Office of Mental Health (OMH) Medicaid Compliance Program Training 2026

NOTE: This training is intended only for OMH contractors who do not have access to SLMS.

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OMH Bills Insurers for Services

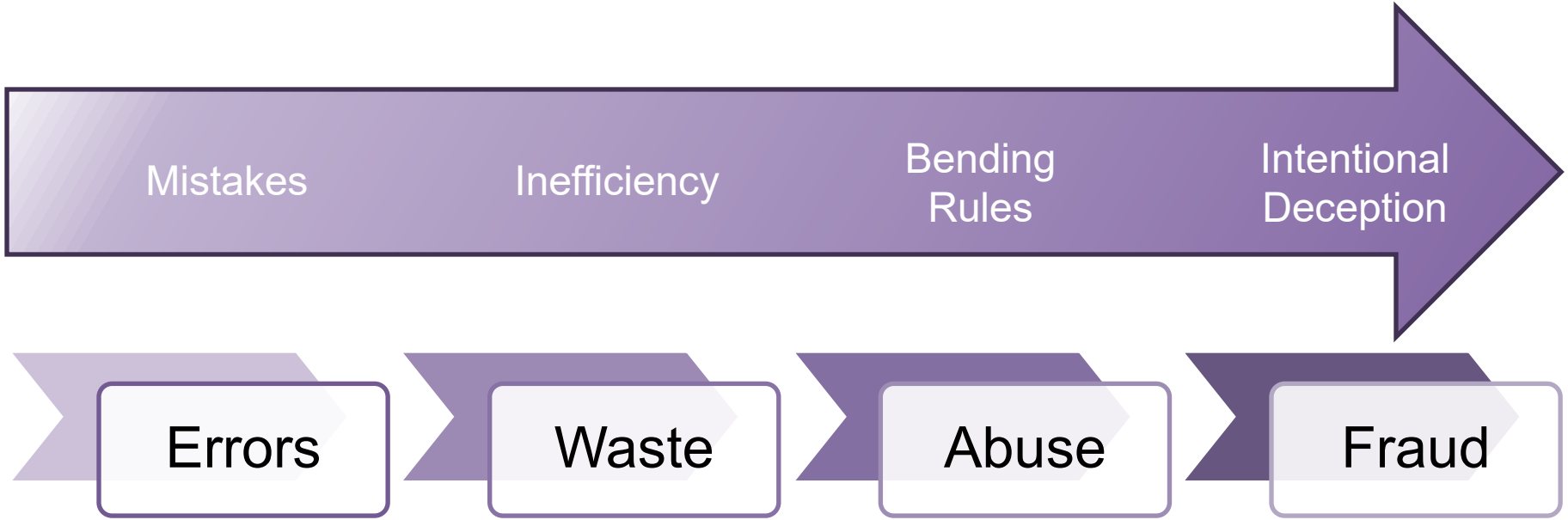
- Section 43.01(a) of the Mental Hygiene Law states OMH "shall charge fees for its services to patients and residents, provided, however, that no person shall be denied services because of inability or failure to pay a fee."
- To comply, OMH bills the insurance plan an individual is enrolled in for services they received at an OMH-operated facility or program.
  - The most common insurers are Medicaid fee-for-service, and Medicaid Managed Care.
  - Other insurers include Original Medicare (Parts A/B), Medicare Advantage (Part C), TRICARE, commercial, etc.
- As a result, OMH must ensure documentation (e.g., progress notes, Individualized Service Plans {ISP}) for services provided at one of its programs/facilities meets the standards to support any insurance reimbursement received.
  - 18 NYCRR §504.3 outlines specific documentation requirements for Medicaid reimbursed services.

