S T A T E O F N E W Y O R K

3184

2011-2012 Regular Sessions

I N S E N A T E

February 10, 2011

Introduced by Sen. LITTLE -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the social services law, in relation to fair procedures, practices and standards for actions by the office of medicaid inspector general and social services districts

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 30 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

S 30. Legislative intent. This title establishes an independent office of Medicaid inspector general within the department to consolidate staff and other Medicaid fraud detection, prevention and recovery functions from the relevant governmental entities into a single office, and grants such office new powers and responsibilities. As such, this title is intended to create a more efficient and accountable structure, dramatically reorganize and streamline the state's process of detecting and combating Medicaid fraud and abuse and maximize the recoupment of improper Medicaid payments.

THE LEGISLATURE RECOGNIZES THE NEED TO BALANCE THE ABILITY OF THE STATE TO ENSURE THE INTEGRITY OF THE MEDICAL ASSISTANCE PROGRAM WITH THE NEED TO AFFORD DUE PROCESS TO PROVIDERS AND RECIPIENTS WHO ARE INVESTIGATED, AUDITED OR SUBJECT TO OTHER ACTIONS, IN ORDER TO ENSURE THAT SUCH ACTIONS ARE CONDUCTED IN A FAIR AND CONSISTENT MANNER. THE LEGISLATURE ALSO RECOGNIZES THE NEED FOR ESTABLISHED STATUTORY STANDARDS REGARDING THE CONDUCT OF INVESTIGATIONS, AUDITS AND RECOVERY OF PAYMENTS AND OTHER ACTIONS.

S 2. Section 30-a of the public health law is amended by adding four new subdivisions 4, 5, 6 and 7 to read as follows:

4. "PROVIDER" MEANS ANY PERSON OR ENTITY ENROLLED AS A PROVIDER IN THE MEDICAL ASSISTANCE PROGRAM.

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

LBD07895-01-1

5. "RECIPIENT" MEANS AN INDIVIDUAL WHO IS ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, INCLUDING AN INDIVIDUAL WHO WAS PREVIOUSLY A RECIPIENT AND, IN AN APPROPRIATE CASE, AN INDIVIDUAL WHO IS LEGALLY RESPONSIBLE FOR THE RECIPIENT.

6. "MEDICAL ASSISTANCE" AND "MEDICAID" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

7. "DRAFT AUDIT REPORT", "INITIAL AUDIT REPORT", "PROPOSED NOTICE OF AGENCY ACTION" AND "FINAL NOTICE OF AGENCY ACTION" MEANS THOSE DOCUMENTS PREPARED AND ISSUED BY THE INSPECTOR UNDER THIS TITLE AND CORRESPONDING REGULATIONS.

S 3. 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 OTHER APPLICABLE FEDERAL AND STATE 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;

S 4. The public health law is amended by adding two new sections 37 and 38 to read as follows:

S 37. FAIR PROCEDURES, PRACTICES AND STANDARDS. 1. NO RECOVERY OF AN OVERPAYMENT RESULTING FROM THE ISSUANCE OF A FINAL AUDIT REPORT OR FINAL NOTICE OF AGENCY ACTION RELATING TO A MONETARY PENALTY BY THE INSPECTOR SHALL COMMENCE UNTIL SIXTY DAYS AFTER THE ISSUANCE OF THE FINAL AUDIT REPORT OR FINAL NOTICE OF AGENCY ACTION OR, WHERE AN ADMINISTRATIVE HEARING HAS BEEN TIMELY REQUESTED BY A PROVIDER, UNTIL AFTER ISSUANCE OF A DECISION AFTER THE ADMINISTRATIVE HEARING. THE INSPECTOR SHALL NOT COMMENCE ANY RECOVERY UNDER THIS SUBDIVISION WITHOUT PROVIDING A MINIMUM OF THIRTY DAYS ADVANCE WRITTEN NOTICE TO THE PROVIDER.

