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

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Department of Health and Human Services
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IN THE MATTER OF:

The Umbrella Agency	)	
Marjorie Averill, LCSW	)	**FINAL DECISION**
73 Biscay Road	)	
Damariscotta, ME 04543	)	

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

The Recommended Decision of Hearing Officer Thackeray, mailed July 16, 2018 and the responses and exceptions filed on behalf of the Umbrella 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 1/1/2015 to 5/1/2016, The Umbrella Agency owes the Department a sum of $39,547.69, related to billing for non-enrolled provider, missing progress notes, inadequately dated or signed Comprehensive Assessments, and Individual Service Plans submitted without required signatures.

DATED: 8/10/18 SIGNED: Ricker Hamilton

RICKER HAMILTON, COMMISSIONER
DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

cc: Thomas Bradley, AAG, Office of the Attorney General
Alice Knapp, Esq.
Patrick Bouchard, DHHS/Program Integrity

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

Paul R. LePage, Governor Ricker Hamilton, Commissioner

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Date Mailed: JUL 16 2018

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station • 221 State Street
Augusta, ME 04333

In the Matter of: The Umbrella Agency

NPI ID No. 1013311521

ADMINISTRATIVE HEARING RECOMMENDED DECISION

An administrative hearing was initially convened in the above-captioned matter on January 22, 2018, and reconvened on January 26, 2018, 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 initially left open through March 28, 2018, to allow a two-tiered schedule of post-hearing briefing: 1) the Department to make post-hearing revisions to its recoupment claim, and 2) both parties to simultaneously submit written closing arguments. After the case was taken under advisement, it was discovered that the appellant's admitted exhibits included protected patient information that had not been redacted, per hearing officer's request. To most efficiently assure full protection of confidential patient information, the hearing record was re-opened and Office of Administrative Hearings staff completed the required redaction. The hearing record was thereafter re-closed on Friday, June 8, 2018.

Pursuant to an Order of Reference dated April 12, 2017, the issue presented *de novo* for hearing was whether the Maine Department of Health and Human Services ["Department"] was "correct when for the review period of 1/1/2015 through 5/1/2016, it determined that The Umbrella Agency owes the department $69,832.76 in recoupment due to billing and payment for a non-enrolled clinician providing services to MaineCare members; missing progress notes; Individual Support Plans missing member and provider signatures; and member signature on TX plan not matching other documentation provided?" Ex. D-1.

APPEARING ON BEHALF OF THE APPELLANT

- Alice E. Knapp, Esq.
- Marjorie Averill
- Jill Perry
- Audrey Dalrymple

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Henry Griffin, AAG
- Patrick Bouchard

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Informal Hearing Reschedule Notice," dated January 16, 2018
HO-1a "Order," dated January 12, 2018
HO-1b "Scheduling Correspondence," dated January 11, 2018
HO-2 "Reschedule Notice," dated November 3, 2017
HO-3 "Reschedule Notice," dated October 11, 2017
HO-4 "Reschedule Correspondence," dated September 29, 2017 to October 3, 2017
HO-5 "Response to Request for Information," dated September 25, 2017
HO-6 "Request for Information," dated August 30, 2017
HO-7 "Notice of an Administrative Hearing," dated June 30, 2017
HO-8 "Order of Reference," dated April 12, 2017
HO-9 "Fair Hearing Report Form," dated June 6, 2017, with attachments:

- "Notice of Violation," dated January 6, 2017
- "Informal Review Request," dated February 13, 2018
- "Final Informal Review Decision," dated April 12, 2017
- Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)
- Final Rule, "Behavioral Health Servs.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65 (eff. Aug. 31, 2013)
- Final Rule, "Behavioral Health Servs.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65 (eff. Apr. 13, 2015)
- "Community Licensing Standards," Div. of Lic. & Reg. Servs. – DHHS, *avail. at* http://www.maine.gov/dhhs/mecdc/dlrs/Licensing/MH-LicensingStandards/CommunitySupport/assessment.html (last visited on June 20, 2017)
- Excerpt, "Gen. Admin. Policies and Proc.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1 (eff. Apr. 16, 2016)

