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## Department of Health

KATHY HOCHUL  
Governor

JAMES V. McDONALD, MD, MPH  
Commissioner

JOHANNE E. MORNE, MS  
Executive Deputy Commissioner

January 16, 2025

**CERTIFIED MAIL/RETURN RECEIPT**

Thomas Smith, Esq.  
NYS – OMIG  
800 North Pearl Street  
Albany, New York 12204

Casey Kyung-Se Lee, Esq.  
Ropes & Gray LLP  
1211 Avenue of the Americas  
New York, New York 10036-8704

**RE: In the Matter of Amida Care, 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,

A handwritten signature in black ink that reads "Natalie J. Bordeaux".

Natalie J. Bordeaux  
Chief Administrative Law Judge  
Bureau of Adjudication

NJB:nm  
Enclosure

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeals of

**Amida Care, Inc.,**

Provider No. 02191582,

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 # 23-7573  
Audit # 23-7583

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: Thomas Smith, Esq.

Amida Care, Inc.

By: Casey Kyung-Se Lee, Esq.  
Ropes & Gray LLP  
1211 Avenue of the Americas  
New York, New York 10036-8704

### **BACKGROUND**

Amida Care, Inc. (Appellant) 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 a March 21, 2024 revised final audit report for Audit # 23-7573 (Audit 1), and a March 21, 2024 revised final audit report for Audit # 23-7583 (Audit 2).

Audit 1 reviewed monthly capitation payments made to the Appellant for the period of March 1, 2019 through October 1, 2022 to determine whether payments were made to the Appellant for enrollees simultaneously enrolled or in receipt of comprehensive third-party health insurance coverage through a different plan. Audit 2 reviewed monthly capitation payments made to the Appellant for the period of October 1, 2015 through February 1, 2020 to determine whether payments were made to the Appellant for enrollees simultaneously enrolled or in receipt of comprehensive health care coverage through a government health insurance program. The OMIG identified the following overpayments (1) Audit 1: \$1,760,494.30; and (2) Audit 2: \$7,825,533.46. The overpayment amounts reflect the improper capitation payments inclusive of interest.

By letter dated May 20, 2024, the Appellant requested a hearing to contest both overpayment determinations. By email dated September 12, 2024, the Appellant confirmed its intent to seek one consolidated hearing to review both audits. On September 30, 2024, the OMIG agreed to a consolidated hearing, and the hearing was scheduled for January 22, 2025.

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).

By letter dated October 10, 2024, the Appellant requested a decision without a hearing pursuant to 18 NYCRR § 519.23 for both audits, and enclosed exhibits (A-E). On November 25, 2024, the OMIG submitted its response to the Appellant's request for a decision without a hearing, along with exhibits (1-8). The Appellant submitted a reply to the OMIG's submission on November 26, 2024, and enclosed an additional exhibit (F). The record closed December 3, 2024, after the OMIG confirmed that it would not submit a response to the Appellant's reply.

### **ISSUES**

Was the OMIG's determination 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, correct?

If so, was the OMIG's determination to impose interest on the overpayments identified in Audit # 23-7573 and Audit # 23-7583 in the amounts specified in those reports correct?

### **APPLICABLE LAW**

The Department of Health (Department) is the single state agency for the administration of the Medicaid Program in New York State. Public Health Law (PHL) § 201(1)(v); SSL § 363-a. The OMIG is an independent office within the Department with the authority to review and audit contracts, cost reports, claims, bills and all other expenditures of medical assistance (Medicaid) program funds to determine compliance with and take such actions as are authorized

by federal or state laws and regulations. In addition, the OMIG is authorized to recover improperly expended Medicaid funds via civil and administrative enforcement actions against any individual or entity who engages in improper acts perpetrated within the Medicaid Program. PHL §§ 30-32.

When the Department has determined that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR § 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). The Department may require repayment for improper services from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. 18 NYCRR § 518.3(b).

