

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



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

July 23, 2026

CERTIFIED MAIL/RETURN RECEIPT

Michael Joseph, Esq.
Dionne Wheatley, Deputy Counsel
NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

MetroPlus Health Plan, Inc.
160 Water Street, FI 3
New York, New York 10038

Cynthia Neidl, Esq.
Greenberg Traurig, LLP
54 State Street, Sixth Floor
Albany, New York 12207

**RE: In the Matter of MetroPlus Health Plan, Inc.
Audit #'s 23-7569, 23-7572, 23-7576, 23-7579, 23-7582 and 23-7586**

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,

A handwritten signature in cursive script that reads "Natalie J. Bordeaux".

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

MetroPlus Health Plan, Inc.

Medicaid Provider Nos. 00894519
02191362
04053201

from a determination to recover Medicaid
Program overpayments.

**DECISION
AFTER
HEARING**

Audit Nos.
23-7569
23-7572
23-7576
23-7579
23-7582
23-7586

Before: Kathleen Dix
Administrative Law Judge

Hearing dates: September 17, 2025
By WebEx Videoconference

Parties: NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Michael Joseph, Esq.
michael.joseph@omig.ny.gov

MetroPlus Health Plan, Inc.
160 Water St. Fl 3
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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 New York State 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 §§ 31-32.

The OMIG determined to seek restitution of payments made under the Medicaid Program to MetroPlus Health Plan, Inc. (Appellant). The Appellant requested this hearing pursuant to SSL § 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination. The Appellant has the burden of showing that the determination of the Department was incorrect. 18 NYCRR 519.18(d).

HEARING RECORD

OMIG Witnesses: Beth Perue, Assistant Medicaid Inspector General

OMIG Exhibits:

1. Audit # 23-7572 Draft Audit Report.
2. Audit # 23-7572 Final Audit Report.
3. Audit # 23-7576 Draft Audit Report.
4. Audit # 23-7576 Final Audit Report.
5. Audit # 23-7569 Draft Audit Report.
6. Audit # 23-7569 Final Audit Report.
7. Audit # 23-7582 Draft Audit Report.
8. Audit # 23-7582 Revised Draft Audit Report.
9. Audit # 23-7582 Final Audit Report.
10. Audit # 23-7586 Draft Audit Report.
11. Audit # 23-7586 Final Audit Report.
12. Audit # 23-7586 Revised Final Audit Report.
13. Audit # 23-7579 Draft Audit Report.
14. Audit # 23-7579 Revised Draft Audit Report.
15. Audit # 23-7579 Final Audit Report.
16. Provider's Response all six audits.

Appellant Witnesses: Lauren Castaldo, Chief Financial Officer for the Appellant.

Appellant Exhibits:

- A. MPH Membership History
- B. Medicaid Managed Care/Family Health Plus / HIV Special Needs Plan/ Health and Recovery Plan Model Contract, March 1, 2019
- C. DOH Reporting Format TPHI
- D. DOH Reimbursement Timeframes
- E. MPH OMIG Audits
- F. MHP - Health Management Systems, Inc. Contract, March 1, 2011
- G. MHP - Health Management Systems, Inc. Contract, April 1, 2021
- H. OMIG Payment Integrity Review Letters to MPH
- I. MHP Letter Response to Draft Audit Reports, April 5, 2024
- J. MHP File Submission, April 5, 2024
- K. Gainwell Response to MPH Response to Draft Audit Report, June 12, 2024
- L. MHP Response to Gainwell Response, June 26, 2024
- M. MHP File Submission, June 26, 2024
- N. Gainwell Response to MHP Response, August 24, 2024
- O. Final OMIG Response September 11, 2024
- P. DOH Encounter Reimbursements (HARP)
- Q. DOH Encounter Reimbursements (MMC)
- R. DOH Encounter Reimbursements (SNP)
- S. Gainwell - OMIG emails, June 5, 2024
- T. Gainwell - OMIG emails, September 11, 2024
- U. OMIG Summary Tracking
- V. OMIG Timeline
- W. OMIG - Health Management Systems, Inc. Medicaid Third Party Liability Match and Recovery Services Contract

A transcript of the hearing was made. (Transcript [Tr.] pages 1-170.) Each party submitted two post-hearing briefs and the record closed on December 5, 2025¹.

