NEW YORK 2011-2012 MEDICAID REIMBURSEMENT GUIDE WITH MEDICAID REDESIGN

Excerpt

Hospital and Clinic Services
Nursing Home and Home Care Services
Mental Hygiene Law Services
Practitioners and Suppliers
Medicaid Managed Care
Audits and Compliance

Written by
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for

Healthcare Association of New York State

Excerpt

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PREFACE

This ***New York 2011-2012 Medicaid Reimbursement Guide With Medicaid Redesign*** is a comprehensive publication available in a searchable disk format and reflects legislative and regulatory enactments through September 2011. It replaces the ***New York 2010-2011 Medicaid Reimbursement Guide*****.** It is expected that additional regulations will be adopted by the State agencies, additional guidance will be issued that affects Medicaid reimbursement for the 2011-2012, and additional legislation will be enacted for the 2012-2013 New York State Fiscal Years.

The ***New York 2011-2012 Medicaid Reimbursement Guide With Medicaid Redesign*** is for general informational purposes only and is not intended to be nor should it be considered legal advice on the reimbursement of particular health care services, procedures, items or supplies. Each specific situation may be subject to complex variables under various reimbursement methodologies.

December 2011

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CHAPTER 1

OVERVIEW

General

Medicaid is a joint federal-State partnership under Title XIX of the federal Social Security Act in which the federal government shares a percentage of a State's expenditures in providing medical assistance to eligible needy individuals.[1] For each State, covered health care items and services, Medicaid eligibility criteria, and State reimbursement methodologies for participating providers, practitioners and suppliers are set forth in a State Medicaid Plan.[2] Each participating State must provide certain mandatory services under its State Medicaid Plan and may provide various optional services. While each State has considerable flexibility in designing its Medicaid program, the State must comply with federal program requirements. Some federal program requirements may be waived and additional services provided upon application of a State for a waiver and federal approval.

New York State provides a broad array of health care services to over 4 million persons enrolled in Medicaid. This has a significant impact on the State's annual budget. For the State fiscal year April 1, 2010 through March 31, 2011, for example, it is estimated that total Medicaid spending in New York State would exceed $52 billion.[3] This includes costs of State and local governments in administering the program, including client eligibility determinations, provider survey and certification, provider payment, and provider audit functions. State Medicaid payment rates must be consistent with efficiency, economy and quality of care and must be sufficient to enlist enough providers so that Medicaid services are available to recipients at least to the same extent that comparable services are available to the general public.[4] Federal courts have ruled, however, that providers of health care services do not have an enforceable right under this provision to sue a State to increase Medicaid reimbursement.[5]

The Secretary of the federal Department of Health and Human Services must approve the State Medicaid Plan and proposed plan amendments to assure compliance with federal requirements.[6] The Medicaid program oversight by the federal government is administered by the Centers for Medicare and

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Medicaid Services (CMS), formerly known as the Health Care Financing Administration, within the federal Department of Health and Human Services. A State Plan Amendment relating to Medicaid payments may be approved by CMS retroactive to the beginning of the quarter in which the proposed amendment is submitted, but no earlier than publication by the State of a public notice of the proposed amendment.[7] In New York, such notices are published in the *New York State Register*. In response to the reductions in Medicaid reimbursement proposed by various States facing budget shortfalls, CMS has issued proposed regulations to provide guidance to the States on ensuring access to health services for Medicaid beneficiaries as a component of the CMS State Plan Amendment approval process.[8] The Commissioner of Health is required to post on the Department of Health Website a copy of the Medicaid State Plan, all approved Plan Amendments, all proposed Plan Amendments and all applications for federal waivers.[9]

The Social Services Law provided for jurisdiction by the State Department of Social Services over various aspects of the Medicaid program.[10] However, the Department of Social Services was reorganized in 1996. General supervision and authority over the Medicaid program was transferred[11] and all references in the law to the State Department of Social Services and to the State Commissioner of Social Services are now deemed to refer to the State Department of Health and to the State Commissioner of Health, respectively.[12] The Department of Health is the "single State agency" authorized under the federal Social Security Act to supervise the State's Medicaid program.[13] Under statutes[14] and memoranda of understanding,[15] various functions are transferred from the Department of Health to other State and local governmental agencies.[16]

In New York State, health care facility and program licenses are called "operating certificates." Health care facilities and programs are often referred to according to the article of State law under which they receive an operating certificate. Hospitals, nursing homes and diagnostic and treatment centers are issued operating certificates under Article 28 of the Public Health Law, home health agencies under Article 36, and hospices under Article 40. Developmental disabilities facilities and programs are issued operating certificates under Article 16, mental health facilities and programs under Article 31, and chemical abuse (alcoholism and substance abuse) facilities and programs under Article 32 of the Mental Hygiene Law, respectively.

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In what can be a confusing use of terminology, the Public Health Law uses the term "hospital" as a generic term applying to three different categories of health care providers: general hospitals, nursing homes and free-standing clinics. The Public Health Law uses the term "general hospital" to cover inpatient, outpatient and emergency services in a facility commonly called a hospital. Nursing homes (nursing facilities under federal terminology) also are referred to as "residential health care facilities" in the Public Health Law and free-standing independent clinics are referred to as "diagnostic and treatment centers." For purposes of this *Guide*, these categories of health care providers are referred to as: hospitals; nursing homes or residential health care facilities; and diagnostic and treatment centers.

Federal Medical Assistance Percentage

The federal share paid to the State for Medicaid expenditures for health care services, called the federal medical assistance percentage (FMAP), varies from State to State depending on a complex formula that measures State levels of need and wealth compared to the national average.[17] For New York State, the FMAP has been generally 50%.[18]

A temporary increase of 2.9 percentage points in the FMAP was provided for the 15-month period April 2003 through June 2004, generating additional federal funds for New York.[19] FMAP enhancements for all states are provided for the 27-month period October 2008 through December 2010 under the federal economic stimulus bill, the American Recovery and Reinvestment Act of 2009, of from 6.2 to over 11 percentage points based in part on unemployment within the state.[20] New York qualified for FMAPs increasing to 61.59% beginning July 2009.[21] The Commissioner of Health is authorized to apply for further enhanced federal financial participation to support State reform initiatives.[22]

The increase in the FMAP was extended for six months through June 2011. The increase phases down each quarter over the six-month extension period.

Local Share

In New York, medical assistance has been a local county or City of New York responsibility with reimbursement from federal funds and from State funds.[23] The State has provided reimbursement for the non-federal component of Medicaid

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expenditures in varying percentages depending upon the particular item or service.[24] Use of local funds as the source of the State share of Medicaid expenditures, considered an intergovernmental transfer, is authorized under federal law.[25] See also the discussion *infra* under "Sources of Medicaid Funds" under Medicaid Funding Limitations in the chapter on General Medicaid Provisions.