2. A RECOVERY OF AN OVERPAYMENT UNDER SUBDIVISION ONE OF THIS SECTION SHALL BE MADE AT A RATE NOT TO EXCEED TEN PERCENT OF A PROVIDER'S MEDICAL ASSISTANCE CLAIMS DUE AND PAYABLE FOR EACH BILLING CYCLE DURING WHICH THE RECOVERY IS SOUGHT, OR SUCH OTHER AMOUNT AGREED ON BY THE INSPECTOR AND THE PROVIDER. IF ANOTHER EXISTING RECOVERY AGAINST THE PROVIDER IS CURRENTLY IN EFFECT, THE TOTAL OF ALL SUCH RECOVERIES MAY NOT EXCEED TEN PERCENT OF A PROVIDER'S MEDICAL ASSISTANCE CLAIMS DUE AND PAYABLE FOR THE BILLING CYCLE FOR WHICH THE RECOVERIES ARE SOUGHT, OR SUCH OTHER AMOUNT AGREED ON BY THE INSPECTOR AND THE PROVIDER. THE INSPECTOR MAY SEEK INTEREST AT A RATE SPECIFIED IN REGULATION THAT SHALL NOT EXCEED NINE PERCENT ON ANY OUTSTANDING OVERPAYMENT REMAINING ONE HUNDRED TWENTY DAYS AFTER THE DATE ON WHICH WRITTEN NOTICE IS SENT TO THE PROVIDER. THIS SUBDIVISION SHALL NOT APPLY IN THE CASE OF FRAUD.

3. THE INSPECTOR SHALL NOT HAVE AUTHORITY TO CONDUCT ANY REVIEWS OR AUDITS OF CONTRACTS, COST REPORTS, CLAIMS, BILLS OR EXPENDITURES OF MEDICAL ASSISTANCE PROGRAM FUNDS THAT WERE THE SUBJECT MATTER OF A PREVIOUS AUDIT OR REVIEW BY OR ON BEHALF OF THE INSPECTOR, ANY OTHER STATE OR LOCAL GOVERNMENTAL AGENCY OR OFFICE OR CONTRACTOR OR AGENT THEREOF AUTHORIZED TO CONDUCT SUCH REVIEWS OR AUDITS IF SUCH AUDIT OR REVIEW WAS COMPLETED WITHIN THE LAST THREE YEARS, 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.

4. THE PERIOD OF ANY AUDIT CONDUCTED BY THE INSPECTOR SHALL NOT EXCEED THREE YEARS UNLESS A FINDING OF FRAUD OR INTENTIONAL MISCONDUCT IS ALLEGED IN THE DRAFT AUDIT REPORT OR DRAFT NOTICE OF AGENCY ACTION.

5. (A) IN CONDUCTING AUDITS OR TAKING OTHER ACTIONS BASED ON LAWS, REGULATIONS, POLICIES, GUIDELINES, STANDARDS OR INTERPRETATIONS ESTABLISHED OR ENFORCED BY A FEDERAL OR STATE AGENCY, INCLUDING THE INSPECTOR, THE INSPECTOR SHALL APPLY THE LAWS, REGULATIONS, POLICIES, GUIDELINES, STANDARDS AND INTERPRETATIONS OF THAT AGENCY THAT WERE IN PLACE AT THE TIME THE SUBJECT CLAIM AROSE OR OTHER CONDUCT TOOK PLACE. DISALLOWANCES MAY BE IMPOSED OR OTHER ACTION TAKEN ONLY FOR NON-COMPLIANCE WITH THOSE LAWS, REGULATIONS, POLICIES, GUIDELINES OR STANDARDS. FOR PURPOSES OF THIS SUBDIVISION, ANY CHANGE IN SUCH LAWS, REGULATIONS, POLICIES, GUIDELINES, STANDARDS OR INTERPRETATIONS SHALL ONLY BE APPLIED PROSPECTIVELY AND UPON REASONABLE NOTICE.