FINDINGS OF FACT

1. The Appellant is enrolled as a provider in the New York State Medicaid Program and has contracted with the Department under the Department's Medicaid Managed Care (MMC) program to provide health care services for Medicaid recipients. (Tr. page 9; Exhibit B.)

2. This is a consolidated hearing involving the following six audits:

1. Audit #23-7569 and Audit #23-7579 were audits of capitation payments paid to MetroPlus Health Plan, Inc. under

¹ The Appellant's Response brief is dated December 14, 2025 but was submitted on December 5, 2025.

Provider ID #00894519;

2. Audit #23-7572 and Audit #23-7582 were audits of capitation payments paid to the MetroPlus Partnership Care SN under Provider ID #02191362; and

3. Audit #23-7576 and Audit #23-7586 were audits of capitation payments paid to MetroPlus Health Plan, Inc. under Provider ID #04053201.

3. Pursuant to its MMC Agreement with the Department (Model Contract), the Appellant is paid a monthly premium, or "capitation payment" for each enrollee as compensation for the services it provides to the enrollee. (Model Contract 3 .1; Exhibit B, page 41.)

4. Pursuant to Section 3.6(a)(viii)&(ix) of the Model Contract, the Department shall have the right to recover capitation payments made to the Contractor for an MMC Enrollee when, for the entire applicable payment month(s), the Department determines that the MMC Enrollee was or is ...

simultaneously enrolled in or in receipt of Comprehensive Third Party Health Insurance coverage... [or] comprehensive health care coverage through any government health insurance program. (Exhibit B, page 44.)

5. The OMIG reviewed MMC capitation payments made to the Appellant for the period 3/1/2019-12/1/2022 (audits #23-7569, 23-7572, & 23-7576) and identified enrollees who were simultaneously enrolled in and covered under commercial third party health insurance (TPHI), listed as "Code 8" in the audits, for the entire month for which a capitation payment was made to the Appellant. (Exhibits 1-6.)

6. The OMIG reviewed MMC capitation payments made to the Appellant for the period 11/1/2015-2/1/2020 (audits #23-7579, 23-7582, 23-7586) and identified enrollees who were simultaneously enrolled in and covered under another government health insurance program, listed as "Code 11" in the audits, for the entire month for which a capitation payment was made to the Appellant. (Exhibits 7-15.)

7. The OMIG issued draft audit reports on January 18, 2024 identifying overpayments under “Code 8”, *comprehensive third-party health coverage through a different plan*, in each of the audits:

1. Audit #23-7569 in the amount of \$21,320,581.61;
2. Audit #23-7572 in the amount of \$943,072.31; and
3. Audit #23-7576 in the amount of \$1,638,139.83.

The total amount of overpayments identified under “Code 8” in the draft audit reports was \$23,901,793.75. (Exhibits 1, 3, 5.)

8. The OMIG issued a draft audit report on January 18, 2024 identifying overpayments under “Code 11”, *coverage through any government health insurance program*, in each of the audits:

1. Audit #23-7579 in the amount of \$23,215,799.3 (sic);
2. Audit #23-7582 in the amount of \$2,371,094.7 (sic); and
3. Audit #23-7586 in the amount of \$8,005,731.5(sic)².

Revised draft audit reports were issued on February 2, 2024 in Audit #23-7582³ correcting the amount to \$2,371,094.67 and in Audit #23-7579 correcting the amount to \$23,215,799.31. The total amount of overpayments identified under “Code 11” in the draft audit reports was \$33,592,625.48. (Exhibits 7, 8, 10, 13, 14.)

9. The Appellant submitted a response dated April 5, 2024 to all six draft audit reports dated January 18, 2024 and the revised draft audit reports dated February 2, 2024, wherein it listed three objections:

² No revised draft audit report was issued in Audit # 23-7586, however the final audit report for this audit references the draft audit report overpayment amount of \$8,005,731.50, which is consistent with the amount as written in the draft audit report.

³ In Audit #23-7582, the draft audit report dated January 18, 2024 identified this audit as a “Code 11” audit. The Revised draft audit report dated February 2, 2024 identified this audit as a “Code 8” audit. The final audit report issued on October 1, 2024 identified this audit as a “Code 11” audit. At the hearing, the OMIG identified this audit as a “Code 11” audit. (Tr.10, 41-42.)

