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TO: **Memo Distribution List**

FROM: Hinman Straub P.C.

RE: OMIG Proposed Rule amending 18 NYCRR Part 516 to address 2021 Budget's Medicaid Program Integrity Amendments

DATE: August 12, 2020

NATURE OF THIS INFORMATION: This memorandum solicits your comments or responses on new proposals or pending action.

DATE FOR RESPONSE OR IMPLEMENTATION: September 4, 2020

HINMAN STRAUB CONTACT PEOPLE: Jennie Shufelt and Raymond Kolarsey

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #9 Medicaid and Medicare Suggested Key Word(s):

In April 2020, as part of New York State's Fiscal Year 2021 Budget (the "2021 Budget"), the Legislature made several changes to the New York Social Services Law ("SSL") that were designed to strengthen Medicaid program integrity efforts and combat fraud, waste and abuse in the Medicaid program. These changes included new operational and programmatic requirements for Medicaid managed care ("MCO") and managed long term care ("MLTC") plans, modifications to Medicaid compliance program requirements for Medicaid plans and providers, and the expansion of the Office of the Medicaid Inspector General's ("OMIG") oversight and sanctioning authority over plans and providers. Our prior memorandum summarizing these statutory changes is **attached**.

On July 15, 2020, OMIG published a notice of proposed rulemaking in the New York State Register, setting forth proposed amendments to 18 NYCRR Part 516 (the "Proposed Rule"). The Proposed Rule sets forth the notice and hearing requirements that would apply to the newly authorized sanctions and penalties. The Proposed Rule also defines certain terms used in the newly amended SSL §§ 145-b(4), 363-d and 364-j(38).

Comments on the Proposed Rule are due 60 days after publication in the NYS Register (since the 60-day period expires on a Sunday, comments would be due by close of business on Monday, September 14, 2020).

As described below, while the Proposed Rule largely reflects current statutory requirements and/or current OMIG processes, we believe the proposed 5% threshold for determining that a violation of Medicaid program requirements has occurred in a "substantial number of cases" is too low and could result in significant monetary penalties. As such, we will be submitting comments on this issue. **If you have any concerns with any other provisions of the Proposed Rule, please let us know no later than Friday, September 4th.**

This memorandum summarizes the proposed amendments to 18 NYCRR Part 516 set forth in the Proposed Rule.

SUMMARY OF PROPOSED RULE

The Proposed Rule repeals and replaces 18 NYCRR Part 516 to outline the notice and hearing rights afforded to Medicaid plans and providers facing potential sanctions and penalties under the amended SSL §§ 145-b(4), 363-d or 364-j(38), and to define certain terms used in the SSL amendments.

The notice and hearing rights would apply to the imposition of monetary penalties for the following statutory violations:

- Violations of N.Y. SSL § 145-b(4), which allows for the imposition of monetary penalties against persons who (1) fail to comply with standards of the Medicaid program or generally accepted medical practice, either in a substantial number of cases or in a gross and flagrant manner, and (2) (i) receive or cause payment from the Medicaid program for services that the person knew or should have known were improper, unnecessary or excessive, not provided or not provided as claimed, or ordered, prescribed

or furnished by a suspended or excluded provider; (ii) failed to grant timely access to facilities and records to OMIG, the Attorney General's Medicaid Fraud Control Unit, or the Department of Health; (iii) failed to report and return an overpayment in accordance with OMIG's self-disclosure program (set forth in NY SSL § 363-d, as amended) within 60 days of the date the person knew or should have known of the overpayment; or (iv) arranged or contracted with an excluded or suspended provider.

- Failing to adopt and maintain an effective compliance program in accordance with NY SSL §363-d; and
- Violations of N.Y. SSL § 364-j(38), which authorizes penalties against managed care providers and managed long-term care plans for submitting cost reports that contain misstatements of fact, such as unsubstantiated or improper costs, number of member months, or number of events.

These aspects of the Proposed Rule are discussed in more detail below.

Procedure for Imposition of Sanctions and Penalties

As noted above, the Proposed Rule sets forth the notice and hearing protections afforded to plans and providers before OMIG can impose a sanction or monetary penalty authorized under SSL §§ 145-b(4), 363-d or 364-j(38). These processes, outlined in more detail below, are similar to the processes followed by OMIG during the completion of routine audits.