A managed care program is a statewide program in which Medicaid Program recipients enroll on a voluntary or mandatory basis to receive Medicaid services, including case management from a managed care provider, including, as applicable, a comprehensive HIV special needs plan. SSL § 364-j(1)(c). Managed care programs are established under the Medicaid Program in accordance with applicable federal law and regulations. SSL § 364-j(2)(a). A managed care provider participates in one or more of these programs and renders or arranges for the provision of Medicaid services and supplies to participants directly or indirectly, including case management. SSL § 364-j(1)(b). The Department has developed reimbursement methodologies and fee schedules for managed care programs, including capitation arrangements

(also referred to as premium rates), that consider costs borne by the managed care program. SSL §§ 364-j(18)(a)&(c).

Medicaid managed care contracts are approved by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). They must contain standard contract requirements, including provisions authorizing the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees to, at any time, inspect and audit records or documents of the managed care provider, or its subcontractors. 42 CFR § 438.3(a)&(h). Other standard contract requirements include a provision for reporting within 30 days all overpayments identified or recovered to the State and a provision for prompt notification to the State when the managed care provider receives notification of changes in an enrollee's circumstances that may affect the enrollee's eligibility. 42 CFR §§ 438.3(a)(2)&(3). In the state of New York, Medicaid managed care providers, including HIP SNP plans, must enter into the Medicaid/Family Health Plus/Special Needs Plan Model Contract (Model Contract) in order to provide health care coverage to eligible individuals enrolled in their plans.

The Department, on behalf of the state of New York, is required to have a monitoring system in effect for all Medicaid managed care providers which addresses all aspects of the managed care program, including program integrity. 42 CFR §§ 438.66(a)&(b). Program integrity obligations are delineated in the Model Contract.

### **DISCUSSION**

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 not properly payable under the Medicaid Program because those payments were made for enrollees who were simultaneously enrolled or

in receipt of comprehensive third-party coverage through a different plan (Audit 1) or were made for enrollees who were simultaneously enrolled or in receipt of comprehensive health care coverage through a government health insurance program (Audit 2). 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).

Citing 18 NYCRR § 519.18, the OMIG argues that the Appellant is precluded from raising its objections to the OMIG's determinations in Audits 1 and 2 in its request for a decision without a hearing because it failed to submit responses to the draft audit reports for these audits. (OMIG's November 25, 2024 Brief, pp. 5-6.) The Appellant contends that this provision applies only to a hearing, and that the Appellant is not similarly precluded here because it has sought a decision without a hearing instead. (Appellant's November 26, 2024 Brief, pp. 1-2.)

The same limitations imposed upon presentations at a hearing apply to a review on papers, the only difference being that a review on papers may obviate the need for a hearing. An appellant may not raise any new matter not considered by the OMIG upon submission of objections to a draft audit report or notice of proposed agency action. 18 NYCRR § 519.18.(a). Despite the Appellant's failure to submit a response to the draft audit reports, the OMIG's determinations to recover disallowed capitation payments as overpayments in Audits 1 and 2 are not "new matter" and are directly related to the final determinations. The OMIG's determination to disallow the identified capitation payments will therefore be considered.

The Department has processes in place for both enrollment (voluntary and mandatory) and disenrollment of individuals, as required by 42 CFR § 438.54 and § 438.56. Two monthly



enrollment rosters are generated by the Department, referred to as the “first” and “second” monthly rosters. Model Contract, Section 3.1(e), Section 3.4, Section 6.9.<sup>1</sup>

The Appellant’s dispute concerning the final audit reports for Audits 1 and 2 centers on its contention that it was required to continue to provide coverage for services and incur corresponding costs for covering those services for enrollees who were ultimately disenrolled until the Department reconciles its enrollment roster. Although the Appellant provides no specific examples of its described cost burden regarding the now-disenrolled individuals for whom it received capitation payments, it contends that the disenrollment reconciliation process “can take [the Department] weeks, months, or even years.” The Appellant further asserts that it “cannot discontinue providing services (and incurring related costs)” until the disenrollment reconciliation has been completed. (Appellant’s October 10, 2024 Brief, p. 2.)

