OAH 71-1800-37124

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS Appeal by Caring Home Health Care Services, Inc.	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

This matter came before Administrative Law Judge Jessica A. Palmer-Denig for a hearing on October 5, 2022, at the Office of Administrative Hearings in St. Paul, Minnesota. The record closed on that date at the conclusion of the hearing.

Leaf McGregor, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). M. Juldeh Jalloh, Jalloh Law Office, P.A., appeared on behalf of Caring Home Health Care Services, Inc.[1] (Appellant).

STATEMENT OF THE ISSUES

1. Has the Department established it may recover an overpayment of Minnesota Health Care Program (MHCP) funds in the amount of $396,397.16, from Appellant pursuant to Minn. Stat. §§ 256B.0625, subds. 19a, 19c, .064, .0659, .0641 (2022), and Minn. R. 9505.0180, .0210, .0335, .0465, .2160-.2245 (2021)?

2. May the Department require Appellant to sign a Stipulated Provider Agreement (SPA) in order for Appellant to continue to act as a provider in the MHCP?

SUMMARY OF RECOMMENDATION

The Department has shown by a preponderance of the evidence that Appellant submitted claims for payment for personal care assistance and qualified professional (QP) services that were not supported by care plans and timesheets meeting all legal requirements. The Department may recover an overpayment from Appellant related to these services in the amount of $396,397.16. The Department may also require Appellant to sign an SPA. Therefore, the Notice of Overpayment and Stipulated Provider Agreement dated June 19, 2020 (Notice of Overpayment), should be **AFFIRMED**.

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

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[1] Appellant is also referred to as "Caring Home & Health Care Services, Inc." *See* Notice and Order for Prehearing Conference and Hearing (Oct. 7, 2020) (Notice and Order for Hearing).

FINDINGS OF FACT

I. Regulatory Background

1. Minnesota participates in the Medicaid program,[2] which funds medical assistance (MA)[3] for eligible individuals who are unable to pay for their medical care.[4] The Department is charged with administering and overseeing this program through the MHCP.[5]

2. Personal care assistance is one of the services available to MA recipients through the MHCP.[6] Eligible personal care assistance services may include assistance with activities of daily living such as dressing, grooming, bathing, eating, and toileting, among others.[7] Recipients may also receive assistance with health-related procedures and tasks, including exercises, assistance with self-administration of medication, and seizure intervention.[8]

3. Personal care services are provided by a personal care assistant (PCA), who is employed by a personal care assistance provider agency.[9] Services provided by PCAs are supervised by a QP.[10]

4. The Department has created an internal unit, called the Surveillance and Integrity Review Section (SIRS) unit, to review and monitor compliance with federal and state law related to the payment for MA-eligible services by service providers and recipients participating in the MHCP.[11] The SIRS unit identifies and investigates "fraud, theft, abuse, or error by vendors or recipients of health services through" the MHCP, and such cases may result in "sanctions against vendors and recipients of health services."[12]

II. The SIRS Investigation of Appellant

5. Appellant is an authorized provider of PCA services.[13] Appellant's owner is Godfrey Edaferierhi.[14]

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[2] *See generally* 42 U.S.C. § 1396-1396w (2018); Minn. Stat. §§ 256B.01-.851 (2022).
[3] *See* Minn. Stat. § 256B.02, subd. 8.
[4] *See* 42 U.S.C. § 1396-1; 42 C.F.R. § 430.0 (2022).
[5] Minn. Stat. § 256B.04; Minn. R. 9505.0011 (2021); *see also* Minn. Stat. §§ 256B.01-.851; Minn. R. 9505.0295, .0335 (2021).
[6] Minn. Stat. § 256B.0659; Minn. R. 9505.0335.
[7] Minn. Stat. § 256B.0659, subds. 1(b), 2(a)-(b).
[8] *Id.*, subds. 1(h), 2(c).
[9] *Id.*, subd. 1(m); Minn. R. 9505.0335, subp. 1(C).
[10] Minn. Stat. §§ 256B.0625, subd. 19c, .0659, subds. 1(k), 14(a).
[11] Minn. Stat. § 256B.04, subd. 10; Minn. R. 9505.0180, .2160-.2245 (2021).
[12] Minn. R. 9505.2160, subp. 1.
[13] Testimony (Test.) of Donald Darling; Test. of Godfrey Edaferierhi; Exhibit (Ex.) 14.
[14] Test. of G. Edaferierhi.