Step 1: Notice of Proposed Agency Action. In the event that OMIG determines that the imposition of a monetary penalty is warranted, OMIG must provide the plan or provider with written notice of proposed agency action ("NOPAA"). The NOPAA must be in writing, mailed to the plan or provider, and contain sufficient detail to put the plan or provider on notice of the basis of such action (e.g. description of alleged violation(s), supporting facts, amount of penalty, legal authority) and information on how to object.

Step 2: Objection to Notice of Proposed Agency Action. A plan or provider has thirty days from receipt of a NOPAA to object to the imposition of the penalty (subject to possible extension for good cause). Receipt is presumed to have occurred five days after mailing. Objections must be made in writing and the basis of such objections must be set forth in detail. Similar to the OMIG audit process, it is critical for a plan or provider to put forward any and all factual and legal arguments, and provide all supporting documentation that it believes supports its arguments, in response to a NOPAA. A plan or provider will be limited to the factual and legal arguments and documents submitted in response to a NOPAA in the event of a hearing before an administrative law judge. Plans and providers are strongly encouraged to work with counsel in preparing such objections.

Step 3: Notice of Agency Action. If, after considering all factual and legal arguments and documentation submitted by a plan or provider in response to a NOPAA, OMIG concludes that a penalty is warranted, OMIG will send the plan or provider a written notice of agency action ("NOAA"), with details about the violation, its factual and legal basis, the effective date of the penalty (at least 20 days from the date of the notice), and a provider's hearing rights.

Step 4: Administrative Hearing. Plans and providers that receive a NOAA from OMIG, confirming OMIG's determination to impose monetary penalties under SSL §§ 145-b(4), 363-d or 364-j(38), have the right to request an administrative hearing. The procedures for requesting such a hearing must be outlined in the NOAA. Administrative hearings under Part 516 will be conducted in accordance with the hearing procedures set forth in 18 NYCRR Part 519.

Step 5: Effect and Enforcement of the Penalty. The Proposed Rule makes clear that imposition of a monetary penalty pursuant to SSL §§ 145-b(4), 363-d or 364-j(38) does not negate the imposition of any other penalty authorized by Federal or State law, or any other fines, penalties or administrative actions by the N.Y. Department of Health. Interest will accrue on the amount of the monetary penalty beginning on the 90th day after the date of OMIG's written NOAA. Should the plan or provider fail to pay the penalty imposed, OMIG may recover the amount of the penalty by following processes authorized by statute, such as through withholdings from future Medicaid payments.

Definitions in Proposed Rule Increase Risk of Penalties

The Proposed Rule sets forth definitions of the following terms used in SSL §§ 145-b(4), 363-d and/or 364-j(38):

- "Encounters";
- "Failure to Grant Timely Access to Records and Facilities";
- "Item or service";
- "Office of the Medicaid Inspector General" or "OMIG";
- "Person";
- Standards of generally accepted practice";
- "Standards of the MA Program"; and
- "Substantial number of cases".

Most of these definitions are relatively straightforward and do not have a significant substantive impact on plans and providers. However, the definition of "substantial number of cases" added by the Proposed Rule could, if adopted, have a significant impact on the meaning and scope of the expanded monetary penalties and sanctions provided for in SSL § 145-b.

SSL § 145-b(4), as amended by the 2021 Budget, authorizes OMIG, in consultation with DOH, to impose monetary penalties of up to $10,000 for each item or service (or $30,000 for each item or service, in the event of a prior penalty within the preceding 5 years) if (1) a person (a) fails to comply with the standards of the medical assistance program or standards of generally accepted medical practice in a "**substantial number of cases**" or (b) grossly and flagrantly violates such standards, and (2) the person commits one of certain enumerated acts, such as (i) knowingly receiving or causing payment from the Medicaid program for care, services or supplies that were medically improper, unnecessary or excessive, not provided as claimed; ordered, prescribed or furnished by a suspended or excluded provider; or not provided at all, (ii) failing to grant timely access to facilities and records, upon reasonable notice, to governmental oversight agencies for the purpose of audits, investigations, reviews, or other statutory functions, (iii) failing to report or return an overpayment that the person identified or should have identified, reported and returned;

or (iv) contracting with an excluded or suspended provider for activities related to the Medicaid program.

