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Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

January 17, 2025

CERTIFIED MAIL/RETURN RECEIPT

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

Healthfirst PHSP Inc.
100 Church Street
New York, New York 10007

Kimo S. Peluso, Esq.
Sher Tremonte
90 Broad Street, 23rd Floor
New York, New York 10004

RE: In the Matter of Healthfirst PHSP

Dear Parties:

Enclosed please find the Decision Without Hearing pursuant to 18 NYCRR 519.23 in the above referenced matter.

If the appellant did not win, 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

COPY

In the Matter of the Appeal of	:	
	:	
Healthfirst PHSP	:	Decision without
Medicaid ID # 01479670, 04003696	:	hearing pursuant to
	:	18 NYCRR 519.23
	:	
from determinations by the NYS Office of the	:	#23-5502
Medicaid Inspector General to recover Medicaid	:	#23-5503
Program overpayments.	:	#23-5625
	:	#23-5626

Before: John Harris Terepka
Administrative Law Judge

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Menands, New York 12204
By: Thomas Smith, Esq.
Thomas.Smith@omig.ny.gov

Healthfirst PHSP Inc.
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JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York State. PHL 201(1)(v), SSL 363-a. Pursuant to PHL 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to recover improperly expended Medicaid funds. The OMIG determined to seek restitution of payments made under the Medicaid Program to Healthfirst PHSP Inc. (the Appellant). The Appellant requested hearings pursuant to Social Services Law 145-a and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determinations. Hearings were scheduled for September 16, 17, 18 and 19, 2024.

The parties agreed that the four hearings would be consolidated into one appeal. On October 24, 2024, the Appellant submitted a request for a decision without hearing pursuant to 18 NYCRR 519.23. The Appellant submitted four affidavits and Exhibits 1-86 with its request. The OMIG submitted its response to the request on December 4, 2024. Replies were submitted December 18 and 31, 2024.

The Appellant has the burden of showing that the determination of the Department was incorrect. 18 NYCRR 519.18(d).

SUMMARY OF FACTS

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. (Exhibit 1.)

2. 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.

3. Pursuant to Section 3.6(a)(viii)&(ix) of the Model Contract:

SDOH shall have the right to recover capitation payments made to the Contractor for an MMC Enrollee when, for the entire applicable payment month(s), SDOH 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 1, page 44.)

4. The OMIG reviewed MMC capitation payments made to the Appellant for the period 3/1/2019-12/1/2022 (audits #23-5502&5503); 10/1/2015-2/1/2020 (audit #23-5625); and 11/1/2015-2/1/2020 (audit #23-5626). The OMIG identified enrollees who were simultaneously enrolled in and covered under third party health insurance (TPHI) (audits #23-5502&5503), or another government health insurance program (audits #23-5625&5626) for the entire month for which a capitation payment was made to the Appellant.

5. OMIG issued draft audit reports on September 12 (audits #23-5502&5503) and September 28, 2023 (audits #23-5625&5626). (Exhibits 46-53.)

6. The Appellant submitted a response to all four draft audit reports dated November 1, 2023. (Exhibit 59.) On November 2, 2023 the OMIG accepted the Appellant’s November 1 response to the draft audit reports as timely for all four audits. (Exhibit 60.) The response did not object to the OMIG’s determinations to recover capitation payments nor did it dispute the amount of those payments. It objected to the failure to consider and credit reimbursements for encounters against the findings, and to the imposition of interest on the capitation recovery amounts.

7. By final audit reports dated October 19 (audits #23-5502&5503) and November 27, 2023 (audits #23-5625&5626), the OMIG notified the Appellant that it had identified and determined to seek restitution of Medicaid Program overpayments in the amount of \$23,971,408.08 inclusive of interest under audit #23-5502; \$1,301,533.58 inclusive of interest under audit #23-5503; \$111,188,921.77 inclusive of interest under audit #23-5625; and \$19,609,117.01 inclusive of interest under audit #23-5626. (Exhibits 54, 55, 63, 64.)

8. The overpayment claim includes capitation payments paid for ineligible enrollees during the audit periods, plus interest from the dates of the payments.

9. The Appellant does not dispute the OMIG's findings that the identified enrollees were enrolled in and covered under comprehensive TPHI or government health insurance for the entire month for which the disallowed capitation payments were made.