1. The Appellant disputed the findings, and associated dollar amounts, for enrollees who were simultaneously enrolled in and covered under commercial third party health insurance (TPHI) for 51,014 capitation records, totaling \$23,901,792.75 (sic)⁴, listed under Code 8 of their attached Excel file because their vendor, Health Management Systems, Inc. (HMS), did not confirm TPHI for the period in question [Audit # 23-7569, 23-7572, and 23-7576 only];
2. The Appellant disputed any recoupment associated with time periods during the national Public Health Emergency when the NYS Medicaid program and Managed Care plans were barred from disenrolling members under the maintenance of effort provisions; and
3. The Appellant disputed the imposition of interest for any amounts that are ultimately determined appropriate for recoupment.

(Exhibits 16, I, J.)

10. The Appellant submitted additional documentation in response to the draft audit reports on June 26, 2024, and after discussions with HMS, who in addition to being its coordination of benefits contractor (COB) was also the Recovery Audit Contractor (RAC) for the OMIG and the Department, reduced its disputed findings and associated dollar amounts for disallowances under "Code 8" to 33,758 capitation records, totaling \$15,624,061 [Audit # 23-7569, 23-7572, and 23-7576 only]. (Exhibits K, L, M, N, O.)

11. The OMIG notified the Appellant by final audit reports dated October 1, 2024, that it had identified and determined to seek restitution of Medicaid Program overpayments under Code 8:

1. in Audit #23-7569, overpayments in the reduced amount of \$20,426,409.67, plus interest of \$4,114,055.11, for a total recoupment of \$ 24,540,464.78;
2. in Audit #23-7572, overpayments in the reduced amount of \$907,036.39, plus interest of \$185,227.39, for a total recoupment of \$1,092,263.78; and
3. in Audit #23-7576, overpayments in the reduced amount of \$1,465,116.39, plus interest of \$308,553.42, for a total recoupment of \$1,773,669.81;

⁴ The correct amount of the overpayments identified in the draft audit reports under "Code 8" is \$23,901,793.75.

(Exhibits 2, 4, 6.)

12. The OMIG notified the Appellant by final audit reports dated October 1, 2024, that it had identified and determined to seek restitution of Medicaid Program overpayments under Code11:

1. in Audit #23-7579, overpayments of \$23,215,799.31 (unchanged), plus interest of \$6,876,459.52, for a total recoupment of \$30,092,258.83;
2. in Audit #23-7582, overpayments of \$2,371,094.67 (unchanged), plus interest of \$737,236.88, for a total recoupment of \$3,108,331.55; and
3. in Audit #23-7586, by revised final audit report dated October 16, 2024, overpayments of \$8,005,731.50 (unchanged), plus interest of \$2,429,569.70, for a total recoupment of \$10,435,301.20.

(Exhibits 9, 12, 15.)

13. The total amount of the capitation payments sought to be recovered in all six audits is \$56,391,187.93. The total amount of the interest sought to be recovered is \$14,651,102.02. (Exhibits 2, 4, 6, 9, 12, 15.)

ISSUES

Were the OMIG's determinations to recover overpayments from the Appellant for capitation payments made for enrollees enrolled or otherwise in receipt of comprehensive third-party health insurance or through any government health insurance program correct?

If so, was the OMIG's determination to impose interest on the overpayments correct?

DISCUSSION

In its responses to the draft audit reports, the Appellant raised three objections: 1) The Appellant disputed 33,758 capitation records totaling \$15,624,061.00 in capitation payments sought to be recouped because the enrollee had comprehensive third-party health insurance (listed as "Code 8" in the audit), contending that its coordination of benefits (COB) vendor, HMS, did not confirm coverage for the period sought to be recouped. 2) The Appellant disputed any

recoupment associated with the time period of the COVID national health emergency because disenrollment was barred during that period. 3) The Appellant asked that interest not be imposed for the amounts determined appropriate for recoupment because, historically, interest had not been imposed in past audits with similar situations. (Exhibits I and 16.)

1. Disputed Capitation Records

The Appellant contends that it has no independent ability to investigate whether a Medicaid enrollee has comprehensive TPHI, hence, since 2011 it has contracted with an outside vendor, HMS, to assist it in identifying TPHI and coordinating benefits. It further contends that HMS may not have TPHI information in “real time” and it can be years before it learns of TPHI for a member. (Appellant brief, page 7; Appellant response brief, page 1.) Under those circumstances, the Appellant claims it has no ability to coordinate benefits or notify the Department of overlapping coverage, and is unable to disenroll a member until it receives confirmation from the Department. (Appellant brief, page 7.)