Thus, under SSL § 145-b(4), a penalty cannot be imposed unless the plan or provider fails to comply with the requirements of the Medicaid program or standards of generally accepted medical practice, and such noncompliance either occurs in a "substantial number of cases" or constitutes a gross and flagrant violation. However, the Proposed Rule includes a broad definition of "substantial number of cases," defining such term to mean "five percent or more of those claims, encounters, or cases identified in any audit, investigation or review, or any sample of cases which were the subject of an audit or otherwise reviewed by the department and for which claims were submitted by a person for payment under the MA program."

Under this definition, if OMIG discovers a violation of a Medicaid program requirement during a routine audit that occurs in five percent or more of claims included in such audit, and determines that the plan or provider either knew of the error or should have known of the error, or that the plan or provider did not grant timely access to its records, OMIG has the authority to impose penalties of up to $10,000 per claim ($30,000 per claim if prior penalties have been imposed).

Plans and most providers participating in the Medicaid program have an obligation, pursuant to N.Y. SSL §363-d, to have an effective compliance program in place that proactively monitors and audits compliance with applicable Medicaid rules and reports and returns overpayments that are identified as a result of such monitoring and auditing activities. Providers that do not have an operational, effective compliance program in place risk a determination by OMIG that the provider "should have identified" the issues found as part of a routine audit. If those issues exist for 5% or more of the claims, SSL § 145-b(4) penalties could be imposed.

It is important to note that even if a compliance program did not identify the particular error at issue in an OMIG audit, providers that can demonstrate the existence of a robust compliance program that regularly audits claims, is actively promoted by the governing authority and senior management, provides routine compliance training, uses disciplinary action and corrective actions to address instances of noncompliance, and has a demonstrated history of reporting and returning overpayments, will be in a much stronger position to defend against a claim that they "should have identified" the particular issue found during the audit, a necessary prerequisite to the imposition of a penalty under SSL § 145-b(4) for failing to report and return an overpayment.

Conclusion

We will continue to monitor the Proposed Rule and will advise you of any changes to the Proposed Rule upon adoption.

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TO: **Memo Distribution List**

FROM: Hinman Straub P.C.

RE: New York State Fiscal Year 2021 Budget Amendments to Program Integrity Provisions Impacting Medicaid Providers

DATE: May 28, 2020

NATURE OF THIS INFORMATION: This is information explaining new requirements you need to be aware of or implement.

DATE FOR RESPONSE OR IMPLEMENTATION: April 1, 2020

HINMAN STRAUB CONTACT PEOPLE: Jennie Shufelt and Raymond Kolarsey

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #9 Medicaid and Medicare Suggested Key Word(s):

Most providers that participate in New York State's Medicaid Program are required, under Social Services Law ("SSL") § 363-d and the implementing regulations at 18 NYCRR Part 521, to adopt and implement an effective compliance program, and to certify annually that such a program is in place. N.Y. SSL § 363-d; 18 N.Y.C.R.R. § 521.3. To satisfy SSL § 363-d, a provider's compliance program must incorporate several programmatic elements, set forth in Section 363-d, and must be effective in practice.

On April 2, 2020, Governor Andrew Cuomo and legislative leaders announced an agreement on the budget for New York State's Fiscal Year (SFY) 2021, covering 2020-21 (the "2021 Budget"). The 2021 Budget included several changes to SSL § 363-d, both with respect to the substantive requirements of a compliance program, and potential financial consequences and penalties for failing to have an effective compliance program in place.

Given the increasing focus on provider compliance programs by the Legislature, coupled with the new sanctioning authority granted to the New York State Office of the Medicaid Inspector General ("OMIG"), the agency charged with oversight of provider compliance with SSL § 363-d, Medicaid providers should review their compliance programs and make any modifications necessary to address these changes, and routinely evaluate their programs to confirm that they are effective in practice.

Changes to Compliance Program Requirements

To satisfy SSL § 363-d, a provider's compliance program must incorporate several programmatic elements, and must be effective in practice, as determined by OMIG. The 2021 Budget makes several important changes to the substantive compliance program requirements as set forth in SSL § 363-d. Most of these changes were intended to align New York's compliance program requirements with federal requirements applicable to managed care plans and other federal compliance program guidance. These changes, which are effective as of April 1, 2020, are discussed in more detail below.