ISSUES

Were the OMIG's determinations to recover Medicaid Program overpayments from the Appellant correct?

DISCUSSION

The Appellant is a managed care provider in the Medicaid Program. *See* SSL 364-j. Under the terms of its Model Contract agreements with the Department, the Appellant is paid in the form of a monthly premium, or "capitation payment" for each enrollee. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract. (Exhibit 1.) The Appellant's agreements with the Department further provide, however, that the Department is entitled to recover capitation payments made for enrollees who are later determined to have been simultaneously enrolled or in receipt of third party or government health insurance. Model Contract 3.6(a) and Appendix H.

It is uncontroverted that capitation payments for the enrollees at issue were made by the Medicaid Program in the amounts determined by the OMIG. (Exhibits 82, 83, 84, 85.) The Department's records of Medicaid payments are entitled to a presumption of accuracy that the Appellant did not challenge. 18 NYCRR 519.18(f). It is also uncontroverted that in the instances identified in the audit report, the enrollee was enrolled in and in receipt of comprehensive TPHI or government health care insurance.

The Appellant does not dispute the OMIG's findings and determination that capitation payments identified in the audit report were made during months when the enrollee had other coverage. It also does not dispute that the OMIG's interest calculations accurately reflect the provisions of 18 NYCRR 518.4. It objects to the recovery of the entire amount of the overpayment identified, and to the imposition of interest, and claims that it was required to and did incur expenses for the provision of care to the enrollees for which it is entitled to credit against the overpayments and interest.

Recovery of capitation payments.

The Medicaid Program is a payment source of last resort and is entitled to reimbursement for any payments for care and services it makes for which a third party is legally responsible. 18 NYCRR 360-7.2. The Appellant does not dispute that pursuant to the express terms of Model Contract 3.6(a), the OMIG is entitled to recover the capitation payments made during months when the enrollees had other comprehensive health care coverage.

The Appellant claims its Model Contract agreement with the Department assigns responsibility to the New York State of Health (NYSoH) marketplace, enrollment broker,

or local department of social services (LDSS) to disenroll MMC enrollees when their eligibility changes due to circumstances such as other coverage, and to notify contractors such as the Appellant. The Appellant points out that it was required to remain responsible for the provision of care to these enrollees until they were formally disenrolled from its MMC program. (10/24/2024 submission, page 8.)

This does not mean the Appellant is entitled to keep all capitation payments it receives before it is notified of a disenrollment. The Model Contract specifically provides:

Failure by the NYSoH, Enrollment Broker, or LDSS to notify the Contractor of a disenrollment does not affect the right of the SDOH to withhold or recover capitation payment(s) as authorized by Section 3.6 of this Agreement. Model Contract Appendix H(7)(a)(xiv).

The Appellant is only entitled to capitation payments for the period before the effective date of disenrollment. In the case of TPHI and government health insurance, the effective date is the first day of the first full month of simultaneous coverage. Model Contract 3.6(e)(v), Appendix H(7)(a)(xv).

Encounter reimbursement.

The Appellant points out that the Model Contract provides, for withholds and recoveries made pursuant to Section 3.6(a)(viii)&(ix), that the Department shall reimburse it for the cost of services for which it paid during the applicable payment months and for which it has not already received reimbursement from any source. The Model Contract provides, however, that such reimbursement “shall be limited to verifiable expenses.” Model Contract 3.6(e)(iii).

The Appellant claims it had \$135 million in reimbursable expenses going back to the beginning of the audit periods. (10/24/2024 submission, page 18.) It objects to the

OMIG's failure to recognize these alleged expenses in the audit findings. It does acknowledge the Department policy of conditioning payment of encounter reimbursements upon full recovery of disallowed capitation payments. It includes in its submission Department letters advising providers of this policy in 2017 and again in 2019 but asserts "This announced policy has never been adopted through agency rulemaking, nor incorporated in the Model Contract." (10/24/2024 submission, pages 9, 19; Exhibits 3, 4.) Notably missing from its submission is any mention of the Medicaid Update, with which the Model Contract obligates all MMC providers to comply, that also sets forth this policy.

