

# STATE OF NEW YORK

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6813--B

2023-2024 Regular Sessions

## IN ASSEMBLY

May 8, 2023

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Introduced by M. of A. PAULIN, L. ROSENTHAL, VANEL, SIMON, McDONALD, JACOBSON, GUNTHER, SANTABARBARA, KELLES, McMAHON, GONZALEZ-ROJAS, BURDICK, ZEBROWSKI, JENSEN, BEEPHAN, LUCAS, LUPARDO, STECK, ARDILA, SHIMSKY, WEPRIN, HEVESI, SEPTIMO, THIELE, LEVENBERG, SIMONE, BLUMENCRANZ, SEAWRIGHT, RAMOS, LAVINE, SAYEGH, GIBBS, TAPIA -- 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 -- 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:

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.

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

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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.

(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 for services furnished under section nineteen hundred two of the federal social security act and which is required to be refunded under section nineteen hundred three of such act.

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 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.

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. The inspector shall publish protocols applicable to and governing any audit or review of a provider or provider contracts, cost reports, claims, bills or medical assistance payments on the office of Medicaid inspector general website.

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.

(b) No overpayment shall be calculated for any administrative or technical error corrected as required in paragraph (a) of this subdivision.

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

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

(b) The final audit report or final notice of agency action shall include a statement of the specific factual and legal basis for utilizing extrapolation and the inappropriate use of extrapolation shall be a basis for appeal. This subdivision shall not be construed to limit the recoupment of an overpayment identified without the use of extrapolation.

(c) If the provider has waived its right to a hearing, or if a provider requests a hearing, until the hearing determination is issued, the provider shall have the right to pay the lower confidence limit plus applicable interest in fulfillment of this paragraph, the applicable lower confidence limit shall be calculated using at least a ninety percent confidence level.

6. (a) The provider shall be provided as part of the draft audit findings 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

1 sample, the results of the sample, the assumptions made about the accu-  
2 racy and reliability of the sample and the level of confidence in the  
3 sample results, and the steps undertaken and statistical methodology  
4 utilized to calculate the alleged overpayment and any applicable offset  
5 based on the sample results. This written information shall include a  
6 description of the sampling and extrapolation methodology.

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

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

17 § 38. Procedures, practices and standards for recipients. 1. This  
18 section applies to any adjustment or recovery of a medical assistance  
19 payment from a recipient, and any investigation or other proceeding  
20 relating thereto.

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

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

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

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

52 (c) In the event that the commissioner of health or the Medicaid  
53 inspector general finds that the provider does not have a satisfactory  
54 program [~~within ninety days after the effective date of the regulations~~  
55 ~~issued pursuant to subdivision four of this section~~], the commissioner  
56 or Medicaid inspector general shall so notify the provider, including

1 specification of the basis of the finding sufficient to enable the  
2 provider to adopt a satisfactory compliance program. The provider shall  
3 submit to the commissioner or Medicaid inspector general a proposed  
4 satisfactory compliance program within sixty days of the notice and  
5 shall adopt the program as expeditiously as possible. If the provider  
6 does not propose and adopt a satisfactory program in such time period,  
7 the provider may be subject to any sanctions or penalties permitted by  
8 federal or state laws and regulations, including revocation of the  
9 provider's agreement to participate in the medical assistance program.

10 8. Any regulation, determination or finding of the commissioner or the  
11 Medicaid inspector general relating to a compliance program under this  
12 section shall be subject to and consistent with subdivision three of  
13 this section.

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

16 6-b. to consult with the commissioner on the preparation of an annual  
17 report, to be made and filed by the commissioner on or before the first  
18 day of July to the governor, the temporary president of the senate, the  
19 speaker of the assembly, the minority leader of the senate, the minority  
20 leader of the assembly, the commissioner, the commissioner of the office  
21 of addiction services and supports, and the commissioner of the office  
22 of mental health on the impacts that all civil and administrative  
23 enforcement actions taken under subdivision six of this section in the  
24 previous calendar year will have and have had on the quality and avail-  
25 ability of medical care and services, the best interests of both the  
26 medical assistance program and its recipients, and fiscal solvency of  
27 the providers who were subject to the civil or administrative enforce-  
28 ment action;

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