Department Exhibits

D-1 "Order of Reference," dated July 26, 2017
D-2 "Fair Hearing Report Form," dated June 6, 2017
D-3 "Notice of Violation," dated January 6, 2017
D-4 "Informal Review Request," dated February 13, 2017
D-5 "Final Informal Review Decision," dated April 12, 2017
D-6 "Hearing Request," effective date May 26, 2017
D-7 "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-8 Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)
D-9 Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Mar. 22, 2016)

D-10 "Community Licensing Standards," Div. of Lic. & Reg. Servs. – DHHS, *avail. at* http://www.maine.gov/dhhs/mecdc/dlrs/Licensing/MH-LicensingStandards/CommunitySupport/assessment.html (last visited on Sept. 25, 2017)

D-11 Final Rule, "Behavioral Health Servs.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65 (eff. Aug. 31, 2013)

D-12 Final Rule, "Behavioral Health Servs.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65 (eff. Apr. 13, 2015)

D-13 "MaineCare/Medicaid Provider Agreement," dated December 4, 2014

D-14 "Agency MaineCare Provider Affiliation Screenshot"

D-15 "Treatment Records," Member #1 /

D-16 "Treatment Records," Member #4 /

D-17 "Treatment Records," Member #12 /

D-18 "Treatment Records," Member #19 /

D-19 "Treatment Records," Member #11 /

D-20 "Treatment Records," Member #13 /

D-21 "Treatment Records," Member #15 /

D-22 "Treatment Records," Member #17 /

D-23 "Revised Recoupment Claim" and supporting documents, dated February 28, 2018

D-24 "Written Closing Brief" and attached "Revised Recoupment" spreadsheet, dated March 22, 2018

Appellant Exhibits

A-1 (removed)

A-2 "Plan of Correction," dated March 19, 2017

A-3 "Letter of Acceptance, Plan of Correction," dated March 28, 2017

A-4 "Emails," dated March 27, 2017

A-5 "Provider Application," Nancy St. Clair, dated September 3, 2015

A-6 "Medicare Enrollment," dated December 5, 2014

A-7 "Plan of Correction," dated March 19, 2017, with attachments

A-8 (empty)

A-9 (removed)

A-10 (empty)

A-11 "Records," Member #3 / (redacted)

A-12 (not admitted)

A-13 "Records," Member #6 / (redacted)

A-14 "Records," Member #9 / (redacted)

A-15 "Records," Member #11 / (redacted)

A-16 "Records," Member #11 / (redacted)

A-17 "Records," Member #11 / (redacted)

A-18 "Records," Member #11 / (redacted)

A-19 "Records," Member #12 / (redacted)

A-20 "Records," Member #13 / (redacted)

A-21 "Records," Member #15 / (redacted); Marjorie Averill certs; Serge Joskow term. notice

A-22 "Records," Member #16 / . (redacted)
A-23 "Records," Member #17 / . (redacted)
A-24 "Records," Member #19 / (redacted)
A-25 (empty)
A-26 "Employee Profile," Kris Kinrade
A-27 "Fax Log," and "Customer Reimbursement Forms," re: Member #11 .
A-28 "Text Transcript"
A-29 "HR Record," dated December 29, 2015
A-30 (empty)
A-31 (empty)
A-32 "Written Closing Brief," dated March 22, 2018

STANDARD OF REVIEW

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

LEGAL FRAMEWORK

The Department administers the MaineCare program, which is designed to provide "medical or remedial care and services for medically indigent persons," pursuant to federal Medicaid law. 22 M.R.S. § 3173. *See also* 42 U.S.C. §§ 1396a, *et seq*. To effectuate this, the Department is authorized to "enter into contracts with health care servicing entities for the provision, financing, management and oversight of the delivery of health care services in order to carry out these programs." *Id.* Enrolled providers are authorized to bill the Department for MaineCare-covered services pursuant to the terms of its Provider Agreement, Departmental regulations, and federal Medicaid law. "Provider Participation," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03 (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). Enrolled providers also "must … [c]omply with requirements of applicable Federal and State law, and with the provisions of this Manual." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (Q). Enrolled providers are also required to maintain records sufficient to "fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (M). "The Division of Audit or duly Authorized Agents appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.16. Pursuant to federal law, the

Department is also authorized to "safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.17. *See also* 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.18; 22 M.R.S. § 42 (7); 42 U.S.C. § 1396a (a)(27); 42 C.F.R. § 431.960. This includes the imposition of "sanctions and/or recoup(ment of) identified overpayments against a provider, individual, or entity," for any of 25 specific reasons for which it may including:

- 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, the The Umbrella Agency ["Umbrella"] was properly notified of the time, date, and location of the immediate proceeding. Ex. HO-1; Ex. HO-7.

