LAWS OF NEW YORK, 2006
CHAPTER 442

AN ACT to amend the public health law, in relation to establishing the office of the Medicaid inspector general, and providing for its powers and duties; to amend the executive law, in relation to designating such office as a qualified agency for the purposes of criminal information; to amend the social services law, in relation to the development and testing of new methods of Medicaid claims and utilization review to improve Medicaid fraud control and expenditure accountability and to create a provider compliance program; to amend the insurance law, in relation to requiring the superintendent of insurance to annually report on health insurance fraud; to amend the social services law, in relation to advisory opinions; and to amend the penal law, the criminal procedure law and the labor law, in relation to health care fraud

Became a law July 26, 2006, with the approval of the Governor. Passed on message of necessity pursuant to Article III, section 14 of the Constitution by a majority vote, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Article 1 of the public health law is amended by adding a new title III to read as follows:

TITLE III

OFFICE OF THE MEDICAID INSPECTOR GENERAL

§ 30. Legislative intent. This title establishes an independent office of Medicaid inspector general within the department to consolidate staff and other Medicaid fraud detection, prevention and recovery functions from the relevant governmental entities into a single office, and grants such office new powers and responsibilities. As such, this title is intended to create a more efficient and accountable structure, dramatically reorganize and streamline the state's process of detecting and combating Medicaid fraud and abuse and maximize the recoupment of improper Medicaid payments.

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

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

2. "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.

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

3. "Office" means the office of the Medicaid inspector general created by this title.

§ 31. Establishment of the office of Medicaid inspector general. 1. There is hereby created within the department the office of Medicaid inspector general. Pursuant to section three hundred sixty-three-a of the social services law, the department is the single state agency for the administration of the medical assistance program in New York state, provided that the office shall undertake and be responsible for the department's duties as the single state agency with respect to: (a) prevention, detection and investigation of fraud and abuse within the medical assistance program; (b) referral of appropriate cases for criminal prosecution; and (c) recovery of improperly expended medical assistance funds. Such responsibility shall include, but not be limited to, medical assistance program audit functions, pursuant to sections three hundred sixty-four and three hundred sixty-eight-c of the social services law, and the function of medical assistance program fraud and abuse prevention, pursuant to sections one hundred forty-five-a and one hundred forty-five-b of the social services law (transferred to the New York state department of health from the former department of social services pursuant to subdivision (e) of section one hundred twenty-two of part B of chapter four hundred thirty-six of the laws of nineteen hundred ninety-seven).

2. The head of the office shall be the Medicaid inspector general who shall be appointed by the governor by and with the advice and consent of the senate. The inspector shall serve at the pleasure of the governor. The inspector shall report directly to the governor. The person appointed as inspector shall, upon his or her appointment, have not less than ten years professional experience in one or more of the following areas of expertise: law, provided the experience involves prosecution or some consideration of fraud; fraud investigation; and auditing. The inspector may possess comparable alternate experience in the area of health care or the area of senior management, in either the public or private setting, provided that such experience involves some consideration of fraud.

3. The inspector shall be compensated within the limits of funds available therefor, provided, however, such salary shall be no less than the salaries of certain state officers holding the positions indicated in paragraph (a) of subdivision one of section one hundred sixty-nine of the executive law.

§ 32. Functions, duties and responsibilities. The inspector shall have the following functions, duties and responsibilities:

1. to appoint such deputies, directors, assistants and other officers and employees as may be needed for the performance of his or her duties and may prescribe their duties and fix their compensation within the amounts appropriated therefor;

2. to conduct and supervise activities to prevent, detect and investigate medical assistance program fraud and abuse amongst the following: the department; the offices of mental health, mental retardation and developmental disabilities, alcoholism and substance abuse services, temporary disability assistance, and children and family services;

3. to coordinate, to the greatest extent possible, activities to prevent, detect and investigate medical assistance program fraud and abuse amongst the following: the department; the offices of mental health, mental retardation and developmental disabilities, alcoholism and substance abuse services, temporary disability assistance, and children and family services; the commission on quality of care and advocacy

for persons with disabilities; the department of education; the fiscal agent employed to operate the Medicaid management information system; local governments and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; the welfare inspector general, federal prosecutors, district attorneys within the state, the special investigative unit maintained by each health insurer operating within the state, and the state comptroller;

4. to solicit, receive and investigate complaints related to fraud and abuse within the medical assistance program;

5. to keep the governor, attorney general, state comptroller, temporary president and minority leader of the senate, the speaker and the minority leader of the assembly, and the heads of agencies with responsibility for the administration of the medical assistance program apprised of efforts to prevent, detect, investigate, and prosecute fraud and abuse within the medical assistance program;