6. On December 15, 2016, an investigator with the Department conducted a screening at Appellant's offices.[15] The screener found deficiencies in Appellant's patient and employee files, and prepared notes stating:

> I reviewed three client files and three employee files. There were concerns with the client files as none of the care plans had effective dates and none of the QP visits had documented times on them or anywhere else. The owner stated he just bills for 8 units each visit because the visits take longer than that with travel time and everything else. I explained to him that we do not pay for travel time and he must document the times of the visit in order to bill for them. He is going to update his form with the in/out times and he is going to update his care plans to include the effective dates. Because of these issues I am referring this case to SIRS for further investigation.[16]

7. SIRS opened an investigation on August 31, 2017, and the file was assigned to investigator Donald Darling on July 2, 2019.[17]

8. Darling initially examined claims for a review period from June 1, 2016, until December 31, 2016.[18] On September 27, 2019, Darling requested that Appellant provide records for four of Appellant's clients during that time period, including all timesheets and care plans, documentation of visits by QPs, and any additional information supporting Appellant's billing.[19]

9. Appellant provided copies of its documentation on October 4, 2019.[20]

10. On December 4, 2019, Darling met with Department supervisory staff to discuss the nature, severity, and chronicity of the issues he discovered with Appellant's documentation.[21] The group was concerned that Appellant's care plans contained erroneous dates or had no dates listed; QP visits did not reflect the duration for the visit; and timesheets for care for three of the four recipients lacked a PCA provider number for most of the review period.[22] The group determined that Darling should request additional documentation for an expanded review of the same four recipients' files for years 2017, 2018, and 2019.[23]

11. Darling sent Appellant a second request for documents on December 5, 2019.[24] In this request, he sought all care plans for the same four recipients identified

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[15] Ex. 1 at DHS315.
[16] *Id.* at DHS317.
[17] Ex. 14 at DHS145.
[18] *Id.*
[19] Ex. 2 at DHS153.
[20] Exs. 3-5.
[21] Ex. 14 at DHS146.
[22] *Id.*
[23] *Id.*
[24] Ex. 6 at DHS156.

earlier, covering the period from January 1, 2017, through December 1, 2019.[25] For two of those recipients, Darling requested documentation for all QP visits, as well as any additional documentation supporting Appellant's billings, for the period January 1, 2017, through December 31, 2018.[26]

12. Appellant provided additional information in response to Darling's request on December 10, 2019.[27]

13. Upon review, Darling determined that Appellant's care plans did not have start and end dates, and lacked emergency numbers and procedures and backup staffing plans.[28] He also found care plans that had a starting date of January 25, 2010, but that were signed with dates of January 16, 2016, January 20, 2016, or March 2, 2016.[29] He found deficiencies in Appellant's timesheet documentation, including timesheets that lacked a provider identification number, or a recipient name or signature, or that were signed by the PCA and recipient prior to the date of service.[30] For some claims, Appellant did not provide a timesheet, or no time was documented for QP visits.[31]

14. For example, a care plan for client C.D. identified a start date of January 25, 2010, but was signed on January 16, 2016, and did not identify an end date.[32] Care plans for C.D. signed in 2017, 2018, and 2019, did not contain start or end dates either.[33] A care plan for client R.K. lacked dates the care plan would start or end.[34] R.K. signed that care plan on January 10, 2017.[35] A care plan that R.K. signed on June 9, 2019, also lacked start and end dates.[36] None of these care plans contained emergency procedures or a back of staffing plan.[37] All of the care plans that Darling examined were missing required elements,[38] including care plans dated after the Department's screening investigator advised Appellant of documentation errors in 2016.[39]