Model Contract 37 provides: "The Contractor shall comply with all applicable guidance within the Medicaid Update publication issued by SDOH." The Medicaid Update that addresses the process for reimbursement of verifiable encounter expenses where an audit has identified inappropriately paid capitation payments, confirms that the reimbursement process takes place only after capitation payments have been identified and recovered in an audit:

The Plan may subsequently receive reimbursement for costs following the issuance of the Final Audit Report, and after the Plan has repaid all identified overpayments. New York State Medicaid Update – May 2017 Volume 33 Number 5.

In response to the OMIG's pointing out this Medicaid Update, the Appellant dismisses it as "an unconventional device: a newsletter," and argues it is inapplicable because it did not include in its examples of various "recovery scenarios" that are and are not eligible for encounter reimbursement, the specific reasons for the disenrollments in this case. (12/18/2024 submission, pages 3-4.) Model Contract 3.6(a) does set forth and include them among the relevant recovery scenarios. The 2017 Medicaid Update is

entirely consistent with the Model Contract and other Department guidance (Exhibits 3, 4) and contractors are required to comply with it. Model Contract 37.

The Appellant complains that the Model Contract does not condition payment of encounter reimbursements on the recovery of capitation payments (10/24/2024 submission, page 19), but neither does it condition recovery of capitation payments upon the payment of encounter reimbursements. They are separate processes. Recovery of capitation payments is the responsibility of OMIG. Subsequent approval and payment of encounter expenses is overseen by the Department's Office of Health Insurance Programs. (Logreira affidavit 10; 10/24/2024 submission, page 9.)

NYSDOH reimbursement procedure for costs incurred is as follows:

- On a semi-annual basis, NYSDOH will receive Plan audit recovery information from OMIG. This information will be reviewed...
- Upon completion of the data matching process, NYSDOH will share results with Plans...
- ... NYSDOH will initiate Plan specific reimbursements... Payment will then be processed.

New York State Medicaid Update – May 2017 Volume 33 Number 5.

Compliance in this case requires recovery of disallowed capitation payments before encounter claims can be processed by NYSDOH.

Contrary to the Appellant's claims, the Medicaid Update is indeed "guidance" that the Appellant can be expected to "comply with." (12/18/2024 submission, pages 4-5.) It is a rational implementation of the Department's procedure for reimbursement of verifiable encounter expenses under the Model Contract, because the issue of encounter reimbursements, processed by NYSDOH, arises only after it has been determined what capitation payments are disallowed, which is an OMIG responsibility. Conditioning encounter reimbursements on the actual recovery of the capitation payments is a reasonable procedure.

According to the Appellant, “Under Section 3.6 [of] the Model Contract, retroactive disenrollment thus restores the MCO to the same financial position as if the cancelled periods of enrollment had never occurred...” (10/24/2024 submission, page 9.) It is not evident where the Appellant derives this claim of an entitlement to being “restored to the same financial position.” The Model Contract does not contain this language. What the Model Contract does provide is that for recoveries of capitation payments for enrollees with other health insurance coverage:

SDOH shall reimburse the Contractor the cost of benefits for any encounter(s) that occurred during the applicable payment month(s) and for which the Contractor has not already received reimbursement from any source. Model Contract 3.6(e).

As the Appellant itself points out (10/24/2024 submission, page 9), encounter reimbursement is a separate process conducted in accordance with Department policy in place since at least 2017.

Neither the Model Contract nor any other Medicaid rule or regulation entitles the Appellant to be restored, at Medicaid Program expense, after having carried ineligible enrollees and collected capitation payments for eight years “to the same financial position as if the cancelled periods of enrollment had never occurred.” Such an entitlement would mean an MMC provider has nothing to lose by failing to investigate or ignoring information suggesting its enrollees are ineligible because of other coverage, because it will be restored at Medicaid Program expense to the “same financial position” whether it fulfills its obligation to make “diligent efforts” or not. This would eliminate any incentive for an MMC provider to make any effort to comply with its own obligation under 18 NYCRR 540.6(e)(6) and Model Contract 3.7, Appendix H(2)(c) & 7(b)(ii) to

make diligent, good faith efforts to determine whether there is third party health care coverage for which Medicaid is not responsible.

