Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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O.K. to post w/redactions.
4-4-17 gs

IN THE MATTER OF:

AngleZ Behavioral Health Services)
Annalee Morris-Polley, CEO) **FINAL DECISION**
15 Old Western Avenue)
Winthrop, ME 04364)

This is the Department of Health and Human Services' Final Decision.

The Recommended Decision of Hearing Officer Thackeray, mailed February 17, 2017 has been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that the Department was correct when, for the review period of 2/13/2013 to 7/20/2013, it determined that AngleZ Behavioral Health Services owes the Department the sum of $392,603.31, related to assessment not being completed in a timely manner, invalid treatment plans, documentation not supporting the hours billed, and other documentation errors.

DATED: 3/22/17 SIGNED: _____
MARY C. MAYHEW, COMMISSIONER
DEPARTMENT OF HEALTH & HUMAN SERVICES

YOU HAVE THE RIGHT TO JUDICIAL REVIEW UNDER THE MAINE RULES OF CIVIL PROCEDURE, RULE 80C. TO TAKE ADVANTAGE OF THIS RIGHT, A PETITION FOR REVIEW MUST BE FILED WITH THE APPROPRIATE SUPERIOR COURT WITHIN 30 DAYS OF THE RECEIPT OF THIS DECISION.

WITH SOME EXCEPTIONS, THE PARTY FILING AN APPEAL (80B OR 80C) OF A DECISION SHALL BE REQUIRED TO PAY THE COSTS TO THE DIVISION OF ADMINISTRATIVE HEARINGS FOR PROVIDING THE COURT WITH A CERTIFIED HEARING RECORD. THIS INCLUDES COSTS RELATED TO THE PROVISION OF A TRANSCRIPT OF THE HEARING RECORDING.

cc: Thomas Bradley, AAG, Office of the Attorney General
Kelli Johnson, DHHS/Program Integrity

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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Date Mailed: FEB 17 2017

Mary C. Mayhew, Commissioner
Department of Health and Human Services
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Augusta, ME 04333

In the Matter of: AngleZ Behavioral Health Services NPI ID No. 1457691263

ADMINISTRATIVE HEARING RECOMMENDED DECISION

An administrative hearing in the above-captioned matter was initially convened on June 9, 2016, before Hearing Officer Richard W. Thackeray, Jr., at Augusta, Maine, and finally convened on October 25, 2016. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner of the Maine Department of Health and Human Services. The hearing record was left open through November 28, 2016, to allow submission of written closing arguments.

Pursuant to an Order of Reference dated March 30, 2016, the issue presented *de novo* for hearing were whether the Maine Department of Health and Human Services ["Department"] was "correct when for the review period of [redacted]/2013 through [redacted]2013, it determined that AngleZ Behavioral Health Services ["AngleZ"] owes the department $430,979.95 because of overpayments as a result of assessments not being completed in a timely manner, invalid treatment plans, documentation not supporting the hours billed, and other documentation errors?" Ex. D-1a.

APPEARING ON BEHALF OF THE APPELLANT

- Annalee Morris-Polley, RN, CEO, AngleZ Behavioral Health Services
- Pamela J. Boivin, Ph.D., JD, Mental Health Services Director, AngleZ Behavioral Health Services

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Greg Nadeau, Program Manager, OMS Program Integrity, Division of Audit, Augusta
- Kelli Johnson, RN, DHHS, Augusta

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Notice of an Administrative Hearing," dated April 5, 2016
HO-2 "Fair Hearing Report Form," dated March 28, 2016
HO-3 "Appointment of an Authorized Representative," dated April 26, 2016

HO-4 "Entry of Appearance," dated April 21, 2016
HO-5 "Administrative Prehearing Order" (corrected), dated April 15, 2016
HO-6 "Prehearing Brief," AngleZ Behavioral Health Services, dated May 4, 2016
HO-7 "Prehearing Brief," Department of Health and Human Services, dated May 13, 2016
HO-8 "Reschedule Notice," dated June 14, 2016
HO-9 "Continuance Request" (unopposed), dated June 22, 2016
HO-10 "Reschedule Notice," dated June 28, 2016
HO-11 "Approved Continuance Request" (unopposed), dated August 22, 2016
HO-12 "Reschedule Notice" (corrected), dated August 24, 2016

Department Exhibits

D-1 "Order of Reference," dated March 30, 2016
D-2 "Emergency Rule - Adopted," effective date December 12, 2012
D-3 "Emergency Rule - Adopted," effective date March 26, 2013
D-4 "Final Rule," effective date June 24, 2013
D-5 "Final Rule," effective date November 1, 2011
D-6 "Final Rule," effective date October 1, 2009
D-7 "Final Rule," effective date December 12, 2007
D-8 "MaineCare/Maine Health Program Provider/Supplier Agreement," dated February 15, 2013
D-9 "Notice of Violation," dated December 24, 2014
D-10 "Final Informal Review Decision," dated January 7, 2016
D-11 "Treatment Records," [redacted] dated [redacted] 2013
D-12 "Treatment Records," [redacted], dated [redacted] 2013
D-13 "Treatment Records," [redacted], dated [redacted] 2013
D-14 "Treatment Records," [redacted], dated [redacted] 2013
D-15 "Treatment Records," [redacted] dated [redacted] 2013
D-16 "Treatment Records," [redacted], dated [redacted] 2013
D-17 "Treatment Records," [redacted] dated [redacted] 2013 & [redacted], 2013
D-18 "Treatment Records," [redacted], dated [redacted] 2013
D-19 "Treatment Records," [redacted] dated [redacted] 2013 & [redacted] 2013
D-20 "Treatment Records," [redacted], dated [redacted] 2013
D-21 "Treatment Records," [redacted], dated [redacted] 2013
D-22 "Closing Argument" and attached "Revised Recoupment" spreadsheet, Dep't of Health and Human Services, dated November 28, 2016

Appellant Exhibits

A-1a "Request for Informal Review," dated February 20, 2015, with attached "Response Document from AngleZ Behavioral Health Services" (redacted)
A-1b "Notice of Appeal," dated March 4, 2016
A-1c "Addn'l Information on the Notice of Violation to NPI # 1457691263," dated May 31, 2016
A-2 "Audit 2013 – 100 Cases"