Managed care providers receive a full month’s capitation payment for the month in which disenrollment occurs. Model Contract, Section 3.4(a). Rosters are but one way of verifying whether an enrollee has third-party health insurance. Model Contract, Section 3.7(a). The 834 file generated by the Department’s New York State of Health 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 day of the enrollment month. Model Contract, Section 6.9(b). Third-party health insurance coverage, including Medicare and/or private managed care coverage, is posted on the eMedNY system (accessible by the Appellant). Model Contract, Section 3.7(b). The local district of social services (LDSS) or an enrollment broker may also provide written notification of adjustments to the roster. Model

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<sup>1</sup> The applicable versions of the Model Contract would be March 1, 2014, as amended October 1, 2015, March 1, 2019, including March 1, 2020 and April 1, 2021 versions. As the Appellant only offered excerpts of the March 1, 2019 Model Contract, this decision will only cite the 2019 version.

Contract, Section 6.9(a). The Model Contract also explicitly advised the Appellant that failure by the New York State of Health, the enrollment broker, or 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 is responsible for reviewing the roster and eMedNY, and for conducting its own efforts to identify third-party health insurance coverage. The Appellant is also responsible for pursuing recoveries for payments made for services from third-party insurers. Model Contract, Section 3.7(b). If third-party health insurance coverage is known at the point of service, the Appellant is required to notify a provider of such coverage and ask them to bill that coverage. Model Contract, Section 3.7(a).

With respect to findings in Audit 1, the Appellant was required to coordinate benefits for enrollees with third-party health insurance to avoid incurring costs and to notify the Department of any known changes to an enrollee's eligibility. Model Contract, Section 3.7(a).

Audit 2 resulted in the OMIG's determination to recover capitation payments for enrollees who were already enrolled in or in receipt of comprehensive health care coverage through a government health insurance program, based on the OMIG's analyses of premium data and third-party health insurance data. (Exhibits 1-3, 5-7.) If enrollees were already in receipt of comprehensive health insurance through another government plan, that would be noted in eMedNY, and the Appellant had a duty to verify enrollees' eligibility. What the Appellant challenges then are its own contractual and legal obligations, which, if followed, would have lessened the overpayments identified in Audits 1 and 2. No legal support exists for the Appellant's challenges to prevail.

The Appellant entered into a Model Contract with the Department on or before the audit periods at issue.<sup>2</sup> As required by federal regulations, the Model Contract describes how monthly capitation payments are made to the Appellant, when capitation payments are made, and the Department's right to recover premiums paid. Most pertinent to Audits 1 and 2, 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 comprehensive third-party health insurance coverage; simultaneously enrolled or in receipt of comprehensive health care coverage through any government health insurance program; or simultaneously enrolled or in receipt of comprehensive health care coverage through a third-party commercial insurer, where the insurer has covered or agrees to cover the enrollee, who is an infant or the mother of an infant if both will be covered, from the infant's date of birth. Model Contract, Section 3.6(a).

When an enrollee is simultaneously enrolled or in receipt of comprehensive third-party health insurance coverage or simultaneously enrolled or in receipt of comprehensive health care coverage through any government health insurance program, disenrollment takes effect the first day of the first full month of simultaneous coverage. When third-party commercial health insurance provided comprehensive health care coverage or agrees to provide coverage for an infant, or the infant and mother effective on the infant's date of birth, disenrollment takes effect on the first day of the month of the infant's birth but if the mother was enrolled prior to the month of the infant's birth, then (just for the mother) disenrollment takes effect the first day of the month following the month of the infant's birth. Model Contract, Appendix H, Section 7. The Appellant is not entitled to keep a capitation payment for someone who is ultimately

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<sup>2</sup> See footnote 1.

disenrolled from its plan for the month(s) for which the Appellant received that payment. That amount is an overpayment.

The Appellant argues that, if the OMIG is entitled to recover premiums deemed to have been improperly paid, then any such recovery must be reduced by costs it incurred for covering the enrollees who were enrolled in or received other health care coverage. 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 Appellant did not respond to the draft audit reports at all. Even in its request for a decision without a hearing, the Appellant made no effort to articulate the basis for its objection to the final audit reports. It is therefore not entitled to a review of its asserted right to receive reimbursement for alleged expenditures in this decision.

