

 Official Policy Manual	Date issued	Supersedes	Page	Section #
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	Administration			
Directive:				
Medicaid Compliance Program				
Policy Owner:				
Bureau of Audit				

A. Policy Statement

The New York State Office of Mental Health (OMH) is dedicated to ensuring a culture of compliance, honesty, and integrity. New York State Social Services Law §363-d requires providers that operate under a license issued by OMH pursuant to Article 31 of the Mental Hygiene Law, or providers which order, provide, bill, or claim \$1,000,000 from Medicaid in a 12-month period, to have an effective Compliance Program. An “effective Compliance Program” is one that satisfies all the mandatory elements in SSL §363-d as supplemented by regulations at 18 NYCRR Part 521.

The required elements include:

- implementing written policies, procedures, and standards of conduct;
- designating a Compliance Officer;
- designating a Compliance Committee;
- conducting appropriate training and education for all Affected Individuals;
- maintaining open lines of communication allowing for appropriate reporting, including anonymous reporting of compliance issues;
- enforcing disciplinary standards through written, well-publicized guidance;
- creation and enforcement of a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program;
- identifying compliance risk areas;
- conducting internal monitoring and auditing;
- annual Compliance Program review;
- monthly review for excluded providers;
- responding appropriately to detected violations and developing corrective actions; and
- ensuring compliance with all requirements of the Medicaid Program, state, and federal laws.

OMH has developed a Medicaid Compliance Program to ensure compliance with SSL §363-d and 18 NYCRR Part 521. Such program also reflects OMH’s commitment to honest and responsible conduct, decreases the likelihood of unlawful and unethical behavior at an early stage, encourages employees to report potential problems, and allows for appropriate internal investigation and corrective action. This policy directive is intended to adopt these required elements, following the recommended structure of an effective Corporate Compliance Program.

B. Purpose

The purpose of this policy directive is to codify OMH's Medicaid Compliance Program. Such program is designed to maintain the integrity of the Medicaid program by both preventing and detecting fraudulent, abusive, and wasteful practices within OMH.

C. Applicability

This policy directive shall apply 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.

D. Relevant Statutes and Standards

New York State Social Services Law §363-d
New York State Social Services Law §366-b
18 NYCRR Part 521
42 USC §1396(a)(68) (Federal Deficit Reduction Act) 31
U.S.C. 3729-3733 et seq. (Federal False Claims Act)
New York State Finance Law §§187-194 (State False Claims Act)
New York State Labor Laws §§740, 741
New York State Penal Law §175 (False Written Statements)
New York State Penal Law §176 (Insurance Fraud)
New York State Penal Law §177 (Health Care Fraud)

E. Definitions

For purposes of this policy directive:

- (1) *Affected Individuals* means all persons who are affected by the required provider's risk areas including the required provider's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.
- (2) *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.
- (3) *Compliance Program* means a proactive and reactive system of internal controls, operating procedures, and organizational policies to ensure that the rules that apply to a provider are regularly followed.
- (4) *Compliance Officer* means the designated OMH Medicaid Compliance Officer.
- (5) *Employee* means any person responsible for complying with this policy directive.
- (6) *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.
- (7) *Intimidation* means any form of coercion or threatening behavior aimed at compelling an employee not to report actual or suspected fraudulent activity.
- (8) *OMIG* means the NYS Office of the Medicaid Inspector General.

- (9) *Retaliation* means harassing, threatening to take, or taking an adverse employment action against an employee for reporting actual or suspected fraudulent activity. Examples include, but are not limited to, disciplinary action, failure to promote, reassignment, denial of time off, or ignoring or shunning an employee who has reported Medicaid misconduct.
- (10) *Waste* means the overutilization, underutilization, or misuse of resources.