6. to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program, including but not limited to: (a) referral of information and evidence to regulatory agencies and licensure boards; (b) withholding payment of medical assistance funds in accordance with state and federal laws and regulations; (c) imposition of administrative sanctions and penalties in accordance with state and federal laws and regulations; (d) exclusion of providers, vendors and contractors from participation in the program; (e) initiating and maintaining actions for civil recovery and, where authorized by law, seizure of property or other assets connected with improper payments; and entering into civil settlements; and (f) recovery of improperly expended medical assistance program funds from those who engage in fraud or abuse, or illegal or improper acts perpetrated within the medical assistance program. In the pursuit of such civil and administrative enforcement actions under this subdivision, the inspector shall consider the quality and availability of medical care and services and the best interest of both the medical assistance program and recipients;

7. to make information and evidence relating to suspected criminal acts which he or she may obtain in carrying out his or her duties available to appropriate law enforcement officials and to consult with the deputy attorney general for Medicaid fraud control, the welfare inspector general, and other state and federal law enforcement officials for coordination of criminal investigations and prosecutions.

The inspector shall refer suspected fraud or criminality to the deputy attorney general for Medicaid fraud control and make any other referrals to such deputy attorney general as required or contemplated by federal law. At any time after such referral, with ten days written notice to the deputy attorney general for Medicaid fraud control or such shorter time as such deputy attorney general consents to, the inspector may additionally provide relevant information about suspected fraud or criminality to any other federal or state law enforcement agency that the inspector deems appropriate under the circumstances;

8. to subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony;

9. to require and compel the production of such books, papers, records and documents as he or she may deem to be relevant or material to an investigation, examination or review undertaken pursuant to this section;

10. to examine and copy or remove documents or records of any kind related to the medical assistance program or necessary for the inspector to perform its duties and responsibilities that are prepared, maintained or held by or available to any state agency or local governmental entity the patients or clients of which are served by the medical assistance program, or which is otherwise responsible for the control of fraud and abuse within the medical assistance program; provided, however, that any such information be afforded confidentiality protection as provided for under state and federal law. The removal of records shall be limited to those circumstances in which a copy thereof is insufficient for an appropriate legal or investigative purpose, provided that in such instances the copying and return of such original, or copy where the original is required for an appropriate legal or investigative purpose, is expedited and such original or copy is readily accessible in accordance with the care and treatment needs of the patient,

11. to recommend and implement policies relating to the prevention and detection of fraud and abuse; provided however, that the consent of the attorney general shall be obtained prior to the implementation of any policy that shall affect the operations of the office of the attorney general;

12. to monitor the implementation of any recommendations made by the office to agencies or other entities with responsibility for administration of the medical assistance program;

13. to prepare cases, provide testimony and support administrative hearings and other legal proceedings;

14. to review and audit contracts, cost reports, claims, bills and all other expenditures of medical assistance program funds to determine compliance with applicable federal and state laws and regulations and take such actions as are authorized by federal or state laws and regulations;

15. to work with the fiscal agent employed to operate the Medicaid management information system to optimize the system;

16. to work in a coordinated manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the medical assistance program, including the surveillance utilization review system and other automated systems pursuant to paragraph (b) of subdivision eight of section three hundred sixty-seven-b of the social services law;

17. to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program;

18. to, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action;

19. to receive and to investigate complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud and abuse in the medical assistance program;

20. to, consistent with provisions of this title, 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;

21. to conduct, in the context of the investigation of fraud and abuse, on-site facility and office inspections;

22. to take appropriate actions to ensure that the medical assistance program is the payor of last resort;

23. to annually submit a budget request, for the ensuing state fiscal year, to the division of budget, provided that the office's budget request shall not be subject to review, alteration or modification by the commissioner or any other entity or person prior to its submission to the division of budget; and

24. to perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office in accordance with federal and state law.

§ 33. Cooperation of agency officials and employees. 1. In addition to the authority otherwise provided by this title, the inspector, in carrying out the provisions of this title, is authorized to request such information, assistance and cooperation from any federal, state or local governmental department, board, bureau, commission, or other agency or unit thereof as may be necessary for carrying out the duties and responsibilities enjoined upon the inspector by this section. State and local agencies or units thereof are hereby authorized and directed to provide such information, assistance and cooperation. Executive agencies shall coordinate and facilitate the transfer of appropriate functions and positions to the office as necessary and in accordance with applicable law.

2. Upon request of a local social services district or a prosecutor of competent jurisdiction, the office, department, any other state or local government entity and the Medicaid fraud control unit shall provide such information and assistance as such entity or unit shall deem necessary, appropriate and available to aid and facilitate the investigation of fraud and abuse within the medical assistance program and the recoupment of improperly expended funds.

