Title: Reimbursement and Self-Disclosure Policy
Date Created: March 5, 2025
Date Modified:
Date Approved by CCN Board of Directors: June 10, 2025
Date Approved by CCC Board of Directors:
Date Approved by IPA Board of Directors:
Policy # CC15

Purpose:

To ensure compliance with all self-disclosure mandates of governmental payors and to fulfill the fiduciary obligations of the Board of Directors relating to the financial affairs of the Care Compass Entities.

Definitions:

Affected Individual(s): All persons who are affected by Care Compass Entities' risk areas including Care Compass Entities' employees, officers, Directors, managers, contractors, agents, subcontractors, independent contractors, governing bodies, or third-parties, who or that, in acting on behalf of the Care Compass Entities: (i) delivers, furnishes, directs, orders, authorizes, or otherwise provides health or social care items and services under State, Federal, or Care Compass programs; and (ii) contributes to the Care Compass Entities' entitlement to payment under Federal health or social care programs, or from other payor sources.

Care Compass Entities: Organizations that are directly, or indirectly through one or more intermediaries, owned or controlled by, or are under common ownership or control of, Care Compass Network, including Care Compass Collaborative, Inc., and Care Compass Supporting IPA, LLC.

Participant: Any organization that has signed an agreement related to a funded program with the Care Compass Entities.

Reimbursement Protocols: Those steps which the Finance Department may take in order to reverse either pending or adjudicated/paid invoices and/or claims submitted for payment to Medicaid, Medicare, or Third-Party Liability programs, along with standards pertaining to "due to third party" reserves, credit balances, and proper billings to patients/clients for private pay/Net Available Monthly Income (NAMI) obligations.

Self-Disclosure: The voluntary and complete disclosure of: (1) significant overpayments received by the Care Compass Entities or others paid by the Care Compass Entities; (2) violations of program standards or legal requirements on the part of the Care Compass Entities or Staff; and/or (3) intentional wrongdoing on the part of the Care Compass Entities' Staff or vendors which affects the Care Compass Entities' operations by exposing it to potential liability.

Staff: Employees, contractors, agents, consultants, volunteers, and others who act on the Care Compass Entities' behalf.

Third-Party Liability (TPL): Responsibility for payment of a claim for a care item or service by a third-party other than the individual, Medicaid, or Medicare. Includes self-insured plans, group health plans, managed care organizations (MCOs), long-term care insurers, worker's compensation, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a care item or service.

Policy:

The Care Compass Entities are dedicated to the protection of the patients and clients of its Affected Individuals and Participants, and to the mission of serving the healthcare and social determinants of health needs of the community. In order to ensure proper payment in meeting this mission, the Care Compass Entities will proactively review issues which may give rise to the refund of payments received by the Care Compass Entities which were found to be unauthorized or in violation of appropriate laws and standards pertaining to Medicaid and/or Third-Party Liability programs.

I. Training. This Policy is designed to enable the Finance Department, management, Affected Individuals, and vendors to recognize issues which may give rise to a risk of receiving payments which are in error so that claims relating to such erroneous payments may be expeditiously voided or repayments made. Staff, Affected Individuals, and outside vendors involved in submitting claims or reconciling payments from payor programs will be trained in these procedures and strictly adhere to the protocols established by the Compliance Program.

II. Progressive Application. This Policy shall be applied on a progressive basis, starting with cases in which a simple voiding of claims or repayment is appropriate through a payor's existing methods of correcting payment errors, then proceeding to the submission of a formal Self-Disclosure to the Office of the Medicaid Inspector General (OMIG), as necessary, and finally to the provisions of Self-Disclosure as recommended by the Federal Office of the Inspector General (OIG), as necessary, which may include a referral for criminal investigation.

III. Scope. This Policy governs fraud, abuse, and reimbursement relating to the following areas of payment received by the Care Compass Entities:

a. New York State Medicaid Program Participation
b. Medicaid Managed Care
c. Third-Party Liability (TPL), including MCOs, Disability Insurance, workers compensation, no-fault, and other payor resources.

IV. Compliance with Regulations. This Policy is not to be used where there are mandated adjustments or corrective actions required by a payor or grant program. Such mandated adjustment and corrective action procedures will supersede the provisions in this Policy to the extent that they differ.