Why OMH Needs a Compliance Program

- NYS Social Services Law §363-d and 18 NYCRR Part 521 require certain Medicaid providers to operate an “effective” Medicaid compliance program.
- OMH must comply with the Medicaid compliance program requirements because it meets the following criteria:
  - Operates programs subject to Article 31 of the NYS Mental Hygiene Law (e.g., MHOTRS programs, ACT programs); and
  - Claimed or received $1 million or more in Medicaid funds during a consecutive 12-month period.
- OMH’s Medicaid Compliance Program also fulfills federal requirements contained in the Federal Deficit Reduction Act (DRA) of 2005.

What is Medicaid Fraud, Waste and Abuse?

Medicaid fraud, waste, and abuse occurs on a continuum.



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Errors

Error definition: when a provider makes a mistake in service delivery, documentation, or billing.

Examples of errors may include:

- Selecting the wrong billing code(s) for the service(s) rendered;
- Recording services incorrectly in the electronic health record system (e.g., MHARS);
- Not fully documenting a service provided;
- Providing a service that does not meet programmatic/regulatory requirements;
- Forgetting to sign a treatment plan or progress note; or
- Entering the incorrect amount of time taken to provide a service.

Errors are usually random and do not have a pattern to them. If patterns persist over time, errors can lead to waste. Wasteful practices may also rise to the level of abuse or fraud.

Waste

Waste definition: overutilization of services, or other practices that directly or indirectly, result in unnecessary cost to the Medicaid program.

Examples of waste may include:

- Redundant testing;
- Misuse of resources;
- Delays in treatment;
- Making processes unnecessarily complex; or
- When a provider routinely orders testing which may not be medically necessary for every individual receiving services.

Waste ***does not require*** intent to misuse resources or deliver inefficient care.

Abuse

Abuse definition: practices that are inconsistent with sound fiscal, business, medical or professional practices, and which result in unnecessary costs to the Medicaid program, reimbursement for services which were not medically necessary, or reimbursement for services which fail to meet professionally recognized standards for health care.

Examples of abuse may include:

- Facility management neglecting to address longstanding documentation issues in a timely manner;
- Routinely upcoding to longer or more complex services (not intentionally to increase revenue, but as a matter of practice or to simplify a billing process); or
- Routinely submitting duplicate claims or unbundled claims (does not need to be intentional; could be due to carelessness or lack of training).

There is ***no requirement*** to prove intent.

Fraud

Fraud definition: an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person, and includes the acts prohibited by section 366-b of the Social Services Law.

Examples of fraud may include:

- Intentionally billing for services not actually performed;
- Intentionally billing for a more expensive service than was actually provided;
- Intentionally ordering tests or billing for services that are not medically necessary;
- Falsifying timesheets, signatures, or other documentation in connection with the provision of services;
- Selling prescriptions (may also violate anti-kickback laws); or
- Giving money or gifts to individuals in return for agreeing to get medical care they do not need.

The Federal Deficit Reduction Act (DRA)

- Requires all healthcare entities who receive at least $5 million per year in Medicaid payments to establish policies and procedures about Federal and State False Claim Acts and whistleblower protections.
- OMH's Notice Pursuant to Deficit Reduction Act of 2005 § 6032 meets the requirement to establish written policies providing detailed information about:
  - The Federal False Claims Act and penalties,
  - Applicable state laws with civil or criminal penalties,
  - Whistleblower rights & protection, and
  - Federal healthcare program fraud and abuse policies.

Federal False Claims Act

- Codified in Title 31 United States Code §3729-3733, protects the government from being overcharged or sold substandard goods or services.
- Imposes civil liability on any person who ***knowingly*** submits or causes to be submitted, a false or fraudulent claim to the Federal Government.
  - The terms "knowing" and "knowingly" mean that a person submits a claim to the federal government that he or she ***knows or should know*** is false.
  - **No proof of specific intent to defraud is required.**
- Provides for fines between $14,308 and $28,619, plus three times the amount of damages that the government sustained because of the false claim.
- Healthcare related Federal False Claims Act settlements and judgments exceeded $5.7 billion in fiscal year 2025.