F. Body of the Directive:

1. Compliance Expectations.

- (a) In addition to the statutory Code of Ethics established in NY Public Officers Law §74, all Affected Individuals shall:
- (i) exercise diligence, care, and integrity when submitting Medicaid claims for payment of services rendered;
 - (ii) maintain honest, fair, and accurate billing practices;
 - (iii) timely report allegations of suspected fraud, waste, or abuse;
 - (iv) comply with all state and federal laws, rules, and regulations, including but not limited to all requirements of the Medicaid program;
 - (v) comply with current OMH policies, procedures, administrative memoranda, accounting rules, procurement rules and internal controls;
 - (vi) refrain 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;
 - (vii) document the provision of all services and transactions in an accurate, honest and timely manner; and
 - (viii) refrain from participating in, or encouraging, directing, facilitating, or permitting non-compliant behavior.
- (b) 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 Compliance Officer. Supervisors have an obligation to report known or suspected compliance issues further up the chain of command or to the Compliance Officer.
- (c) Neither OMH, nor any employee, shall intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any employee who reports a compliance complaint or concern or for participating in any compliance-related review, investigation, proceeding, or hearing, or for engaging in reasonable opposition to any act or practice that the employee in good faith believes to be unlawful or in violation of the Compliance Program.

- (d) Failure to comply with the Compliance Program and any ensuing investigation may result in administrative action, with the application of penalties based on the severity of the violation(s) committed and may range from retraining or a reprimand through fine, suspension without pay to termination of employment. Existing disciplinary processes, as identified in Section 75 of the NYS Civil Service Law or in applicable collective bargaining agreements, will be followed for violations of the Compliance Plan. In cases where violations were committed by contract employees, OMH shall revoke the individual's privileges, refer the matter to such person's contract agency or employer for appropriate disciplinary action or may terminate its business relationship with such individual, as appropriate.

2. OMH Medicaid Compliance Officer

- (a) Responsibility for monitoring the OMH Medicaid Compliance Program shall be vested in the OMH Medicaid Compliance Officer.
- (b) Such Compliance Officer shall perform an independent oversight function within OMH and shall report no less than quarterly to the Executive Deputy Commissioner and the OMH Compliance Committee. Reporting to the Executive Deputy Commissioner shall in no way hinder the Compliance Officer from performing their duties and shall not prevent, forestall, or otherwise limit the Compliance Officer's access to and communication with the Commissioner of OMH.
- (c) The Compliance Officer shall oversee the Compliance Program for Central Office and the State-operated facilities, and is responsible for ensuring that OMH meets its statutory and regulatory requirements, and shall have the following duties and responsibilities:
 - (i) drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to federal and state laws, rules, regulations, policies and standards, a compliance work plan;
 - (ii) reviewing and revising the Compliance Program, and the written policies and procedures and standards of conduct, to incorporate changes implemented by the agency and promptly incorporate changes to federal and state laws, rules, regulations, policies and standards;
 - (iii) providing the Executive Deputy Commissioner and Compliance Committee with quarterly reports on the implementation and effectiveness of the Compliance Program;
 - (iv) communicating information to management and staff on Compliance Program requirements and agency responsibilities;
 - (v) ensuring that Compliance Program training and educational materials are reviewed and updated as necessary;
 - (vi) investigating allegations of fraud, waste, and abuse and referring matters to other parties where appropriate;
 - (vii) transmitting self-disclosure reporting on Medicaid issues where necessary to the OMIG;

- (viii) ensuring required compliance certification forms are submitted to the DOH annually; and,
 - (ix) ensuring compliance certification forms are submitted to each MMCO for which OMH is a participating provider upon signing the provider agreement with the MMCO, and annually thereafter.
- (d) OMH shall ensure that the Compliance Officer has sufficient staff and resources, including access to all records, documents, information, facilities, and Affected Individuals necessary to carry out his or her responsibilities.