(B) TO THE EXTENT THAT THE INSPECTOR SANCTIONS A PROVIDER BASED SOLELY ON LAWS, REGULATIONS, POLICIES, GUIDELINES, STANDARDS OR INTERPRETATIONS ENFORCED BY A FEDERAL OR STATE AGENCY OTHER THAN THE INSPECTOR, THE INSPECTOR MAY ONLY IMPOSE A SANCTION CONTEMPORANEOUS WITH, AND NO LONGER IN DURATION THAN, ANY SUCH SANCTION IMPOSED BY SUCH OTHER AGENCY. UPON THE EXPIRATION OF ANY SUCH SANCTION BY SUCH OTHER AGENCY, THE INSPECTOR SHALL IMMEDIATELY REMOVE HIS OR HER SANCTION OF THAT PROVIDER, WITHOUT NEED BY THE PROVIDER TO REAPPLY TO THE MEDICAL ASSISTANCE PROGRAM TO BECOME REINSTATED AS A PROVIDER.

(C) IN ANY ACTION UNDER THIS TITLE, THE INSPECTOR SHALL ACCEPT ANY DETERMINATION OF COMPLIANCE MADE BY A GOVERNMENTAL AGENCY WITH JURISDICTION TO MAKE SUCH A DETERMINATION, UNLESS THE INSPECTOR FINDS THAT SUCH DETERMINATION OF COMPLIANCE WAS BASED ON MISINFORMATION, WAS CLEARLY ERRONEOUS, OR WAS AFFECTED BY FRAUD OR OTHER INTENTIONAL MISCONDUCT.

6. AT LEAST TEN DAYS PRIOR TO AN ADMINISTRATIVE HEARING UNDER THIS TITLE, EACH PARTY TO THE HEARING SHALL MAKE A GOOD FAITH EFFORT TO DISCLOSE AT A PRE-HEARING CONFERENCE THE EVIDENCE IT INTENDS TO INTRODUCE AND A LIST OF WITNESSES IT INTENDS TO PRODUCE AT THE HEARING. THIS SUBDIVISION SHALL NOT PROHIBIT EITHER THE INSPECTOR OR THE PROVIDER FROM INTRODUCING ANY EVIDENCE INCLUDING DOCUMENTARY EVIDENCE OR THE TESTIMONY FROM A WITNESS THAT WAS NOT DISCLOSED PRIOR TO OR AT THE PRE-HEARING CONFERENCE. THE INSPECTOR SHALL IMMEDIATELY PROVIDE TO THE PROVIDER ANY EVIDENCE THAT THE INSPECTOR MAY POSSESS OR ACQUIRE THAT WOULD SUPPORT THE ALLOWABILITY OR PROPRIETY OF THE PROVIDER'S COST REPORTING, BILLING OR OTHER PRACTICE OR PRACTICES AT ISSUE IN THE HEARING OR IS OTHERWISE EXCULPATORY. UNLESS ANY EVIDENCE IS DETERMINED BY THE ADMINISTRATIVE LAW JUDGE TO BE IRRELEVANT OR IMMATERIAL OR ANY TESTIMONY UNDULY REPETITIOUS, ALL EVIDENCE, INCLUDING BUT NOT LIMITED TO NON CONTEMPORANEOUSLY PREPARED DOCUMENTARY EVIDENCE, AND ALL TESTIMONY FROM WITNESSES, SHALL BE ADMITTED BY THE ADMINISTRATIVE LAW JUDGE WHO SHALL GIVE SUCH EVIDENCE OR TESTIMONY APPROPRIATE WEIGHT IN RENDERING A RECOMMENDATION OR DECISION.

7. THE INSPECTOR SHALL MAKE NO RECOVERY FROM A PROVIDER FOR FINDINGS THAT ARE BASED ON THE ACTIONS OR THE RESPONSIBILITY OF ANOTHER PROVIDER OR GOVERNMENTAL AGENCY, UNLESS THE PROVIDER KNEW OR REASONABLY SHOULD HAVE KNOWN THAT IT WAS CLAIMING PAYMENT TO WHICH IT WAS NOT ENTITLED. IN ANY RECOVERY SUBJECT TO THIS SUBDIVISION, THE INSPECTOR SHALL SEEK RECOVERY PRIMARILY FROM THE PROVIDER BEARING THE PRIMARY RESPONSIBILITY FOR THE OVERPAYMENT OR IMPROPER PAYMENT.

