

# STATE OF NEW YORK

5329--A

2023-2024 Regular Sessions

## IN SENATE

March 2, 2023

Introduced by Sens. HARCKHAM, KENNEDY, WEBB -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee and committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law and the social services law, in relation to the functions of the Medicaid inspector general with respect to audit and review of medical assistance program funds and requiring notice of certain investigations

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Section 30-a of the public health law is amended by adding  
2 three new subdivisions 4, 5, and 6 to read as follows:

3 4. "Medical assistance," "Medicaid," and "recipient" shall have the  
4 same meaning as those terms in title eleven of article five of the  
5 social services law and shall include any payments to providers under  
6 any Medicaid managed care program.

7 5. "Provider" means any person or entity enrolled as a provider in the  
8 medical assistance program.

9 6. "Overpayment" shall mean any amount paid to a provider for medical  
10 assistance in excess of the amount allowable under the state plan for  
11 medical assistance in effect at the time of such service, or allowable  
12 under any federally approved Medicaid waiver, experiment, pilot, or  
13 demonstration project. An overpayment shall not include circumstances of  
14 provider noncompliance with state laws, regulations or applicable  
15 promulgated state agency policies, guidelines, standards, protocols or  
16 interpretations which are not a condition of payment, unless the provid-  
17 er obtained payment by fraud or deceit, or where the provider was previ-  
18 ously provided notice of its failure to comply and has failed to correct  
19 such noncompliance. An overpayment shall not include noncompliance with  
20 any applicable promulgated state agency policies, guidelines, standards,

EXPLANATION--Matter in italics (underscored) is new; matter in brackets  
[-] is old law to be omitted.

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protocols or interpretations where such policy, guideline, standard, protocol or interpretation is facially, or as applied, reasonably susceptible to more than one meaning, provided the provider complied with one such reasonable meaning.

§ 2. Subdivision 20 of section 32 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

20. to, consistent with [~~provisions of~~] this title and applicable federal laws, regulations, policies, guidelines and standards, implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation and referral of fraud and abuse within the medical assistance program and the recovery of improperly expended medical assistance program funds;

§ 3. The public health law is amended by adding two new sections 37 and 38 to read as follows:

§ 37. Audit and recovery of medical assistance payments to providers. Any audit or review of any provider contracts, cost reports, claims, bills, or medical assistance payments by the inspector, anyone designated by the inspector or otherwise lawfully authorized to conduct such audit or review, or any other agency with jurisdiction to conduct such audit or review, shall comply with the following standards:

1. Recovery of any overpayment resulting from any audit or review of provider contracts, cost reports, claims, bills, or medical assistance payments shall not commence prior to sixty days after delivery to the provider of a final audit report or final notice of agency action, or where the provider requests a hearing or appeal within sixty days of delivery of the final audit report or final notice of agency action, until a final determination of such hearing or appeal is made. This subdivision shall not apply where the withholding is pursuant to a pending investigation of a credible allegation of fraud or where there is a finding that the provider has abused the program or committed an unacceptable practice.

2. Provider contracts, cost reports, claims, bills or medical assistance payments that were the subject matter of a previous audit or review within the last three years shall not be subject to review or audit again except on the basis of new information, for good cause to believe that the previous review or audit was erroneous, or where the scope of the inspector's review or audit is significantly different from the scope of the previous review or audit.

3. Any reviews or audits of provider contracts, cost reports, claims, bills or medical assistance payments shall apply the state laws, regulations and the applicable, duly promulgated policies, guidelines, standards, protocols and interpretations of state agencies with jurisdiction and in effect at the time the provider engaged in the applicable regulated conduct or provision of services. For the purpose of this subdivision, the state law, regulation or the applicable promulgated agency policy, guideline, standard, protocol or interpretation shall not be deemed in effect if federal governmental approval is pending or denied.

4. (a) In the event of any overpayment based upon a provider's administrative or technical error, the provider shall have the longer of sixty days from notice of the mistake or six years from the date of service to submit a corrected claim provided (i) the error was a genuine error without intent to falsify or defraud, (ii) the provider maintained contemporaneous documentation to substantiate the correct claims information, (iii) such error is the sole basis for the finding of an overpayment, and (iv) there is no finding of any overpayment for such error by a federal agency or official.

1 (b) No overpayment shall be calculated for any administrative or tech-  
2 nical error corrected as required in paragraph (a) of this subdivision.

3 5. (a) In determining the amount of any overpayment to a provider,  
4 extrapolation shall be permitted only upon a finding of a sustained or  
5 high level of payment error or where the provider has been the subject  
6 of educational intervention and failed to correct the payment error  
7 after a reasonable opportunity to do so. The final audit report or  
8 final notice of agency action shall include a statement of the factual  
9 basis for utilizing extrapolation and the inappropriate use of extrapo-  
10 lation shall be a basis for appeal. This subdivision shall not be  
11 construed to limit the recoupment of an overpayment identified without  
12 the use of extrapolation.

