cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
Mr. Cohen by Scan
BOA by scan
SAPA File

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 29, 2026

CERTIFIED MAIL/RETURN RECEIPT

Daniel Weisbard, Esq.
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Daniel Lebowitz
Mercy Care Transportation, Inc.
237 Woodward Avenue
Staten Island, New York 10314

RE: In the Matter of Mercy Care Transportation, Inc.

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of

Mercy Care Transportation, Inc.
Provider ID: 01719653,
Appellant,

from a determination by the New York State Office of the Medicaid Inspector General to recover Medicaid Program overpayments

COPY

DECISION AFTER HEARING

Audit Number: 24-6825

Before: Shelby L. Foster
Administrative Law Judge

Held via: WebEx Video Conference

Hearing Date: February 18, 2026

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Daniel Weisbard, Esq.

Mercy Care Transportation, Inc.
237 Woodward Avenue
Staten Island, New York 10314
By: Daniel Lebowitz, Director of Operations

JURISDICTION

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of the Medical Assistance (Medicaid) Program in New York State. 42 USC 1396a; Public Health Law (PHL) § 201(1)(v); Social Services Law (SSL) § 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is authorized to investigate and pursue civil and administrative enforcement actions to recover improperly expended Medicaid funds. PHL §§ 30-32.

The OMIG determined to recover Medicaid overpayments made to Mercy Care Transportation, Inc. (Appellant). The Appellant requested a hearing pursuant to SSL § 145-a and former Department of Social Services (DSS) regulations at 18 New York Codes, Rules and Regulations (NYCRR) 519.4 to review the OMIG's determination.

HEARING RECORD

OMIG Witnesses:	Damian Myron, OMIG Audit Manager
OMIG Exhibits:	1 – 7A
Appellant Witnesses:	Daniel Lebowitz, Director of Operations Henry Minckler, OMIG Audit Supervisor
Appellant Exhibits:	A, B, M

A transcript of the hearing was made. (Transcript [Tr.] pages 1 – 125.)

FINDINGS OF FACT

1. At all times relevant hereto, the Appellant was enrolled in the New York State Medicaid Program as an ambulette services provider with ID # 01719653. (Exhibit [Ex.] 6; Tr. 22.)

2. By letter dated October 17, 2024, the OMIG advised the Appellant that it would be auditing the Appellant's records pertaining to Health Care and Mental Hygiene Worker Bonus (HWB) claims paid by the Medicaid Program during the period October 1, 2021 through March 31, 2024. (Ex. 1.)

3. Between October 1, 2021 and September 30, 2022, the Appellant was paid $6,000 for four HWB claims. (Ex. 3.)

4. On April 3, 2025, the OMIG issued a draft audit report (DAR) to the Appellant, which identified two claims with at least one error; bonus incorrectly paid to an ineligible employee (Samples 2 and 4). The OMIG sought to recover a Medicaid overpayment of $3,000. (Ex. 3.)

5. On June 12, 2025, the OMIG issued a revised DAR[1] to the Appellant, which identified four claims with at least one error. The OMIG sought to recover a Medicaid overpayment of $6,459, consisting of $6,000 for all four claims, plus $459 in Federal Insurance Contributions Act (FICA) taxes. The OMIG categorized its findings into the following disallowance categories:

   a. In four instances pertaining to two employees, the HWBs were paid to an ineligible employer. (Samples 1, 2, 3, and 4.)

[1] Mr. Myron testified that the April 3, 2025, DAR was returned as undeliverable, and it had to go through the approval process again. In June 2025, the OMIG, inconsistent with its own original DAR, added the new disallowance finding that the Appellant was an "ineligible employer." (T. 26-27.)

b. In two instances pertaining to one employee, the HWBs were paid to an ineligible employee. (Samples 2 and 4.)

(Ex. 4.)

The payments for claims 2 and 4, disallowed in both categories, were only disallowed once.

