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
TTY Users: Dial 711 (Maine Relay)

IN THE MATTER OF:

Ocean Way Manor & Ocean Way Mental Health Laurie Ryan, President	)	**FINAL DECISION**

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

The Recommended Decision of Hearing Officer Thackeray, mailed March 27, 2017 and the responses and exceptions filed on behalf of Ocean Way Manor & Ocean Way Mehtal Health have been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that the Department was correct when it suspended Medicaid payments to Ocean Way Mental Health Agency and Ocean Way Manor because of its determination that there existed a credible allegation of fraud for which an investigation was pending, absent a good cause exception.

DATED: 5/24/17 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: Charles F. Dingman, Esq., PretiFlaherty, PO Box 1058, Augusta, ME 04332
Thomas Bradley, AAG, Office of the Attorney General
Patrick Bouchard, 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

Department of Health and Human Services
Administrative Hearings
35 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 624-5350; Fax (207) 287-8448
TTY Users: Dial 711 (Maine Relay)

Date Mailed: MAR 27 2017

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

In the Matter of: Ocean Way Manor
& Ocean Way Mental Health Agency

NPI ID Nos. 1205903820
1407192958

ADMINISTRATIVE HEARING RECOMMENDED DECISION

An administrative hearing in the above-captioned matter was held on January 31, 2017, before Hearing Officer Richard W. Thackeray, Jr., at Rockland, Maine. 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 February 9, 2017, to allow submission of written closing arguments.

Pursuant to an Order of Reference dated December 1, 2016, the issue presented *de novo* for hearing was whether the Maine Department of Health and Human Services ["Department"] was "correct when it suspended Ocean Way Mental Health Agency [and Ocean Way Manor] because of its determination that there exists a credible allegation of fraud for which an investigation is pending, absent a good cause exception?" Ex. D-1.

APPEARING ON BEHALF OF THE APPELLANT

- Charles F. Dingman, Esq., PRETI FLAHERTY BELIVEAU & PACHIOS, LLP
- Michael S. Smith, Esq., PRETI FLAHERTY BELIVEAU & PACHIOS, LLP
- Laurie Ryan, President/Owner, Ocean Way Manor & Ocean Way Mental Health Agency
- Stephanie Truman, Nurse Consultant, Ocean Way Manor & Ocean Way Mental Health Agency

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG, MAINE OFFICE OF THE ATTORNEY GENERAL
- Patrick Bouchard, Comp. Health Planner II, Program Integrity, Division of Audit, Augusta

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Notice of Administrative Hearing," dated December 7, 2016

HO-2 "Administrative Prehearing Order," dated December 13, 2016

HO-3 "Entry of Appearance," Taylor D. Fawns, Esq., dated December 13, 2016

HO-4 "Entry of Appearance," Charles F. Dingman, Esq., & Michael S. Smith, Esq., dated January 3, 2017

HO-5 "Scheduling Request" (unopposed, dated January 19, 2017

HO-6 "Scheduling Order," dated January 20, 2017

HO-7 "Prehearing Brief," DHHS, dated January 27, 2017

HO-8 "Prehearing Brief," Ocean Way Manor/MHA, dated January 31, 2017

Department Exhibits

D-1 "Order of Reference," dated December 1, 2016

D-2 "Fair Hearing Report Form," dated November 28, 2016

D-3 "Notice of Suspension of Medicaid Payments," dated October 26, 2016

D-4 "Request for Informal Review and/or Reconsideration," dated November 8, 2016

D-5 "Final Informal Review Decision," dated November 14, 2016

D-6 "Request for Expedited Administrative Review," dated November 27, 2016

D-7a "General Administrative Policies and Procedures," MaineCare Benefits Manual, 10-144 C.M.R. Ch.101, sub-Ch. I, § 1 (eff. Apr. 16, 2016)

D-7b "General Administrative Policies and Procedures," MaineCare Benefits Manual, 10-144 C.M.R. Ch.101, sub-Ch. I, § 1 (eff. Jan. 1, 2014)

D-8 "Program Integrity: Medicaid," Ctrs. for Medicare and Medicaid Servs., 42 C.F.R. pt. 455 (Oct. 1, 2012 ver.)