The escalating cost of the Medicaid program placed an increasing burden on local government (counties and the City of New York) revenue from property taxes, sales taxes, and New York City income tax to meet the local share contribution.[26] Under 2005 legislation, local governments' shares of Medicaid expenditures, other than for the Family Health Plus program, are limited to a capped amount.[27] For 2006, each local government's share of Medicaid expenditures is capped at a 3.5% increase over base year 2005 expenditures with additional cumulative non-compounded increases over base year expenditures of: 3.25% for 2007 and a further additional 3.0% per year for 2008 and each year thereafter.[28] Various Medicaid payments for the benefit of county-operated facilities or public benefit corporations for which the county is responsible for the non-federal share of the payment are excluded from the cap.

The calculated Medicaid expenditure cap for each county and the City of New York is paid to the Department of Health in equal weekly installments as their maximum responsibility for Medicaid expenditures. The Commissioner of Health maintains an accounting of what would have been each local government's share without the cap, and applies that amount if lower. Each county and the City of New York had the option to elect by September 30, 2007 whether for 2008 and thereafter to continue under the capped share methodology or have the State assume the full local cost of the Medicaid program in exchange for remitting to the State a certain percentage of the local sales tax revenue. Only Monroe County elected the sales tax option.

As a condition of receiving the increased FMAP under the American Recovery and Reinvestment Act of 2009, a state may not increase the local government percentage share of Medicaid expenditures in effect on September 30, 2008.[29] The Director of the Budget is given the discretionary authority to decrease an expenditure cap to account for an increase in the state FMAP, which was implemented by payments to counties and the City of New York based on the increased FMAP.[30]

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The cap may be adjusted for recovery by the State from a local social services district of the amount of any federal Medicaid disallowance or recovery based upon an action by the local social services district that the Commissioner of Health finds violates State law, regulation or policy. A local social services district would have an opportunity to submit written objections to any such finding.

To encourage innovations, the savings from any local government Medicaid demonstration program approved by the Department of Health will be shared equally by the State and such local government.[31]

For the Family Health Plus program, the State assumed the full county share cost for services provided on and after October 1, 2005. For New York City, the State assumed the full local share January 1, 2006.[32]

As required by legislation, the Commissioner of Health developed a plan for assumption by the State over a 5-year period beginning in 2011 of the administrative services performed by counties and the City of New York under the Medicaid program.[33] An implementation report was issued by the Department of Health November 2010.[34]

Rate Methodologies

Formula-based Medicaid rates of payment are established by the Commissioner of Health for hospitals, nursing homes, diagnostic and treatment centers, home health care providers, and hospices. Formula-based rates of payment are established by the Commissioner of Mental Health for inpatient and outpatient mental health services providers, by the Commissioner of Developmental Disabilities for inpatient and outpatient developmental disabilities services providers, and by the Commissioner of Alcoholism and Substance Abuse Services for inpatient chemical abuse services providers. For providers dually licensed by the Department of Health and another agency, the rates are established by the Department of Health except for certain outpatient mental health services. All Medicaid reimbursement rates are subject to approval by the Director of the Budget.

The federal Social Security Act governing the Medicaid program formerly required, under a provision known as the Boren Amendment, that Medicaid inpatient rates must be "reasonable and

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adequate to meet the costs which must be incurred by efficiently and economically operated providers." This applied to hospitals, nursing homes, and intermediate care facilities for the mentally retarded and developmentally disabled. States were required to make findings and submit assurances to the federal government that the standard was met. Providers were often successful in legal challenges to State Medicaid reimbursement rates as not meeting procedural or substantive requirements.[35] The Balanced Budget Act of 1997 repealed this requirement.[36] States are now provided greater flexibility in establishing inpatient provider Medicaid payment rates, but under the federal Social Security Act, must use a public process in developing payment rates for inpatient services.[37]

Medicaid cost-based rate-setting begins with a comprehensive cost report submitted by a provider. From the cost report, allowable costs for rate-setting purposes are determined in accordance with federal Medicare reimbursement principles and specific costs disallowed in State regulations. For example, advertising to attract patients would not be an allowable cost for rate-setting but advertising costs to announce job openings would. Medicare reimbursement principles are set forth in a *Health Insurance Manual* published by CMS (publication HIM-15).

The State then applies complex rate-setting methodologies to convert provider allowable costs into Medicaid reimbursement rates. The methodologies vary among different types of service providers and may include such factors as ceilings on certain costs, peer group efficiency comparisons, group average costs, and adjustments to reflect regional or provider differences in wage levels and other costs. Rates generally are established for a prospective rate period.[38] However, rates may be retroactively revised when: prior notice requirements are waived by statute;[39] and federal approval of a Medicaid State Plan amendment is received during or after a rate period and the federal approval date is retroactive to the beginning of the quarter in which the proposed plan amendment was submitted. In the alternative, the regulatory agency may include the fiscal impact of a Medicaid rate adjustment for a retroactive period in the calculation of a prospective Medicaid rate for the providers. If a provider fails to file required financial and statistical reports and data, Medicaid payment rates may be reduced.[40]

Provider cost reports submitted to a State agency are subject to audit. Cost-based Medicaid reimbursement rates may be

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adjusted based on audit findings.[41] See discussion *infra* in the chapter on Audits and Recoveries.

Fee Schedules

Reimbursement for services provided by health care practitioners and suppliers enrolled in the Medicaid program is made by the State in accordance with State fee schedules. Billing instructions are published in the New York State Department of Health MMIS (Medicaid Management Information Systems) *Provider Manuals. Provider Manuals* are issued by Computer Sciences Corporation, the State's contracted fiscal agent.[42] Most *Provider* Manuals are available online; see discussion below regarding eMedNY in this chapter. State fee schedules, policies and billing instructions are updated and revised in *Medicaid Update*, a monthly publication of the New York State Department of Health, Office of Medicaid Management, available to providers and to the public at http://www.health.state.ny.us/nysdoh/mancare/omm/main.htm. Provider fee schedules are established by the Department of Health and approved by the Director of the Budget.

Fee schedules for certain services provided by facilities licensed by their respective agencies also may be established by the Commissioner of Health, Commissioner of Mental Health, Commissioner of Developmental Disabilities, and Commissioner of Alcoholism and Substance Abuse Services, subject to approval by the Director of the Budget.

Medicaid Managed Care

Under Medicaid managed care programs and Medicaid managed long term care programs, the State pays a monthly premium, a capitated rate, to the managed care plan for each Medicaid beneficiary enrolled. Capitation rates are established per member per month for various actuarial classifications of enrollees. See discussion *infra* in the chapter on Medicaid Managed Care Programs. As enrollment of Medicaid beneficiaries in managed care increases, the role of fee-for-service Medicaid rates or fees decreases for services included in the managed care benefit package.

