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

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

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
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IN THE MATTER OF:

O.K.
JG
8-10-16

Manna, Inc.)
William Rae, Executive Director) **FINAL DECISION**
629 Main Street, PO Box 2763)
Bangor, ME 04402-2763)

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

The Recommended Decision of Hearing Officer LeBlanc, mailed June 6, 2016 has been reviewed. I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that the Department was not correct when it determined that for the review period of [redacted]2010 through [redacted]2013, Manna, Inc. owes the Department $499,343.49 for recoupment of overpayments because of failure to maintain adequate records to support services billed and for overbilling of services. I further accept the Recommendation of the Hearing Officer that Manna, Inc. owes the Department $496,836.23 for recoupment of overpayments because of failure to maintain adequate records to support services billed and for overbilling of services.

DATED: 8/10/16 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

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
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35 Anthony Avenue
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O.K. w/redactions
ga 8-10-16

TO: Mary C. Mayhew, Commissioner
Department of Health and Human Services
221 State Street
11 State House Station
Augusta, ME 04333

DATE MAILED: JUN - 6 2016

In Re: Manna, Inc.–Appeal of Notice of Violation dated August 4, 2015 and Final Informal Review Decision dated December 10, 2015

RECOMMENDED DECISION

A *de novo* administrative hearing was held on March 31, 2016, at Bangor, Maine in the case of Manna, Inc., before Hearing Officer Michael L. LeBlanc. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner, Department of Health and Human Services. On April 29, 2016, on the Hearing Officer's motion the hearing record was reopened to determine a method of identifying the records reviewed without including protected health information in the recommended decision. The hearing record closed on May 4, 2016.

FACTUAL BACKGROUND AND ISSUE:

On or about August 4, 2015, the Department of Health and Human Services, Division of Audit, Program Integrity (the "Department") notified Manna, Inc. ("Manna") that it had been overpaid $893,759.53 in MaineCare funds during the period [redacted]2010 through [redacted] 2013, and demanded repayment of the overpayment. See Exhibit DHHS #7. On or about August 21, 2015, Manna requested an informal review of the Department's Notice of Violation. See Exhibit DHHS #8. After its informal review, on or about December 10, 2015, the Department notified Manna that the Department had decreased the recoupment amount to $499,343.49. See Exhibit DHHS #9. On or about January 5, 2016, Manna requested an administrative hearing. See Exhibit DHHS #10. Pursuant to an Order of Reference dated January 21, 2016, this matter was assigned by James D. Bivins, Esq., Chief Administrative Hearing Officer to the undersigned Hearing Officer to conduct an administrative hearing and to submit to the Commissioner written findings of fact and recommendations on the following issue:

> "Was the Department correct when it determined that for the review period of [redacted]010 through [redacted]2013, Manna, Inc., owes the Department $499,343.49 for recoupment of overpayments because of failure to maintain adequate records to support services billed and for overbilling of services? See Exhibits HO-2 and DHHS-1.

APPEARING ON BEHALF OF APPELLANT:

William Rae, Executive Director, Manna, Inc.

APPEARING ON BEHALF OF AGENCY:

Thomas Bradley, AAG
Valerie Hooper, Comprehensive Health Planner I

ITEMS INTRODUCED INTO EVIDENCE:

Hearing Officer Exhibits:

HO-1. Notice of Hearing dated 1/26/16
HO-2. Order of Reference dated 1/21/16
HO-3. Hearing Report dated 1/14/16
HO-4. Letter, dated 4/29/16, to Thomas Bradley from Hearing Officer LeBlanc
HO-5. E-mail, dated 5/4/16, to Hearing Officer LeBlanc from Thomas Bradley
HO-6. Member-Exhibit List
HO-7. Key (sealed exhibit)

Department Exhibits:

DHHS-1. Order of Reference dated 1/21/16
DHHS-2. Hearing Report dated 1/14/16
DHHS-3. Request for records letter dated 2/7/14
DHHS-4. Second request for records letter dated 3/25/14
DHHS-5. Expanded record request letter dated 2/24/15
DHHS-6. Second request for records letter dated 5/7/15
DHHS-7. Notice of Violation dated 8/4/15, with attachments (sealed exhibit)
DHHS-8. Request for Informal Review dated 8/21/15
DHHS-9. Final Informal Review Decision dated 12/10/15, with attachments (sealed exhibit)
DHHS-10. Request for an Administrative Hearing dated 1/5/16
DHHS-11. MaineCare Benefits Manual, Chapter I, effective 1/11/10
DHHS-12. MaineCare Benefits Manual, Chapter I, effective 11/16/10
DHHS-13. MaineCare Benefits Manual, Chapter I, effective 2/13/11
DHHS-14. MaineCare Benefits Manual, Chapter I, effective 3/26/13
DHHS-15. MaineCare Benefits Manual, Chapter I, effective 6/30/13
DHHS-16. MaineCare Benefits Manual, Chapter II, Section 65, effective 7/1/10
DHHS-17. MaineCare Benefits Manual, Chapter II, Section 65, effective 7/1/10 emergency rule)
DHHS-18. MaineCare Benefits Manual, Chapter II, Section 65, effective9/28/10
DHHS-19. MaineCare Benefits Manual, Chapter II, Section 65, effective 10/31/12
DHHS-20. MaineCare Benefits Manual, Chapter II, Section 65, effective 1/1/13
DHHS-21. MaineCare Benefits Manual, Chapter II, Section 65, effective 8/31/13
DHHS-22. MaineCare Benefits Manual, Chapter III, Section 65, effective 7/1/10
DHHS-23. MaineCare Benefits Manual, Chapter III, Section 65, effective 7/1/10 (emergency rule)

DHHS-24. MaineCare Benefits Manual, Chapter III, Section 65, effective 9/28/10
DHHS-25. MaineCare Benefits Manual, Chapter III, Section 65, effective 6/7/11
DHHS-26. MaineCare Benefits Manual, Chapter III, Section 65, effective 4/1/12
DHHS-27. MaineCare Benefits Manual, Chapter III, Section 65, effective 10/31/12
DHHS-28. MaineCare Benefits Manual, Chapter III, Section 65, effective 7/1/13
DHHS-29. MaineCare Benefits Manual, Chapter III, Section 65, effective 9/28/13
DHHS-30. MaineCare Provider Agreement signed by provider on 12/21/09
DHHS-31. Progress note ([redacted]11), treatment plan ([redacted]11), and annual summary ([redacted]11) for Member #1 (sealed exhibit)
DHHS-32. Treatment plan ([redacted]12), and comprehensive assessment ([redacted]11) for Member #2 for date of service [redacted]/12 (sealed exhibit)
DHHS-33. Cover sheet ([redacted]/13) and comprehensive assessment (not dated) for Member #3 for date of service [redacted]13 (sealed exhibit)
DHHS-34. Comprehensive assessment ([redacted]11) and annual assessment update ([redacted]13) for Member #4 for date of service [redacted]13 (sealed exhibit)
DHHS-35. Comprehensive assessment ([redacted]08) for Member #5 for date of service [redacted]1 (sealed exhibit)
DHHS-36. Comprehensive assessment ([redacted]10), mental health summary ([redacted]11), and comprehensive assessment ([redacted]09) for Member #6 for date of service [redacted]1 (sealed exhibit)
DHHS-37. DEEP assessment (not dated), treatment plans [redacted]11 and [redacted]/11), and progress note [redacted]11) for Member #7 (sealed exhibit)
DHHS-38. Comprehensive assessment [redacted]11) for Member #8 for date of service [redacted]11 (sealed exhibit)
DHHS-39. Comprehensive assessment ([redacted]1), annual assessment update ([redacted]/12), treatment plan [redacted]/13), and progress note [redacted]13 for Member #9 (sealed exhibit)
DHHS-40. Comprehensive assessment [redacted]2) and treatment plan [redacted]12) for Member #10 for dates of service [redacted]12 and [redacted]12 (sealed exhibit)
DHHS-41. Comprehensive assessment [redacted]13) and progress note [redacted]13) for Member #11 (sealed exhibit)
DHHS-42. Comprehensive assessment [redacted]11) for Member #12 for date of service [redacted]11 (sealed exhibit)
DHHS-43. Discharge Summary ([redacted]2), progress note [redacted]2), and summary ([redacted]12) for Member #13 (sealed exhibit)
DHHS-44. Treatment plan [redacted]/11) for Member #14 for date of service [redacted]13
DHHS-45. Treatment plans [redacted]11, [redacted]11, [redacted]/11, and [redacted]2), comprehensive assessment [redacted]11), and progress notes [redacted]12 and [redacted]/11) for Member #15 (sealed exhibit)
DHHS-46. Treatment plan [redacted]12) and comprehensive assessments [redacted]11 an[redacted]12) for Member #16 for date of service [redacted]12 (sealed exhibit)
DHHS-47. Treatment plan ([redacted]1) for Member #17 for date of service [redacted]/11 (sealed exhibit)
DHHS-48. Comprehensive assessment [redacted]1) and treatment plans [redacted]11, [redacted]/11, and [redacted]12) for Member #18 for date of service [redacted]12 (sealed exhibit)
DHHS-49. Progress note ([redacted]13) for Member #19 (sealed exhibit)
DHHS-50. Progress note ([redacted]12) and comprehensive assessment [redacted]12) for Member #20 (sealed exhibit)