§ 34. Transfer of employees. Upon the transfer of the medical assistance program audit and fraud and abuse prevention functions from the department and the offices of mental health, mental retardation and developmental disabilities, alcoholism and substance abuse services, temporary disability assistance, and children and family services to the office within the department pursuant to section thirty-one of this title, provision shall be made for the transfer of necessary officers and employees who are substantially engaged in the performance of the function to be transferred, and any documents and records necessary and related to the transfer of such functions. The heads of the departments or agencies from which such function is to be transferred and the inspector shall confer to determine the officers and employees who are substantially engaged in the medical assistance program audit and fraud and abuse prevention function to be transferred. In accordance with subdivision two of section seventy of the civil service law, officers and employees so transferred shall be transferred without further examination or qualification to the same or similar titles and shall remain in the same collective bargaining unit and shall retain their respective civil service classification, status and rights pursuant to their collective bargaining unit and collective bargaining agreement. Notwithstanding the office's regional operations, all office employees shall be co-located, to the greatest extent practicable. The inspector shall have sole responsibility for establishing methods of administration for the office.

§ 35. Reports required of the inspector. 1. The inspector shall, no later than October first of each year, submit to the governor, the temporary president of the senate, the speaker of the assembly, the state comptroller and the attorney general, a report summarizing the activities of the office during the preceding calendar year. Such report shall include:

(a) the number, subject and other relevant characteristics of investigations initiated, and those completed, including but not limited to outcome, region, source of complaint and whether or not such investigation was conducted jointly with the attorney general;

(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;

(c) the number, subject and other relevant characteristics of administrative actions initiated, and those completed, including but not limited to outcome, region and type;

(d) the number, subject and other relevant characteristics of referrals for prosecution to the deputy attorney general for Medicaid fraud control and other federal or state law enforcement agencies, or for licensure action; such information shall include but not be limited to status and region;

(e) the number, subject and other relevant characteristics of civil actions initiated by the office related to improper payments, the resulting civil settlements entered and overpayments identified and the total dollar value both identified and collected; and

(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.

2. Pursuant to the reporting requirements contained within subdivision one of this section, the inspector shall not disclose information that jeopardizes an ongoing investigation or proceeding, provided that the inspector shall disclose required information that does not jeopardize an ongoing investigation or proceeding and fully apprises the designated recipients of the scope and quality of the office's activities.

3. The inspector shall, on or before April first, July first, October first and January first of each year following the calendar year in which this title shall take effect, submit to the governor, temporary president of the senate and speaker of the assembly an accountability statement providing a statistical profile of the referrals made to the state Medicaid fraud control unit, audits, investigations and recoveries.

§ 36. Disclosure of information. The inspector shall not disclose information which is prohibited from disclosure by any other provision of law.

§ 2. Subdivision 9 of section 835 of the executive law, as separately amended by chapters 175 and 574 of the laws of 2004, is amended to read as follows:

9. "Qualified agencies" means courts in the unified court system, the administrative board of the judicial conference, probation departments, sheriffs' offices, district attorneys' offices, the state department of correctional services, the state division of probation, the department of correction of any municipality, the insurance frauds bureau of the state department of insurance, the office of professional medical

conduct of the state department of health for the purposes of section two hundred thirty of the public health law, **the office of Medicaid inspector general,** the temporary state commission of investigation, the criminal investigations bureau of the banking department, police forces and departments having responsibility for enforcement of the general criminal laws of the state and the Onondaga County Center for Forensic Sciences Laboratory when acting within the scope of its law enforcement duties.

§ 3. Subdivision 8 of section 367-b of the social services law, as amended by chapter 407 of the laws of 1978, is amended to read as follows:

8. **(a)** For the purpose of orderly and timely implementation of the medical assistance payments and information system, the department is hereby authorized to enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payments, subject to audits being conducted by the state in accordance with the terms of such agreements, for medical assistance claims under the system described by this section in any social services district. Such agreements shall specifically provide that the state shall have complete oversight responsibility for the fiscal intermediaries' or fiscal agents' performance and shall be solely responsible for establishing eligibility requirements for recipients, provider qualifications, rates of payment, investigation of suspected fraud and abuse, issuance of identification cards, establishing and maintaining recipient eligibility files, provider profiles, and conducting state audits of the fiscal intermediaries' or agents' at least once annually. The system described in this subdivision shall be operated by a fiscal intermediary or fiscal agent in accordance with this subdivision unless the department is otherwise authorized by a law enacted subsequent to the effective date of this subdivision to operate the system in another manner. In no event shall such intermediary or agent be a political subdivision of the state or any other governmental agency or entity. **The department shall consult with the office of Medicaid inspector general regarding any activities undertaken by the fiscal intermediaries or fiscal agents regarding investigation of suspected fraud and abuse.**