6. The Appellant submitted a response to the revised DAR on July 1, 2025. It included documentation to support that it was a Medicaid enrolled provider, billing for Medicaid services, employing at least one eligible employee, and serving at least 20% Medicaid enrollees. It also included a description of the disallowed employee's job responsibilities. (Ex. 6.)

7. On August 28, 2025, the OMIG issued a final audit report (FAR), in which the overpayment of $6,459 identified in the revised DAR remained unchanged. (Ex. 6.)

8. By letter dated October 10, 2025, the Appellant requested a hearing to review the OMIG's determination. (Ex. 7.)

ISSUES

Was the OMIG's determination to recover HWB payments from the Appellant correct?

APPLICABLE LAW

By enrolling in the Medicaid Program, providers agree to prepare contemporaneous records demonstrating the right to receive payments under the Medicaid Program and to furnish such records and information, upon request, to the Department. The information submitted in relation to any claim for payment must be true, accurate, and complete. Medicaid providers also agree to comply with the rules, regulations, and official directives of the Department. 18 NYCRR 504.3(a), (g)-(i), 540.7(a)(8). Medicaid providers claiming and receiving HWB payments are subject to these requirements. SSL 367-w(3)(d)&(5)(a).

Medicaid providers are subject to audit by the Department, and all information regarding claims for payment must be maintained for six years. Notification by the OMIG to a provider of its intent to audit shall toll the six-year period for record retention and audit. 18 NYCRR 504.3(a), 504.8(a), 517.3(b)-(c).

When a provider has submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made, the OMIG may require repayment of the amount determined to have been overpaid. 18 NYCRR 504.8(a)(1), 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. 18 NYCRR 518.1(c).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of an overpayment. 18 NYCRR 519.4. The Appellant has the burden of showing that the OMIG's determination was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR 519.18(d)(1).

Social Services Law 367-w was enacted in 2022 to codify the HWB program, the purpose of which was to recruit, retain, and reward health care workers by awarding financial bonuses for certain essential front line health care and mental hygiene workers. The statute defines "employer" and "employee" for the purposes of eligibility for Medicaid reimbursement for employee bonuses during a series of six-month "vesting periods" between October 1, 2021 and March 31, 2024. SSL 367-w(2).

An employer seeking Medicaid reimbursement for HWB program bonuses was responsible for determining whether employees were eligible for bonuses and for maintaining all

records, data, and information it relied on in making that determination. SSL 367-w(3)(c). Qualified employers were required to apply for bonuses for their eligible employees and were subject to Medicaid Program penalties and sanctions up to and including exclusion from the Medicaid Program for failure to do so. SSL 367-w(5).

In order to administer the HWB program, the Department established a HWB website[2] and online portal providing guidance to providers. (Ex. A.) It also issued "Frequently Asked Questions" (FAQs) explaining program policy. (Ex. B.)

DISCUSSION

At the hearing, the OMIG presented the audit file and summarized the case, as required by 18 NYCRR 519.17. The OMIG is seeking to recover the disallowed bonus amounts paid, plus an additional 7.65% for FICA taxes in the sum of $459. The OMIG identified six disallowances among four claims, for a total overpayment of $6,459. The payments for claims 2 and 4, disallowed in two categories, were only disallowed once. (Ex. 6.)

Disallowance Category 1: Bonus Incorrectly Paid to an Ineligible Employer.

The OMIG identified four claims pertaining to two employees where the bonus was incorrectly paid to an ineligible employer. According to the OMIG, the Appellant was not an HWB program "employer" as defined by SSL 367-w and was not eligible to claim reimbursement for the four bonuses paid to its two employees. (Ex. 6.)