15. Darling discovered many of the timesheets submitted to support Appellant's claims for payment lacked PCA provider numbers.[40] Some timesheets lacked the name of the service recipient and the client's signature, in addition to lacking

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[25] *Id.*
[26] *Id.*
[27] Ex. 7.
[28] Ex. 14 at DHS146; Test. of D. Darling.
[29] Ex. 14 at DHS146; Test. of D. Darling.
[30] Ex. 14 at DHS146; Test. of D. Darling.
[31] Ex. 14 at DHS146; Test. of D. Darling.
[32] Ex. 5 at DHS260.
[33] Ex. 7 at DHS289-91.
[34] *Id.* at DHS292.
[35] *Id.*
[36] *Id.* at DHS293.
[37] Ex. 5 at DHS260; Ex. 7 at DHS292-93.
[38] Test. of D. Darling.
[39] Ex. 1 at DHS317.
[40] Ex. 3 at DHS159-66, DHS172-96; Ex. 4 at DHS198-99, DHS205-26.

a PCA provider number.[41] Some services were documented on a timesheet that was signed by the PCA and recipient prior to the dates of service for the period covered.[42] Documentation of the services provided to Appellant's clients by a QP did not indicate the time spent on the visit.[43] Darling also discovered Appellant had submitted claims for some services that were not supported by any timesheet documentation.[44]

16. Based upon these deficiencies, Darling calculated that Appellant received an overpayment of MA funds in the amount of $396,397.16.[45] This amount represents all of the MHCP funds paid to Appellant between January 1, 2016, and December 31, 2019, because Darling identified deficiencies that spanned all four recipients for the entire time period.[46]

17. Darling prepared an investigative report documenting his findings, along with a spreadsheet identifying of all of the claims that were not supported by compliant documents, and stating the specific reason for each deficiency.[47]

18. Darling met again with his supervisors on January 15, 2020, to discuss the nature, severity, and chronicity of the deficiencies in Appellant's documentation.[48] SIRS determined that Appellant should be required to repay the entire overpayment amount Darling identified, and that the Department would also require Appellant to enter into an SPA.[49]

III. The Department's Actions and Appellant's Appeal

19. On June 19, 2020, the Department issued a Notice of Overpayment to Appellant indicating that it would recover $396,397.16, for services provided between January 1, 2016, and December 31, 2019.[50] The Department based the overpayment determination on:

- No care plan start dates;
- No care plan end dates;
- Care plan start date is 1/25/2010, but signature date is 1/16/2016, 1/20/2016 or 3/2/2016;
- No emergency numbers, procedures or backup staffing plan on care plans;
- No provider ID on timesheets;
- No recipient name on timesheets;

[41] Ex. 5 at DHS264-65.
[42] Ex. 4 at DHS220.
[43] Ex. 5 at DHS262-63; Ex. 7 at DHS298-13.
[44] Test. of D. Darling; *see also* Ex. 16 ("FINAL" spreadsheet at claim lines 2631-2637).
[45] Ex. 14 at DHS146; Test. of D. Darling.
[46] Test. of D. Darling.
[47] Exs. 14, 16.
[48] Ex. 14 at DHS146-47.
[49] Ex. 14 at DHS147; Test. of D. Darling, Test. of Kimberly Ralidak.
[50] Ex. 9 at DHS4.

- No timesheets;
- No time documented for Qualified Professional (QP) visits; and
- Timesheets signed by PCA and recipient prior to date of service.[51]

20. The Notice of Overpayment also advised Appellant that it was required to sign an SPA in order to continue participating as a provider in the MHCP, and included a copy of an SPA for Appellant to sign and return.[52] The SPA included with the Notice of Overpayment required Appellant to institute internal controls to ensure that the time claimed was for services actually provided and to ensure that documentation related to PCA and QP services was fully and accurately completed.[53]