8. (A) THE INSPECTOR SHALL MAKE NO RECOVERY FROM A PROVIDER, BASED ON AN ADMINISTRATIVE OR TECHNICAL DEFECT IN PROCEDURE OR DOCUMENTATION MADE WITHOUT INTENT TO FALSIFY OR DEFRAUD, IN CONNECTION WITH CLAIMS FOR PAYMENT FOR MEDICALLY NECESSARY CARE, SERVICES AND SUPPLIES OR THE COST THEREOF AS SPECIFIED IN SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW PROVIDED IN OTHER RESPECTS APPROPRI-

ATELY TO A BENEFICIARY OF THE MEDICAL ASSISTANCE PROGRAM, EXCEPT AS PROVIDED IN PARAGRAPH (B) OF THIS SUBDIVISION.

(B) WHERE THE BASIS FOR RECOVERY IS AN ADMINISTRATIVE OR TECHNICAL DEFECT IN PROCEDURE OR DOCUMENTATION WITHOUT INTENT TO FALSIFY OR DEFRAUD, THE INSPECTOR SHALL AFFORD THE PROVIDER AN OPPORTUNITY TO CORRECT THE DEFECT AND RESUBMIT THE CLAIM WITHIN SIXTY DAYS OF NOTICE OF THE DEFECT. IF A SATISFACTORY CLAIM IS NOT RESUBMITTED UNDER THIS PARAGRAPH, THE INSPECTOR MAY SEEK TO RECOVER UP TO TEN PERCENT OF THE AMOUNT THAT WOULD OTHERWISE BE RECOVERABLE, EXCEPT THAT WHERE THE DEFECT DETERMINED THE QUANTITY OR VALUE OF PAYMENT CLAIMED, THEN THE RECOVERY MAY BE THE DIFFERENCE BETWEEN THE AMOUNT RECEIVED BY THE PROVIDER AND THE AMOUNT THAT SHOULD HAVE BEEN RECEIVED IF THE CLAIM HAD BEEN SUBMITTED PROPERLY.

9. (A) THE INSPECTOR SHALL NOT APPLY ANY EXTRAPOLATION METHOD TO A CATEGORY OF ERROR OR DEFECT WITHIN A SAMPLE UNLESS THE INSPECTOR SHALL FIRST DETERMINE THAT THE CATEGORY OF ERROR OR DEFECT IN THE BILLING OR OTHER PRACTICE IDENTIFIED BY THE INSPECTOR IN THE SAMPLE OF CLAIMS EXCEEDS A RATE OF FIVE PERCENT WITHIN THE SAMPLE OF CLAIMS, AFTER THE INSPECTOR AFFORDS THE PROVIDER REASONABLE OPPORTUNITY TO RESPOND TO THE INSPECTOR'S INITIAL FINDINGS. HOWEVER, NOTWITHSTANDING THE PRECEDING SENTENCE, THE INSPECTOR AND THE PROVIDER MAY AGREE TO THE USE OF EXTRAPOLATION.

(B) THE INSPECTOR SHALL FURNISH TO THE PROVIDER AT AN AUDIT ENTRANCE CONFERENCE OR IN ANY DRAFT AUDIT FINDINGS ISSUED OR TO BE ISSUED TO THE PROVIDER, A DETAILED WRITTEN EXPLANATION OF THE EXTRAPOLATION METHOD EMPLOYED, INCLUDING THE SIZE OF THE SAMPLE, THE SAMPLING METHODOLOGY, THE DEFINED UNIVERSE OF CLAIMS, THE SPECIFIC CLAIMS INCLUDED IN THE SAMPLE, THE RESULTS OF THE SAMPLE, THE ASSUMPTIONS MADE ABOUT THE ACCURACY AND RELIABILITY OF THE SAMPLE AND THE LEVEL OF CONFIDENCE IN THE SAMPLE RESULTS, AND THE STEPS UNDERTAKEN AND STATISTICS UTILIZED TO CALCULATE THE ALLEGED OVERPAYMENT AND ANY APPLICABLE OFFSET BASED ON THE SAMPLE RESULTS. THIS WRITTEN INFORMATION SHALL INCLUDE A DESCRIPTION OF THE SAMPLING AND EXTRAPOLATION METHODOLOGY, IN SUFFICIENT DETAIL TO PERMIT THE PROVIDER TO TEST AND RECREATE THE METHODOLOGY IN ORDER TO PROPERLY AND FULLY DEFEND ANY DETERMINATION OF OVERPAYMENT WHICH IS BASED ON THIS PROCESS.