SSL 367-w(2)(b) defines "employer" for the purposes of the HWB program as:

> a provider enrolled in the medical assistance program under this title that employs at least one employee and that bills for services under the state plan or a home and community based services

[2] www.health.ny.gov/health_care/medicaid/providers/hwb_program

> waiver authorized pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, or that has a provider agreement to bill for services provided or arranged through a managed care provider under section three hundred sixty-four-j of this title or a managed long term care plan under section forty-four hundred three-f of the public health law, to include:
>
> (i) providers and facilities licensed, certified or otherwise authorized under articles twenty-eight, thirty, thirty-six or forty of the public health law, articles sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, article seven of this chapter, fiscal intermediaries under section three hundred sixty-five-f of this title, pharmacies registered under section six thousand eight hundred eight of the education law, or school based health centers;
>
> (ii) programs that participate in the medical assistance program and are funded by the office of mental health, the office of addiction services and supports, or the office for people with developmental disabilities; and
>
> (iii) other provider types determined by the commissioner and approved by the director of the budget;
>
> (iv) provided, however, that unless the provider is subject to a certificate of need process as a condition of state licensure or approval, such provider shall not be an employer under this section unless at least twenty percent of the provider's patients or persons served are eligible for services under this title and title XIX of the federal social security act.

The corresponding Department FAQs, provided in an email to the Appellant by Henry Minckler, OMIG Auditor 2, read as follows (including emphasis):

> **Q: Please clarify the criteria necessary for an employer to be subject to the Healthcare Workforce Bonus (HWB) Program?**
>
> A: The HWB statute provides two separate definitions of qualified employers, both of which are subject to the requirements of the HWB program.
>
> - *See SOS § 367-w(2)(b) and (c)*

Under paragraph (2)(b), an employer is subject to the HWB program if they meet all the four following criteria:

1. They are a Medicaid enrolled provider.
2. They bill for Medicaid services (either through FFS, managed care, or a 1915(c) waiver).
3. Employ at least one eligible employee.
4. A. Are included in the list of provider and facility types in the statute, OR
   B. Are subject to a certificate of need (CON) process, OR
   C. The provider serves at least 20% Medicaid enrollees.

...

Q. Please clarify the types of employers eligible for the HWB program?

A. Paragraph (2)(b) identifies employers eligible for the HWB program, and are limited to:

- Providers and facilities licensed, certified, or otherwise authorized under:
  - articles 28, 30, 36 or 40 of the public health law
  - articles 16, 31, 32 or 36 of the mental hygiene law
  - article 7 of the social services law
- Pharmacies registered under §6808 the education law
- School-based health centers
- Programs funded by the OMH, OASAS, Office of the Aging, or OPWDD, AND
- Other provider types determined by the commissioner and approved by the director of the budget (***at this time no other provider types have been determined***).

If the provider is subject to a certificate of need (CON) process OR the provider serves at least 20% Medicaid enrollees, they are not limited to this list defined in Paragraph (2)(b).

(Ex. 6.)

Damian Myron, the OMIG Audit Manager, testified that the Appellant is not an eligible employer based on SSL 367-w because it does not fall within one of the four categories in (2)(b)(i)-(iv). (T. 29, 31-32.) Mr. Myron testified that, to be eligible for the HWB Program, an employer must fall within one of the three categories listed in SSL § 367-w(2)(b)(i)-(iii), **or** they must be subject to a CON **and** serve at least 20 percent Medicaid enrollees. (Tr. 30-31.)[3]

Mr. Myron explained that there is a variance between SSL 367-w and what is documented in the Department FAQs, which repeatedly state the employer is eligible if it is included in the categories listed in SSL, **or** is subject to a CON, **or** serves at least 20 percent Medicaid enrollees. (Tr. 63-64.) He admitted that it would have been better for the OMIG auditor to have sent the Appellant language from the SSL itself, rather than the FAQs, when the Appellant requested clarification. He opined that Henry Minckler, the auditor who sent the FAQs, may not have been aware of the variance when he emailed the FAQs to the Appellant. (Tr. 54, 75.) Mr. Myron conceded that, based on the information contained in the FAQs, the Appellant met the criteria for an eligible employer. (Tr. 52.) This testimony is consistent with the conclusion that even the OMIG relied entirely on the Department's FAQs and presumed the Appellant was an eligible employer when it completed and issued its DAR in April 2025.