2. Umbrella is a Community Support Services and Behavioral Health Services provider based in Damariscotta that was in operation during the period from January 1, 2015 through May 1, 2016.

3. Effective January 16, 2015, Umbrella entered into a "Medicaid/Maine Health Program Provider/Supplier Agreement" with the Department, through which Umbrella 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-13.

4. On an unspecified date in 2016, the Department initiated a post-payment review of billing claims submitted by Umbrella, using random selection of 100 dates of service within an identified review period of January 1, 2015 to May 1, 2016.

5. The Departmental post-payment review identified that during the January 1, 2015 to May 1, 2016 period, MaineCare reimbursed Umbrella for a total of $246,733.00 for claims billed to the Department. The 100 reviewed claims from the same period corresponded to MaineCare reimbursement of $15,717.79 to Umbrella. Of the 100 sets of reviewed claims paid on the randomly-selected dates between January 1, 2015 and May 1, 2016, the Department initially identified an error rate of 66.37 percent where it found that $10,431.35 of the $15,717.79 paid by the Department toward those claims should not have been paid due to missing records, or otherwise being non-reimbursable or unacceptable as billed. Ex. D-3.

6. On January 6, 2017, the Department issued a "Notice of Violation" against Umbrella, in which it initially alleged a total overpayment in the amount of $163,748.12, derived from applying the 66.37 percent error rate against the amount in total claims it paid Umbrella from January 1, 2015 to May 1, 2016 ($246,733.00). Through the same notice, the Department alleged a "final overpayment amount" of $144,572.32, derived by subtracting a sum of $19,175.81 from $163,748.12, reflecting an assumption that "the probability of it being any smaller in subsequent samples is 5%." Ex. D-3.

7. On February 13, 2017, Umbrella timely requested an informal review of the Department's "Notice of Violation," and more specifically alleged the following in defense:

> The Umbrella Agency disagrees with the conclusions of The Program Integrity Unit as outlined in the Notice of Violation and is requesting an Informal Review by the Director of the Division of Audit, or his/her designee, in accordance with MaineCare Benefits Manual (MBM), Chapter 1, and Section 1.21.

Ex. A-4.

8. On April 12, 2017, the Department issued a "Final Informal Review Decision" against Umbrella, in response to the "Request for Informal Review," dated February 13, 2017. The Department determined that the revised total of mistakenly paid claims was $5,691.24 of the $15,717.79 paid by the Department in the 100 claims, reflecting an adjusted error rate of 35.61 percent. Applying the 35.61 percent error rate, the Department identified a recalculated recoupment claim amount of $69,832.76. Ex. D-5.

9. On May 26, 2017, Umbrella timely requested an administrative hearing. Ex. D-6.

10. After the parties presented their cases-in-chief at hearing, the Department reviewed and revised its recoupment claim in light of new evidence and/or explanation received from Umbrella. On February 28, 2018, the Department determined that the revised total of mistakenly paid claims was $3,606.52 of the $15,717.79 paid by the Department in the 100 claims, reflecting an adjusted error rate of 22.95 percent. Applying the 22.95 percent error rate, the Department initially identified a recalculated recoupment claim amount of $56,614.04. Thereafter, the Department further reduced that sum "until the probability of it being any smaller in subsequent samples [was] 5%," and alleged a final, amended recoupment claim of $39,547.69, based on a finally-adjusted error rate of 16.03 percent. Ex. D-23.

11. On September 3, 2005, Umbrella owner and director Marjorie Averill, LCSW, submitted an application for a Mental Health Agency License Application from the Department, on which she identified all Umbrella employees. Among these, she identified herself as "Clinical Supervisor/CEO" and Nancy St. Clair, LCPC-C, as "clinician." Ex. A-5.

12. Throughout the period from January 1, 2015 to May 1, 2016, Umbrella employee Nancy St. Clair, LCPC-C, was not a MaineCare-enrolled provider.