Interestingly, according to the Appellant “the true economic impact of OMIG’s retroactive disenrollments is that the State owes millions of dollars to Healthfirst.” (10/24/2024 submission, page 18.) The Appellant alleges it is owed \$135 million in encounter reimbursements for these ineligible enrollees over a period in which it was paid \$123 million in capitation payments for them. (10/24/2024 submission, pages 18-19.) Under the Model Contract, the Appellant had agreed to accept the \$123 million to cover the health care costs of these enrollees. The Appellant is now alleging “DOH owes Healthfirst \$12.3 million” more for carrying ineligible enrollees than it agreed in the first place to accept to provide health care for eligible enrollees. And this for enrollees who all along had other comprehensive health care coverage. According to the Appellant, it should be restored “to the same financial position as if the canceled periods of enrollment had never occurred” (10/24/2024 submission, page 9), while the Medicaid Program ends up paying \$135 million, not \$123 million, for health care services, managed by the Appellant, for ineligible enrollees who had other coverage. Under the Appellant’s view, then, it seems that the state will have achieved the opposite of, as the Appellant puts it, “the managed care model of Medicaid, by which the State transfers the administrative burden and risk of covering the benefits of Medicaid enrollees to a private company such as Healthfirst.” (10/24/2024 submission, page 5.)

Notably missing from the Appellant’s claims to be owed \$135 million in encounter reimbursement is mention of any efforts it made to verify and monitor the eligibility of its enrollees, to coordinate benefits or to recover these costs from third-party

insurers who were responsible for them. According to the Appellant, the OMIG “suggests with literally zero support that Healthfirst breached its own contractual duty to attempt to learn when its members had other health insurance... there are no factual findings supporting OMIG’s intimation that Healthfirst neglected its duties in this regard.” (12/18/2024 submission, pages 2, 8n6, 14-15.) The Appellant has the 18 NYCRR 519.18(d) burden of proof wrong:

The provider must reimburse Medicaid unless the provider can show that it undertook reasonable efforts to comply with 18 NYCRR 540.6(e)(6). VNS of NY v. NYS Department of Health, 13 A.D.3d 745, 786 N.Y.S.2d 623 (3rd Dept. 2004), *affirmed*, 5 N.Y.3d 499, 806 N.Y.S.2d 465 (2005).

The Appellant had an affirmative obligation under 18 NYCRR 540.6(e) and the Model Contract to make these efforts. It was the Appellant that requested this decision without hearing on the grounds that there are no factual issues to be resolved, without offering any factual findings to support any “intimation,” let alone meet its burden of proving, that it fulfilled “its duties in this regard.”

The Appellant points out that it remained “at risk” for the provision of services to enrollees until the Department disenrolled them. The delay in submitting verifiable expenses, however, can be attributed to the Appellant, which first erred in accepting capitation payments for enrollees who were ineligible, then failed to correct that error or submit expenses for reimbursement while it collected those payments for eight years until the overpayments were discovered by the OMIG.

While the Appellant complains the Department improperly refused to undertake the encounter reimbursements, it does not even allege that the capitation claims that had to be identified as recoverable before encounter reimbursement could be verified and assessed had been established before June 2022. (10/24/2024 submission, page 24.) The

audits under review here were done from September to November 2023. (10/24/2024 submission, page 10.) The final audit reports were issued in October and November 2023, and recoupment of the capitation payments was not completed until February 2024. According to the Appellant, as of August 2024 the encounter reimbursement process was proceeding in which, as the Appellant points out, “OMIG has carried out the [capitation recoupment], whereas the Office of Health Insurance Programs has generally overseen [encounter reimbursement].” (10/24/2024 submission, pages 9, 17; Logiera Affidavit 42-43.) This review process is completely consistent with the process set forth in the Medicaid Update, which is to review, verify, and pay encounter claims only after the relevant capitation payments have been identified and recovered.

Imposition of interest.

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)(1), 518.1. Interest may be collected on overpayments and will accrue from the date of the overpayment. Interest may be waived in whole or in part when the Department determines the imposition of interest would effect an unjust result or would unduly burden the provider. 18 NYCRR 518.4.