3. OMH Compliance Committee

- (a) OMH shall designate a compliance committee which shall be responsible for assisting agency management in overseeing the OMH Medicaid Compliance Program and to coordinate with the OMH Medicaid Compliance Officer and OMH Counsel's Office to ensure OMH is conducting its business in an ethical and responsible manner, consistent with the OMH Medicaid Compliance Program and applicable OMH policies and legal requirements.
- (b) The compliance committee shall be governed by a committee charter.
- (c) Committee Composition
 - (i) The Committee members will be appointed by the Commissioner and shall include the Executive Deputy Commissioner, as well as senior managers from the OMH Medicaid Compliance Office and departments of finance, operations, counsel's office, and human resources. The Committee shall consist of a minimum of 7 members.
 - (ii) Committee members shall serve for such term or terms as the Commissioner may determine or until resignation or separation from state service, whichever comes earlier.
 - (iii) The OMH Commissioner will designate a Chairperson of the Committee. In addition, the Committee shall elect a Vice-Chair and Executive Secretary who shall serve for one year or until their successor(s) have been elected. The Officers of the Committee shall perform the duties ordinarily associated with their respective offices. In the absence of the Chairperson, the Vice Chairperson shall perform the duties of the Chairperson. In the absence of the Chair and Vice Chair, the Committee may elect one of its members to preside during such absence.
- (d) Meetings and Procedures
 - (i) The Committee shall meet no less frequently than quarterly in each calendar year. Additional meetings may be called upon the individual initiative of either the Commissioner or the Chairperson. Meetings may take place in-person or using teleconference technology to accommodate some or all Committee members.
 - (ii) Meetings of the Committee requiring action by the Committee shall require attendance of a quorum of appointed Committee members. A quorum shall mean

at least half of the current appointees are in attendance, exclusive of any appointees who have been removed by the Commissioner, resigned from the Committee, retired or otherwise separated from state service. For purposes of a quorum, the Chairperson and Compliance Officer shall be counted.

- (iii) The Committee may request that any employees of OMH, or other persons whose advice and counsel are sought by the Committee, attend any meeting of the Committee to provide such pertinent information as the Committee requests.
 - (iv) The Committee shall keep written minutes of its meetings, which shall be maintained in accordance with the OMH record retention policy.
 - (v) Following each of its meetings, the Chairperson or any person the Chairperson appoints shall deliver a report of the meeting to the OMH Commissioner.
 - (vi) The Committee shall review and reassess the adequacy of the Charter annually and maintain a record of the dates of such reviews and a description of revisions in the written meeting minutes or a separate document.
- (e) Committee Responsibilities
- (i) In carrying out its responsibilities, the Committee shall coordinate with the Medicaid Compliance Officer to:
 - (A) Oversee the structure, operation, and efficacy of OMH's Medicaid Compliance Program and ensure appropriate accountability for compliance with current legal and regulatory requirements.
 - (B) Ensure effective systems and processes are in place to identify compliance risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues.
 - (C) Ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other function or activity required by law.
 - (D) Ensure that the written policies and procedures, and standards of conduct as included in the OMH Medicaid Compliance Program policy are current, accurate, and complete, and that the training topics required by law are completed timely.
 - (E) Ensure that all Affected Individuals complete compliance training and education during orientation and annually.
 - (F) Review and reassess the Medicaid Compliance Program annually to ensure Compliance Program requirements have been met and to determine whether any revision or corrective action is required.
 - (G) Advocate for the allocation of sufficient funding, resources, and staff for the Compliance Officer to fully perform their responsibilities.
 - (H) Advocate for adoption and implementation of required modifications to the Compliance Program.

(ii) The Committee shall report directly to and be accountable to the Commissioner.

4. Training and Education

- (a) OMH requires all Affected Individuals to receive training on the Compliance Program, including compliance issues, expectations, and operation. Such training emphasizes OMH's commitment to compliance with all federal and state laws governing the provision and payment for Medicaid services. This includes information on False Claims and Whistleblower Protections as required by 42 USC §1396(a)(68) (Federal Deficit Reduction Act).
- (b) New employees receive compliance training within 30 days of hire. OMH's Medicaid Compliance *New Employee Training Brochure* is disseminated as part of initial compliance training to all new employees via the Statewide Learning Management System (SLMS) or for staff who do not have computer access or access to SLMS, this training is provided by the facility training office. The brochure is also available as a link from the OMH Medicaid Compliance page on the OMH Hub.
- (c) All Affected Individuals must receive annual training on OMH's Compliance Program, which is disseminated each year via SLMS or by the facility training office for those who do not have computer access or access to SLMS, including contractors.
- (d) Records of Medicaid Compliance training for all Affected Individuals shall be maintained for 15 years in accordance with OMH Records Disposition Authorization number 11682.

