Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

IN THE MATTER OF:

Ocean Way Manor &)
Ocean Way Mental Health Agency)
c/o Riley L. Fenner, Esq.) **FINAL DECISION**
97 India Street)
Portland, ME 04101)

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

The Recommended Decision of Hearing Officer Thackeray, mailed July 23, 2019 and the responses and exceptions filed on behalf of Ocean Way Manor & Ocean Way Mental Health Agency have been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that for the review period of [redacted] 2016 to [redacted] 16, Ocean Way Manor owes the Department a sum of $25,614.57, related to claims billed for services provided by unqualified staff (lacking DSP certifications and required background checks) and claims billed for services while the member was out of the facility. For the review period from [redacted] 2015 to [redacted] 016, Ocean Way Mental Health Agency owes the Department a sum of $186,766.47 related to claims billed for non-covered services; backdating of Comprehensive Assessments, Treatment Plans and Locus Assessments; billing for indirect services that are included in the rate of reimbursement, i.e., transportation, etc.; Comprehensive Assessments that show no medical necessity for services being provided to MaineCare members; and missing progress notes required to support claims billed to MaineCare.

DATED: 9-12-19 SIGNED: Jeanne M. Lambrew
JEANNE M. LAMBREW, Ph.D., 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: William Logan, DHHS/OMS
Patrick Bouchard, DHHS/Division of Audit

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Acting Commissioner

Maine Department of Health and Human Services
Administrative Hearings
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Date Mailed: JUL 23 2019

Jeanne M. Lambrew, Ph.D., Commissioner
Department of Health and Human Services
11 State House Station • 109 Capitol Street
Augusta, ME 04333

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

NPI ID Nos. 1447484704 / 1407192958

ADMINISTRATIVE HEARING RECOMMENDED DECISION

A consolidated administrative hearing was initially convened in the two above-captioned matters on December 19, 2018, before Hearing Officer Richard W. Thackeray, Jr., at Rockland, Maine, and then reconvened on January 28, 2019. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner of the Maine Department of Health and Human Services. The post-hearing record was left open through (and closed on) February 28, 2019, to allow submission of post-hearing briefs and a Departmental technical correction memorandum. The issues presented for appeal were identified by Orders of Reference issued on March 7, 2017, and May 8, 2017, as follows:

> Was the Department correct when it determined for the review period of [redacted]6 through [redacted]16, Ocean Way Manor owes the Department $25,614.57 for recoupment of identified overpayments because unqualified staff provided services (lacking DSP certifications and required background checks); and because Ocean Way Manor billed for services while the member was out of the facility?
>
> ...
>
> Was the Department correct when for the review period of [redacted]2015 to [redacted]2016, it determined that Ocean Way Mental Health Agency improperly billed for, and was paid for, services provided under MaineCare policy Section 17 for the following reasons:
>
> 1. Billing for non-covered services;
> 2. Backdating of Comprehensive Assessments, Treatment Plans and Locus Assessments;
> 3. Billing for indirect services that are included in the rate of reimbursement, i.e. transportation, etc.;
> 4. Assessments that show no medical necessity for services being provided to MaineCare members;
> 5. Missing required progress notes to support claims billed to MaineCare;
>
> Furthermore, is the resulting recoupment demand for the identified overpayment in the amount of $372,299.32 correct?

Ex. HO-31; Ex. HO-34.

By stipulation of the Department, the final recoupment claims identified on appeal, as of February 28, 2019, were $25,614.57 against Ocean Way Manor and $186,766.47 against Ocean Way Mental Health Agency. Ex. D-43.

APPEARING ON BEHALF OF THE APPELLANT

- Riley L. Fenner, Esq. (from November 21, 2018)
- Charles F. Dingman, Esq., (February 21, 2017 to August 10, 2018)
- Michael S. Smith, Esq., (February 21, 2017 to August 10, 2018)
- Laurie L. Ryan
- Jeannette Knowlton
- Carol A. Davis, BSN, BS Ed., LSW, QMRP (by telephone)
- Heather Hyatt, State Surveyor (by telephone)

APPEARING ON BEHALF OF THE DEPARTMENT

- William P. Logan, Esq. (from November 30, 2018)
- Thomas C. Bradley, AAG (February 27, 2017 to November 29, 2018)
- Patrick Bouchard
- Jodi Ingraham Albert (by telephone)
- Suzanne Kearns (by telephone)

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Reschedule Notice," dated December 20, 2018
HO-2 "Reschedule Notice," dated December 4, 2018
HO-3 "Change of Venue Order," dated December 4, 2018
HO-4 "Entry of Appearance – William P. Logan, Esq.," dated November 30, 2018
HO-5 "Withdrawal of Representation – Thomas C. Bradley, AAG," dated November 29, 2018
HO-6 "Order: Continuance," and "Email Chain," dated November 27, 2018
HO-7 "Witness List and Response to Motion for Continuance," dated November 29, 2018
HO-8 "Entry of Appearance – Riley L. Fenner, Esq. and Motion for Continuance," dated November 21, 2018
HO-9 "Status Update Request and Response," dated November 19, 2018
HO-10 "Withdrawal of Representation," dated August 10, 2018
HO-11 "Reschedule Notice," dated July 17, 2018
HO-12 "Motion for Continuance (granted)," dated July 11, 2018
HO-13 "Reschedule Notice," dated July 3, 2018
HO-14 "Motion for Continuance (granted)," dated June 22, 2018
HO-15 "Reschedule Notice," dated May 24, 2018
HO-16 "Motion for Continuance (granted)," dated May 11, 2018
HO-17 "Reschedule Notice," dated March 28, 2018
HO-18 "Reschedule Notice," dated February 7, 2018
HO-19 "Reschedule Notice," dated January 24, 2018
HO-20 "Motion for Continuance (granted)," dated January 11, 2018
HO-21 "Reschedule Notice," dated December 19, 2017
HO-22 "Motion for Continuance (granted)," dated December 13, 2017
HO-23 "Email Prehearing Correspondence," October 17, 2017 to November 13, 2017
HO-24 "Reschedule Notice," dated November 1, 2017
HO-25 "Email Prehearing Correspondence," October 17, 2017
HO-26 "Reschedule Notice," dated September 28, 2017

HO-27 "Exhibit List and Witness List – appellant," dated September 15, 2017

HO-28 "Exhibit List and Witness List – appellant," dated September 13, 2017

HO-29 "Motion for Continuance and Response," May 24, 2017 to June 5, 2017

HO-30 "Reschedule Notice," dated June 14, 2017

HO-31 "Order of Reference – Ocean Way Manor," dated May 8, 2017

HO-32 "Notice of Administrative Hearing – Ocean Way Manor," dated May 9, 2017

HO-33 "Fair Hearing Report form – Ocean Way Manor," dated May 9, 2017, and attachments:

- "Notice of Violation," dated November 15, 2016
- "Request for Reconsideration," dated November 21, 2016
- "Request for Informal Review," dated January 17, 2017
- "Final Informal Review Decision," dated February 3, 2017
- "Appeal and Request for Administrative Hearing," dated April 7, 2017
- "Excerpts," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101

HO-34 "Order of Reference – Ocean Way MHA," dated March 7, 2017

HO-35 "Notice of Administrative Hearing – Ocean Way MHA," dated March 14, 2017

HO-36 "Fair Hearing Report form – Ocean Way MHA," dated February 27, 2017, and attachments:

- "Notice of Violation," dated October 19, 2016
- "Request for Informal Review," dated November 1, 2016
- "Final Informal Review Decision," dated December 22, 2016
- "Appeal and Request for Administrative Hearing," dated February 21, 2017
- "Excerpts," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101

Department Exhibits

D-1 "Order of Reference – OWMHA," dated March 7, 2017

D-2 "Fair Hearing Report Form – OWMHA," dated February 27, 2017

D-3 "Notice of Violation – OWMHA," dated October 19, 2016

D-4 "Informal Review Request – OWMHA," dated November 1, 2016

D-5 "Final Informal Review Decision – OWMHA," dated December 22, 2016

D-6 "Hearing Request – OWMHA," dated February 21, 2017

D-7 "Revised Recoupment Claim Spreadsheet," dated October 2017

D-8 "Final Rule – Gen. Admin. Policies and Proc.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1 (eff. Jan. 1, 2014)

D-9 Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)

D-10 Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Mar. 22, 2016)

D-11 "Community Licensing Standards CS.4 and CS.7"

D-12 "MaineCare Provider Agreement," dated January 4, 2013

D-13 "Member Records – Member #1 [redacted]

D-14 "Member Records – Member #2 [redacted]

D-15 "Member Records – Member #22 [redacted]

D-16 "Member Records – Member #24 [redacted]

D-17 "Member Records – Member #30 [redacted]

D-18 "Member Records – Member #34 [redacted]

D-19 "Member Records – Member #38 [redacted]

D-20 "Member Records – Member #41 [redacted]
D-21 "Member Records – Member #65 [redacted]
D-22 "Member Records – Member #1 [redacted]
D-23 "Member Records – Member #49 [redacted]
D-24 "Member Records – Member #5 [redacted]
D-25 "Email," Laurie Ryan, dated October 15, 2016
D-26 <blank>
D-27 "Order of Reference – OW Manor," dated May 8, 2017
D-28 "Fair Hearing Report Form – OW Manor," dated April 24, 2017
D-29 "Notice of Violation – OW Manor," dated November 15, 2016
D-30 "Informal Review Request – OW Manor," dated November 21, 2016
D-31 "Final Informal Review Decision – OW Manor," dated February 3, 2017
D-32 "Hearing Request – OW Manor," dated April 7, 2017
D-33 "Final Rule – Gen. Admin. Policies and Proc.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1 (eff. Jan. 1, 2014)
D-34 Final Rule, "Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21 (eff. Sept. 1, 2014)
D-35 "MaineCare Provider Agreement," dated September 14, 2009
D-36 "Employment documents"
D-37 "Employment Background Checks," dated January 4, 2013
D-38 "Email," Laurie Ryan, dated October 15, 2016
D-39 "Email," Laurie Ryan, dated August 11, 2016
D-40 "Ocean Way Employee Schedule," June 2016
D-41 "Ocean Way Employee Schedule," July 2016
D-42 "Member Record – Member #3 [redacted]
D-43 "Written Closing Brief," dated February 28, 2018

Appellant Exhibits

A-1 (excluded, duplicative of Departmental exhibit)
A-2 (excluded, duplicative of Departmental exhibit)
A-3 (excluded, duplicative of Departmental exhibit)
A-4 "Letter," Carlton Lewis, LCSW, LADC, dated [redacted] 2015
A-5 "Email," dated September 17, 2015
A-6a "Emails," multiple senders, 2014 & 2015
A-6b "Emails," multiple senders, 2015
A-6c "Emails," multiple senders, November 2015
A-6d "Emails," multiple senders, 2015
A-7a "Letter," Suzanne J. Kearns, BS, dated October 18, 2016
A-7b "Letter," Suzanne J. Kearns, BS, dated October 26, 2016
A-8 "Agreement to Purchase Services," dated July 28, 2015
A-9 "Letter," Suzanne J. Kearns, BS, dated January 25, 2017
A-10 "Settlement Agreement," *Bates v. Glover*, No. KEN-CV-89-088 (Me. Super. Ct. Aug. 2, 1990)
A-11 "Written Closing Brief," dated February 28, 2019

LEGAL FRAMEWORK

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) (eff. Jan. 23, 2006); "Provider Appeals," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (A) (eff. Jan. 1, 2014). 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).

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.* An enrolled provider is 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. 1, 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) (provider agreements must require providers "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan," and "to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request."). 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 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). Enrolled providers are also required to "[b]ill only for covered services and supplies delivered." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (J).

"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; 42 C.F.R. § 455.1; 42 C.F.R. § 456.3 (a), (b). 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, including but not limited to:

- 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;
- Violating the applicable provision of any law governing benefits governed by the MaineCare Benefits Manual, or any rule or regulation promulgated pursuant thereto;
- 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 (eff. Jan. 1, 2014).

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 in accordance with the following:

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 (eff. Jan. 1, 2014).

RECOMMENDED FINDINGS OF FACT

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

2. For all periods relevant to this proceeding, Ocean Way Manor ["OWM"] consisted of two Departmentally-licensed, Level III Residential Care Facilities located in Thomaston and Rockland that provided residential and MaineCare Section 21 services for individuals with intellectual disabilities or Autistic Disorder.

3. For all periods relevant to this proceeding, Ocean Way Mental Health Agency ["OWMHA"] was an agency headquartered in Thomaston, which provided MaineCare Section 17 services for individuals with mental health diagnoses including but not limited to schizophrenia, affective disorders, anxiety-related disorders, and substance use-related disorders.

4. Effective January 2, 2013, OWMHA entered into a "Medicaid/Maine Health Program Provider / Supplier Agreement" with the Department, through which OWMHA 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-12.

5. Effective April 22, 2010, OWM entered into a "Medicaid/Maine Health Program Provider / Supplier Agreement" with the Department, through which OWM 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-35.

6. On or about June 14, 2016, the Department initiated a post-payment review of billing claims submitted by OWMHA, specifically obtaining copies and reviewing records related to 5,639 claims that the Department paid to OWMHA from [redacted], 2015 to [redacted] 2016. Test. of Patrick Bouchard.