D-9a "Community Support Services," MaineCare Benefits Manual, 10-144 C.M.R. Ch.101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)

D-9b "Community Support Services," MaineCare Benefits Manual, 10-144 C.M.R. Ch.101, sub-Ch. II, § 17 (eff. Mar. 22, 2016)

D-10a "MaineCare/Medicaid Provider Agreement," dated September 14, 2009

D-10b "MaineCare/Medicaid Provider Agreement," dated January 22, 2013

D-11a "DLSS Progress Note," dated [redacted], 2015

D-11b "DLSS Progress Note," dated [redacted], 2015

D-12a "DLSS Progress Note," dated [redacted], 2016

D-12b "CI Progress Note," dated [redacted], 2016

D-13a "Progress Note," dated [redacted] 2015

D-13b "Progress Note," dated [redacted], 2015

D-13c "Case Management Note," dated [redacted], 2015

D-13d "Case Management Note," [redacted], 2015

D-13e "Case Management Note," [redacted], 2015

D-13f "Case Management Note," [redacted], 2015

D-13g "Case Management Note," [redacted], 2015

D-13h "Case Management Note," [redacted], 2015

D-13i "Case Management Note," [redacted], 2015

D-13j "Case Management Note," [redacted], 2015

D-13k "Case Management Note," [redacted], 2016

D-13l "Case Management Note," [redacted], 2016

D-13m "Department of Labor Quarterly Wage Information Report," September 2015 to June 2016

D-14a "Claims Data Report," April 23, 2015 to March 7, 2016

D-14b "CI Progress Note," dated [redacted], 2015

D-14c "CI Progress Note," dated [redacted], 2015

D-14d "CI Progress Note," dated [redacted], 2015

D-14e "CI Progress Note," dated [redacted], 2015

D-14f "CI Progress Note," dated [redacted], 2015

D-14g "CI Progress Note," dated [redacted], 2015

D-14h "CI Progress Note," dated [redacted], 2015

D-14i "CI Progress Note," dated [redacted], 2015

D-14j "Department of Labor Quarterly Wage Information Report," September 2015 to June 2016

D-15a "CI Progress Note," dated [redacted], 2015

D-15b "Adult Locus Scoring Sheet," dated [redacted], 2015

D-15c "Adult Locus Scoring Sheet," dated [redacted], 2015

D-15d "KEPRO Care Connection Prior Authorization Request," dated [redacted], 2015

D-15e "LOCUS Rater ID Approval," dated December 4, 2008

D-15f "Claims Data Report," October 2, 2015 to April 29, 2016

D-16a "Progress Note," dated [redacted], 2016

D-16b "Comprehensive Assessment," dated [redacted], 2016

D-16c "Claims Data Report," January 27, 2016 to April 22, 2016

D-17a "Progress Note," dated [redacted] 2015

D-17b "Individual Service Plan," dated [redacted], 2015

D-17c "Claims Data Report," April 13, 2015 to March 7, 2016

D-18 "Notice of Suspension of Medicaid Payments," dated October 26, 2016

D-19 "Request for Informal Review and/or Reconsideration," dated November 8, 2016

D-20 "Final Informal Review Decision," dated November 14, 2016

D-21 "Home and Community Benefits For Members With Intellectual Disabilities or Autistic Disorder," MaineCare Benefits Manual, 10-144 C.M.R. Ch.101, sub-Ch. II, § 21 (eff. Sept. 1, 2014)

D-22 "Ocean Way – Staff Information" (undatated)