13. With regard to nine claims identified by the Department in its February 28, 2018 revised recoupment claim as being sanctionable at 100-percent due to the lack of progress notes, Umbrella did not document the nine underlying services in the manner required (at a minimum) by the MaineCare regulations to demonstrate that they were medically necessary, covered services, and actually provided. Ex. A-11; Ex. A-19; Ex. A-20; Ex. A-21; Ex. A-22; Ex. A-23.

14. With regard to two claims identified by the Department in its February 28, 2018 revised recoupment claim as being sanctionable at 20-percent due to the lack of a sufficiently dated Comprehensive Assessment, Umbrella demonstrated that the services underlying the two claims were medically necessary, covered services, and actually provided, but did not demonstrate by a preponderance of the evidence that the Comprehensive Assessments were completed within 30 days of the service request or prior to the preparation of the same member's Individual Support Plan. Ex. D-18.

15. With regard to three claims identified by the Department in its February 28, 2018 revised recoupment claim as being sanctionable at 20-percent due to the lack of a signature on Member #17's Individual Support Plan, Umbrella demonstrated that the services underlying the three claims were medically necessary, covered services, and actually provided, but did not demonstrate by a preponderance of the evidence that the relevant Individual Support Plan had been signed by a qualifying clinician. Ex. D-22.

16. With regard to seven claims identified by the Department in its February 28, 2018 revised recoupment claim as being sanctionable at 100-percent related to Individual Support Plans and/or missing Progress Notes for Member #11, Umbrella did not demonstrate by a preponderance of the evidence that the services underlying the claims were medically necessary, covered services, and/or actually provided. Ex. D-19; Ex. A-17.

17. With regard to one claim identified by the Department in its February 28, 2018 revised recoupment claim as being sanctionable at 20-percent related to the lack of signatures on an Individual Support Plan for Member #11, Umbrella demonstrated that the underlying service was medically necessary, a covered service, and actually provided, but did not demonstrate by a preponderance of the evidence that the necessary signatures had been provided. Ex. D-19; Ex. A-17.

RECOMMENDED DECISION

For the review period of January 1, 2015 to May 1, 2016, it should be concluded that The Umbrella Agency owes the Department a sum of **$39,547.69**, related to billing for a non-enrolled provider, missing progress notes, inadequately dated or signed Comprehensive Assessments, and Individual Services Plans submitted without required signatures.

REASONS FOR RECOMMENDATION

The ultimate question presented for adjudication is whether the Department correctly established its finally-revised recoupment claim of $39,547.69, as presented after hearing. At hearing, the Department described the process by which it employed a random sampling of Umbrella's billing claims to investigate and establish that Umbrella was incorrectly reimbursed for certain behavioral health services and community support services provided for its patients/clients. Test. of Patrick Bouchard. Partial to this, the Department demonstrated that it sought 100 percent recoupment of specific claims where Umbrella had not shown that the questioned services had been medically necessary, covered services, and actually provided to eligible MaineCare members, and that it limited its recoupment to 20 percent of billed/paid amounts for documentation errors where it became satisfied that the underlying services had been medically necessary, covered services, and actually provided. Test. of Patrick Bouchard.

Thereafter, Umbrella responded with additional evidence in support of its arguments that its documentation was proper and/or made in support of delivered, medically-necessary, covered MaineCare services. Test. of Marjorie Averill, LCSW. In closing, Umbrella finally argued that the record evidence reflected that all required documentation had been maintained and that the Department exceeded the scope of its discretion by imposing a full 20-percent sanction on applicable claims. An issue-by-issue analysis of Umbrella's arguments follows below.

Method of Extrapolation Employed by the Department in Establishing Recoupment Claim

There was no essential dispute between the parties as to the Department's authority to use "an extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare" as a method by which it could determine a claim for recoupment for identified provider violations. 10-144 C.M.R. Ch. 101, sub-Ch. I, §§ 1.18 (C), 1.19-4 (C). Umbrella did not supply any legal support for its arguments made at hearing that the Department improperly utilized extrapolation in its post-payment review, or that extrapolation is constitutionally or otherwise barred. Accordingly, it should be concluded that the Department acted within its regulatory discretion when it elected to perform an extrapolation based on a random sampling of claims submitted by Umbrella and paid by MaineCare during the January 1, 2015 to May 1, 2016 review period.

