

# STATE OF NEW YORK

5329--B

2023-2024 Regular Sessions

## IN SENATE

March 2, 2023

Introduced by Sens. HARCKHAM, FERNANDEZ, KENNEDY, MAY, 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 -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- 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, as added by chapter  
2 442 of the laws of 2006, is amended to read as follows:

3 § 30-a. Definitions. For the purposes of this title, the following  
4 definitions shall apply:

5 1. "Abuse" means provider practices that are inconsistent with sound  
6 fiscal, business or medical practices, and result in an unnecessary cost  
7 to the Medicaid program, or in reimbursement for services that are not  
8 medically necessary or that fail to meet professionally recognized stan-  
9 dards for health care. It also includes beneficiary practices that  
10 result in unnecessary cost to the Medicaid program.

11 2. "Creditable allegation of fraud" (a) means an allegation which has  
12 been verified by the inspector, from any source, including but not  
13 limited to the following:

14 i. fraud hotlines tips verified by further evidence;

15 ii. claims data mining; and

16 iii. patterns identified through provider audits, civil false claims  
17 cases, and law enforcement investigations.

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

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1 (b) Allegations are considered to be credible when they have an indi-  
2 cia of reliability and the inspector has reviewed all allegations, facts  
3 and evidence carefully and acts judiciously on a case-by-case basis.

4 3. "Fraud" means an intentional deception or misrepresentation made by  
5 a person with the knowledge that the deception or misrepresentation  
6 could result in some unauthorized benefit to the person or some other  
7 person. It includes any act that constitutes fraud under applicable  
8 federal or state law.

9 4. "Inspector" means the Medicaid inspector general created by this  
10 title.

11 [~~2~~] 5. "Investigation" means investigations of fraud, abuse, or ille-  
12 gal acts perpetrated within the medical assistance program, by providers  
13 or recipients of medical assistance care, services and supplies.

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

18 [~~3~~] 7. "Office" means the office of the Medicaid inspector general  
19 created by this title.

20 8. "Overpayment" shall mean any amount paid to a provider for medical  
21 assistance in excess of the amount allowable under the state plan for  
22 medical assistance in effect at the time of such service, or allowable  
23 under any federally approved Medicaid waiver, experiment, pilot, or  
24 demonstration project. Notwithstanding any state law to the contrary, an  
25 overpayment shall not include circumstances of provider noncompliance  
26 with state laws, regulations or applicable promulgated state agency  
27 policies, guidelines, standards, protocols or interpretations which are  
28 not a condition of payment, unless the provider obtained payment by  
29 fraud or deceit, or where the provider was previously provided notice of  
30 its failure to comply and has failed to correct such noncompliance. An  
31 overpayment shall not include noncompliance with any applicable promul-  
32 gated state agency policies, guidelines, standards, protocols or inter-  
33 pretations where such policy, guideline, standard, protocol or interpre-  
34 pretation is facially, or as applied, reasonably susceptible to more than  
35 one meaning, provided the provider complied with one such reasonable  
36 meaning.

37 9. "Provider" means any person or entity enrolled as a provider in the  
38 medical assistance program.

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

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

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

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

55 1. Recovery of any overpayment resulting from any audit or review of  
56 provider contracts, cost reports, claims, bills, or medical assistance

1 payments shall not commence prior to sixty days after delivery to the  
2 provider of a final audit report or final notice of agency action, or  
3 where the provider requests a hearing or appeal within sixty days of  
4 delivery of the final audit report or final notice of agency action,  
5 until a final determination of such hearing or appeal is made.

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

13 3. Any reviews or audits of provider contracts, cost reports, claims,  
14 bills or medical assistance payments shall apply the state laws, regu-  
15 lations and the applicable, duly promulgated policies, guidelines, stan-  
16 dards, protocols and interpretations of state agencies with jurisdiction  
17 and in effect at the time the provider engaged in the applicable regu-  
18 lated conduct or provision of services. For the purpose of this subdivi-  
19 sion, the state law, regulation or the applicable promulgated agency  
20 policy, guideline, standard, protocol or interpretation shall not be  
21 deemed in effect if federal governmental approval is pending or denied.  
22 The inspector shall publish protocols applicable to and governing any  
23 audit or review of a provider or provider contracts, cost reports,  
24 claims, bills or medical assistance payments on the office of Medicaid  
25 inspector general website.

26 4. (a) In the event of any overpayment based upon a provider's admin-  
27 istrative or technical error, the provider shall have the longer of  
28 sixty days from notice of the mistake or six years from the date of  
29 service to submit a corrected claim provided (i) the error was a genuine  
30 error without intent to falsify or defraud, (ii) the provider maintained  
31 contemporaneous documentation to substantiate the correct claims infor-  
32 mation, (iii) such error is the sole basis for the finding of an over-  
33 payment, and (iv) there is no finding of any overpayment for such error  
34 by a federal agency or official.

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

37 (c) "Administrative or technical error" shall include any error that  
38 constitutes either a (i) minor error or omission or (ii) clerical error  
39 or omission under the Medicare modernization act or centers for Medicaid  
40 and Medicaid service regulations, and shall include human and clerical  
41 errors that result in errors as to form or content of a claim.

42 5. (a) In determining the amount of any overpayment to a provider, the  
43 inspector shall utilize sampling and extrapolation consistent with the  
44 Centers for Medicare and Medicaid services policies as described in the  
45 Centers for Medicare and Medicaid program integrity manual.