D-23 "Employee Background Checks – Ocean Way Manor," dated October 17, 2016

D-24a "Email," dated October 15, 2016

D-24b "Email," dated August 4, 2016

D-24c "Email," dated August 11, 2016

D-25a "Claims Data Report," January 1, 2016 to June 21, 2016

D-25b "Progress Note," dated [redacted], 2016

D-25c "Progress Note," dated [redacted], 2016

D-25d "Progress Note," dated [redacted] 2016

D-25e "Progress Note," dated [redacted] 2016

D-26a "Employee Work Schedule, dated June 2016

D-26b "Employee Work Schedule," July 2016

D-27a "DLSS Progress Note," dated [redacted], 2015

D-27b "CI Progress Note," dated [redacted] 2015

D-27c "CI Progress Note," dated [redacted] 2015

D-27d "DLSS Progress Note," dated [redacted], 2015

D-27e "DLSS Progress Note," dated [redacted], 2015

D-27f "DLSS Progress Note," dated [redacted], 2015

D-27g "CI Progress Note," dated [redacted], 2015

D-27h "CI Progress Note," dated [redacted] 2015

D-27i "DLSS Progress Note," dated [redacted] 2016

D-27j "DLSS Progress Note," dated [redacted] 2016

D-27k "DLSS Progress Note," dated [redacted] 2016

D-27l "DLSS Progress Note," dated [redacted] 2016

D-28 "Written Closing Statement," dated February 10, 2017

Appellant Exhibits

A-1: "RCF Licensure Verification, expiration dated June 6, 2017

A-2: "License," dated October 26, 2016

A-3: "Client Notice," dated January 10, 2017

A-4: "DHHS Agreement to Purchase Services," dated July 28, 2015

A-5: "Letter," dated November 12, 2015

A-6: "Written Closing Statement," dated February 10, 2017

LEGAL FRAMEWORK

The hearing officer reviews an appeal of a Departmental Notice of Suspension of MaineCare Provider Payments *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) (eff. Jan. 11, 2014). In such an appeal, the Department has the initial burden to persuade the Hearing Officer that it had a sufficient basis to determine that there existed a credible allegation of fraud for which an investigation was pending. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (J). Thereafter, "[i]f the Department has made a finding as to lack of good cause regarding a payment suspension, the provider must demonstrate by a preponderance of the evidence that the Department erred upon information review in its finding." *Id.*

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 (eff. Jan. 11, 2014). *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 [the MaineCare Benefits] Manual." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (R) (eff. Jan. 11, 2014).

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) (eff. Jan. 11, 2014). "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 (eff. Jan. 11, 2014). 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," and determine "whether to suspend payments to a provider based upon a credible allegation of fraud." 10-144 C.M.R. Ch. 101, sub-Ch. I, §§ 1.17, 1.18 (H) (eff. Jan. 11, 2014). *See also* 42 C.F.R. § 455.23.

"The Department shall suspend payments to a provider upon a Credible Allegation of Fraud for which an investigation is pending under the MaineCare program or any Medicaid Program." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (A) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (a). "A Credible Allegation of Fraud is an allegation that the department has verified, from any source, which has one or more indicia of reliability and which allegation, facts and evidence have been carefully reviewed by the Department, on a case-by-case basis," and "may be, but is not limited to, fraud hotline complaints, claims data mining or patterns identified through provider audits, civil false claims cases and law enforcement investigations." *Id.* Except where asked by law enforcement to withhold such notice, "[t]he Department shall send notice to a provider of a suspension of payments within five days after suspending payments," specifically including the following:

1. State that payments are being suspended in accordance with the relevant federal and State provision.
2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation.
3. State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.
4. Specify, when applicable, the type of MaineCare claims or business units as to which the suspension is effective.
5. Inform the provider of the right to timely submit written evidence for consideration by the department in an informal review.
6. Set forth the administrative appeals process and corresponding citations to this Chapter.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (B), (C) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (b).

"The suspension of payments is for a temporary period," and "will not continue after either of the following:

1. The determination is made by the investigating or prosecuting authorities that there is insufficient evidence of fraud by the provider; or
2. Civil and criminal legal proceedings related to the provider's alleged fraud are completed.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (D) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (c).

Upon receipt of a Notice of Temporary Suspension of Medicaid payments (in-whole or in-part), a provider has a two-tiered right of appeal. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (E)-(K) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (d)-(g). First, "a request for informal review may include or consist of a request to the Department to find good cause not to continue a payment suspension or to convert a suspension to one only in part, in accordance with any of the criteria" further described in the regulation. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (E) (eff. Jan. 1, 2014). The informal review request may include a request for expedited informal review, "which the Department in its discretion may accommodate." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (F) (eff. Jan. 1, 2014). "The Department may find that good cause exists not to suspend payments, or not to continue a payment suspension, when:

1. Law enforcement officials specifically have requested that a payment suspension not be imposed because it may compromise or jeopardize an investigation;
2. Other available remedies implemented by the State more effectively or quickly protect Medicaid funds;
3. The Department determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;
4. Member access to items or services would be jeopardized by a payment suspension because either the provider is the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area;
5. The relevant law enforcement entity declines to certify that a matter continues to be under investigation as required by 42 CFR 455.23(d)(3) (2011), or
6. The Department determines that payment suspension is not in the best interests of the MaineCare program.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (G) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (e).

