OAH 80-1800-37138

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS Appeal by Smart Choice Health Care Corp. and Farah Jama Mohamed	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

This matter came before Administrative Law Judge LauraSue Schlatter for a hearing on June 8, 2021. The record closed with the submission of the parties' closing arguments on July 9, 2021.

Molly Beckius, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). David J. Holt, Holt Law LLC, appeared on behalf of Smart Choice Health Care Corp. (Appellant or Smart Choice) and Farah Jama Mohamed (Farah Mohamed).

STATEMENT OF THE ISSUES

1. Did the Department properly claim recovery of an overpayment of $424,564.20 in connection with amounts paid to Appellant for personal care assistance services?

2. Did the Department properly suspend Appellant, and its owner, Farah Jama Mohamed, from participating as providers in Minnesota Health Care Programs (MHCP) for a period of two years?

SUMMARY OF RECOMMENDATION

The Administrative Law Judge finds that the Department established it has the authority, but is not required, to recover an overpayment of $424,564.20 in connection with amounts paid to Appellant for personal care assistance services. While the Department has the statutory authority to suspend Appellant, the Department did not establish that a suspension of Appellant from participating as a provider in the MHCP for a period of two years is supported by the record. The Department did not establish that it has the authority to suspend Farah Mohamed, individually, from participating as a provider in the MHCP at all. The Administrative Law Judge respectfully recommends that the Commissioner of the Department (Commissioner) **RESCIND** the overpayment order requiring Appellant to repay $424,564.20 and **RESCIND** the two-year suspension of Appellant's and Farah Mohamed's MHCP provider identification numbers. The Administrative Law Judge instead respectfully recommends that the Commissioner

ISSUE an order requiring Appellant to repay an overpayment for inappropriately billing for 21.75 hours of PCA services allegedly provided to K.K. during the recipient's hospitalization on April 10-12, 2019. Finally, the Administrative Law Judge respectfully recommends that the Commissioner **IMPOSE** a fine of $84,912.84 upon Appellant pursuant to Minn. Stat. § 256B.064, subd. 2(f) (2020).

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

FINDINGS OF FACT

I. Regulatory Background and Requirements

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

2. The Department 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.[5] The SIRS unit is directed to identify and investigate "fraud, theft, abuse, or error by vendors or recipients of health services through" the MHCP, and in such cases impose "sanctions against vendors and recipients of health services."[6] SIRS conducts post-payment reviews and seeks recover of amounts that have been overpaid - whether because of fraud, abuse, or error.[7]

3. Personal care assistance is one of the services available to MA recipients through the MHCP.[8] Eligible personal care assistance services may include assistance with activities of daily living such as dressing, grooming, bathing, eating, and toileting, among others.[9] Recipients may also receive assistance with health-related procedures and tasks, including exercises, assistance with self-administration of medication, and seizure intervention.[10]

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[1] *See generally* 42 U.S.C. § 1396-1396v (2018); Minn. Stat. §§ 256B.01-.85 (2020).
[2] *See* Minn. Stat. § 256B.02, subd. 8.
[3] *See* 42 U.S.C. § 1396-1; 42 C.F.R. § 430.0 (2020).
[4] Minn. Stat. § 256B.04; Minn. R. 9505.0011 (2021); *see also* Minn. Stat. §§ 256B.01-.85; Minn. R. 9505.0295, .0335 (2021).
[5] Minn. Stat. § 256B.04, subd. 10; Minn. R. 9505.0180, .2160-.2245 (2021).
[6] Minn. R. 9505.2160, subp. 1.
[7] Testimony (Test.) of Mai Pha. Minn. R. 9505.0180 (2021).
[8] Minn. Stat. § 256B.0659; Minn. R. 9505.0335.
[9] Minn. Stat. § 256B.0659, subds. 1(b), 2(a)-(b).
[10] *Id.*, subds. 1(h), 2(c).

4. Each recipient must be assessed to determine the type and amount of personal care assistance services for which the person qualifies.[11] A public health nurse conducts this assessment and creates a service plan.[12]

5. Services are then provided by a personal care assistant (PCA), who is employed by a personal care assistance provider agency.[13] Services provided by PCAs are supervised by a qualified professional (QP).[14]

6. PCAs provide services to recipients pursuant to a care plan, which is a "written description of personal care assistance services developed by the personal care assistance provider according to the service plan."[15] Each recipient "must have a current personal care assistance care plan based on the service plan. . . that is developed by the [QP] with the recipient and responsible party."[16] The care plan must be completed within the first week after a provider agency begins providing services, and then updated as needed and at least annually.[17]

7. Care plans contain certain specific information, including a description of the "recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors."[18] The care plan must be signed and dated by the recipient or responsible party and the QP,[19] and a copy is kept in the recipient's home and in the recipient's file at the provider agency.[20]

8. A QP may be a mental health professional, registered nurse, licensed social worker, or a qualified designated coordinator.[21] The QP works for the provider agency, and must train, supervise, and evaluate PCAs.[22] Among their duties, QPs develop and monitor the recipient's care plan, and document all training, communication, evaluations, and actions needed to improve the performance of the PCAs who provide services.[23] The QP documents the services provided in the agency's recipient and employee files and in the recipient's home, including completing documentation related to the care plan, the results of the QP's evaluations, and communications with the recipient and agency staff.[24]

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[11] *Id.*, subds. 3a(a), 4.
[12] *Id.*, subds. 3a(a), 6, 1(q) (defining a service plan as a "written summary of the assessment and description of the services needed by the recipient").
[13] *Id.*, subd. 1(m); Minn. R. 9505.0335, subp. 1(C).
[14] Minn. Stat. §§ 256B.0625, subd. 19c, .0659, subds. 1(k), 14(a).
[15] Minn. Stat. § 256B.0659, subds. 1(a)(n),12(b).
[16] *Id.*, subd. 7(a).
[17] *Id.*, subd. 7(c).
[18] *Id.*, subd. 7(b)(5).
[19] *Id.*, subd. 7(b)(6).
[20] *Id.*, subd. 7(a).
[21] Minn. Stat. §§ 256B.0625, subd. 19c, .0659, subd. 1(k).
[22] Minn. Stat. § 256B.0659, subds. 13(a)-(b), 14.
[23] *Id.*, subd. 13(b)(1), (5).
[24] *Id.*, subd. 14(f).

