

Texas Health and Human Services
Office of Inspector General
SELF-DISCLOSURE PROTOCOL

August 2023



I. Introduction

A. Implementation of IG Mission Statement

The mission of the Texas Health and Human Services Office of the Inspector General (OIG) is to protect integrity and ensure accountability in health and human services programs and protect the health and welfare of recipients of those programs, by identifying, communicating, and correcting activities of waste, fraud, or abuse in Texas. OIG is committed to fulfilling this mission, in part, by recovering inappropriate payments. As part of our multidisciplinary approach to fulfilling this mission, OIG is making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues, and return inappropriate payments.

B. Purpose of Self-Disclosure Protocol

Section 1128J(d)(2) of the Affordable Care Act (the Act) requires that a Medicaid overpayment be reported and returned by the later of (1) the date that is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable. 42 U.S.C. 1320a-7k(d). The following Protocol is designed to provide guidance to a health and human services program provider who has self-discovered evidence of an overpayment by a health and human services program due to a mistake or potential fraud by a provider. Self-disclosure by a provider allows that provider to potentially avoid prolonged investigation and litigation, and the costs associated with each. Although OIG does not administer any health and human services programs, it does consult with these programs when seeking to recover overpayments.

OIG's principal purpose in publishing this Protocol is to provide guidance to health care providers that decide voluntarily to disclose irregularities in their dealings with the Texas Medicaid Program and other state health and human service programs. OIG 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. By forming a partnership with providers through this self-disclosure approach, OIG'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.

C. Applicability of Self-Disclosure Protocol

This Protocol is open to all Medicaid health care providers, whether individuals or entities, and is not limited to any particular industry, medical specialty, or type of service. This Protocol may

also be used by other health and human service providers, contractors, grant recipients and vendors whose compliance may be audited or investigated by OIG.

D. Requirements of Self-Disclosure Protocol

This Protocol has no rigid requirements or limitations, and no written agreement setting out the terms of the self-assessment is required. Rather, this Protocol and the Self-Report Checklist set forth below provide OIG's views on what are the appropriate elements of an effective investigative and audit working plan to address instances of non-compliance. Although OIG will accept a self-disclosure in any form, disclosures that comply with the Protocol, including the Self-Report Checklist, will expedite OIG's verification process and thus diminish the time it takes before the matter can be formally resolved. Moreover, a thorough self-disclosure that complies with this Protocol will carry more weight in supporting subsequent requests for leniency.

E. Limits of Self-Disclosure Protocol

While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, OIG understands that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both the State of Texas and the provider involved. Because a provider's disclosure may involve anything from a simple error to intentional fraud, OIG cannot reasonably make firm commitments regarding how a particular disclosure will be resolved or whether a specific benefit will inure to the disclosing entity. Nevertheless, experience dictates that a provider's initiative in opening communication and making full disclosure to OIG at an early stage generally benefits the individual or company.

II. Determining Whether to Self-Disclose

A. Benefits of Self-Disclosure

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

1. Forgiveness or reduction of interest payments (for up to two years)
2. Extended repayment terms
3. Waiver of penalties or sanctions

4. Possible allowance for more flexible probe sample sizes than the typical standards employed by OIG
5. Timely resolution of the overpayment
6. Recognition of the effectiveness of provider's compliance program and presumption against requiring integrity agreement obligations
7. Suspension of the obligation to report overpayments under section 1128J(d) of the Act when OIG acknowledges receipt of a self-disclosure, so long as the submission is timely made
8. Suspension of the obligation to return overpayments until a settlement agreement is entered into
9. Reduced likelihood of implementation of permissive exclusion
10. Lower multiplier on single damages that would normally be required in resolving an OIG-initiated investigation
11. Less severe or restrictive administrative action or sanction by OIG as allowed by 1 TAC 371.1603(h)¹

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

B. Self-Disclosure to OIG versus Administrative Recoupment

OIG recognizes that many improper payments are discovered during a provider's internal review processes. 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 best handled through an administrative billing process. Each incident must be considered on an individual basis, and provider's initial decision of where to refer a matter of non-compliance should be made carefully.

C. Effect of Self-Disclosure

OIG is not bound by any findings submitted by the disclosing provider, and it is not obligated to resolve the matter in any particular manner. Furthermore, OIG may conclude that the disclosed matter warrants a referral to other county, state, or federal authorities for additional civil or criminal enforcement. If OIG makes a case referral, it will report on provider's involvement and

¹ These potential outcomes (1-11) are at the discretion of the OIG and are not guaranteed.

level of cooperation throughout the disclosure process to any other governmental agencies. Additionally, OIG will attempt to work closely with self-reporting providers in coordinating any investigatory steps or other activities necessary to reach an effective and prompt resolution.

