New York State Office of the Medicaid Inspector General 2024 Work Plan

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OMIG 2024 Work Plan Overview

- In January 2024, the New York State Office of the Medicaid Inspector General (OMIG) posted its 2024 Work Plan.
  - The Work Plan provides insight into OMIG's initiatives planned for the year.
  - This is the first Work Plan released since the 2019-2020 Work Plan.
- It is not an exclusive list of all activities that OMIG will conduct, but it does provide a roadmap of the OMIG's areas of focus for the year.
- OMIG invites input from stakeholders, which can be provided via email at information@omig.ny.gov.

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OMIG's Areas of Focus

This Webinar features the following Areas of Focus included within the Work Plan:

- Compliance Program Reviews
- Self-Disclosures
- Healthcare Worker Bonus
- Provider Audits
- Third Party Liability Match
- Recovery Audit Contract (RAC) Reviews
- Investigations
- System Match
- Pharmacy/Drug Diversion
- Collections

- Other Areas of Focus listed in the Work Plan include:
  - Medicaid Managed Care Audits and; and
  - Estate/Medicaid Liens Reconciliations

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Compliance Program Reviews: What to Expect

- OMIG will continue to conduct compliance program reviews to assess whether a Medicaid provider's compliance program is implemented and operating as required.
- OMIG commenced provider compliance program reviews in July 2023 to review compliance with the updates to the part 521 regulations.
- The reviews are for a retroactive period.
  - In July 2023, the review period was from April 1, 2023 to June 30, 2023.
- To initiate the review, OMIG sends providers a notification letter of a compliance program review.
- Providers are given thirty (30) days to submit the completed review module with documentation.
- The notification letter will direct providers to complete the Compliance Program Review Module which is available at https://omig.ny.gov/compliance/compliance-library.
- After submission, OMIG may reach out with questions or to request additional documentation.
  - If a missing documentation letter is issued, providers will have seven (7) days to complete and provide the requested information.

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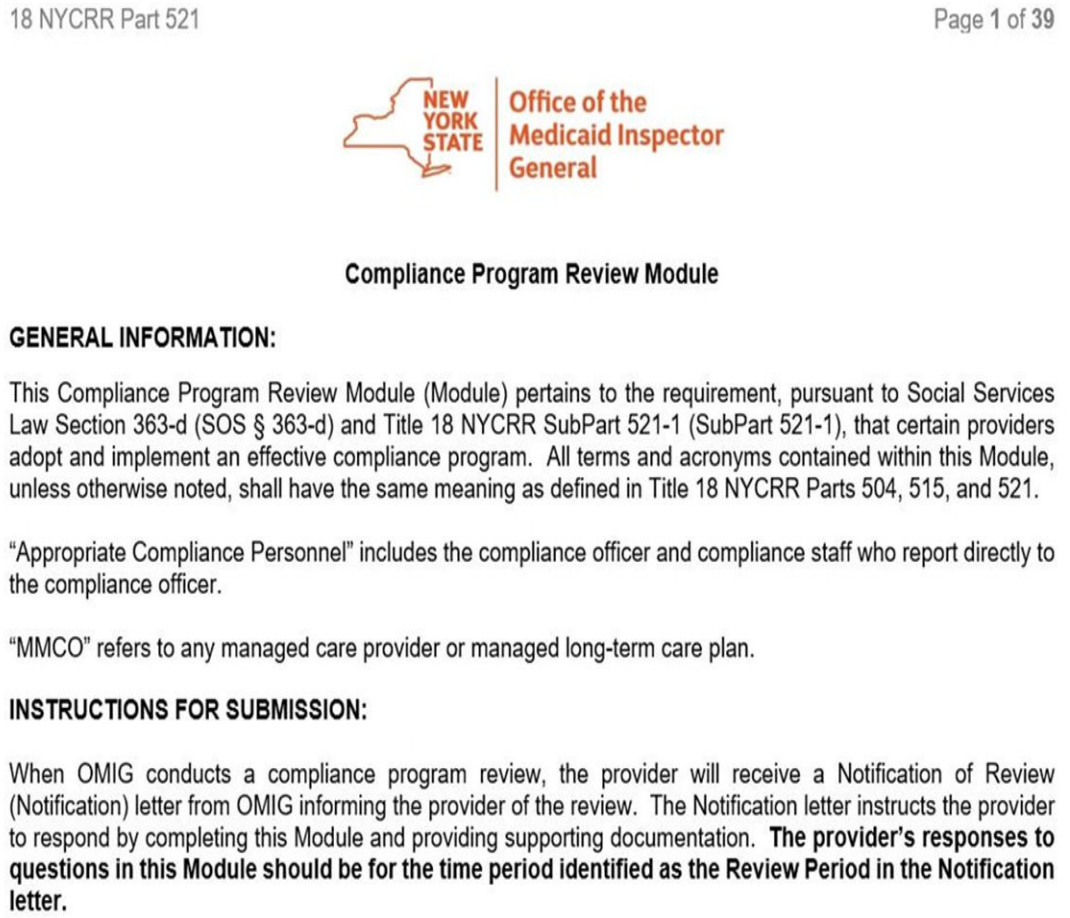
Compliance Review Module: Components