DHHS-51. Progress note [redacted] 11) and comprehensive assessment [redacted] 11) for Member #21 (sealed exhibit)

Appellant Exhibits:

None offered.

RECOMMENDED FINDINGS OF FACT:

1. Notice of these proceedings was given in a timely and adequate manner. Manna, Inc. ("Manna") made a timely appeal.

2. Manna is a MaineCare provider who was selected by the Department for a post-payment review or audit. Manna's services included Behavioral Health Services pursuant to MaineCare Benefits Manual, Chapter II, Section 65.

3. On February 10, 2014, the Department served Manna with a written request for copies of its medical records including the member's social and medical history, diagnoses, assessment, treatment plan, and written progress notes for ten (10) specific MaineCare members for dates of service betwee[redacted] 2010 through [redacted] 2013.

4. Receiving no response from Manna, on March 27, 2014, the Department served Manna with a second written request for the same records.

5. Based on Valerie Hooper's ("Ms. Hooper") review of the records Manna provided, the Department decided to expand the audit to a random sample of one hundred (100) specific claims, i.e., specific claim dates of services to specific MaineCare members.

6. On March 4, 2015, the Department served Manna with a written request for copies of records for outpatient therapy, including initial assessments, treatment plans, evaluations, progress notes, and discharge plans, for the specific claim dates for the specific MaineCare members provided in the request.

7. On or about May 10, 2015, the Department sent Manna a second written request for the randomly selected one hundred (100) claims.

8. The Department used Federally recognized software to select the random sample.

9. The software randomly selected one hundred (100) claims out of a universe of 10,772 claims paid during the period [redacted] 2010 through [redacted] 2013. The value of the universe of claims paid is $1,006,712.49. The Department applied a ninety-five percent (95%) Confidence Level , a five percent (5%) Precision, and a five percent (5%) Government Risk.

10. Initially, the Department discovered, based on the records provided by Manna, that ninety-nine (99) of the one hundred (100) claims received improper payments totaling $8,509.70. The total amount paid for the entire sample was $8,650.60. This equals an error rate of 98.4% ($8,509.70 ÷ $8,650.60).

11. During the informal review, the Department received additional records from Manna The Department determined that seventy-seven (77) of the claims totaling $4,754.76 were overpaid. This equals an error rate of 54.96% ($8,509.70 ÷ $4,754.76).

12. In asserting its claim of overpayment, the Department does not assert that Manna engaged in fraud or any intentional wrong-doing.