A-3 "CAFAS Assessment Report," [redacted], dated June 7, 2013
A-4 "7 ABHS Program Areas"
A-5 "Records," [redacted], dated [redacted] 13, 2013
A-6 "Records," [redacted], dated [redacted] 2013
A-7 "Records," [redacted] dated [redacted], 2013
A-8 "Records," [redacted], dated [redacted] 013
A-9 "Records," [redacted] dated [redacted] 013
A-10 "Records," [redacted], dated [redacted], 2013
A-11 "Records," [redacted] dated [redacted] 2013
A-12 "Records," [redacted], dated [redacted] 2013
A-13 "Loss Summary," MEMIC, dated April 29, 2013
A-14 "Records," [redacted] dated [redacted] 013
A-15 "Records," [redacted], dated [redacted] 2013
A-16 "Records," [redacted], dated [redacted] 013
A-17 "Records," [redacted], dated [redacted], 2013
A-18 "Records," [redacted], dated [redacted] 2013
A-19 "Records," [redacted], dated [redacted] 2013
A-20 "Records," [redacted] dated [redacted] 2013
A-21 "Records," [redacted], dated [redacted] 2013
A-22 "Records," [redacted], dated [redacted] 2013
A-23 "Records," [redacted], dated [redacted] 2013
A-24 "Records," [redacted], dated [redacted] 2013
A-25 "Records," [redacted], dated [redacted] 013
A-26 "Records," [redacted], dated [redacted] 013
A-27 "Records," [redacted], dated [redacted] 2013
A-28 "Records," [redacted], dated [redacted] 013
A-29 "Records," [redacted], dated [redacted] 2013
A-30 "Records," [redacted] dated [redacted] 013
A-31 "Records," [redacted] date[redacted] 2013
A-32 "Records," [redacted], dated [redacted] 2013
A-33 "Records," [redacted], date[redacted] 2013
A-34 "Records," [redacted] dated [redacted] 2013
A-35 "Records," [redacted], date[redacted] 2013
A-36 "Records," [redacted], dated [redacted] 2013
A-37 "Email," dated February 12, 2016
A-38 "Adult Locus Scoring Sheet"
A-39 unassigned
A-40 "Module 9: Health and Safety"
A-41 "Module 11: Maine's Mental Health System and Related Resources"
A-42 "Written Closing Statement" and attachments, dated November 28, 2016

STANDARD OF REVIEW

The hearing officer reviews the Department's claim for recoupment against an approved MaineCare services provider *de novo*. DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (C)(1); Provider Appeals, MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (A). The Department bears the burden to persuade the Hearing Officer that, based on a preponderance of the evidence, it was correct in establishing a claim for repayment or recoupment against an approved provider of MaineCare services. 10-144 C.M.R. Ch. 1, § VII (B)(1), (2).

LEGAL FRAMEWORK

The Department administers the MaineCare program, which is designed to provide "medical or remedial care and services for medically indigent persons," pursuant to federal Medicaid law. 22 M.R.S. § 3173. *See also* 42 U.S.C. §§ 1396a, *et seq*. To effectuate this, the Department is authorized to "enter into contracts with health care servicing entities for the provision, financing, management and oversight of the delivery of health care services in order to carry out these programs." *Id.* Enrolled providers are authorized to bill the Department for MaineCare-covered services pursuant to the terms of its Provider Agreement, Departmental regulations, and federal Medicaid law. "Provider Participation," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03. *See also* 42 C.F.R. § 431.107 (b) (state Medicaid payments only allowable pursuant to a provider agreement reflecting certain documentation requirements); 42 U.S.C. § 1396a (a)(27). Enrolled providers also "must … [c]omply with requirements of applicable Federal and State law, and with the provisions of this Manual." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (Q). Enrolled providers are also required to maintain records sufficient to "fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (M). "The Division of Audit or duly Authorized Agents appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.16. Pursuant to federal law, the Department is also authorized to "safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.17. *See also* 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.18; 22 M.R.S. § 42 (7); 42 U.S.C. § 1396a (a)(27); 42 C.F.R. § 431.960. This includes the imposition of "sanctions and/or recoup(ment of) identified overpayments against a provider, individual, or entity," for any of 25 specific reasons for which it may including:

- Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise;
- Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
- Failing to retain or disclose or make available to the Department or its Authorized Agent contemporaneous records of services provided to MaineCare members and related records of payments;

- Breaching the terms of the MaineCare Provider Agreement, and/or the Requirements of Section 1.03-3 for provider participation;
- Failure to meet standards required by State and Federal law for participation (e.g. licensure or certification requirements). ...

MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-1 (D).

The Department bears the initial burden to prove "by a preponderance of evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (G). Once that threshold proof has been made, the Department is afforded discretion to recoup a penalty. The scope of that penalty, however, is limited by the degree to which the provider is able to demonstrate that the billed services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. *Id.* The regulations provide that, "[w]hen the Department proves by a preponderance of the evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services, the Department in its discretion may impose the following penalties:

1. A penalty equal to one hundred percent (100%) recoupment of MaineCare payments for services or goods, if the provider has failed to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members.
2. A penalty not to exceed twenty-percent (20%), if the provider is able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. The penalty will be applied against each MaineCare payment associated with the missing mandated records.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (G).

To investigate and establish a Section 1.19 sanction, the Department may employ "surveillance and referral activities that may include, but are not limited to:

A. a continuous sampling review of the utilization of care and services for which payment is claimed;

B. an on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;

C. an extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;

D. a post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;

E. the implementation of the Restriction Plans (described in Chapter IV of this Manual);

F. referral to appropriate licensing boards or registries as necessary; and

G. referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases where fraudulent activity is suspected.

H. a determination whether to suspend payments to a provider based upon a credible allegation of fraud.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.18.

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, the AngleZ Behavioral Health Services ["AngleZ"] was properly notified of the time, date, and location of the immediate proceeding. Ex. HO-1; Ex. HO-8; Ex. HO-10; Ex. HO-12.

2. AngleZ is a behavioral health services provider based in Winthrop that opened its practice in 2013. Ex. D-8.

3. Effective February 15, 2013, AngleZ entered into a "Medicaid/Maine Health Program Provider/Supplier Agreement" with the Department, through which AngleZ became able to receive reimbursement from the Department for provision of covered medical and related services to enrolled members of the MaineCare program. Ex. D-8.