Examples of what may lead to a False Claim:

- Presenting a false claim for payment or approval (intentionally billing a federal healthcare program like Medicaid for a service not provided); or
- Making or using a false record or statement, such as an inaccurate or untimely progress note, in support of a false claim.

Please remember:

- ***OMH relies on accurate service recording to justify the claims we submit to Medicaid and other federal healthcare programs for payment.***

- ***If you enter a progress note for a service you did not provide, you are putting the agency and yourself at risk for major financial penalties!***

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NYS Civil, Administrative, and Criminal Laws

New York False Claims Act (State Finance Law § § 189, 191): Similar to the Federal False Claims Act. It imposes penalties and fines on individuals/entities who knowingly file false or fraudulent claims for payment from any state or local government. Civil penalties are between $14,308 and $28,619 per claim, plus three times the amount of damages the state or local government sustains because of the false claim.

False Statements (Social Services Law §145-b): It is a violation to knowingly obtain, or attempt to obtain, payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or local government may recover three times the amount incorrectly paid, and the DOH may impose a civil penalty of up to $30,000 per violation.

Penalties for Fraudulent Practices (Medicaid) (Social Services Law § 366-b): Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information to obtain authorization to provide items or services is guilty of a **class A misdemeanor**.

Larceny (Penal Law, Article 155): Larceny applies to a person who, with intent to deprive another of their property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases. There are different degrees of larceny, **which range from a misdemeanor to a felony**.

Healthcare Fraud and Abuse Laws

Numerous other federal laws govern and seek to prevent fraud and abuse in the delivery and payment of health care, including the:

- Fraud Enforcement and Recovery Act of 2009;
- Anti-Kickback Statute (42 USC §1320a 7b(b);
- Criminal Health Care Fraud Statute (18 USC §1347); and
- Patient Protection and Affordable Care Act.

Additionally, the New York State Penal Law provides criminal penalties for submitting false written statements and committing insurance, and healthcare fraud, including:

- Penal Law Article 175, False Written Statements;
- Penal Law Article 176, Insurance Fraud; and
- Penal Law Article 177, Health Care Fraud.

Penalties

Recap: Medicaid fraud is a violation of federal and state laws carrying significant civil monetary penalties and may also lead to criminal conviction, fines, and possible imprisonment.

Penalties for Medicaid fraud may also include:

- Nonpayment of claims,
- Recoupment of overpayments for fraudulent claims,
- Loss of provider license, or
- Exclusion of the provider from federal/state health insurance programs.

In addition to the above penalties, OMH employees who commit fraud may be subject to administrative or disciplinary action, up to and including, termination of employment.

Rights & Protections

- **Whistleblower Rights & Protections:** The Federal and NYS False Claims Acts provide protection to individuals who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment because of commencing a False Claims action.
- **Non-Discrimination & Non-Intimidation Protections:** OMH employees have a duty to report suspected or known Medicaid compliance issues and are encouraged to assist in their resolution. OMH will not take any adverse personnel action against an employee for reporting a Medicaid compliance issue. Any type of retaliation or intimidation against individuals who participate in good faith in the Compliance Program is prohibited.

Medicaid Program Exclusion Lists

The U.S. Department of Health and Human Services Office of Inspector General (OIG) is required to exclude providers convicted of specific criminal offenses from participating in all federal healthcare programs, including Medicaid. The criminal offenses include Medicaid or Medicare fraud, client abuse or neglect, and felony convictions for health care related fraud, theft, other financial misconduct, or unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The NYS Office of Medicaid Inspector General (OMIG) also maintains a list of providers excluded from participating in the NYS Medicaid program.

The OIG and OMIG excluded provider lists include provider agencies/practices and individual practitioners.

Excluded providers cannot work independently, or for another provider who bills federal health care programs, including Medicaid.

OMH is required to check these exclusion lists regularly and may not permit employees or contractors on the exclusion lists to provide services related to federal healthcare programs.

