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Ms. Mailloux by Scan
Ms. Bordeaux by Scan
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NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

January 21, 2026

CERTIFIED MAIL/RETURN RECEIPT

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54 State Street, 6th Floor
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RE: In the Matter of MVP Health Plan, Inc.
Audit #24-4822 and #24-4823

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

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeals of **MVP Health Plan, Inc.,** Provider No. 04342334, 01111375 Appellant, from determinations by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**DECISION PURSUANT TO 18 NYCRR § 519.23** Audit # 24-4822 # 24-4823

Administrative Law Judge: Natalie J. Bordeaux

Parties:

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

MVP Health Plan, Inc.
By: Zackary Knaub, Esq.
Greenberg Traurig, LLP
54 State Street, 6th Floor
Albany, New York 12207

BACKGROUND

MVP Health Plan, Inc. (Appellant), an operator of Medicaid Managed Care plans in the State of New York, requested hearings pursuant to Social Services Law (SSL) § 145-a and former Department of Social Services regulations at 18 NYCRR § 519.4 to appeal determinations by the Office of the Medicaid Inspector General (OMIG) to recover Medicaid Program overpayments. The determinations were set forth in May 6, 2025 final audit reports for Audit # 24-4822 (Audit 1), and for Audit # 24-4823 (Audit 2).

Both audits reviewed monthly capitation payments made to the Appellant for the period March 1, 2021 through December 31, 2021 to determine whether payments were made to the Appellant for Medicaid Managed Care enrollees simultaneously enrolled or in receipt of comprehensive third-party health insurance coverage through a different plan. The OMIG identified the following overpayments (1) Audit 1: $703,269.10; and (2) Audit 2: $10,136,283.59. The overpayment amounts reflect the improper capitation payments inclusive of interest.

By separate letters dated May 29, 2025, the Appellant requested a hearing to contest both overpayment determinations, and a hearing was scheduled. On October 29, 2025, the Appellant submitted its request for a decision without a hearing pursuant to 18 NYCRR § 519.23 for both audits and enclosed exhibits (1-19). The OMIG submitted its response to the Appellant's request on December 12, 2025 and enclosed exhibits (A-K).

Either party may request that an appeal from an OMIG determination be decided without a hearing when no unresolved material issue of fact is involved in the case and the only questions presented are questions of the OMIG's application of the law or its regulations. A request for a decision without a hearing must be accompanied by sufficient information to permit a

determination of whether any unresolved material issue of fact exists and should contain a full and clear statement of the issue and the party's position on the issue. 18 NYCRR § 519.23(a).

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 through a different plan, identified in Audit # 24-4822 and Audit # 24-4823, correct?

If so, was the OMIG's determination to impose interest on the overpayments identified in Audit # 24-4822 and Audit # 24-4823 in the amounts specified in those reports correct?

DISCUSSION

The Appellant is a managed care provider in the Medicaid Program that has entered into contracts with the New York State Department of Health (Department) to render or arrange for the provision of services to enrollees. It is paid in the form of a monthly capitation or premium for each enrollee. *See* SSL § 364-j. The terms of its contractual arrangement are set forth in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (Model Contract).

The Appellant's submission of a request for a decision without a hearing constitutes an admission that there is no factual dispute about the accuracy of the OMIG's specific audit findings that the disallowed capitation payments were made for enrollees who were simultaneously enrolled or in receipt of comprehensive third-party coverage (TPHI) through a different plan. Those specific findings are accordingly affirmed.

As no factual issues are in dispute and the only questions presented are questions concerning the OMIG's application of the law and its regulations, the Appellant's requests for appeals will be decided herein pursuant to 18 NYCRR § 519.23(a).

Capitations Identified in Audits 1 and 2

Retroactive Disenrollment and Capitation Recovery Precluded Due to COVID-19 Emergency

In its response to the draft audit reports and in its request for a decision without a hearing, the Appellant contended that it was required to continue to provide coverage for services and incur corresponding costs for covering those services for enrollees identified in the audits because of the COVID-19 pandemic. (Exhibit F; Exhibits 13, 14.) Contrary to the OMIG's objection (OMIG's brief, p. 6), the Appellant preserved this argument for appeal. The Appellant's response to the draft audit reports claimed that

> there was no indication during the Audit Period that members would be terminated from their Medicaid Plans. For a considerable time, [the Department] paused disenrollments…[h]ealth plans were strictly prohibited from disenrolling Medicaid enrollees without a termination file from [the Department] or until Medicaid recertifications for those enrollees…

(Exhibit F.)

Although the Appellant did not cite particular departmental or other regulatory guidance to support its asserted belief, the information it did provide served as adequate notification to the OMIG regarding the nature of the Appellant's disagreement with the audit findings. Therefore, the argument will be considered in this decision.