(b) The department of health, in consultation with the office of Medicaid inspector general, shall develop, test and implement new methods to strengthen the capability of the Medicaid payment information system to detect and control fraud and improve expenditure accountability, and is hereby authorized to enter into further agreements with fiscal and/or information technology agents for the development, testing and implementation of such new methods. Any such agreements shall be with agents which have demonstrated expertise in the areas addressed by the agreement. Such methods shall, at a minimum, address the following areas:

(1) Prepayment claims review. Develop, test and implement an automated claims review process which, prior to payment, shall subject medical assistance program services claims to review for proper coding and such other review as may be deemed necessary. Services subject to review shall be based on: the expected cost-effectiveness of reviewing such service; the capabilities of the automated system for conducting such a review; and the potential to implement such review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services. Such initiative shall be designed to provide for the efficient and effective operation of the medical assistance program claims payment system by performing functions including,

but not limited to, capturing coding errors, misjudgments, incorrect or multiple billing for the same service and possible excesses in billing or service use, whether intentional or unintentional.

(2) Coordination of benefits. Develop, test and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients. Such initiative shall initially examine the savings potential to the medical assistance program through retrospective review of claims paid which shall be completed not later than January thirty-first, two thousand seven. If, based upon such initial experience, the Medicaid inspector general deems the automated process to be capable of including or moving to a prospective review, with negligible effect on the turnaround of claims for provider payment or on recipient access to services, then the Medicaid inspector general in subsequent tests shall examine the savings potential through prospective, pre-claims payment review.

(3) Comprehensive review of paid claims. Take all reasonable and necessary actions to intensify the state's current level of monitoring, analyzing, reporting and responding to medical assistance program claims data maintained by the state's Medicaid management information system contract agents. Pursuant to this initiative, the department of health, in collaboration with the office of Medicaid inspector general, shall make efforts to improve the utilization of such data in order to better identify fraud and abuse within the medical assistance program and to identify and implement further program and patient care reforms for the improvement of such program. In addition, the department of health, in consultation with such contract agents and the office of Medicaid inspector general, shall identify additional data elements that are maintained and otherwise accessible by the state, directly or through any of its contractors, that would, if coordinated with medical assistance data, further increase the effectiveness of data analysis for the management of the medical assistance program. To further the objectives of this subparagraph, the department of health, in collaboration with the office of Medicaid inspector general, shall provide or arrange in-service training for state and county medical assistance personnel to increase the capability for state and local data analysis, leading to a more cost-effective operation of the medical assistance program.

(4) Targeted claims and utilization review. Develop, test and implement an automated process for the targeted review of claims, services and/or populations not later than January thirty-first, two thousand seven. Such review shall be for the purposes of identifying statistical aberrations in the use or billing of such services and for assisting in the development and implementation of measures to ensure that service use and billing are appropriate to recipients' needs.

(c) The commissioner of health shall prepare and submit an interim report to the governor and legislature on the implementation of the initiatives specified in paragraph (b) of this subdivision no later than December first, two thousand seven. Such report shall also include recommendations for any revisions that would further facilitate the goals of such paragraph, including recommendations for expansion. In addition, the commissioner of health shall submit a final report not later than December first, two thousand eight. In preparing such interim and final reports, the commissioner of health shall consult with the Medicaid inspector general, third-party agents, providers and recipients associated with the implementation of paragraph (b) of this subdivision.

§ 4. The social services law is amended by adding a new section 363-d to read as follows:

§ 363-d. Provider compliance program. 1. The legislature finds that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. The legislature accordingly declares that it is in the public interest that providers within the medical assistance program implement compliance programs. The legislature also recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics. At the same time, however, the legislature determines that there are key components that must be included in every compliance program and such components should be required if a provider is to be a medical assistance program participant. Accordingly, the provisions of this section require providers to adopt effective compliance program elements, and make each provider responsible for implementing such a program appropriate to its characteristics.

2. Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program. The office of Medicaid inspector general shall create and make available on its website guidelines, which may include a model compliance program, that reflect the requirements of this section. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required pursuant to this section may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements:

(a) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(b) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program;

(c) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(d) communication lines to the responsible compliance position, as described in paragraph (b) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(e) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; or (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(f) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits;

(g) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(h) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section.

(a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section.

(b) 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 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.

4. The Medicaid inspector general, in consultation with the department of health, shall promulgate regulations establishing those providers that shall be subject to the provisions of this section including, but not limited to, those subject to the provisions of articles twenty-eight and thirty-six of the public health law, articles sixteen and thirty-one of the mental hygiene law, and other providers of care, services and

supplies under the medical assistance program for which the medical assistance program is a substantial portion of their business operations.

§ 5. The insurance law is amended by adding a new section 410 to read as follows:

§ 410. Superintendent's report on health insurance fraud. Annually, on or before March first, the superintendent, shall submit to the governor, the state comptroller, the attorney general, the temporary president of the senate, the speaker of the assembly, the chairpersons of the senate finance and health committees, and the assembly ways and means and health committees, a report summarizing the department's activities to investigate and combat health insurance fraud including, but not limited to, information regarding referrals received, investigations initiated, investigations completed, and any other material necessary or desirable to evaluate the department's efforts.