21. On July 2, 2020, Edaferierhi and Darling spoke by telephone.[54] Edaferierhi stated that he had collaborated with other provider agency owners regarding drafting care plans and was unaware that he was drafting care plans incorrectly.[55] He told Darling that he took responsibility for the lack of compliance in the documents and that he would make changes to the care plans.[56]

22. On July 14, 2020, Appellant submitted its appeal of the Notice of Overpayment.[57] In the appeal letter, Edaferierhi stated that Appellant's practice had been to attach care plans to nursing assessments prepared by the county, which contained start and end dates, but that he recognized that Appellant's care plan document was "obsolete."[58] He indicated that Appellant had revised the care plans to contain start and end dates, along with backup staffing plans, and emergency numbers and procedures.[59] Regarding timesheet deficiencies, Edaferierhi stated that Appellant had adopted corrective strategies to ensure that "clerical issues are a thing of the past."[60]

23. Edaferierhi then stated:

> Our Errors and Omissions are not an intentional act. Thus, If we are been [sic] asked to pay back all services that we provided as a result of these errors, we will be out of business. Caring home is a very small minority own [sic] business that is barely scratching the surface. We want to appeal to the Review community to pardon us and give us another opportunity to correct our unintentional wrong by waiving the stipulated fine.[61]

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[51] *Id.*
[52] *Id.* at DHS5, DHS7-10.
[53] *Id.* at DHS7-8.
[54] Ex. 12 at DHS148.
[55] *Id.*
[56] *Id.*
[57] Ex. 8.
[58] *Id.* at DHS126.
[59] *Id.*
[60] *Id.*
[61] *Id.*

24. On August 28, 2020, the Department notified Appellant that its decision had not changed, and that the matter would proceed to a contested case hearing.[62]

25. Appellant never signed the SPA or paid any portion of the overpayment amount.[63] As of the hearing, Appellant had ceased operating.[64]

26. Any Conclusion of Law more properly considered to be a Finding of Fact is incorporated herein.

27. Any portion of the accompanying Memorandum more properly constituting a Finding of Fact is adopted herein.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 256B.04, subd. 15, .064, subd. 2 (2022).

2. The Department has complied with all procedural requirements of law and rule and this matter is properly before the Administrative Law Judge and the Commissioner.

3. As a provider of MA-covered services, Appellant is a "vendor of medical care."[65]

4. The Commissioner may impose sanctions against a vendor of medical care for fraud, theft, or abuse in connection with services provided to MA recipients.[66] The Commissioner may also obtain monetary recovery from a vendor who has been improperly paid as a result of fraud, theft, abuse, or error.[67]

5. The term "abuse" is deemed to include the following conduct:

   a. submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect; and

[62] Ex. 10.
[63] Test. of D. Darling; Test. of G. Edaferierhi.
[64] Test. of G. Edaferierhi
[65] *See* Minn. Stat. § 256B.02, subd. 7; Minn. R. 9505.2165, subp. 16a; *see also* Minn. R. 9505.0295, subp. 2(D).
[66] Minn. Stat. § 256B.064, subd. 1a(a)(1).
[67] *Id.*, subd. 1c(a).

b. failing to develop and maintain health service records as required under Minn. R. 9505.2175.[68]

6. Under Minn. R. 9505.2175, subp. 1, a vendor must document each occurrence of a health service provided to a recipient as a condition for payment by the MHCP.

7. The recipient's care plan is a health service record that must meet required documentation standards.[69] Under Minn. Stat. § 256B.0659, subd. 7(b), a care plan must include the start and end date for the plan, emergency numbers and procedures, and a backup staffing plan.[70]

8. Further, each entry in a health service record must contain the length of time spent with the recipient if the amount paid for service depends on the time spent.[71]

9. Personal care assistance services provided to a resident must be documented daily by each PCA on a timesheet.[72] Completed timesheets must include the individual provider number of the PCA who provides services, the name of the recipient, and a signature of the recipient or responsible party.[73]

10. Program funds paid for a health service not documented in a recipient's health service record shall be recovered by the Department.[74]

11. Among the administrative sanctions available, the Commissioner may require a provider agreement stipulating specific conditions of participation.[75]

12. In imposing a sanction, the Commissioner must consider "the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor."[76]

13. The Department bears the burden to establish that the alleged violations occurred by a preponderance of the evidence.[77]

14. The Department demonstrated by a preponderance of the evidence that Appellant engaged in abuse by repeatedly submitting claims based on documentation missing required information and by failing to maintain health service records for four recipients.