The Appellant also claims that HMS was unable to verify TPHI coverage for members identified in the audits with respect to 33,667 (reduced from 33,758) months of coverage, totaling \$15,584,961 (reduced from \$15,624,061.00) in recoupments. (Appellant brief, pages 3, 25.) (The difference in the number of claims and amount challenged by the Appellant was the result of the removal from the audit of an additional 91 claims by HMS. (Exhibit N, page 2.)) The Appellant failed to offer any evidence from HMS to support this allegation, and no one from HMS, either as the Appellant’s COB vendor or the OMIG’s RAC vendor, testified at the hearing. In any event, the Appellant failed to explain why its vendor’s alleged inability to verify TPHI coverage entitles it to retain payment of capitation claims for members who in fact had such coverage.

The Appellant argues that neither the Department nor HMS provided it with information

so that it could validate TPHI coverage; that neither the draft nor final audit reports include any evidence of comprehensive TPHI; that the record is “simply devoid” of any proof of TPHI during the months identified by the Appellant in its responses to the draft audit reports; and that no one from HMS testified at the hearing to explain their acknowledgment that “there is no way to re-verify aged [*sic*] coverage for each claim” (Exhibit T, page 2⁵). The Appellant asserts that OMIG witness Perue’s “conclusory assertions” in her testimony are “insufficient to establish the existence of comprehensive TPHI during the relevant months.” (Appellant brief, page 25.) Therefore, the Appellant claims there is “no basis in the record to conclude that there was overlapping, comprehensive TPHI” with respect to the claims challenged by it, and contends that the decision to recoup capitation payments totaling \$15,584,961 should be reversed. (Appellant brief, pages 3, 25-26.)

The Appellant misplaces the burden of proof. It is not incumbent upon the OMIG to produce proof of the existence of the comprehensive TPHI in order to justify recoupment of capitation payments. The OMIG’s responsibility is to present the audit file and explain its findings, which it has done. 18 NYCRR 519.17. The burden is on the Appellant to show that the determination of the Department to recover capitation payments was incorrect. 18 NYCRR 519.18(d). The Appellant offered no evidence to meet its burden of proving the OMIG’s determination that TPHI coverage existed for any of these enrollees was incorrect.

The Appellant had ample opportunities to develop evidence to investigate the audit findings and demonstrate any errors in them. Indeed, the Appellant’s own exhibits reveal that, by emails dated June 12, 2024 and August 28, 2024, HMS advised the Appellant that it had reverified TPHI coverage and had removed certain claims from the audit because TPHI coverage

⁵ The full text of HMS’s September 11, 2024 email to the OMIG from where this quote is taken is: “Gainwell [HMS] has done what is possible to review the disputed claims, we are confident that they are consistent with the review selection criteria (coverage from NY TPHI data), and MetroPlus has not provided any concrete documentation/evidence that they are incorrect. As we have stated in our communications with MetroPlus to date, there is no way to re-verify aged coverage for each claim, so MetroPlus will probably continue to dispute that at hearing (as well as the interest). So with that caveat, Gainwell is comfortable moving to FAR.” (Exhibit T, page 2.)

could not be validated or had updated coverage termination dates, but that except for those removed claims *“NY DOH TPHI data shows that comprehensive TPHI coverage did exist for the claim dates of service identified in the [draft audit reports], and we are unable to substantiate/support removal of the remaining disputed claims from the DAR populations.”* Exhibit K; Exhibit N, page 2 (*emphasis added*).