9. PCAs are required to document the services they provide to recipients on a daily basis on a timesheet form, and the timesheet form must be submitted on a monthly basis to the provider and then kept in the recipient's health record.[25] The services identified on the timesheet must correspond to the care plan, and the timesheet must also contain specific information required by law. [26]

10. Certain required documentation must be completed and kept in the PCA provider agency file or at the recipient's home.[27] Such required documentation includes employee files containing applications, background study documents, verification of training completion, supervisory visit information, and employment evaluations; recipient files containing the service plan and care plan; and agency policy manuals documenting employment-related policies and policies related to the provision of care; timesheets for each personal care assistant along with completed activity sheets for each recipient served; and agency marketing materials.[28]

11. Care plans are required to include:

A. Start and end date of the care plan;

B. Recipient demographic information, including name and telephone number;

C. Emergency numbers, procedures, and a description of measures to address identified safety and vulnerability issues, including a backup staffing plan;

D. Name of responsible party and instructions for contact;

E. Description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

F. Dated signatures of recipient or responsible party and qualified professional.[29]

12. To obtain payment for services provided, each occurrence in which a health service is provided to a recipient must be documented.[30] Providers must maintain certain specific documents, identified as health service records, related to the provision of and billing for PCA services, including the recipient's care plan, daily timesheets containing all required items of information, and documentation of supervision of PCA services by a

[25] *Id.*, subd. 12(a).
[26] *Id.*, subd. 12(b)-(c).
[27] *Id.*, subd 28(a).
[28] *Id.*
[29] Minn. Stat. § 256B.0659, subd. 7(b).
[30] Minn. R. 9505.2175, subp. 1.

QP.[31] Providers are also required to maintain certain financial records, and this includes employee timesheets.[32] Health service records and financial records related to a service for which a provider billed or received payment must be retained for at least five years after the initial date of billing, though in years four and five after the billing date, the records may be stored on microfilm or in an electronic format.[33]

13. PCA provider agencies are required to provide investigators with immediate access to their offices during business hours, without prior notice, and must provide investigators with documents and records related to services provided and claims submitted.[34] Health service and financial records must be available at the provider's place of business on the day on which investigators request access.[35] A provider must store records in a manner that allows review by investigators at the provider's place of business during business hours.[36]

II. Background: Appellant and Mr. Farah Mohamed

14. Appellant is a personal care provider agency licensed by the Department and it participates in the MHCP.[37] At all times relevant to this appeal, Mr. Farah Mohamed has been Appellant's sole owner.[38]

15. Mr. Farah Mohamed moved to Rochester, Minnesota in 1999. He lives there with his family, including six children. Beginning in the late 1990s, Mr. Farah Mohamed took care of his very sick father, without payment. As a result of this experience, Mr. Farah Mohamed became interested in work permitting him to take care of people who are unable to care for themselves.[39]

16. In 2002, Mr. Farah Mohamed began to work at the Mayo Clinic (Mayo). He obtained and has maintained an MHCP individual provider identification number in connection with that work.[40]

17. As he observed patients who were discharged from Mayo, Mr. Farah Mohamed recognized a need for home health care, especially for those patients who might need fewer hours than many agencies offered.[41]

18. During this time, Mr. Farah Mohamed continued to care for his father, who passed away in 2016 at Hennepin County Medical Center. In 2016, Mr. Farah Mohamed founded Appellant. He continues to work at Mayo on a part time basis, and he keeps

[31] *Id.*, subps. 1-2, 7(B), (H), (L).
[32] Minn. R. 9505.2180, subp. 1(H).
[33] Minn. R. 9505.2190, subp. 1.
[34] Minn. Stat. § 256B.0659, subd. 31.
[35] Minn. R. 9505.2185, subp. 2.
[36] Minn. R. 9505.2190, subp. 1.
[37] Exhibit (Ex.) 2; Test. of M. Pha.
[38] Test. of Farah Jama Mohamed.
[39] *Id.*
[40] *Id.*
[41] *Id.*

current his continuing education and other requirements so that he can maintain his required certification for that employment.[42]

19. Appellant is one of the largest PCA agencies in Olmsted County; Appellant serves approximately 153 clients, and employs about 173 PCAs, despite having left their positions during the pandemic.[43]

III. Stipulated Provider Agreement

20. In February 2019, SIRS issued a Notice of Agency Action to Appellant seeking to recover an alleged overpayment of approximately $39,300.00 in MHCP funds, based primarily on its determination that Appellant had inaccurate billing and timesheet practices.[44] At that time, SIRS also required Appellant to enter into a Stipulated Provider Agreement (SPA).[45] The SPA required Appellant to comply with 20 conditions that are spelled out in the SPA. The most relevant conditions (also known as "terms") in this case, are:

a. Term 10: Develop internal controls to ensure that time records submitted for clients reflect the actual care provided:

   i. For example, Smart Choice Home Health Care Corp. will ensure that time records submitted for recipients who attend school do not list services provided during times the recipient was actually in school.

   ii. For example, Smart Choice Home Health Care Corp. will ensure that PCAs do notsubmit overlapping or conflicting time records when they have multiple clients, or have other employment.

b. Term 15: Ensure care plans are on file for each recipient. Care plans must be completed within the first week after services start and must be updated as needed. A new care plan is required annually at the time of the reassessment. Care plans must be filled out according to DHS standards:

   i. A start and end date of the care plan;

   ii. Recipient demographic information including name and telephone number;

   iii. Emergency numbers, procedures, and a description of measures to address identified safety and vulnerability issues, including a backup staffing plan;

[42] Test. of Farah Mohamed.
[43] *Id.*
[44] Ex. 5 at 1020.
[45] Ex. 19 at 737.

iv. Name of responsible party and instructions for contact;

v. Description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors;

vi. Dated signatures of recipient or responsible party and qualified professional.

c. Term 17: Submit billings that list only the total units of service reflected on time records and SmartChoice Home Health Care Corp. will not submit billings in the absence of time records.

d. Term 18: Ensure all Smart Choice Home Health Care Corp. owners, managers, billers, and qualified professionals: Farah Mohamed. Issa Sheikh, Roda Heylan, Farsowsa Abdall and Salwa Abdalla complete all three days of DHS' "Steps for Success" personal care provider agency training. The training must be completed in person within six months of the date of this agreement.