NYS Medicaid Compliance Requirements

- OMIG is an independent entity created within the NYS Department of Health whose mission is to enhance integrity of the NYS Medicaid program by:
  - Preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program, and
  - Recovering improperly expended Medicaid funds while promoting a high quality of client care.
- OMIG issued Medicaid compliance program regulations which OMH must follow.
- The OMH Medicaid Compliance Program applies to all persons impacted by OMH's risk areas, who are called Affected Individuals. This includes:
  - OMH employees (state, RFMH, paid interns),
  - Contracted staff (consultants, locum tenens, etc.), and
  - Contractors and subcontractors.

OMH's Medicaid Compliance Program

OMH's Medicaid Compliance Program is structured to ensure that:

- Affected Individuals know how to identify, and report suspected Medicaid misconduct, waste, abuse and fraud as soon as possible.
- Clear policies, procedures, and processes to identify, report, and correct issues are in place.
- OMH can detect issues of fraud, waste, and abuse, conduct appropriate internal investigations, and implement corrective actions.
- Affected Individuals comply with all applicable laws, regulations, and OMH policies.
- Services are delivered in an appropriate manner to individuals who are eligible for such services, consistent with programmatic standards.
- Claims submitted to Medicaid are accurate and consistent with billing standards.
- A culture of compliance is encouraged to support the integrity of the Medicaid program, and OMH as a provider of Medicaid services.

Compliance Expectations

OMH expects all Affected Individuals to comply with the Compliance Program by:

1. Exercising diligence, care, and integrity when submitting Medicaid claims for payment of services rendered;
2. Maintaining honest, fair, and accurate billing practices;
3. Timely reporting allegations of suspected fraud, waste, or abuse;
4. Complying with all state and federal laws, rules, and regulations, including but not limited to all requirements of the Medicaid program;
5. Complying with current OMH policies, procedures, administrative memoranda, accounting rules, procurement rules and internal controls;
6. Documenting the provision of all services and transactions in an accurate, honest and timely manner;
7. Refraining from filing any false, fictitious, or fraudulent statements or documents in connection with the delivery of, or payment for, health care benefits, items, or services; and
8. Refraining from participating in, or encouraging, directing, facilitating, or permitting non-compliant behavior.

OMH Risk Areas

OMH has various processes and systems for routine identification of its Medicaid compliance risk areas including self-evaluation, auditing and monitoring activities relating to operational compliance risk areas. OMH's risk areas include:

1. Billing
2. Payments
3. Ordered Services
4. Medical Necessity and Quality of Care
5. Governance
6. Mandatory Reporting
7. Credentialing
8. Contractor, Subcontractor, Agent, or Independent Contract Oversight
9. Excluded Provider Screening

**Monitoring activities for each risk area are detailed in the OMH Medicaid Compliance Program Policy, A-500.*

7 Required Compliance Program Elements

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Policies & Procedures

- OMH must have written policies and procedures which:
  - Incorporate required compliance program legal and ethical obligations, including federal standards.
  - Document implementation and ongoing operation of each compliance program element.
  - Are reviewed annually to confirm policies and procedures have been implemented, are being followed by Affected Individuals, are effective, and determine whether updates are needed.
- OMH Medicaid compliance policies are available online:
  - Medicaid Compliance Program Policy
  - Notice Pursuant to Deficit Reduction Act of 2005 § 6032

Medicaid Compliance Officer and Committee

- OMH must have a Medicaid Compliance Officer.
  - The Medicaid Compliance Officer is responsible for daily operation of the OMH Medicaid Compliance Program and for ensuring OMH meets its statutory and regulatory requirements.
- OMH must have a Medicaid Compliance Committee comprised of senior managers, appointed by the OMH Commissioner.
  - Members are from Financial Management, State Operated Services, Counsel, Human Resources, Medical Informatics, Quality Improvement, and Audit & Compliance.
  - The Committee meets quarterly and helps ensure OMH is engaging in ethical and responsible conduct, consistent with the OMH Medicaid Compliance Program and applicable OMH policies and legal requirements.