Every provider who has enrolled in the Medicaid Program in New York state did so through enrolling in the eMedNY system.⁶ A component of this system serves as a Medicaid Eligibility Verification System which enables providers to verify member eligibility prior to provision of services. The Medicaid Provider manual advises that a provider not verifying eligibility prior to provision of services will risk the possibility of nonpayment for those services. The rosters received by the Appellant each month included TPHI information, as did the eMedNY system, a resource accessible to the Appellant. (Model Contract, § 3.7(b).) The Appellant was obligated to ascertain the existence of TPHI for enrollees and applicants, to coordinate benefits, and to maintain TPHI information on the eMedNY system. (Model Contract, § 3.7(a).) The verification process through eMedNY can be accessed through several methods, including a telephone verification process, ePACES, CPU-CPU link, eMedNY eXchange, and File Transfer Service using SOAP. (*eMedNY Medicaid Eligibility Verification System (MEVS) and Dispensing Validation System (DVS) Provider Manual*, Version Number 4.48, HIPAA Version 5010, October 2025⁷, section 1.0.) Eligibility information available through eMedNY includes eligibility status for a Medicaid member for a specific date, and the Medicare, third party insurance or Managed Care plan contact information a member has on file for the date of service. (*Id.*)

⁶ <https://www.emedny.org/info/ProviderEnrollment/>

⁷ [https://www.emedny.org/ProviderManuals/5010/MEVS/MEVS_DVS_Provider_Manual_\(5010\).pdf](https://www.emedny.org/ProviderManuals/5010/MEVS/MEVS_DVS_Provider_Manual_(5010).pdf)

The Appellant's assertion that it just could not have known that any of these enrollees had TPHI does not refute the audit findings that they did have TPHI. The Model Contract explicitly advised the Appellant that failure by the New York State of Health (NYSoH), the enrollment broker, or the Local Department of Social Services (LDSS) to notify the Appellant of a disenrollment does not affect the Department's right to withhold or recover capitation payments as authorized by Section 3.6 of the Model Contract. (Model Contract, Appendix H(7)(a)(xiv) (*emphasis added*).)

The Appellant has failed to prove that third party health insurance was unable to be verified, let alone that it did not exist, with respect to the \$15,584,961 in capitation payments sought to be recouped because the enrollee had comprehensive third-party health insurance.

2. COVID national health emergency

As was stated in all six of the Final Audit Reports (at page 2 of each report):

Upon completion of a review of all claims associated with this audit, there were zero (0) claims identified in this audit correlating to the Public Health Emergency (PHE) period of 3/1/2020 to 2/28/2021.

The Appellant offered no evidence that this audit report finding was incorrect or to substantiate that any recoupment in these audits was associated with the time period of the COVID national health emergency.

3. Interest

Pursuant to 18 NYCRR 518.4, the OMIG is authorized to collect interest from the date of the overpayments. The total interest from the date of payments assessed for these six audits was \$14,651,102.02. The Appellant proffered several reasons why it believes that interest should not be assessed. Initially, the Appellant contended that it had actively sought to coordinate benefits to minimize situations where TPHI is not identified, by retaining HMS to conduct its coordination of benefits analysis. The Appellant also argued that while the Department may

recoup monthly capitation payments under section 3.6 of the Model Contract, it also has the obligation to reimburse the Appellant for encounters that occurred during that same month. (Appellant brief pages 16-17.) The Appellant asserts that the capitation payments sought to be recouped were not funds that simply sat with it earning interest, but were largely paid out for encounters, and noted that for any amount determined appropriately payable for those encounters, it often takes years before it receives reimbursement. Thus, imposing interest on past periods “does compound this situation.” (Exhibits I and 16.) The Appellant contends that this process of reimbursement reflects an understanding that MCO’s often lack TPHI and government coverage information and that it takes some months for the Department to disenroll enrollees. (Appellant brief, pages 15-16.)

The Appellant also asserts that the assessment of interest is inconsistent with the text and the purpose of section 3.6 of the Model Contract to limit the financial impact on MCOs in the event of a retroactive disenrollment due to overlapping coverage, and claims that under the Model Contract the OMIG lacked authority to charge interest in connection with these audits. (Appellant Response brief, page 4.) Specifically, the Appellant contended that interest is not provided for or authorized, expressly or implicitly, under section 3.6 of the Model Contract for recoupments/recoveries made pursuant thereto. (Appellant Response brief at pages 5, 17.)