- Completing the questions in the Compliance Review Module;
- Gathering the responsive documentation including all effective versions during the review period; and
- Completing the provider documentation table.



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Compliance Program Review Module

GENERAL INFORMATION:

This Compliance Program Review Module (Module) pertains to the requirement, pursuant to Social Services Law Section 363-d (SOS § 363-d) and Title 18 NYCRR SubPart 521-1 (SubPart 521-1), that certain providers adopt and implement an effective compliance program. All terms and acronyms contained within this Module, unless otherwise noted, shall have the same meaning as defined in Title 18 NYCRR Parts 504, 515, and 521.

"Appropriate Compliance Personnel" includes the compliance officer and compliance staff who report directly to the compliance officer.

"MMCO" refers to any managed care provider or managed long-term care plan.

INSTRUCTIONS FOR SUBMISSION:

When OMIG conducts a compliance program review, the provider will receive a Notification of Review (Notification) letter from OMIG informing the provider of the review. The Notification letter instructs the provider to respond by completing this Module and providing supporting documentation. **The provider's responses to questions in this Module should be for the time period identified as the Review Period in the Notification letter.**

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Compliance Review Module

- Each applicable question must be answered.
- Certain documentation must be submitted to support the responses to the questions.

6-1	**18 NYCRR § 521-1.4(g)(1)** Did the provider perform audits during the Review Period which met the requirements of 18 NYCRR § 521-1.4(g)(1)(i)? Yes ____ No ____	Provide, as "Attachment 6-1" documentation evidencing the provider met the requirement which may include, but is not limited to: a. summary of auditing and monitoring results, dates completed, and any compliance issues identified; b. dated meeting minutes that documented discussion of such activities, if applicable; and c. any other evidence of how the provider performed audits that focused on risk areas identified in 18 NYCRR § 521-1.3(d) during the Review Period. d. any additional explanation, if needed.

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Compliance Review Module: Provider Documentation Table

- The provider documentation table must be completed including:
  - the name of the document;
  - related attachment numbers (from the questions in the Compliance Review Module); and
  - the effective dates of the documentations.
- If no responsive document exists, this must be indicated on the table (e.g., information on website).

Add additional rows as needed.		
Document Name (i.e., electronic file name)	**Related Attachment Number(s)**	**Effective Dates (From-To) or Do Not Have**
Sample: Standards of Conduct	Attachment 1-1a	01/01/2019 - Present
Sample: Compliance Training Policy	1-1a	Do not have
Copy of OMIG's Notification Letter	Not Applicable	00/00/0000
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Compliance Program Reviews: Outcomes

- The results of the Compliance Program Review will be provided in a written compliance program assessment.
- In response to OMIG's assessment, providers should identify and implement corrective actions in all areas identified by OMIG as needing improvement.
- A score will be provided per month for each question and then an average score for each month of the Review Period will be calculated.
  - At least 60% is a satisfactory score; and
  - If a provider scores less than 60%, there may be a monetary penalty.

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Consequences of not having an Effective Compliance Program

- The consequences may include:
  - Monetary penalties up to $5,000 for each month a provider fails to adopt, implement and maintain an effective compliance program (this amount may be increased to $10,000 per month for a second violation);
  - Recoupment of monies paid to the provider during the period in which it did not have a compliance program;
  - Termination of enrollment in the Medicaid program; or
  - Sanctions, up to and including, exclusion from participation in the Medicaid program.

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Compliance Program Reviews: An Ounce of Prevention . . .

