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Robert Hussar, Esq.
First Deputy
Medicaid Inspector General
State of New York
Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Re: Self-Disclosure Guidance

Dear Robert:

Thank you for hosting the discussion regarding the OMIG's new self-disclosure guidance. Ellen Weissman and I, on behalf of the Health Law Section of the New York State Bar Association, submit below broad suggestions in regard to provider self-disclosure. We look forward to a line by line review (as Mark Thomas suggested), once the fundamental issues are resolved. (In this regard, I see far fewer line by line issues and certainly nothing as potentially contentious as the core issues that are raised in this letter.)

1. OMIG should clarify that this protocol is designed to replace the existing DOH self-disclosure protocol.

2. OMIG should provide more detail as to the potential benefits of self-disclosure.[1]

3. OMIG should also confirm that when self-disclosure is made pursuant to the guidance, it is the subject of "pending administrative action" by OMIG, and thus pursuant to Section 190(9)(a) of the New York False Claims Act, which bars qui tam actions based on allegations which are "the subject of a pending...

[1] It would be useful for OMIG to note that the New York False Claims Act, like its federal contemplation, caps relief at double damages if "all information known... about the violation" is furnished to "those officials responsible for investigating false claims" within 30 days, and that your office consists of such officials. It would also be useful to add the benefits of disclosure on qui tam actions discussed in Paragraph 3.

administrative action in which the State... is a party," a qui tam relator would not be able to bring a claim related thereto.

4. This is a provider self-disclosure. It seems to me that the best approach would be to remind the reader that this policy only governs self-disclosures formally authorized by the provider, and not individuals who may be affiliated with the provider. Presumably separate guidance governs disclosure by individuals in regard to a provider, but there are not "self-disclosures."

5. A critical issue is differentiating routine errors from more "systemic" or material issues for which self-disclosure is anticipated. It would seem that the potential differentiating issue would be if the matter involved a conscious decision (which may have been erroneous or which may have been made intentionally or recklessly). Thus, a mistake that is unconscious or, for example, due to a mistake in data entry or coding (by coding staff that is not incentivized to maximize coding) would not require a self-disclosure (subject to 3 below). We understand John Foley to state that even in the case of such "innocent" mistakes, if the amount at issue is in excess of a particular dollar amount (such as $500,000), self-disclosure should be made.

6. OMIG should clarify that providers may void claims, make other corrective claims adjustments or issue checks to the Medicaid program without regard to whether a self-disclosure has been made. Such actions, we understand, will not resolve the matter, but the provider will receive financial credit for all repayments made.

7. The choice between disclosure to OMIG and disclosure to MFCU should be delineated in a joint understanding issued by the agencies for guidance to providers. It is quite possible that a matter will involve potential criminal penalties, and the MFCU may be unhappy that the initial contact with the State was through OMIG as opposed to the prosecutorial agency. The understanding should also confirm that the disclosures have the benefits noted in paragraph 3 and the footnote on page 1.

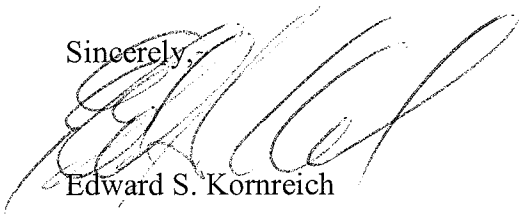
8. Much more information is needed on the details for disclosure. There was general support for a preliminary call, followed by a short letter giving the broad outlines of the disclosable matter, followed by a more substantial period for investigation with disclosure made roughly four to six weeks thereafter. For each stage, we need a clear delineation of the information to be submitted. (The federal disclosure protocol spells out these requirements by stage in substantial detail.)

9. The general tone of the letter should be softer with more emphasis on encouraging cooperation, noting the cooperative spirit and the fairness with which disclosures will be viewed.

10. Finally, and in fact most importantly from the Bar Association's perspective, we need an affirmation of the sanctity of the attorney/client and work product privileges as it relates to conversations between the disclosing hospital and its counsel. The price of cooperation cannot be waiver of these privileges, nor should the government interfere with the rights of employees and corporations regarding indemnification.

We are hopeful that the foregoing suggestions will help to make the process better. We thank you for the opportunity to provide this input.

Sincerely,



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