



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

Self-Disclosure Guidance

March 12, 2009

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Introduction

The mission of the New York State Office of the Medicaid Inspector General (OMIG) is to work with providers and our state agency partners to improve the integrity of the Medicaid program, while simultaneously ensuring access to services for enrollees and cost effectiveness to New York State's taxpayers. We are committed to detecting potential fraud, waste and abuse within the state's Medicaid program and recovering inappropriate payments. As part of our multi-disciplinary approach to attaining these goals, we are making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues to the OMIG, and return inappropriate payments.

The OMIG recognizes that many improper payments are discovered during the course of a provider's internal review processes. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments,¹ we appreciate that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both New York State and the provider involved. OMIG has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds—whether intentional or unintentional—under the state's Medicaid program. By forming a partnership with providers through this self-disclosure approach, OMIG's overall efforts to eliminate fraud, waste and abuse will be enhanced, while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

This guidance replaces the existing Department of Health (DOH) disclosure protocol and establishes the process for participating in the OMIG's Self-Disclosure Program, in accordance with OMIG's enabling legislation:

[T]o, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action. N.Y. PUB. HEALTH LAW § 32(18).

In addition, the intended use of this guidance is significantly more expansive in scope than the protocol of the federal Department of Health and Human Services (DHHS) Office of the Inspector General's (OIG), which focuses on potential violations of criminal, civil or administrative law. The OMIG recognizes that situations which are subject to this guidance could vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

¹ See 18 NYCRR § 515.2

Advantages of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if OMIG staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the OMIG typically extends the following benefits to providers who, in good-faith, participate in a self-disclosure:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of penalties and/or sanctions
- Timely resolution of the overpayment
- Recognition of the effectiveness of the provider's compliance and a decrease in the likelihood of imposition of an OMIG Corporate Integrity Program
- Possible preclusion of subsequently filed New York State False Claims Act qui tam actions based on the disclosed matters²

Developing such a partnership with the OMIG during the self-disclosure process may also lead to more thorough understanding of the OMIG's audit and investigatory processes, which could benefit the provider in the future.

When to Disclose

Once an inappropriate payment is discovered that warrants self-disclosure, providers are encouraged to contact OMIG as early in the process as possible to maximize the potential benefits of self-disclosure.³ However, because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes.⁴

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may

² See N.Y. Finance Law § 190(9) and USA ex rel Grant v. Rush-Presbyterian St. Lukes Medical Center, 2000 US Dist. Lexis 19249 (ND Ill. 8/14/2000) (disclosure to a competent public official who has managerial responsibility over the very claims made constitutes public disclosure because it effectuates the purpose of disclosure as to allow the government to take the proper steps in dealing with it).

³ Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If OMIG is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of the on-site audit staff. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to OMIG, the provider should follow this guidance accordingly.

⁴ Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants.

demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of fraud and abuse laws⁵

OMIG is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. Providers should be aware that the OMIG monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. The OMIG highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

The Process

Once a provider makes the determination to disclose a problem, the following steps comprise an **initial** report:

- At a minimum, gather the following information:
 - The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
 - The Medicaid program rules potentially implicated;
 - Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent reoccurrence; and
 - The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in an appropriate position to speak for the organization.
- Contact the OMIG with the above information by telephone or via formal letter to:

The Office of the Medicaid Inspector General
Attention: Provider Self-Disclosure
800 North Pearl Street
Albany, NY 12204
(518) 473-3782

⁵ Upon review of the provider's disclosure and related information, the OMIG may conclude that the disclosed matter warrants referral to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, DHHS OIG, the Department of Justice or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws.

Providers may also use the printable version of OMIG's self-disclosure form, which is available at www.omig.state.ny.us.

After this initial reporting phase, the OMIG will consult with the provider and determine the most appropriate process for proceeding. OMIG staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

- A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;
- Detailed list of claims paid that comprise the overpayments (in an electronic medium and preferably in an Excel spreadsheet format). Each claim should list the provider Medicaid ID number, client name and Medicaid ID, dates of service(s), rates or procedure codes, and the amount(s) paid by Medicaid; and
- The names of individuals involved in any suspected improper or illegal conduct.

Assuming complete provider cooperation and timely response to information requests, the OMIG expects that the vast majority of self-disclosures will be completed within six months of submission of this information.

The OMIG will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OMIG cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with the OMIG to resolve the disclosure, the OMIG may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms may no longer apply.⁶

Access to Information

Providers are expected to promptly comply with OMIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OMIG also expects the provider to execute and provide business record affidavits whenever requested, in an acceptable form.

The OMIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's counsel will explore ways to gain access to factual or other non-protected information pertinent to the case in the event that documents or other material contain thought processes or advice from the provider's legal counsel, without the need to waive the protection provided by an appropriately asserted claim of attorney-client privilege or attorney work product.⁷

⁶ Assuming the provider acts in good-faith, the mere fact that the provider and OMIG are unable to agree on an amount and resolve the disclosure will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and OMIG are able to agree.

Restitution

All provider self-disclosures are subject to a thorough OMIG review to determine whether the amount identified is accurate. While repayment is encouraged/accepted as early in the process as possible, and any repayment will be credited toward the final settlement amount, the OMIG will not accept money as full and final payment for self-disclosures prior to finalizing the audit/investigatory process.

Following the review, OMIG staff will consult with the provider's respective state oversight agency to establish a repayment amount and schedule and explore the need to pursue any further administrative action. OMIG's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the time period, thoroughness and timing of the provider's disclosure, any potential harm to the health and safety of Medicaid patients, and the provider's efforts to prevent the problem from recurring.

Once a repayment amount has been established, assuming full repayment has not previously been made, the OMIG expects the provider to reimburse the State of New York for the overpayment with a check for the full amount, made payable to the New York State Department of Health or enter into a repayment agreement. Repayments can occur through monthly payments to OMIG or by having OMIG withhold a portion of that provider's weekly reimbursement. The OMIG will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms will be required to submit audited financial statements, if available, and/or other documentation to assist the OMIG in making that determination. Once the repayment has been finalized, the OMIG will issue a letter indicating closure of the matter.

⁷ The OMIG will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege or work product protection. A lack of information may make it difficult for OMIG to determine the nature and extent of the conduct which caused the improper payment.