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Healthcare Alert

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New York State OMIG releases 2026 Work Plan

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New York's Office of the Medicaid Inspector General (OMIG) has released its 2026 Work Plan, signaling an aggressive year of oversight, audits, and data-driven program integrity efforts.

What's the impact?

- OMIG plans to conduct approximately two hundred Compliance Program Reviews using a newly expanded twelve-month review period, significantly increasing the depth and scope of provider oversight.
- The agency is deploying advanced analytics, pattern-recognition tools, and Medicare data integration to proactively identify improper payments and accelerate recoveries across both fee-for-service and managed care.
- With major audit expansions spanning long-term care, behavioral health, home- and community-based services, direct medical care, and children's programs, providers face one of OMIG's most comprehensive enforcement agendas to date.

The agency is deploying advanced analytics, pattern-recognition tools, and Medicare data integration to proactively identify improper payments and accelerate recoveries across both fee-for-service and managed care. February 2026, the New York State Office of the Medicaid Inspector General (OMIG), the agency responsible for program integrity of the Medicaid program, released its 2026 Work Plan. While the Work Plan is not an exhaustive list of the OMIG's planned activities, it is an important indicator of where the agency intends to direct its resources and scrutiny over the coming year. Medicaid providers should take note of several key developments announced by the OMIG, which are summarized below.

Expanded Compliance Program reviews and education

The OMIG anticipates completing approximately 200 Compliance Program Reviews (CPRs) this year, which will help the agency assess whether providers' compliance programs meet regulatory requirements, identify additional program integrity risks, and provide adequate feedback to providers. Notably, all CPRs initiated after July 1, 2025, will use a 12-month review period, replacing the prior three-month model. Additionally, the OMIG will seek supplementary information from providers so that it can better inform reviewers about a provider's unique characteristics before they commence a CPR.

The OMIG will also continue its education efforts by responding to provider inquiries, updating and publishing guidance, and delivering in-person presentations. The agency aims to provide more focused presentations tailored to specific content areas and provider types and, where applicable, will publish compliance trends on its webpage. The OMIG also plans to expand the channels through which compliance-related guidance is distributed, including through the Medicaid Updates and eMedNY.

Self-Disclosure Program enhancements

The OMIG's Self-Disclosure Program and Abbreviated Self-Disclosure Process will continue processing submissions and will explore options to streamline the submission process. The agency intends to increase awareness of self-disclosure requirements through targeted outreach to providers with lower self-disclosure rates and by incorporating additional self-disclosure information on the OMIG website, eMedNY, and in Medicaid Updates. The OMIG will continue to update its self-disclosure guidance and FAQs as needed.

Damaged, lost, or destroyed Medicaid Records

The OMIG has identified a growing trend of providers being unable to maintain contemporaneous records supporting their claims for payment. The agency will continue outreach and education to address this issue and encourages providers to regularly assess whether they maintain adequate access and control of their Medicaid records. Providers that

identify damaged, lost, or destroyed records are reminded that they must report the issue to the OMIG no later than 30 days after discovery.

Medicaid Managed Care Audits

The OMIG will continue conducting reviews of Medicaid Managed Care Operating Reports and Managed Long Term Care Cost Reports to ensure the allowability of reported medical, administrative, and care management costs. The agency will also conduct Managed Care Program Integrity Reviews and will make a continued effort to engage different plan types, including Medicaid Managed Care, Managed Long Term Care Partial Capitation, Health and Recovery Plans (HARP), and Special Needs Plans (SNP).

Additional managed care audit areas will include the identification and recovery of payments made for incarcerated individuals, deceased enrollees, retroactive disenrollments, out-of-state recipients, duplicate client identification numbers, enhanced nursing home capitation payments, and supplemental maternity, newborn, and low birth weight capitation payments.

Extensive provider and service-specific audits

The 2026 Work Plan identifies a broad range of service-specific audit areas targeting particular provider types and program categories. Those service areas and program categories include:

- **Long-Term Care Services**. The OMIG will continue auditing nursing homes and assisted living programs (ALPs), focusing on audit capital and ancillary rates. The OMIG will also continue reviewing Minimum Data Set submissions used to calculate Medicaid rates and will initiate new audits of ALP providers following the publication of updated protocols in November 2025.
- **Home Health and Community-Based Services**. The OMIG will continue oversight of home and community-based services, including Home Health, Personal Care, Private Duty Nursing (agency and independent), Nursing Home Transition and Diversion, the Consumer Directed Personal Assistance Program (CDPAP), and Traumatic Brain Injury programs.
- **Behavioral Health and Addiction Services**. In coordination with the Office of Mental Health and the Office of Addiction Services and Supports, the OMIG will conduct audits of OMH Personalized Recovery Oriented Services, OMH Mental Health Outpatient Treatment and Rehabilitative Services, OMH Community Rehabilitation Services, and, new for 2026, OMH Telehealth Services.
- **Person-Centered Services and Supports**. The OMIG, in collaboration with the Office of Persons with Developmental Disabilities, will audit Community Habilitation, Care Coordination/Health Home Services, Supported Employment, Day Habilitation, IRA Residential Habilitation, and Prevocational Services.

