatory interventions including, but not limited to: re-assessment following a period of time that allows the provider to cure the insufficiency or insufficiencies; a recommendation that a notice of proposed agency action be issued to the provider; and/or variations between the two.

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 insufficiencies identified during the Bureau of Compliance's reviews of providers' compliance programs.<sup>1</sup> These insufficiencies are being presented as **examples** to assist Medicaid providers in developing, operating, and managing their compliance programs. The insufficiencies could apply to all provider types.

This listing is broken down by compliance program required element and will be updated periodically on OMIG's website. 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.

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

## ELEMENT 1 - WRITTEN POLICIES AND PROCEDURES

1. No compliance program, code of conduct, policies, or procedures on compliance exist. (7/2011)
2. No policy and/or procedure describing how potential compliance issues are investigated and resolved exists. (1/2014)
3. No guidance is provided to “employees and others” associated with the provider on how to identify and communicate issues to the compliance function. (1/2013)
4. The compliance program has not been implemented within the provider. (1/2013)
5. There are no written policies and procedures that provide guidance to non-employees associated with the Medicaid provider on dealing with potential compliance issues, as well as how to identify and communicate compliance issues to compliance personnel. (12/2013)
6. Policies were not documented that articulate expectations for assisting in the resolution of compliance issues. (12/2013)
7. A policy of non-intimidation for good faith participation in the compliance program was not evidenced in a written policy and procedure. (12/2013)
8. Provider does not have written policies and procedures that adequately describe compliance expectations, specifically expectations for routine identification of compliance risk areas specific to its provider type. (12/2013)
9. The Compliance Program is not operational. (12/2013)

## ELEMENT 2 - DESIGNATE AN EMPLOYEE VESTED WITH RESPONSIBILITY

1. Compliance Officer Reporting
  - a. Organization chart indicates a reporting structure to the CEO or other senior administrator, but the actual reporting relationship is to the CFO or other position where a conflict of interest could reasonably be expected to exist. (7/2011)
  - b. Compliance Officer does not have a periodic report directly to the governing board. (10/2011)
  - c. There are no documented lines of communication between the compliance function and the non-corporate owner of the provider. (1/2013)
  - d. Compliance Officer’s reporting structure has the potential to create a conflict of interest for the Compliance Officer. For example, 18 NYCRR §521.3(a) requires the compliance program to be applicable to billing and payments functions, among others. If the Compliance Officer reports to the person who is responsible for the billing and payment function (like the CFO), a conflict of interest relative to the objective operation of the compliance program over those functions will be brought into question. (1/2013)
2. Compliance Officer’s noncompliance functions conflict with pursuit of compliance duties. For example, the Compliance Officer should not also serve as the Chief Financial Officer or administrator over the billing function. (7/2011)
3. Compliance officer’s job description does not describe any compliance-related duties or functions. (1/2013)
4. The Compliance Officer has not been trained in compliance and no training resources are available to the Compliance officer. (1/2013)
5. The Compliance Officer does not have an understanding of the compliance obligations established in the Social Services Law and the accompanying regulations. (1/2013)
6. The Compliance Officer does not regularly interact with others providing assistance in the compliance function. (1/2013)

7. The compliance office fails to carry out compliance responsibilities as set out in the Compliance Plan and manuals. (1/2013)
8. Although the Compliance Plan requires a staff compliance committee, there is no evidence of its existence. (1/2013)
9. The designated employee's compliance duties are combined with other duties and the compliance responsibilities are not satisfactorily carried out. (3/2014)
10. An employee has not been vested with responsibility for the day-to-day operation of the compliance program. (3/2014)
11. Areas of oversight by the compliance function include coding and billing, but the compliance function is not given access to financial information and audits so that the oversight can occur. (6/2014).

### ELEMENT 3 - TRAINING AND EDUCATION

1. Compliance training does not include the governing board, senior management, staff, or other essential parties. (7/2011)
2. Compliance training does not include "persons associated with the provider." (1/2013)
3. Despite the identification in the Compliance Plan that compliance training is performed, no evidence exists that compliance training has ever occurred. (1/2013)
4. Compliance training does not describe how the compliance program operates, other than setting out a reporting obligation and the ways to contact the compliance function. (1/2013)
5. There is no compliance-related training performed. (1/2013)
6. Compliance training is not part of the orientation for governing body members, executives, appointees, associates, or new employees. (3/2014)
7. Training and education are not provided to all governing body members on compliance issues, expectations and the compliance program operation. (9/2013)
8. There is no training and education provided to all executives on compliance issues, expectations and the compliance program operation. (12/2013)
9. The compliance training does not occur periodically. (3/2014)