4. On September 6, 2013, the U.S. Department of Health and Human Services' Office of Inspector General ["OIG"] ordered the Department to review billing claims submitted by AngleZ, using random selection of 100 dates of service within an identified review period of [redacted] 2013 to [redacted] 2013. Ex. D-9.

5. On or about September 6, 2013, OIG obtained all claims billing records submitted by AngleZ to the Department during the [redacted] 2013 to [redacted], 2013 period and determined that MaineCare reimbursed AngleZ's for a total of $613,929.18 for claims associated with the following programs: Community Integration Services (H2015), Daily Living Support Services (HO2017), Skills Development Services (H2014), Comprehensive Assessment (H2000), Outpatient Therapy (H0004), Medication Management (H2010), Home and Community Based Treatment (H2021), Targeted Case Management (T1017), and Therapeutic Behavioral Services (H2019). Such claims were more specifically paid out in the following amounts in the corresponding months:

- $17,620.14 ([redacted] 2013)
- $67,464.22 ([redacted] 2013)
- $93,846.87 ([redacted] 2013)
- $140,149.78 ([redacted] 2013)
- $158,061.08 ([redacted] 2013)
- $137,317.97 ([redacted] 2013)

Ex. D-9.

6. Of the 100 sets of reviewed claims paid on the randomly-selected dates between [redacted] 2013 and [redacted] 2013, the Department initially identified an error rate of 80.25 percent where it found

that $10,178.89 of the $12,683.82 paid by the Department toward those claims should not have been paid due to missing records, or otherwise being non-reimbursable or unacceptable as billed. Ex. D-9.

7. On December 24, 2014, the Department issued a "Notice of Violation" against AngleZ, in which it alleged a total overpayment in the amount of $492,684.09, derived from applying the 80.25 percent error rate against the amount in total claims it paid AngleZ from [redacted] 2013 to J[redacted] 2013 ($613,929.18). Ex. D-9.

8. On February 20, 2015, AngleZ timely requested an informal review of the Department's "Notice of Violation," and more specifically alleged the following in defense:

- Section 17 does not bar a provider's use of an Individual Service Plan ["ISP"] or Comprehensive Assessment developed by another agency;
- Section 17 allows initiation of services before completing an assessment where needed to address an immediate psychiatric need and/or avoid a crisis situation and provide stability;
- Identified instances of non-covered Section 17 services (i.e. housekeeping) were actually coverable as "cueing and prompting a member to manage their home environment";
- Vague Section 17 DLS services definition should be read as allowing coverage of any activities provided to "help members remain oriented, healthy, and safe";
- No penalty should be established based on provider's use of "words taken directly from the MBM" in documenting a member's treatment notes;
- It is "unfair" to seek 100 percent recoupment for claims where reauthorization was granted without additional documentation;
- The Department should not assess penalties for variance in billing claims that were tacitly approved by the Department's authorized agent, APS HealthCare (now "KEPRO Health");
- No penalties should be assessed for Targeted Case Management notes that were entered by individuals without a clear record of those individuals' credentials;
- The Department should not base penalties upon alleged documentation errors/overbilling reflected within informal records, like employee shift calendars;
- The extrapolation method utilized by the Department was flawed whether it applied the 80.25 percent error rate across all seven AngleZ programs, and would have more accurately reflected the alleged errors if individual error rates were identified and extrapolations made within each of the audited programs;
- For several claims, if any penalty is imposed, it should be done at the 20 percent rate rather than the 100 percent rate, where the alleged errors were associated with delivered services;
- Reference to unsubstantiated allegations of fraud against AngleZ professionals are not relevant to the establishment of a recoupment claim against AngleZ;
- The recoupment claim against AngleZ should be established at an amount no greater than $14,734.30, based on recalculations done by AngelZ.

Ex. A-1a.

9. On January 7, 2016, the Department issued a "Final Informal Review Decision" against AngleZ, reflecting changes it deemed appropriate in light of the arguments raised by AngleZ in its "Request for

Informal Review," dated February 20, 2015. The Department revised its findings with respect to 16 of the identified claims, and found overpayments totaling $8,904.08 of the $12,683.82 paid by the Department in the 100 claims, reflecting an error rate of 70.20 percent. Applying the 70.20 percent error rate, the Department identified a recalculated recoupment claim amount of $430,979.95. Ex. D-10.

10. On March 4, 2016, AngleZ timely requested an administrative hearing. With its Notice of Appeal, AngleZ more specifically identified the following arguments against the Department's Final Informal Review Decision:

- AngleZ method of practice was consistent with the Department's provider training materials, which should preclude the Department from identifying the same methods of practice was grounds for violation and/or sanction;
- A 100-percent recoupment is only allowable for three types of violations, which are also included within the definition of "fraud," and is thus, not allowable against AngleZ because a separation investigation concluded without reaching a finding of fraud by AngleZ;
- Recoupment for any wrongly billed claims identified by the Department should be limited to 20-percent, where there was no proof of fraud by AngleZ;
- The Department's use of extrapolation across all seven of AngleZ's programs was not appropriate, where the claims identified by the Department as wrongly-billed were wholly confined to four of those programs;

Ex. A-1b.

11. After the parties presented their cases-in-chief at hearing, the Department reviewed its recoupment claim in light of new evidence and/or explanation received from AngleZ. In its written closing statement dated November 28, 2016, the Department "amend[ed] its recoupment demand to $392,603.31" after allowing payment for claims previously included in the overpayment and re-calculating the error rate as 63.95 percent. Ex. D-22.

RECOMMENDED DECISION

The Department was correct when, for the review period of [redacted] 2013 to [redacted] 2013, it determined that AngleZ Behavioral Health Services owes the Department the sum of $392,603.31, related to assessments not being completed in a timely manner, invalid treatment plans, documentation not supporting the hours billed, and other documentation errors.