- Providers should ensure that they have an effective compliance program in accordance with OMIG regulations.
- A Self-Assessment Form and the Review Module are available on the Compliance Library section of OMIG's website.
- The Review Module requires providers to gather documents in response to questions and the documents must be submitted in a searchable electronic format.
  - The requests include, but are not limited to, the compliance program policies and procedures, results of audits of risk areas and exclusion checks.
- Having your compliance program material organized and tracking your documentation will help with the submission.
  - If there were multiple versions of a document in effect during the Review Period, all versions should be submitted and the effective dates for each document must be listed in the accompanying provider documentation table.

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Self-Disclosure: Overview

- Providers are required to report, return, and explain any overpayments they have received to the OMIG Self-Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later.
- An overpayment has been identified when a Medicaid Entity/Provider has, or should have through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was received, and they have quantified the amount of the overpayment to the best of their ability.
- Once a Medicaid Entity/Provider has submitted a Self-Disclosure Full Statement, or a Self-Disclosure Abbreviated Statement, OMIG may request additional information.

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Self-Disclosure: Full Statement

- Examples of information to be disclosed using the Self-Disclosure Full Statement include, but are not limited to, the following:
  - Any error that requires a Medicaid Entity/Provider to create and implement a formal corrective action plan;
  - Actual, potential, or credible allegations of fraudulent behavior by employees or others;
  - Discovery of an employee on the Excluded Provider list;
  - Documentation errors that resulted in overpayments;
  - Overpayments that resulted from software or billing systems updates;
  - Systemic billing or claim processing issues;
  - Non-claim based Medicaid overpayments;
  - Any error with substantial monetary or program impacts; and
  - Any instance upon direction by OMIG.

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Self-Disclosure: Abbreviated Self-Disclosure Process

- In August 2023, OMIG implemented a second pathway for self-disclosures, in addition to the existing Full Self-Disclosure Process.
- The second pathway, called the Abbreviated Self-Disclosure Process, is used for reporting and explaining voids and adjustments where the error had minimal monetary or program impact.
- This process should be used for:
  - routine credit balance/coordination of benefits overpayments;
  - typographical human errors;
  - routine net available monthly income (NAMI) adjustments;
  - instances of missing or faulty authorization for services due to human error;
  - instances of missing or insufficient support documentation due to human error;
  - inappropriate rate, procedure of fee code used due to typographical or human error; and
  - routine recipient enrollment issues.

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Abbreviated Self-Disclosure Process

- The Abbreviated Self-Disclosure Process includes submitting an abbreviated statement available at: https://apps.omig.ny.gov/SelfDisclosures/selfdisclosures.aspx.
- The submission also requires the upload of a fillable spreadsheet.
- Overpaid claims are voided or adjusted within sixty (60) days of identification and added to the Self-Disclosure Abbreviated Statement form.
- Submissions may be aggregated in a monthly report which will be submitted by the 5th of the month following the month in which the claims were voided or adjusted.
- OMIG will not contact the disclosing party unless it needs more information.
- If additional information is requested by OMIG, the Medicaid Entity/Provider will have fifteen (15) days to supply any additional requested information.