### ELEMENT 4 - COMMUNICATION LINES TO THE RESPONSIBLE COMPLIANCE POSITION

1. No anonymous method of communication to the compliance function exists. (7/2011)
2. Little or no meaningful communication between the compliance function and the governing board and/or senior management exists on compliance-related issues. (7/2011)
3. No dedicated hot line or other communication method that is exclusively monitored by the Compliance Officer or compliance function exists. The hotline phone is accessible to be answered by staff other than the Compliance Officer and designated backup. (3/2014)
4. Use of a general complaint line that is monitored by the human resources function or noncompliance function does not constitute an anonymous compliance reporting method. (10/2011).
5. There is no clear direction that confidential disclosures to the compliance function can occur and there are no confidential lines of communication available. (1/2013)
6. There are no communication methods available to employees or others associated with the provider to communicate to the compliance function. (1/2013)

7. There are no lines of communication to the designated employee that are accessible to all members of the governing body to allow compliance issues to be reported. (12/2013).
8. The Compliance Plan and the applicable policies and procedures do not identify accessible lines of communication for members of the governing body to report compliance issues to the Compliance Officer. (12/2013)

## ELEMENT 5 - DISCIPLINARY POLICIES TO ENCOURAGE GOOD FAITH PARTICIPATION

1. No disciplinary policies to encourage good faith participation in the compliance program exist. (7/2011)
2. Disciplinary policies exist to encourage good faith participation in the compliance program, but those policies are not enforced. (7/2011)
3. Disciplinary policies are not applied equally. For example, firing or suspending a line staff employee for violation(s) of the code of conduct, but not applying the same sanction to a senior management person for the same or similar violation does not result in equal application of the disciplinary policies. (7/2011)
4. Disciplinary policies do not encourage good faith participation in the compliance program. (10/2011)
5. Disciplinary policies address employees, but do not address all other constituencies covered by the compliance program, including the governing body. (1/2013)
6. Disciplinary policies do not set out expectations for assisting in resolution of compliance-related issues. (1/2013)
7. Disciplinary policies do not address sanctions for failing to report suspected problems; participating in non-compliant behavior; or encouraging, directing, facilitation or permitted non-compliant behavior. (1/2013)
8. There are no policies in effect that articulate expectations for assisting in the resolution of compliance issues for all affected individuals. (12/2013)

## ELEMENT 6 - A SYSTEM FOR ROUTINE IDENTIFICATION OF COMPLIANCE RISK AREAS

1. No system is in place to routinely identify compliance risk areas specific to the provider's service type. (9/2013)
2. No system is in place to routinely conduct self-evaluations and audits specific to its provider type. (1/2013)
3. There was no system for evaluation of potential or actual non-compliance as a result of self-evaluations and identified by external or internal audits. (12/2013).
4. There is no evidence of a connection between the compliance function and the results of relevant external audits. (3/2014)
5. For a large enterprise, there is no system in place at the regional level for routine identification of compliance risk areas specific to the provider's service type(s). (3/2014).
6. There is no evidence of Compliance Officer involvement in the external audit process. (2/2014)

## ELEMENT (7) A SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES

1. Failure to respond to matters identified to the provider by OMIG or other NYS or federal regulatory bodies as program deficiencies and/or weaknesses. (7/2011)
2. There is no evidence that compliance related complaints, hotline calls, drop boxes, e-mails, or in-person disclosures to the compliance function are addressed. (7/2011)
3. Failure to have a system to respond to compliance issues as they are raised. (10/2011)
4. Failure to have an operating system that addresses compliance issues promptly and thoroughly and reduces the potential for recurrence of the issue. (10/2011)
5. Failure to have a system for identifying and reporting compliance issues to NYS Department of Health or OMIG. (10/2011)
6. Failure to have a system for investigating potential compliance issues. (1/2013)
7. Failure to have a system to respond to compliance issues identified in the course of self-evaluations and audits. (2/2014)
8. No system or methodology exists to periodically prioritize compliance oversight of activities that are either most serious or most likely to occur. (12/2013)
9. In practice there is no system in place for implementing procedures, policies, and systems as necessary to reduce the potential for recurrence. (3/2014)
10. There is no system in place for refunding Medicaid overpayments. (3/2014)
11. For a large enterprise, there is no system in place at the regional or corporate levels to investigate potential compliance problems. (3/2014).
12. The system identified does not provide for *prompt* correction of compliance problems. (3/2014)

#### ELEMENT (8) A POLICY OF NON-INTIMIDATION AND NON-RETALIATION

1. Failure to have a system or process to address allegations of intimidation or retaliation and to fully investigate the allegations. (10/2011)
2. Failure of the Compliance Plan to adequately address claims of intimidation and the reporting that is required under NYS Labor Law Sections 740 and 741. (1/2013)
3. A policy was not evidenced for non-intimidation 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 New York State Labor Law. (12/2013)