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BOA by scan
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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

Elliot E. Smeltzer, Esq.
NYS - OMIG
800 North Pearl Street
Albany, New York 12204

VNS Choice Select Health SNP
220 East 42nd Street, 3rd Floor
New York, New York 10017

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

RE: In the Matter of VNS Choice Select Health SNP

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	:	
	:	
VNS Choice Select Health SNP	:	Decision without
Medicaid ID # 03420871	:	hearing pursuant to
	:	18 NYCRR 519.23
	:	
from determinations by the NYS Office of the	:	
Medicaid Inspector General to recover Medicaid	:	#23-7575
Program overpayments.	:	#23-7584
	:	

Before: John Harris Terepka
Administrative Law Judge

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Elliot E. Smeltzer, Esq.
Elliot.Smeltzer@OMIG.ny.gov

VNS Choice Select Health SNP
220 East 42nd Street, 3rd Floor
New York, New York 10017
By: Casey Kyung-Se Lee, Esq.
Ropes & Gray LLP
1211 Avenue of the Americas
New York, New York 10036
Casey.lee@ropesgray.com

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 VNS Choice Select Health SNP (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 October 16 and 17, 2024. The parties agreed that the two hearings would be consolidated into one appeal.

By letter dated October 7, 2024, the Appellant requested a decision without hearing pursuant to 18 NYCRR 519.23. The OMIG submitted its response to the request on November 18, 2024. The Appellant submitted Exhibits A-E with its request. The OMIG submitted Exhibits 1-10 with its response. Although it was not authorized to do so by 18 NYCRR 519.23 or by the hearing officer, the Appellant submitted a reply on November 22, 2024, which has been considered in this decision.

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.

2. Pursuant to Section 3.1 of 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. (Exhibit A.)¹

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

SDOH [State Department of Health] 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.

4. The OMIG reviewed MMC capitation payments made to the Appellant, and identified enrollees who were simultaneously enrolled in and covered under third party health insurance (TPHI) (audit #23-7575), or under another government health insurance program (audit #23-7584) for the entire month for which a capitation payment was made to the Appellant.

5. On January 18, 2024 the OMIG issued draft audit reports in both audits, which were both received by the Appellant on January 22, 2024. (Exhibit 9.) The draft audit reports notified the Appellant that the OMIG had identified and determined to seek restitution of Medicaid Program overpayments in the amount of \$647,218.74 in audit #23-7575, and \$2,190,003.12 in audit #23-7584. (Exhibits 1, 5.)

6. The draft audit report for audit #23-7575 advised the Appellant that the \$647,218.74 overpayment claim included capitation payments made during the audit

¹ With its submission the Appellant produced and relied upon the March 1, 2019 Model Contract. (Exhibits A, B.) The Model Contract provisions quoted in the audit reports and relied upon by the OMIG are also as they appear in that contract. As both parties cite and rely on the 2019 version, it is concluded that both sides agree that the provisions relied upon by the parties are applicable to the entire audit period for both audits.

period March 1, 2019 through May 1, 2022 in the amount of \$539,450.58, plus interest from the date of each payment in the total amount of \$107,768.16. (Exhibits 1, 4.)

7. The draft audit report for audit #23-7584 advised the Appellant that the \$2,190,003.12 overpayment claim included capitation payments made during the audit period January 1, 2016 through February 1, 2020 in the amount of \$1,703,786.90, plus interest from the date of each payment in the amount of \$486,216.20. (Exhibits 5, 8.)

8. The draft audit reports advised the Appellant, pursuant to 18 NYCRR 517.5, that it had the opportunity to object to the proposed findings within 30 days of receiving them. The draft audit reports further advised the Appellant that pursuant to 18 NYCRR 519.18, the issues to be addressed at any administrative hearing would be limited to issues directly relating to the final determination and that the Appellant could not raise any new issue not submitted in response to the draft audit report. (Exhibits 1 & 5.)

9. On February 29, 2024, the OMIG issued final audit reports which stated that the Appellant had not responded to the draft audit reports and that, as a result, the final audit findings were unchanged from the draft. (Exhibits 2 & 6.)

10. On March 21, 2024, the OMIG issued "Revised Final Audit Reports" for both audits which both stated: "After reviewing the Plan's responses to OMIG's January 18, 2024 Draft Audit Report, OMIG has confirmed that the overpayment has not changed." (Exhibits 3 & 7.)