Required Policies and Procedures

The 2021 Budget makes several modifications to the first statutorily required element of a compliance program: written compliance policies and procedures. First, the 2021 Budget integrates the requirement for a non-retaliation and non-intimidation policy, which was previously a separate element, into the "written policies and procedures" element.[1] In addition, the amendments broaden the scope of the protected activities that must be covered by the non-intimidation/non-retaliation policy. Previously, SSL § 363-d required that a provider's non-intimidation/non-retaliation policy protect persons for reporting to appropriate officials "as provided in sections seven hundred forty and seven hundred forty-one of the labor law." The reference to the labor law provisions has been removed, thereby expanding the required protection to any report to government officials. This would, for example, protect reporting to OMIG or the Medicaid Fraud Control Unit ("MFCU"), the Department of Health, the Department of Labor, or

[1] While this is not, in and of itself, a substantive change to the requirement, we generally recommend that providers organize and structure their compliance plans by the statutory elements. As such, providers may want to revise their compliance plans to follow this new organizational structure.

any other governmental agency. Providers should revise their non-intimidation/non-retaliation policies to be consistent with this language.

Second, the 2021 Budget specifically requires that compliance policies articulate the organization's commitment to comply with all applicable federal and state standards. While most providers already include language to this effect in their compliance plans and codes of conduct, providers should review their plans to ensure that this commitment is clearly stated now that it is a requirement of the law.

Third, providers are now required to include policies and procedures to address the requirements of the 2005 Deficit Reduction Act ("DRA"). The DRA requires any entity that receives or makes at least $5,000,000 in Medicaid payments, as a condition of receiving such payments, to (A) establish written policies that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and (C) include such information in any employee handbooks. While the DRA requirement itself is not new, because of the additional sanctions available for noncompliance with SSL § 363-d (discussed below), providers now risk additional sanctions for failing to comply with the DRA requirements. Providers should confirm that they have adopted written DRA policies, and that such policies are identified in the provider's compliance plan as one of the provider's written compliance policies.

Finally, provision of services by personnel with appropriate credentials and training who are not excluded from participation in the Medicaid program is critical to billing and payment integrity and, thus, an effective compliance program. Provider compliance plans should, thus, include written policies and procedures to ensure that all employees providing services to Medicaid beneficiaries meet all applicable requirements for providing such services and billing the Medicaid program. These include policies requiring monthly excluded provider checks, licensing verification and credentialing, and policies requiring confirmation that employees providing services have received all required certifications and training and met all other statutory or regulatory requirements. The 2021 Budget amends SSL § 145-b to add new penalties – up to $10,000 per violation (or up to $30,000 per violation if a previous violation has occurred within the past five years) -- for employing or contracting with an excluded person or entity. As such, all providers should confirm that they have policies and processes in place to check all employees and contractors involved in service provision or billing for exclusions.

In addition, the 2021 Budget amended Public Health Law § 3613 to add a new subdivision 1-a, which requires every home care services worker, personal care aide, and personal assistant to obtain an individual unique identifier from the state on or before a date to be determined by the commissioner of health in consultation with OMIG. LHCSAs, CHHAs, and Fiscal Intermediaries should modify any written policies addressing home health aide, personal care aide, and personal assistant certification and training requirements to require such persons to obtain a unique identifier as required.

Compliance Officer Requirements

The 2021 Budget changes the requirements related to the compliance officer by eliminating the language requiring that the compliance officer periodically report directly to the board of directors. However, as this is still currently a requirement set forth in OMIG's implementing regulations, such reporting remains a requirement for a provider compliance program at this time. Further, it remains a best practice to keep the governing body apprised of the operation of the compliance program so that the governing body can properly monitor its effectiveness. Thus, we would not recommend changing this practice, not withstanding the removal of this language.

The 2021 Budget also removes the language expressly permitting the compliance officer to have other duties, although such language remains in OMIG's regulations, and is not expressly prohibited by the amended SSL § 363-d. Thus, it appears that a compliance officer can continue to have other duties, provided that the compliance officer dedicates sufficient time to the compliance function to effectively implement the compliance program.

Finally, as amended, SSL § 363-d now requires providers to have a compliance committee, in addition to the compliance officer, to oversee the compliance program. Given that the establishment of such a committee is best practice, many providers already have compliance committees in place. However, providers that have not established a compliance committee should incorporate such a committee into their programs. The size, composition, and frequency of meetings will likely vary by provider type and size.