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Judicial Review

Upon exhaustion of available administrative remedies, a health care provider may initiate a court proceeding for judicial review of the Medicaid rate or fee established for the provider or the determination of Medicaid audit adjustments. Judicial proceedings to review administrative agency actions generally must be initiated pursuant to Article 78 of the New York Civil Practice Law and Rules, although in circumstances where the challenged action is considered legislative in character, the proceeding may be initiated as an action for declaratory judgment.[43] Regardless of the form in which it is brought, where the proceeding challenges administrative action it must be initiated within four months of the final administrative determination.[44]

The federal courts generally are not the forum in which a challenge to Medicaid reimbursement currently may be brought.[45] Alleged non-compliance by the State with the State Medicaid Plan must also demonstrate conflict with federal law for federal court jurisdiction to apply.[46]

Enrollment & Termination

Participation in the Medicaid program by a provider is voluntary. Health care institutional providers, practitioners, suppliers, and vendors of items and services must apply to the Department of Health to enroll in the Medicaid program and, upon approval, sign a Provider Agreement with the State.[47]

By enrolling in the Medicaid program, the provider agrees: "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department ..."[48]

If a practitioner provides services in a group setting, the group and all members of the group must be enrolled in Medicaid. In submitting a claim for reimbursement, the group and the individual who provided the service must be identified.[49] A low Medicaid volume practitioner is not required to enroll to order or

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prescribe care, services or supplies.[50] Provider duties and responsibilities,[51] provider unacceptable practices,[52] and provisions relating to sanctions for unacceptable practices, including termination of a provider's enrollment in Medicaid,[53] are specified in regulation. A change in ownership or control must be reported.[54]

A provider terminated from the Medicaid program for cause is entitled to an administrative hearing to contest the basis for the termination.[55] A provider also may be terminated without cause, upon 30 days notice, in which event an administrative hearing is not afforded to the provider.[56] The courts have held that continued participation in the Medicaid program is not a protected property interest and termination without cause does not implicate a liberty interest. Therefore, due process does not require that a provider be afforded a hearing upon termination without cause.[57] The State must provide its reasons for termination so that the matter may be reviewed by a court on appeal.

Exclusion from the Medicaid and Medicare programs is mandatory for criminal convictions related to delivery of a health care item or service, and is permissive for conviction of other crimes and for improper practices.[58] A provider may not contract with or employ any person or entity that has been excluded from the Medicare or Medicaid program.[59]

Upon loss of a professional license, a practitioner would be excluded from the Medicaid program, but upon restoration of the license could reapply. The determinations of the Office of Medicaid Inspector General regarding exclusion from or readmission to the Medicaid program should be coordinated and consistent with determinations of the professional licensing authority.[60]

Claims

Claims for payment for medical care, items, and services provided to Medicaid patients must be submitted within 90 days of the date of service to be valid and enforceable, unless the claim is delayed due to circumstances beyond the provider's control.[61] With a valid explanation of delay, Medicaid claims may be submitted if less than two years from the date of service. Claims two years old or older are only accepted if the delay is caused by errors of the State or its agents or when a court has ordered payment.[62] Medicaid claims are submitted to Computer Sciences Corporation, the State's contracted fiscal agent, for processing.

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Billing agents submitting claims for a provider must enroll in the Medicaid program as Service Bureaus[63] and be paid on a basis reasonably related to costs.[64] Payments to a provider may be made by electronic funds transfer.[65] Except for certain nominal co-payment amounts, Medicaid reimbursement is payment in full for items and services and a beneficiary or responsible relative may not be billed.[66] Medicaid may not be billed for appointments not kept by a beneficiary.[67]

Medicaid is considered the "payer of last resort;" all other sources of payment must be exhausted before claims will be paid by the Medicaid program.[68] If the State has paid a Medicaid claim, the State is subrogated to the individual enrollee's rights to recover against third parties that have primary responsibility for payment.[69] Under New York regulations, health care providers are authorized to act as agents of the State for purposes of submitting claims for recovery of payments for which a third party should have been primarily responsible.[70]

Claims are subject to various edits in processing for compliance with Medicaid billing requirements.[71] Claims may be pended for various reasons, including erroneous information or for manual pricing. Claims also may be pended during an audit or investigation of a provider.[72] Claims may be denied if they do not meet Medicaid program billing requirements.[73] Providers submit an annual Certification Statement to the effect that Medicaid claims submitted are appropriate.[74] The MMIS Remittance Statement sent to each provider for each payment cycle contains information on all claims paid, pended, or denied.

Federal law and regulations prohibit a State from making payments for Medicaid services to anyone other than an enrolled entity or to a recipient of services.[75] This prevents factoring of Medicaid receivables by a provider. However, a security interest in Medicaid receivables may be provided as security for a loan.[76]

Claims for Medicaid reimbursement are subject to audit. Records must be maintained for six years after payment to establish the medical necessity for and the extent of services, care, and supplies provided.[77] Records to support Medicaid claims and to record the care, services and supplies that have been provided to a patient may be maintained in an electronic format.[78]

CMS, using a federal contractor for audits under the Payment Error Rate Measurement Program (PERM), periodically

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estimates Medicaid claim error rates for each State for fee-for-service claims, managed care claims, and program eligibility, and an estimate of improper payments under the Medicaid program.[79] These estimates are reported by CMS to Congress.[80] The process seeks to identify where common billing errors are occurring in order to find solutions.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)[81] has required development of a health care standard electronic transaction system, including uniform coding and electronic billing procedures for all providers of and payers for health care services. Local billing codes were eliminated by October 2002. New York State's Medicaid billing system is compliant with the requirements for electronic transmission of data. Updated electronic transaction standards, HIPAA 5010/D.0., will be implemented January 2012.[82]

National Provider Identifier (NPI)

The New York State Department of Health delayed implementation for Medicaid claims of the federal National Provider Identifier (NPI) requirement until September 2008 due to system difficulties in establishing cross-walks between New York State data and the new national identifiers. Effective September 2008, Medicaid claims must include the provider's unique federal identifier.[83] For facilities such as hospitals and clinics, Medicaid claims also must include the NPI for the patient attending practitioner. Facilities must maintain and file with Medicaid a roster of attending practitioners.[84]

eMedNY

New York State entered into a multi-year contract through June 2010 with Computer Sciences Corporation to modernize and replace the MMIS. The new system is called eMedNY. The Electronic Provider Assisted Claim Entry System (ePACES) component of this new system became effective in 2003, providing for electronic submission of HIPAA-compliant Medicaid claims, Medicaid patient eligibility verification, Medicaid service authorizations, and related transactions. A transition period for compliance was provided through December 29, 2004. Now only HIPAA-compliant claim forms are processed for claims that are submitted electronically.

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Implementation of eMedNY Phase II occurred March 2005, including eligibility benefit inquiry and response, claim status request inquiry and response, service authorization, prior approval and prior authorization requests, and claim payment advice. A transition period for Medicaid providers to comply with the new system expired December 31, 2005.[85] The eMedNY system replaces MMIS and provides various electronic system enhancements.[86]

This Web-based system is located at http://www.emedny.org. The system offers a wide range of Medicaid administrative services and information to providers, Medicaid enrollees, and the public. The site provides online access to Medicaid manuals and reference materials.