However, if the Appellant’s argument was considered, it would not support overturning the OMIG’s determination. Reimbursement procedures are a separate process, described in the May 2017 New York State Medicaid Update, that is outside the scope of review with respect to the determinations set forth in Audits 1 and 2. Although the Model Contract does require the Appellant to continue providing services delineated in the Benefit Package prior to the effective date of disenrollment when disenrollment is effectuated because an enrollee is simultaneously enrolled or in receipt of comprehensive third-party health insurance coverage or comprehensive health care coverage through any government health insurance program, the Department 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). The Appellant has made no effort to show what costs it incurred for the enrollees identified as having other coverage in the months specified in Audits 1 and 2 which are properly chargeable to the Medicaid Program.

The Appellant cites Model Contract, Section 3.6(e), but then refines its grievance to assert:

...Medicaid funds change hands three times. *First*, DOH makes monthly capitation payments to Amida Care. *Second*, OMIG either recoups or withholds capitation premiums for enrollees with [third-party health insurance]. *Third*, DOH then reimburses Amida Care for “verifiable expenses.”

(Appellant’s October 10, 2024 Brief, p. 2.)

The Appellant’s summary of the process confirms its understanding that reimbursement is separate from and subsequent to these audits. The enforceability of the Model Contract is not in dispute in this matter. The Appellant’s newfound disagreement with its terms 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 Appellant is attempting to use its appeal of Audit 1 and Audit 2 as a mechanism for overturning established payment, audit, and recovery processes. If it disagreed with the terms of the Model Contract, it was certainly under no obligation to enter into that agreement and was also free to terminate its agreement with the Department. Capitation payments incorrectly paid to the contracted managed care plan 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 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. Here too, the OMIG asserts

that the Appellant is precluded from raising an objection to the imposition of interest for the first time in its request for a decision without a hearing. 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).

In any event, none of the Appellant's objections to the OMIG's imposition of interest on the overpayments, if considered, would establish that the OMIG's determination was incorrect. The OMIG is authorized to collect interest on any overpayment determined to have been made pursuant to the terms set forth in 18 NYCRR § 518.4. The Appellant asserts that the recovered capitation payments are not overpayments subject to the imposition of interest, arguing that the Model Contract somehow supplants legal authority otherwise afforded the OMIG. (Appellant's October 10, 2024 Brief, pp. 4-7.) No conflict exists between the Model Contract and applicable federal and state regulations.

Capitation payments that were improperly or incorrectly paid are overpayments. Model Contract, Section 1 "overpayment definition", and Section 18.5(viii)(G). The Appellant's receipt of capitation payments for individuals who were not or should not have been enrolled in its HIV SNP for a particular month or months constitutes an overpayment for which the OMIG is authorized to impose interest. 18 NYCRR § 518.1(c) and § 518.3(b).

The Appellant asserts that the OMIG failed to provide a "reasoned basis" for imposing interest on the recovered capitation payments. (Appellant's October 10, 2024 Brief, pp. 3-4.) The "reasoned basis" for the OMIG's determinations to recover improper capitation payments is set forth in both the draft and final audit reports for each audit. That is, overpayments were identified for which the OMIG is legally authorized to impose interest. The Appellant has had

the benefit of using the unauthorized capitation payments for between two to 10 years. During that time, the Department has been deprived of the ability to use those same funds.