5. Communication Lines for Reporting Compliance Issues

- (a) An open line of communication with the Compliance Officer is critical to the successful implementation and operation of the Compliance Program. Accordingly, the Compliance Officer shall provide an open door, confidential, non-retribution assurance to all Affected Individuals and Medicaid service recipients to encourage goodfaith reporting of potential compliance issues.
- (b) In an effort to keep the communication lines to the Compliance Officer accessible to all Affected Individuals, OMH provides a variety of methods that employees and others may use to report potential compliance issues as they are identified. This includes a method for anonymous and confidential good faith reporting.
- (c) The following methods are available for reporting suspected Medicaid misconduct, which shall be detailed in training materials and on the OMH public internet page.
 - (i) Using a public-facing online submission form.
 - (ii) Discuss the question or concern with the direct supervisor (who in turn can seek assistance from the Compliance Officer, if necessary).
 - (iii) Call the Compliance Officer directly at (518) 549-5370.

(iv) Email the Compliance Officer at: Compliance@omh.ny.gov. This email address is only accessed by the Compliance Officer or program staff who have been assigned compliance responsibilities.

(v) Make a report through the U.S. mail by writing to:

OMH Medicaid Compliance Officer
NYS Office of Mental Health
Capital District Psychiatric Center
75 New Scotland Avenue, Lower Unit N
Albany, NY 12208

(vi) Contact the OMH Customer Relations Line (which is equipped with Interpret-Talk, an on-demand telephonic interpreter service that is available in real time to ensure that language is not a barrier to reporting).

Telephone: 1 (800) 597-8481; or email

https://omh.ny.gov/omhweb/email/compose_mail.php?tid=DQM

(vii) Report the matter to the OMIG at 1-877-87FRAUD (1-877-873-7283) or via their website at <https://omig.ny.gov/medicaid-fraud/file-allegation>

(viii) Report the matter to the Office of the Inspector General by phone at 1-800-DO-RIGHT (1-800-367-4448) or by email to inspector.general@iq.ny.gov.

(ix) Report the matter to the NYS Attorney General's Medicaid Fraud Control Unit at 212-417-5397.

(d) The confidentiality of persons reporting compliance issues, including but not limited to Affected Individuals and Medicaid service recipients, shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under OMH's policy for non-intimidation and non-retaliation.

6. Disciplinary Action

- (a) All Affected Individuals have a duty to report suspected or known Medicaid compliance issues to their supervisor or the Medicaid Compliance Officer 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 other type of retaliation or intimidation against individuals who participate in good faith in the Compliance Program is also prohibited.
- (b) Failure to comply with any provisions of this 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.
- (c) Disciplinary procedures are governed by the provisions of Section 75 of Civil Service Law and the collective bargaining agreements negotiated between New York State and its various bargaining units. Discipline may include administrative action (e.g., counseling and retraining) or disciplinary action (e.g., letters of reprimand, loss of

accrued leave, monetary fines, suspension without pay, demotion, termination from employment) depending 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.

- (d) Affected individuals who are not OMH employees, but serve as members of the OMH workforce, including volunteers, contractors, and vendors who fail to comply with the Compliance Program, or contractors or vendors who are determined to be excluded from participation in federal health insurance programs, may be subject to dismissal or contract termination.
- (e) The Compliance Officer shall ensure that disciplinary policies are firmly and fairly enforced to all Affected Individuals regardless of employment status, job title, salary, or contract status.
- (f) The Compliance Officer shall ensure guidance is readily available, published, and disseminated to all Affected Individuals that explains the need for compliance with the Compliance Program, identifies the duty to report, describes the potential consequences for failure to comply, and indicates that disciplinary policies shall be firmly and fairly enforced.