Electronic Health Records

The American Recovery and Reinvestment Act provides for incentive payments to providers beginning in 2011, including hospitals and practitioners, who adopt and become "meaningful users" of electronic health records ("EHR").[87] The New York Medicaid program received federal funds for State planning activities.[88] The Department of Health will implement an EHR incentive payment program beginning December 2011.

Regulatory Oversight

State Agencies. The New York State Department of Health has had the primary administrative agency responsibility of investigating improper Medicaid payments, unacceptable practices, and issues of fraud, waste and abuse, and of instituting recovery of Medicaid funds under an audit process (see discussion *infra* in the chapter on Audits and Recoveries) and may impose monetary penalties and revoke, suspend, limit or annul the authorization of a provider to participate in the Medicaid program.[89] Fraud is considered an intentional deception or misrepresentation made by a person with the knowledge that it could result in an unauthorized financial benefit.[90] Abuse is considered provider practices that are inconsistent with Medicaid program requirements and guidance and sound fiscal, business or medical practices and result in unnecessary costs to the Medicaid program, including reimbursement for services that are not medically necessary or that fail to meet standards of care.[91]

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The Department of Health has the authority to offset Medicaid overpayments against current payments due to a health care provider, supplier or practitioner. The New York State Department of Health, Office for People With Developmental Disabilities, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and Office of Children and Family Services share responsibility for oversight of quality of care, certain Medicaid rate and fee setting functions, and issues of Medicaid fraud and abuse and can take enforcement actions within their respective service systems. The New York State Division of the Budget has the responsibility for approval of all Medicaid rates and fees established by the rate and fee setting State agencies. The New York State Education Department and Department of Health have the authority to take disciplinary action against licensed health care professionals.

Administrative oversight responsibilities of various agencies for Medicaid fraud and abuse were consolidated in 2006 in a new Office of Medicaid Inspector General. See discussion below in this chapter. The Department of Health, in consultation with the Office of Medicaid Inspector General, is directed to enhance the abilities of the Medicaid payment system to detect fraud and abuse and improve expenditure accountability, including such areas as: prepayment claims review, coordination of benefits, comprehensive review of paid claims, and targeted review of claims and utilization review.[92] In February 2009, the Department of Health awarded a contract to perform retrospective utilization review of Medicaid claims related to conformity with evidence-based standards or inappropriate resource utilization.

The Commissioner of Health is authorized, beginning in 2006, to issue advisory opinions to requestors on the applicability of Medicaid laws and regulations to a set of facts. Issues may be posed as hypothetical questions.[93]

One of the performance milestones in the October 2006 agreement between the State and CMS that makes $1.5 billion in federal funds available over five years to New York State under the Federal-State Health Reform Partnership (F-SHRP), discussed *infra* in the chapter on Medicaid Managed Care, requires the State to achieve, over time, specified increasing amounts in Medicaid fraud and abuse recoveries. Savings must reach $644 million in 2011, a substantial increase over 2006 recoveries.

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State Medicaid Inspector General. During the summer of 2005, a series of articles in *The New York Times* focused on an exposé of Medicaid fraud and abuse that had gone undetected by regulators.[94] In response to these disclosures, Governor Pataki appointed, by Executive Order,[95] a Medicaid Inspector General of the State of New York to coordinate the investigation of waste, fraud and abuse in the Medicaid program. In 2006, an independent Medicaid Inspector General and Office of Medicaid Inspector General (OMIG) were established by law in the Department of Health, and their authority, duties and responsibilities delineated.[96] The OMIG also can hire contractors to conduct audits on behalf of the State. The responsibilities of the various State agencies regarding fraud and abuse were consolidated in the new Office, including the audit functions. Under federal regulations[97] and a Memorandum of Understanding, where the OMIG suspects fraud or abuse the case must be referred to the Attorney General's Medicaid Fraud Control Unit for criminal or civil prosecution. If the Attorney General does not proceed, the OMIG may then pursue the matter.

Under the supervision of the OMIG, various counties and the City of New York are implementing Medicaid provider audit programs within their jurisdictions. The OMIG beginning in 2008 has issued annual Medicaid Work Plans identifying audit priorities, available at http://www.omig.state.ny.us.

As discussed above, the OMIG has the authority to exclude a provider from the Medicaid program and maintains a list of excluded persons on its Website. Providers must review the excluded persons lists of the OMIG and the federal Office of Inspector General and the federal General Services Administration to assure that the provider does not employ or deal with an excluded person.[98]

Upon complaints by a coalition of approximately 40 provider organizations of overly aggressive OMIG audit tactics, the legislature passed legislation in 2011 that would have curbed the OMIG and enhanced due process protections afforded providers in the audit process.[99] The bill was vetoed by Governor Cuomo, who directed the OMIG to review its audit policies and procedures and to convene a working group to address the issues identified in the legislation.

Medicaid Recovery Audit Contractor. The Affordable Care Act requires each State to establish a Medicaid Recovery Audit

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Contractor ("RAC") program to audit Medicaid providers to identify and recover overpayments and identify underpayments.[100] Federal regulations were adopted September 2011.[101] The Medicaid RAC auditors are paid a percentage of their recoveries. HMS has been designated a Medicaid RAC auditor in New York.

Attorney General. The New York State Attorney General's Office, acting through its Medicaid Fraud Control Unit (MFCU), has the authority to investigate issues of improper Medicaid payments, Medicaid fraud, waste and abuse, and violations of quality of care standards. This satisfies federal requirements for the operation of a Medicaid fraud control unit that is within the Office of the State Attorney General and is independent of the State's single State agency.[102] The Attorney General's Office may institute provider audits and civil proceedings to recover Medicaid overpayments and criminal prosecutions.

Comptroller. The New York State Comptroller also has authority to conduct audits of payments under the State's Medicaid program.[103]

Federal Medicaid Integrity Program. In 2006, CMS began implementation of the Medicaid Integrity Program under which contractors are hired to review Medicaid provider actions to detect fraud or potential fraud, conduct audits of Medicaid provider claims, identify overpayments, and educate providers and others on payment integrity and quality of care issues.[104] A comprehensive Medicaid Integrity Plan was issued by CMS July 2006. The MEDI-MEDI Program provides for coordination of analysis of Medicare and Medicaid data among federal and State investigation agencies to ascertain aberrant billing and service patterns for investigation.

In 2008, Thomas Reuters was awarded the contract to be the Review Medicaid Integrity Contractor for the region including New York. In August 2009, Island Peer Review Organization (IPRO) was awarded the contract to be the Audit Medicaid Integrity Contractor for the region.

Federal Office of Inspector General. The federal Office of Inspector General (OIG) conducts audits of federal program expenditures under the Department of Health and Human Services, including Medicaid. The OIG also coordinates activities with State Medicaid Fraud Control Units.