21. The closing paragraph of the SPA stated, in relevant part:

> At any time from the date of this agreement through December 31, 2020, if DHS determines Smart Choice . . . has failed to meet the terms and conditions of this agreement, DHS will suspend Smart Choice . . . from participation in MHCP for a period of two (2) years . . . The provider may appeal such a suspension under the provisions of Minnesota Statutes, Chapter 14, and section 256B.064, subd. 2.[46]

IV. 2020 Investigation

a. Preliminary Investigation

22. In February 2020, SIRS received a referral from Blue Cross Blue Shield (BCBS) indicating Appellant billed for PCA services that failed to meet statutory requirements.[47] SIRS initiated a preliminary investigation, during which investigator Katherine Isaacson requested care plans, timesheets, and QP supervisory visit documentation for eleven recipients for March 1 - October 31, 2019.[48] The preliminary investigation showed that some of the requested documents failed to meet statutory requirements. Ms. Isaacson completed the preliminary investigation on February 25,

[46] Ex. 19 at DHS 939.
[47] Ex. 5.
[48] *Id.*

2020. She recommended that SIRS open a case on Appellant.[49] Senior investigator Mai Pha opened a full investigation of Appellant on February 27, 2020.[50]

23. Of the eleven recipients whose documents were included in the full investigation, Appellant billed claims for five recipients to BCBS. The payments made on their behalf were not considered for repayment by the Department, because BCBS bears the responsibility of recovering overpayments it makes to providers.[51]

B. Care Plans Provided

24. The care plans on file for the six fee-for-services (FFS) recipients[52] for whom the Department made direct payments were missing the following information:

a. demographic information: recipient date of birth, address, and telephone number;[53]

b. emergency numbers, procedures, and description of measures to address identified safety issues;

c. backup staffing plan;

d. signature and date by recipient or responsible person (RP)

e. signature and date by QP.[54]

25. Care plans must contain all of the required information so recipients can obtain help quickly in the event of an emergency, or so that backup staff can be brought in immediately if scheduled staff cannot be there. The recipient's date of birth is important so that the PCA will know how old the recipient is, and signatures on the document are important to show that the recipient or the recipient's RP was involved in the creation of the care plan, and that the QP drafted the plan.[55]

26. Recipient M.A.'s file contained two care plans. The first had a start date of 10/1/2019 and an end date of 9/30/2020.[56] The second had a start date of 10/1/2018 and an end date of 9/30/2019.[57] Both care plans on file for M.A. contained M.A.'s name, but lacked the following: address, telephone number, emergency numbers, procedures, and

[49] Ex. 5; Test. of Mai Pha.
[50] *Id.*
[51] Test. of M. Pha.
[52] The 6 recipients are M.A., R.B., D.D., Z.M. T.T., and B.Y. Test. of M. Pha.
[53] The Department's investigative report alleged that the recipient's names were missing from the care plans. Ex. 5 at 1021; Test. of M. Pha. That allegation was incorrect. Every care plan included the recipient's name.
[54] Test. of M. Pha.
[55] *Id.*
[56] Ex. 9 at 2407.
[57] *Id.* at 2408.

description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and signature and date by the QP. [58]

27. Recipient R.B.'s file also contained two care plans. The first had a start date of 8/1/2019 and an end date of 7/31/2020.[59] The second had a start date of 8/1/2018 and an end date of 7/31/2019.[60] Both care plans on file for R.B. contained R.B.'s name, but lacked the following: address, telephone number, emergency numbers, procedures, and description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and signature and the date by QP.[61]

28. The care plan on file for recipient D.D. had a start date of 1/1/19 and an end date of 12/31/19.[62] The care plan contained D.D.'s name, but lacked the following: address, telephone number, emergency numbers, procedures, and description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and signature and date by the QP.[63]

29. There were two care plans included in the file for recipient Z.M. The first had a start date of 7/1/2019 and an end date of 6/30/2020.[64] The second had a start date of 7/1/2018 and an end date of 7/31/2019.[65] Both care plans contained Z.M.'s name, but lacked the following: address, telephone number, emergency numbers, procedures, and description of measures to address identified safety issues, backup staffing plan, signature and date by recipient or RP, and signature and date by the QP.[66]

30. Recipient T.T.'s file contained one care plan with a start date of 12/01/18 and an "updated" date of 11/30/19.[67] It contained T.T.'s name, but lacked the following end date, address, telephone number, emergency numbers, procedures, and description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and signature and date by the QP.[68]

31. The one care plan on file for recipient B.Y. had a start date of 11/1/2018 and an end date of 10/31/2019.[69] The care plan contained B.Y.'s name, but lacked the following: address, telephone number, emergency numbers, procedures, and description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and signature and date by the QP.[70]

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[58] *Id.* at 2407-2408; Test. of M. Pha.
[59] Ex. 10 at 2450.
[60] *Id.* at 2449.
[61] *Id.* at 2449-2450; Test. of M. Pha.
[62] Ex. 11 at 2491.
[63] *Id.* at 2491. Test. of M. Pha.
[64] *Id.* at 2722.
[65] *Id.* at 2723.
[66] *Id.* at 2722-23. Test. of M. Pha.
[67] *Id.* at 2839.
[68] *Id.* at 2839-40. Test. of M. Pha.
[69] Ex. 14 at 2917.
[70] *Id.* at 2917. Test. of M. Pha.