13. Manna does not raise any dispute except with the missing signatures of [redacted]("[redacted]") and Dr. Stephen Andrew ("Dr. Andrew").

14. [redacted] is disabled and is unable to sign his name. He uses computer software to electronically sign his name.

15. There are thirteen (13) entries in the Department's spreadsheet where [redacted] is the rendering provider. In one (1) the Department overturned the overpayment, in ten (10) deficits other than the signature were found, and in two (2) the only deficit was the signature.

16. The combined overpayment found for the two (2) with a signature deficit only is $24.36. Therefore, the Hearing Officer concludes that seventy-five claims totaling $4,730.40 were overpaid. This equals an error rate of 54.68%

17. Using the same method used by the Department, the Hearing Officer concludes that the correct overpayment amount is 51.95% of $956,373.87, which equals $496,836.23.

RECOMMENDED DECISION:

The Department was not correct when it determined that for the review period of [redacted]2010 throug[redacted]2013, Manna, Inc., owes the Department $499,343.49 for recoupment of overpayments because of failure to maintain adequate records to support services billed and for overbilling of services. The correct amount is $496,836.23.

REASON FOR RECOMMENDATION:

The policy governing this appeal is, in relevant part:

> 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. See MaineCare Benefits Manual, Chapter I, Section 1.16.
>
> The Division of Program Integrity and/or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:
>
> 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; See Ibid, Section 1.18, Subsections C and D.

The Department may impose sanctions and recoup identified overpayments against a provider, individual, or entity for any one or more of the following reasons:

G. Breaching the terms of the MaineCare Provider/Supplier Agreement, and/or the Requirements of Section 1.03-3 for provider participation; See Ibid, Section 1.19-1 (G).

Enrolled providers must:

M. Maintain and retain 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.

N. 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....

S. Comply with requirements of applicable Federal and State law, and with the provisions of this Manual. See Ibid, Section 1.03-3, Subjections M, N, and S.

The following sanctions may be invoked against providers, individuals or entities based on the grounds specified in Section 1.19-1, in accordance with applicable State and Federal rules and regulations.

G. Imposition of penalty due to lack of adequate documentation. When 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. See Ibid, Section 1.19-2 (G).

A member's record must contain written documentation of a Comprehensive Assessment, an Individual Treatment Plan and progress notes. The Comprehensive Assessment process determines the intensity and frequency of medically necessary services and includes utilization of instruments as may be approved or required by DHHS. Individual Treatment Plans are the plans of care developed by the clinician or the treatment team with the member and in consultation with the parent or guardian, if appropriate, based on a Comprehensive Assessment of the member. Individualized plans include the Individual Treatment Plan, the Crisis/Safety Plan (where indicated by the Covered Service), and the Discharge Plan.

A. Comprehensive Assessment

1. A clinician must complete a Comprehensive Assessment that integrates co-occurring mental health and substance abuse issues within thirty (30) days of the day the member begins services. The Comprehensive Assessment must be included in the member's record. The Comprehensive Assessment process must include a direct encounter with the member and if appropriate, family members, parents, friends and guardian. The Comprehensive Assessment must be updated at a minimum, when there is a change in level of care, or when major life events occur, and annually.

   The Comprehensive Assessment must contain documentation of the member's current status, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, housing, financial, vocational, educational, leisure/recreation, potential need for crisis intervention, physical/sexual and emotional abuse.

   The Comprehensive Assessment may also contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs, physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.

   Additionally, for a Comprehensive Assessment for a member with substance abuse, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types and response to previous treatment.

2. The Comprehensive Assessment must be summarized, and include a diagnosis using all Diagnostic and Statistical Manual of Mental Health Disorders (DSM) axes or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC 0-3) diagnosis, as appropriate. The Comprehensive Assessment must be signed, credentialed and dated by the clinician conducting the Comprehensive Assessment. A Comprehensive Assessment for a member with a substance abuse diagnosis must also contain ASAM level of care criteria. If the Comprehensive Assessments for a member receiving integrated treatment for co-occurring disorders, the Comprehensive Assessment must contain both the DSM and ASAM criteria.