(C) THE SAMPLING AND EXTRAPOLATION METHODOLOGIES USED BY THE INSPECTOR SHALL BE STATISTICALLY REASONABLY VALID FOR THE INTENDED USE AND SHALL BE ESTABLISHED IN REGULATIONS OF THE INSPECTOR.

10. ANY FUNDS AND INTEREST THEREON DETERMINED BY THE INSPECTOR, THE COMMISSIONER OR HIS OR HER DESIGNEE, ADMINISTRATIVE PROCEEDING, OR COURT TO HAVE BEEN IMPROPERLY WITHHELD OR RECOUPED FROM A PROVIDER SHALL BE REFUNDED TO THE PROVIDER, WITH INTEREST ON THE AMOUNT OF THE WITHHELD OR RECOUPED FUNDS FROM THE DATE OF WITHHOLDING OR RECOUPMENT THROUGH THE DATE OF REFUND PAYABLE AT THE SAME RATE AS ANY INTEREST ASSESSED BY THE STATE ON RECOUPED FUNDS, TO BE REFUNDED AND PAID TO THE PROVIDER AS SOON AS PRACTICABLE BUT IN NO EVENT MORE THAN NINETY DAYS AFTER THE DETERMINATION.

11. WHERE ANY AUDIT OR CIVIL OR ADMINISTRATIVE ENFORCEMENT ACTION UNDER THIS TITLE WOULD EITHER (A) RECOUP FROM THE PROVIDER AN AMOUNT GREATER THAN TEN PERCENT OF THE AMOUNT IT WOULD OTHERWISE RECEIVE FROM THE MEDICAL ASSISTANCE PROGRAM DURING THE PERIOD IN WHICH THE RECOUPMENT WOULD OCCUR, OR (B) SUSPEND OR TERMINATE THE PROVIDER'S PARTICIPATION IN THE MEDICAL ASSISTANCE PROGRAM, THE INSPECTOR SHALL DEMONSTRATE THAT THE ENFORCEMENT ACTION WILL NOT UNDULY JEOPARDIZE THE QUALITY AND AVAILABILITY OF MEDICAL CARE AND SERVICES IN THE AREA SERVED BY A PROVIDER,

INCLUDING ALTERNATIVES TO THE CARE, SERVICES AND SUPPLIES PROVIDED BY THE PROVIDER AND THE ABILITY OF A PROVIDER TO CONTINUE PROVIDING CARE, SERVICES AND SUPPLIES AND THE BEST INTEREST OF THE MEDICAL ASSISTANCE PROGRAM AND MEDICAL ASSISTANCE RECIPIENTS.

12. IN CARRYING OUT HIS OR HER DUTIES UNDER THIS TITLE, THE INSPECTOR SHALL ASSIGN PERSONNEL, AGENTS AND CONTRACTORS WITH APPROPRIATE TRAINING, EDUCATION, OR EXPERTISE (INCLUDING CLINICAL EXPERTISE WHERE THE MATTER IN DISPUTE CONCERNS THE VALIDITY OF THE PROVIDER'S CLINICAL OBSERVATION, DIAGNOSIS, TREATMENT, OR DOCUMENTATION) AND SHALL NOT ASSIGN ANY PERSON, AGENT OR CONTRACTOR TO CONDUCT, REVIEW, OR PARTICIPATE, DIRECTLY OR INDIRECTLY IN AN AUDIT, REVIEW, EXAMINATION OR INVESTIGATION OF AN ENTITY WITH WHICH SUCH PERSON, AGENT OR CONTRACTOR WAS EMPLOYED OR ASSOCIATED OR HAD A CONTRACTUAL RELATIONSHIP OR OTHER ENGAGEMENT WITH AT ANY TIME PRIOR TO THE COMMENCEMENT OF SUCH AUDIT, REVIEW, EXAMINATION OR INVESTIGATION.