7. The Departmental post-payment review identified that during the [redacted] 2015 to [redacted] 2016 period, MaineCare paid OWMHA a total of $641,490.80 for all claims billed to the Department for Community Integration and Daily Living Support services rendered pursuant to MaineCare Section 17. Of this amount, the Department determined that OWMHA was overpaid $437,796.37. Ex. D-3.

8. On October 19, 2016, Departmental comprehensive health planner Patrick Bouchard issued a "Notice of Violation" to OWMHA, establishing a claim for recoupment in the amount of $437,796.37, related to the post-payment review findings. Mr. Bouchard found the OWMHA either breached "the terms of its MaineCare Provider/Supplier Agreement, and/or the Requirements of Section 1.03-3 for provider participation," or failed "to repay or make arrangements to repay overpayments or payments made in error." Mr. Bouchard specifically found:

- Comprehensive Assessments required for services to be coverable under Section 17 were "missing, not clinically approved, or contained minimal information regarding

the progress made for the member, their current needs and justification for continued services at the time of their annual review";

- Individual Service Plans required for services to be coverable under Section 17 were "missing, incomplete, or not signed by the member or provider";
- Progress Notes required for services to be coverable under Section 17 "did not match the number of units billed to and paid by MaineCare" or were "missing required components";
- Non-covered educational, transportation, socialization, recreation, custodial care, and administrative tasks were improperly billed to MaineCare under Section 17.

Ex. D-3.

9. On November 1, 2016, OWMHA President Laurie L. Ryan, a/k/a Laurie Tardiff timely requested an informal review of the Department's "Notice of Violation." In doing so, she did not substantively dispute any of the alleged violations but rather identified personal medical problems she had suffered and acknowledged "dishonest and unethical" behavior by her administrative staff and employees. Additional records and documentation were supplied to the Department to assist in the final informal review. Ex. D-4.

10. On December 22, 2016, Departmental Division of Audit Director Hebert F. Downs issued a "Final Informal Review Decision" ["FIRD"] against OWMHA, in response to the "Request for Informal Review," dated November 1, 2016. The FIRD included a revised recoupment claim, reduced to $372,299.32, and noted the following bases for that reduction:

- Documentation submitted demonstrated that certain services had been provided and therefore reduced the overpayment for affected claims to zero;
- Documentation provided did not meet all requirements of the MaineCare benefits manual resulting in a reduction of the overpayment to 20 percent;
- Documentation provided was not pertinent to the issues identified on the NOV spreadsheet. This resulted in no change to the identified overpayment.

Ex. D-5.

9. On February 21, 2017, OWHMA timely requested an administrative hearing. In so doing, OWMHA argued that "this $65,497.05 reduction in the recoupment demand as a result of the Request was insufficient by a considerable margin," and that "many of the claims for which it was allegedly overpaid were in fact properly billed and paid, and that otherwise were subject to at most a 20%, rather than 100% recoupment." Ex. D-6.

10. One unspecified dates between February 21, 2017 and October 2017, OWMHA submitted additional documentation in support of its claim for a reduced MaineCare recoupment claim. Ex. D-6.

11. In October 2017, the Department produced a revised recoupment claim against OWMHA in the amount of $186,766.47, based on its review of the newly submitted documentation. Ex. D-7.

12. On an unspecified date in 2016, the Department initiated a post-payment review of billing claims submitted by OWM, specifically requesting all records related to services it provided during the period of [redacted] 2016 to [redacted] 2016. Test. of Patrick Bouchard.

13. The Departmental post-payment review identified that during the [redacted] 2016 to [redacted] 2016 period, MaineCare paid OWM a total of $122,610.78 for all claims billed to the Department for Home Support / Habilitation services provided under the MaineCare Section 21 Home and Community Benefits Waiver Program for Members with Intellectual Disabilities or Autistic Disorder. Of this amount, the Department determined that OWM was overpaid $25,614,57. Ex. D-29.

14. On October 19, 2016, Departmental comprehensive health planner Mr. Bouchard issued a "Notice of Violation" to OWM, establishing a claim for recoupment in the amount of $25,614.57, related to its post-payment review findings. Mr. Bouchard found the OWM either breached "the terms of its MaineCare Provider/Supplier Agreement, and/or the Requirements of Section 1.03-3 for provider participation," or failed "to repay or make arrangements to repay overpayments or payments made in error." Mr. Bouchard specifically found:

- OWM employed service providers who were not certified as Direct Support Professionals ["DSPs"] at times when they provided Home Support services to MaineCare members that were billed to the Department;
- OWM did not complete required background checks and nor did it request employee checks for abuse, neglect or exploitation prior to allowing them to provide Home Support services to MaineCare members that were billed to the Department;
- OWM billed for services for a member when evidence showed the same member was out of the facility and not utilizing support from the identified provider.

Ex. D-29.

15. On November 21, 2016, OWM President Ms. Ryan timely requested an informal review of the Department's "Notice of Violation," in which she responded as follows:

- Acknowledged "a mistake of billing on [redacted]" and indicated she was "more than agreeable to pay this back immediately."
- Acknowledged at least two service provider staff were not DSP certified during periods when they provided Section 21 services that were billed to the Department.

Ex. D-30.

16. On December 22, 2016, Departmental Division of Audit Director Mr. Downs issued a "Final Informal Review Decision" ["FIRD"] against OWM, in response to the "Request for Informal Review," dated November 21, 2016. The FIRD noted that no additional documentation had been received. As a result, the FIRD affirmed the recoupment claim in the amount of $25,614.57. Ex. D-33.

17. On April 7, 2017, OWHMA timely requested an administrative hearing. In so doing, OWMHA argued that "guidance with respect to DSP qualifications" is unclear; "much of the recoupment demand should be reduced from 20% to significantly less"; and that "any penalty for this record-keeping error

should apply only to the shifts employed by the two employees in question, rather than to the entire amount claimed and paid." Ex. D-32.

18. OWM employed service providers who were not certified as Direct Support Professionals ["DSPs"] at times when the same individuals provided Home Support services to MaineCare members that were billed to the Department.

19. OWM did not complete required background checks and/or adult and child protective record checks for abuse, neglect, or exploitation of its employees prior to allowing those employees to provide Home Support services to MaineCare members that were billed to the Department.

20. The Department was within its discretion in assessing a penalty equal to 20-percent of the $122,610.78 in claims billed between [redacted] 2016 and [redacted] 2016 (i.e. $24,522.16) where OWM failed to complete required employee background checks and/or adult and child protective record checks for abuse, neglect, or exploitation.

21. OWM billed for services for a member (OWM Member #3 / [redacted]) for four dates [redacted] on which the same member was out of the facility and not utilizing support from the identified provider. Ex. D-42; Test. of Patrick Bouchard.