3. If a provisional diagnosis is made by an MHRT or CADC providing the direct service, the diagnosis will be reviewed within five (5) working days by the supervising licensed clinician and documented in the record.

4. Historical data may be limited in crisis services. The Comprehensive Assessment must contain documentation if information is missing and the reason the information cannot be obtained or is not clinically applicable to the service being provided. See MaineCare Benefits Manual, Chapter II, Section 65.09-3 (A).

B. Individual Treatment Plan (ITP)

1. The clinician, member and other participants (service providers, parents or guardian) must develop an ITP, based on the Comprehensive Assessment that is appropriate to the developmental level of the member within thirty (30) days of the day the members begins services.

2. When an ITP is required, it must contain the following unless there is an exception:
   a. The member's diagnosis and reason for receiving the service;
   b. Measurable long-term goals with target dates for achieving the goals;
   c. Measurable short-term goals with target dates for achieving the goals with objectives that allow for measurement of progress;
   d. Specific services to be provided with amount, frequency, duration and practice methods of services and designation of who will provide the service, including documentation of co-occurring services and natural supports, when applicable;
   e. Measurable Discharge criteria;
   f. Special accommodations needed to address physical or other disabilities to provide the service; and
   g. All participants must sign, credential (if applicable) and date the ITP. The first ninety (90) day period begins with date of the initial, signed ITP. The ITP must be reviewed at all major decision points but no less frequently than ninety (90) days, or as described in 65.09-3.B.7. If clinically indicated, the member's needs may be reassessed and the ITP may be reviewed and amended more frequently than every ninety (90) days. Changes to the ITP are considered to be in effect as of the date it is signed by the clinician and member or, when appropriate, the parent or guardian.

   All participants must sign, credential (if applicable) and date the reviewed ITP. See Ibid, Section 65.09 (B) (2).

C. Documentation

   Providers must maintain written progress notes for all services, in chronological order.

   All entries in the progress note must include the service provided, the provider's signature and credentials, the date on which the service was provided, the duration of the service, and the progress the member is making toward attaining the goals or outcomes identified in the ITP.... See Ibid, Section 65.09 (C).

Only services included in the ITP will be reimbursed. Reimbursement will be allowed for covered services prior to the approval of the initial ITP, when the provider obtains subsequent approval of those services within thirty (30) days of the date the member begins treatment. See Ibid, Section 65.08-1.

Notice of these proceedings was given in a timely and adequate manner. See Exhibit HO-1. Manna, Inc. ("Manna") made a timely appeal. See Exhibits DHHS-2, DHHS-8, and DHHS-10.

Manna is a MaineCare provider who was selected by the Department for a post-payment review or audit. See Testimony of Valerie Hooper ("Ms. Hooper"). Manna's services included Behavioral Health Services pursuant to MaineCare Benefits Manual, Chapter II, Section 65. *Id.* On February 10, 2014, the Department served Manna with a written request for copies of its medical records including the member's social and medical history, diagnoses, assessment, treatment plan, and written progress notes for ten (10) specific MaineCare members for dates of service between [redacted] 2010 through [redacted] 2013. See Exhibit DHHS-3. Receiving no response from Manna, on March 27, 2014, the Department served Manna with a

second written request for the same records. See Exhibit DHHS-4. Based on Ms. Hooper's review of the records Manna provided, the Department decided to expand the audit to a random sample of one hundred (100) specific claims, i.e., specific claim dates of services to specific MaineCare members. See Testimony of Ms. Hooper. On March 4, 2015, the Department served Manna with a written request for copies of records for outpatient therapy, including initial assessments, treatment plans, evaluations, progress notes, and discharge plans, for the specific claim dates for the specific MaineCare members provided in the request. See Exhibit DHHS-5. On or about May 10, 2015, the Department sent Manna a second written request for the randomly selected one hundred (100) claims.[1] See Exhibit DHHS-6.