13. FOR THE PURPOSES OF THIS TITLE, THERE SHALL BE A REBUTTABLE PRESUMPTION THAT THE CLINICAL OBSERVATION, DIAGNOSIS, TREATMENT, AND DOCUMENTATION BY A PROVIDER ARE VALID. THE INSPECTOR MAY NOT DISALLOW, RECOVER, OR WITHHOLD A MEDICAL ASSISTANCE PAYMENT ON THE BASIS OF MEDICAL NECESSITY OR CLINICAL JUDGMENT OR STANDARDS WITHOUT AFFIRMATIVELY FINDING IN WRITING THAT THE PROVIDER'S CLINICAL OBSERVATION, DIAGNOSIS, TREATMENT, OR DOCUMENTATION IS NOT VALID. SUCH A FINDING MAY NOT BE RELIED UPON OR USED AS THE BASIS FOR ANY EXTRAPOLATION.

14. IN CONDUCTING AUDITS, REVIEWS, INVESTIGATIONS, AND CIVIL OR ADMINISTRATIVE ACTIONS, THE INSPECTOR SHALL CONSIDER ALL DOCUMENTS AND OTHER INFORMATION, IN ANY MEDIUM AND IN ANY FORM, SUBMITTED BY A PROVIDER OR SUPPLIER THAT ARE RELEVANT TO DETERMINE WHETHER MEDICALLY NECESSARY COVERED CARE, SERVICES OR SUPPLIES WERE PROVIDED TO AN ELIGIBLE RECIPIENT.

15. IN CONDUCTING AUDITS, REVIEWS, INVESTIGATIONS, AND CIVIL OR ADMINISTRATIVE ACTIONS, THE INSPECTOR SHALL DETERMINE IN WRITING WHICH BOOKS, PAPERS, RECORDS, AND DOCUMENTS THAT ARE NECESSARY, RELEVANT, AND MATERIAL TO A SPECIFIC ACTION THAT THE INSPECTOR MAY SEEK TO INSPECT, COPY, OR OBTAIN. THE INSPECTOR SHALL GIVE THE PROVIDER REASONABLE WRITTEN NOTICE OF THE WRITTEN DETERMINATION PRIOR TO SEEKING TO INSPECT, COPY, OR OBTAIN THE BOOKS, PAPERS, RECORDS OR DOCUMENTS.

16. NOTWITHSTANDING ANY LAW OR REGULATION TO THE CONTRARY, THE INSPECTOR SHALL MAKE NO RECOVERY BASED ON THE FAILURE OF THE PROVIDER TO SUBMIT A CLAIM FOR PAYMENT FOR MEDICAL CARE, SERVICES, OR SUPPLIES WITHIN NINETY DAYS OF THE DATE THE MEDICAL CARE, SERVICES, OR SUPPLIES WERE FURNISHED, PROVIDED THAT SUCH CLAIM IS SUBMITTED WITHIN TWO YEARS OF THE DATE FURNISHED.

S 38. FAIR PROCEDURES, PRACTICES AND STANDARDS FOR RECIPIENTS. 1. THIS SECTION APPLIES TO ANY ADJUSTMENT OR RECOVERY OF A MEDICAL ASSISTANCE PAYMENT FROM A RECIPIENT, AND ANY INVESTIGATION OR OTHER PROCEEDING RELATING THERETO. NO ADJUSTMENT OR RECOVERY SUBJECT TO THIS SECTION SHALL OCCUR UNLESS THE RECIPIENT HAS BEEN AFFORDED THE PROTECTIONS OF THE PROCEDURES, PRACTICES AND STANDARDS UNDER THIS SECTION, INCLUDING NOTICE AND HEARING RIGHTS.