- **Direct Medical Care**. The OMIG announced a new review area that will validate services and confirm physician visits and orders in both fee-for-service and managed care environments. In addition to traditional diagnostic and treatment centers and hospital outpatient departments, the audits will also cover physician services and independent laboratories. The OMIG intends to publish audit protocols for physicians' services and independent laboratory services in 2026.
- **Children and Youth Services**. The OMIG is developing audit protocols for Applied Behavior Analysis, Children and Family Treatment and Support Services, and Children's Home and Community-Based Services, and anticipates audits beginning in late 2026. Audits for fee-for-service Early Intervention will continue under existing protocols.
- **Other Areas of Focus**. Fee-for-service Health Homes, non-emergency transportation (such as ambulette and taxi/livery), durable medical equipment suppliers, and pharmacies will continue to be areas of focus for audits. Additionally, the OMIG will continue its audits of the Healthcare Worker Bonus program.

Data analytics, system matches, and recovery initiatives

The OMIG will use data mining and analytical tools to identify improper claims and recover inappropriate Medicaid expenditures in its audits. The agency anticipates auditing Medicaid Managed Care Organization (MMCO) payments for services not coordinated through Recipient Restriction Program providers, MMCO payments to unenrolled or excluded providers, and payments for clinic, emergency room, or ancillary services billed during inpatient hospital stays.

The OMIG will also leverage its Advanced Analytics Team to apply sophisticated data analysis techniques, such as pattern recognition, outlier analysis, integration of new data sources, and development of customized dashboards, to proactively detect suspicious patterns and irregularities in claims data. OMIG will also continue working with its contractor, HMS, utilizing pre-payment insurance verification and retroactive recovery processes, to ensure Medicaid is billed only after all other forms of insurance have been exhausted.

Recovery Audit Contract (RAC) reviews

The OMIG will continue working with its Recovery Audit Contractor (RAC) to identify and collect overpayments. Notably, this year, the RAC projects will incorporate available Medicare data from the Centers for Medicare & Medicaid Services. This will enable the OMIG to better identify Medicare-Medicaid duplicate payments and outpatient crossovers, as well as overpayments attributable to unreported or misreported Medicare payments for dual-eligible recipients.

Investigations and enforcement

OMIG will continue to employ a broad range of investigative tools, including credential verification reviews, pre-payment claims review, provider education and outreach, fraud referrals, and targeted oversight of high-risk areas. Given the shift of provider billing activity through Managed Care, the OMIG will expand its focus in 2026 on managed care billings and patterns of practice.

The OMIG will also use its Explanations of Medical Benefits as an investigative tool, issuing education letters based on investigative findings and referring fraud allegations to the Medicaid Fraud Control Unit and law enforcement partners. In addition, the OMIG will continue to enhance its oversight through the Restricted Recipient Program service area, which focuses on implementing, monitoring, and managing the use of healthcare services by recipients identified as having a pattern of inappropriate or excessive utilization.

Lastly, the OMIG stated it will continue its secondary review of enrollment applications in high-risk categories such as pharmacies, DME suppliers, physical therapists, and transportation providers, and will review all reinstatement applications and requests for removal from the Exclusion List.

Collections and financial hardship processes

OMIG will continue developing provider-friendly processes, including the Financial Hardship and Electronic Payment Portals for the collection of repayments. The Hardship Process provides extended repayment opportunities for plans or providers unable to repay OMIG liabilities within the standard two-year timeframe at a rate of no less than 15 percent of prior year billings.

Key takeaways for providers

Providers are encouraged to review the Work Plan carefully, assess their compliance programs, and ensure they meet all Medicaid documentation, billing, and self-disclosure requirements. Nixon Peabody will continue to monitor updates regarding the OMIG's Work Plan, enforcement priorities, and other related industry developments.

For more information on the content of this alert, or if you are the subject of an OMIG audit, please contact your Nixon Peabody attorney or:

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