Claims Made for Services Provided by an Unenrolled Provider

In its final, revised recoupment claim, the Department maintained its position that Umbrella's reimbursement claims submitted for services provided by Nancy St. Clair, LCPC-C, were recoupable at 100 percent due to the absence of any proof that Ms. St. Clair was individually enrolled as a MaineCare provider with the Department. Ex. D-23.

The regulations in effect throughout the review period defined "provider" as "any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners,

managing employees, or agents of any partnership, group association, corporation, institution, or entity that is enrolled in the MaineCare program as one of the following:

1. Rendering Provider (also known as a Servicing Provider) is defined as an individual MaineCare provider who performs services for eligible MaineCare members through a Group or Facility/Agency/Organization (FAO). A rendering provider does not bill MaineCare directly. The billing provider submits claims and receives payment on behalf of the rendering provider.

2. Billing Provider means the MaineCare provider submitting claims and receiving MaineCare payment for services. Billing providers perform these functions on behalf of the rendering provider.

3. Ordering Prescribing and Referring (OPR) Provider – … a physician or non-physician practitioner who is eligible to enroll in MaineCare, qualified to order, prescribe and/or refer services or supplies for MaineCare-eligible members, and has a NPI, but may not submit claims for payment for services provided to Medicaid Members. In order for MaineCare to reimburse for orders, prescriptions and/or referral of services or supplies resulting from the order of an OPR Provider, the OPR Provider must be enrolled in MaineCare as a MaineCare OPR Provider.

"General Administative Policies and Procedures," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.02-4 (H) (eff. Jan. 1, 2014).

The regulations also provided that, "[c]onsistent with 42 CFR §431.107, the Provider understands and agrees that an executed Provider Agreement by and between the Provider and MaineCare is mandatory for participation or continued participation in the MaineCare Program," and that "MaineCare does not reimburse in-state providers, including rendering providers, for services provided to members prior to enrollment approval." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-1 (A), (B).

Umbrella did not dispute the Department's essential position that Ms. St. Clair was not enrolled as a provider in the MaineCare program, relying instead on evidence demonstrating that Ms. St. Clair had been listed as a "clinician" on Umbrella's application for a Mental Health Agency License from the Department and that Ms. St. Clair was not identified as an "excluded provider" under MaineCare. Ex. A-5; Test. of Patrick Bouchard.

These arguments do not overcome Umbrella's obligation under its Provider Agreement to operate in full compliance with federal Medicaid and state MaineCare requirements, among which is the requirement that all rendering providers be formally enrolled with MaineCare before claims for services become correctly reimbursable by the Department. Because Ms. St. Clair was not a MaineCare-enrolled provider at the time Umbrella submitted claims for services she provided, the Department correctly included 100-percent recovery of those claims in its final, revised recoupment claim.

Sufficiency of Documentation: Comprehensive Assessments, Individual Plans, and Progress Notes

Umbrella's second and largest set of arguments against the Department's recoupment claim concerned its documentation efforts as required by Sections 17 and 65 of the MaineCare Benefits Manual. This focused, more specifically, on alleged deficiencies related to 1) Comprehensive Assessments required under both programs, 2) "Individual Support Plans" ["ISPs"] (Section 17) and "Individual Treatment Plans" ["ITPs"] (Section 65), and 3) "Progress Notes" documenting services provided under both programs.

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

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

- identify the medical, social, residential, educational, vocational, emotional, and other related needs of the member;
- perform a comprehensive psychosocial assessment, including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs;
- develop an Individual Support Plan ["ISP"] that is based on the results of the comprehensive assessment in Section 17.04-1(B), which includes:

1. statements of the member's desired goals and related treatment/rehabilitation goals;
2. a description of the services and natural supports needed by the member to address the goals;

- draft a statement for each goal of the frequency and duration of the needed service(s) and supports;
- identify providers of the needed services and natural supports;
- identify and document the member's unmet needs;
- review the ISP at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary;
- coordinate referrals, and advocate access by the member to the services and natural supports identified in the ISP;
- make face-to-face contact with other professionals, caregivers, or individuals included in the ISP in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per the ISP.

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

The version of Section 17 in effect during the review period also established the following prerequisites before claims for Community Support Services would become reimbursable by MaineCare:

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

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

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

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

[1] Section 17 was revised, effective March 22, 2016. *See* 10-144 C.M.R. Ch. 101, ch. II, § 17 (eff. Mar. 22, 2016). No relevant changes to the Section affected the substantive governing provisions described above, but pagination changes resulted in provisions describing the requirements of Assessments and ISPs to be moved from Section 17.07 to Section 17.08. *See id.*

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

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-1.