2. AT LEAST TEN DAYS PRIOR TO COMMENCEMENT OF ANY INTERVIEW WITH A RECIPIENT AS PART OF AN INVESTIGATION, THE INSPECTOR OR OTHER INVESTIGATING ENTITY SHALL PROVIDE THE RECIPIENT WITH WRITTEN NOTICE OF THE INVESTIGATION. THE NOTICE OF THE INVESTIGATION SHALL SET FORTH THE BASIS FOR THE INVESTIGATION; THE POTENTIAL FOR REFERRAL FOR CRIMINAL INVESTIGATION; THE INDIVIDUAL'S RIGHT TO BE ACCOMPANIED BY A RELATIVE, FRIEND, ADVOCATE OR ATTORNEY DURING QUESTIONING; CONTACT INFORMATION FOR LOCAL

LEGAL SERVICES OFFICES; THE INDIVIDUAL'S RIGHT TO DECLINE TO BE INTERVIEWED OR PARTICIPATE IN AN INTERVIEW BUT TERMINATE THE QUESTIONING AT ANY TIME WITHOUT LOSS OF BENEFITS; AND THE RIGHT TO A FAIR HEARING IN THE EVENT THAT THE INVESTIGATION RESULTS IN A DETERMINATION OF INCORRECT PAYMENT.

3. THE PERIOD THAT IS THE SUBJECT OF AN INVESTIGATION SHALL NOT EXCEED THREE YEARS, UNLESS THE INITIAL NOTICE OF INVESTIGATION UNDER SUBDIVISION TWO OF THIS SECTION INCLUDES ALLEGATIONS OF FRAUD OR INTENTIONAL MISREPRESENTATION. DURING THE INVESTIGATION, THE INSPECTOR OR OTHER INVESTIGATING ENTITY MAY REQUEST DOCUMENTATION THAT IS RELEVANT TO THE ISSUE OF INELIGIBILITY, AND MAY ENTER INTO AN AGREEMENT WITH THE RECIPIENT SUBJECT TO THE INVESTIGATION FOR VOLUNTARY REPAYMENTS. HOWEVER, NO SUCH AGREEMENT SHALL BE ENTERED INTO PRIOR TO THE RECIPIENT HAVING ACCESS TO PROOF OF THE ALLEGATION OF INELIGIBILITY AND THE AMOUNT OF MEDICAL ASSISTANCE PAYMENT AT ISSUE. IN CASES INVOLVING FINANCIAL HARDSHIP, THE RATE OF REPAYMENT SHALL NOT BE IN EXCESS OF TEN PERCENT OF THE RECIPIENT'S HOUSEHOLD INCOME, UNLESS THE INSPECTOR OR INVESTIGATING ENTITY AND THE RECIPIENT AGREE TO ANOTHER AMOUNT.

4. FOLLOWING COMPLETION OF THE INVESTIGATION AND AT LEAST SIXTY DAYS PRIOR TO COMMENCING A RECOVERY OR ADJUSTMENT ACTION OR REQUESTING VOLUNTARY REPAYMENT, THE INSPECTOR OR OTHER INVESTIGATING ENTITY SHALL PROVIDE THE RECIPIENT WITH WRITTEN NOTICE OF THE DETERMINATION OF INCORRECT PAYMENT TO BE RECOVERED OR ADJUSTED. THE NOTICE OF DETERMINATION SHALL IDENTIFY THE EVIDENCE RELIED UPON, SET FORTH THE FACTUAL CONCLUSIONS OF THE INVESTIGATION, AND EXPLAIN THE RECIPIENT'S RIGHT TO REQUEST A FAIR HEARING IN ORDER TO CONTEST THE OUTCOME OF THE INVESTIGATION. THE EXPLANATION OF THE RIGHT TO A FAIR HEARING SHALL CONFORM TO THE REQUIREMENTS OF SUBDIVISION TWELVE OF SECTION TWENTY-TWO OF THE SOCIAL SERVICES LAW AND REGULATIONS THEREUNDER.