REASONS FOR RECOMMENDATION

As noted above, the Department bore the burden at hearing to demonstrate by a preponderance of evidence that it correctly established the amount of its recoupment claim against AngleZ, identified in its January 7, 2016 Final Informal Review Decision in the amount of $430,979.95, for reasons supported by the MaineCare statutes and regulations. At hearing, the Department described the process by which it

employed random sampling of AngleZ's billing claims to investigate and establish that AngleZ was incorrectly reimbursed for certain behavioral health services provided for its patient/clients. Test. of Greg Nadeau; Test. of Kelli Johnson. Partial to this, the Department demonstrated that it sought 100 percent recoupment of specific claims where AngleZ had not shown that the questioned services had been medically necessary, covered services, and actually provided to eligible MaineCare members, and that it limited its recoupment to 20 percent of billed/paid amounts for documentation errors where it was satisfied that the underlying services had been medically necessary, covered services, and actually provided. Test. of Greg Nadeau; Test. of Kelli Johnson.

Thereafter, AngleZ responded with additional evidence in support of its arguments that its documentation was proper and/or made in support of delivered, medically-necessary, covered MaineCare services. Test. of Annalee Morris-Polley; Test. of Pamela J. Boivin, Ph.D. In closing, the Department revised its recoupment claim to reflect new findings that several errors initially assigned the 100 percent recoupment factor were either more appropriately recoverable at 20 percent or not at all. Ex. D-22. Thus, the final analysis requires review of the Department's final recoupment claim figure identified in its closing argument, i.e. $392,603.21, in light of the arguments and evidence presented by AngleZ at hearing. That issue-by-issue analysis follows below.

Method of Extrapolation Employed by the Department in Establishing Recoupment Claim

There was no essential dispute between the parties as to the Department's authority to use "an extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare" as a method by which it could determine a claim for recoupment for identified provider violations. 10-144 C.M.R. Ch. 101, sub-Ch. I, §§ 1.18 (C), 1.19-4 (C). However, AngleZ argued that the Department's method of extrapolation irrationally established penalties against AngleZ by uniformly applying the error rate factor to claims across all of seven of its highlighted programs rather than in proportion to the number of errors identified in each program. As noted in its closing statement, Angles argued:

> While ABHS recognizes this statute allows for extrapolation, the statute is silent as to allowable extrapolation across programs that were not audited. The audit in question only pulled random samples on six out of the seven of ABHS's program areas. Upon audit review only four out of the seven programs resulted in having recoupment monies identified. Additionally, out of those four programs OPT was found to have one violation ... and one other of the four programs, CCM, was found to have only three violations. ... Therefore, this leaves two ABHS program areas (ACM and DLSS) that were truly audited.
>
> [B]ecause client needs and services vary from program to program, that documentation for each program differs as well. Based on vagueness of statute, and the fact that the audit only truly addressed two program areas ... the extrapolation should only be appropriately applied to those two programs. ... [A]ny recoupment amount should be associated within the records and programs sampled; and any extrapolation applied to the programs with which there was no recoupment associated would be unjustified, and therefore, inappropriate.

Ex. A-42.

The Department acknowledged that 90 percent of the claims submitted by AngleZ during the [redacted] 2013 to [redacted] 2013 review period were for Section 17 MaineCare services, i.e. daily living support ["DLS"] services, community integration ["CI"] services, skills development services ["SDS"], and comprehensive assessment, "with the remainder split evenly between Section 13 [Targeted Case Management] and Section 65 claims." Ex. D-22. On June 9, 2016, former Program Integrity Program Manager Greg Nadeau testified about the methodology employed by the Department in identifying the sample and making extrapolation therefrom:

> We took all claims during that time period, and that created our universe of claims. And then what we did is we did a random sample of 100 claims out of that universe. And that gives us a statistically ... it allows us to extrapolate based on the error rates that was in the sample. What we found was a distribution of ... we found three particular sections of policy that were being billed – Section 13, Section 17, and Section 65. We found that about 90 percent of the claims were in Section 17, approximately five percent in each of 13 and 65, and ... our sample actually reflected almost exactly the same numbers.

Test. of Greg Nadeau.

In its closing argument, the Department defended its extrapolation methodology, noting that if it extrapolated claims in the manner urged by AngleZ, the provider would have been exposed to an even larger recoupment claim, more specifically explaining:

> To isolate programs as organized internally by AngleZ for sampling, or to fashion the sampling based on the providers' internal organization is contrary to the concept of the random sampling used by the Department and could involve the Department in cherry-picking for results within each provider, which again would be inconsistent with the Department's sampling methodology.

Ex. D-22.

Based on the evidence and arguments presented, it should be concluded that the Department employed a permitted form of claims review when it elected to perform an extrapolation based on a random sampling of claims submitted by a provider and paid by MaineCare, and that its sample was reasonably representative of the claims universe for AngleZ during the [redacted] 2013 to [redacted] 2013 review period.[1]

Timing of Comprehensive Assessments and ISP Development under Section 17

AngleZ's second set of arguments against the Department's recoupment claim concerned its documentation efforts related to Comprehensive Assessments required under Section 17 of the

[1] In its closing argument, AngleZ also argued that it was entitled to its own re-extrapolation of the Department's recoupment claim based on AngleZ's re-classification of the error rate to which the Department "agreed" at hearing. Ex. A-42. As noted above, Departmental regulations authorize the Department to extrapolate an error rate based on the sample it identifies. The hearing officer has determined that the revised sample was reasonably representative of the claims universe, such that the reduced recoupment claim that the Department established after re-assessing the claims discussed at hearing was also rationally derived. As such, the hearing officer gives no weight to the supplemental extrapolation urged by AngleZ in its closing argument.

MaineCare Benefits Manual. The December 24, 2014 Notice of Violation identified several categories of documentation errors in the AngleZ sample, including but not limited to:

- Missing documentation
- Missing timely clinician review/signatures/diagnostic information
- Illegible signatures, credentials, non-qualified staff signing Comprehensive Assessments
- Invalid Comprehensive Assessments
- Invalid Treatment Plans (ITP)
- Treatment Plans do not relate to Comprehensive Assessments
- Adoption of Comprehensive Assessments issued by other mental health providers

Ex. D-9.