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Federal and State Enforcement

In addition to the Medicaid audit and recovery process vested in the Department of Health and State Medicaid Inspector General, discussed *infra* in the chapter on Audits and Recoveries, there are various federal and State criminal and civil remedy provisions relating to the recovery of improper Medicaid payments and penalties. These include: federal criminal penalties for submission of false information or claims;[105] the federal False Claims Act;[106] the federal Program Fraud Civil Remedies Act of 1986,[107] federal criminal penalties for acts involving federal health care programs;[108] federal civil monetary penalties;[109] federal and State prohibitions on physician self-referral actions;[110] federal and State anti-kickback provisions;[111] State criminal and civil penalties for submission of false information or claims;[112] State criminal penalties for health care fraud,[113] the New York False Claims Act,[114] and State regulatory provisions regarding unacceptable practices in the medical assistance program[115] and provider sanctions.[116]

2008 - 2010 State Budgets

Deep reductions were enacted in the Medicaid program in the State Fiscal Year 2008-2009, 2009-2010 and 2010-2011 State Budgets and additional provider taxes imposed in response to the fiscal constraints facing New York State as a result of the national recession and New York's decreasing tax revenues. The federal FMAP increase beginning in 2009 only partly ameliorated even larger reductions that had been proposed by the Governor. In addition, State reimbursement reform initiatives reduced Medicaid inpatient reimbursement for hospitals, only partially offset by increases in outpatient reimbursement payment rates.

FMAP Contingency Fund Payment Reductions. A contingency plan was adopted for the 2010-2011 budget for the potential loss of enhanced FMAP funds.[117] The Department of Health was authorized to institute payment reductions with funds being diverted to a "lock box," subject to a reconciliation at the end of the State fiscal year. An extension of the enhanced federal funding was enacted, at reducing amounts through June 2011, reducing the impact of the contingency plan from $1.085 billion to $281 million State funds. Under the contingency plan, across-the-board cuts to undisbursed general and special revenue funds have been instituted in accordance with a written allocation plan, subject

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for Medicaid reductions to federal approval. Payment reductions of 1.1% were instituted by the Department of Health effective for payments beginning September 16, 2010 through March 2011. Based on concerns of CMS, the reduction was revised to apply for services provided on or after September 16, 2010, with a reconciliation for reductions that had been imposed on services provided prior to September 16, 2010. Exemptions are provided for various categories of Medicaid payments, consistent with federal requirements.[118] Nursing homes have instituted litigation challenging the authority of the Department of Health.

2011 - 2013 State Budgets

Medicaid Redesign Task Force. Governor Cuomo convened a Medicaid Redesign Task Force in 2011 to examine the Medicaid system, hold hearings, solicit recommendations for reform and cost savings, and propose Medicaid Redesign initiatives for legislation and administrative changes to achieve substantial State share savings under the Medicaid program to close the projected State fiscal deficit. Significant program reforms and Medicaid cost savings were enacted as 2011 N.Y. Laws Chapter 59 as a budget bill, discussed in the specific chapters in this *Medicaid Guide*. The Task Force continues to evaluate the Medicaid program and develop program and reimbursement changes. Goals of the Task Force include to promote a phase-in to care management for all Medicaid beneficiaries, develop new models of care for special populations and to move from the fee-for-service payment model.

Annual Medicaid Rate of Growth. A two-year budget was adopted in 2011 for Medicaid spending in 2011-2013.[119] For State fiscal years beginning with 2012-2013 and thereafter, the annual rate of growth of the Department of Health State funds Medicaid spending shall not exceed the 10-year rolling average rate of growth of the medical component of the consumer price index for the preceding 10 years.[120] State funds exclude payments for services provided at State facilities operated by the Office of Mental Health, Office for People with Developmental Disabilities and Office of Alcoholism and Substance Abuse Services. State funds do not include the federal and local shares of Medicaid expenditures or funds not appropriated to the Department of Health.

State funds expenditures shall not exceed the appropriations to the Department of Health in the aggregate of $15.3 billion for

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State fiscal year 2011-2012 and $15.9 billion for State fiscal year 2012-2013.

Medicaid Savings Allocation Plan. The Director of the Budget and Commissioner of Health will monitor known and projected Department of Health State funds Medicaid expenditures monthly for the periods April 2011 through March 2012 and April 2012 through March 2013 by category of service and geographic region. If such expenditures are expected to exceed projected expenditures under the budget financial plan, a Medicaid savings allocation plan will be developed to limit Medicaid spending to the budget financial plan limit consistent with federal law and subject to federal approval.[121]

Reductions in Department of Health State funds Medicaid disbursements to the extent practicable shall be made uniformly among categories of service and geographic regions and uniformly within a category of service. However, reductions may be non-uniform if sufficient grounds are determined to exist by the Commissioner of Health, considering such factors as: the extent categories of services contribute to the excess expenditures; the need to maintain safety net services; or potential benefits of innovative payment models.

The Medicaid savings allocation plan would be developed with input from stakeholders and would be posted on the Department of Health Website, except if necessary to respond to a public health emergency. Actions under the plan by the Commissioner of Health may include: modifying or suspending reimbursement methods, including fees, premium levels and rates of payment; modifying Medicaid program benefits; seeking federal approvals and waivers; and suspending statutory time frames for notice of payment rates.

The Department of Health will issue monthly reports of known and projected Department of Health Medicaid expenditures and actions taken to implement any Medicaid savings allocation plan adopted, including impacts by service categories and geographic regions.

Percentage Payment Reductions. Payment reductions of 2% are effective for Medicaid services provided from April 2011 through March 2013, subject to federal approval.[122] The health care industry may propose alternatives to the uniform reduction

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which may be implemented by the Commissioner of Health provided that specified State share Medicaid savings targets are achieved. Exemptions are provided for various categories of Medicaid payments, consistent with federal requirements and State policy. For payments for services provided under the Mental Hygiene Law, alternative reductions apply. Payment reductions are being implemented beginning November 2011, with funds to be recovered retroactive to April 2011. Increases in the provider tax rates for nursing homes and for long term home health care programs, reductions in premiums for managed care programs, and for physician services fee schedule reductions for office based radiology services were among the proposals implemented as alternatives to the payment reduction for such providers.[123]

Patient Protection and Affordable Care Act Health Care and Education Reconciliation Act

Federal comprehensive health insurance and delivery system reform,[124] together referred to as the Affordable Care Act, will change the reimbursement and regulatory environment of the healthcare industry as initiatives phase-in over several years. Increased focus will be placed on disease prevention and on home- and community-based care.

Most of the reforms directly affect expansion of the health insurance system to cover additional persons. Approximately $500 billion in cuts from planned Medicare payments over 10 years will support funding for these initiatives. Medicare initiative and pilot programs such as bundling hospital and physician payments, development of accountable care organizations, and fostering the development of patient centered medical homes will also impact the Medicaid delivery and reimbursement system through development of comparable Medicaid programs and waiver initiatives.