22. The Department correctly established a penalty equal to $1,092.41, reflecting the sum of 100-percent penalties assembled for each of five days on which OWM billed for Home Support services for [redacted] when evidence reflects she was away from the facility and not actually receiving such services.

23. OWMHA improperly billed as Section 17 CIS or DLS services certain non-covered services that included clerical/administrative work, cancelled appointments, attending / studying for non-clinical classes, activities that were primarily social or recreational in nature, transportation, car shopping, and other retail shopping. Ex. D-17; Ex. D-19; Ex. D-20; Ex. D-21; Ex. D-24; Test. of Patrick Bouchard.

24. OWMHA backdated, misdated, falsified, failed to provide signed approval on Comprehensive Assessments related to member service claims that were billed to and paid by the Department as Section 17 CIS or DLS services claims. Ex. D-13; Ex. D-16; Ex. D-17; Ex. D-18; Ex. D-21; Ex. D-22; Ex. D-23; Ex. D-24; Ex. D-25; Test. of Patrick Bouchard.

25. OWMHA did not timely review, approve, and maintain Individual Service Plans ["ISPs"] that were based on Comprehensive Assessments and accurately identified clinical services to be provided. required to support claims billed to MaineCare. Ex. D-13; Ex. D-16; Test. of Patrick Bouchard.

26. OWMHA did not timely develop and maintain accurate progress notes that identified dates of services actually provided, types of services actually provided, signatures of individuals providing the services, and the amounts of services actually billed to and paid by MaineCare. Ex. D-13; Ex. D-14; Ex. D-15; Ex. D-16; Ex. D-18; Ex. D-21; Ex. D-24; Test. of Patrick Bouchard.

27. OWMHA falsified records of a member's LOCUS score and diagnosis for the purpose of qualifying the member for services for which the member would not have otherwise been eligible. Ex. D-25; Test. of Patrick Bouchard.

28. OWMHA did not receive Departmental authorization to provide DLS services for Member #24 / in any manner that would have been exempt from the requirements of the MaineCare Benefits Manual. Ex. D-16; Ex. A-4; Test. of Patrick Bouchard; Test. of Jeanette Knowlton; Test. of Carol Davis.

29. OWMHA did not prepare or maintain a Comprehensive Assessment for Member #24 / within 30 days of SAMHS's [redacted] 2015 endorsement of a 20-hour-per-day course of DLS services and did not prepare or maintain an Individual Service Plan for Member #24 / [redacted] that identified a need for DLS services or identify goals for the same member to be achieved through DLS services. Ex. D-16; Test. of Patrick Bouchard.

30. MaineCare claims billed by OWMHA were subject to 20-percent where there were demonstrated documentation errors but the paid claims were for services that were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members.

31. MaineCare claims billed by OWMHA were subject to 100-percent where the Department identified documentation errors and OWMHA 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.

RECOMMENDED DECISION

For the review period of [redacted] 2016 to [redacted] 16, Ocean Way Manor owes the Department a sum of **$25,614.57**, related to claims billed for services provided by unqualified staff (lacking DSP certifications and required background checks) and claims billed for services while the member was out of the facility. For the review period from [redacted] 2015 to [redacted] 2016, Ocean Way Mental Health Agency owes the Department a sum of **$186,766.47** related to claims billed for non-covered services; backdating of Comprehensive Assessments, Treatment Plans and Locus Assessments; billing for indirect services that are included in the rate of reimbursement, i.e. transportation, etc.; Comprehensive Assessments that show no medical necessity for services being provided to MaineCare members; and missing progress notes required to support claims billed to MaineCare.

REASONS FOR RECOMMENDATION

The two recoupment claims maintained by the Department were re-identified at of the opening of the hearing and confirmed through the Department's written closing brief filed on February 28, 2019. Ex. D-43. As of February 28, 2019, the Departmental claim against OWM for the period of [redacted] 2016 to [redacted] 2016 was identified in the amount of $25,614.57. Ex. D-43. As of February 28, 2019,

the Departmental claim against OWMHA for the period from [redacted], 2015 to [redacted] 2016 was identified in the amount of $186,766.47. Ex. D-43.

Ocean Way presented a number of categorical arguments against the Department's two recoupment claims consolidated on appeal. With regard to Ocean Way Manor ["OWM"], Ocean Way disputed the Department's assessment of a 20-percent penalty for all billed claims during the review period of [redacted] 2016 to [redacted] 2016, based on findings that MaineCare Section 21 "home support services" were provided by individuals who were credentialed as Direct Support Professionals ["DSPs"] and that OWM failed to timely submit background check requests for its employees. With regard to the Department's recoupment claim Ocean Way Mental Health Agency ["OWMHA"], Ocean Way focused its arguments on those claims for Daily Living Support ["DLS"] services provided to a single member ("Member #24 / [redacted] and its position that OWMHA had been authorized by a separate Departmental division – the Office of Substance Abuse and Mental Health Services ["SAMHS"] – to provide up to the same amount that was actually billed to MaineCare. While the matter was consolidated on appeal, clarity requires that the issues are separately addressed with respect to each provider.

Recoupment Claim Against Ocean Way Manor

The Departmental claim against OWM essentially consisted of violations that fell into three categories. First, the Department established a 100-percent penalty for each in a series of claims billed for Section 21 Home Support Services where the Department found that the documentation and other evidence reflected that the underlying services were never provided. Claims falling in the other two categories, in combination, gave rise to the Departmental assessment of a 20-percent penalty on all Section 21 "Home Support" claims billed by OWM during the review period.

As noted above, enrolled providers must "[b]ill only for covered services and supplies delivered." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (J). Section 21 identifies covered services, limitations, and other requirements that apply to services covered under the Home and Community Based Benefit for Members with Intellectual Disabilities or Autistic Disorders. 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.01. Section 21 services, broadly speaking, are designed for qualifying members living in a community-based setting, including Departmentally-licensed residential care facilities, like those operated by OWM. *Id.* Covered services include, but are not limited to "Home Support – Agency Per Diem," more specifically defined as follows:

> **Home Support-Agency Per Diem** is direct support provided in the member's home (Agency Home), by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL) (self-care, self management), development and personal well-being.
>
> Home Support may be provided as either a regularly scheduled "round the clock" service or as individual hours, or blocks of hours, of service depending upon the member's activities.
>
> Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Payment is not made directly, or indirectly, to the member's immediate family.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home.

This is allowable as long as it does not duplicate Community Support. Home Support cannot be provided at a Member's employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.05-11 (eff. Sept. 1, 2014) (*emphasis in original*).