32. Recipient S.D.'s file contained two care plans. The first had a start date of 9/1/2019 and an end date of 8/31/2020.[71] The second had a start date of 9/1/2018 and an end date of 8/31/2019.[72]

33. There were two care plans included in the file for recipient N.J. The first had a start date of 5/1/2019 and an end date of 4/30/2020.[73] The second had a start date of 5/1/2018 and an end date of 4/30/2019.[74]

34. Recipient H.M.'s file contained two care plans. The first had a start date of 6/1/2019 and an end date of 5/31/2020.[75] The second had a start date of 6/1/2018 and an end date of 5/31/2019.[76]

35. There were two care plans included in the file for recipient K.K. The first had a start date of 7/1/2019 and an end date of 6/30/2020.[77] The second had a start date of 7/1/2018 and an end date of 6/30/2019.[78]

36. Recipient H.N.'s file contained one care plan listing a start date of 12/01/2018 and an end date of 11/30/19.[79]

37. Each of the care plans for all of the recipients included a list of the cares the recipient needed.[80]

38. In conducting the full investigation, Ms. Pha, expanded the scope of the time period involved. She included data covering a time period from February 1, 2017, through February 29, 2020, to calculate the amount the Department claimed Appellant owed in overpayments. The start date for this period was chosen to correlate to the original start date of the BCBS investigation (February 1, 2017). The end date of February 29, 2020, was selected based on the end date of September 30, 2020, listed in some of the affected care plans.[81]

39. Because the care plans for the six recipients did not contain all the information required by statute and under the SPA, the Department sought monetary recovery from Appellant for a total of $424,564.20, representing the total payments made

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[71] Ex. 7 at 1109.
[72] *Id.* at 1110. Recipients S.D., N.J., H.M., K.K., and H.N. were all clients of BCBSM and thus were not counted in the total overpayment. There was no testimony regarding the content of their care plans, but the presence of their care plans was taken into consideration. The paragraphs regarding the updating of their care plans are included to demonstrate whether Appellant regularly updated care plans, as is discussed later in this Report.
[73] Ex. 12 at 2603.
[74] *Id.* at 2604.
[75] Ex. 13 at 2797.
[76] *Id.* at 2798.
[77] Ex. 17 at 2644.
[78] *Id.* at 2645.
[79] Ex. 101 at 011.
[80] Exs. 7-17 and 101.
[81] Test. of M. Pha.

to Appellant for care provided to the six recipients between July 1, 2018, and February 22, 2020.[82]

40. As soon as he received the Department's Notice of Agency Action in this case, Farah Mohamed undertook an investigation to determine why the care plans were defective. Prior to receiving that notice, he was unaware that any problem with the care plans existed. Mr. Mohamed determined that some information was missing from the care plans because an employee revised the care plan form in an attempt to make the form fit on one page. The employee shrank the form, eliminating some of the required elements, including signature lines. Mr. Mohamed understood the formatting problem to be the result of human error. He consulted with his attorney immediately and reinstated all the required elements into the care plan form.[83]

41. All the elements missing from the care plans were already covered in the recipients' intake application forms, which were provided to them in special folders and made a part of their at-home files. The SIRS investigators did not ask for recipients' intake applications; if they had, the investigators would have found that the required care plan information was in the recipients' files. [84]

42. During the time period encompassed by the SIRS investigation in this matter, none of Appellant's clients were ever put at risk because information was missing omitted from care plans. he client information was always available in the client folder, easily accessible to the client and the PCA. In addition, emergency contact information was printed on a separate sheet and posted on the client's refrigerator or in some other prominent place, if possible.[85]

43. Appellant's backup plan includes a nurse number, a social worker number, and Mr. Mohamed's personal cell phone number. Outside of business hours, all calls are forwarded directly to Mr. Mohamed's own number. If a PCA is unable to work on a particular day, Mr. Mohamed receives a notification and Appellant's other staff are available to fill in.[86]

44. Mr. Mohamed was not aware of any situation during the review period when there was a problem with backup or emergency for any of Appellant's clients.[87]

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[82] Ex. 24, Test. of M. Pha.
[83] Test. of Farah Mohamed.
[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*

C. SPA Violations

45. The Department determined Appellant should be suspended from participating in the MHCP based on four violations of the SPA, in addition to the inadequate care plans.[88]

46. The Department determined Appellant failed to:

a) Develop internal controls to ensure that time records submitted for clients reflect the actual care provided (term 10);

b) Ensure that care plans are on file for each recipient (term 15);

c) Submit billings that list only the total units of services reflected on time records and not submitting billings in the absence of time records (term 17);

d) Send owners, managers, billers and qualified professionals to complete required training – in person, within 6 months of date of agreement (term 18).

1. Internal Controls for Accurate Time Records – Violation of Term 10

47. The Department does not require providers to use any particular kind of internal controls for keeping accurate time records. SIRS is aware that different providers use different kinds of controls. [89]

48. SIRS did not request that Appellant provide any information regarding what, if any, internal controls Appellant uses to ensure that time records submitted for clients reflect the actual care provided. SIRS views one problem timesheet as proof of a systemic issue. [90]

49. The Department did not present any evidence regarding what, if any, internal controls Appellant uses to ensure that time records submitted for its clients reflect the actual care provided.

[88] Test. of M. Pha.
[89] Test. of T. Welter.
[90] *Id.*

2. Missing Care Plan and PCA Supervision Records for Recipient H.N. – Violation of Term 15

50. Appellant provided recipient H.N.'s records to SIRS on November 12, 2019, by fax, during the preliminary investigation.[91] Ms. Isaacson, the investigator, did not visit Appellant's office, but had requested that all records be sent to her.[92]

51. The cover sheet Appellant sent with the fax of H.N.'s records indicated that the submission contained 122 pages, including the cover page in the fax, but the Department only received 118 pages.[93] The faxed record did not include H.N.'s care plan or records of PCA supervision visit reports for the period covered by the investigator's request.[94]

52. For each of the other recipients whose records Appellant faxed to the investigator, the care plan and PCA supervision reports were the final pages of that faxed record.[95]

53. Appellants offered H.N.'s care plan dated December 1, 2018, through November 30, 2019, along with PCA supervision reports dated May 19, 2019, and September 30, 2019, as Exhibit 101 in the contested case hearing.[96]

54. The documents in Exhibit 101, had they been part of the original fax containing H.N.'s records, would have added three pages. The Department's copy of the fax Appellant submitted also includes a single blank page between DHS pages 1147 and 1148.[97] It is unclear whether the blank page was part of the original fax. If it was, it would have brought the total number of pages attempted to be faxed to 122.[98] If not, there remains a one-page discrepancy between the number of pages the Appellant attempted to fax, and the total number of pages indicated on the fax cover sheet.