In 2014, Medicaid eligibility expands to provide coverage to 133% of the federal poverty level and includes single adults and childless couples. New York already provides coverage above the 133% level and provides coverage of single adults and childless couples to 100% of the federal poverty level under the Partnership Program waiver; see discussion of the Partnership Program *infra* in the chapter on Medicaid Managed Care. However, the legislation

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provides for increased federal financial participation in the payments for services provided to these expansion categories of individuals (who would no longer require a waiver to be covered), which it has been estimated by the New York State Assembly would provide approximately $1 billion in additional federal funds for New York in 2014.

Criminal, civil and administrative enforcement mechanisms available to the government to combat fraud and abuse are enhanced. Increased funding for enforcement efforts and fraud and abuse amendments in the Act exposes providers to closer scrutiny and increased potential criminal and civil liability. The federal anti-kickback statute is amended to eliminate the "knowing and willful" requirement, that a specific "intent" to violate the anti-kickback law be established that courts have applied in interpreting this law. This makes it far easier to charge providers with violations. In addition, the anti-kickback law is amended to clearly provide that a claim related to a violation under the anti-kickback law constitutes a false and fraudulent claim subject to recovery under the federal False Claims Act, discussed *infra* in the chapter on Audits and Recoveries. However, the beneficiary inducement prohibition is relaxed to now exclude remuneration that promotes access to care and poses a low risk of harm to patients and to the health care programs.

The federal False Claims Act is amended to relax the "public disclosure" threshold issue, which barred as a jurisdictional matter suits where there had been previous public disclosure of the false claim unless the party bringing the suit met an "original source" test. Now, the bar would apply only to previous disclosures in a federal forum, not a state forum or in private litigation. Further, the requirements to qualify as an "original source" are relaxed. In addition, where the public disclosure bar would still apply, the federal government may oppose dismissal of a suit and overrule any dismissal. These amendments may result in additional suits under the Act and dismissal of fewer of such suits based on prior disclosure.

Identified overpayments must be returned by a provider to the Medicare or Medicaid program within 60 days. Retention beyond 60 days results in an obligation that may be recovered under the False Claims Act. This builds on provisions already added to the False Claims Act regarding recovery of overpayments.

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CMS is required to establish a self-disclosure protocol for violations of the physician self-referral prohibitions, known as the Stark Law. Violations of the Stark Law create an overpayment liability. This is a strict liability statute without regard to intent. The government is provided flexibility and discretion in assessing the amount of a provider's repayment obligation for a violation.

In recognition of the expanded health insurance and Medicaid coverage under the Act, federal funding for Medicaid disproportionate share payments to hospitals to cover services provided to the uninsured is reduced beginning in 2014.

Endnotes Chapter 1:

[1] *See* Social Security Act §§1901-1936 (2010), 42 U.S.C.S. §§ 1396-1396v (Law. Co-op. 2001 and Supp. 2010)
[2] *See* New York State Medicaid State Plan, available from the N.Y.S. Department of Health
[3] *See 2010-11 Enacted Budget Report*, New York State Division of the Budget, available online at http://www.budget.state.ny.us
[4] *See* Social Security Act §1902(a)(30)(A) (2010), 42 U.S.C.S. § 1396a(a)(30)(A) (Law. Co-op. 2001)
[5] *See, e.g.,* Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005)
[6] *See* Letter from Timothy M. Westmoreland, Director, Health Care Financing Administration, to State Medicaid Directors, SDM 010201, (January 2, 2001) available on the CMS Website; *see also* State of New York v. Shalala, 119 F.3d 175 (2nd Cir. 1997)
[7] *See* 42 C.F.R. § 447.205 (2010)
[8] *See* 88 Fed. Reg. 26342 (2011)
[9] *See* N.Y. Social Services Law § 363-e as added by 2011 N.Y. Laws Ch. 59, Part H, § 39
[10] *See id.* §§ 363-369 (McKinney 2010)
[11] *See* 1996 N.Y. Laws Ch. 474, §§ 233-248
[12] *See* N.Y. Social Services Law § 2(1), (6) (McKinney 2003)
[13] *See* N.Y. Public Health Law § 201(1)(v) (McKinney 2002)
[14] *See, e.g.,* N.Y. Social Services Law § 364 (McKinney 2010), N.Y. Mental Hygiene Law § 43.02 (McKinney 2006)
[15] *See* N.Y. Social Services Law § 364-a (McKinney 2010)
[16] *See Administration of Medicaid in New York State*, Medicaid Institute at United Hospital Fund (2006) available online at http://www.medicaidinstitute.org/publications/publications_show.htm?doc_id=434595
[17] *See* Social Security Act § 1905(b) (2010), 42 U.S.C.S. § 1396d(b) (Law. Co-op. 2001)
[18] *See, e.g.,* 65 Fed. Reg. 69,560 (2000)
[19] *See* Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108-27, Title IV, § 401(a), 117 Stat. 752, 764 (2003)
[20] *See* The American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, Title V, § 5001, 123 Stat. 115, 496 (2009)