§ 6. The social services law is amended by adding a new section 365-j to read as follows:

§ 365-j. Advisory opinions. 1. General. (a) Definition and nature of advisory opinions. An advisory opinion is a written statement, issued pursuant to the provisions of this chapter, by the commissioner of the department of health or his or her specifically authorized designee or designees setting forth the applicability to a specified set of facts of pertinent statutory and regulatory provisions relating to the provision of medical items or services pursuant to the medical assistance program administered by the department of health as the single state agency responsible for the administration of the program. Advisory opinions are issued at the request of any provider enrolled in the medical assistance program, and are binding upon the commissioner with respect to that provider only.

(b) Areas in which advisory opinions may be requested. An advisory opinion may be sought with respect to a substantive question, or a procedural matter. Advisory opinions may be requested with respect to questions arising prior to an audit or investigation with respect to questions relating to a provider's claim for payment or reimbursement. Advisory opinions may also be utilized for purposes of service planning. Thus, they may be requested with respect to a hypothetical or projected future set of facts.

(c) An advisory opinion will not be issued where the petition for an advisory opinion relates to a pending question raised by the provider in an ongoing or initiated investigation conducted by the Medicaid inspector general, deputy attorney general for the Medicaid fraud unit, or any other criminal investigation or any civil or criminal proceeding, or where the provider has received any written notice of the commissioner or the Medicaid inspector general which advises a provider of an imminent investigation, audit, pended or otherwise suspended claim, or withhold of payment or reimbursement.

(d) Nothing in this section shall be construed as superseding any federal rule, law, requirement or guidance.

(e) The commissioner shall promulgate rules and regulations establishing the time period for issuance of such advisory opinion and the criteria for determining the eligibility of a request for departmental response.

2. Effect of advisory opinions. (a) An advisory opinion represents an expression of the views of the commissioner of health as to the application of law, regulations and other precedential material to the set of facts specified in the petition for advisory opinion. An advisory opin-

ion shall apply only with respect to the provider to whom the advisory opinion is rendered.

(b) A previously issued advisory opinion found by the commissioner to be in error may be modified or revoked, provided however, that a subsequent modification by such commissioner of such advisory opinion shall operate prospectively. In such instance, any recoupment of medical assistance overpayments caused by a provider's reliance on such an opinion shall be limited to the actual overpayments made, without interest, penalty, multiple damages, or other sanctions. The department shall promptly notify the provider of modification or revocation of an advisory opinion.

(c) All advisory opinions shall include the following notice: "This advisory opinion is limited to the person or persons who requested the opinion and it pertains only to the facts and circumstances presented in the petition."

(d) All advisory opinions shall cite the pertinent law and regulation upon which the advisory opinion is based.

(e) All advisory opinions and all modifications and revocations of a previously issued advisory opinion shall be deemed a public record.

§ 7. Subdivision 2 of section 145-b of the social services law, as amended by chapter 2 of the laws of 1998, is amended to read as follows:

2. For any violation of subdivision one, the local social services district or the state shall have a right to recover civil damages equal to three times the amount by which any figure is falsely overstated or in the case of non-monetary false statements or representations, three times the amount of damages which the state, political subdivision of the state, or entity performing services under contract to the state or political subdivision of the state sustain as a result of the violation or five thousand dollars, whichever is greater. [~~**Amounts collected pursuant to a judgment under this section**~~] **Notwithstanding part C of chapter fifty-eight of the laws of two thousand five: (a) For civil damages collected by a local social services district, relating to the medical assistance program, pursuant to a judgment under this subdivision, such amounts** shall be apportioned between the local social services district and the state [~~**in accordance with regulations of the department or the department of health, as appropriate. The remedy provided by this subdivision shall be in addition to any other remedy provided by law**~~]**. If the violation occurred: (i) prior to January first, two thousand six, the amount apportioned to the local social services district shall be the local share percentage in effect immediately prior to such date as certified by the division of the budget, or (ii) after January first, two thousand six, the amount apportioned to the local social services district shall be based on a reimbursement schedule, created by the office of Medicaid inspector general, in effect at the time the violation occurred; provided that, if there is no schedule in effect at the time the violation occurred, the schedule to be used shall be the first schedule adopted pursuant to this subdivision. Such schedule shall provide for reimbursement to a local social services district in an amount between ten and fifteen percent of the gross amount collected. Such schedule shall be set on a county by county basis and shall be periodically reviewed and updated as necessary; provided, however, that any such updated schedule shall not be less than ten percent nor greater than fifteen percent of the gross amount collected; and (b) For civil damages collected by the state relating to the medical assistance program pursuant to a judgment under this subdivision, the local social services district shall be entitled to compensation up to**

fifteen percent of the gross amount collected for such participation, including but not limited to identification, investigation or development of a case, commensurate with its level of effort or value added as determined by the Medicaid inspector general.