55. On the evening of the day Appellant faxed the requested documents to the Department, Mr. Farah Mohamed emailed Ms. Isaacson as follows:

> Hello Katherine this is Farah from Smart Choice Health Care. I faxed all the paperwork today and I will sent (sic) by mail tomorrow. [C]ould you please let me know if you received the fax and you don't need by mail. Otherwise you should be receiving by Thursday or Friday. You can contact us any question or concern[99]

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[91] Ex. 8.
[92] Ex. 18 at 1250.
[93] Ex. 8. The fax page count stopped at page 99. That is, every page following page 99 was marked page 99/99, requiring a hand count for all pages beyond DHS 1212, which was the actual page 99 of the fax.
[94] *Id.*
[95] Exs. 7-17.
[96] Ex. 101 at 9-11.
[97] Ex. 8 at 1147-1148.
[98] Exs. 8, 101.
[99] Ex. 101.

56. Ms. Isaacson responded early the next morning with an email to Mr. Farah Mohamed:

> Good Morning Mr. Mohamed
>
> Thank you for reaching out to me regarding the faxed requested information. It appears I have received it all. At this time there is no need to mail the records, if I have any questions I will contact you.[100]

57. Mr. Farah Mohamed continued to try to contact the Department to confirm that they had everything they needed in the investigation. He left telephone messages for Ms. Pha after she took over the investigation, but Mr. Farah Mohamed received no response from her, even at times when Ms. Pha did respond to inquiries from Mr. Farah Mohamed regarding other matters.[101]

58. When she became aware of the discrepancy in the number of pages in H.N.'s record after taking over the case, Ms. Pha believed it was her job to contact Appellant to ask about the pages missing from the fax. Nonetheless, she did not attempt to do so.[102]

59. Ms. Pha's supervisor, Tinna Welter, did not fault Ms. Pha for failing to check with Appellant to inquire about possible missing faxed pages. Ms. Welter stated that it is the Department's position that it is the obligation of the provider, not Department staff, to ensure that an entire fax has come through. Providers are welcome to contact investigators to make sure that all their documents have been faxed successfully. This is partly because the investigators are busy, with multiple cases and lots of documents. In addition, the Department sees this as the provider's burden, especially during an audit, since missing records could mean the provider will be charged with an overpayment.[103]

60. As a "rule of thumb" the Department does not point out missing documents unless the provider contacts the Department and asks about possible specific missing documents. This practice is meant to avoid the possibility that providers will fabricate documents after the fact.[104]

61. Because the Department saw any possible faxing problem as Appellant's responsibility and has a general concern about providers creating fraudulent documents; and because Ms. Welter claims she does not recall ever receiving an incomplete fax during her time working at the Department, the Department refused to consider Appellant's QP supervision reports and care plan for H.N. initially during the evidentiary hearing.[105]

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[100] *Id.*
[101] Test. of Farah Mohamed.
[102] Test. of M. Pha, T. Welter.
[103] Test. of T. Welter.
[104] *Id.*
[105] Test. of M. Pha and T. Welter.

62. After H.N.'s care plan and QP supervision reports were received as Ex. 101 over the Department's objections, the Department and Appellant stipulated that the care plan lacked the same elements as the other 10 care plans in this matter.[106]

63. Despite the parties' stipulation, and even while claiming that the errors in H.N.'s care plan showed that 100 percent of the care plans were missing required elements, the Department maintained its argument that H.N.'s care plan was never faxed to it and should not be considered.[107]

64. Ms. Welter did not suspect that Appellant fabricated any documents.[108]

65. The remaining care plans did not meet the standards set forth in the SPA, as discussed in the section addressing the Order for Repayment.[109]

3. Submitting Time Records Reflecting Actual Services Provided – Violations of Term 17

66. Appellant submitted timesheets for care provided to recipient K.K. by provider P.D., including for the week of April 7, 2019, through April 13, 2019.[110] According to the timesheet for that week, P.D. claimed to have provided care to K.K. for 7.25 hours - from 10:00 a.m. to 2:00 p.m. and 6:00 p.m. to 9:15 p.m. each day.[111]

67. K.K. was hospitalized beginning at approximately 5:20 p.m. on April 10, 2019, and discharged at approximately 4:30 p.m. on April 12, 2019.[112] P.D. could not have provided care for K.K. after 2:00 p.m. on April 10, 2019; or before 6:00 p.m. on April 13, 2019.[113]

68. Appellant acknowledged that they erred in submitting the time sheet for P.D.'s care for K.K. on April 10 through 12. Appellant concedes that an overpayment of the amount paid for those hours must be repaid.[114]

[106] Hearing Digital Recording (on file with the Minn. Office Admin. Hearings June 8, 2021).
[107] Department Memorandum at 4, 14.
[108] Test. of T. Welter.
[109] Ex. 19 at 938.
[110] Ex. 17 at 2614.
[111] Ex. 17 at 2614.
[112] Ex. 20 at 3081, 3088.
[113] Ex. 17 at 2614.
[114] Test. of Farah Mohamed.