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[21] *See* REPORT OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, A-02-09-01037, REVIEW OF NEW YORK STATE'S COMPLIANCE WITH THE PROMPT PAY REQUIREMENTS FOR THE INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (Aug. 2010)
[22] *See* 2009 N.Y. Laws Ch. 58, Part C, § 13-b
[23] *See* Toia v. Regan, 54 A.D.2d 46, *aff'd* 40 N.Y.2d 837 (1976)
[24] *See*, *e.g.*, N.Y. Social Services Law § 365 (McKinney 2010)
[25] *See* Social Security Act § 1903(w) (2010), 42 U.S.C.S. § 1396b(w) (Law. Co-op. 2001 and Supp. 2010)
[26] *See* County of Niagara v. Daines, 60 A.D.3d 1460 (2009), *lv denied* 13 N.Y.3d 708 (2009); County of Herkimer v. Daines, 60 A.D.3d 1456 (2009), *lv denied* 13 N.Y.3d 707 (2009); County of St. Lawrence v. Daines, 81 A.D.3d 212 (2011)
[27] *See* City of New York v. Novello, 77 A.D.3d 514 (2010)
[28] *See* 2005 N.Y. Laws Ch. 58, Part C, §§ 1-4, 6, § 1(f), as amended by 2008 N.Y. Laws Ch. 58, Part C, § 62, § 1(h), as added by 2008 N.Y. Laws Ch. 58, Part C, § 44-b and repealed by 2008 N.Y. Laws Ch. 57, Part OO, § 17, and § 1(f) as further amended and §§ 1(b) and 6 as amended by 2010 N.Y. Laws Ch. 109, Part B, §§ 22, 23, and 24, and § 1(a) as amended by 2010 N.Y. Laws Ch. 58, Part B, § 3-e; Tax Law §§ 1261(f), (g), 1313 (McKinney Supp. 2011)
[29] *See* The American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, Title V, § 5001(g)(2), 123 Stat. 115, 501 (2009); *see also* Letter to State Medicaid Directors from CMS, SDML# 10-010, *Political Subdivisions*, dated June 21, 2010, available on the CMS Website
[30] *See* REPORT OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, A-02-09-01029, REVIEW OF NEW YORK STATE'S COMPLIANCE WITH THE POLITICAL SUBDIVISION REQUIREMENT FOR THE INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (May 2010)
[31] *See* 2005 N.Y. Laws Ch. 58, Part C, § 5
[32] *See* N.Y. Social Services Law § 368-a(1)(t) (McKinney 2010)
[33] *See* 2010 N.Y. Laws Ch. 58, Part B, § 47-b
[34] *See* NEW YORK STATE MEDICAID ADMINISTRATION NOVEMBER 2010 REPORT, available at www.nyhealth.gov
[35] *See, e.g.,* Wilder v. Virginia Hospital Association, 496 U.S. 498, 110 L.Ed.2d 455, 10 S.Ct. 2510 (1990), Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991), Avon Nursing Home v. Axelrod, 83 N.Y.2d 977 (1994), St. James Nursing Home v. DeBuono, 12 A.D.3d 921 (2004)
[36] *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a)(1), 111 Stat. 251, 507-508 (1997)
[37] *See* Social Security Act § 1902(a)(13)(A) (2010), 42 U.S.C.S. § 1396a(a)(13)(A) (Law. Co-op. 2001)
[38] *See, e.g.,* N.Y. Public Health Law § 2807(7), (7-a) (McKinney 2002); Anthony L. Jordan Health Corporation v. Axelrod, 67 N.Y.2d 935 (1986)
[39] *See, e.g.,* 2008 N.Y. Laws Ch. 58 Part A, § 67, Part C, § 91
[40] *See, e.g.,* N.Y. Public Health Law § 12-d (McKinney 2002); N.Y. Comp. Codes R. & Regs. tit. 14 §§ 578.5 (1995), 635-4.4 (2002), 841.5 (2002)
[41] *See* N.Y. Comp. Codes R. & Regs. tit. 18, Part 517 (1995)
[42] *See* N.Y. Social Services Law § 367-b(8) (McKinney 2010)
[43] *See*, *e.g.*, Solnick v. Whalen, 49 N.Y.2d 224 (1980); New York City Health & Hospitals Corporation v. McBarnette, 84 N.Y.2d 194 (1994)
[44] *See id.*

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[45] *See, e.g.*, Gonzaga University v. Doe, 536 U.S. 273 (2002); Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005); Trustees of the Masonic Hall v. Leavitt, 2006 U.S. Dist. LEXIS 37704 (N.D.N.Y., June 7, 2006); Wesley Health Care Center, Inc. v. DeBuono, 244 F.3d 280 (2nd Cir. 2001)
[46] *See* Concourse Rehabilitation & Nursing Center, Inc. v. DeBuono, 179 F.3d 38 (2nd Cir. 1999)
[47] *See* N.Y. Social Services Law § 365(a) (McKinney 2010); N.Y. Comp. Codes R. & Regs. tit. 18, Part 504 (1995); Schaubman v. Blum, 49 N.Y.2d 375 (1980)
[48] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 504.3 (1995)
[49] *See* [1999] 2 New York State Department of Health Medicaid Update (Feb. 1999); [2008] 1 New York State Department of Health Medicaid Update (Jan. 2008)
[50] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 504.1(19) (1995)
[51] *See id.* § 504.3
[52] *See id.* § 515.2 (2002)
[53] *See id.* § 504.7 (1995)
[54] *See* 5 New York State Department of Health Medicaid Update (April 2008)
[55] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 504.7(b), Part 515 (2002)
[56] *See id.* § 504.7(a) (1995)
[57] *See* Kelly Kare, Ltd. V. O'Rourke, 930 F.2d 170 (2nd Cir. 1991), *cert.* denied, 502 U.S. 907 (1991); 701 Pharmacy Corp. v. Perales, 930 F.2d 163 (2nd Cir. 1991)
[58] *See* Social Security Act § 1128 (2010), 42 U.S.C.S. § 1320a-7 (Law. Co-op. 1998 and Supp. 2010)
[59] *See* [2010] 6 New York State Department of Health Medicaid Update (April 2010); Letter to State Medicaid Directors from CMS, SDML 09-001, dated January 16, 2009 available on the CMS Website
[60] *See* Mihailescu v. Sheehan, 25 Misc.3d 258 (Sup. Ct. New York County 2009)
[61] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 540.6(a) (1997); [2006] 12 New York State Department of Health Medicaid Update (Nov. 2006)
[62] *See* 1990 N.Y. Laws Ch. 938 § 37; [2008] 6 New York State Department of Health Medicaid Update (June 2008)
[63] *See* N.Y. Comp. Codes R. & Regs. tit. 18,.§ 504.9 (1995); [2010] 3 New York State Department of Health Medicaid Update (Feb. 2010)
[64] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 360-7.5(c) (1995)
[65] *See* [2008] 5 New York State Department of Health Medicaid Update (May 2008)
[66] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 504.3(c) (1995); [2008] 7 New York State Medicaid Update (June 2008); [2011] 3 New York State Medicaid Update (Feb. 2011)
[67] *See* N.Y. Comp. Codes R. & Regs. tit. 18,.§ 500.5 (1995)
[68] *See* N.Y. Social Services Law § 367-a(2)(b), (4) (McKinney 2010); N.Y. Comp. Codes R. & Regs. tit. 18, § 540.6(e)(1), (2) (1995, (6), (7) (1997), § 370-7.2, 7.3 (1995); [2008] 2 New York State Department of Health Medicaid Update (Feb. 2008); Social Security Act § 1902a(a)(25) (2010), 42 U.S.C.A. § 1396a(a)(25) (Law. Co-op. 2001); *see also* Gold v. United Health Services Hospitals, 95 N.Y.2d 683 (2001)
[69] *See* Social Security Act § 1902(a)(25) (2010), 42 U.S.C.S. § 1396a(a)(25) (Law. Co-op. 2001 and Supp. 2010); 42 C.F.R. 433.138, 433.139 (2010); New York State Dep't of Social Services v. Bowen, 846 F.2d 129 (2nd Cir. 1988); Wesley Health Care Center, Inc. v. DeBuono, 244 F.3d 280 (2nd Cir. 2001)
[70] *See* N.Y. Comp. Codes R. & Regs. tit. 18,.§§ 542.2, 542.3 (1995)
[71] *See, e.g.,* [200] 17 New York State Department of Health Medicaid Update (Dec. 2009)
[72] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 504.8(d) (1995)