With regard to ISPs, Section 17 provided that "[t]he following apply to covered services related to a member's individual support plan ...

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. Review ISP to determine efficacy of the services and natural supports and to formulate changes in the plan as necessary; 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, § 17.07-2 (eff. Oct. 1, 2009).

With regard to Progress Notes, a Section 17 "Community Support Provider shall maintain an individual record for each member receiving covered services," which "must minimally include:

> Documentation 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) (eff. Oct. 1, 2009)

Section 65 provided that "[a] member's record must contain written documentation of a Comprehensive Assessment, an Individual Treatment Plan and progress notes," adding that:

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

10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (eff. Aug. 31, 2013).[2]

A Section 65 "Comprehensive Assessment" must be completed by a clinician 'within thirty (30) days of the day the member begins services," "must be included in the member's record," and "must be updated at a minimum, when there is a change in level of care, or when major life events occur, and annually." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (A)(1). The Comprehensive Assessment must document the entirety of the member's personal and clinical history, and "be signed, credentialed and dated by the clinician conducting the Comprehensive Assessment." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (A)(2), (3).

Section 65 also requires that an "ITP" must be developed "based on the Comprehensive Assessment" and "contain the following unless there is an exception:

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

All participants must sign, credential (if applicable) and date the reviewed ITP.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (B)(1), (2).

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[2] As with Section 17, the Department revised Section 65 during the period of its post-payment review in the present matter, but made no substantive changes to the relevant descriptions of ITPs and CAs. *Compare* 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (eff. Aug. 31, 2013); 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (eff. Apr. 13, 2015)

Finally, Section 65 requires that "[p]roviders must maintain written progress notes for all services, in chronological order," and that "[a]ll entries in the progress note must include the service provided, the provider's signature and credentials, the date on which the service was provided, the duration of the service, and the progress the member is making toward attaining the goals or outcomes identified in the ITP." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 65.09-3 (C).

Comprehensive Assessment Deficiencies

The Department's final, revised recoupment claim included two individual claims sanctioned at 20 percent, which were identified as having deficient Comprehensive Assessments. Ex. D-23. More specifically, the Department identified that two claims for Member #19 (, for dates of service 2016 and 2016, did not correspond to a timely dated Comprehensive Assessment for the member. Ex. D-18. The Department conceded, based on the new evidence supplied by Umbrella, that the services corresponding with the two claims were medically necessary, covered services, and actually provided, but maintained that they were sanctionable at 20 percent due to the lack of evidence that the Comprehensive Assessments were provided before the ISP was prepared and subsequent services provided. Umbrella did not provide any additional evidence to support a finding that the Comprehensive Assessments were, in fact, timely signed by the preparing clinician. Accordingly, the Department was correct to identify these claims as sanctionable at 20 percent.

Individual Support Plan – Missing Signature (Member #17 – ')

The Department's final, revised recoupment claim included three individual Section 17 claims sanctioned at 20 percent, which were identified as relating back to an ISP for Member #17 ( ) that lacked a clinician's signature. Ex. D-23. The specific dates of service referenced were 2015; 2016; and 2016. Ex. D-22; Ex. D-23. The Department conceded, based on the new evidence supplied by Umbrella, that the services corresponding with the two claims were medically necessary, covered services, and actually provided, but maintained that they were sanctionable at 20 percent due to the lack of documentary evidence that a clinician timely prepared and signed the ISP before the course of Section 17 Skills Development Services was undertaken. Umbrella did not provide evidence to support a finding that a qualified clinician did, more likely than not, timely sign the relevant ISP. Accordingly, the Department was correct to identify these claims as sanctionable at 20 percent.