4. Training Requirement – Violation of Term 18

69. Appellant signed the SPA on February 7, 2019.[115] The Department executed it on February 14, 2019.[116]

70. On February 11, 2019, Mr. Mohamed sent an email to Patricia Ripperton, the SIRS investigator on the prior case connected to the SPA. Mr. Mohamed's email read, in part:

> couple weeks age (sic) I sent to you an Email requesting to wave (sic) the attendance of Steps for Success because of all Smart Choice employees did it on 05-14-18 TO 05-16-2018 and we are very aware and familiar the rules and regulation. [117]

71. On the same date, Ms. Ripperton replied:

> I will look in provider enrollment documents where you send the information about who has attended the Steps for Success. Sometimes there is a delay, if I don't see them in the files I'll contact you and you can send me a copy of the certificate. **That will fulfill that portion of the Stipulated Provider Agreement.**[118]

72. Approximately twenty minutes later, Mr. Mohamed responded with copies of Steps for Success Certificates of Completion for the employees named in the SPA. The certificates showed the employees had attended the training online in May of 2018, nine months before the SPA was signed.[119]

73. Ms. Ripperton responded to the Certificates of Completion with, "Thank you, you saved me a step."[120]

74. Mr. Mohamed understood Ms. Ripperton's combined emails to mean, "You've met the requirement – you've satisfied the request." Mr. Mohamed would have gladly completed the Steps-for-Success training again, had he known the Department considered the requirement unfulfilled.[121]

75. The SPA required in-person attendance at the Steps-for-Success training to ensure that the individuals required to attend really are present, and in-person

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[115] Ex. 19 at 939. The Respondents' signature is dated February 7, 2018, and is not corrected. The Administrative Law Judge believes this is a clerical error, because the SPA resolved a Notice of Agency Action issued on January 4, 2019. *See* Ex. 19 at 937.
[116] Ex. 19 at 939. The date on the Department's signature was first written in as February 19, 2019, but corrected to February 14, 2019, with the correction initialed by the signer.
[117] Ex. 100 at 1.
[118] *Id.* Emphasis added.
[119] Ex. 100 at 3-8. Several of the names on the certificates were stated with slight differences than the way the names appeared in the SPA. Mr. Mohamed testified they were the same individuals.
[120] *Id.* at 1.
[121] Test. of Farah Mohamed.

attendance also helps to assure that attendees pay attention to the instruction provided.[122]

V. Sanctions

76. Once Ms. Pha finished her investigation, she calculated the total overpayment to be assessed by adding the amount billed for each day within the range of the dates included in the investigation for each of the six recipients for whom a care plan lacked certain elements, or for whom there was no care plan. Ms. Pha then added the amount Appellant' billed for the three days of overlapping time for recipient K.K.'s hospitalization during April 10-12, 2019. The total overpayment was initially calculated to be $461,377.94.[123]

77. Ms. Pha consulted Ms. Welter about whether further action, such as suspension, would be appropriate, based on the inadequate care plans and the SPA violations. Ms. Welter directed Ms. Pha to discuss the matter with a nature, severity, chronicity (NSC) panel. On April 1, 2020, Ms. Pha met to discuss the findings in the case with the NSC panel, which included Ms. Welter, two other SIRS supervisors, Kim Ralidak and Melanie LaBrie, SIRS Legal Manager Corrie Oberg, and Deputy Inspector General Kristin Preston.[124] Ms. Pha recommended that Appellant be suspended from MHCP for a period of two years, due to the violations of four of the terms included in the SPA. The NSC panel agreed with the recommendation.[125]

78. In deciding to impose the suspension, the NSC panel considered the nature, severity, and chronicity of the SPA and care plan violations. The nature of the violations raised concerns because most of the documentation problems involved care plans and this type of violation presents risks to the patient. The care plan violations were considered severe because inadequate care plans present the possibility that a patient is not receiving needed cares, that cares are not being updated as the patient's needs change, that it is not clear to the PCA, the QP, and the patient or the RP just what cares are needed. When care providers are unaware what cares are needed, that can present a risk to the patient's health and safety. Further, the group deemed the violations to be particularly severe because Appellant had been allowed to enter into an SPA and to correct previous violations, but then violated the SPA., Finally, the group considered that the violations were chronic because of the eleven patient files examined, ten had incomplete care plans over a two-year period.[126] The supervisors also took into account an analysis performed by Ms. Welter comparing a two-year suspension in this case with other providers who had also received two-year suspensions. [127]

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[122] Test. of T. Welter.
[123] Test. of M. Pha. Ex. 5 at 1022-1023.
[124] Test. of M. Pha and T. Welter.
[125] Test. of M. Pha. Ex. 5 at 1023.
[126] The remaining patient file was H.N.'s file, which the Department believed had no care plan. However, as discussed at Findings 50 through 65, the Department's belief was mistaken. .
[127] Test. of T. Welter.

79. SIRS does not use any specific metric to determine whether a violation of an SPA is significant enough to impose the suspension authorized by the agreement. Some factors weigh more heavily than others, such as how many violations have occurred, the severity of the violations, and whether fraud was involved. SIRS views the length of suspension set out in a SPA to be non-discretionary once the SPA is signed. Stated another way, SIRS does not believe it has discretion to reduce the suspension, regardless of the severity of the SPA violation. If SIRS determines the suspension should apply, it imposes the full suspension provided in the SPA.[128]

80. In addition to suspending Appellant, the NSC panel concluded the Department was required to suspend Mr. Mohamed individually. The Department believes his individual suspension is necessary so that he cannot open another MHCP program and "do the same thing" during the pendency of the suspension.[129] The Department relied on Minn. Stat. § 256B.0659, subd. 23 (2020), for its authority to suspend Mr. Mohamed's individual provider status.[130]

81. On April 8, 2020, Ms. Pha met again with the NSC panel. She recommended collecting an overpayment of $461,377.94 and referring the case to the Attorney General's Medicaid Fraud Control Unit (MFCU). The NSC group approved the overpayment recovery but did not approve referral to the MFCU, because it determined that the findings relating to Appellant were "merely administrative."[131]

82. On June 30, 2020, Ms. Pha mailed a Notice of Overpayment and Suspension (NOS) to Appellant. The NOS imposed a $461,377.94 overpayment, and a two-year suspension on Appellant and Mr. Farah Mohamed.

83. According to the NOS, once the suspension took effect, Appellant "and all of its owners, controlling individuals, license holders, directors, and managerial officials, will also be removed from all other programs administered by DHS . . .."[132]

84. This NOS was the first time that Mr. Farah Mohamed was made aware that he was subject to suspension as an individual provider. There was no mention of suspending Mr. Farah Mohamed's individual provider number in the SPA. It does not appear that his provider number is listed separately on the NOS.