The Appellant agrees that interest may be collected on “overpayments” which are defined as “any amount not authorized to be paid under the medical assistance program . . .”. According to the Appellant, however, the OMIG presented no evidence whatsoever that the recoupments were based on any “[inaccurate or improper] cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.” (Appellant brief, page 17, citing 18 NYCRR 518.1(c).) It argues that the capitation payments at issue were not overpayments because they were “authorized to be paid,” and that simply because payments may be recovered does not mean they

were “unauthorized” in the first instance. (Appellant brief, page 17; Appellant Response brief, page 6.) The Appellant also points out that while the Model Contract defines “overpayment” and uses the term “overpayments” in other provisions, section 3.6 does not use the term “overpayments”, nor does it refer to 18 NYCRR Part 518. (Appellant Response brief, page 5; Appellant brief, page 17.) From this, the Appellant argues that “[t]o the contrary” it properly billed for enrolled members until they were disenrolled by the Department because there is no evidence in the record suggesting that at the time it billed for these capitation payments it had any knowledge that even a single member was ineligible, or that it made any “mistake” in billing for enrolled members. (Appellant brief, page 17.)

In addition, the Appellant argues that the OMIG’s decision to charge interest “was inconsistent with prior practice, irrational, arbitrary, capricious, and an abuse of discretion” and was unsupported by any rational reason. (Appellant brief pages 16-18; Appellant Response brief, page 4). The Appellant further suggests that the OMIG’s decision to discontinue payment integrity reviews, issue draft audit reports, and charge interest was made at a time when the Appellant and others were urging the OMIG and the Department to align the timing of the recoupments with encounter reimbursements, and that the decision to issue draft audit reports and assess interest was made in retaliation for the Appellant and the others exercising their First Amendment right of free speech and to petition the government; not because, as stated in the OMIG’s brief, the Appellant refused to pay the recoupments sought in the prior payment integrity reviews of these same claims. (Appellant brief, pages 8-9; Appellant Response Brief, page 9.)

The Appellant points out that 18 NYCRR 518.4 does not require the OMIG to charge interest, rather it expressly authorizes the waiver of interest where “the imposition of interest would effect an unjust result, would unduly burden the provider or would substantially delay the prompt and efficient resolution of an outstanding audit or investigation.” (Appellant brief at page

19.) The Appellant claims that the assessment of \$14,651,102.02 in interest unduly burdens it and effects an unjust result because the OMIG has not historically charged interest when recouping capitation payments under section 3.6 of the Model Contract; because consistent with its contractual obligations the Appellant actively sought to coordinate benefits and minimize situations where TPHI was not identified; and because there is nothing in the record that suggests that the OMIG considered the factors raised by the Appellant or otherwise exercised its discretion in deciding to charge interest. (Appellant brief, pages 19-20.)

The Appellant maintains that it engaged HMS to coordinate benefits and identify TPHI, and that it incurred \$44.8 million in encounter costs and administrative costs, until the Department authorized disenrollment. (Appellant Brief, page 20; Appellant Response brief, page 10.) However, the Appellant then also asserts that HMS may not have TPHI information in “real time” and it may be years before it learns of TPHI for a member. Under those circumstances, the Appellant has no ability to coordinate benefits or notify the Department of overlapping coverage, and it is not able to disenroll a member until it receives confirmation from the Department. (Appellant brief, page 7.) Hence, the Appellant asserts that as the Department owes it “more than” \$44.8 million in reimbursements, the OMIG should have held off charging interest until after reimbursements were made and charged interest on only the difference between recoupments and reimbursements. (Appellant Response brief, page 10.)

Finally, the Appellant contends that the OMIG’s reliance in its brief on prior administrative decisions is misplaced as none of those decisions address the fact that Model Contract § 3.6 does not use the term overpayment or that charging interest is inconsistent with the terms and intent of that provision, nor do they acknowledge that, for years, the OMIG conducted payment integrity reviews to recover capitation payments pursuant to Model Contract § 3.6 and did not charge interest in connection therewith. (Appellant brief, pages 5, 7.) The

Appellant points out that these prior administrative decisions were all issued without a hearing where the ALJ did not have the “benefit of testimony establishing that [the Appellant therein] complied with its obligations under the Model Contract and applicable laws.”⁸ (Appellant Response brief, pages 7-8.)

The Department is explicitly authorized to recover premiums made to the Appellant when the Department determines that an enrollee was or is simultaneously enrolled or in receipt of TPHI. (Model Contract, § 3.6(a).) If a Department audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR 504.8(a)(l), 518.1. Interest may be collected on overpayments and will accrue from the date of the overpayment. 18 NYCRR 518.4.