§ 8. Section 145-b of the social services law is amended by adding a new subdivision 5 to read as follows:

5. When in the course of conducting an investigation relating to the investigation relating to the medical assistance program, a local social services district deduces that a provider may have committed criminal fraud, it shall refer the case to the office of medicaid inspector general along with appropriate supporting information. The office shall promptly review the case and, if deemed appropriate, refer the case pursuant to subdivision seven of section thirty-two of the public health law. If the deputy attorney general for Medicaid fraud control accepts a referral from the office of Medicaid inspector general that was identified, investigated or developed by a local social services district, and the state collects damages, the participating local social services district shall be entitled to compensation up to fifteen percent of the gross amount collected for such participation commensurate with its level of effort or value added as determined by the deputy attorney general for Medicaid fraud control. If the office of medicaid inspector general determines that it is not appropriate for referral in accordance with subdivision seven of section thirty-two of the public health law the office of medicaid inspector general shall further investigate the case, with notice to the participating local social services district, or return the case to the participating social services district, which may resume its investigation of the provider.

§ 9. The penal law is amended by adding a new article 177 to read as follows:

ARTICLE 177
HEALTH CARE FRAUD

Section 177.00 Definitions.
177.05 Health care fraud in the fifth degree.
177.10 Health care fraud in the fourth degree.
177.15 Health care fraud in the third degree.
177.20 Health care fraud in the second degree.
177.25 Health care fraud in the first degree.
177.30 Health care fraud; affirmative defense.

§ 177.00 Definitions.

The following definitions are applicable to this article:

1. "Health plan" means any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided, and through which payment may be made to the person who provided the health care item or service. The state's medical assistance program (Medicaid) shall be considered a single health plan. For purposes of this article, a payment made pursuant to the state's managed care program as defined in paragraph (c) of subdivision one of section three hundred sixty-four-j of the social services law shall be deemed a payment by the state's medical assistance program (Medicaid).

2. "Person" means any individual or entity, other than a recipient of a health care item or service under a health plan unless such recipient acts as an accessory to such an individual or entity.

§ 177.05 Health care fraud in the fifth degree.

A person is guilty of health care fraud in the fifth degree when, with intent to defraud a health plan, he or she knowingly and willfully

provides materially false information or omits material information for the purpose of requesting payment from a health plan for a health care item or service and, as a result of such information or omission, he or she or another person receives payment in an amount that he, she or such other person is not entitled to under the circumstances.

Health care fraud in the fifth degree is a class A misdemeanor.

§ 177.10 Health care fraud in the fourth degree.

A person is guilty of health care fraud in the fourth degree when such person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment or portion of the payment wrongfully received, as the case may be, from a single health plan, in a period of not more than one year, exceeds three thousand dollars in the aggregate.

Health care fraud in the fourth degree is a class E felony.

§ 177.15 Health care fraud in the third degree.

A person is guilty of health care fraud in the third degree when such person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment or portion of the payment wrongfully received, as the case may be, from a single health plan, in a period of not more than one year, exceeds ten thousand dollars in the aggregate.

Health care fraud in the third degree is a class D felony.

§ 177.20 Health care fraud in the second degree.

A person is guilty of health care fraud in the second degree when such person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment or portion of the payment wrongfully received, as the case may be, from a single health plan, in a period of not more than one year, exceeds fifty thousand dollars in the aggregate.

Health care fraud in the second degree is a class C felony.

§ 177.25 Health care fraud in the first degree.

A person is guilty of health care fraud in the first degree when such person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment or portion of the payment wrongfully received, as the case may be, from a single health plan, in a period of not more than one year, exceeds one million dollars in the aggregate.

Health care fraud in the first degree is a class B felony.

§ 177.30 Health care fraud; affirmative defense.

In any prosecution under this article, it shall be an affirmative defense that the defendant was a clerk, bookkeeper or other employee, other than an employee charged with the active management and control, in an executive capacity, of the affairs of the corporation, who, without personal benefit, merely executed the orders of his or her employer or of a superior employee generally authorized to direct his or her activities.