"The Department may find that good cause exists to suspend payments only in part, or to convert a payment suspension previously imposed in whole to one only in part, when:

1. Member access to items or services would be jeopardized by a payment suspension in whole or in part because either the provider is the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area;
2. The Department determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be imposed only in part;
3. The Credible Allegation of Fraud focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Department determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;
4. The relevant law enforcement entity declines to certify that a matter continues to be under investigation as required by 42 CFR 455.23(d)(3) (2011); or

5. The Department determines that payment suspension only in part is in the best interests of the MaineCare program.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (H) (eff. Jan. 1, 2014); 42 C.F.R. § 455.23 (f).

The Department must then issue a "Final Informal Review Decision," upon receipt of which, "a provider whose payments have been suspended in whole or in part may request expedited appeal to an administrative hearing, which the Department in its discretion may accommodate." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (I) (eff. Jan. 1, 2014). "In an administrative appeal, the Department must show that, at the time of its determination of the existence of a Credible Allegation of Fraud for which an investigation is pending, a sufficient basis existed for that determination." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (H) (eff. Jan. 1, 2014). "If the Department has made a finding as to lack of good cause regarding a payment suspension, the provider must demonstrate by a preponderance of evidence that the Department erred upon informal review in its finding." *Id.*

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, the Ocean Way Mental Health Agency and Ocean Way Manor were properly notified of the time, date, and location of the immediate proceeding.

2. Since September 1999, Ocean Way Mental Health Agency ["MHA"] has provided mental health case management services and daily living support services to individuals, based out of offices in

3. Since September 1995, Ocean Way Manor has provided residential care services to persons with intellectual disabilities at two locations: , and , in

4. On or about September 14, 2009, Ocean Way Manor entered a MaineCare/Medicaid Provider Agreement with the Department, which governed Ocean Way Manor's right to receive MaineCare payments for authorized services provided that it complied with all of its responsibilities outlined in the agreement and under applicable federal and state laws.

5. On January 22, 2013, Ocean Way MHA entered a MaineCare/Medicaid Provider Agreement with the Department, which governed the agency's right to receive MaineCare payments for authorized services provided that it complied with all of its responsibilities outlined in the agreement and under applicable federal and state laws.

6. On June 14, 2016, the Department's Division of Program Integrity ["Program Integrity"] conducted an unannounced on-site inspection at Ocean Way MHA, based on its receipt of "several complaints" related to operations and quality of care provided by both Ocean Way Manor and Ocean Way MHA. The complaint subjects more specifically included but were not limited to substance

use/abuse by staff during work, prescription drug diversion, billing for uncovered services, and backdating of assessments and individual service plans. Test. of Patrick Bouchard.

7. On an unspecified date after the June 14, 2016 on-site inspection at Ocean Way MHA, Program Integrity opened a records-based investigation of Ocean Way Manor related to records from January 1, 2016 to June 1, 2016. Test. of Patrick Bouchard.

8. On an unspecified date in July 2016, Program Integrity presented the results of its investigation into Ocean Way MHA to the Healthcare Crimes Unit of the Office of the Attorney General for further investigation. Test. of Patrick Bouchard.

9. On an unspecified date in August 2016, Program Integrity presented the results of its investigation into Ocean Way Manor to the Healthcare Crimes Unit of the Office of the Attorney General for further investigation. Test. of Patrick Bouchard.

10. On an unspecified date in October 2016, the Healthcare Crimes Unit of the Office of the Attorney General recommended suspension of MaineCare payments to both Ocean Way MHA and Ocean Way Manor, based on the results on its ongoing investigation. Test. of Patrick Bouchard.

11. On October 26, 2016, Program Integrity issued a Notice of Suspension of Medicaid Payments to Ocean Way MHA, effective October 25, 2016, specifically noting that the Department had received a credible allegation of fraud, and that an investigation was pending into that credible allegation of fraud. The Notice specifically identified the following "general allegations" supporting the decision to suspend Medicaid payments:

- Backdating of assessments and treatment plans
- Significant non-compliance with the MaineCare Benefits Manual
- Billing for non-covered services
- Duplication of services between Daily Living Support Services (DLSS) and Community Integration (CIS)

Ex. D-3.