Individual Support Plan – Missing Progress Notes and Signatures (Member #11 – ")

The Department's final, revised recoupment claim included seven individual Section 17 claims sanctioned at 100 percent and one Section 17 claim sanctioned at 20 percent, all of which related back to documentation deficiencies related to Member #11 ('). Ex. D-23. Of the seven claims sanctioned at 100 percent, four were identified as relating back to an ISP that lacked all required signatures and did not have a documented progress note for the specified service date (i.e. 2015; 2015; 2015; 2016), while the other three merely lacked the required

signatures on the ISP (i.e. [redacted] 2015; [redacted] 2015; [redacted] 2015). Ex. D-19; Ex. D-23. Finally, the Department conceded, based on new evidence from Umbrella, that the services provided on [redacted] 2015, were appropriately sanctioned at 20 percent because a progress note was produced, albeit unsigned, which supported the medical necessity, covered service, and actually provided claims of Umbrella. Ex. D-23; Ex. A-17; Ex. A-18.

Umbrella's argument against Departmental sanctions for the Member #11 claims did not flow from production of new evidence of timely signatures demonstrating to a greater-than-not likelihood that the respective documents had been timely prepared by a qualified clinician. Ex. A-32. Rather, Umbrella produced testimony and other evidence demonstrating that the documentation failures corresponded to allegedly fraudulent acts performed by one of its employees, which allegedly culminated in that employee stealing or destroying critical case documents out of retaliation against Umbrella, his employer. Ex. A-26; Ex. A-27; Ex. A-28; Ex. A-29; Test. of Marjorie Averill, LCSW; Test. of Audri Dalrymple. Implied in this is the presumption that the allegedly stolen or destroyed documents would have demonstrated that Umbrella complied with its documentation requirements with respect to each of the identified claims. In essence, Umbrella requested some discretionary relief from the Department, either reducing or eliminating the sanctions for the eight claims, reflecting its lack of practical ability to demonstrate a proper course of documentation for Member #11 directly attributable to the alleged bad acts of its former employee.

The evidence reflects a not-unsubstantial likelihood that the former Umbrella employee was properly terminated for cause, thus giving him a reasonably likely basis for having a retaliatory motive to impair Umbrella and/or destroy potentially incriminating evidence in its files. Nevertheless, the MaineCare regulations do not provide a basis for the hearing officer to account for such factors in weighing whether the documentation admitted into evidence satisfied the regulatory standards. Here, a preponderance of the evidence reflects that the documentation supplied to the Department by Umbrella did not demonstrate that the ISPs for Member #11 had the required clinical approval and/or were timely signed by the member. Accordingly, it should be concluded that the Department correctly identified seven of these claims as sanctionable at 100 percent and one claim as sanctionable at 20 percent.

Missing Progress Notes – Member #s 3, 12, 13, 15, 16, 17

The Department's final, revised recoupment claim included nine individual Section 17 claims sanctioned at 100 percent due to Umbrella's failure to produce documentation of progress notes corresponding to the noted dates of service. Ex. D-23. The Department made its threshold case that Umbrella failed to produce the progress notes for the following members and claim dates-of-service: Member #3 ('), [redacted] 2016; Member #12 ('), [redacted] 2015, and [redacted] 2016; Member #13 ('), [redacted] 2015; Member #15 ( ), [redacted] 2016, and [redacted] 2016; Member #16 ("), [redacted] 2015, and [redacted] 2015; and Member #17 ( ); [redacted] 2015. With regard to these nine claims, Umbrella did not produce proof satisfying the baseline standard for the "minimal" contents of a progress note, instead highlighting the presence in its records of

other collateral documents that supported conclusions that the services were, in fact, provided – i.e. employee timesheets and employee work logs. Ex. A-11; Ex. A-19; Ex. A-20; Ex. A-21; Ex. A-22; Ex. A-23.

Umbrella specifically highlighted two of the relevant claims in this grouping as warranting consideration as qualifying progress notes: Member #12 (' '), [redacted] 2016; and Member #16 ('), [redacted] 2015. Ex. A-32. With regard to the first claim, Umbrella specifically referenced a handwritten note dated [redacted] 2016, signed by Umbrella staff member Kim Kaler and member , which stated the following:

> DLS in at 1:15 p.m. and engaged with client worked on house hold (sic) chores and then went to store to get what was needed to meal a meal for her father and his four weekend dinners. Client had DLS went over paperwork. DLS out at 5:15 p.m.

Ex. A-19.

With regard to the Member #16, [redacted] 2015 claim, Umbrella argued that a progress note prepared for Case Manager, Joan M. Jordan, MHRT-C Prov B, should be deemed to satisfy the regulatory requirement, despite identifying no "goal areas" for the member, not identifying the time and date of service, and included only the following text under "Summary of Appointment": "Case Manager contacted client by phone to discussed (sic) [redacted] Case Manager will continue to call for applications for housing." Ex. A-22.