§ 10. Paragraphs (a) and (b) of subdivision 1 of section 460.10 of the penal law, paragraph (a) as amended by chapter 489 of the laws of 2000 and paragraph (b) as added by chapter 516 of the laws of 1986, are amended to read as follows:

(a) Any of the felonies set forth in this chapter: sections 120.05, 120.10 and 120.11 relating to assault; sections 125.10 to 125.27 relating to homicide; sections 130.25, 130.30 and 130.35 relating to rape; sections 135.20 and 135.25 relating to kidnapping; section 135.65 relating to coercion; sections 140.20, 140.25 and 140.30 relating to burglary; sections 145.05, 145.10 and 145.12 relating to criminal mischief; article one hundred fifty relating to arson; sections 155.30, 155.35, 155.40 and 155.42 relating to grand larceny; **sections 177.10, 177.15, 177.20 and 177.25 relating to health care fraud;** article one hundred sixty relating to robbery; sections 165.45, 165.50, 165.52 and

165.54 relating to criminal possession of stolen property; sections 170.10, 170.15, 170.25, 170.30, 170.40, 170.65 and 170.70 relating to forgery; sections 175.10, 175.25, 175.35, 175.40 and 210.40 relating to false statements; sections 176.15, 176.20, 176.25 and 176.30 relating to insurance fraud; sections 178.20 and 178.25 relating to criminal diversion of prescription medications and prescriptions; sections 180.03, 180.08, 180.15, 180.25, 180.40, 180.45, 200.00, 200.03, 200.04, 200.10, 200.11, 200.12, 200.20, 200.22, 200.25, 200.27, 215.00, 215.05 and 215.19 relating to bribery; sections 190.40 and 190.42 relating to criminal usury; section 190.65 relating to schemes to defraud; sections 205.60 and 205.65 relating to hindering prosecution; sections 210.10, 210.15, and 215.51 relating to perjury and contempt; section 215.40 relating to tampering with physical evidence; sections 220.06, 220.09, 220.16, 220.18, 220.21, 220.31, 220.34, 220.39, 220.41, 220.43, 220.46, 220.55 and 220.60 relating to controlled substances; sections 225.10 and 225.20 relating to gambling; sections 230.25, 230.30, and 230.32 relating to promoting prostitution; sections 235.06, 235.07 and 235.21 relating to obscenity; section 263.10 relating to promoting an obscene performance by a child; sections 265.02, 265.03, 265.04, 265.11, 265.12, 265.13 and the provisions of section 265.10 which constitute a felony relating to firearms and other dangerous weapons; and sections 265.14 and 265.16 relating to criminal sale of a firearm; and section 275.10, 275.20, 275.30, or 275.40 relating to unauthorized recordings; and sections 470.05, 470.10, 470.15 and 470.20 relating to money laundering; or

(b) Any felony set forth elsewhere in the laws of this state and defined by the tax law relating to alcoholic beverage, cigarette, gasoline and similar motor fuel taxes; [~~**title**~~] **article** seventy-one of the environmental conservation law relating to water pollution, hazardous waste or substances hazardous or acutely hazardous to public health or safety of the environment; article [~~**twenty-three-a**~~] **twenty-three-A** of the general business law relating to prohibited acts concerning stocks, bonds and other securities [~~**or**~~]**,** article twenty-two of the general business law concerning monopolies.

§ 11. Paragraph (b) of subdivision 8 of section 700.05 of the criminal procedure law, as amended by chapter 264 of the laws of 2003, is amended to read as follows:

(b) Any of the following felonies: assault in the second degree as defined in section 120.05 of the penal law, assault in the first degree as defined in section 120.10 of the penal law, reckless endangerment in the first degree as defined in section 120.25 of the penal law, promoting a suicide attempt as defined in section 120.30 of the penal law, criminally negligent homicide as defined in section 125.10 of the penal law, manslaughter in the second degree as defined in section 125.15 of the penal law, manslaughter in the first degree as defined in section 125.20 of the penal law, murder in the second degree as defined in section 125.25 of the penal law, murder in the first degree as defined in section 125.27 of the penal law, abortion in the second degree as defined in section 125.40 of the penal law, abortion in the first degree as defined in section 125.45 of the penal law, rape in the third degree as defined in section 130.25 of the penal law, rape in the second degree as defined in section 130.30 of the penal law, rape in the first degree as defined in section 130.35 of the penal law, criminal sexual act in the third degree as defined in section 130.40 of the penal law, criminal sexual act in the second degree as defined in section 130.45 of the penal law, criminal sexual act in the first degree as defined in section