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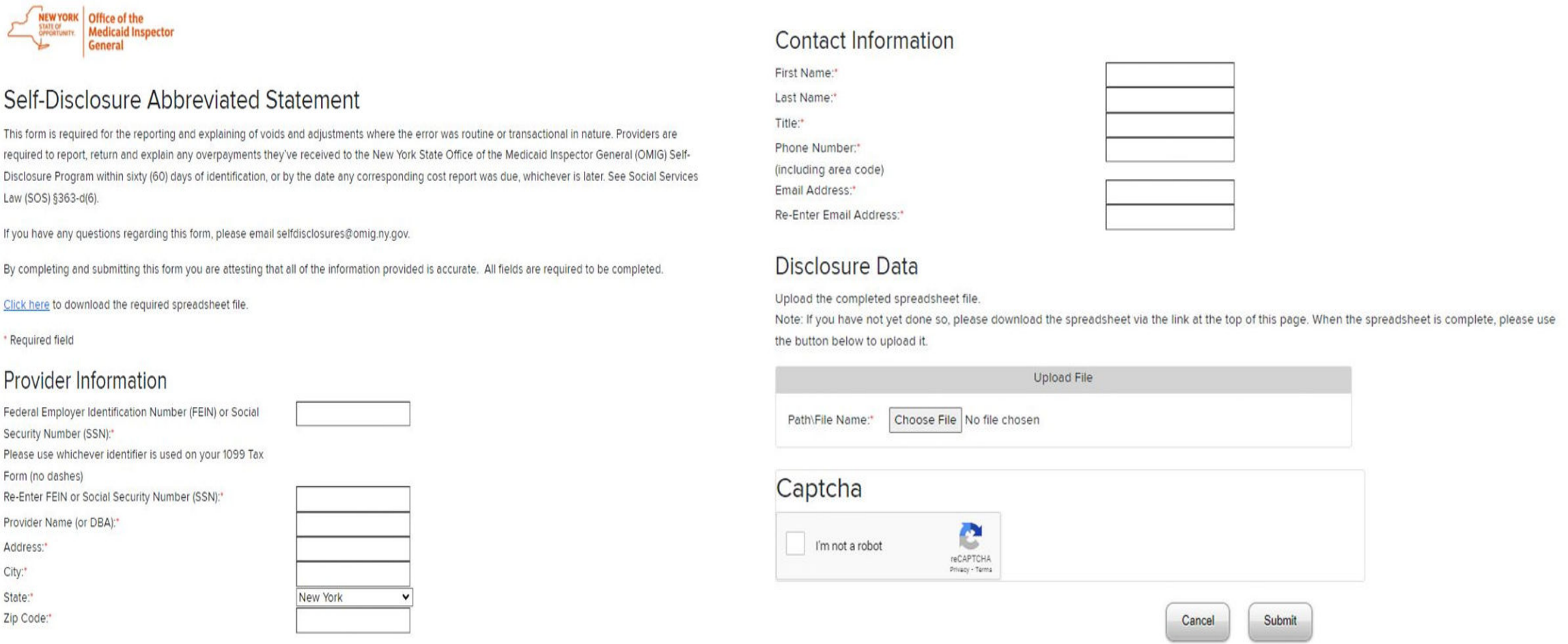
Abbreviated Self-Disclosure Statement



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Self-Disclosure Abbreviated Statement

This form is required for the reporting and explaining of voids and adjustments where the error was routine or transactional in nature. Providers are required to report, return and explain any overpayments they've received to the New York State Office of the Medicaid Inspector General (OMIG) Self-Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) §363-d(6).

If you have any questions regarding this form, please email selfdisclosures@omig.ny.gov.

By completing and submitting this form you are attesting that all of the information provided is accurate. All fields are required to be completed.

Click here to download the required spreadsheet file.

* Required field

Provider Information

Federal Employer Identification Number (FEIN) or Social Security Number (SSN):*
Please use whichever identifier is used on your 1099 Tax Form (no dashes)
Re-Enter FEIN or Social Security Number (SSN):*
Provider Name (or DBA):*
Address:*
City:*
State:* New York
Zip Code:*

Contact Information

First Name:*
Last Name:*
Title:*
Phone Number:*
(including area code)
Email Address:*
Re-Enter Email Address:*

Disclosure Data

Upload the completed spreadsheet file.
Note: If you have not yet done so, please download the spreadsheet via the link at the top of this page. When the spreadsheet is complete, please use the button below to upload it.

Upload File

Path\File Name:* Choose File No file chosen

Captcha

I'm not a robot reCAPTCHA Privacy - Terms

Cancel Submit

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Abbreviated Self-Disclosure Spreadsheet Overpayment Summary

	A	B	C
1	Self-Disclosure Abbreviated Statement		
2			
3	This form is required for the reporting and explaining of voids and adjustments where the error was routine or transactional in nature.		
4	By completing and submitting this form you are attesting that all of the information provided is accurate.		
5			
6	Provider FEIN or SSN		
7			
8	Provider Contact Information		
9	First Name		
10	Last Name		
11	Title		
12			
13	Overpayment Information		
14	Total Voided/Adjusted *automatically calculated*	$0.00	
15			
16	Overpayments must be reported within 60 days from the date identified		
17	Overpayment Identification Period		
18			
19			
20	Total Amount Voided or Adjusted	Overpayment Reason	Additional Information
21			
22			

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Abbreviated Self-Disclosure Spreadsheet Void & Adjustments Data

	A	B
1	Self-Disclosure Abbreviated Statement	
2		
3	This form is required for the reporting and explaining of voids and adjustments where the error was routine or transactional in nature.	
4	By completing and submitting this form you are attesting that all of the information provided is accurate.	
5		
6	Overpayment Reason	TCNs of voided or adjusted claims
7		
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Self-Disclosure: Damaged, Lost or Destroyed Records

- When records are damaged, lost or destroyed, providers should disclose using the self-disclosure program.
- A Statement of Damaged, Lost or Destroyed Records and accompanying documentation should be completed and submitted to OMIG's Self-Disclosure Unit via the secure uplink on OMIG's website.
- The disclosure should be made as soon as practicable, but no later than thirty (30) calendar days following discovery.
- If the records are requested upon audit or investigation, OMIG will evaluate Statements of Damaged, Lost or Destroyed Records and determine on a case-by-case basis whether there are mitigating circumstances for the failure to maintain these documents.
  - This may have a significant financial impact on audits.