The generally applicable regulations in effect at the time of the review period required all MaineCare providers to "[m]aintain and retain contemporaneous financial, provider, and professional records sufficient to fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member," and that:

> Records must be consistent with the unit of service specified in the applicable policy covering that service. Records must include, but are not limited to all required signatures, treatment plans, progress notes, discharge summaries, date and nature of services, duration of services, titles of persons providing the services, all service/product orders, verification of delivery of service/product quantity, and applicable acquisition cost invoices. Providers must make a notation in the record for each service billed. For example, if a service is billed on a per diem basis the provider must make a notation for each day billed. If a service is billed on a fifteen (15) minute unit basis, a notation for each visit is sufficient.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (M) (eff. Dec. 28, 2012).

As noted above, the Department was thereafter authorized to apply a tiered penalty schedule – 100 percent vs. 20 percent – based on its determination about the underlying MaineCare services as to whether the provider had demonstrated 1). medical necessity of the underlying service, 2) that the service was a covered service, and 3) that the service had been actually provided to an eligible MaineCare member. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (G).

The Section 17 regulations in effect during the review period specifically described the process and order of documentation that had to be followed for a service to be reimbursable through MaineCare. CI services. For example, CI services had to be performed by an individual certified as a Mental Health Rehabilitation Technician/Community, or MHRT/C, and had to include the following specific services/tasks:

- identify the medical, social, residential, educational, vocational, emotional, and other related needs of the member;
- perform a comprehensive psychosocial assessment, including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general

capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs;

- develop an Individual Support Plan ["ISP"] that is based on the results of the comprehensive assessment in Section 17.04-1(B), which includes:
  1. statements of the member's desired goals and related treatment/rehabilitation goals;
  2. a description of the services and natural supports needed by the member to address the goals;
- draft a statement for each goal of the frequency and duration of the needed service(s) and supports;
- identify providers of the needed services and natural supports;
- identify and document the member's unmet needs;
- review the ISP at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary;
- coordinate referrals, and advocate access by the member to the services and natural supports identified in the ISP;
- make face-to-face contact with other professionals, caregivers, or individuals included in the ISP in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per the ISP.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.04-1 (eff. Oct. 1, 2009).

The regulations in effect during the review period also provided that Comprehensive Assessments, to be reimbursable by MaineCare, were subject to the following requirements:

A. If the member seeking Community Support Services is in a crisis/outreach situation, it may not be necessary or possible for the assessment to cover all of the areas generally covered in an assessment. An exception to the scope of the assessment may be made by a supervisory mental health professional and recorded in the member's record. A complete Community Support Services assessment must be developed as soon as clinically feasible, but no later than thirty (30) days.

B. The clinical components of an assessment will be:
   1. Performed by the appropriate mental health professionals acting within the scope of their license;
   2. Coordinated by a Community Support Provider.

C. The member or guardian seeking Community Support Services will be an integral part of the assessment and will provide essential information. The member's family or significant other also may be involved, unless such involvement is not feasible or contrary to the wishes of the member or guardian.

D. A Community Support Provider shall develop a comprehensive ISP as defined in 17.04-1(C) within thirty (30) days of application of a member for covered services 17.04-1 (Community Integration), 17.04-2 (Community Rehabilitation Services), 17.04-3 (Assertive Community Treatment-ACT). For all other Section 17 Covered Services, an ISP as specified in 17.01-11 must be developed within thirty (30) days of acceptance. These timeframes must be met unless there is documentation in the member's file that supports a clinical reason why the assessment was not done within thirty (30) days. In these cases, the assessment and the ISP or treatment plan must be developed as soon as clinically feasible.

E. Assessments must indicate the member's diagnosis and the name and credentials of the clinician who determined the diagnosis.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-1 (eff. Oct. 1, 2009).

The Department's sample, as referenced in the December 24, 2014 Notice of Violation, included a substantial number of claims for which AngleZ completed an ISP (or, termed in some records, ITP) for a Section 17-eligible MaineCare member before a Comprehensive Assessment had been completed, but for which none of the indicia of an exception from the Comprehensive Assessment requirement were readily apparent. Ex. D-9.

At hearing, AngleZ presented exhaustive testimony about several specific MaineCare members' treatment profiles, generally identifying instances where no Comprehensive Assessment had been completed due to acute crisis risks or other immediate psychiatric needs exhibited by the members. Ex. A-15; Ex. A-31; Ex. A-42; Test. of Annalee Morris-Polley; Test. of Pamela J. Boivin, Ph.D. In response to additional evidence supplied by AngleZ during the informal review and at hearing, the Department revised its recoupment claim to give credit for some claims where it had been convinced that:

- a properly credentialed professional had completed a Comprehensive Assessment and/or Comprehensive Assessment was timely completed, but that fact was unintentionally obscured in the records;
- services were performed for up to 30 days without a Comprehensive Assessment, but only where necessary (i.e. to address an immediate psychiatric need or avoid a crisis) and until completion of a Comprehensive Assessment was clinically feasible;

Ex. D-10; Ex. D-22; Ex. A-42.

Based on the Section 17 requirements, it should be concluded that the Department was within its authority to reduce its original recoupment claim based on late-submitted or additionally explained evidence from AngleZ. It should also be concluded that, where the preponderance of evidence did not support findings that an exception was warranted from Comprehensive Assessment requirements, the Department correctly upheld its recoupment claims.

Method of Identifying "Covered Services" under MaineCare

AngleZ's third set of arguments against the Department's recoupment claim fell under the broad heading of "covered services," as defined in the MaineCare Benefits Manual, and into three general sub-categories:

- The Department was wrong to identify errors with DLS services and/or CI services claims that billed for time spent transporting a member;
- The Department was wrong to identify errors with DLS services and/or CI services claims that billed for time spent with a member during an appointment with another services provider;

- The Department was wrong to identify errors with DLS services claims that billed for time spent on grocery shopping, cooking, and housekeeping.

Ex. A-42; Test. of Annalee Morris-Polley; Test. of Pamela J. Boivin, Ph.D.

The version of Section 17 in effect at the time of the AngleZ review period identified a list of "non-covered services" that expressly included "transportation services," and noted: "Costs related to transportation are built into the rates for services provided under this Section. Therefore, separate billings for travel time are not reimbursable." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.06 (G) (eff. Oct. 1, 2009). The same version of Section 17 also identified the following as "non-covered services":

- Programs, services, or components of services that are primarily opportunities for socialization and activities that are solely recreational in nature (such as picnics, dances, ball games, parties, field trips, religious activities, social clubs, camps, and companionship activities);
- Programs, services, or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry service);
- Costs for paperwork, internal meetings, or appointment reminders associated with the delivery of covered services are built into the rates and are not reimbursable as separate services.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.06 (A), (B) (eff. Oct. 1, 2009).