The Appellant also contends that the OMIG's determinations to impose interest as a result of the findings for Audit 1 and Audit 2 are arbitrary and capricious, and an abuse of discretion, because the OMIG had not previously imposed interest on the Appellant for "overpayments recovered due to [third-party health insurance]." (Appellant's October 10, 2024 Brief, pp. 7-8.) The Appellant's presentation inaccurately depicts the OMIG's prior determinations. The Appellant does not specify whether previously identified overpayments in other audits involved recovery of capitation payments made, costs reported by the Appellant, or other funds paid by the Department towards the cost of caring for enrollees identified as having third-party health insurance. However, a cursory review of publicly available OMIG audit reports reflects that the OMIG did impose interest on overpayments identified in seven recent audits in which capitation payments were deemed improperly paid to the Appellant. *See* Audit # 19-4037, Audit # 21-5848, Audit # 22-1975, Audit # 22-4721, Audit # 23-1491, Audit # 23-4449, Audit # 24-3197, all available at: <https://omig.ny.gov/audit/final-audit-reports>. In any event, overpayments identified by the OMIG in audits other than Audit 1 and Audit 2 are not the subject of this hearing.

The OMIG may elect to utilize its discretion for purposes of settlement, etc. and waive, in whole or in part, the imposition of interest. Regulations at 18 NYCRR § 518.4(e) permit waiving interest in whole or in part "when 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." The circumstances in these audits do not justify waiving the imposition of interest.

The Appellant's claims of hardship elide its own obligations to avoid incurring unnecessary and improper costs. The Appellant is required to return any capitation payments or other payments in excess of amounts specified in the Model Contract. These improper payments are, again, referred to as overpayments. Model Contract, Section 23.3. The Appellant is also required to make diligent efforts to determine whether enrollees have third-party health insurance, coordinate benefits with any identified third-party insurer, and notify the LDSS within five business days of learning of a change in third-party health insurance. Model Contract, Section 3.7(a). The Appellant must also implement procedures to detect fraud, waste, and abuse. 42 CFR § 438.608; Model Contract, Section 23.1(b). This Appellant and its procedures, if any, failed to work with the Department to cull enrollees receiving government health insurance coverage from its roster and, if its claimed extensive costs (currently unsubstantiated and not subject to review in this decision) are accurate, failed to properly coordinate benefits with other insurers.

The Appellant is required to report improperly paid capitation payments within 60 days of identification and return those overpayments within 60 days of identification or receipt of notice of such payments. Model Contract, Section 18.5(a)(viii)(G). The Appellant's failure to uphold its contractual obligations has now resulted in audits several years back seeking to recover those improper payments with considerable interest. This is not an unjust result.

The contractual obligations set forth in the Model Contract encourage ongoing oversight by managed care providers and proactive measures designed to avoid unnecessary costs and minimize the burden on managed care providers as well as New York state entities tasked with monitoring Medicaid Program integrity. The audits are necessary to remind and require managed care providers to uphold their legal and contractual obligations. The Appellant is a



fiduciary of government funds and must utilize those funds within the constraints of the law, and as restated in the Model Contract.

Finally, the Appellant argues that, if this decision affirms the OMIG's legal authority to impose interest on the overpayments identified in Audits 1 and 2, the overpayment amount upon which interest is imposed should be limited to capitation payments minus verifiable expenses. (Appellant's October 10, 2024 Brief, p. 6.) If such expenses were actually incurred, are "verifiable", and are not reimbursable by a third-party insurer, they can be reimbursed via other methods of reporting to the Department, described in the May 2017 New York State Medicaid Update. Consideration of any Appellant applications for "encounter costs" is beyond the scope of this 18 NYCRR Part 519 audit overpayment proceeding.

Computer-generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR § 519.18(f). The Appellant has failed to offer argument or evidence that the OMIG's calculations are incorrect.

As the recoupment sought by the OMIG qualifies as a Medicaid overpayment pursuant to 18 NYCRR § 518.1(c), the interest on the principal sum must be calculated at the rate and in the manner set forth in 18 NYCRR § 518.4. *Commissioner of the Department of Social Services of the City of New York v. New York-Presbyterian Hospital*, 133 N.Y.S.2d 805 (App. Div. 1st Dep't 2020).

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 determination 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 # 23-7573 and Audit # 23-7583, was correct and is affirmed.

The OMIG's determination to impose interest on the overpayments identified in Audit # 23-7573 and Audit # 23-7583 in the amounts specified in those reports are affirmed.

Dated: January 16, 2025  
Menands, New York



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Natalie J. Bordeaux  
Administrative Law Judge