11. The Appellant did not submit any response or objections to either draft audit report.

12. 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 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. (Exhibits A, B.) 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 and Appendix H.

It is uncontroverted that capitation payments for the enrollees at issue were made by the Medicaid Program in the amounts and on the dates determined by the OMIG. (Exhibits 4, 8.) 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.

In its request for this decision without hearing, the Appellant objected to the recovery of the entire amount of the identified overpayments, and to the imposition of interest, and claimed it was required to and did incur expenses for the provision of care to

the enrollees which must be considered in connection with the OMIG's audit findings and overpayment determination. The OMIG argues that the Appellant failed to preserve these arguments because it did not respond to the draft audit reports. The Appellant did not produce nor does it claim it ever submitted a response to either draft audit report.

Recovery of capitation payments.

The Appellant does not challenge the Department's findings and determination that capitation payments identified in the audit reports were made during months when the enrollees had other coverage. 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. Pursuant to the express terms of the Model Contract 3.6(a) the OMIG is entitled to recover these payments.

The Appellant's argument (10/7/2024 submission, page 5) that capitation payments are not recoverable as 18 NYCRR Part 518 "overpayments" within the meaning of the regulations because they were paid in connection with the Model Contract is rejected. Every provider agrees, by enrolling in the Medicaid Program, to comply with Medicaid reimbursement regulations and the rules, regulations and official directives of the Department. 18 NYCRR 504.3. A Medicaid Program 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). "Overpayment" is also defined in the Model Contract itself as "any payment to the Contractor to which the Contractor is not entitled under the Medicaid program." Model Contract 1 at 1-10. The Appellant, an

enrolled Medicaid provider, received payments from the Medicaid Program to which it is not entitled because they were for enrollees who had other health care coverage. The Medicaid Program is entitled to recover the payments in accordance with state law and regulations and in accordance with the Model Contract. 18 NYCRR Part 518.

The Appellant asserts, inaccurately:

Under the regulations relevant to these appeals, “overpayments” are defined as unauthorized payments... the at-issue recouped capitation premiums cannot reasonably be characterized as “unauthorized” – they were expressly authorized under the Model Contract. (10/7/24 submission, page 5.)

While, as the Appellant says, capitation premiums in general “were expressly authorized under the Model Contract,” the specific capitation payments at issue in this case, for enrollees who in fact had comprehensive TPHI or other government coverage, were not. The Model Contract explicitly provides that the Department is entitled to recover capitation payments made for any enrollee later determined to have had other coverage. Model Contract 3.6(a).

Payments under the Medicaid Program are not “authorized” simply because they were made. 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, are overpayments that may be identified and recovered under both the Model Contract and under 10 NYCRR Part 518.

The Model Contract does not exempt the Appellant, a Medicaid provider, from the applicable Medicaid reimbursement rules and regulations. 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 insurance. As such they constitute recoverable overpayments within the meaning of 18 NYCRR Part 518.

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 argues it was required to remain responsible for the provision of care to these enrollees until they were formally disenrolled from its MMC program.

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).

Claims for encounter reimbursements.

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 the cost of benefits provided for any encounters that occurred during the

applicable payment months and for which it has not already received reimbursement from any source. Model Contract 3.6(e). The Appellant also invokes the 42 USC 1320a-7k(d)(4)(B) definition stating that “The term ‘overpayment’ means any funds that a person receives or retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such subchapter.”

The Model Contract goes on to provide that such reimbursement “shall be limited to verifiable expenses.” Section 3.6(e)(iii). The Appellant claims \$2,153,164.85 in “reimbursable verifiable expenses,” but it offered no evidence to verify these alleged expenses. It also offered no evidence whether it made any efforts to or did receive any reimbursement for them from the government or third-party insurers who covered these enrollees. Its so-called “Verifiable Expenses Calculation” of the alleged expenses consists of nothing more than a total dollar figure. (10/7/24 submission, page 2; Exhibit E.)

The Appellant complains it is being obligated to repay the capitation payments but is still waiting for reimbursement for its encounter expenses. The issue of encounter reimbursement, nowhere mentioned in the draft audit reports, was not raised by the Appellant in any response to the draft audit reports. Its complaints alleging delays in this reimbursement and that it is entitled to credit against the overpayment for encounter reimbursements are precluded because they raise “new matter” not considered by the Department in an objection to the draft audit reports. 18 NYCRR 519.18(a).