The Appellant claims these capitation payments are not 18 NYCRR Part 518 overpayments subject to the imposition of interest. (10/24/2024 submission, pages 25-30.) It asserts, inaccurately:

By definition, ‘overpayments’ are payments that were unauthorized at the time they were made; the term does not automatically extend to program payments later determined to be recoupable. (10/24/2024 submission, page 26.)

That is not the definition of an overpayment. As the Appellant itself goes on to state, “Section 518.1(c) defines ‘overpayments’ as ‘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.” (10/24/2024 submission, page 26.)

Payments under the Medicaid Program are not “authorized” simply because they were made. (12/18/2024 submission, pages 2, 8.) 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.

The Model Contract did not exempt the Appellant, a Medicaid provider, from the applicable Medicaid reimbursement rules and regulations. Model Contract 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 were made by mistake and 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. It complains it was “required” to provide services until disenrollment

without mentioning that it did not deny these enrollments pursuant to Model Contract Appendix H(6)(c)(ii), and then failed, for eight years between October 2015 and the September 2023 issuance of the draft audit reports, to identify and seek disenrollment of any of these ineligible enrollees itself.

The Appellant complains about the Department not disenrolling enrollees sooner, without acknowledging the significance of its own obligations under the Model Contract and 18 NYCRR 540.6(e). These enrollees all had other comprehensive health insurance coverage. Department regulations applicable to all Medicaid providers require, as a condition of payment, that all providers must take reasonable measures to investigate and ascertain the legal liability of third parties to pay for medical care and services.

The purpose of the entire paragraph (e) of 18 NYCRR 540.6, as indicated in its notice of adoption, is “[t]o provide a regulatory basis for requiring providers of medical assistance to pursue and utilize resources of third parties known to have a legal liability to pay for care and services otherwise available from [Medicaid], thus assuring that [Medicaid] remains a ‘payor of last resort’ ” (N.Y. Reg., Oct. 8, 1986, at 16)... if the provider failed to comply with the conditions of payment, namely by seeking out all other sources of payment before billing Medicaid, then the provider must reimburse Medicaid unless the provider can show that it undertook reasonable efforts to comply with 18 NYCRR 540.6(e)(6). VNS of NY v. NYS Department of Health, *supra*.

The Model Contract is replete with references to the MMC provider’s entitlement and responsibility in this regard:

The Contractor will make diligent efforts to determine whether Enrollees have third party health insurance (TPHI)... The Contractor shall make good faith efforts to coordinate benefits and must inform the LDSS of any known changes in status of TPHI insurance eligibility within five (5) business days of learning of a change in TPHI. Model Contract 3.7(a).

The Contractor must report any changes... that affect or may affect the eligibility... of its enrolled members to the NYSoH or LDSS, as appropriate, within five (5) business days of such information becoming known to the Contractor. Model Contract, Appendix H(2)(c)(ii).

The Contractor will make a good faith effort to identify cases which may be appropriate for an NYSoH or LDSS-initiated Disenrollment. Within five (5) business days of identifying such cases... refer cases which are appropriate for an NYSoH or LDSS-initiated Disenrollment. Model Contract, Appendix H(7)(b)(ii).

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 make efforts to identify, from 2015-2024, these concededly ineligible enrollees, report them to the Department, and take steps to coordinate coverage. The Appellant's submission of this 18 NYCRR 519.23 request without addressing this obligation implicitly concedes it has no relevant efforts to disclose.

The Appellant complains the Department did not expeditiously disenroll these enrollees, but it is also clear that 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 eight years for enrollees who all had comprehensive TPHI or government insurance, without investigating or detecting that error or seeking disenrollment until the capitation overpayments were revealed by the OMIG in this audit. The Appellant shares responsibility for the accumulation of interest on the capitation payments it received for eight 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 imposition of interest would unduly burden it but offered no evidence to substantiate it. 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

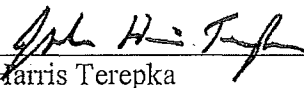
the Appellant to repay, with interest, money actually paid over to it during the audit periods is an undue burden. To assume otherwise is to remove any incentive for an MMC provider to make "diligent efforts" to avoid collecting capitation payments to which it is not entitled.

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

DECISION: The OMIG's determinations to recover Medicaid Program overpayments, with interest, are affirmed

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York
January 17, 2025



John Harris Terepka
Bureau of Adjudication