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Healthcare Worker Bonus Program

- This program allocated $1.3 billion for the recruitment, retention and to reward, certain healthcare and mental hygiene workers who met eligibility requirements.
- Employers who receive an overpayment of Healthcare Worker Bonus funds are required to report, return and explain that overpayment to OMIG.
- A Healthcare Worker Bonus Self-Disclosure Submission Statement, Certification Statement and Healthcare Worker Bonus Self-Disclosure Overpayment Report Excel Spreadsheet should be completed and submitted via OMIG's secure uplink.
- After submission, OMIG's Self-Disclosure Unit will contact the provider with a project number for reference and a request for any additional information required to process the disclosure.
- At the conclusion its review, OMIG will provide a Final Letter, which includes instructions on repayment.

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Provider Audits

Provider audits remain an area of focus for OMIG:

- OMIG will continue to focus on nursing homes and assisted living programs.
  - The 2019 audit period for minimum data set (MDS) reviews will start in 2024.
    - MDS is a tool used by nursing homes to evaluate each resident's needs and develop a plan for services, which becomes part of the calculations for the direct cost portion of a facility's Medicaid rate.
- Notably, updates for 2024 include the anticipated publication of Audit Protocols for:
  - Office of Mental Health (OMH) Personalized Recovery Oriented Services (PROS);
  - OMH Telehealth Services; and
  - Office for People with Developmental Disabilities (OPWDD) Community Habilitation.
- https://omig.ny.gov/audit/audit-protocols
  - Audit protocols are released by OMIG as guidance to assist providers in developing programs to evaluate compliance with Medicaid requirements under federal and state law.
    - These protocols do not encompass all current requirements for payment of Medicaid claims and are not a substitute for a review of statutory and regulatory law.

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Provider Audits – Auditing Activities Focus Areas

Long-Term Care Services:

- Performing nursing home rate audits of costs and data related to capital calculations and ancillary services (services that are required to be provided to Medicaid recipients receiving nursing facility care, but that the nursing facility is not required to provide directly) and
- Continuing adult day healthcare and assisted living programs audits.

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Provider Audits – Auditing Activities Focus Areas

Home Health & Community-Based Services:

- Performing audits on:
  - Diagnostic & Treatment Centers;
  - Certified Home Health Agencies (CHHA) for payments made via episodic payment system (EPS);
    - (EPS is based on a price for 60-day episodes of care adjusted by patient severity of illness and regional wage differences)
  - Personal Care Aides;
  - Licensed Home Care Services Agencies (LHCSA) and Independent Providers for private duty nursing;
  - Nursing Home Transition and Diversion Waivers (NHTD); and
    - (NHTD allows recipients to receive comprehensive services in a community-based setting)
  - Consumer Directed Personal Assistance Programs (CDPAP).
    - (CDPAP allows consumers/caregivers to control who provides care and how, rather than assigning a home care vendor/agency)

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Provider Audits – Auditing Activities Focus Areas

Behavioral Health/Addiction Services and Person-Centered Services & Supports:

- In addition to continued focus areas, new areas for auditing activities in 2024:
  - OMH Personalized Recovery Oriented Services (PROS)
    - PROS helps people stay in their communities while still receiving services and has four components: (1) community rehabilitation and support, (2) intensive rehabilitation, (3) ongoing rehabilitation and support, and (4) clinic treatment
  - OMH Telehealth Services
    - OMH guidance notes that the use of telehealth technologies to provide mental health services at a distance includes all regulatory requirements applicable to mental health services to the same extent as they apply to in-person services
  - OPWDD Community Habilitation
    - These services provide one-to-one training to people with intellectual/developmental disabilities typically in the person's home, non-certified community locations, and sometimes in certified residential settings

Note OMIG has not published the Audit Protocols for these newly added 2024 audit activities

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Provider Audits – Auditing Activities Focus Areas

Pharmacy focus areas include:

- Auditing to ensure compliance with existing Medicaid regulations
- Auditing to ensure appropriate authorization of payment for controlled substance claims
  - The Audit Protocol includes criteria related to controlled substance claims such as:
    - Original prescription fill dates beyond the allowed timeframe
    - Invalid fax orders
    - Missing DEA numbers
    - Claims billed in excess of supply limits for emergency prescriptions
    - Prescriptions missing the pharmacist endorsement
- Fee-for-service pharmacy audits

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Third Party Liability Match

Third Party Liability Match applies to all Medicaid providers:

- This continues to be a focus area for OMIG because Medicaid is generally intended to be the payor of last resort, after all other forms of insurance coverage have been exhausted
  - (unless an exception applies, such as for prenatal and preventive pediatric care, good cause recipients, or for medical care provided at a time when the source of payment may be in question such as in automobile insurance settlements)
- If the State determines that Medicaid benefits could have been covered by a third-party payer, the State may recover the payment through subrogation for up to three years after services are rendered
- The State uses two approaches to ensure application of third-party coverage:
  - Claims Processing Edits (including the Medicare crossover process); and
  - Post-Payment Reviews/Audits and Recovery
    - These recovery attempts are made by sending Medicaid reclamation claims to insurance carriers or by engaging directly with Medicaid providers

Recovery Audit Contract (RAC) Reviews

The Affordable Care Act requires Medicaid agencies to contract with Recovery Audit Contractors (RACs) to reduce improper payments through detection and collection of overpayments, underpayments, reporting suspected fraud or criminal activities, and to implement actions to prevent future improper payments.

- OMIG contracts with Gainwell Technologies (and Health Management Systems, Inc., a Gainwell company).
- OMIG will continue to work with its contractor, providers, and CMS's Unified Program Integrity Contractor and accomplishes these goals primarily through the following tools:
  - Claim selection and improper payment recovery;
  - Underpayment and overpayment identification; and
  - Self-disclosure recovery.

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Recovery Audit Contract (RAC) Reviews

Detection and Collection Tool #1 – Claim Selection and Improper Payment Recovery

- OMIG's contractor works to identify providers that have received erroneous, duplicative, or incorrect payment amounts, non-covered services, incorrectly coded claims, reimbursement errors (both excessive and insufficient), coverage or eligibility errors, or payments made for services not ordered or otherwise performed, or are otherwise ineligible under the law, rules, terms or conditions of the Medicaid program.
  - These identifications may be determined via an "automated review" which is determined at the system level, without a human review of the medical record or supporting documentation; or
  - Via a "complex review", involving a human review of medical records, vendor records, and other supporting documentation.

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Recovery Audit Contract (RAC) Reviews

Detection and Collection Tool #2 – Underpayment/Overpayment Identification

- OMIG's contractor reviews each claim line and considers all possible occurrences of an underpayment for all provider types.
  - Providers will be informed of the underpayment and will be asked to sign an OMIG-approved agreement form to be sent to OMIG.
  - Providers are responsible for recovering the underpayments.
- For overpayments, a preliminary findings letter is sent to providers detailing each claim line and discrepancy.
  - Providers can submit additional documentation regarding the discrepancy.
  - Providers are sent final letters with the results.
    - If a provider agrees an overpayment was found, they may repay by check or void/adjustment through the Medicaid Management Information System (MMIS), offsetting future payments.

Detection and Collection Tool #3 – Self-Disclosure Recovery

- Here, providers are required to self-disclose overpayments within 60 days of identification.

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Investigations

- OMIG will continue conducting on-site and remote Credential Verification Reviews (CVRs) of a provider's place of business to determine overall compliance with Medicaid requirements.
- CVRs assess areas such as:
  - Provider and staff identification and credentialing;
  - Physical attributes and conditions of the place of business (including inspection for public health and safety issues); and
  - Recordkeeping protocols and procedures regarding Medicaid claiming.
- Conducted at sites such as:
  - Physician and dental offices;
  - Pharmacies;
  - Durable medical equipment retailers; and
  - Part time clinics.
- While CVRs apply to all Medicaid providers, note that the Work Plan highlighted a specific example in which OMIG plans continue conducting CVRs and collaborating with state partners in the NYS Department of Motor Vehicles (DMV), the Medicaid Fraud Control Unit (MFCU), NYS Department of Transportation (DOT), and individual counties, to ensure Medicaid transportation providers adhere to DOH's Transportation Manual requirements.