The OMIG is hardly advancing, as the Appellant dismissively characterizes it, a “Make-Believe Waiver Argument” as a “lead tactic.” (11/22/24 submission, page 1.) There is nothing “make-believe” about 18 NYCRR 519.18(a). A Medicaid provider’s

failure to bring issues to the attention of the OMIG during the audit by response to a draft audit report has clearly defined and well-established consequences that have been repeatedly upheld in the courts. Wegman v. NYS Dept. of Health, 229 A.D.3d 862, 215 N.Y.S.3d 562 (3rd Dept. 2024); Beth Israel Medical Center v. OMIG, 221 A.D.3d 446, 198 N.Y.S.3d 64 (1st Dept. 2023); Staten Island Care Center v. Zucker, 212 A.D.3d 489, 181 N.Y.S.3d 552 (1st Dept. 2023); Rego Park Nursing Home v. Perales, 206 A.D.2d 781, 615 N.Y.S.2d 773 (3rd Dept. 1994); Westmount Health Facility v. Bane, 195 A.D.2d 129, 606 N.Y.S.2d 832 (3rd Dept. 1994). The Appellant did not raise any issues or even respond to the draft audit reports, although it was specifically advised in the draft audit reports that it was required to do so in order to preserve them for review.

The OMIG's reliance on Department regulations in its conduct of the audits and issuance of final audit reports hardly constitutes, as the Appellant claims, a "tactic to deprive VNS Health of 'due process' in this proceeding, which 'requires that there be an opportunity to present every available defense.'" (11/22/24 submission, page 1.) The draft audit reports made no mention of encounter reimbursement because it has, in the OMIG's view, no relevance to the audit findings. The Appellant was afforded due process and the opportunity to present "every available defense" that it claimed was relevant by submitting, as instructed, a response to those draft audit reports. It was incumbent upon the Appellant to raise any issue it wanted the OMIG to consider if it wanted to preserve it for subsequent review, and it chose not to do so. Having raised no issues at all in response, indeed having failed to even respond to the draft audit reports, the Appellant is precluded from raising these issues in this proceeding.

The Appellant's argument (11/22/24 submission, pages 1-2) that because it has requested a decision without hearing pursuant to 18 NYCRR 519.23 it has become retroactively excused from the 18 NYCRR 519.18(a) requirement of raising any new matter in a response to the draft audit reports is without merit. The OMIG's 519.18(a) objection, based on the very same Part 519 regulations in which 519.23 appears, is hardly an attempt to "smuggle into Section 519.23" (11/22/24 submission, page 2) an unrelated regulation that does not apply to it. This is an 18 NYCRR Part 519 Provider Hearing. It is taking place because the Appellant invoked it by making a request pursuant to 18 NYCRR 519.4&7. The Appellant's subsequent 519.23 request was made pursuant to those same Part 519 hearing procedures and was submitted long after the draft audit reports were issued and the time to object to them expired, and after this Part 519 hearing was requested and scheduled. Section 519.23 is simply a method, invoked by the Appellant, of narrowing the issues and proceedings necessary to conduct the Part 519 hearing and decide it. It does not retroactively excuse the Appellant from compliance with 18 NYCRR 519.18, 517.5(b), or indeed any other provisions of Parts 517 or 519.

The question whether the Appellant actually incurred costs for care, in addition to being 18 NYCRR 519.18(a) "new matter," is in any event beyond the scope of this hearing. 18 NYCRR Part 519 regulations "govern the hearing process for providers of medical assistance and other persons sanctioned by the department or from whom the department requests repayment of overpayments or restitution." 18 NYCRR 519.1. It is beyond the scope of this audit hearing to direct or review the processing or amount of alleged encounter expenses, which are separately reimbursed and are not adjustments of capitation payments. Model Contract 3.6(e)(i)&(ii).

Encounter reimbursement is limited to “verifiable expenses,” and “the submission of costs for reimbursement, shall be made pursuant to Appendix H of this Agreement and Guidelines developed by SDOH.” Model Contract 3.6(e)(iii)&(iv). The Department has developed guidelines and a process for encounter reimbursements which is set forth in a Medicaid Update with which, pursuant to Model Contract 37, MMC providers are required to comply:

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.