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[73] *See* id. 540.7 (1997)
[74] *See* NEW YORK STATE MMIS PROVIDER MANUALS, INFORMATION FOR ALL PROVIDERS, GENERAL BILLING, CLAIM CERTIFICATION STATEMENT; [2008] 10 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Sept. 2008)
[75] *See* Social Security Act § 1902(a)(32) (2010), 42 U.S.C.S. § 1396a(a)(32) (Law. Co-op. 2001); 42 C.F.R. §§ 447.10, 400.203 (2010)
[76] *See* Joseph H. Levie, *Security Interests In Medicare And Medicaid Receivables*, N.Y.L.J., Jan. 5, 1989, at 5
[77] *See* N.Y. Comp. Codes R. & Regs. tit. 18, Part 517 (1995)
[78] *See* [2003] 11NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Nov. 2003)
[79] *See* [2010] 6 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (May 2010), 2010] 11 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Sept. 2010); [2011] 8 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (June 2011)
[80] *See* Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350 (2002); 42 C.F.R. Part 431, Subpart Q, §§ 431.950-431.1002 (2010); [2008] 10 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Oct. 2008); 5 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (April 2008); REPORT OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, A-06-08-00078, OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2007 PAYMENT ERROR RATE MEASUREMENT PROGRAM (May 2010)
[81] *See* Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, Title II, Subtitle F, 110 Stat. 1936, 2021 (1996); 42 U.S.C.S. §§ 1171 – 1179 (Law. Co-op. 1998)
[82] *See* [2011] 2 New York State Department of Health Medicaid Update (Feb. 2011 Special Edition, [2011] 13 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Sept. 2011)
[83] *See* [2008] 7 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (June 2008); [2008] 9 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE – SPECIAL EDITION (Aug. 2008); [2009] 6 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (June 2009)
[84] *See* [2008] 7 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (June 2008); [2010] 7 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (May 2010)
[85] *See* [2005] 11 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Oct. 2005)
[86] *See* [2005] 3 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (March 2005); [2011] 1 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Jan. 2011)
[87] *See* [2011] 11 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (Aug. 2011)
[88] *See* [2010] 4 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (March 2010)
[89] *See* N.Y. Social Services Law §§ 145-a (McKinney 2003), 145-b (McKinney 2003 and Supp. 2011), 368-c (McKinney 2003); N.Y. Comp. Codes R. & Regs. tit. 18, Part 515 (2002)
[90] *See* 42 C.F.R. 455.2 (2010)
[91] *See* N.Y. Comp. Codes R. & Regs. tit. 18, Part 515 (2002)
[92] *See* NY Social Services Law § 367-b(8) (McKinney 2010)
[93] *See id.* § 365-j

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[94] *See* Michael Luo and Clifford J. Levy, *New York Medicaid Fraud May Reach Into Billions*, N.Y. Times, July 18, 2005 at A1, *As Medicaid Balloons, Watchdog Force Shrinks*, N.Y. Times, July 19, 2005 at A1
[95] *See* Executive Orders No. 140, Aug. 5, 2005, No. 140-1, Feb. 2, 2006, N.Y. Comp. Codes R. & Regs. tit. 9, §§ 140, 140-1 (2006)
[96] *See* N.Y. Public Health Law Article 1, Title III, §§ 30-36 (McKinney Supp. 2011)
[97] *See* 42 C.F.R. 455.15 (2010)
[98] *See* Letter to State Medicaid Directors from CMS, SDML 09-001, dated January 16, 2009 available on the CMS Website
[99] *See* S.3184-A of 2011
[100] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 6411, 124 Stat. 119 (2010)
[101] *See* 76 FR 57,808, Sept. 16, 2011
[102] *See* Social Security Act § 1903(q) (2010), 42 U.S.C.S. 1396b(q) (Law. Co-op 2001)
[103] *See* Signature Health Center, LLC v. Hevesi, 13 Misc. 3d 1189 (2006)
[104] *See* Social Security Act § 1936 (2010), 42 U.S.C.S. § 1396v (Law. Co-op. Supp. 2010)
[105] *See* 18 U.S.C.S. §§ 1001 (Law. Co-op. 2010), 1035 (Law. Co-op. 2005), 1347 (Law. Co-op. 2008) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3571, 124 Stat. 119 (2010)
[106] *See* 31 U.S.C.S. §§ 3729 - 3733 (Law. Co-op. 2006) as amended by the Fraud Enforcement and Recovery Act of 2009, Pub. Law No. 111-21, § 4, 123 Stat. 1617, 1621 (2009) codified at 31 U.S.C.S. § 3729)
[107] *See* 31 U.S.C.S. Chapter 38, §§ 3801 - 3812 (Law Co-op. 2006 and Supp. 2010)
[108] *See* Social Security Act § 1128B (2010), 42 U.S.C.S. § 1320a-7b (Law. Co-op. 2008) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 6402(f), 124 Stat. 119 (2010)
[109] *See* Social Security Act (2010) § 1128A, 42 U.S.C.S. § 1320a-7a (Law. Co-op. 2008) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 6402(d), 6408(a), 124 Stat. 119 (2010); 18 U.S.C.S. § 1347 (Law. Co-op 2008) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); 18 U.S.C.S. § 24(a) (Law. Co-op. 2009) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)
[110] *See* Social Security Act § 1877 (2010), 42 U.S.C.S. § 1395nn (Law. Co-op. 2001 and Supp. 2010; N.Y. Public Health Law § 238 (McKinney 2002)
[111] *See* Social Security Act § 1128B(b) (2010), 42 U.S.C.S. § 1320a-7b(b) (Law. Co-op. 2008) as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 6402(f), 124 Stat. 119 (2010); N.Y. Social Services Law § 366-d (McKinney 2010)
[112] *See* N.Y. State Social Services Law §§ 366-b (McKinney 2010), 145-b (McKinney 2003 and Supp. 2011); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 516.1(c), 516.2, 516.5 (2009)
[113] *See* N.Y. Penal Law Articles 155, 175, 176, 177 (McKinney Supp. 2011)
[114] *See* N.Y. State Finance Law Article XIII, §§ 187–194 (McKinney Supp. 2011)
[115] *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 515.2 (2002)
[116] *See id.* § 504.7 (1995)
[117] *See* 2010 N.Y. Laws Ch. 313
[118] *See* N.Y.S. Department of Health Public Notice, [2010] 37 N.Y. St. Reg. 123; [2010] 11 New York State Department of Health Medicaid Update (Sept. 2010)
[119] *See* 2011 N.Y. Laws Ch. 53, Aid to Localities, Appropriations, Department of Health
[120] *See* 2011 N.Y. Laws Ch. 59, Part H, § 91
[121] *See* 2011 N.Y. Laws Ch. 59, Part H, § 92
[122] *See* 2011 N.Y. Laws Ch. 59, Part H, § 90

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[123] *See* [2011] 15 NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID UPDATE (NOV. 2011)
[124] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, (2010); Health Care and Education Reconciliation Act, Pub. L. No. 111- 152, 124 Stat. 1029 (2010)

Excerpt