85. The Department received a Notice of Appeal on July 21, 2021. The Notice of Appeal was sent on behalf of Mr. Farah Mohamed and Smart Choice Health Care Corp., by their counsel.[133]

86. In response to the appeal notice, Ms. Pha completed a line-by-line review of the overpayment amount and discovered she had included claims for T.T.'s care plan

[128] *Id.*
[129] Test. of T. Welter.
[130] *Id.*
[131] Test. of M. Pha. Ex. 5 at 1023.
[132] Ex. 1 at 353.
[133] Ex. 3 at 335.

deficiencies that Appellant submitted outside the review period she selected. She removed 220 claims and reduced the amount of the overpayment by $36,813.74, leaving an overpayment amount of $424,564.20. On August 31, 2020, Ms. Pha sent Appellant an Amended NOS reflecting the reduced overpayment claim.[134]

87. The Department issued the Notice and Order for Prehearing Conference and Hearing on October 14, 2020, commencing this contested case.[135]

88. Any Conclusion of Law more properly considered a Finding of Fact is adopted herein.

89. Any portion of the Memorandum more properly considered as a Finding of Fact is incorporated herein.

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner have jurisdiction to consider this matter pursuant to Minn. Stat. §§ 14.50, 256B.04, subd. 15(c), .064, subd. 2 (2020).

2. The Department has complied with all relevant procedural requirements of statute and rule. Appellant and Mr. Mohamed received due and proper notice of the Department's determinations in this matter and timely appealed. Therefore, this matter is properly before the Administrative Law Judge and the Commissioner.

3. Appellant is a "personal care assistance provider agency,"[136] and a "vendor of medical care."[137]

4. The Commissioner may obtain monetary recovery from a vendor who has been improperly paid as a result of conduct prohibited under Minn. Stat. § 256B.064, subd. 1a, including fraud, theft, or abuse, or due to an error by the vendor or the Department.[138]

5. The Commissioner may impose sanctions against a "vendor of medical care" for fraud, theft, or abuse in connection with services provided to medical assistance recipients.[139]

6. Abuse by a vendor is defined as "a pattern of practices that are inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs" to the MHCP.[140] Specific practices deemed by rule to be abuse by a vendor include failing to develop and maintain health service records as required under Minn.

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[134] Ex. 2 at 2.
[135] Notice and Order for Prehearing Conference and Hearing (Oct. 16, 2020).
[136] *See* Minn. Stat. § 256B.0659, subd. 1(l); Minn. R. 9505.0335, subp. 1(D).
[137] *See* Minn. Stat, § 256B.02, subd. 7(a); Minn. R. 9505.0175, subp. 50, .2165, subp. 16a (2021).
[138] *Id.*, subd. 1c(a).
[139] Minn. Stat. § 256B.064, subd. 1a.
[140] Minn. R. 9505.2165, subp. 2(A).

R. 9505.2175, and repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by Minn. R. 9505.2160-.2245.[141]

7. Among the available sanctions, the Commissioner may suspend or withhold payments to a vendor, suspend or terminate the vendor from participation in the MHCP, or impose a fine.[142] In determining an appropriate sanction, the Commissioner must consider the nature, chronicity, and severity of the vendor's conduct and the effect of the conduct on the health and safety of persons served by the vendor.[143]

8. The Commissioner may order a vendor to forfeit a fine for failing to document services fully according to standards in Minn. R. ch. 9505, and if specific required components of documentation are missing.[144]

9. In a case of incomplete documentation, the fine 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. If the Commissioner determines that a vendor repeatedly violated chapter 256B, or Minnesota Rules, chapter 9505, the Commissioner may order a vendor to forfeit a fine on the nature, severity, and chronicity of the violations, in an amount up to $5,000 or 20 percent of the value of the claims, whichever is greater.[145]

10. A recipient of PCA services must have a current personal care assistance plan, or care plan, developed by the QP with the recipient and the RP. The care plan is based on the service plan completed on a form determined by the Commissioner, pursuant to Minn. Stat. § 256B.0659, subd. 6 (2020). Copies of the care plan must be kept in the recipient's home and the recipient's file at the provider agency.[146]

11. Minn. R. 9505.2175, subp. 7, requires that personal care provider service records include the care plan completed by the QP detailing the QP's instruction to the PCA. The care plan is subject to the requirements of Minn. R. 9505.2175, subps. 1 and 2.

12. As a condition of payment by the MHCP, a vendor must document each occurrence of a health service rendered to a recipient.[147]

13. Providers must maintain certain specific documents, identified as health service records, related to the provision of and billing for PCA services. The health service records must be maintained consistent with the standards specified in 9505.2175, subp. 2 items 1 through I.

14. The care plan must contain the components listed in Minn. Stat. § 256B.0659, subd. 7(b).

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[141] *Id.*, subp. 2(A)(7), (18).
[142] Minn. Stat. § 256B.064, subd. 1b.
[143] *Id.*
[144] Minn. Stat. § 256B.064, subd. 2(f).
[145] *Id.*
[146] Minn. Stat. § 256B.0659, subd. 7(a) (2020).
[147] Minn. R. 9505.2175, subp. 1.

15. PCA services provided to a recipient must be performed under the supervision of a QP.[148]

16. "Plan of care," as defined by Minn. R. 9505.0175, subp. 35, means a written plan that:

> **A. states with specificity the recipient's condition, functional level, treatment objectives, the physician's orders, plans for continuing care, modifications to the plan, and the plans for discharge from treatment; and**
>
> **B. except in an emergency, is reviewed and approved, before implementation, by the recipient's attending physician in a hospital or long-term care facility or by the provider of a covered service as required in parts 9505.0170 to 9505.0475.**

17. A vendor "shall make its records available" at the vendor's place of business or another agreed-upon location "on the day for which access was requested."[149]

18. Minn. Stat. § 256B.0659, subd. 23, requires that "[a] terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination."