Compliance Training and Education

- All Affected Individuals are required to receive Medicaid compliance program training annually.
- This training emphasizes OMH's commitment to compliance with all federal and state laws governing the provision and payment for Medicaid services.

Lines of Communication for Reporting Issues

- OMH must have open lines of communication to report compliance issues or ask questions, and which must:
  - Be available to all Affected Individuals and Medicaid service recipients.
  - Allow for anonymous reporting.
  - Ensure confidentiality of individuals reporting compliance issues.
- Medicaid compliance issues or questions can be reported via:
  - Medicaid Compliance Reporting Form
  - Email to Compliance@omh.ny.gov.
  - Phone by calling 518-549-5370.

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Disciplinary Standards

- Sanctions may be imposed for failing to report suspected or known compliance issues, participating in non-compliant behavior, or encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior.
- Disciplinary procedures are governed by the provisions of section 75 of the Civil Service Law and the collective bargaining agreements negotiated between New York State and its various bargaining units.
- Disciplinary action may include letters of reprimand, loss of accrued leave, monetary fines, suspension without pay, demotion, or termination from employment, and will depend on a variety of factors, including the employee's previous administrative/disciplinary history, the level of severity of the misconduct, and the extent of the individual's participation and involvement in the misconduct.

Auditing & Monitoring

OMH's compliance program is designed to prevent, detect, and correct Medicaid program non-compliance.

OMH must develop and implement an annual compliance workplan that identifies areas of focus, including:

- Ongoing identification of compliance risk areas (e.g., evaluation and management codes, timeliness and completeness of documentation in case records),
- Routine risk area auditing and monitoring (e.g., facility-specific Medicaid compliance reviews),
- Reviewing compliance program effectiveness annually, and
- Checking exclusion status of all Affected Individuals.

Examples of Support for Medicaid Claims

- *Accurate Service Recording:* OMH relies on the creation and maintenance of accurate service documentation and recording, to justify the claims submitted for payment. All billing and reimbursements are dependent on accurate and timely recording of services in MHARS. Services which have been entered into MHARS for licensed programs must pass a series of billing system edits to determine which services will eventually be billed.
  - NYS Social Services regulation at 18 NYCRR Section 504.3(a) states Medicaid providers must prepare and maintain contemporaneous records that demonstrate the provider's right to receive payment under the Medicaid program. "Contemporaneous" records means documentation of the services that have been provided as close to the conclusion of the session as practicable.
- *Supporting Clinical Documentation*: Most Medicaid reimbursable mental health services require an active treatment plan/ISP signed by a physician or other qualified professional. Claims are disallowed, and reimbursement must be returned to the Medicaid program, during any time for which there is not documentation of an active treatment plan/ISP in a client's record.

Examples of Support for Medicaid Claims

- *Cost-Effectiveness:* To avoid the ordering and provision of unnecessary, inappropriate, or excessive services, when OMH clinicians order or provide ordered services for clients, OMH ensures that adequate and less costly alternatives for services have been explored and, where appropriate and cost effective, are provided.
- *Documentation of Medical Necessity:* OMH ensures that it only orders or provides medically necessary ordered services. Appropriately licensed OMH clinicians include documentation supporting medical necessity in the client's medical record for all ordered services. Supporting documentation includes a clinical evaluation of the client by the ordering practitioner related to the ordered services.

Responding to Compliance Issues

The OMH Medicaid Compliance Office will investigate concerns regarding actual, potential, or perceived wrongdoing which may amount to waste, fraud, or abuse of the Medicaid program.

OMH's compliance program includes systems for promptly responding to compliance issues, including:

- Investigating and correcting problems,
- Monitoring plans of correction to prevent reoccurrence,
- Ensuring compliance with state and federal laws, rules, regulations, and requirements of the Medicaid program, and
- Self-disclosing violations of federal or state statute/regulation to appropriate government entity (e.g., OMIG).