"The per diem rate is calculated using the number of Agency Home Support hours authorized or provided for each member served in the agency's facility and the standard unit rates for Agency Home Support listed in Appendix I." 10-144 C.M.R. Ch. 101, sub-Ch. III, § 1300 (3) (eff. Sept. 28, 2010).

A "Direct Support Professional (DSP) is a person who provides Home Support, Work Support, Community Support, Career Planning or Crisis Intervention and:

A. Has successfully completed the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the curriculum from the Maine College of Direct Support within six (6) months of date of hire. The Maine College of Direct Support is accessed on the internet at: http://www.maine.gov/dhhs/oads/disability/ds/cds/index.shtml;

B. Has a background check consistent with Section 21.10-5;

C. Has an adult protective and child protective record check;

D. Be at least 18 years of age;

E. Has graduated from high school or acquired a GED; and

F. Completed the following four modules from the College of Direct Support prior to providing services to a member alone:

   1. Introduction to Developmental Disabilities
   2. Professionalism
   3. Individual Rights and Choice
   4. Maltreatment

Documentation of completion must be retained in the personnel record.

G. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services.

H. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional 6 hours of Career Planning and Discovery training provided through Maine's Workforce Development System.

All new staff or subcontractors shall have six (6) months date of hire to obtain DSP certification. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor.

Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

A person who provides Direct Support must be a DSP regardless of his or her status as an employee or subcontractor of an agency.

A DSP can supervise another DSP.

Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN)may administer medications to a member.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.10-1 (eff. Sept. 1, 2014).

"The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide direct support services under this Section." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.10-5. "Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity." *Id.*

The Department demonstrated at hearing that OWM submitted three billing claims for Section 21 Home Support Services for an individual, "[redacted] also identified as "OWM Member #3," related to five days on which the evidence reflected that the same member was out of the facility on a "home visit." Ex. D-42; Test. of Patrick Bouchard. The Department also demonstrated that it correctly identified the applicable portion of each multi-day billing claim that was subject to a 100-percent penalty based on the number of days in each claim that "[redacted]" was not actually receiving Home Support Services. Ex. D-16; Test. of Patrick Bouchard. Ocean Way did not present any evidence disputing or casting any doubt on the Department's identification of violations in this category or assessment of 100-percent penalties for each instance. As such, the Departmental findings and assessment of 100-percent penalties for this violation category should be upheld.

With regard to the remaining penalties assessed against OWM, the Department made a threshold showing that OWM employed two individuals at the facility – i.e. Annette Burns and Laurence Tardiff – who were not certified as DSPs while providing Home Support services to OWM residents during the review period. Ex. D-30; Ex. D-36; Ex. D-39; Ex. D-40; Ex. D-41; Test. of Patrick Bouchard. The Department also demonstrated that OWM failed to timely request background checks and child/adult abuse or neglect checks for 11 of its employees. Ex. D-37; Test. of Patrick Bouchard.

Ocean Way did not present any evidence contradicting the Department's findings. However, it presented the following arguments against the Department's discretionary assessment of 20-percent penalties for the entire claim universe for the [redacted] 2016 to [redacted] 2016 period:

- The DSP certification requirement should be waived for the two non-DSP employees, where they were certified as MHRT/C and CRMAs, qualifications of which were arguably "equal to or greater than those of a DSP".

- Once all of the background checks were processed, all of the employee histories were returned as satisfactory.
- The two employees without DSP certification only worked 18 shifts during the review period, representing 12.4 percent of the total shifts worked by all employees. Therefore, any for lack of DSP certification should be limited to the claims billed for those two employee's shifts.
- The Department should apply a five-percent, rather than a 20-percent penalty for the relevant claims, where the 20-percent penalty is arguably "excessive" for reasons not explained.

Ex. A-11.

A preponderance of the evidence reflects that the entire universe of paid claims during the [redacted] 2016 to [redacted] 2016 is subject to the "up to 20-percent" penalty authorized by Section 1.20-2 (H)(2), where such claims were paid despite the staff having not been cleared on background checks throughout that period. Ocean Way cannot prevail on the argument that, if any penalty must be applied, that penalty should only apply to claims billed during shifts worked by the two individuals who were not DSP-certified during the review period. The DSP-certification issue occurred concurrently with OWM's failure to secure and maintain proof of completed background checks for all providing employees during the review period. The background check issue alone can support imposition of an up-to-20-percent penalty. Thus, the only remaining question is whether the Department can be compelled to issue a penalty amount less than 20-percent where the Department has identified a documentation error, but the provider subsequently demonstrated that the applicable MaineCare services were medically necessary, covered services, and actually provided to MaineCare-eligible members.

Ocean Way essentially argued that the Department exceeded its discretionary authority by imposing a 20-percent penalty, where a five-percent penalty is – for reasons that are not explained – more appropriate. Ex. A-11. Ocean Way specifically argued that the Department failed to account for the purportedly low "seriousness of the offense" by applying the full 20 percent allowed for the described claims.

MaineCare regulations provide that a "sanction may be applied to a provider, individual, or entity, or to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.-3 (B)(1) (*emphasis added*). "The following factors may be considered in determining the sanction(s) to be imposed:

a. Seriousness of the offense(s);
b. Extent of violation(s);
c. History of prior violation(s);
d. Prior imposition of sanction(s);
e. Prior provision of provider education;
f. Provider willingness to obey MaineCare rules;
g. Whether a lesser sanction will be sufficient to remedy the problem; and

h. Actions taken or recommended by peer review groups, other payers, or licensing boards.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (A)(1) (*emphasis added*)

"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 … [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." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-2 (H)(2) (*emphasis added*).

Under the plain language of the regulation, the Department was within its discretion to follow such a course as it did here. Each of the provisions authorizing the Department to consider applying such discretion is an unqualified, permissive "may" clause. There is no cross reference to any express mandate or duty to consider ancillary factors related to any of the determinations to exercise discretion. Were the appellant inclined to challenge the propriety of the Department's regulatory authority to assess the discussed provider sanctions, that challenge would more likely need to take the form of a facial challenge rather than an as-applied challenge, and more critically, would need to take place in a judicial rather than an administrative forum. No such argument was raised in the present case. Here, there are no grounds to support a conclusion that the Department exceeded its discretion when it assessed 20-percent sanctions against OWM for claims billed for services that were provided by individuals who had not been verified as having passed background and/or abuse or neglect checks.

A preponderance of the evidence supports a finding that the Department was within its discretion in assessing a penalty equal to 20-percent of the $122,610.78 in claims billed between [redacted] 2016 and [redacted] 2016, i.e. $24,522.16. A preponderance of the evidence also supports a finding that the Department correctly established an additional penalty equal to $1,092.41, reflecting the sum of 100-percent penalties assembled for each of five days on which OWM billed for Home Support services for when evidence reflects she was away from the facility and not actually receiving such services. Accordingly, the recoupment claim in the amount of $25,614.57 should be upheld.