46 (b) The final audit report or final notice of agency action shall  
47 include a statement of the specific factual and legal basis for utiliz-  
48 ing extrapolation and the inappropriate use of extrapolation shall be a  
49 basis for appeal. This subdivision shall not be construed to limit the  
50 recoupment of an overpayment identified without the use of extrapo-  
51 lation.

52 (c) Until the provider has waived its right to a hearing, or if a  
53 provider requests a hearing, until the hearing determination is issued,  
54 the provider shall have the right to pay the lower confidence limit plus  
55 applicable interest in fulfillment of this paragraph, the applicable

1 lower confidence limit shall be calculated using at least a ninety  
2 percent confidence level.

3 6. (a) The provider shall be provided as part of the draft audit find-  
4 ings a detailed written explanation of the extrapolation method  
5 employed, including the size of the sample, the sampling methodology,  
6 the defined universe of claims, the specific claims included in the  
7 sample, the results of the sample, the assumptions made about the accu-  
8 racy and reliability of the sample and the level of confidence in the  
9 sample results, and the steps undertaken and statistical methodology  
10 utilized to calculate the alleged overpayment and any applicable offset  
11 based on the sample results. This written information shall include a  
12 description of the sampling and extrapolation methodology.

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

16 7. The requirements of this section shall be interpreted consistent  
17 with and subject to any applicable federal law, rules and regulations,  
18 or binding federal agency guidance and directives. The requirements of  
19 this section shall not apply to any investigation by the inspector where  
20 there is credible allegations of fraud or where there is a finding that  
21 the provider has engaged in deliberate abuse of the medical assistance  
22 program.

23 § 38. Procedures, practices and standards for recipients. 1. This  
24 section applies to any adjustment or recovery of a medical assistance  
25 payment from a recipient, and any investigation or other proceeding  
26 relating thereto.

27 2. At least five business days prior to commencement of any interview  
28 with a recipient as part of an investigation, the inspector or other  
29 investigating entity shall provide the recipient with written notice of  
30 the investigation. The notice of the investigation shall set forth the  
31 basis for the investigation; the potential for referral for criminal  
32 investigation; the individual's right to be accompanied by a relative,  
33 friend, advocate or attorney during questioning; contact information for  
34 local legal services offices; the individual's right to decline to be  
35 interviewed or participate in an interview but terminate the questioning  
36 at any time without loss of benefits; and the right to a fair hearing in  
37 the event that the investigation results in a determination of incorrect  
38 payment.

39 3. Following completion of the investigation and at least thirty days  
40 prior to commencing a recovery or adjustment action or requesting volun-  
41 tary repayment, the inspector or other investigating entity shall  
42 provide the recipient with written notice of the determination of incor-  
43 rect payment to be recovered or adjusted. The notice of determination  
44 shall identify the evidence relied upon, set forth the factual conclu-  
45 sions of the investigation, and explain the recipient's right to request  
46 a fair hearing in order to contest the outcome of the investigation. The  
47 explanation of the right to a fair hearing shall conform to the require-  
48 ments of subdivision twelve of section twenty-two of the social services  
49 law and regulations thereunder.

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

54 § 4. Paragraph (c) of subdivision 3 of section 363-d of the social  
55 services law, as amended by section 4 of part V of chapter 57 of the

1 laws of 2019, is amended and a new subdivision 8 is added to read as  
2 follows:

3 (c) In the event that the commissioner of health or the Medicaid  
4 inspector general finds that the provider does not have a satisfactory  
5 program [~~within ninety days after the effective date of the regulations~~  
6 ~~issued pursuant to subdivision four of this section~~], the commissioner  
7 or Medicaid inspector general shall so notify the provider, including  
8 specification of the basis of the finding sufficient to enable the  
9 provider to adopt a satisfactory compliance program. The provider shall  
10 submit to the commissioner or Medicaid inspector general a proposed  
11 satisfactory compliance program within sixty days of the notice and  
12 shall adopt the program as expeditiously as possible. If the provider  
13 does not propose and adopt a satisfactory program in such time period,  
14 the provider may be subject to any sanctions or penalties permitted by  
15 federal or state laws and regulations, including revocation of the  
16 provider's agreement to participate in the medical assistance program.

17 8. Any regulation, determination or finding of the commissioner or the  
18 Medicaid inspector general relating to a compliance program under this  
19 section shall be subject to and consistent with subdivision three of  
20 this section.

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

23 6-b. to consult with the commissioner on the preparation of an annual  
24 report, to be made and filed by the commissioner on or before the first  
25 day of July to the governor, the temporary president of the senate, the  
26 speaker of the assembly, the minority leader of the senate, the minority  
27 leader of the assembly, the commissioner, the commissioner of the office  
28 of addiction services and supports, and the commissioner of the office  
29 of mental health on the impacts that all civil and administrative  
30 enforcement actions taken under subdivision six of this section in the  
31 previous calendar year will have and have had on the quality and avail-  
32 ability of medical care and services, the best interests of both the  
33 medical assistance program and its recipients, and fiscal solvency of  
34 the providers who were subject to the civil or administrative enforce-  
35 ment action;

36 § 6. This act shall take effect on the thirtieth day after it shall  
37 have become a law.