12. On November 8, 2016, Laurie L. Ryan, President of Ocean Way MHA and Ocean Way Manor, provided the Department a written request for Informal Review of the Notice of Suspension of Medicaid Payments. The Informal Review request provided responsive answers to each of the four general allegations identified in the October 26, 2016 Notice of Suspension and requested an expedited review. The request did not specifically request a Departmental finding of good cause not to continue the payment suspension or to convert a suspension to one only in part. The request identified equitable reasons for Departmental forbearance of the payment suspensions. Ex. D-4.

13. On November 14, 2016, Division of Audit Director Herb F. Downs issued a "Final Informal Review Decision (expedited)" in response to the request for Informal Review filed by Ms. Ryan on November 8, 2016. The Department determined that a credible allegation of fraud existed and that the

procedural requirements to implement a temporary suspension of Medicaid payments had been satisfied. The Final Informal Review Decision included no finding as to the presence or lack of good cause for staying implementation of the payment suspension or converting it to a suspension in part. Ex. D-5.

14. On November 27, 2016, Laurie L. Ryan, President of Ocean Way MHA and Ocean Way Manor, filed a written request for "Expedited Administrative Review related to the Ocean Way Mental Health Agency denial, as well as our Manor billing and authorizations." Ex. D-6.

15. As of October 26, 2016, the Department had received a credible allegation of fraud against Ocean Way MHA and Ocean Way Manor.

16. As of October 26, 2016, and November 14, 2016, an investigation was pending into the credible allegation of fraud made against Ocean Way MHA and Ocean Way Manor.

17. The Healthcare Crimes Unit of the Office of the Attorney General determined on an unspecified date before October 26, 2016 that imposition of a Medicaid Payment Suspension against Ocean Way MHA and Ocean Way Manor would not jeopardize its investigation into those agencies, which have remained under investigation throughout the pendency of the present appeal.

18. No remedies other than Medicaid Payment Suspension against Ocean Way MHA and Ocean Way Manor would more effectively or quickly protect Medicaid funds.

19. Written evidence submitted to the Department by Ocean Way MHA and Ocean Way Manor did not result in a Departmental determination that the payment suspension should be removed or imposed only in part.

20. Ocean Way MHA is neither the sole source of essential specialized services in the community, nor the servicer of a large number of members within a HRSA-designated medically underserved area.

21. Ocean Way Manor is neither the sole source of essential specialized services in the community, nor the servicer of a large number of members within a HRSA-designated medically underserved area.

22. The Credible Allegations of Fraud were not solely and definitively focused on only a specific type of claim or arising from a specific business unit of a provider.

23. There is insufficient evidence to support a finding that Departmental payment of potentially fraudulent claims would not continue if the payment suspensions against Ocean Way MHA and Ocean Way Manor were converted to payment suspensions in part.

24. There is insufficient evidence to support a finding that Medicaid Payment Suspension to Ocean Way MHA and Ocean Way Manor is not in the best interests of the MaineCare program.

RECOMMENDED DECISION

The Department was **correct** when it suspended Medicaid payments to Ocean Way Mental Health Agency and Ocean Way Manor because of its determination that there existed a credible allegation of fraud for which an investigation was pending, absent a good cause exception.

REASONS FOR RECOMMENDATION

At hearing, Ocean Way MHC and Ocean Way Manor [hereinafter "Ocean Way"] did not challenge the validity of the Department's Notice dated October 26, 2016, and stipulated that:

- the Department received what it deemed a credible allegation of fraud against Ocean Way;
- the Department referred the credible allegation to the Healthcare Crimes Unit of the Office of the Attorney General for investigation;
- the Healthcare Crimes Unit accepted the Department's referral as a credible allegation of fraud;
- the Department was "within the bounds of the rule in suspending payments, absent good cause not to suspend payments."

Hearing Record, at 1:23:30.

By so stipulating, Ocean Way did not yield that the Department drew all of the correct conclusions from the information that was "credibly alleged," and expressly reserved the right to argue about the substance of those allegations when/if such allegations are re-raised in another legal context. However, Ocean Way yielded that the allegations were sufficiently credible and that the referral and subsequent investigation by the Healthcare Crimes Unit was sufficient for the purposes of satisfying the regulatory standard of Section 1.20-3 (A). Accordingly, the parties essentially agreed that the sole issues presented for appeal concerned good cause for forbearing the payment suspension or converting it from a suspension in-whole to one only in part.