The Appellant's request for this decision without a hearing also argues that due to the State's receipt of enhanced federal funding to ensure continued coverage, retroactive disenrollment only serves as a "windfall" to the State of New York at the expense of Medicaid Managed Care plans and, as such, neither retroactive disenrollment nor overpayment recovery in this situation is appropriate. (Appellant's brief, pp. 14-15.) The State's receipt or nonreceipt of

funding is irrelevant to the issue for this hearing. The issue is whether the Appellant continued to maintain ineligible individuals on its rosters.

Individuals with TPHI are not eligible for enrollment in a Medicaid Managed Care plan or, if already enrolled, must be disenrolled for months in which an individual has TPHI. Model Contract, Appendix H, Section 7(a)(ix), (xv)(F) and (H). 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, Section 3.6(a).

The applicable Model Contract into which the Appellant entered with the Department was amended, effective March 1, 2020, and again on April 1, 2021. The amended versions included a new Section 38, entitled "Special Contract Provisions in Response to the [N]ovel [C]oronavirus (COVID-19) Pandemic," to take effect March 7, 2020. Among other things, Medicaid Managed Care plans were advised that enrollment and disenrollment requirements regarding individuals receiving TPHI were suspended until the last day of the month in which the federal emergency period ended or until such notice by the Department prior to the end of the federal emergency period. Model Contract, Section 38(g)(iii).

Model Contract Section 38(c) also confirmed that during the period in which ordinary requirements for the disenrollment of individuals with TPHI coverage was suspended, "recovery scenarios described under Section 3.6(a)(viii)" did not apply to premiums paid for enrollments. Even during the pause of otherwise applicable rules, however, the new Section 38 also explicitly stated that the new provisions shall not be construed to limit the authority of the Department or the OMIG "to audit and investigate cases of fraud, waste and abuse, and to take any action authorized by law or" the Model Contract. Section 38(h)(i).

Section 38(c) of the Model Contract is irrelevant to these audits because it ended before the audit period. Medicaid Managed Care plans were notified on January 19, 2021 that the Department would resume prospective disenrollment of members with TPHI. (Appellant Exhibit 19.) The January 19, 2021 advisory to Medicaid Managed Care plans did not state or even suggest that retroactive disenrollments would no longer occur.

The Department notified Medicaid Managed Care plans again in March 2021 that enrollees with TPHI were excluded from enrollment and the effective date of disenrollment for enrollees with TPHI would begin February 28, 2021(i.e., immediately before the period audited.)

The Department of Health and Human Services (HHS) allowed its public health emergency declaration to expire on May 11, 2023.[1] In a Dear Managed Care Coordinator Letter dated July 29, 2024, Medicaid Managed Care plans were reminded anew that enrollees with TPHI were eligible for disenrollment and precluded from enrollment in Medicaid Managed Care plans starting March 2021. (Exhibits F, J.) The Appellant provided no evidence demonstrating the illegality of the OMIG's audit determinations at issue.

The Appellant argued in its response to the draft audit reports and reasserted in its request for a decision on papers that, for over 95% of its enrollees identified in the audits, it was not informed in an "834" file that those enrollees would be disenrolled. (Exhibit F; Appellant's brief p. 10.) The 834 file is generated by the Department's New York State of Health and is the official enrollment notification for the expanded Medicaid eligibility population for purposes of eMedNY premium billing and payment, subject to enrollees' ongoing eligibility as of the first

[1] https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html#:~:text=The%20federal%20Public%20Health%20Emergency,remains%20a%20public%20health%20priority.

day of the enrollment month. Model Contract, Section 6.9(b). It is a process occurring independently of any audit conducted by the OMIG.

Although the March 2021 letter to Medicaid Managed Care plans indicated that Medicaid Managed Care plans would be notified of disenrollments due to TPHI via the 834 process described above, neither the Model Contract nor any guidance issued by the Department permanently absolved Medicaid Managed Care plans such as the Appellant of their responsibility to verify whether prospective and current enrollees had TPHI. Nor did the March 2021 letter, the Model Contract, applicable law, or other guidance ever advise Medicaid Managed Care plans that a delayed enrollment reconciliation, in the form of the 834 file or precipitated by an audit, would preclude recovery by the Department or the OMIG of capitations for enrollees who were not eligible for Medicaid Managed Care due to their receipt of comprehensive TPHI.

The rosters received by the Appellant each month included TPHI information, as did the eMedNY system, a resource accessible to the Appellant. Model Contract, Section 3.7b. 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, Section 3.7(a). The Model Contract explicitly advised the Appellant that failure by the New York State of Health, 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).