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[68] Minn. R. 9505.2165, subp. 2(A)(1), (7).
[69] Minn. R. 9505.2175, subp. 2(G).
[70] Minn. Stat. § 256B.0659, subd. 7(b)(1), (3).
[71] Minn. R. 9505.2175, subp. 2(C)(3).
[72] Minn. Stat. § 256B.0659, subd. 12(a).
[73] *Id.*, subd. 12(c).
[74] Minn. R. 9505.2175, subp. 1.
[75] Minn. R. 9505.2210, subp. 2(B)(2).
[76] Minn. Stat. § 256B.064, subd. 1b.
[77] Minn. R. 1400.7300, subp. 5 (2021).

15. The Department may recover the claimed overpayment of MHCP funds in its entirety and may require execution of an SPA as a condition of continued participation in the program.

16. Any Finding of Fact more properly considered to be a Conclusion of Law is incorporated herein.

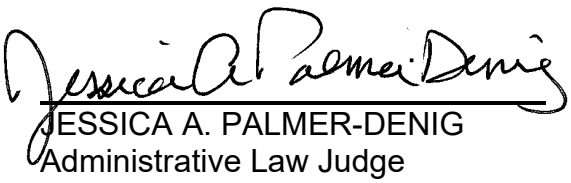
17. Any portion of the Memorandum below that is more properly considered as a Conclusion of Law is incorporated herein.

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, which is incorporated herein, the Administrative Law Judge makes the following:

RECOMMENDATION

The Commissioner should **AFFIRM** the Notice of Overpayment and require Appellant to execute an SPA as a condition of continued participation in the MHCP, and to repay $396,397.16, in MHCP funds.

Dated: November 18, 2022



JESSICA A. PALMER-DENIG
Administrative Law Judge

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NOTICE

This Report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. Under Minn. Stat. § 14.61 (2022), the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Administrative Law Office staff at DHS_AdminLaw@state.mn.us to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and Administrative Law Judge of the date the record closes. If the Commissioner fails to issue a final decision within 90

days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2022). In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten working days to allow the Judge to determine the discipline to be imposed.

Under Minn. Stat. § 14.62, subd. 1 (2022), the Commissioner is required to serve a final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

The Department has established that Appellant billed the MHCP for services that were not supported by care plans, timesheets, and QP records that met all documentation requirements. Appellant characterizes these deficiencies as clerical errors and disagrees that they constitute abuse. "Abuse," however, is defined by rule and is deemed to include the repeated submission of claims with missing or incomplete information and the failure to maintain compliant health records containing all information required by statute and rule.[78] The Department has proven that Appellant engaged in abuse as that term is defined by the rule.

Appellant argues that recovery of the entire overpayment amount is too harsh a sanction, and that the Department should instead impose a lesser consequence. The Commissioner has the authority to impose sanctions, including a fine, on a vendor participating in the MHCP.[79] Under Minn. Stat. § 256B.064, subd. 2(f), the Commissioner may order a vendor to forfeit a fine for the failure to fully document the services provided. Specifically, "[t]he [C]ommissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less."[80]

Notwithstanding that, the Minnesota Court of Appeals has recently repeatedly concluded that the Commissioner may recover the entire amount of an overpayment based on documentation errors that constitute abuse under Minn. R. 9505.2165, subp. 2(A).[81] These cases are unpublished, and therefore non-precedential, but the Administrative Law Judge concludes that the reasoning expressed is sound.[82]