Finally, Section 17 strictly limited the situations where more than one Community Support Services provider could provide specified services to a single member, except where expressly waived by the Department:

> Only a single Community Support Provider may be reimbursed at the same time for services to any one member under this Section for Community Integration Services, Community Rehabilitation Services, or Assertive Community Treatment. Other Community Support Services are reimbursable under this Section to more than one Community Support Provider at a time.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.05-2 (eff. Oct. 1, 2009).

As noted above, AngleZ identified three basic categories of claims that were included in the Department's recoupment claim, for which it argued no recoupment was warranted. Those three arguments are addressed in kind below.

Claims for DLS and/or CI Services including Transportation

AngleZ's argument with disqualified transportation time claims centered on its position that providers were allowed to bill time spent by CI workers transporting members to appointments or by DLS workers transporting members to purportedly covered DLS activities. Examples cited by the

Department in its December 24, 2014 Notice of Violation included instances where a DLS worker billed for time spent transporting a member to a therapy session (member, [redacted]; line #11) and in one instance, where a DLS worker billed for time spent transporting a member to a unspecified destination and included time spent during and after a driving accident without any description of any coverable Section 17 services provided (member [redacted]., line #74). Ex. D-9; Ex. D-16; Ex. D-22; Ex. A-12; Ex. A-17.

At hearing, Ms. Morris-Polley testified that it was AngleZ's reading that the plain language of the regulation did not bar providers from billing transportation time as DLS or CI services within a course of DLS or CI services, so long as a provider did not independently bill for non-emergency transportation services under another chapter:

> It's our understanding according to MaineCare, and that ... it clearly states that transportation services, costs related to transportation are built into the rate for services provided under the section. ABHS believes that if the transportation are (sic) built into the rate, then it has to be allowed. Other than that, there wouldn't be a rate for it to be built into. ... So, we sought clarification after this audit to identify whether or not our understanding of the regulation was correct. And that was the answer that we received from ... our provider relations specialist who was assigned to our agency, which clearly identifies that we are correct in our thought process around transportation being built into the rate of services.

Test. of Annalee Morris-Polley.

In support, AngleZ pointed to an email received from Departmental provider relations specialist Joshua Birdwell on February 12, 2016, in which Mr. Birdwell advised AngleZ director of operations Vanessa McPeak the following about the provision, Section 17.06 (G) ("Costs related to transportation are built into the rates for services provided under this Section"): "This is meant to reference that providers may not use the option of MaineCare's NET transportation unit in order to provide transportation or seek mileage reimbursement when the member needs to be transported during the providing of services." Ex. D-37. The same email featured a question from Ms. McPeak – "Also if an ACM is supporting a client to an appointment (per the request of the client) and or to resources in the community this would be a covered service correct?" to which Mr. Birdwell stated: "The answer to this is yes." Ex. D-37.

In rebuttal, Program Integrity supervisor Kelli Johnson, RN, testified that travel time of a provider under Section 17 is not a covered service under Section 17, and that a provider transporting a member to a covered service cannot bill for the transportation time, explaining:

> If you are "providing a service in transportation," there is distracted driving, there is a bunch of stuff that can be built into that as well as not paying full attention to the member. ... Although transportation may be necessary, it is not covered by MaineCare, and it is not our responsibility to ensure that they do have transportation. ...
>
> If people started to bill for that, there could be the possibility that a 15 minute ride turns into an hour ride. And that ends up being carved out of a rate that's already been set. The transportation rate that is already built into services, that could be a carve-out and that could be at risk for abuse for spending [for] transportation.

Test. of Kelli Johnson, RN.

AngleZ's interpretation misconstrued the limitation in Section 17.06 (G). The plain language of the regulation was comprised of two independent clauses:

1. Costs related to transportation are built into the rates for services provided under this Section.
2. Therefore, separate billings for travel time are not reimbursable.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.06 (G) (eff. Oct. 1, 2009).

The first clause specified that transportation costs were "built into the rates" of services that were specifically covered under Section 17. *Id.* Transportation was not a separately identified "covered service" under Section 17. *See* 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.04 (eff. Oct. 1, 2009) (list of covered services and associated criteria). The only separately claimable transportation costs that could be billed to the Department were those identified under Section 113 of the MaineCare Benefits Manual, as noted in Chapter I, Section 1:

> For necessary MaineCare covered services, providers or members may make requests for non-ambulance transportation to a transportation agency serving the area where the member resides. ... The transportation agency must arrange transportation in the most economical manner that is suitable to the member's medical needs. ...

10-144 C.M.R. Ch. I, § 1.15 (eff. Dec. 30, 2012).

However, MaineCare also barred providers from double-billing for the same essential service, and thus, Section 113 transportation was unavailable to individuals seeking transportation to covered Section 17 services, where transportation costs were already "built into the rates." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.04 (eff. Oct. 1, 2009). *See also* 10-144 C.M.R. Ch. I, § 1.06-1 (eff. Dec. 30, 2012) (Covered services limited to those "that are medically necessary and within the limitations outlined in applicable sections of this Manual."). Thus, the only reasonable construction that could be applied to the first clause – i.e. "built into the rates for services provided under this Section" – was that time spent transporting a member to a covered Section 17 service was not billable as additional time expended performing the underlying Section 17 service. Rather, the cost of transporting a member to a Section 17 service was wholly built into the time and cost of actually providing the underlying Section 17 service to which the member is being transported.

This construction also provides context for the second clause in Section 17.06 (G), i.e. that "separate billings for travel time are not reimbursable." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.06 (G) (eff. Oct. 1, 2009). The second clause specifically forbade separate billing *under Section 113* for transportation to/from Section 17 services. Because the language of Section 17.06 (G) plainly forbade a Section 17 services provider from billing for time spent transporting a member to/from covered Section

17 services, the Department correctly included such billings by AngleZ in its recoupment claim as non-covered services.

