STATE OF NEW YORK

5329--A

2023-2024 Regular Sessions

IN SENATE

March 2, 2023

Introduced by Sens. HARCKHAM, KENNEDY, 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

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 three new subdivisions 4, 5, and 6 to read as follows:

4. "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.

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

6. "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. 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,

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

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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.

§ 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. This subdivision shall not apply where the withholding is pursuant to a pending investigation of a credible allegation of fraud or where there is a finding that the provider has abused the program or committed an unacceptable practice.

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.

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.

5. (a) In determining the amount of any overpayment to a provider, extrapolation shall be permitted only upon a finding of a sustained or high level of payment error or where the provider has been the subject of educational intervention and failed to correct the payment error after a reasonable opportunity to do so. The final audit report or final notice of agency action shall include a statement of the factual 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.

(b) Sustained or high level of payment error shall exist under the following circumstances: (i) the audit or review results in a finding of a payment error rate equal to or greater than fifty percent, (ii) the audit or review results in a finding of identical payment errors identified in a prior audit or review, (iii) the provider was previously sanctioned or investigated for identical payment errors, (iv) there is a prior judgment against, or settlement involving, the provider based upon a finding that the provider engaged in fraud and/or abuse related to federal or state payment programs, (v) there are prior complaints by provider employees related to identical payment errors, and (vi) there is a prior finding of identical payment error by a federal agency or official.

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 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 statistical methodology 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 utilized by the inspector shall be consistent with accepted standards of sound auditing practice and statistical analysis.

7. The requirements of this section shall be interpreted consistent with and subject to any applicable federal law, rules and regulations, or binding federal agency guidance and directives.

§ 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 consult with the commissioner on the preparation of an annual report, to be made and filed by the commissioner 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.