7. Systems for Routine Identification of Compliance Risk Areas

OMH has various processes and systems for routine identification of its risk areas, including self-evaluation, auditing and monitoring activities relating to operational compliance risk areas. The Compliance Officer shall maintain written documentation of monitoring activities, as well as a prioritized list of those identified risks. These include:

- (a) **Billing Risks**
 - (i) *Reviews of Medicaid Billing Services.* OMH periodically reviews internal billing systems to ensure that submitted claims are in accordance with regulatory and policy guidelines. Where OMH has implemented system edits to prevent billing errors, reviews are performed to ensure that the edits are working as expected.
 - (ii) *Validation of Edit Check.* OMH requests eMedNY system edits that include various rate/combination edits, as well as creation of client Restriction/Exception (R/E) codes that limit payment to OMH for those individuals authorized to receive services. OMH staff work directly with the New York State Department of Health to implement necessary eMedNY system changes.
 - (iii) *Desk Reviews.* Patient Resources senior agents conduct desk reviews of subordinate agent cases to ensure that OMH is only billing against a patient's authorized health insurance or benefits.
 - (iv) *Services Recording.* OMH uses an electronic medical record (EMR) to record patient services. The EMR provides data to the billing systems. Systems edits are in place to ensure that the billing systems pick up the relevant data necessary from the EMR to bill. Information necessary for billing includes patient movements, diagnoses, attending physicians, and services.
 - (v) *Services Recording Reports.* Reports are generated to determine when

services are appropriate to bill. Such reports include information on patient movements, diagnosis, dropped services (when services are too short to be billable), and active licenses for attending physicians.

- (vi) *Client Management Monitoring.* OMH assigns each OMH patient a State ID number that is unique to each individual. This information is contained in the agency's EMR. While the State ID is intended to prevent duplication of billings, eMedNY contains edits to further prevent duplicative payments.
- (vii) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 504.3 (Duties of Provider); 18 NYCRR Part 505 (Requirements for Specific Services); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas).

(b) Payment Risks

- (i) *Controls over Medicaid Reimbursement.* OMH utilizes various measures to monitor the accuracy of reimbursements. Monthly negative receivable reports are worked by Patient Resource agents to ensure that payments are appropriate. Reviews are on a case-by-case basis, and not all negative receivables are due to overpayment. However, in cases of overpayment, Medicaid refunds are processed automatically. Revenue Management staff perform quarterly reconciliations of claims against adjudications to determine possible over/under payments and future Medicaid claims are adjusted accordingly. In the case of denials, Patient Resource agents review cases and where appropriate, they are rebilled on a quarterly basis.
- (ii) *Controls over Salary Payments.* OMH implements controls over salary payments to ensure they are supported by accurate and properly completed time records. These controls include automated systems to ensure accurate time records, proper supervisory review of time records, and proper supervisory approval of overtime.

Most salary payments, including overtime, are submitted directly from OMH's automated time and attendance systems (LATS/ATARS). Both employees and supervisors are required to certify the accuracy of the time records on a bi-weekly basis. Responsibility for salary payments that require manual transactions is split between the Personnel Office (where a transaction is entered in the Department of Civil Service's NYSTEP system) and the Payroll or Business Office (where a corresponding transaction is entered into the New York State Comptroller's (OSC) PayServ system). Timesheets are subject to review by Human Resources Management.

- (iii) *Vendor Contract Payments.* OMH verifies the existence of a current, valid contract for each vendor/contractor which:
 - (A) is signed and dated by both parties;
 - (B) has effective beginning and end dates or termination clause;
 - (C) describes the services or goods under contract including reporting requirements;

(D) describes how invoices are to be submitted and how the vendor is to be paid; and,

(E) indicates how much the vendor is to be paid.

OMH reviews invoices to verify that services were received, the rates are in accordance with the contract, and the services are within the contract period. OMH is subject to NYS ethics and procurement laws and contracts are awarded after a careful review and in accordance with such laws, to ensure contract parties are eligible to contract with the State of New York.

- (iv) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 504.3 (Duties of Provider); 18 NYCRR Part 505 (Requirements for Specific Services); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR § 504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR Part 518 (Recovery and Withholding of Payments or Overpayments).

(c) Ordered Services

Clinicians providing services in OMH facilities may order other medical services for patients, such as laboratory testing, imaging, durable medical equipment, or specialized services, such as physical or speech or language therapy. Rarely, OMH may also provide ordered services.