III. Submission of a Self-Disclosure Report

A. Transmittal

The disclosure must be submitted in writing. Submissions should be directed to HHS-OIG Deputy Chief Counsel for Litigation, P.O. Box 85200, MC-1350, Austin, Texas 78708-5200 or to OIGSelf-Report@hhs.texas.gov. Submissions that contain personal health information must be sent securely.

B. Self-Disclosure Report Checklist

Providers may elect to submit a letter or may use OIG Self-Disclosure Checklist form. Providers who have identified specific claims affected by an error should use OIG Self-Disclosure Checklist Form to report on claims information.

Self-Disclosure Letter Checklist

If provider chooses to submit a letter, the letter should contain a complete description of the circumstances surrounding the disclosure including:

- ___ Provider's name, address and type of health care provided
- ___ Provider's Medicaid TPI, tax ID number and/or NPI number
- ___ If provider is an entity that is owned or controlled by or is otherwise part of a system or network; an organizational chart; a description of diagram describing the pertinent relationships; the names and addresses of any related entities; and any affected corporate divisions, departments, or branches
- ___ The name, street address, phone number, and email address of provider's designated representative for purposes of voluntary disclosure
- ___ Description of the error(s) that occurred
- ___ How the error was (or errors were) found
- ___ Amount of Medicaid overpayment
- ___ Dates of service (DOS) encompassed by the error(s)
- ___ The names of persons believed to be implicated, including an explanation of their roles in the matter

___ Actions taken to stop the error(s) and prevent recurrence (Corrective action should be complete and effective at the time of disclosure.)

___ Names of personnel involved in the error(s), those who discovered the problem(s), and those involved in rectifying the problem(s)

___ Provider's contact person's name, phone number, and both mailing and e-mail addresses

___ If the claims at issue have been voided, or if provider has notified either TMHP or an MCO about the error(s), please note this in the self-disclosure letter

___ A written certification by provider that the submission contains true, accurate, and complete information, and that there are no material misstatements or omissions of fact or law. (If provider is a business entity, an authorized representative of the entity may execute the certification.)

___ A statement of the specific federal and criminal, civil, or administrative laws that were potentially violated

___ The health and human services programs affected by the disclosed conduct

___ A statement of whether provider has knowledge that the matter is under current inquiry by a government agency or contractor. (If provider has knowledge of a pending inquiry, it must identify any involved government entity and its individual representatives. Provider must also disclose whether it is under investigation or other inquiry for any other matters related to a federal health care program and provide similar information relating to those other matters.)

___ With respect to the employment of any excluded employees, in addition to the general information required above, please provide:

- A. the identity of the excluded individual and any provider identification number;
- B. the job duties performed by that individual;
- C. the dates of the individual's employment or contractual relationship; and
- D. a description of any background checks that the disclosing party completed before and/or during the individual's employment or contract

___ Anything else provider deems relevant.

Claims Data File (if provider can identify specific claims that have been affected by the error)

Claims should be submitted in an Excel format (properly encrypted) and should include the following:

___ Complete claim number (ICN);

___ Provider's Medicaid TPI, tax ID number and/or NPI number;

___ Medicaid recipient's first name;

___ Medicaid recipient's last name;

___ Medicaid recipient's identification number (PCN);

___ Date of service (*not the date billed*);

___ Incorrect rate or procedure codes, if applicable;

- ___ Correct rate or procedure codes;
- ___ Amount paid;
- ___ Amount that should have been paid, if applicable; and
- ___ Amount paid by Medicare or any other third party, if applicable

The submission also should include a brief narrative explaining how the overpayment came about, how it was discovered, and what provider feels would be the fairest resolution of the overpayment claim.

IV. Calculating Damages for Employing An Excluded Person

Texas Medicaid and health care programs may not pay, directly or indirectly, for items or services furnished, ordered, or prescribed by excluded individuals or entities.² If a disclosing party employed or contracted with an excluded person who was a direct provider, such as a physician or a pharmacist, and the items or services furnished, ordered, or prescribed by that person were separately billed to Texas Medicaid and health care programs, the disclosure must include the total amounts claimed and paid by the Texas Medicaid and health care programs for those items or services.

OIG understands that when an excluded individual provides items or services that are not billed separately to Texas Medicaid and health care programs, such as certain items or services furnished by nurses, respiratory therapists, and billing and other administrative personnel, the damages or amounts can be difficult to quantify. For purposes of resolving SDP matters involving such non-separately-billable items or services, OIG uses the disclosing party's total costs of employment or contracting during the exclusion to estimate the value of the items and services provided by that excluded individual. The costs of employment or contracting include, but are not limited to, all salary and benefits and other money or items of value, health insurance, life insurance, disability insurance, and employer taxes paid related to employment of the individual (e.g., employer's share of FICA and Medicare taxes).³ This total amount should be multiplied by the disclosing party's revenue-based Federal health care program payor mix for the relevant time period. (If a disclosing party can measure the payor mix for the department or unit in which the excluded person worked, it is appropriate to apply that payor mix. If the departmental payor mix cannot reasonably be measured, the disclosing party must apply the payor mix for the whole entity.) The resulting amount will be used as a proxy for the amount paid and the single damages to the Texas Medicaid and health care programs resulting from the employment of the excluded individual. When the disclosing party is using a payor mix, the disclosure must include a separate calculation for each health care program. For example, if the

² 1 Tex. Admin. Code § 371.1705(e)(4) (2016).