As noted above, Section 1.20-3 of the Chapter 1 of the MaineCare Benefits Manual affords the Department discretion "not to suspend payments" or "continue a payment suspension," upon a finding that good cause exists. 10-144 C.M.R Ch. I, § 1.20-3 (G). The same discretion is afforded "to suspend payments only in part, or to convert a payment suspension previously imposed in whole to one only in part," provided that a finding of good cause is made. 10-144 C.M.R Ch. I, § 1.20-3 (H).

The Department's position presented at hearing was that the burden to initiate the good cause provisions is upon the provider, whose request for informal review "may include or consist of a request to the Department to find good cause not to continue a payment suspension or to convert a suspension to one only in part ...." *See* 10-144 C.M.R. Ch. I, § 1.20-3 (E). While it is clear that providers are empowered to request good cause, it is not clear that the Department is barred from finding good cause absent a Section 1.20-3 (E) provider request. Rather, the regulations suggest that the Department's

discretionary option to consider good cause to forbear a payment suspension becomes obligatory if a provider requests a Departmental finding as to the presence or absence of good cause. This is supported by the language used in the provision outlining the issues that can be raised in an administrative appeal from a Final Informal Review Decision. *See* 10-144 C.M.R. Ch. I, § 1.20-3 (J).[1] The provision contains two clauses, the first of which describes the Department's primary burden at hearing – that it "must show that, at the time of its determination of the existence of a Credible Allegation of Fraud for which an investigation is pending, a sufficient basis existed for that determination." *Id.* (emphasis added). The second clause, however, begins with a burden shift to the provider. The provider is afforded an opportunity to prove, by preponderance of the evidence, that "the Department erred upon information review in its finding" with respect to either the absence or presence of good cause. *Id.* However, this secondary issue is wholly contingent upon the election by the Department to make a finding, one way or the other. Thus, if the provider does not request a Departmental good cause finding as a part of its informal review request, and the Department does not electively issue a finding as to the presence or lack of good cause in its Final Informal Review Decision, the provider is foreclosed from raising the good cause issue at hearing.

Here, Ocean Way did not request consideration of good cause by the Department when it filed its "Request for Review and/or Reconsideration," on November 8, 2016. Ocean Way President Laurie L. Ryan's letter did identify hardships to herself and her employees that would likely result from a payment suspension. Ex. D-4. However, the letter only incidentally described the likely impact upon "clients that have been with me for up to 21 years as they may have to be sent to another facility." Ex. D-4. Thus, the letter explicitly acknowledged the availability of comparable services with other providers in the [redacted] region.

Program Integrity health planner Patrick Bouchard and Ms. Ryan each testified about the efforts to find replacement mental health services for Ocean Way MHA clients and for residential clients at Ocean Way Manor's two sites. Test. of Patrick Bouchard; Test. of Laurie L. Ryan. Both identified that there was at least one placement that had not yet been completed due to resistance by the member, but otherwise reflected that other providers located in the same coverage region were available to assume care for all affected individuals. Test. of Patrick Bouchard; Test. of Laurie L. Ryan. The one enunciated good cause basis broadly addressing factors like those alleged by Ms. Ryan in her November 8, 2016 informal review request – i.e. that "[m]ember access to items or services would be jeopardized by a payment suspension ...." – does not contemplate scenarios where clients are unhappy about the need to change providers. 10-144 C.M.R. Ch. I, §1.20-3 (G)(4), (H)(1). That good cause basis

[1] Section 1.20-3 (J) provides:

> In an administrative appeal, the Department must show that, at the time of its determination of the existence of a Credible Allegation of Fraud for which an investigation is pending, a sufficient basis existed for that determination. If the Department has made a finding as to lack of good cause regarding a payment suspension, the provider must demonstrate by a preponderance of evidence that the Department erred upon informal review in its finding.

10-144 C.M.R. Ch. I, § 1.20-3 (J).

contemplates members whose access to services is "jeopardized," or "exposed to danger or risk." "Jeopardize," Merriam-Webster Online Dictionary, *available at* http://www.merriam-webster.com/dictionary/jeopardize (last visited on March 23, 2017). If members have alternative placements but are resistant to change, those members' access to comparable services is not in jeopardy. As such, Ms. Ryan's November 8, 2016 Request for Review and/or Reconsideration letter should not be construed as requesting a Departmental good cause finding.

