A6813-A Paulin No Same as
Public Health Law
TITLE....Relates 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
05/08/23 referred to health
05/23/23 reported referred to codes
05/31/23 reported referred to ways and means
01/03/24 referred to ways and means
01/16/24 amend and recommit to ways and means
01/16/24 print number 6813a

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 indicia 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

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) Until 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 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. The requirements of this section shall not apply to any investigation by the inspector where there is credible allegations of fraud or where there is a finding that the provider has engaged in deliberate abuse of the medical assistance program.

§ 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 on the thirtieth day after it shall have become a law.

NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)

BILL NUMBER: A6813A

SPONSOR: Paulin

TITLE OF BILL:

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

PURPOSE:

To provide additional due process protections to health care providers and recipients in the medical assistance program when under scrutiny by the Office of the Medicaid Inspector General.

SUMMARY OF SPECIFIC PROVISIONS:

Section 1 amends Public Health Law § 30,-a by adding new subdivi- sions, which defines various terms including "abuse", "creditable allegations of fraud", "fraud"," medical assistance", "overpayment " and " provid- er".

§ 2 amends Public Health Law § 32 subdivision 20 to make clear that the Office of the Medicaid Inspector General (OMIG) must act consistently with all applicable state and federal laws, regulations, policies, guidelines, and standards.

§ 3 adds two new sections to the Public Health Law, § 37 and § 38. § 37 addresses audit and recovery of medical assistance to providers. § 38 addresses procedures, practices and standards for recipients.

§ 4 amends Social Services Law § 363-d (3) (c) to require OMIG to notify a provider if the provider's compliance program is not satisfactory, and to allow the provider 60 days to submit a proposal for a satisfactory compliance program. It also adds a new subdivision 8 to the section to require OMIG regulations, determinations, or findings relating to a compliance program to be consistent with subdivision 3.

§ 5 adds a new subsection 6-b to Public Health Law § 32, requiring OMIG to consult with the Commissioner of Health on preparing and filing an annual report by the Commissioner on the impacts that all civil and administrative enforcement actions taken in the previous year have had and will have on the quality and availability of medical care and services, the best interests of the medical assistance program and its recipients, and the fiscal solvency of the providers subject to these actions.

§ 6 is the effective date which is thirty days after enactment

JUSTIFICATION:

When the OMIG was created in 2007, the emphasis of the legislature and the concern of the public was on fraud and waste in the Medicaid system. Experience with the law has made it clear that the current statute is missing key provisions necessary to assure fairness and procedural clarity for all the parties involved.

OMIG audits that punish providers for technical errors, not fraud, do not help anyone in the Medicaid system, especially when those errors are the result of contradictory guidance provided by different state agencies. Further, the OMIG's practice of extrapolating millions of dollars of claims from a small sample of technical errors has been forcing some already fiscally perilous health care providers to close, which ultimately harms patients.

This bill also addresses due process for Medicaid beneficiaries, who deserve advance notice of any investigations and details about what exactly is being investigated. They also deserve to know their rights before the OMIG makes any recoveries or enforcement actions against them.

An earlier version of this bill, A7889A passed the Legislature in 2022 and was vetoed by the Governor. This new amended version includes a number of common sense provisions including: enhancements that define overpayments and the circumstances that would not apply, expanded provider rights for the correction of technical errors and timeframes involved, delay in any recoupments until providers have exhausted their appeal rights, limits on extrapolation consistent with CMS standards for its use in federal audits and acknowledges federal supremacy over auditing and recoupment standards.

PRIOR LEGISLATIVE HISTORY:

2022: A7889A - vetoed

FISCAL IMPLICATIONS FOR STATE AND LOCAL GOVERNMENTS:

None.

EFFECTIVE DATE:
This act shall take effect thirty days after enactment.