³ 1 Tex. Admin. Code § 371.1655(29) (2016).

disclosing party's payor mix is 60 percent, the disclosure should break down how the health care programs make up that 60 percent, such as 40 percent Medicare, 10 percent Medicaid State A, 5 percent Medicaid State B, and 5 percent TRICARE.

V. Payments

A. Interim Payments

Upon receipt of a health care provider's disclosure submission, OIG will begin its verification of the disclosure information. Payments submitted along with the self-disclosure will be accepted as interim payments pending the final outcome of the verification process. Interim payments will not be considered full and final payment of the self-disclosure, notwithstanding any such representations on provider's check or self-disclosure report. Submission of an interim payment constitutes an agreement by provider that OIG is entitled to apply and disburse the interim payment to the affected program area. All interim payments will be credited toward the final settlement amount.

B. Claims Adjustment

If provider has submitted an interim payment that was calculated by a dollar-for-dollar review, the provider may elect to have the individual claims at issue adjusted to reflect the repayment. Upon receiving notification from provider, OIG will verify the request on a claim-by-claim basis. After verification, OIG will submit a State Action Request to the claims administrator, instructing it to adjust the individual claims. Provider should be aware that if the rates have changed since the claim was originally filed the adjustment may result in a refund or may result in the assessment of an additional overpayment.

C. Payment Terms

Provider may request a payment schedule upon submission of the self-disclosure report or upon final settlement of the matter. OIG will consider the circumstances of each case in determining whether to offer a payment schedule, including, but not limited to, the following:

1. Nature of the matter being disclosed
2. Effectiveness of provider's compliance program
3. Dollar amounts involved
4. Duration of the program violations
5. Thoroughness and timing of the self-disclosure report

6. Provider's efforts to prevent a recurrence of the matter
7. Access to care within provider's geographical region
8. Financial solvency of provider
9. Willingness of provider to respond to the OIG's additional requests for documentation or information

Repayments may occur through periodic payments to OIG or by authorizing OIG to withhold a portion of provider's regular reimbursement. Providers interested in extended repayment terms may be required to submit audited financial statements or other documentation to assist OIG in making a repayment determination.

D. Final Payment

Upon completion of the verification process, the OIG will notify provider of the full settlement amount. If the full settlement amount is greater than the amount disclosed by provider, OIG may send provider a notice of overpayment pursuant to OIG's rules contained in the Texas Administrative Code, Title 1, Part 15, Chapter 371, Subchapter G.

VI. Verification by the OIG

A. Verification Process

Upon receipt of provider's self-disclosure submission, the Litigation section of OIG Chief Counsel Division may refer the self-disclosure report to OIG's Medicaid Program Integrity (MPI), Audit, or other section for verification, or may request additional information from provider if necessary. If referred, appropriate section will convey its findings back to the Litigation section for final resolution of the matter. While OIG is not obligated to accept the results of a provider's self-assessment, findings based upon procedures that conform to this Protocol will be given substantial weight in determining any program overpayments.

B. Access to Records

To facilitate OIG's verification and validation processes, OIG personnel may request access to provider's audit work papers or other relevant and supporting documents. Although OIG expects to receive documents and information from provider without the need to resort to compulsory methods, OIG is entitled to impose a payment hold without prior notice upon any provider that refuses to comply with a request for records.

C. Collateral Matters

Matters uncovered during the verification process, which are outside of the scope of the matter disclosed to OIG, may be treated as new matters outside the Provider Self-Disclosure Protocol. Such collateral matters may be consolidated into the self-disclosure to facilitate final settlement, or they may be severed into a separate investigation. Collateral matters may also be referred to other federal or state agencies for criminal, civil, or administrative enforcement action.

D. Mitigating and Aggravating Circumstances

Provider's diligent and good faith cooperation throughout the entire process is essential, and it will be considered as a mitigating circumstance. Conversely, failure to work in good faith or lack of cooperation, submission of false or otherwise untruthful information, and the omission of relevant facts will be considered as aggravating factors and may constitute grounds for independent enforcement action. Cooperation includes, for example, submitting all necessary information, communicating through a consistent point of contact, and being responsive to OIG requests for additional information. Upon request, OIG may submit a written statement of provider's cooperation and other mitigating factors to other state or federal enforcement agencies.