Recoupment Claim Against Ocean Way Mental Health Agency

The Departmental claim against OWMHA included penalties that broadly fell into three categories related to the provider's documentation requirements under MaineCare Section 17 and the fourth category related to the general proposition that a provider cannot bill for activities identified as "non-covered services."

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. Jan. 1, 2014).

As noted above, the Department is authorized to recoup "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." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (G) (eff. Jan. 1, 2014). "The following factors may be considered in determining the sanction(s) to be imposed:

a. Seriousness of the offense(s);
b. Extent of violation(s);
c. History of prior violation(s);
d. Prior imposition of sanction(s);
e. Prior provision of provider education;
f. Provider willingness to obey MaineCare rules;
g. Whether a lesser sanction will be sufficient to remedy the problem; and
h. Actions taken or recommended by peer review groups, other payers, or licensing boards.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-3 (A)(1) (eff. Jan. 1, 2014).

The allegedly flawed documentation at issue in the present case all flowed from OWMHA's provision of two types of services authorized under Section 17 of the MaineCare Benefits Manual: Community Integration services ["CIS"] and Daily Living Support ["DLS"] services.

The Section 17 regulations in effect during the review period specifically described the documentation process that had to be followed for services – including Daily Living Support ["DLS"] Services – to be reimbursable through MaineCare. *See* 10-144 C.M.R. Ch. II, § 17.07 (eff. Oct. 1, 2009).[1] In general terms, the Section 17 services provider must

1. perform a comprehensive psychosocial assessment ["CA"] of the member,
2. develop an Individual Support Plan ["ISP"] identifying treatment goals and services needed to achieve those goals, and
3. record and maintain progress notes throughout the course of the member's services.

10-144 C.M.R. Ch. 101, sub-Ch. II, §§ 17.07-1, 17.07-2, 17.07-3 (D) (eff. Oct. 1, 2009).

[1] Effective March 22, 2016, Section 17 was amended in ways that changed the numbering and pagination, but not the substance of most of the rule sub-sections at issue in the present hearing. *Cf.* 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009), 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Mar. 22, 2016). Except where there are substantive differences between the two versions of the rule section at issue, citations will only be made to the October 1, 2009 version of the rule.

Generally, a Comprehensive Assessment "must be developed as soon as clinically feasible, but no later than thirty (30) days," and must be both "[p]erformed by the appropriate mental health professionals acting within the scope of their license" and "[c]oordinated by a Community Support Provider." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-1 (A), (B) (eff. Oct. 1, 2009). "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 (E) (eff. Oct. 1, 2009). Thereafter, for members receiving CIS, a certified MHRT/C must "[d]evelop[ ] an ISP that is based on the results of the assessment … which includes:

1. Statements of the member's desired goals and related treatment and rehabilitation goal(s);
2. A description of the service(s) and support(s) needed by the member to address the goal(s);
3. A statement for each goal of the frequency and duration of the needed service(s) and support(s);
4. The identification of providers of the needed service(s) and support(s);
5. The identification and documentation of the member's unmet needs; and
6. A review of the plan at least every ninety (90) days to determine the efficacy of the services and supports and to formulate changes in the plan as necessary.

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

For members receiving DLS services, an ISP must be prepared that:

A. Reflects the strengths and needs of the member;
B. Reflects services that follow the member's goals; and
C. Reflects the resources that will meet the member's goals in the community, including the social supports available or in need of being created.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.01-11 (eff. Oct. 1, 2009).

ISPs prepared during the course of providing both kinds of services must satisfy the following criteria:

A. The ISP must be based on the results of the assessment;
B. All identified clinical services indicated in the ISP must be approved by a mental health professional;
C. To help the member achieve the objectives of his or her ISP, the Community Support Provider shall provide information and support to the member or guardian and, unless not feasible or contrary to the wishes of the member or guardian, to his or her family or significant other;
D. To ensure that the member has access to specific services, supports, and resources identified in his or her ISP, the Community Support Provider shall provide coordination and advocacy and by working directly with providers, advocates, and informal support systems;
E. To ensure that the ISP is being followed and is appropriate to a member's needs, the Community Support Provider shall:

1. Monitor the services and supports; and
2. Evaluate the effectiveness of the ISP with the member or guardian and, unless not feasible or contrary to the wishes of the member or guardian, with other providers and the member's family or significant other; and

F. The ISP as defined in 17.04-1.C. must be reviewed and approved in writing by a mental health professional within the first thirty (30) calendar days of application of the member for those services and every ninety (90) calendar days thereafter, or more frequently as indicated in the ISP. An ISP related to 17.04-5 (Daily Living Support Services), 17.04-6 (Skills Development Services), 17.04-7 (Day Support Services), or 17.04-8 (Specialized Group Services) must be reviewed and approved in writing by a Mental Health Professional within the first thirty (30) days of acceptance.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.01-11 (eff. Oct. 1, 2009).

Member records pertaining to a course of CIS or DLS services must also include all progress notes prepared by provisions, reflecting "[d]ocumentation of each service provided, including the date of service, the type of service, the goal to which the service relates, the duration of the service, the progress the member has made towards goal attainment and the signature and credentials of the individual performing the service." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-3 (D).

Finally, providers of all services must limit their billings to claims for services that are both medically necessary and covered services, as defined by Section 17 or elsewhere in the MaineCare Benefits Manual. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3(J); 10-144 C.M.R. Ch. 101, sub-Ch. II, §§ 17.01-8, 17.04 (eff. Oct. 1, 2009). Non-Covered Services include "custodial services," "socialization or recreational services," "housekeeping, shopping, child care, laundry services," "educational services," and "vocational services." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.06-5 (eff. Jan. 1, 2014); 10-144 C.M.R. Ch. II, § 17.06 (eff. Oct. 1, 2009). Non-Covered Services also expressly include: "[c]osts for paperwork, internal meetings, or appointment reminders associated with the delivery of covered services," because such costs "are built into the rates and are not reimbursable as separate services." 10-144 C.M.R. Ch. II, § 17.06 (E) (eff. Oct. 1, 2009).