Moreover, the Department's Final Informal Review Decision, dated November 14, 2016, did not include any finding about the presence or lack of good cause for the purposes of forbearing the payment suspension despite the credible allegation of fraud and referral for investigation. Ex. D-5. Thus, when Ocean Way perfected its administrative appeal, it was foreclosed from arguing that the Department issued an erroneous finding. More simply, Ocean Way could not argue that the Department made the wrong finding where the Department made no finding at all.

In its closing statement, Ocean Way argued that such a regulatory construction by the Commissioner would have "form ... elevated over substance," and implicate the "spirit of these rules." Ex. A-6. 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, that is, the language in question is not "reasonably susceptible to different interpretations." *Voter v. Voter*, 2015 ME 11, ¶8, 109 A.3d 626, 630. Thus, no resort to the "spirit of the law," where doing so would be in conflict with the plain language of the regulation, is appropriate. *See Dep't of Human Servs. ex rel. Hampson v. Hager*, 2000 ME 140, ¶21, 756 A.2d 489, 493 (regulatory language "should be construed to avoid absurd, illogical, or inconsistent results," and in light of the whole regulatory scheme "for which the section at issue forms a part so that a harmonious result ... may be achieved."). For these reasons, there is insufficient basis for concluding that the Department was incorrect when it suspended Medicaid payments to Ocean Way based on a credible allegation of fraud for which an investigation was pending.

Alternatively, if the Commissioner were to construe the regulation in such a way that it required the Hearing Officer to review the applicability of the good cause factors *de novo*, there is still insufficient basis for finding that there was good cause to forbear the payment suspension here. As noted above, the burden is on the provider to demonstrate, by a preponderance of evidence, that the Department erred upon informal review in failing to find good cause 1) not to suspend payments / continue a payment suspension, and 2) not to suspend payments only in part, or convert a payment suspension previously imposed in whole to one only in part. *See* 10-144 C.M.R. Ch. I, § 1.20-3 (J).

Ocean Way did not identify the specific factors under which it alleged that the Department incorrectly failed to find good cause. However, as both parties identified in their closing arguments, there are two of the factors that reasonably relate to the evidence supplied by Ocean Way:

- Member access to items or services would be jeopardized by a payment suspension because either the provider is the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area;
- Other remedies were available to the Department that could more effectively or quickly protect Medicaid funds
- The Department determines that payment suspension is not in the best interests of the MaineCare program.

Ex. D-28; Ex. A-6. *See* 10-144 C.M.R. Ch. I, § 1.20-3 (G), (H).

With respect to its argument and supporting evidence that members' ongoing access to services was in jeopardy, Ocean Way noted in its closing:

> Ocean Way is a small but well-established provider, delivering services to vulnerable individuals who have not been successful in treatment elsewhere. It has been difficult to find alternative sources of treatment and care for the individuals served by Ocean way, during the payment suspension. Ms. Ryan testified that many of the clients at Ocean Way mental health agency had been unsuccessful in treatment elsewhere and did not want to leave behind the services that have been helpful to them at Ocean Way mental health agency.
>
> Even more compelling are the circumstances faced by the smaller number of clients receiving residential services. One client of OWMHA resides at _____ and receives intensive DLSS services as authorized by the Department. Five others, two of whom have now been placed elsewhere, were at the time of the suspension receiving services from OWM. All of these individuals require essentially lifelong services, and finding the right combination of residential circumstances and treatment environment is extremely challenging.

Ex. A-6, at 4.

For the same reasons noted above, Ocean Way's argument and supporting evidence with respect to this good cause basis are insufficient to meet the standard identified in the regulation. Difficulty in accessing new, available placements, partly due to individual members' purported resistance to change, does not justify a finding that a payment suspension requiring such changes would jeopardize those members' access to services. Moreover, the regulation specifies that any actual jeopardy identified must be directly caused by the fact that the provider is "the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area." 10-144 C.M.R. Ch. I, § 1.20-3 (G), (H). Ocean Way raised no argument, and there is no evidence in the record that the _____ coverage area was a HRSA-designated medically underserved area. Moreover, the evidence reflects that there is at least one other provider in the _____' coverage area that has been identified as available to provide replacement DLS, CI, and residential care services to all affected members in due course.