OMH expects employees to provide the OMH Medicaid Compliance Officer with information requested and to cooperate with any investigation, whether or not the employee reported the issue.

What Are My Responsibilities?

Affected Individuals must adhere to OMH's Medicaid Compliance Program, and report concerns regarding actual, potential, or perceived wrongdoing which may amount to waste, fraud or abuse of the Medicaid Program.

After you report an issue, the OMH Medicaid Compliance Officer will:

- Follow up to investigate all claims made;
- Refer issues to appropriate individuals within your facility or Central OMH divisions for further investigation or to take remedial action; and
- Report to OMH Executive Staff regarding the status of pending investigations.

You can report violations of:

- Fraud or abuse, embezzlement, billing irregularities;
- Known documentation issues or falsification of information;
- Quality of care client issues;
- Conflicts of interest, self-referrals or kickbacks; and
- Other conduct that may be a violation of law, ethics, or agency policy.

Reporting Fraud and Abuse

OMH is committed to investigating and resolving all Medicaid program integrity issues which we discover through self-assessment and direct reports. Affected Individuals may report compliance issues and concerns anonymously and confidentially by mail or phone. Please remember that OMH will not intimidate or retaliate against you merely for reporting compliance issues.

Employees should report issues to their manager or supervisor, or

Directly to the OMH Compliance Officer by phone at 518-549-5370 or by email to Compliance@omh.ny.gov;

Submit an online complaint using the Medicaid Compliance Reporting Form (can report anonymously); or To the Central Office Customer Relations Line at 1-800-597-8481.

Medicaid misconduct may also be reported:

Directly to the OMIG by phone at 1-877-87-FRAUD (1-877-873-7283) or via their website at www.omig.ny.gov; or

To the NYS Office of the Inspector General by phone at 1-800-DO-RIGHT (1-800-367-4448) or by email to inspector.general@ig.ny.gov; or

To the NYS Attorney General's Medicaid Fraud Control Unit at 212-417-5397 or their Medicaid fraud complaint form.

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What should you include in your report?

Affected Individuals should report as much relevant information as possible on the issue, including:

- What wrongdoing occurred;
- Who was involved;
- When and where it occurred;
- Whether there were witnesses to the misconduct;
- How the issue was discovered; and
- Any other relevant information or details to support how the offense was committed.

Test Your Knowledge – True/False

1. The purpose of the OMH Medicaid Compliance Program is to maintain the integrity of the Medicaid program by both preventing and detecting fraudulent, abusive, and wasteful practices within OMH.

2. The OMH Medicaid Compliance Program applies to all Affected Individuals which shall include, but not be limited to, OMH employees, clinicians providing services under contracts with OMH or any of its facilities, paid student interns, and other persons whose conduct, in the performance of work for the Office, including its programs or facilities, is under the direct control of the Office of Mental Health.

3. *Fraud* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and which result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Test Your Knowledge – True/False

4. Employees who have knowledge of violations of law or agency policy, operating procedures or conduct, which might reasonably constitute fraud, corruption, or misconduct must report what they know as soon as possible, to either their supervisor or the OMH Medicaid Compliance Officer. Supervisors have an obligation to report known or suspected compliance issues further up the chain of command or to the OMH Medicaid Compliance Officer.

5. Failure to comply with any provisions of the OMH Compliance Program may result in disciplinary action. Sanctions may be imposed for failing to report suspected or known compliance issues, participating in non-compliant behavior, or encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior.

6. OMH will not permit intimidation or retaliation against individuals who participate in the OMH Medicaid Compliance Program in good faith. This shall apply to all OMH employees, regardless of title or position, and includes those involved in assisting in investigations as well as those that are conducting investigations, self-evaluations, audits and remedial actions.

Test Your Knowledge - Answers

1. True

2. True

3. False. *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and which result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. *Fraud* means an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person and includes the acts prohibited by section 366-b of the Social Services Law.

Test Your Knowledge - Answers

4. True
5. True
6. True