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Investigations

- In the most recently available OMIG Annual Report (2022), OMIG investigation staff used CVRs to:
  - Educate providers on Medicaid guidelines; and
  - Gather information on:
    - Staff credentials and training;
    - Service delivery;
    - Storage of pharmaceuticals and medical supplies; and
    - The physical layout of businesses;
    - Record keeping protocols and Medicaid claiming practices
- Since 2020, a portion of these reviews were conducted remotely through telephone, video, or photographs.
- According to OMIG's most recent Annual Report, in 2022 the majority of CVR reviews conducted (92 CVRs) were of transportation and pharmacy providers.
  - The 2022 Report did not specify the number overall CVRs that year, but in past years OMIG completed:
    - 202 CVRs in 2019;
    - 365 CVRs in 2020; and
    - 286 CVRs in 2021.

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Investigations

CVRs are random inspections of provider locations and can be initiated as a response to an allegation received through OMIG's Fraud Hotline or referrals from other agencies, tailored to the specific provider type.

- CVRs can quickly yield additional and/or criminal findings such as:
  - Drug diversion;
  - Credible allegations of fraud including false claims and kickbacks; and/or
  - Noncompliance with safety standards in transportation CVRs.

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System Match

OMIG uses analytical tools, techniques, and knowledge of Medicaid billing rules to data mine Medicaid claims.

- This is done to identify potential recoveries of inappropriate payments due to improper claims.
- OMIG's anticipated audit project areas for 2024 include:
  - Physician Services in Office of Mental Health (OMH) Licensed Clinics
    - Auditing to ensure that only the licensed OMH program seeks and receives Medicaid reimbursement. This is because physicians and other licensed clinicians, regardless of how they are engaged by the OMH licensed program, may not seek separate fee-for-service Medicaid reimbursement for services provided by the OMH licensed outpatient program.
  - Partial Hospitalization
    - Auditing to ensure that partial hospitalization treatment (an intensive outpatient treatment program) does not exceed 6 calendar weeks.
  - Transportation
    - Auditing fee-for-service transportation claims for recipients who were hospital inpatients on the date of service; and
    - Auditing claims for ambulette services to verify the vehicle and driver's license numbers were authorized on the date of service.

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Pharmacy/Drug Diversion

- OMIG conducts Pharmacy Credential Verification Reviews (Pharmacy CVRs) to evaluate compliance with the NYS Medicaid pharmacy program requirements and pharmacy laws, rules, and regulations.
  - In 2024, OMIG plans to conduct more frequent Pharmacy CVRs throughout the state.
  - Pharmacy CVRs are conducted periodically, unannounced, and consist of an interview, a pharmacy inspection, and a records review.
    - Key focus areas highlighted for 2024:
      - Pharmacy ownership
        - Owners and supervising pharmacists must ensure operations within the pharmacy adhere to Medicaid requirements and NYS law; and
        - Providers must notify NYS DOH of changes in ownership within fifteen (15) days of the ownership change.
      - Lack of appropriate pharmacy supervision
        - Concerns risk of fraud, waste and abuse, and safety of Medicaid recipients; and
        - Supervising pharmacists must be enrolled as a NYS Medicaid provider and a NYS registered pharmacist must be on site at all times while the pharmacy is open.

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Pharmacy/Drug Diversion

- Findings from Pharmacy CVRs have led to large settlements such as:
  - Drug Diversion - $76,500
    - While conducting a Pharmacy CVR, OMIG identified expired, empty pharmaceutical bottles on shelves, and clear plastic bags containing unknown drugs, which were used to create the appearance of legitimate inventory. The pharmacy owner also admitted to buying and dispensing diverted drugs. MFCU entered a settlement in which the pharmacy and owner agreed to pay $76,500 for violation of the federal False Claims Act and NYS Social Services Law.
  - Credible Allegation of Fraud - $250,000
    - During a Pharmacy CVR, OMIG found documentation in patient files for kickbacks for certain medications, and records of non-dispensed pills billed to Medicaid and referred the case to MFCU as a credible allegation of fraud, along with receiving an employee complaint regarding the same. MFCU entered a settlement in which providers agreed to pay $250,000 in restitution for filing false claims to Medicaid.