In its closing, Ocean Way argued that, "at least in the short term, Ocean Way is *in fact* the sole source of services in the community of the kind these clients require," based on evidence that on the date of the hearing, "three of the five clients of Ocean Way Manor, and approximately 14 of the clients at Ocean Way Mental Health Agency had not yet been placed elsewhere by the Department." Ex. A-6, at 5. This argument misconstrues the plain language of the regulation and ignores undisputed testimony that other providers were available to provide the same services within the same community. That some members had not been placed in fact by a discrete date does not mean that no other providers were available in the community to provide the essential, specialized services. As such, it should not be concluded that Ocean Way sustained its burden to prove that members' access to essential, specialized services was jeopardized, that Ocean Way was the sole community provider of the relevant essential specialized services, or that the region was a HRSA-designated medically underserved area.

Finally, Ocean Way argued in its closing that the Department should have found good cause based on two other closely-related factors, i.e. that "available remedies implemented by the State [could] more effectively or quickly protect Medicaid funds" and "payment suspension is not in the best interests of the MaineCare program." Ex. A-6. *See* 10-144 C.M.R. Ch. I, § 1.20-3 (G), (H). The Department made a threshold determination that, based on the credible allegation of fraud, there was justification to immediately and temporarily suspend Medicaid payments to Ocean Way. Ocean Way provided no additional evidence suggesting some comparative determination that MaineCare funds would be "more effectively or quickly protected" by continuing to pay Ocean Way's billed claims rather than suspending such payments. Therefore, it should not be concluded that Ocean Way sustained its burden on this score.

Nor did Ocean Way sufficiently demonstrate that the "best interests of the MaineCare program" would be better served by a full or partial lifting of the payment suspension. Ocean Way's argument on this point was reflected in its closing as follows:

> Ending the payment suspension, while continuing the Department's diligent investigation and also allowing Ocean Way to appeal any final determinations by the Department, is a more reasonable and appropriate strategy, serving the best interests of the MaineCare program.
>
> The Department has countered that resuming payments does not serve MaineCare's interests because of the audit findings that PI has made. Those findings, however, are subject to appeal and either have been or will be appealed now that informal review decision have been issued. The mere existence of appealable findings does not establish that providers who have been in business for many years with a record of successful operation should be forced out of business while their appeals are pending.

Ex. A-6, p. 5.

Ocean Way's argument would be persuasive if was not premised upon a misconstruction of the regulatory assignment of the burden of proof. The Department made no finding as to good cause based

on the "best interests of the MaineCare program" in its Final Informal Review Decision, and was under no obligation to affirmatively demonstrate at hearing that the payment suspension was in the best interests of the MaineCare program. At hearing, Ocean Way bore the burden to demonstrate, by a preponderance of the evidence, that the payment suspension was not in the best interests of the MaineCare program. Ocean Way urges an inference that imposition of payment suspensions during the pendency of related audit appeals have the effect of forcing providers out of business, and is therefore not in the best interests of the MaineCare program. To prevail on this argument, Ocean Way had the burden to come forward with evidence showing that the best interests of the MaineCare program were not served by the Department acting in the manner required by Section 1.20-3, 42 C.F.R. § 455.23, and its State Medicaid Plan approved by the Centers for Medicare & Medicaid Services. Ocean Way did not sustain this burden.

The preponderance of the evidence here reflects a likelihood that the payment suspension will negatively impact Ocean Way's ability to remain in operation, both as a mental health services provider and as a residential care services provider. The preponderance of the evidence also reflects the likelihood that the payment suspension required the re-placement of all members into relationships with other mental health and residential services providers in the region. The preponderance of the evidence does not reflect that these two likely circumstances were of such import that the payment suspension was not in the best interests of the MaineCare program.

For these reasons, the Hearing Officer respectfully recommends that it be concluded that the Department was **correct** when it suspended Medicaid payments to Ocean Way Mental Health Agency and Ocean Way Manor because of its determination that there existed a credible allegation of fraud for which an investigation was pending, absent a good cause exception.

MANUAL CITATIONS

- DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (eff. Jan. 23, 2006)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101 (eff. Jan. 1, 2014; Apr. 16, 2016).

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: 3/24/2017

Richard W. Thackeray, Jr.
Administrative Hearing Officer

cc: Charles F. Dingman, Esq., PRETI FLAHERTY BELIVEAU & PACHIOS, LLP, Augusta
Laurie L. Ryan, President, Ocean Way MHC and Ocean Way Manor,
Thomas Bradley, AAG, OFFICE OF THE ATTORNEY GENERAL, Augusta
Patrick Bouchard, Program Integrity, OMS, DHHS, Augusta