Compliance Training

The 2021 Budget also makes minor modifications to the training requirements for a provider compliance program. Specifically, SSL § 363-d, as amended, now requires that training be provided to the compliance officer, as well as employees, senior management and governing body members. Many compliance officers provide training internally for the organization. However, providers will now have to make sure that the compliance officer himself/herself also receives compliance training.

In addition, the Legislature has now specified that compliance training must be provided at orientation for new hires and at least annually. Previously, SSL § 363-d only required that such training be provided "periodically." While many providers already adhere to best practices and provide training annually, providers should review their compliance plans and training program frequency to ensure that training is being provided at orientation for new employees or at appointment for new executives, managers or governing body members, and on at least an annual basis for existing employees, executives, managers, and governing body members.

Lines of Communication

The amended SSL § 363-d expands the requirements for "lines of communication" with the compliance function to require the "[e]stablishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the organization's employees, managers and governing body, and the

organizations first tier, down-stream, and related entities." Previously, this component of SSL § 363-d only referenced effective lines of communication to the compliance officer. This change appears intended to strengthen reporting and communication within the organization and with downstream contractors, about compliance-related issues and reporting of non-compliance, and to ensure confidentiality in those communications. We recommend that providers implement or strengthen processes to document compliance issues reported to the compliance officer, and how they are reported and reviewed by the compliance committee and governing body, to demonstrate that effective lines of communication are in place. Providers should also ensure that lines of communication with the compliance function are in place and accessible to contractors.

Disciplinary Policies

Prior to the amendment to SSL § 363-d, providers were required to have in place "disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; or (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced." The 2021 Budget amended this subsection by deleting the specific categories of actions for which sanctions must be outlined. However, these requirements are still set forth in OMIG's implementing regulations. Thus, unless OMIG promulgates amended regulations, disciplinary policies should continue to reference these categories of activities as being subject to the disciplinary policy.

In addition, consistent with federal regulations and guidance, SSL § 363-d now states that the disciplinary policies must be "well-publicized." At a minimum, providers should ensure that their written compliance plans clearly articulate the organization's disciplinary policy with respect to compliance responsibilities, distribute that plan as part of compliance trainings, and specifically discuss that disciplinary policy during such trainings.

The remainder of the required elements remain largely unchanged at this time. Providers should be aware, however, that OMIG is likely to amend its implementing regulations to incorporate these changes, which may necessitate further review and revision of compliance programs to address such potential amendments.

Increased Consequences of Failing to Have an Effective Compliance Program

As noted above, OMIG is responsible for evaluating and enforcing the requirements of SS § 363-d. OMIG is permitted to impose "any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program," if it finds that a provider does not have a satisfactory compliance program in place. 18 N.Y.C.R.R. § 521.4. To carry out its oversight responsibilities, OMIG's Bureau of Compliance conducts compliance plan reviews. To date, the Bureau of Compliance's approach to these reviews has largely been to request that a provider complete an evaluation tool and submit supporting documentation (e.g. compliance plan, policies and procedures), issue a report identifying any insufficiencies that were found, and direct the provider to correct such deficiencies. OMIG has not routinely imposed sanctions or penalties as a result of such reviews.

The 2021 Budget, however, includes several provisions that increase the likelihood a provider that fails to implement and maintain an effective compliance program could face substantial consequences:

- First, the 2021 Budget amended SSL § 363-d(2) to make the adoption and implementation of a provider compliance program "a condition of payment from the medical assistance program." As a result of this change, OMIG has clear authority to recoup all Medicaid payments received by a provider during a period for which it determined the provider did not have an effective compliance program in place. This change took effect as of April 1, 2020.
- Second, the Final Budget amends SSL 363-d to explicitly authorize OMIG to impose a monetary penalty of $5,000 per month, up to twelve months, for the failure to adopt and implement a compliance program that meets statutory requirements. The penalty increases to $10,000 per month, for up to twelve months, if a penalty was previously imposed within the past five years. These penalties are available for compliance program reviews conducted on or after January 1, 2021.
- Third, as discussed below, OMIG is authorized to impose monetary penalties on any provider that fails to report and return an overpayment within 60 days of its identification (or date a cost report is due, if applicable), under SSL § 145-b. Penalties can be imposed when a provider "has or should have through the exercise of reasonable diligence, determined that [it] has received an overpayment and quantified the amount of the overpayment." § 363-d(6)(b). Thus, if OMIG determines that a provider should have identified an overpayment through reasonable diligence, such as through required internal audits or other compliance activities, substantial monetary penalties could attach. This change took effect as of April 1, 2020.