The Department made a threshold showing at hearing that, with many service dates, OWMHA failed to timely complete Comprehensive Assessments and/or ISPs or maintained documentation that contained information that did not accurately correspond to the MaineCare member for which the documentation was purportedly prepared. Such cases reflected a range of deficiencies including backdated, misdated, falsified, or un-signed/approved Comprehensive Assessments. Ex. D-13; Ex. D-16; Ex. D-17; Ex. D-18; Ex. D-21; Ex. D-22; Ex. D-23; Ex. D-24; Ex. D-25; Test. of Patrick Bouchard. For other identified billing claims, the Department demonstrated that OWMHA improperly billed as Section 17 CIS or DLS services certain non-covered services that included clerical/administrative work, cancelled appointments, attending / studying for non-clinical classes, activities that were primarily social or recreational in nature, transportation, car shopping, and other retail shopping. Ex. D-17; Ex. D-19; Ex. D-20; Ex. D-21; Ex. D-24; Test. of Patrick Bouchard. For other identified billing claims, the Department demonstrated in the first instance that OWMHA had failed to timely review, approve, and maintain Individual Service Plans ["ISPs"] that were based on Comprehensive Assessments and

accurately identified clinical services to be provided. Ex. D-13; Ex. D-16; Test. of Patrick Bouchard. The Department also demonstrated that, in some cases, OWMHA did not timely develop and maintain accurate progress notes that identified service dates, types of services actually provided, signatures of individuals providing the services, and the amounts of services actually billed to and paid by MaineCare. Ex. D-13; Ex. D-14; Ex. D-15; Ex. D-16; Ex. D-18; Ex. D-21; Ex. D-24; Test. of Patrick Bouchard. In one specific case, the Department demonstrated that OWMHA falsified records of a member's LOCUS score and diagnosis for the purpose of qualifying the member for services for which the member would not have otherwise been eligible. Ex. D-25; Test. of Patrick Bouchard. For such cases where OWMHA had failed to demonstrate that the underlying services billed were medically necessary, MaineCare covered services, and actually provided to the corresponding members, the Department met its threshold burden to demonstrate that it was justified in seeking 100-percent recoupment for such claims paid. In cases where supplemental evidence shared by OWMHA supported a finding that the underlying services billed were medically necessary, MaineCare covered services, and actually provided to the corresponding members, the Department demonstrated that a penalty of 20-percent was appropriately assessed.

OWMHA did not produce any evidence at hearing casting any doubt upon the Department's proof with respect to all of billings compiled in the recoupment claim, except with regard to numerous billing claims involving a single member (Member #24 . In its final, revised recoupment spreadsheet, the Department affirmed its position that it correctly identified documentation violations related to course of DLS services during the period from Ex. D-7; Ex. D-16. The rationale for the 100-percent penalties varied by date of service, but included flawed progress notes, billing for non-covered services, lack of medical necessity identified in Comprehensive Assessments and/or ISPs, and billing in excess of expressed authorization/medical necessity. Ex. D-7; Ex. D-16; Test. of Patrick Bouchard. Notably, Department identified as subject to 100-percent recoupment a series of OWMHA billings made at or in excess of 80 units (i.e. 20 hours) of DLS services per day fo Ex. D-7; Ex. D-16; Test. of Patrick Bouchard. Departmental auditor Mr. Bouchard specifically testified that the rationale involved the "assessment and the treatment plan not identifying DLS services or justifying having 20 to 24 hours of services per day." Test. of Patrick Bouchard. The documentation reviewed reflected numerous blank entries on ISPs, blank or incomplete progress notes, a Comprehensive Assessment absent any claim of need for DLS services, and ISPs without any reference to hourly or frequency of DLS services needed. Ex. D-16. The Department highlighted a single progress note – for – as representative of the kind of problematic note generally submitted in support of 20-hour billings for DLS services in a single day. Ex. D-16. In that note, activities listed were "Dump, Redemption, Groomers, Smoke Shop, Walmart," with "Dog Groomed" identified as the "Highlight of Day." Ex. D-16. Mr. Bouchard testified: "It does not show that they provided, really, a one-on-one service. And not for a 20-hour period of time." Test. of Patrick Bouchard.

Ocean Way President Laurie L. Ryan invoked a privilege against self-incrimination and declined to testify in support of her appeal at hearing. Test. of Laurie L. Ryan. Former Ocean Way office manager Jeanette Knowlton testified that she attended one meeting with former Substance Abuse and Mental Health Services ["SAMHS"] program manager for Residential Treatment Carlton Lewis on or

about [redacted] 2015, at which Mr. Lewis had authorized OWMHA to provide [redacted] up-to-20-hours of DLS services per day. Test. of Jeanette Knowlton. In support, Ocean Way provided a letter dated [redacted] 2015, from Mr. Lewis to Ms. Ryan, in which he stated:

> At this time, she ([redacted]) will transition to Daily Living Support Services (DLSS), provided by Oceanway Mental Health Services. ([redacted]) will share the residence with the consumer of Section 21 Waiver Services. The "Department", Substance Abuse and Mental Health Services (SAHMS), has discussed this option with Oceanway and with APS Healthcare to waive the amount of time required to provide DLSS to ([redacted]). SAMHS has authorized APS Healthcare to allow Oceanway to provide up to 20 hours of DLSS per day to [redacted] for a 90 day period, to assist her in the transition then reevaluate. The goal will be for ([redacted] to level out at her baseline between 14-16 hours per day of DLSS.
>
> I have alerted APS Healthcare that this will be an ongoing solution to meet ([redacted] needs in the community. She will have familiar staff that she knows. This will ensure her smooth transition to this new setting. APS Healthcare will make a note in the client's file at APS that this is ongoing and has been waived by SAMHS as a solution that will meet her needs and allow her to live successfully in the community ongoing.
>
> ...
>
> Again, the "Department," SAMHS will waive the number of hours of service for DLSS for ([redacted] with the understanding that her baseline will be 14-16 hours per day ongoing, after the initial transition period. SAMHS and Oceanway will meet initially at 90 days to determine if [redacted] is at her baseline and most likely will authorize DLSS on a yearly basis from that time on.

Ex. A-4.

Ms. Knowlton testified that, after 90 days following the [redacted] 015 letter, "nobody re-evaluated her to my knowledge." Test. of Jeanette Knowlton. With regard to the recoupment claim for [redacted] course of services, "a major, underlying issue was that the paperwork did not support standard billing for DLS services, but she was not intended to be a standard client." Test. of Jeanette Knowlton. According to Ms. Knowlton's testimony, OWMHA presumed from the lack of any follow-up communication from SAMHS that OWMHA was authorized to continue providing [redacted] DLS services at the 20-hour-per-day level and to bill MaineCare for such services despite knowing that 20-hour-per-day exceeded what was normally permitted under Section 17. Test. of Jeanette Knowlton.