The Department used Federally recognized software to select the random sample. See Testimony of Ms. Hooper. The software randomly selected one hundred (100) claims out of a universe of 10,772 claims paid during the period [redacted] 2010 through [redacted] 2013. See Exhibits DHHS-7 and DHHS-9. The value of the universe of claims paid is $1,006,712.49. *Id.* The Department applied a ninety-five percent (95%) Confidence Level , a five percent (5%) Precision, and a five percent (5%) Government Risk. *Id.* Initially, the Department discovered, based on the records provided by Manna, that ninety-nine (99) of the one hundred (100) claims received improper payments totaling $8,509.70. See Exhibit DHHS-7. The total amount paid for the entire sample was $8,650.60. *Id.* This equals an error rate of 98.4% ($8,509.70 ÷ $8,650.60). See Testimony of Ms. Hooper. During the informal review, the Department received additional records from Manna *Id.* The Department determined that seventy-seven (77) of the claims totaling $4,754.76 were overpaid. See DHHS-7. This equals an error rate of 54.96% ($4,754.76 ÷ $8,650.60). See Testimony of Ms. Hooper.

In asserting its claim of overpayment, the Department does not assert that Manna engaged in fraud or any intentional wrong-doing. See Testimony of Ms. Hooper.

Manna does not raise any dispute except with the missing signatures of [redacted]") and Dr. Stephen Andrew ("Dr. Andrew"). See Testimony of William Rae ("Mr. Rae"). [redacted] is disabled and is unable to sign his name. *Id.* He uses computer software to electronically sign his name. *Id.* Dr. Andrew signed his name in green ink. *Id.* Although Mr. Rae attempted to make copies that would include Dr. Andrew's signature, the green ink would not come out in the photocopy. *Id.*

There are thirteen (13) entries in the Department's spreadsheet where [redacted] is the rendering provider. See Exhibit DHHS-9. In one (1) the Department overturned the overpayment, in ten (10) deficits other than the signature were found, and in two (2) the only deficit was the signature. *Id.* The combined overpayment found for the two (2) with a signature deficit only is $24.36. *Id.* Therefore, the Hearing Officer concludes that seventy-five claims totaling $4,730.40 were overpaid. This equals an error rate of 54.68% ($4,730.40 ÷ $8,650.60). In making this determination, the Hearing Officer finds that the documents showed that [redacted] electronically signed them. That with Mr. Rae's testimony rose to a preponderance of the evidence.

[1] The request indicates it was sent by certified mail, but a copy of any certified mail receipt was not provided.

The Hearing Officer concludes that Mr. Rae's testimony alone with respect to Dr. Andrew's signature does not rise to a preponderance of the evidence because it was within Mr. Rae's ability to bring the original records to the hearing to show that the signatures were in green ink.

The method consistently use by the Department to determine the initial overpayment claim and the overpayment claim after informal review was to multiply the universe claim amount of $1,006,712.49 by ninety-five percent (95%) to arrive at $956,373.87. See Exhibits DHHS-7 and DHHS-9. Then it multiplied the error rate by ninety-five percent (95%) and multiplied $956,373.87 by the product. *Id.* Using the same method, 54.68% times 95% equals 51.95%. The correct overpayment amount is 51.95% of $956,373.87, which equals $496,836.23.

For all of the above reasons, the Hearing Officer recommends that the Commissioner conclude that the amount Manna, Inc., owes the Department is $496,836.23.

MANUAL CITATIONS:

MaineCare Benefits Manual, Chapter I, Section 1 and Chapter II, Section 65

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 TWENTY (20) 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.

DATED: June 6, 2016

SIGNED: Michael L. LeBlanc

Michael L. LeBlanc
Administrative Hearing Officer
Division of Administrative Hearings

cc: Thomas Bradley, AAG, Office of the Attorney General, 6 State House Station, Augusta, ME 04333-0006
William Rae, Executive Director, Manna, Inc., 629 Main Street, PO Box 2763, Bangor, ME 04402-2763