While these collateral notes suggest the likelihood that certain work was performed by the employees, they do not satisfy the baseline documentation requirement – i.e. that the "documentation of each service provided" must minimally include:

- 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).

Neither of these two documents put forth as "progress notes" identify any reference to service goals or any progress made by either member as a result of the services contemplated. Ex. A-19; Ex. A-22. The documentation requirement provides a basis upon which the Department can verify that the performed work was both medically necessary and a MaineCare-covered service. Without that information, it cannot be said that the provider has demonstrated that those two crucial criteria have been met. In simplest terms, Umbrella did not provide documentation satisfying the minimal standard required to demonstrate that the seven claimed services were reimbursable. Without a fully developed progress note or some other document listing the six data points required at a minimum, the Department is correct to seek 100 percent recoupment of the amounts paid for those service dates.

Departmental discretion to assess percentage-based sanctions

At hearing and through its post-hearing brief, Umbrella raised – in the first instance - an argument that the Department exceeded its discretionary authority by imposing the maximum penalty for improperly documented claims, where the Department determined that the underlying services were medically necessary, covered services, and actually provided to eligible MaineCare members – i.e. 20 percent. With respect to the six relevant claims, Umbrella identified that "the Auditor imposed a full 20% recoupment despite his discretion to impose a lesser recoupment or no recoupment at all." Ex. A-32.

As noted, Umbrella did not raise this issue as a part of its request for Final Informal Review. "Issues that are not raised by the provider, provider applicant, individual, or entity through the written request for an informal review or the submission of additional materials for consideration prior to the informal review are waived in subsequent appeal proceedings." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.23-1. "The request for informal review may not be amended to add further issues." *Id.* While the Hearing Officer's authority in this matter is to conduct a *de novo* review of the matters in issue, the issues that are subject to that *de novo* review cannot be expanded beyond what was pleaded through the Final Informal Review Request. Accordingly, it should be concluded that Umbrella has waived this issue for appeal purposes.

Even if Umbrella had not waived this issue by failing to raise it in its Final Informal Review Request, it should still be concluded that the Department acted within its discretion to apply the full 20 percent allowed for the described claims, and that it had no duty to account for any mitigating factors by reducing that percentage below 20 percent. 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, § 1.20-3 (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*).

The Department conceded that it routinely assesses 20-percent sanctions for qualifying documentation-related violations, and does not contemplate any lesser-percentage sanction without a specific request by the provider to consider the factors listed in Section 1.20-3 (A)(1). Under the plain language of the regulation, the Department is within its discretion to follow such a course. Each of the provisions authorizing the Department to consider applying such discretion is a 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, and thus, no more discussion is warranted.

For these reasons, it should be concluded that the Department was within its discretion to assess 20-percent sanctions for each improper documentation-related violation it identified, where it conceded that the underlying services were MaineCare-covered, medically necessary, and actually provided to a MaineCare member.

Based on the foregoing, the Hearing Officer respectfully recommends that it be concluded that the Department was correct when, for the review period of January 1, 2015 to May 1, 2016, it determined that Umbrella Agency owes the Department a sum of **$39,547.69**, related to billing for a non-enrolled provider, missing progress notes, inadequately dated or signed Comprehensive Assessments, and Individual Services Plans submitted without required signatures.

MANUAL CITATIONS

- DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (eff. Jan. 23, 2016)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101 (eff. 2015-16).

RIGHT TO FILE RESPONSES AND EXCEPTIONS

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

A REASONABLE EXTENSION OF TIME TO FILE EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER FOR GOOD

CAUSE SHOWN OR IF ALL PARTIES ARE IN AGREEMENT. RESPONSES AND EXCEPTIONS SHOULD BE FILED WITH THE DIVISION OF ADMINISTRATIVE HEARINGS, 11 STATE HOUSE STATION, AUGUSTA, ME 04333-0011. COPIES OF WRITTEN RESPONSES AND EXCEPTIONS MUST BE PROVIDED TO ALL PARTIES. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER.

CONFIDENTIALITY

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: 7/16/2018

Richard W. Thackeray, Jr.
Administrative Hearing Officer

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