V. Reimbursement Protocols. Reimbursement Protocols apply to routine payment errors or those which involve less than five thousand dollars ($5,000.00) in the aggregate and where

there is no abusive practice or intentional wrongdoing. Errors which appear to recur, or which raise concerns, must be immediately reported to the Director of Compliance, regardless of the amounts involved. A summary of corrections made by the Finance Department for both routine errors and isolated cases under the five thousand dollars ($5,000.00) shall be reviewed by the Compliance Committee. All overpayments, regardless of the amounts involved, must be returned to the appropriate source of the original payment. Reimbursement Protocols include:

a. Financial Department Knowledge of Error Correction Procedures.
    i. Under the direction of the Chief Financial Officer (CFO) and Director of Compliance, the Finance Department will ascertain and routinely update the procedures used by payors for the correction of routine claiming errors, and adhere to such procedures. The following standards currently apply:
        1. Medicaid payments are made through eMedNY, which is a contractor of the State of New York for payment of Medicaid claims. The eMedNY Provider Manual, relating to the voiding and adjustment of claims and Medicaid TPL requirements, should be referenced in making error corrections and to coordinate available payment benefits for patients/clients.
        2. TPL Carriers which have contracts with a provider may provide for methods of correcting payments and claims data and documents outlining those methods should be referenced in making error corrections.
        3. Reconciliation of accounts is required under State and Federal Law.
    ii. Review of Financial Reconciliations.
        1. Errors in financial reporting discovered in the preparation of the Care Compass Entities' financial statements must be identified and brought to the attention of the Finance Committee, as well as the Compliance Committee.
        2. All reserves to be established as "due to third parties", either as contingent liabilities, short/long term liabilities, and/or for reserve purposes must be reviewed by the CFO and Director of Compliance to determine whether corrective actions are required by the Care Compass Entities in order to liquidate any items deemed to be payable to a third party, such as Medicaid or a TPL, or amounts to be refunded to patients/clients or their estates.
    iii. Self-Audits.
        1. The Compliance Program will establish self-auditing protocols, as Title 18 NYCRR subpart 521 audits are a requirement of an OMIG Compliance Program, and to ensure compliance with this Policy. Such audits will include an assessment of the changes required by payors, such as Medicaid, with respect to the voiding and correction of errors.
        2. The Compliance Committee will review any findings as a result of self-auditing and determine whether affirmative action is required to initiate repayment of sums.

VI. Self-Disclosure Protocols.

a. §6402(a) of the Patient Protection and Affordable Care Act mandates self-disclosure with regard to overpayments identified as a result of a Provider's participation in any federally funded health care program, including Medicare and Medicaid (42 U.S.C. § 1320a-7k[d]). Related to the reporting and returning of overpayments, the federal law states:
    i. In General. If a person has received an overpayment, the person shall:
        1. Report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
        2. Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
    ii. Deadline for Reporting and Returning Overpayments. An overpayment must be reported and returned under paragraph (1) by the latter of:
        1. The date which is 60 days after the date on which the overpayment was identified; or
        2. The date any corresponding cost report is due, if applicable.[1]
b. In most other circumstances, Self-Disclosure is discretionary. However, in accordance with the Compliance Program, the Care Compass Entities have adopted an Overpayment Self-Disclosure Procedure, which requires uniform compliance among all payor programs. This includes the "reporting and repayment" to a federally funded program within the 60-day period called for under the Federal statute.
c. Any discrepancies identified, either through monitoring processes or by investigation of a complaint, must be reported in accordance with the Compliance Program. Investigations undertaken through the Compliance Policies and Procedures of the Care Compass Entities may also result in corrective actions which require Self-Disclosure.
d. Self-Disclosure Protocols include:
    i. Uniform Self-Disclosure.
        1. Except as expressly required by individual program rules, the Care Compass Entities will endeavor to provide for a Self-Disclosure process which includes all programs (including any grant programs) in which it receives payment for services provided.
        2. The CFO and Executive Director will review all payor contracts and protocols (along with workers compensation, no-fault plans, and other payors) to assure that any existing procedures for Self-Disclosure are added under this Policy.
        3. To the extent that no such protocols have been provided by a payor, the Care Compass Entities will review such matters on a case-by-case basis through the Compliance Committee.
    ii. Medicaid Self-Disclosure.

[1] The 60-day period starts with the "identification" of an overpayment receipt. Investigation into the reasons for the overpayment receipt and the calculation of the total amount improperly received must be completed, and the total repaid, with the requisite 60-day period.

1. OMIG has issued a document entitled "Self-Disclosure Guidance", which can be found at the following OMIG website - https://omig.ny.gov/self-disclosure-submission-information-and-instructions. The Care Compass Entities adhere to the OMIG Guidance and, in particular, the protocols outlined below.
    a. Initial Assessment. An initial assessment of whether to conduct a review for Self-Disclosure purposes will be made by the CFO and Director of Compliance, with the approval of the Compliance Committee.
    b. Guidance.
        i. OMIG expects all Medicaid overpayments found and corrected in the normal course of business and resulting in repayment to be reported using the OMIG Self-Disclosure Abbreviated Statement within sixty (60) calendar days of identification.
        ii. OMIG expects routine matters to be corrected through the paying agents, as opposed to a formal Self-Disclosure. It is the responsibility of the CFO, Director of Compliance, Executive Director, and Compliance Committee to determine whether a matter involves more than routine errors.
            1. To the extent that self-disclosure protocols are provided by a payor, The Care Compass Entities will report repayments due to a payor and found and corrected in the normal course of business through a payor's existing methods of reporting payment errors.
            2. To the extent that self-disclosure protocols are not provided by a payor, the Care Compass Entities will report repayments due to a payor and found and corrected in the normal course of business to OMIG using the OMIG Self-Disclosure Full Statement within sixty (60) calendar days of identification.
    c. Disclosure during Active Audit/Investigation. OMIG has noted that a Self-Disclosure made during an on-going audit or investigation of a provider will not be considered when it relates to the subject matter of the investigation:
        i. Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under the Self-Disclosure protocol.
        ii. 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.