Henry Minckler, OMIG Auditor 2, testified that he emailed the Appellant the language from the FAQs and advised that the Appellant could submit a response "based off of that information." He confirmed that the Appellant responded with documentation establishing that it is a Medicaid

[3] It is noted that the witness' uses of "or" as well as "and" in his testimony on this point are both misrepresentations of the plain language of SSL 367-w(2)(b).

enrolled provider, with at least one eligible employee, billing for Medicaid services, and serving at least 20 percent Medicaid enrollees. (Tr. 80-82.)

The presentation from an HWB Program Townhall Meeting held on August 26, 2022, and published on the Department's HWB website, issued a correction of a misinterpretation presented at a previous Townhall meeting regarding qualified employers. Even as corrected, this published guidance explicitly states, including emphasis:

> Under paragraph (2)(b), an employer is subject to the HWB program if they meet all of the **four** following criteria:
>
> 1. They are a Medicaid enrolled provider
> 2. They bill for Medicaid services (either through FFS, managed care, or a 1915(c) waiver)
> 3. Employ at least one eligible employee
> 4. A. Are included in the list of provider and facility types in the statute, **OR**
>
> B. Subject to a certificate of need (CON) process, **OR**
>
> C. **The Employer serves at least 20% Medicaid enrollees**

https://www.health.ny.gov/health_care/medicaid/providers/hwb_program/docs/2022-08-26_townhall.pdf.

The Appellant reasonably relied on official Department guidance and determined in good faith that it met the employer eligibility requirements. Since August 26, 2022, the Department's guidance on the interpretation of SSL § 367-w(2)(b) has been, and remains to be[4], different than the interpretation offered here by the OMIG. The OMIG is endeavoring to hold providers accountable for the Department's own inconsistent interpretations. The Appellant has

[4] As of the date of issuance of this determination, the Department's interpretation of SSL 367-w(2)(b) remains in the Department FAQs on the HWB website. www.health.ny.gov/health_care/medicaid/providers/hwb_program.

established that it is a qualified employer pursuant to SSL § 367-w(2)(b) under the Department's own written policy guidelines and the OMIG's disallowance category 1 was improper.

The audit findings in this category are reversed.

Disallowance Category 2: Bonus Incorrectly Paid to an Ineligible Employee.

The OMIG identified two claims where the bonus was incorrectly paid to an ineligible employee. The OMIG indicated that "[t]he claimed job title was Health Care Support Worker (All Other). Transportation drivers are not an eligible job title unless they are considered a Paramedic, EMT, or Certified First Responder." The language in the FAR quoted the definition of employee contained in SSL 367-w(2)(a) and provided no further context or detail. (Ex. 6.)

SSL § 367-w(2)(a) defines "employee" for purposes of the HWB Program. It includes a list of "certain front line health care and mental hygiene practitioners, technicians, assistants and aides that provide hands on health or care services ... to include: (i) ... all other health care support workers..." as well as "staff who perform functions as described in the consolidated fiscal report (CFR) manual" with respect to specific title codes found in that manual. The Appellant used the "all other health care support workers" title when it submitted the claims for its ambulette driver.

The relevant Department FAQ reads:

> **Q: What does "All Other Health Care Support Workers" mean?**
>
> **A: "All Other Health Care Support Workers"** refers to workers that support the provision of health care services to patients in font-line settings for these titles. Such workers must provide patient-facing care provided within a patient care unit of a hospital or other institutional medical setting in support of treating and caring for patients.

It goes on to provide a list of settings and list of "all other patient facing care support workers in Article 28 facilities" titles. (Ex. B.)

Mr. Myron testified that the employee in this disallowance category, an ambulette driver, did not meet the definition of employee under SSL § 367-w. (Tr. 32.) He first explained that the OMIG reviewed the job title and job duties provided by the Appellant and determined that an ambulette driver was ineligible as the job description matched that of a "transportation worker" in Appendix R of the CFR manual, which is not included in the list of CFR manual titles recognized by SSL 367-w(2)(a)(ii). (Ex. 5; Tr. 34.)