The Model Contract makes it very clear that the Department is entitled to recover capitation payments made for enrollees with other insurance. The Model Contract and Department regulations also make it clear that the Appellant had an ongoing obligation to make “diligent” and “good faith” efforts identify any third-party coverage and to coordinate benefits in order to reduce or eliminate improper capitation payments and its own verifiable encounter expenses. 18 NYCRR 540.6(e); Model Contract 3.7(a). Requiring the OMIG to correctly identify and credit verifiable encounter expenses before it can recover unauthorized capitation payments would eliminate any incentive for a Medicaid Managed Care provider to make any effort to comply with these obligations. It could simply collect capitation payments, in this case for eight years, with nothing to lose when and if the Department eventually learns they were improperly paid.

If the Appellant believes it is now entitled to reimbursement from the Medicaid Program for actual health care expenditures for which it did not receive reimbursement from any other source, it may pursue that entitlement by establishing its “verifiable expenses” in accordance with the “Guidelines developed by SDOH.” Model Contract

3.6(e)(iii)&(iv). It is not entitled in this proceeding to a review of its alleged entitlement to such reimbursement.

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 failed to raise any objection to the OMIG's interest determinations in response to the draft audit reports. Having offered no notice of or explanation for any disagreement with the interest determinations in the draft audit reports, it is precluded from arguing the issue at this hearing. 18 NYCRR 519.18(a); Staten Island Care Center v. Zucker, *supra* (failure to object to interest calculation precluded review of it); Westmount Health Facility v. Bane, *supra* (reversing a lower court decision that allowed an Appellant to raise an unpreserved objection to a disallowance of interest).

It is noted that the Appellant claims, without presenting any supporting information, that "In an about-face from its prior practices with VNS Health, OMIG charged VNS Health interest on Medicaid capitation premiums.... The Final Audit Reports do not provide any rationale for OMIG's U-turn." (10/7/24 submission, page 3.) The Appellant offered nothing to substantiate this claimed "U-turn." While it claims "OMIG cannot deny that it has never previously imposed interest on VNS Health for overpayments recovered due to TPHI" (10/7/24 submission, page 4), it did not identify

any previous final audit report in which the OMIG allegedly waived interest on capitation overpayments for enrollees with TPHI or government health insurance. In any event, the draft audit reports clearly put the Appellant on notice that interest was being imposed in the audits under review, and the Appellant failed to raise any objection to them.

The imposition of interest is explicitly authorized by 18 NYCRR 518.4. The OMIG may have discretion to waive interest, but it is not obligated, as the Appellant claims, to explain why it has determined to apply and not waive the regulation in this audit. The burden is on the Appellant to establish an abuse of discretion, and a bare allegation of an “about-face” does not meet that burden.

The Appellant also argues that the imposition of interest in this case would effect an unjust result because “the circumstances leading to OMIG’s recovery of capitation premiums are beyond VNS Health’s control.” (10/7/24 submission, page 4.) The Appellant’s claim “VNS did nothing wrong” (10/7/24 submission, page 7) is difficult to square with its failure to comply for eight years with its obligations under the Model Contract and under Department regulations to make efforts to identify these concededly ineligible enrollees and report them to the Department for disenrollment.

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. 18 NYCRR 540.6(e).

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, 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 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 acknowledges having been instructed by the Department to notify the Department if a member with TPHI can be disenrolled. (11/22/24 submission, pages 2-3, *citing* N.Y. State Dep't of Health, *Frequently Asked Questions (FAQs) for 834 Transactions*, <https://www.emedny.org/HIPAA/5010/834FAQs> (QID: L180.))

Notably missing from the Appellant's submissions is a discussion of its compliance with these obligations. The circumstances were not entirely, as the Appellant argues, "beyond VNS Health's control – and squarely in DOH's control." (10/7/2024 submission, page 4.) Having itself failed to review and identify the ineligibility of these enrollees, the Appellant shares responsibility for the accumulation of interest on the improper capitation payments it received.

The Appellant complains it was “required” (10/7/2024 submission, page 7) 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 January 2016 and the January 2024 issuance of the draft audit reports, to itself identify and seek disenrollment of any of these ineligible enrollees. The Appellant complains the Department did not expeditiously disenroll them, 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 were ineligible for them, without investigating or detecting that error or seeking disenrollment until the capitation overpayments were revealed by the OMIG in this audit. 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, explicitly authorized by 18 NYCRR 518.4, is an abuse of discretion. The Appellant asserts imposition of interest would unduly burden it but did not timely raise this objection in response to the draft audit reports and 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 period is an undue burden. To assume otherwise is to remove any incentive for an MMC provider 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 determination to recover Medicaid Program overpayments, with interest, is 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