iii. If OMIG is already auditing or investigating a matter, and the Care Compass Entities wish to disclose an issue, in addition to submitting a disclosure under this protocol, the Care Compass Entities should bring the matter to the attention of the on-site audit staff.

iv. If another outside agency is auditing or investigating a matter, and the Care Compass Entities seek to disclose an issue to OMIG, the Care Compass Entities should follow this guidance accordingly.

d. Once a determination is made to provide for a Self-Disclosure, the Compliance Committee will assign the Director of Compliance, CFO, and/or outside consultants/attorneys, as necessary, to conduct an assessment of the circumstances, giving rise to such Self-Disclosure and provide a written assessment for review.

   i. An initial assessment should be provided within five (5) business days. Although a full review may require further time, depending on the issues involved, it is expected that an initial assessment will be provided within the five (5) day period. To the extent further time is required, such an assessment will state that more time is needed and provide the reasons for such extension.

e. Required Details. The investigation and draft submittal shall be sufficient so that the following information is included within the review, as set forth under OMIG Guidance:

   i. The following steps comprise an initial report:

      1. The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
      2. The Medicaid program rules potentially implicated;
      3. 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;
      4. The name and telephone number(s) of the individual making the report on behalf of the Care Compass Entities. 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;
      5. A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;

6. 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 service/procedure codes, and the amount(s) paid by Medicaid; and
7. The names of individuals involved in any suspected improper or illegal conduct.

iii. OIG Investigations and Self-Disclosure.

1. The OIG has issued discretionary and non-binding guidance entitled "Updated OIG's Health Care Fraud Self-Disclosure Protocol". This guidance was first issued by the OIG on October 30, 1998, as the "Provider Self-Disclosure Protocol", and was updated in March of 2009, April of 2013, and November of 2021. It may be found at the following OIG website: https://oig.hhs.gov/documents/self-disclosure-info/1006/Self-Disclosure-Protocol-2021.pdf.
2. This guidance sets forth how and to whom voluntary disclosure must be made with regard to Federal programs and describes the guidelines to be used by those that are subject to OIG's civil monetary penalties (CMP) authorities in conducting its internal investigation for Federal compliance purposes.
3. The Compliance Committee may use such OIG guidance in assessing Self-Disclosure to the extent that there is potential liability relating to Federal program participation and/or serious issues concerning Medicaid participation resulting from an OMIG Self-Disclosure review.
4. The following principles will be applied by the Care Compass Entities in assessing OIG related issues for Self-Disclosure:
    a. Only matters involving violations of criminal or civil rules and/or serious administrative violations should be considered under OIG's self-reporting protocol.
    b. Matters involving overpayments or errors should be brought to the attention of the entity involved in funding the payments, as per the Reimbursement Protocols.
    c. Internal Investigation Guidelines are set forth in the OIG guidance document and include:
        i. Full examination of improper or illegal practice, including potential causes, how a matter arose, identity of individuals involved and those who should have known, and an estimate of the monetary impact;
        ii. Review of circumstances of discovery and action taken in response: and
        iii. Self-assessment to be performed by the Care Compass Entities to audit their liability.

VII. Fraud/Criminal Investigations. This Policy is not meant to provide for all possible methods of "self-disclosure" as may be appropriate for the Care Compass Entities as non-profit entities. The Compliance Committee and Boards of Directors must review all serious issues of potential criminal activity with outside counsel and assure appropriate corrective actions, as it could potentially involve individuals who may have acted in knowing violation of the law. The Care Compass Entities do not have the jurisdiction to determine criminal culpability. Where required by law or by the Compliance Program, the Compliance Committee will review whether an appropriate referral to prosecuting authorities is required. Such authorities may include local district attorneys, the New York State Attorney General, and/or the Office of the United States Attorney having jurisdiction over the matter.

VIII. Attorney Client Privilege. Notwithstanding anything set forth in this Policy or any actions taken hereunder, the Care Compass Entities do not waive their attorney client privilege in any manner whatsoever. Any such waiver may only be authorized by a vote of the Boards of Directors in accordance with the Care Compass Entities' Bylaws.

CCN Board Approval History: 6/10/2025

CCC Board Approval History:

IPA Board Approval History:

Compliance Committee Review History: 5/22/2025

Finance Committee Review History: 5/22/2025

Policy Revisions:

Date	Revision Log	Updated By
3/5/2025	Original Creation	Cathy Petrak

This Policy shall be reviewed periodically, but not less than once every 12 months, and updated consistent with the requirements established by the Board of Directors, Care Compass Network's Leadership Team, Federal and State law(s) and regulations, and applicable accrediting and review organizations.