STATE OF NEW YORK

7889

2021-2022 Regular Sessions

IN ASSEMBLY

May 28, 2021

Introduced by M. of A. GOTTFRIED, L. ROSENTHAL -- read once and referred to the Committee on Health

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:

Section 1. 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.

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.

§ 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 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;

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

LBD11500-01-1

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

§ 37. Procedures, practices and standards. 1. Subject to federal law or regulation, recovery of an overpayment resulting from the issuance of a final audit report or final notice of agency action by the inspector shall commence not less than sixty days after the issuance of the final audit report or final notice of agency action. The inspector shall not commence any recovery under this subdivision without providing a minimum of ten days advance written notice to the provider.

2. Contracts, cost reports, claims, bills or expenditures of medical assistance funds that were the subject matter of a previous audit or review by or on behalf of the inspector, within the last three years, shall not be subject again to review or audit 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. In conducting reviews or audits, the inspector shall apply the laws, regulations, policies, guidelines, standards and interpretations of the appropriate agency, including temporary or emergency regulations, policies, guidelines, standards and interpretations, 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 those laws, regulations, policies, guidelines, standards or interpretations shall only be applied prospectively and upon reasonable notice.

4. (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 appropriately to a beneficiary of the medical assistance program, except as provided in paragraphs (b) and (c) of this subdivision.

(b) Where there 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 thirty days of notice of the defect.

(c) Where a claim relates to a service that was provided more than two years prior to the commencement of the audit, the provider may submit or resubmit the claim or accept the disallowance of the amount of the claim.

(d) The inspector shall not use extrapolation in recoveries made under this subdivision.

5. (a) The inspector shall furnish to the provider at an audit exit 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.

(b) 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.

§ 38. 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.

2. At least five business 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. Following completion of the investigation and at least thirty 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.

4. 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 three of this section, regardless of whether the recipient is still enrolled in the medical assistance program.

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

(c) 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 commissioner or Medicaid inspector general shall so notify the provider, including specification of the 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.

8. 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.

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

6-b. to file an annual report on or before the first day of July to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, the minority leader of the assembly, the commissioner, the commissioner of the office of addiction services and supports, and the commissioner of the office of mental health on the impacts that all civil and administrative enforcement actions taken under subdivision six of this section in the previous calendar year will have and have had on the quality and availability of medical care and services, the best interests of both the medical assistance program and its recipients, and fiscal solvency of the providers who were subject to the civil or administrative enforcement action;

§ 6. This act shall take effect immediately.