- (i) *Cost-effective Services.* In order to avoid the ordering or provision of unnecessary, inappropriate, or excessive services, when OMH clinicians order or provide ordered services for patients, OMH ensures that adequate and less costly alternatives for services have been explored and, where appropriate and cost effective, are provided.
- (ii) *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 patient's medical record for all ordered services. Supporting documentation includes a clinical evaluation of the patient by the ordering practitioner relating to the ordered service.
- (iii) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR Part 505 (Requirements for Specific Services); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas).

(d) Medical Necessity and Quality of Care

- (i) *Programmatic Quality Reviews (Surveys).* The OMH Division of Quality Management maintains an annual work plan for the routine monitoring of the quality of care delivered by OMH facilities. Additionally, health and safety alerts are issued on significant or emerging health and safety related topics.
- (ii) *Incidents and Abuse.* OMH's Risk Management Unit provides real-time

oversight of critical elements of incident management across the state. This unit reviews incident reports and events to assure appropriate measures are put in place to protect individuals in care, including required notifications when appropriate. This is accomplished through the use of the New York Incident Management and Reporting System (NIMRS), which is a secure web-based statewide database. It is used to ensure consistency in incident reporting by both state operations and nonprofit providers within the OMH network.

- (iii) *Policies related to quality of care.* OMH maintains an official OMH Policy Manual, which includes policies related to quality of care.
- (iv) *Medical Necessity.* As part of OMH's compliance activities, facility personnel conduct admissions reviews and continued stay reviews as part of their ongoing monitoring process. The admissions review determines if the medical appropriateness of the admission has been sufficiently established through a review of the medical record. The appropriateness of a patient's continued stay is reviewed periodically through review of medical record documentation.
- (v) *Governing Law.* 42 CFR § 482.13 (Use of Restraint and Seclusion in the Medicaid Program); MHL Article 31 (Regulation and Quality Control of Services for the Mentally Disabled); MHL §§ 31.30, (Abuse and Neglect Involving Vulnerable Persons), 33.03 (Authority to Promulgate Regulations on Quality of Care), 33.04 (Use of Restraint and Seclusion in Facilities Under OMH Jurisdiction); SSL Article 11 (Protection of People with Special Needs); SSL § 363-D (Medicaid Provider Compliance Program); 14 NYCRR Part 526 (Use of Restraint and Seclusion); 14 NYCRR Part 527 (Rights of Patients); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR § 504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas).

(e) Governance

- (i) OMH's Central Office organizational structure consists of a Commissioner and Executive Deputy Commissioner, with a leadership team in place. State operations directors are members of the leadership team, as are Central Office Deputy Commissioners. Psychiatric facilities within OMH have a governance team consisting of the executive directors, deputy directors, and key senior staff (which include quality management staff).
- (ii) *Governing Law.* MHL §§ 7.11 (Organization and Administration of the Office of Mental Health and Its Facilities); 7.19 (Personnel of the Office); SSL § 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas).

(f) Mandatory Reporting

- (i) OMH has various processes and systems for identifying improper payments and reporting to the Centers for Medicare and Medicaid Services (CMS) as well as state control agencies. For instance, OMH participates in an annual independent certified audit which determines if Medicaid Disproportionate Share payments are accurate. If not, funds are returned to CMS. Other reports include the Agency Financial Reporting Package for OSC which reports on OMH accounts receivable (including Medicaid and Medicare) and includes an explanation for variances between reporting periods. OMH also provides

financial information reports with detailed information on revenue tracking which include Medicaid and Medicare to OSC and the NYS Division of Budget within the Executive Chamber.

- (ii) *Governing Law.* SSL § 363-D (Medicaid Provider Compliance Program); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR Part 518 (Recovery and Withholding of Payments or Overpayments); 18 NYCRR §504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas).