5. A FAIR HEARING UNDER SECTION TWENTY-TWO OF THE SOCIAL SERVICES LAW SHALL BE AVAILABLE TO ANY RECIPIENT WHO RECEIVES A NOTICE OF DETERMINATION UNDER SUBDIVISION FOUR OF THIS SECTION, REGARDLESS OF WHETHER THE RECIPIENT IS STILL ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM. IF A FAIR HEARING IS REQUESTED, NO RECOVERY OR ADJUSTMENT ACTION SHALL BE COMMENCED UNLESS THE REQUEST FOR A FAIR HEARING HAS BEEN WITHDRAWN OR THE FAIR HEARING HAS BEEN HELD AND RESULTED IN AN UNFAVORABLE DECISION TO THE RECIPIENT.

S 5. Paragraph (b) of subdivision 3 of section 363-d of the social services law, as amended by section 44 of part C of chapter 58 of the laws of 2007, is amended and a new subdivision 5 is added to read as follows:

(b) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program [within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, the] UNDER THIS SECTION, THE COMMISSIONER OR MEDICAID INSPECTOR GENERAL SHALL SO NOTIFY THE PROVIDER, INCLUDING SPECIFICATION OF BASIS OF THE FINDING SUFFICIENT TO ENABLE THE PROVIDER TO ADOPT A SATISFACTORY COMPLIANCE PROGRAM. THE provider SHALL SUBMIT TO THE COMMISSIONER OR MEDICAID INSPECTOR GENERAL A PROPOSED SATISFACTORY COMPLIANCE PROGRAM WITHIN SIXTY DAYS OF THE NOTICE AND SHALL ADOPT THE PROGRAM AS EXPEDITIOUSLY AS POSSIBLE. IF THE PROVIDER DOES NOT PROPOSE AND ADOPT A SATISFACTORY PROGRAM IN SUCH TIME PERIOD, THE PROVIDER may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

5. ANY REGULATION, DETERMINATION OR FINDING OF THE COMMISSIONER OR THE MEDICAID INSPECTOR GENERAL RELATING TO A COMPLIANCE PROGRAM UNDER THIS SECTION SHALL BE SUBJECT TO AND CONSISTENT WITH SUBDIVISION THREE OF THIS SECTION.

S 6. Subdivision 2 of section 369 of the social services law is amended by adding a new paragraph (e) to read as follows:

(E)(I) MEDICAL ASSISTANCE SHALL BE CONSIDERED INCORRECTLY PAID WHEN AN INDIVIDUAL HAS RECEIVED AN ADEQUATE EXPLANATION OF HIS OR HER DUTY TO PROVIDE OR REPORT INFORMATION RELEVANT TO AN ELIGIBILITY DETERMINATION, AND, EITHER FAILED TO PROVIDE OR REPORT RELEVANT INFORMATION THAT WAS KNOWN, OR UNDER THE CIRCUMSTANCES REASONABLY SHOULD HAVE BEEN KNOWN, BY THE INDIVIDUAL, OR THE INDIVIDUAL WAS RESPONSIBLE FOR INTENTIONAL MISREPRESENTATIONS OR FRAUD DURING THE APPLICATION OR RECERTIFICATION PROCESS.

(II) NO ADJUSTMENT OR RECOVERY, INCLUDING A REQUEST FOR VOLUNTARY REPAYMENT, MAY BE MADE AGAINST THE PROPERTY OF ANY INDIVIDUAL ON ACCOUNT OF ANY MEDICAL ASSISTANCE INCORRECTLY PAID TO OR ON BEHALF OF AN INDIVIDUAL UNDER THIS TITLE, EXCEPT AFTER AN INVESTIGATION HAS BEEN COMPLETED BY A SOCIAL SERVICES DISTRICT OR APPROPRIATE STATE AGENCY, SUBJECT TO SECTION THIRTY-EIGHT OF THE PUBLIC HEALTH LAW.

S 7. This act shall take effect on the ninetieth day after it shall have become a law and shall apply to any matter commenced or pending on or after such date. However with respect to any matter pending on or after such date, this act shall not invalidate any actions or steps taken or commenced prior to such date and shall only apply to actions or steps commenced on or after such date.