STATE OF NEW YORK

4955--B

2025-2026 Regular Sessions

IN SENATE

February 14, 2025

Introduced by Sens. HARCKHAM, ADDABBO, BORRELLO, FERNANDEZ, GALLIVAN, JACKSON, MAY, MAYER, RHOADS, RIVERA, ROLISON, SEPULVEDA, WEBB -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- 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, in relation to the functions of the Medicaid inspector general with respect to audit and review of medical assistance program funds

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. "Overpayment" shall mean any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

5. "Applicable standards" shall mean the state laws, regulations and duly promulgated policies, guidelines, protocols and interpretations of state agencies with jurisdiction in effect at the time the provider engaged in the regulated conduct or provision of services that the inspector general is auditing or reviewing.

6. "Clerical or minor error or omission" shall include mathematical or computational mistakes; transposed procedure or diagnostic codes; inaccurate data entry; computer errors; duplicate claims; and incorrect data items, such as provider number, use of a modifier or date of service.

§ 2. The public health law is amended by adding a new section 37 to read as follows:

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

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§ 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 to conduct such audit or review, shall comply with the following standards:

1. Any reviews or audits of provider contracts, cost reports, claims, bills or medical assistance payments shall apply the applicable standard. Prior to commencing an audit or review, the inspector shall provide to the provider access to any applicable standards. For the purpose of this subdivision, an applicable standard shall not be deemed in effect if federal governmental approval was pending or denied at the time the provider engaged in the regulated conduct or provision of services.

2. The inspector shall publish the most current version of 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 the Medicaid inspector general website in advance of commencing such audit or review, which protocols shall include any and all applicable standards.

3. In determining the amount of an overpayment a provider must repay following an audit or review, consistent with subdivision six of section thirty-two of this title, the inspector must consider the following factors:

(a) Whether the findings suggest a sustained or high level of payment error;

(b) Whether the nature of the error is a clerical or minor error or omission;

(c) Impacts to the provider's financial solvency; and

(d) The potential for the repayment, if ordered, to negatively impact access to services.

4. Any sampling and extrapolation methodologies utilized by the inspector shall be consistent with accepted standards of sound auditing practice and statistical analysis.

5. If the inspector determines that the basis of an overpayment is a clerical or minor error or omission, and if the inspector further determines such clerical or minor error or omission are isolated occurrences, limited to three or less, then the inspector shall not apply extrapolation in those cases and recoupment will be limited to each such affected audited claim.

6. The draft audit report given to the provider shall include the inspector's findings and a detailed written explanation of the extrapolation method if used, 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 to calculate the alleged overpayment and any applicable offset based on the sample results.

7. The inspector shall consider any supporting documentation that the provider submits prior to the issuance of the final audit report that the provider thinks is relevant to the audit, including, but not limited to attestations addressing missing documentation and/or signatures. The inspector shall use the totality of the record to determine if the documentation or signature requirement, as outlined in statute or regulation, is met, and/or consider submitted attestations to resolve the issue. If the inspector rejects such supporting documentation, an explanation for such rejection shall be provided in writing.

8. The inspector's final audit report or final notice of agency action shall include a specific explanation of the inspector's consideration of the factors described in paragraphs (a) through (d) of subdivision three of this section.

9. The inspector shall not foreclose or prohibit the provider from settling through repayment at the lower confidence limit plus applicable interest, even if the provider requests a hearing, up until the hearing determination is issued.

10. Neither recoupment by the inspector nor repayment by the provider of overpayments shall commence earlier than sixty days from the issuance date of the final audit report or, if the provider requests a hearing, then sixty days from the issuance date of the hearing determination.

11. Nothing in this section shall prevent the inspector from complying with Medicaid audit requirements established by federal law, rules and regulations, or binding federal agency guidance and directives.

§ 3. The opening paragraph of subdivision 1 of section 35 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

The inspector shall, no later than October first of each year, [~~submit~~] consult with the commissioner on the preparation of an annual report, to be made and filed by the inspector and submitted 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, the commissioner of the office of persons with developmental disabilities, the state comptroller and the attorney general[~~, a report summarizing the activities of the office during the preceding calendar year~~]. Such report shall include:

§ 4. Paragraphs (b), (f) and (g) of subdivision 1 of section 35 of the public health law, paragraph (b) as added by chapter 442 of the laws of 2006, paragraph (f) as amended and paragraph (g) as added by section 111 of part E of chapter 56 of the laws of 2013, are amended and a new paragraph (h) is added to read as follows:

(b) the number, subject and other relevant characteristics of audits initiated, and those completed, including but not limited to outcome, region, reason for audit and the total dollar value identified for recovery [~~and~~], the actual recovery from such audits and how many audits where overpayments were recovered used extrapolation;

(f) a narrative that evaluates the office's performance, describes any specific problems and connection with the procedures and agreements required under this section, discusses any other matters that may have impaired its effectiveness and summarizes the total savings to the state's medical assistance program; [~~and~~]

(g) a narrative, provided by the department in its annual report pursuant to paragraph (t) of subdivision one of section two hundred six of this chapter that summarizes the department's activities to mitigate fraud, waste and abuse during the preceding calendar year[~~.~~]; and

(h) a narrative that describes the steps taken by the office in the past year to comply with subdivision six of section thirty-two of this title, which requires consideration of quality and availability of medical and long term care and services and the best interest of both the medical assistance program and recipients, in the pursuit of civil and administrative enforcement actions.

§ 5. This act shall take effect on the first of April next succeeding the date on which it shall have become a law.