(g) Credentialing

- (i) Consistent with the OMH Credential Verification Policy, facility and Central Office personnel offices, program area managers, and/or the Facility Privileging & Credentialing committees review and verify documentation and other resources to ensure that candidates foremployment meet the minimum qualifications for appointment and thatstaff maintain required licenses and credentials for the duration of employment.
- (ii) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 504.3 (Duties of Provider); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR § 504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR § 515.3 (Authority to Sanction); 18 NYCRR § 515.7 (Immediate Sanctions); 18 NYCRR § 515.8 (Mandatory Exclusions).

(h) Contractor, Subcontractor, Agent, or Independent Contract Oversight.

- (i) Contractors are provided with the OMH Medicaid Compliance Program and Affected Individuals are required to complete the OMH Medicaid Compliance training upon contract approval and annually thereafter. Contractors agree to contract terms requiring the determination of the exclusion status of any person who provides services (as defined by the contract) and any persons with an ownership or control interest, as defined in 42 C.F.R. Section 455.101, through at least monthly checks by the contractor of the New York State Office of the Medicaid Inspector General Exclusion List; and Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE), and through at least annual checks by the contractor of the Social Security Administration's Death Master File; the National Plan and Provider Enumeration System (NPPES); and the Excluded Parties List System (EPLS).
- (ii) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 504.3 (Duties of Provider); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR § 504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR § 515.3 (Authority to Sanction); 18 NYCRR § 515.7 (Immediate Sanctions); 18 NYCRR § 515.8 (Mandatory Exclusions).

(i) Excluded Provider Screening

- (i) *New Employees.* OMH screens all prospective employees against state and federal exclusion lists before extending a conditional offer of employment. Facilities are instructed to contact the OMH Center for Human Resources

Management immediately if a prospective employee is identified as being an excluded provider. A conditional offer of employment cannot be extended to any individual identified as being an excluded provider on any state or federal exclusion list.

- (ii) *Current Employees.* OMH sends a comprehensive list of its current employees to OMIG for screening against state and federal exclusion lists. In the event that a current employee is identified as an excluded provider, the OMH Center for Human Resources Management works with the identified employee's facility, Counsel's Office, and the Compliance Officer to take appropriate action to ensure that the individual is not providing services for which OMH obtains reimbursement from federal health insurance programs.
- (iii) *Vendors.* New vendors are either screened by OMH, in the case of direct care staff, or are required to submit an attestation indicating that the vendor has completed the requisite exclusion screening. The OMH boilerplate contract, which is used for nearly all contracts for goods and services, contains language requiring compliance with exclusion screening procedures. OMH will not make employment or contract offers to an individual or business that is verified to be excluded from participation in federal health insurance programs.
- (iv) Excluded provider screenings shall be conducted monthly and shared directly with the Compliance Officer and other compliance staff as appropriate.
- (v) *Governing Law.* Social Services Law 363-D (Medicaid Provider Compliance Program); 18 NYCRR § 504.3 (Duties of Provider); 18 NYCRR § 515.2 (Unacceptable Practices); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR Part 517 (Provider Audits); 18 NYCRR § 504.8 (Audit and Claim Review); 18 NYCRR § 521-1.3 (Compliance Program Risk Areas); 18 NYCRR § 515.3 (Authority to Sanction); 18 NYCRR § 515.7 (Immediate Sanctions); 18 NYCRR § 515.8 (Mandatory Exclusions).

8. System for Promptly Responding to Medicaid Compliance Issues

- (a) As part of OMH's commitment to foster a culture of compliance and to support the integrity of the Medicaid program, OMH has established procedures for promptly responding to Medicaid compliance issues as they are raised. Under the direction of the Compliance Officer, all complaints and allegations of Medicaid misconduct, fraud, waste, and abuse will be reviewed and investigated.
- (b) Reports regarding known or suspected Medicaid misconduct will be logged, even if made anonymously. Each such report will be referred either to Customer Relations Line staff or the Compliance Officer to determine if the complaint involves OMH's operations as a provider of Medicaid services. If so, these complaints remain the responsibility of the Compliance Officer.
 - (i) Complaints or reports regarding program operations, quality issues, or allegations of abuse or neglect should be referred to the Division of Quality Management for appropriate follow up.
 - (ii) Complaints or issues received involving OMH licensed providers should

be referred to the Bureau of Inspection and Certification for investigation or to the OMIG or other appropriate external parties or agencies, depending upon the specific nature of the issue.