The Appellant asserted in its response to the draft audit report and in its request for a decision without a hearing that it was under no obligation to disenroll members. (Appellant's brief, p. 9.) It does not follow, from this, that if it chose not to disenroll members with TPHI that

it was entitled to continued capitation payments for those members. The Appellant was obligated to minimize unnecessary costs to the Medicaid Program. The Appellant always remained responsible for reviewing the enrollment rosters received from the Department and eMedNY, and for conducting its own efforts to identify TPHI coverage to inform the Department of the need to disenroll enrollees with such coverage and to avert enrolling applicants with TPHI. By fulfilling those obligations, the Appellant would avert improper enrollments; minimize overpayments by working with the Department to more efficiently cull its rosters of improper enrollments; or at least minimize unnecessary costs incurred for medical care of enrollees with TPHI when such costs should be shouldered by another plan. The OMIG acted appropriately in identifying overpayments that occurred during the audit period.

The OMIG's Recovery Authority Pursuant to 18 NYCRR Part 518

The Appellant asserts that the OMIG lacked authority to recover overpayments because the capitations at issue do not constitute overpayments pursuant to 18 NYCRR Part 518. (Appellant's brief, pp. 15-17.) Capitation payments incorrectly paid to a contracted Medicaid Managed Care plan are not authorized to be paid by the Medicaid Program and are overpayments subject to recovery. 18 NYCRR § 518.1(c); Model Contract, Section 1 "overpayment definition", Section 18.5(viii)(G), Section 23.3.

The Appellant also contends that the capitations at issue are not overpayments they were "authorized" when made. (Appellant's brief, pp. 3-4, 12-17.) Payments under the Medicaid Program are not "authorized" simply because they were made. The Medicaid Program utilizes a pay first and audit later approach to ensure prompt payments to providers. However, these payments are always subject to review post facto. *VNS Choice Select Health SNP*, Decision Without a Hearing, p. 7 (Audit #23-7575 and #23-7584, issued January 17, 2025, ALJ John

Terepka). The amounts at issue in this decision should not have been paid by the Medicaid Program and therefore constitute overpayments which the OMIG is authorized to recover.

Capitation Recovery Distinct from Encounter Cost Reimbursement

The Appellant argues that the OMIG "acted unreasonably and irrationally by failing to account for the encounter reimbursements" the Appellant believes it is owed. (Appellant's brief, p. 17.) This argument is precluded as "new matter" unrelated to the audit determinations at issue, which the Appellant failed to raise as required by 18 NYCRR § 519.18(a) in response to the draft audit reports.

The Department, not the OMIG, is required to reimburse the Appellant the cost of benefits provided for any encounters that occurred during the applicable payment month(s), except for instances when the Appellant has already received reimbursement from any source; or the comprehensive third-party health insurance coverage is provided through another product offered by the Appellant or a parent, subsidiary, or sister entity. Model Contract, Section 3.6(e). These reimbursement procedures are a separate process, described in the May 2017 New York State Medicaid Update, which are outside the scope of review with respect to the determinations set forth in Audits 1 and 2.

By letter dated June 8, 2019, the Department advised LDSS of its encounter reimbursement process approved by Centers for Medicare and Medicaid Services (CMS). The letter explains that the Department will reimburse a Medicaid Managed Care plan for costs incurred during a recovered capitation month after the Medicaid Managed Care plan "has repaid all identified overpayments." (Appellant Exhibit 18.) The CMS-approved process remains in place.

The Appellant's disagreement with contractual terms, Medicaid Updates (with which the Model Contract requires compliance (*see* Section 37), and a CMS-approved process is irrelevant and fails to establish that the OMIG has inaccurately interpreted the law or the Model Contract regarding its determination to recover improperly paid capitation payments.

The OMIG's Determination to Impose Interest on the Identified Overpayments

In its request for a decision on written submission, the Appellant contests the OMIG's determination to impose interest on the identified overpayments. (Appellant's brief, pp. 19-23.) The OMIG asserts that the Appellant should be precluded from raising an objection to the imposition of interest for the first time in its request for a decision without a hearing. (OMIG's brief, pp. 5-6.)

Inasmuch as the Appellant failed to raise an objection to the OMIG's interest determinations in response to the draft audit reports, it is precluded from raising such objection in this decision. 18 NYCRR § 517.5 and § 519.18(a); *Staten Island Care Center v. Zucker*, 181 N.Y.S.3d 552 (App. Div. 1st Dep't 2023).

The Appellant has failed to meet its burden of establishing that the OMIG's determinations for Audits 1 and 2 were incorrect.

DECISION

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 through a different plan or through a government health insurance program, identified in Audit # 24-4822 and Audit # 24-4823, were correct and are affirmed.

The OMIG's determination to impose interest on the overpayments identified in Audit # 24-4822 and Audit # 24-4823 in the amounts specified in those reports is affirmed.

Dated: January 21, 2026
Menands, New York

Natalie J. Bordeaux
Administrative Law Judge