Mr. Myron then testified that Department guidance requires that "all other health care support workers" support patient-facing care provided within a patient care unit of a hospital or other institutional medical setting in support of treating and caring for patients and only certain employer types are permitted to submit claims using the "all other health care support workers" title, including hospitals, nursing homes, OMH psychiatric centers, OASAS addiction treatment centers, residential programs certified by various agencies, Medicaid assisted living programs, and hospice residences. (Ex. A; Tr. 35, 37.) Mr. Myron asserted that the Appellant does not fall within any of the employer types that may use the job title "all other health care support workers." (Ex. B; Tr. 37, 39.)

However, Mr. Myron also testified that it was determined that the Appellant's administrative employee could have been eligible under the job title "clerk," which is found on the list of "all other healthcare support workers" on the Department's HWB website. (Tr. 68.) While Mr. Myron testified that the administrative employee "could have been eligible," the OMIG did not disallow the bonuses paid to the administrative employee under this disallowance

category, demonstrating an inconsistent application of Department guidance. (Exs. A, 6.) As such, the OMIG's explanation for disallowance of the bonuses paid to the ambulette driver based on the Appellant's employer type is rejected.

At the hearing the Appellant argued that its ambulette driver was a "front-line patient-facing transportation worker," who transported COVID positive patients on Staten Island. (Tr. 17.) In its response to the OMIG's DAR, the Appellant explained that the ambulette driver operates a specialized ambulette and is directly responsible for the transfer and transport of patients to and from medical facilities, assisting them in and out of their wheelchairs, ensuring their safety and security for transport, and providing critical transfer of care instructions from one facility to the next. The OMIG did not dispute the Appellant's assertion that the ambulette driver "is a DMV/DOT 19A certified driver, who transports wheelchair dependent patients from inside one patient care unit and drops them off inside another patient care unit." (Ex. 6.)

The New York State Medicaid Transportation Provider Policy Manual (Transportation Manual) describes the service provided by the Appellant's ambulette driver in transporting wheelchair bound persons in an ambulette:

> Ambulette or paratransit vehicle means a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals. (Section 1, page 4 of 52.)
>
> ...
>
> Personal assistance by the staff of the transportation company is required by the Medicaid program and consists of the rendering of physical assistance to the ambulatory and non-ambulatory (wheelchair-bound) Medicaid enrollees. (Section 3.2, page 45 of 52.)
>
> ...
>
> Personal Assistance means the provision of physical assistance by a provider of transportation services to a Medicaid enrollee for the purpose of assuring safe access to and from the enrollee's place of residence, the transportation provider's

> vehicle, and the Medicaid-covered health service provider's place of business. Personal assistance is the rendering of physical assistance to the enrollee to enable walking, climbing or descending stairs, ramps, curbs, or other obstacles; opening or closing doors; accessing a vehicle; and the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the enrollee. In providing personal assistance, the provider or the provider's employee will physically assist the enrollee which shall include touching, or, if the enrollee prefers not to be touched, guiding the enrollee in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance. An enrollee who can walk to and from a vehicle to their home and place of medical services without such assistance is deemed not to require personal assistance. (Section 1, page 7 of 52.)

The record establishes that this employee served as a certified ambulette driver transporting patients to and from health care facilities, and the Transportation Manual is consistent with the evidence in the record. Although the OMIG equated the ambulette driver's job description to that contained in Appendix R of the CFR manual for "transportation worker," the evidence establishes that the duties of the ambulette driver went beyond simple transportation and included the provision of front-line hands-on patient care. Accordingly, the audit findings in this category are reversed.

DECISION

1. With respect to Disallowance Category 1, the OMIG's determination to recover Medicaid Program overpayments from the Appellant is reversed.

2. With respect to Disallowance Category 2, the OMIG's determination to recover Medicaid Program overpayments from the Appellant is reversed.

This decision is made by Shelby L. Foster, who has been designated to make such decisions.

Dated: Menands, New York
June 26, 2026

Shelby L. Foster
Administrative Law Judge

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