While AngleZ did not specifically plead it in such terms, AngleZ's argument suggested that, even if the plain language of the regulations forbade supplemental billing for transportation time under Section 17, the Department should be equitably estopped from imposing or enforcing a penalty for such claims because one of its provider relations staff misrepresented the meaning of those regulations in a February 12, 2016 email. Ex. A-42; Test. of Annalee Morris-Polley. *See Dep't of Health and Human Servs. v. Pelletier*, 2009 ME 11, ¶17, 964 A.2d 630, 635 ("To prove equitable estoppel against a governmental entity, the party asserting it must demonstrate that (1) the statements or conduct of the governmental official or agency induced the party to act; (2) the reliance was detrimental; and (3) the reliance was reasonable.").

Here, AngleZ cannot prevail on an equitable estoppel argument to rationalize its claims billing activities during the [redacted] 2013 to [redacted] 2013 period, where the alleged Departmental statement was made nearly three years after those claims were billed. No reasonable argument can be made that AngleZ was induced by statements made by Mr. Birdwell in 2016 to wrongly bill for transportation time in 2013. Accordingly, any effort to assert equitable estoppel against the Department must fail.

Claims for CI Services and/or DLS Services Attending Other Provider Service Sessions

AngleZ's next argument was that DLS and/or CI workers were entitled to bill for time spent accompanying MaineCare members to appointments with other MaineCare providers. For example, AngleZ disputed the Department's assessment of a 100 percent penalty for a $247.92 claim for member [redacted] (line #11), about which the Department recorded on its "Notice of Violation – Attachment A":

> Case manager drove member to/from therapy session & attending session with member. Billed [CI Services code] H2015 (3 hrs) & [Outpatient Therapy code] H0004 (2 hrs) for this date. Note for this code does not support time billed: staff provided transportation to/from therapy apt & billed for therapy time, as did the actual therapist. Confusing treatment plans.

Ex. D-9; Ex. 16; Ex. A-17; Ex. A-18; Ex. A-19.

AngleZ's argument noted in response to this Departmental note included language that reflected the essence of its position that its CI workers were entitled to bill for time spent accompanying a member during service provision by another type of MaineCare service provider:

> ACM notes clearly document services rendered during DOS; service provided are clearly covered under 17.04-1 (D) "coordinate referrals, advocate access by the member to the service and support and identify in ISP". And 17.04-1 (G) make face to face contact with other professionals or individuals included in the treatment plan in order to achieve continuity of care, coordination of services and the most appropriate mix of services for the member. Therefore ABHS asserts that documentation supports 3 hr. [T]ime billed

does not represent duplicate billing and is not transportation, and should be paid at the rate of 100%.

Ex. A-42.

Ms. Johnson testified at hearing that, while the regulations do require CI workers to make "face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan," this requirement does not authorize providers to bill as CI services time-spent attending services provided by another MaineCare provider: "That means that, to break the ice, you can introduce and do the introductions. But this isn't clearly saying that you can bill for two services." Test. of Kelli Johnson, RN.

Again, the plain language of the regulations – to make "face-to-face contact" – presupposes that, once the contact has been made, the billable CI hours end. This is supported by the concept underlying the CI worker's charge to identify the member's other providers to ensure that continuity of care and service coordination are being effectuated. Such contact would presumably end once another provider detaches from engagement the CI worker and begins direct service provision. With respect the CI services provided for [redacted] as noted on Line #11, AngleZ billed for 3 hours of CI services – clearly more than the kind of introductory contact contemplated by the regulations. Ex. D-16; Ex. A-17.

The Department demonstrated that it correctly identified erroneous billing by CI and/or DLS workers related to time spent accompanying MaineCare members during appointments or service sessions with other MaineCare direct service providers. Accordingly, it should be concluded that the Department correctly included such billings by AngleZ in its recoupment claim as non-covered services.

Claims for DLS Services including Grocery Shopping, Cooking, and Housekeeping Assistance

In support of its belief that it correctly billed for tasks related to grocery shopping, cooking, and housekeeping, AngleZ first referenced the Section 17 language identifying the scope of covered services in the DLS program:

> Daily Living Support Services are designed to assist a member to maintain the highest level of independence possible. The services provide personal supervision and therapeutic support to assist members to develop and maintain the skills of daily living. The services help members remain oriented, healthy, and safe. Without these supportive services, members likely would not be able to retain community tenure and would require crisis intervention or hospitalization. These services are provided to members in or from their homes or temporary living quarters in accordance with an individual support plan. Support methods include modeling, cueing, and coaching. The services do not include specialized crisis support services as described in the MaineCare Benefits Manual, Chapter II, Section 65, Behavioral Health Services, subsection 65.06-1, Crisis Resolution. Daily Living Support Services are provided by an MHRT-1, except that when Daily Living Support Services includes administration and supervision of medication, a CRMA must provide that portion of the services.
>
> Daily Living Support Services do not include:
>
> A. Programs, services or components of services that are primarily opportunities for socialization and activities that are solely recreational in nature (such as picnics,

dances, ball games, parties, field trips, religious activities, social clubs, camp and companionship activities).

B. Programs, services or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking or basic services for the convenience of a person receiving services (including housekeeping, shopping, child care and laundry services).

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.04-5 (eff. Oct. 1, 2009).

AngleZ's position with respect to the cover-ability of grocery, laundry, and other housekeeping tasks was effectively stated in its initial "Request for Information Review," dated February 20, 2015:

> AngleZ has been unable to find any other source of information upon which to rely for the determination of the parameters of covered services under this program. Therefore, we reasonably relied upon our own interpretation of the 17.04-5 language to perform services under this program that help members remain "oriented, health and safe."
>
> AngleZ' understanding of non-covered services under this section was based upon language gleaned from MBM Section 17.06, subsections A and B. The process by which AngleZ developed and facilitated the DLSS program relied on the difference between "doing for" and "supporting with" or "assisting." For example, a *non-covered* Section 17 service would be identified as "housekeeping," whereas a *covered* Section 17 services (sic) would be identified as "cueing and prompting a member to manage their home environment. In other words, AngleZ distinguishes between the actions of cleaning a client's house for the client (which is not billable) and *assisting* them with the skills necessary to clean the client's own house (which is).

Ex. A-1a.