The appellant also presented the testimony of Departmental Division of Licensing and Certification (formerly "Licensing and Regulatory Services") health consultant Carol A. Davis, BSN, BS Ed., LSW, QMRP, who participated in OWMHA's licensure proceedings during the same period addressed by Department's MaineCare post-payment review. Ms. Davis testified that her involvement did not address funding, where her office only focused on abuse or neglect investigation, and that "we don't get involved in funding or any of that." Test. of Carol A. Davis. Documentary evidence produced by the appellant, in fact, reflected that Ms. Ryan was uncomfortable relying on the Carlton Lewis letter's purported authorization of up-to-20 hours per day for [redacted] and that she requested assurance from Ms. Davis. Ex. A-6d. Ms. Davis repeatedly urged Ms. Ryan not to rely on representations from licensure workers about funding, and to direct her questions to Office of MaineCare Services. Ex. A-6a; Ex. A-6b; Ex. A-6c; Ex. A-6d. In an email reply dated [redacted] 2015, Ms. Davis notified Ms. Ryan that

"[i]t is now between you and him (Carlton Lewis) and Maine Care reimbursement. They are who you should show." Ex. A-6d. In an email reply dated [redacted] 2015, Ms. Davis specifically advised Ms. Ryan that OWMHA was "the one accepting responsibility" for any reliance on Mr. Lewis' letter and directed her to "talk directly with the Maine Care person who reviews your letters of authorization to determine if the letter includes all that is necessary for ongoing funding." Ex. A-6d.

Clearly, OWMHA / Ms. Ryan suspected that any "authorization" reflected by Mr. Lewis' [redacted] 2015 letter was, at best, incomplete, based on evidence that Ms. Ryan repeatedly sought assurance and clarification by email from Mr. Lewis and Ms. Davis. Ex. A-6a; Ex. A-6b; Ex. A-6c.; Ex. A-6d. However, OWMHA did not present any testimony from Mr. Lewis, and as noted, Ms. Ryan invoked privilege against self-incrimination in electing not to testify about any clarification of her expectation or reliance based upon any purported statements about authorization for funding for DLS services. Test. of Laurie L. Ryan.

Carlton Lewis' [redacted] 2015 letter appears to have given SAMHS's endorsement for a course of treatment for [redacted] that included up-to-20-hours-per-day of DLS services for at least the 90-day period beginning on [redacted] 2015. However, that endorsement provided no reasonable grounds upon which it can be concluded that OWMHA was justified in billing MaineCare 80 units per-day for those services without an express contract or MaineCare authorization for such an admittedly high level of service. Mr. Lewis' [redacted] 2015 letter noted that "SAMHS has authorized APS Healthcare[2] to allow Oceanway to provide up to 20 hours of DLSS per day to [redacted] for a 90-day period, to assist her in the transition and then reevaluate." Ex. A-4. However, there is no evidence in the record reflecting that APS Healthcare or Office of MaineCare Services received this "authorization" and approved MaineCare coverage in the absence of the otherwise required procedural necessities.

The appellant produced a copy of a Departmental "Agreement to Purchase Services," broadly authorizing provision of mental health services by OWMHA from July 1, 2015 to June 30, 2017. Ex. A-8. This contract has no bearing on the question of the penalties assessed for DLS services provided to ., as the contract only authorizes CIS for *Bates v. DHHS* class members "who do not currently have MaineCare Insurance, but otherwise meet the specific eligibility requirements for this service," i.e. community integration services, "as stated in the MaineCare Benefits Manual, Chapter 2, Section 17." Ex. A-8.

Even if the [redacted] 2015 letter from Carlton Lewis were construed as a basis for establishing a new course of DLS services for [redacted], Section 17 would still require OWMHA to undertake a new Comprehensive Assessment by a qualified clinician "as soon as clinically feasible, but no later than 30 days." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-1 (A) (eff. Oct. 1, 2009). Thereafter, an ISP must be completed by a qualified mental health professional within 30 days that specifies: 1) the needed clinical services that will be provided, and 2) the member's goals to be achieved through the prescribed Section 17 services. 10-144 C.M.R. Ch. 101, sub-Ch. II, §§ 17.01-11, 17.07-2 (eff. Oct. 1, 2009). Finally, the record must include progress notes for each date of service

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[2] Throughout the MaineCare review period, APS Healthcare was the Department's authorized agent charged with the responsibility to review prior authorization requests and utilization review services under Section 17.

identifying the type of service, goals to which the service relates, and progress toward those goals made by the member as a result of the service performed. 10-144 C.M.R. Ch. 101, sub-Ch. II, §§ 17.07-3 (D) (eff. Oct. 1, 2009).

In short, the Department did not authorize OWMHA to bill MaineCare for up-to-20-hours per day of DLS services for [redacted] Further, a preponderance of the evidence supports a finding that OWMHA did not meet the threshold requirements to support provision of any DLS services for [redacted] The only Comprehensive Assessment in evidence for [redacted] – issued on [redacted] 2015 – fails to identify any need for or recommended course of DLS services. Ex. D-16. The [redacted] 2015 Comprehensive Assessment solely identifies the need for ongoing Community Integration / case management services. Ex. D-16. The only ISP in evidence, signed by Sheila Hall, MHRT/C on [redacted] 2015, appears to have been drafted without any reference to DLS services, instead focusing on goals and discharge criteria to come out of a course of Community Integration / case management services. Ex. D-16. Progress notes presented, in addition to previously referenced deficiencies, cannot be said to relate to DLS services' goals identified in the ISP, where the record does not indicate that any such ISP with DLS goals was ever prepared.

For these reasons, it should be concluded that the Department was justified in establishing a 100-percent penalty for all DLS services claims billed by OWMHA for [redacted] during the period from [redacted] 2015 and [redacted] 2016.

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] 2016 to [redacted] 2016, Ocean Way Manor owes the Department a sum of **$25,614.57**, related to claims billed for services provided by unqualified staff (lacking DSP certifications and required background checks) and claims billed for services while the member was out of the facility. It is further recommended that it be concluded that the Department was correct when, for the review period from [redacted] 2015 to [redacted] 30, 2016, Ocean Way Mental Health Agency owes the Department a sum of **$186,766.47** related to claims billed for non-covered services; backdating of Comprehensive Assessments, Treatment Plans and Locus Assessments; billing for indirect services that are included in the rate of reimbursement, i.e. transportation, etc.; Comprehensive Assessments that show no medical necessity for services being provided to MaineCare members; and missing progress notes required to support claims billed to MaineCare.

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, sub-Ch. I, § 1, 17, 21 (eff. Jan. 1, 2014)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Mar. 22, 2016)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21 (eff. Sept. 1, 2014)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. III; § 17 ((eff. Sept. 28, 2010)

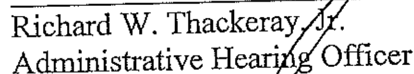
RIGHT TO FILE RESPONSES AND EXCEPTIONS

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

CERTAIN 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 OF CONFIDENTIAL INFORMATION IS PROHIBITED.



Dated: 7/19/2019

Richard W. Thackeray, Jr.
Administrative Hearing Officer

cc: Riley L. Fenner, Esq.
William P. Logan, Esq., DHHS, OMS
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