13 (b) Sustained or high level of payment error shall exist under the  
14 following circumstances: (i) the audit or review results in a finding of  
15 a payment error rate equal to or greater than fifty percent, (ii) the  
16 audit or review results in a finding of identical payment errors identi-  
17 fied in a prior audit or review, (iii) the provider was previously sanc-  
18 tioned or investigated for identical payment errors, (iv) there is a  
19 prior judgment against, or settlement involving, the provider based upon  
20 a finding that the provider engaged in fraud and/or abuse related to  
21 federal or state payment programs, (v) there are prior complaints by  
22 provider employees related to identical payment errors, and (vi) there  
23 is a prior finding of identical payment error by a federal agency or  
24 official.

25 6. (a) The provider shall be provided as part of the draft audit find-  
26 ings a detailed written explanation of the extrapolation method  
27 employed, including the size of the sample, the sampling methodology,  
28 the defined universe of claims, the specific claims included in the  
29 sample, the results of the sample, the assumptions made about the accu-  
30 racy and reliability of the sample and the level of confidence in the  
31 sample results, and the steps undertaken and statistical methodology  
32 utilized to calculate the alleged overpayment and any applicable offset  
33 based on the sample results. This written information shall include a  
34 description of the sampling and extrapolation methodology.

35 (b) The sampling and extrapolation methodologies utilized by the  
36 inspector shall be consistent with accepted standards of sound auditing  
37 practice and statistical analysis.

38 7. The requirements of this section shall be interpreted consistent  
39 with and subject to any applicable federal law, rules and regulations,  
40 or binding federal agency guidance and directives.

41 § 38. Procedures, practices and standards for recipients. 1. This  
42 section applies to any adjustment or recovery of a medical assistance  
43 payment from a recipient, and any investigation or other proceeding  
44 relating thereto.

45 2. At least five business days prior to commencement of any interview  
46 with a recipient as part of an investigation, the inspector or other  
47 investigating entity shall provide the recipient with written notice of  
48 the investigation. The notice of the investigation shall set forth the  
49 basis for the investigation; the potential for referral for criminal  
50 investigation; the individual's right to be accompanied by a relative,  
51 friend, advocate or attorney during questioning; contact information for  
52 local legal services offices; the individual's right to decline to be  
53 interviewed or participate in an interview but terminate the questioning  
54 at any time without loss of benefits; and the right to a fair hearing in  
55 the event that the investigation results in a determination of incorrect  
56 payment.

1 3. Following completion of the investigation and at least thirty days  
2 prior to commencing a recovery or adjustment action or requesting volun-  
3 tary repayment, the inspector or other investigating entity shall  
4 provide the recipient with written notice of the determination of incor-  
5 rect payment to be recovered or adjusted. The notice of determination  
6 shall identify the evidence relied upon, set forth the factual conclu-  
7 sions of the investigation, and explain the recipient's right to request  
8 a fair hearing in order to contest the outcome of the investigation. The  
9 explanation of the right to a fair hearing shall conform to the require-  
10 ments of subdivision twelve of section twenty-two of the social services  
11 law and regulations thereunder.

12 4. A fair hearing under section twenty-two of the social services law  
13 shall be available to any recipient who receives a notice of determi-  
14 nation under subdivision three of this section, regardless of whether  
15 the recipient is still enrolled in the medical assistance program.

16 § 4. Paragraph (c) of subdivision 3 of section 363-d of the social  
17 services law, as amended by section 4 of part V of chapter 57 of the  
18 laws of 2019, is amended and a new subdivision 8 is added to read as  
19 follows:

20 (c) In the event that the commissioner of health or the Medicaid  
21 inspector general finds that the provider does not have a satisfactory  
22 program [~~within ninety days after the effective date of the regulations~~  
23 ~~issued pursuant to subdivision four of this section~~], the commissioner  
24 or Medicaid inspector general shall so notify the provider, including  
25 specification of the basis of the finding sufficient to enable the  
26 provider to adopt a satisfactory compliance program. The provider shall  
27 submit to the commissioner or Medicaid inspector general a proposed  
28 satisfactory compliance program within sixty days of the notice and  
29 shall adopt the program as expeditiously as possible. If the provider  
30 does not propose and adopt a satisfactory program in such time period,  
31 the provider may be subject to any sanctions or penalties permitted by  
32 federal or state laws and regulations, including revocation of the  
33 provider's agreement to participate in the medical assistance program.

34 8. Any regulation, determination or finding of the commissioner or the  
35 Medicaid inspector general relating to a compliance program under this  
36 section shall be subject to and consistent with subdivision three of  
37 this section.

38 § 5. Section 32 of the public health law is amended by adding a new  
39 subdivision 6-b to read as follows:

40 6-b. to consult with the commissioner on the preparation of an annual  
41 report, to be made and filed by the commissioner on or before the first  
42 day of July to the governor, the temporary president of the senate, the  
43 speaker of the assembly, the minority leader of the senate, the minority  
44 leader of the assembly, the commissioner, the commissioner of the office  
45 of addiction services and supports, and the commissioner of the office  
46 of mental health on the impacts that all civil and administrative  
47 enforcement actions taken under subdivision six of this section in the  
48 previous calendar year will have and have had on the quality and avail-  
49 ability of medical care and services, the best interests of both the  
50 medical assistance program and its recipients, and fiscal solvency of  
51 the providers who were subject to the civil or administrative enforce-  
52 ment action;

53 § 6. This act shall take effect immediately.