At hearing, AngleZ added to this argument its evidence about the Department's training program for "Mental Health Support Specialists," which includes MHRT-1s (certification level required to perform DLS services), and specifically referenced a series of training modules prepared by the Department. Ex. A-42; Test. of Annalee Morris-Polley; Test. of Pamela J. Boivin, Ph.D. As stated in its closing argument, AngleZ argued:

> The MHHS (sic) manual provides compelling support for ABHS's position, that services in question have been provided and billed for appropriately under this DHHS recognized training manual. While, ABHS acknowledges that the MHSS curriculum is not in whole or part prescriptive, nor rule or regulation, ABHS asserts that it is the State's mandatory course of instruction. The MHSS Manual was specifically written by DHHS to train and certify DLSS workers. Furthermore, this manual mandates that it is taught and trained in its entirety; without additions or omissions by certified DHHS instructors.

Ex. A-42.

AngleZ offered the MHSS Manual into evidence at hearing. The Department objected, arguing that an MHRT-1 certification training manual was not relevant to the underlying question as to whether AngleZ's claims billing personnel were authorized, under the regulations, to bill for tasks that were expressly identified in the regulations as "non-covered services." Hearing Record (June 9, 2016). The MHSS Manual was excluded for lack of relevance, on the rationale that providers are required to follow

the terms of their MaineCare provider agreement and the requirements of the MaineCare Benefits Manual, and nothing included in individual training to line workers can be offered to relieve providers of that responsibility. Hearing Record (June 9, 2016).

The hearing officer's "decision must be based on the agency regulations and the evidence which is a matter of hearing record." Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (B)(3). Only "where the agency's regulations are ambiguous or silent on the point critical to a determination" is "reference to other sources of law for guidance in interpreting the agency's regulations ... appropriate." *Id.* Here, there is no ambiguity. "Daily Living Support Services do not include ... services or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking or basic services for the convenience of a person receiving services (including housekeeping, shopping, child care and laundry services)." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.04-5 (eff. Oct. 1, 2009). In its claims review, the Department found that the "basic nature" of the identified activities was "to maintain or supplement housekeeping, homemaking or basic services for the convenience of a person receiving services." AngleZ did not dispute the facts at the heart of those findings – that it had billed for time spent by DLS workers grocery shopping, cooking, housecleaning, and doing laundry with/for MaineCare members. AngleZ's position was essentially to acknowledge the Department's findings, but then to argue that such activities ought to be "covered services" on general principle. The Hearing Officer does not have authority to re-write the Department's regulations. Accordingly, it should be concluded that the Department correctly determined that DLS services claims for such services were improperly made and were properly included in its recoupment claim.

Comparability of 100 percent Recoupment Standard and Fraud Standard

AngleZ also urged the hearing officer to draw an inference about the comparability of the standards used to require 100-percent recoupment of claims in the MaineCare Benefits Manual with the definition of fraud identified in a related provision in the same section. Ex. A-42. *See* 10-144 C.M.R. Ch. 101, sub-Ch. I, §§ 1.19-2 (G)(1); 1.20-1 (B). AngleZ asked the hearing officer to take notice of a finding made by the Office of Inspector General in July 2014 "of no fraudulent activity on ABHS's part," and that "those same facts, investigation results, and conclusions also apply to this integrity audit ...." Ex. A-42. By this rationale, AngleZ is asking the hearing officer to conclude, because an OIG investigation ended without making a finding of fraud against AngleZ, that the OIG implicitly found that all of the services underlying the claims that were later identified in the Department's recoupment claim were 1) medically necessary, 2) covered services under MaineCare, and 3) actually provided. Ex. A-42.

The theory underlying this argument is logically flawed. There is no substantial evidence in the record that OIG found that all services underlying the Department's recoupment claim were medically necessary, covered services, and actually provided. At most, the evidence reflects that the OIG elected not to continue its investigation after determining there was insufficient evidence to sustain the higher standard of proof required to prove fraud. The fact that the essential criteria required in a fraud investigation are comparable to those authorizing the Department to impose a penalty of 100 percent has

no legal meaning. For this reason, the hearing officer rejects AngleZ's argument that any OIG decision with respect to a fraud investigation required the Department to limit its recoupment penalty to 20 percent of the value of the subject claims.

Based on the foregoing, the Hearing Officer respectfully recommends that it be concluded that the Department was correct when, for the review period of [redacted] 2013 to [redacted] 2013, it determined that AngleZ Behavioral Health Services owes the Department the sum of $392,603.31, related to assessments not being completed in a timely manner, invalid treatment plans, documentation not supporting the hours billed, and other documentation errors..

MANUAL CITATIONS

- DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (2016)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101 (2013-16).

RIGHT TO FILE RESPONSES AND EXCEPTIONS

THE PARTIES MAY FILE WRITTEN RESPONSES AND EXCEPTIONS TO THE ABOVE RECOMMENDATIONS. ANY WRITTEN RESPONSES AND EXCEPTIONS MUST BE RECEIVED BY THE DIVISION OF ADMINISTRATIVE HEARINGS WITHIN FIFTEEN (15) CALENDAR DAYS OF THE DATE OF MAILING OF THIS RECOMMENDED DECISION.

A REASONABLE EXTENSION OF TIME TO FILE EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER FOR GOOD CAUSE SHOWN OR IF ALL PARTIES ARE IN AGREEMENT. RESPONSES AND EXCEPTIONS SHOULD BE FILED WITH THE DIVISION OF ADMINISTRATIVE HEARINGS, 11 STATE HOUSE STATION, AUGUSTA, ME 04333-0011. COPIES OF WRITTEN RESPONSES AND EXCEPTIONS MUST BE PROVIDED TO ALL PARTIES. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER.

CONFIDENTIALITY

THE INFORMATION CONTAINED IN THIS DECISION IS CONFIDENTIAL. *See* 42 U.S.C. § 1396a (a)(7); 22 M.R.S. § 42 (2); 22 M.R.S. § 1828 (1)(A); 42 C.F.R. § 431.304; 10-144 C.M.R. Ch. 101 (I), § 1.03-5. ANY UNAUTHORIZED DISCLOSURE OR DISTRIBUTION IS PROHIBITED.

Dated: 2/16/2017

Richard W. Thackeray, Jr.
Administrative Hearing Officer

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