130.50 of the penal law, sexual abuse in the first degree as defined in section 130.65 of the penal law, unlawful imprisonment in the first degree as defined in section 135.10 of the penal law, kidnapping in the second degree as defined in section 135.20 of the penal law, kidnapping in the first degree as defined in section 135.25 of the penal law, custodial interference in the first degree as defined in section 135.50 of the penal law, coercion in the first degree as defined in section 135.65 of the penal law, criminal trespass in the first degree as defined in section 140.17 of the penal law, burglary in the third degree as defined in section 140.20 of the penal law, burglary in the second degree as defined in section 140.25 of the penal law, burglary in the first degree as defined in section 140.30 of the penal law, criminal mischief in the third degree as defined in section 145.05 of the penal law, criminal mischief in the second degree as defined in section 145.10 of the penal law, criminal mischief in the first degree as defined in section 145.12 of the penal law, criminal tampering in the first degree as defined in section 145.20 of the penal law, arson in the fourth degree as defined in section 150.05 of the penal law, arson in the third degree as defined in section 150.10 of the penal law, arson in the second degree as defined in section 150.15 of the penal law, arson in the first degree as defined in section 150.20 of the penal law, grand larceny in the fourth degree as defined in section 155.30 of the penal law, grand larceny in the third degree as defined in section 155.35 of the penal law, grand larceny in the second degree as defined in section 155.40 of the penal law, grand larceny in the first degree as defined in section 155.42 of the penal law, **health care fraud in the fourth degree as defined in section 177.10 of the penal law, health care fraud in the third degree as defined in section 177.15 of the penal law, health care fraud in the second degree as defined in section 177.20 of the penal law, health care fraud in the first degree as defined in section 177.25 of the penal law,** robbery in the third degree as defined in section 160.05 of the penal law, robbery in the second degree as defined in section 160.10 of the penal law, robbery in the first degree as defined in section 160.15 of the penal law, unlawful use of secret scientific material as defined in section 165.07 of the penal law, criminal possession of stolen property in the fourth degree as defined in section 165.45 of the penal law, criminal possession of stolen property in the third degree as defined in section 165.50 of the penal law, criminal possession of stolen property in the second degree as defined by section 165.52 of the penal law, criminal possession of stolen property in the first degree as defined by section 165.54 of the penal law, trademark counterfeiting in the first degree as defined in section 165.73 of the penal law, forgery in the second degree as defined in section 170.10 of the penal law, forgery in the first degree as defined in section 170.15 of the penal law, criminal possession of a forged instrument in the second degree as defined in section 170.25 of the penal law, criminal possession of a forged instrument in the first degree as defined in section 170.30 of the penal law, criminal possession of forgery devices as defined in section 170.40 of the penal law, falsifying business records in the first degree as defined in section 175.10 of the penal law, tampering with public records in the first degree as defined in section 175.25 of the penal law, offering a false instrument for filing in the first degree as defined in section 175.35 of the penal law, issuing a false certificate as defined in section 175.40 of the penal law, criminal diversion of prescription medications and prescriptions in the second degree as defined in section 178.20 of the penal law, criminal

diversion of prescription medications and prescriptions in the first degree as defined in section 178.25 of the penal law, escape in the second degree as defined in section 205.10 of the penal law, escape in the first degree as defined in section 205.15 of the penal law, absconding from temporary release in the first degree as defined in section 205.17 of the penal law, promoting prison contraband in the first degree as defined in section 205.25 of the penal law, hindering prosecution in the second degree as defined in section 205.60 of the penal law, hindering prosecution in the first degree as defined in section 205.65 of the penal law, criminal possession of a weapon in the third degree as defined in subdivisions two, three, four and five of section 265.02 of the penal law, criminal possession of a weapon in the second degree as defined in section 265.03 of the penal law, criminal possession of a dangerous weapon in the first degree as defined in section 265.04 of the penal law, manufacture, transport, disposition and defacement of weapons and dangerous instruments and appliances defined as felonies in subdivisions one, two, and three of section 265.10 of the penal law, sections 265.11, 265.12 and 265.13 of the penal law, or prohibited use of weapons as defined in subdivision two of section 265.35 of the penal law, relating to firearms and other dangerous weapons;

§ 12. Subdivision 1 of section 740 of the labor law is amended by adding a new paragraph (g) to read as follows:

(g) "Health care fraud" means health care fraud as defined by article one hundred seventy-seven of the penal law.

§ 13. Paragraph (a) of subdivision 2 of section 740 of the labor law, as added by chapter 660 of the laws of 1984, is amended to read as follows:

(a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety**, or which constitutes health care fraud**;

§ 14. This act shall take effect immediately, except that:

(a) section 363-d of the social services law, as added by section four of this act, shall take effect on the first of January next succeeding the date on which this act shall have become a law;

(b) section 365-j of the social services law, as added by section six of this act, shall take effect on the sixtieth day after this act shall have become a law and shall apply to requests for guidance submitted on or after such effective date;

(c) the schedule required pursuant to subparagraph (ii) of paragraph (a) of subdivision 2 of section 145-b of the social services law, as amended by section seven of this act, shall be created by the Medicaid inspector general no later than thirty days after appointment of such inspector general; and

(d) sections nine, ten, eleven, fourteen and fifteen of this act shall take effect on the first of November next succeeding the date on which it shall have become a law.

The Legislature of the STATE OF NEW YORK **ss:**

Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

JOSEPH L. BRUNO
Temporary President of the Senate

SHELDON SILVER
Speaker of the Assembly