Payments under the Medicaid Program are not "authorized" simply because they were “duly paid by DOH.” (Appellant Response brief, page 6.) If that were the case, the OMIG could never recover any Medicaid overpayments. This is contrary to the entire Medicaid reimbursement system, which employs a pay first and audit later approach which ensures prompt payment to providers. Medicaid Program payments are always subject to post payment review, and any payments that should not have been made, including payments made by mistake, may be identified and recovered under both the Model Contract and under 10 NYCRR Part 518. 18 NYCRR 518.1(c) provides:

(c) An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

⁸ Appellant's footnote “2” states: “In each of these matters, the ALJ concluded, without any evidence whatsoever, that the MCO failed to detect and report overlapping TPHI coverage. See *In re Amida Care, Inc.*, Decision p. 8; *Matter of VNS Choice Select Health SNP*, p. 14-16; *Matter of Healthfirst PHSP*, p. 14-16. The three MCOs have commenced an Article 78 proceeding against OMIG and DOH, challenging DOH's final determinations. See *Matter of Healthfirst PHSP, Inc., VNS Choice Select Health SNP, and Amida Care Inc. v. New York State Department of Health, and New York State Office of the Medicaid Inspector General*, Supreme Court, New York County, Index No. 156345/2025.

The Appellant's claim that "the definition of 'overpayment' in Section 518.4 necessarily requires some wrongdoing or error by the MCO" (Appellant Response brief pages 6-7) is a misrepresentation of the regulation. "Mistake" is not specified to be provider mistake.

The Model Contract did not exempt the Appellant, a Medicaid provider, from 18 NYCRR Part 518 regulations. Model Contract section 3.6, in explicitly providing that the Department is entitled to recover capitation payments made for any enrollee later determined to have had other coverage, is entirely consistent with the regulatory definition of Medicaid overpayments. The capitation payments at issue should not have been made by the Medicaid Program because the enrollees were covered by other comprehensive health care insurance. As such they constitute recoverable overpayments within the meaning of 18 NYCRR Part 518.

The Appellant argues that the imposition of interest in this case would effect an unjust result because it actively sought to coordinate benefits to minimize situations where TPHIs are not identified and it did so by retaining HMS to conduct its coordination of benefits analysis. However, the Appellant failed to identify any effort of its own to identify enrollees with TPHI coverage, *e.g.*, through the eMedNY system, MEVS, or any other database available to them. It simply blames HMS.

The Model Contract is replete with references to the MMC provider's entitlement and responsibilities. The Appellant's objection to the imposition of interest is difficult to square with its failure under the Model Contract and under 18 NYCRR 540.6(e), to identify, from 2019-2022, these concededly ineligible enrollees, report them to the Department, and take steps to coordinate coverage. The Appellant did not act expeditiously, or at all, to notify the NYSoH or LDSS that they should be disenrolled. Instead, it collected capitation payments for over three years for enrollees who all had comprehensive TPHI, without investigating or detecting that error or seeking disenrollment until the capitation overpayments were revealed by the OMIG in the

payment integrity reviews and in these audits. The Appellant shares responsibility for the accumulation of interest on the capitation payments it received for these years, and the Medicaid Program is entitled to recover those payments with interest.

The Appellant has failed to meet its burden of proving that the assessment of interest pursuant to the explicit provisions of 18 NYCRR 518.4 is an abuse of discretion. The Appellant asserts that the imposition of interest would unduly burden it but offered no evidence to substantiate this claim. The overpayments the OMIG seeks to recover are for payments actually made to the Appellant and which it had the use of for years. The overpayment and accrued interest is substantial, but it is not self-evident that requiring the Appellant to repay, with interest, money actually paid over to it during the audit periods, is an undue burden. To assume otherwise is to remove any incentive for an MMC provider to make "diligent efforts" to avoid collecting capitation payments to which it is not entitled.

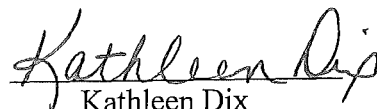
The Appellant has failed to meet its burden of proving that the Department's determination to recover interest on the capitation payments it seeks to recoup was incorrect. Interest is authorized pursuant to 18 NYCRR 518.4.

DECISION

The OMIG's determination to recover Medicaid Program overpayments, with interest, is affirmed.

This decision is made by Kathleen Dix, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Menands, New York
July 22, 2026


Kathleen Dix
Administrative Law Judge

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