

STATE OF NEW YORK

6813--A

2023-2024 Regular Sessions

IN ASSEMBLY

May 8, 2023

Introduced by M. of A. PAULIN, L. ROSENTHAL, VANEL, SIMON, McDONALD, JACOBSON, GUNTHER, SANTABARBARA, KELLES, McMAHON -- read once and referred to the Committee on Health -- reported and referred to the Committee on Ways and Means -- recommitted to the Committee on Ways and Means in accordance with Assembly Rule 3, sec. 2 -- 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:

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

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

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

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

i. fraud hotlines tips verified by further evidence;

ii. claims data mining; and

iii. patterns identified through provider audits, civil false claims 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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(b) Allegations are considered to be credible when they have an indication of reliability and the inspector has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

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

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

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

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

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

8. "Overpayment" shall mean any amount paid to a provider for medical assistance in excess of the amount allowable under the state plan for medical assistance in effect at the time of such service, or allowable under any federally approved Medicaid waiver, experiment, pilot, or demonstration project. Notwithstanding any state law to the contrary, an overpayment shall not include circumstances of provider noncompliance with state laws, regulations or applicable promulgated state agency policies, guidelines, standards, protocols or interpretations which are not a condition of payment, unless the provider obtained payment by fraud or deceit, or where the provider was previously provided notice of its failure to comply and has failed to correct such noncompliance. An overpayment shall not include noncompliance with any applicable promulgated state agency policies, guidelines, standards, 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.

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

§ 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

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 subdi-
19 vision, 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.