OMIG Self-Disclosure Program

Providers participating in New York's Medicaid program are required, by virtue of the 2010 Affordable Care Act, to report and return overpayments within sixty days of identification (or date a corresponding cost report is due, if applicable). For New York Medicaid providers, reporting and returning Medicaid overpayments has historically occurred through a self-disclosure program implemented by OMIG. The 2021 Budget added provisions to SSL § 363-d to codify this self-disclosure program, with certain modifications. These provisions were effective as of April 1, 2020. For the most part, this new statutory language is consistent with OMIG's existing self-disclosure program. However, providers should be aware of certain important changes that have been enacted with respect to eligibility, process and potential sanctions.

As codified, OMIG, in consultation with DOH, will continue to administer the voluntary self-disclosure program. In order to be eligible for the self-disclosure program: (1) the provider must not currently be under audit, investigation or review unless the overpayment does not relate to the audit, investigation or review; (2) the overpayment being disclosed has not already been determined, identified, calculated, or researched by OMIG; (3) the overpayment is reported within 60 days of its identification or by the date the cost report is due, if applicable; and (4) the provider is not a party to a criminal investigation by MFCU or an agency of the United States.

To report an overpayment through the self-disclosure program, a provider must submit a self-disclosure statement containing all information required by OMIG. The deadline for returning the overpayment is tolled if OMIG acknowledges receipt of a self-disclosure submission until (1) a self-disclosure compliance agreement is executed, (2) the provider withdraws from the self-disclosure program, (3) the provider repays the overpayment plus interest, or (4) the provider is removed from the self-disclosure program by OMIG. In addition, the deadline may be tolled where the provider and OMIG enter into a repayment program and timely payments pursuant to that program are being made. Return of the overpayment is due within fifteen days after OMIG notifies the provider of its determination of amount due. Any overpayment retained after the deadline can be subject to monetary penalties for not returning an overpayment.

OMIG may waive interest on an overpayment reported and returned pursuant to the self-disclosure program. In addition, good faith participation in the self-disclosure program may be considered as a mitigating factor in an administrative enforcement action. OMIG is also authorized to enter into an installment plan with a provider for repayment of the overpayment if the provider can establish that it cannot make immediate full payment. Additionally, OMIG is authorized to require providers to enter into a compliance agreement requiring future compliance with Medicaid requirements. A provider will be removed from the self-disclosure program if they (1) provide misstatements or omissions of material information in the provider's submission to OMIG, (2) attempt to evade an overpayment due under the self-disclosure compliance agreement, (3) fail to comply with the self-disclosure compliance agreement, or (4) refuse to execute the self-disclosure compliance agreement.

As noted above, OMIG is authorized to impose penalties if a provider knew or should have known that it had received an overpayment but does not report, return and explain it within 60 days in accordance with the self-disclosure process established by SSL § 363-d. The limit for monetary penalties assessed for retaining an overpayment is not to exceed $10,000 for each item which was the subject of OMIG's determination. If a provider has previously been penalized within the past 5 years, the penalty shall not exceed $30,000 for each item. The 2021 Budget also removes language limiting the amount of an overpayment that may be recovered to the amount paid for such claim.

As a result of these changes, providers that fail to implement a compliance program that contains an effective system for investigating potential non-compliance, conducting internal audits, and timely reporting and returning any identified overpayments within the applicable timeframe through OMIG's self-disclosure process, risk substantial monetary penalties, in addition to recoupment of overpayments.

Implications for OMIG Audits

The emphasis placed on provider compliance programs and self-disclosure of overpayments in the 2021 Budget, coupled with the increased sanctioning authority of OMIG, suggests that OMIG may begin scrutinizing provider compliance programs and internal auditing processes as part of routine claims audits. OMIG could begin imposing monetary penalties, in addition to payment recoupment, as part of these audits. Of note, SSL § 145-b(4) previously limited the availability of monetary penalties when less than 25% of the claims subject to an audit result in an overpayment. That

limitation has now been removed. Monetary penalties can also be imposed for the failure to grant timely access to facilities and records, upon reasonable notice, for the purpose of audits, investigations, or reviews.

Conclusion

In light of the significant changes to SSL § 363-d, and the expansion of OMIG's authority to sanction providers, we recommend all providers review and modify their internal compliance programs as necessary to address the changes discussed above.