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Repayments Options

- After the Final Audit Report is issued providers are provided with two options for repayments:
  - Option #1: Make a full payment by check, money order, or OMIG's Online Payment Portal within twenty (20) days of the date of the Final Audit Report.
  - Option #2: Enter into a repayment agreement with OMIG. If the repayment terms exceed ninety (90) days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If you wish to enter into a repayment agreement, the OMIG Bureau of Collections Management must be contacted within twenty (20) days.
  - If a payment option is not selected within twenty (20) days of the date of the Final Audit Report, OMIG will initiate recoupment by withholding all or a part of your payments.

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Collections

The Financial Hardship Process Application will continue to be available and OMIG will continue to engage in such provider-friendly projects.

- If an OMIG audit poses a financial hardship to providers who must repay OMIG liabilities, the Hardship Process Application provides an opportunity for extended repayment when providers cannot afford to repay within the standard repayment timeframe.
  - The standard repayment timeframe is two (2) years at a rate of no less than 15% of a provider's prior year's billings.
- The Hardship Process Application has been available since 2021.
  - Providers that have received a Final Audit Report and wish to apply may contact the Bureau of Collections Management at collections@omig.ny.gov for an application.

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Questions?

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Robert Del Giorno is the Chair of Garfunkel Wild's Investigations, Audits and Regulatory Compliance Practice Group. Robert's practice includes representation of skilled nursing facilities, laboratories, physicians and other health care industry-related clients (both for profit and not-for-profit) in the area of health care compliance, with a specific focus on fraud and abuse laws. He has particular expertise assisting clients with internal investigations and frequently defends clients in both civil and criminal investigations conducted by federal and state agencies. Robert has defended local New York hospitals and individual providers in complex, multi-million dollar Federal and New York State False Claims Act cases and has handled a wide variety of other high-profile matters. Robert also represents clients in the health care and early intervention industries with regard to audits conducted by government agencies.

In addition, Robert frequently assists clients in developing effective compliance programs, working with them to develop and implement policies tailored to meet their individual needs.

Robert frequently consults on a variety of business transactions and arrangements, including asset purchases, financing and factoring agreements, among others. In this regard, Robert conducts due diligence reviews of health care providers in order to help clients identify and understand potential health care compliance risks and liabilities.

Robert started his career with a large corporate law firm in New York City, where he focused on commercial litigation and criminal defense matters. Prior to joining the firm, Robert served as an Assistant District Attorney in the Nassau County District Attorney's Office where he tried numerous cases to verdict. As a member of the Special Victims Bureau, he handled cases involving victims of sex crimes and domestic violence. Many of Robert's cases and trials were covered by the media, including his trial of a man featured on America's Most Wanted.

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Andrew Z. Ko

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Andrew Ko joined Garfunkel Wild, P.C. in 2021. Andrew represents various healthcare providers on regulatory and transactional matters. He has represented providers with challenging audits conducted by the New York State Office of the Medicaid Inspector General (OMIG), the Office for People with Developmental Disabilities (OPWDD), and Centers for Medicare & Medicaid Services (CMS). During this representation, he has contested the statistical sampling and extrapolation methodology implemented to calculate the purported overpayments. He has also counseled clients on regulatory compliance issues, government investigations, and self-disclosures.

Prior to joining the firm, Andrew worked as a health law associate for a regional law firm. He also was an Appellate Court Attorney at the State of New York Supreme Court, Appellate Division, Third Judicial Department, where he conducted legal research and drafted preliminary reports for the Court. While in law school, Andrew was a judicial extern for Hon. Christian F. Hummel in the United States District Court, Northern District of New York, interned for the Claims Bureau at the Office of the Attorney General, and interned for the Innovations and Partnership group at the Research Foundation for the State University of New York.

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Vanessa A. Giunta

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Vanessa Giunta joined Garfunkel Wild, P.C. in 2022. She works on regulatory, corporate, and transactional matters for clients including, but not limited to, hospitals, medical providers, ambulatory care facilities, physician practices, and other for-profit and not-for-profit entities. Vanessa also has experience working on clinical trial and grant award agreements with research sponsors.

Prior to joining the firm, Vanessa was a Public Health Law Program Legal Intern at the Centers for Disease Control and Prevention, a Research Fellow at the Gitenstein Institute for Health Law and Policy, and a Clinic Intern at the Robert W. Entenmann Veterans Law Clinic. Vanessa was also a Certified Pharmacy Technician at local pharmacy companies and a Director of Reimbursement for a long term care pharmacy.

While in law school, Vanessa had her Note published in the Hofstra Labor & Employment Law Journal and received the highest level of Hofstra Law's Public Service Awards for completing over 750 hours of public service work.

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