- (c) The Compliance Officer must review, log, and investigate all reports of known or suspected Medicaid fraud, waste or abuse in OMH operated facilities. The Compliance Officer shall collaborate as appropriate with other OMH staff, including the applicable facility director, the Director of the Division of Quality Management, the Chief Fiscal Officer, Bureau of Internal Affairs, Bureau of Audit, Office of Counsel, or others, depending on the specific nature of the issue.
- (d) If, at any time in an investigation, it appears that a crime may have been committed, it must be referred to the Bureau of Internal Affairs. The Bureau of Internal Affairs may consult with Human Resources Management, Bureau of Employee Relations, Bureau of Audit or other state or federal agencies as appropriate.
- (e) Staff in the OMH State Operations Finance Group (SOFG) have responsibility for entering charges, credits, processing claims, and reconciling accounts. SOFG staff are required to comply with applicable rules and their supervisors monitor their compliance with these rules.
 - (i) In cases where routine billing and claiming issues are discovered by SOFG, staff may investigate and remedy without formal reporting to the Compliance Officer. However, when waste, fraud, abuse or systemic errors are identified, SOFG must report the issue to the Compliance Officer within five business days of discovery, whether or not the issue is resolved by the SOFG. The Compliance Officer will advise if the claims should be voided, if they have not already been voided, and whether self-disclosure to the OMIG is required. The Compliance Officer may also recommend the agency conduct an audit depending upon the nature of the issue.
 - (ii) When routine cases of incorrect payments (not suspected to be systemic issues or related to waste, fraud, abuse) are discovered by Patient Resource agents, in coordination with the supervising senior agent, they must implement any necessary corrective actions to mitigate errors. In cases of overpayment, the agent and senior agent complete and submit a refund request form. In cases of refunds that meet a certain dollar threshold, the form is approved by the supervising assistant patient resources director in the field. The forms are issued to the SOFG's Central Revenue Unit for processing, and refund checks are signed by two designated officials. In accordance with 42 U.S.C. § 1320a-7k(d), the unit reports and returns overpayments by the latter of the date a corresponding cost report is due, or 60 days after identification and also notifies the state's intermediary of the reason for the overpayment. In cases of refund over a certain dollar threshold, OSC is also notified.
 - (iii) In cases suspected to be waste, fraud or abuse, the Bureau of Patient Resources Director will consult with the Director of Billing Operations. Billing Operations will perform a limited fiscal audit, and in concert with Patient Resources, recommend corrective action(s) to their shared principal, the director of SOFG. The Directors of Billing Operations and Patient Resources will seek guidance from the director of the SOFG on next steps. The Compliance Officer will be informed, shall determine if any self-disclosure to

the OMIG is required and, if so, work with all involved parties to ensure appropriate reporting.

- (f) OMH shall correct all compliance issues promptly and thoroughly to reduce the potential for reoccurrence.

9. Non-Intimidation and Non-Retaliation

- (a) OMH will not permit intimidation or retaliation against individuals who participate in the 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.
- (b) If an Affected Individual or other person participating in the Compliance Program believes that he or she has been retaliated against for reporting a Medicaid compliance issue or concern, for participating or assisting in any investigation of such a report or complaint, or assisting with remedial action related to a complaint, the Affected Individual should report the retaliation to his or her supervisor or to the Compliance Officer. Other individuals including, but not limited to services recipients should report any retaliation to the Compliance Officer. It is the responsibility of the Compliance Officer to investigate allegations of intimidation/retaliation and to report such instances up the chain of command.
- (c) Notwithstanding the non-intimidation, non-retaliation policy, discipline can be imposed on Affected Individuals who report in bad faith and seek to use the Compliance Program for self-interested motives in accordance with section six of this policy.
- (d) OMH shall post information relating to federal and New York statutes relating to false claims, and whistleblower protections provided by federal and state laws on the OMH Hub and will make information available to facility human resources offices.