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[78] Minn. R. 9505.2165, subp. 2(A)(1), (7).
[79] Minn. Stat. § 256B.064, subds. 1b, 2(f); Minn. R. 9505.2210.
[80] Minn. Stat. § 256B.064, subd. 2(f).
[81] *In re the Surveillance and Integrity Review Appeal by Smart Choice Health Care Corp.*, No. A22-0367, 2022 WL 4295330, at *4 (Minn. Ct. App. Sept. 19, 2022); *In re the Surveillance and Integrity Review (SIRS) Appeal by Nobility Home Health Care, Inc.*, No. A21-1477, 2022 WL 3711485, at *3-4 (Minn. Ct. App. Aug. 29, 2022); *see also In re the SIRS Appeal of Elite Nursing Services, Inc.*, No. 84-1800-34588, 2018 WL 3586883, at *11 (Minn. Office Admin. Hearings May 22, 2018) ("The Department's ability to recover overpayments is not limited by its ability to also impose fines for noncompliant PCA documentation.").
[82] Under Minn. Stat. § 480A.08, subd. 3(b) (2022), unpublished decisions issued by the Minnesota Court of Appeals are not precedential. They may, however, be cited as persuasive authority. Minn. R. Civ. App. P. 136.01, subd. 1(c).

Minn. Stat. § 256B.064, subd. 1c(a), provides that the Commissioner may obtain monetary recovery from a vendor who has been improperly paid as a result of abuse. Minn. R. 9505.2175, subp. 1, directs that the Department shall recover program funds paid for a health service not documented in a recipient's health record. While the Commissioner also may impose a fine, the availability of that alternative does not prohibit the Commissioner from recovering an overpayment.

The Commissioner also has authority to require Appellant to enter into an SPA to continue participating in the program. Appellant argues that portions of the SPA are not relevant to the violations alleged. The SPA's terms memorialize legal requirements for providers and add additional terms designed to assist Appellant in complying. No term of the SPA is unlawful. Appellant also suggested at the hearing that it was not unwilling to sign an SPA. Whatever its intent, there is no dispute that Appellant has not signed the SPA provided with the Notice of Overpayment, leaving this as an open issue in the case.

In determining the action to take here, the Department properly considered the nature, severity, and chronicity of Appellant's violations.[83] Of note, Appellant's documentation errors were widespread, involving the care of several recipients over a number of years. The deficiencies were so extensive that not a single claim for care provided to the four recipients identified in the review was supported by compliant documentation. These deficiencies continued even after the Department's screening investigator notified Appellant in 2016 that its documentation was flawed and provided information about the requirements it needed to follow. The investigator noted that Appellant agreed to make changes to bring its documentation into compliance,[84] but it never did so.

The Department does not claim that Appellant failed to provide services to recipients and there is no evidence that any recipient suffered actual harm as a result of Appellant's documentation errors. This does not defeat the Department's claims, however. The failure to accurately document health services interferes with the Department's efforts to ensure accountability in the provision of publicly-funded health care to vulnerable recipients. Further, by requiring that Appellant sign an SPA, the Department creates an additional layer of requirements designed to ensure consistent compliance.

Finally, Appellant contends that it has been required to close the business and cease providing PCA services as a result of this case. The Department originally commenced this action by filing the Notice and Order for Hearing on October 7, 2020. Due to a series of continuances, this matter did not come on for hearing until October 5, 2022. Appellant received payment of public funds between 2016 and 2019 that were not supported by proper documentation, continued operating during the pendency of this case, and has never paid any portion of the overpayment. Though the Administrative

[83] Minn. Stat. § 256B.064, subd. 1b; Ex. 14 at DHS146-47; Test. of D. Darling, Test. of K. Ralidak.
[84] Ex. 1 at DHS317.

Law Judge recognizes that repayment of the overpayment is a daunting prospect, there is no evidence that this case or the Department's actions put Appellant out of business.

The Department has established that Appellant received payments from the MHCP totaling $396,397.16, for services that were not supported by compliant documentation. This constitutes abuse and supports recovery of an overpayment in the entire amount claimed. The Department may also require Appellant to sign an SPA. Therefore, the Commissioner should **AFFIRM** the Notice of Overpayment.

J. P. D.