19. The Commissioner may require a vendor to sign a Stipulated Provider Agreement as a condition of participating in MHCP which may require "specific conditions of participation" in MHCP.[150]

20. The Department bears the burden of proof to show, by a preponderance of the evidence, that Appellant should be subject to monetary recovery or sanctioned under Minn. Stat. § 256B.064, .0659, subd. 7; Minn. R. 9505.0465, subp. 1, .2165, subp. 2(A)(1), (3), .2175, subp. 2, 7, and .2215, subp. 1 (2021). If the evidence is equally balanced, then that fact or issue has not been proven by a preponderance of the evidence.[151]

21. The Department failed to demonstrate by a preponderance of the evidence that Appellant violated Term 10 of the SPA, which required Appellant to "develop internal controls to ensure that time records submitted for clients reflect the actual care provided."[152]

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[148] Minn. Stat. § 256B.0659, subd. 14.
[149] Minn. R. 9505.2185, subp. 2.
[150] Minn. R. 9505.2210, subp. 2.B.
[151] *Id.*
[152] Ex. 19 at 938.

22. The preponderance of the evidence demonstrates that Exhibit 101 is the final three pages of H.N.'s records and that Appellant sent those three pages as part of the 122-page record Appellant faxed to the Department on November 12, 2019. Appellant provided all of H.N.'s records at the time they were requested, including H.N.'s supervision reports and care plans. Thus, the Department did not demonstrate that Appellant failed to ensure that care plans and QP supervision reports are on file for each recipient, in violation of term 15 of the SPA.

23. The Department demonstrated by a preponderance of the evidence that Appellant failed to comply with the SPA requirement at term 15 that care plans be completed according to DHS standards.

24. The Department demonstrated by a preponderance of the evidence that Appellant violated term 17 of the SPA when it failed to "submit billings that list only the total units of services reflected on time records and.. . .not. . . . in the absence of time records" when Appellant billed for services provided to K.K. during a time K.K. was hospitalized.[153]

25. The email exchange between Ms. Ripperton and Mr. Farah Mohamed demonstrates, by a preponderance of the evidence, that Appellant reasonably understood the Department accepted Appellant's Steps for Success attendance certificates and waived additional SPA requirements regarding Steps for Success attendance. [154] Therefore, the Department did not establish that Appellant violated term 18 of the SPA.The Department established by a preponderance of the evidence that Appellant committed abuse by failing to develop and maintain personal care plans for the recipients whose files the Department reviewed in this case.[155]

26. The Department established by a preponderance of the evidence that it is entitled to repayment of the amount paid to Appellant for PCA services during on April 10 through April 12, 2019, while K.K. was hospitalized. Appellant reported 7.25 for each of those days for a total of 21.75 hours.[156]

27. With the exception of repayment for the 21.75 hours during K.K.'s hospitalization, the Department failed to establish by a preponderance of the evidence that it is required to recover an overpayment of $424,564.20, because it did not demonstrate that the demonstrated abuse resulted in payment for a health service, or in unnecessary costs to the programs, reimbursements for medically unnecessary services, or that failed to meet recognized standards for health service.[157]

28. Because "[m]onetary recovery under the medical assistance program is permitted for . . . .abusive actions on the part of the provider," the Department may recover an amount the provider claimed for reimbursement in this case, up to

[153] Ex. 19 at 939; Test. of M. Pha.
[154] Test. of F. Mohamed. Ex. 102.
[155] Minn. R. 9505.2165, subp. 2A, .2175, subps. 2, 7.
[156] Ex. 17 at 2614.
[157] Minn. R. 9505.2215, subp.1; Minn. R. 9505.2165, subp. 2.A.

$424,564.20, including the amount it is required to recoup for the services provided to K.K. on April 10 through 12, 2019.[158]

29. The Department failed to establish that the nature, severity and chronicity of the Appellant's conduct supports a two-year suspension from eligibility to participate in the MHCP.

30. The Department failed to establish a legal or factual basis to suspend Mr. Farah Mohamed's individual provider number from participation in the MHCP for a two-year period.

31. The Department established that, over a period of at least four years, Appellant has repeatedly violated requirements of chapter 256B and Minn. R. 9505 related to the provision of services to program recipients and the submission of claims for payment. Based on the serious nature and chronicity of the violations, the Department is entitled to impose a fine on Appellant in an amount of up to $5,000 or 20 percent of the value of the claims for reimbursement submitted by Appellant ($84,912.84), whichever is greater.

32. Any of the foregoing Findings of Fact more properly designated as Conclusions of Law are hereby adopted as such.

33. Any portion of the Memorandum that is more properly included in these Conclusions of Law is incorporated herein.

Based on these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge respectfully recommends that the Commissioner **RESCIND** the overpayment order requiring Appellant to repay $424,564.20.00 and **RESCIND** the two-year suspension of the MHCP provider identification numbers for Appellant and Mr. Mohamed. The Administrative Law Judge instead respectfully recommends that the Commissioner **ISSUE** an overpayment order requiring Appellant to repay the amount paid for 21.75 hours of PCA services during the time K.K. was hospitalized on April 10-12, 2019. Finally, the Administrative Law Judge respectfully recommends that the Commissioner **ISSUE** a fine of $84,912.84, pursuant to Minn. Stat. § 256B.064, subd. 2(f).

Dated: October 7, 2021

LAURASUE SCHLATTER
Administrative Law Judge

[158] Minn. R. 9505.0465, subp. 1D.

Digitally Recorded
No transcript prepared

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 (2020), 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 (2020). 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 (2020), 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

I. Overpayment Recovery

Relying on its authority under Minn. R. 9505.2215, subp. 1A, the Department contends it is entitled to recover an overpayment amount of $424,564.20 based on Appellant's failure to maintain complete personal care plans, and because Appellant erroneously billed for services it could not have provided due to K.K.'s hospitalization Appellant agrees that it should not have billed for services for K.K. during the time K.K. was in the hospital, and it concedes that the Department appropriately seeks recovery of payment for those hours. Appellant acknowledges that its care plans did not contain all the elements required by Minn. Stat. § 256.0659, subd. 7(b), and reiterated in the SPA. Appellant argues, however, that its failure to maintain the care plans as required does not warrant recovery of the remaining overpayment.

A. Missing Elements from Care Plan as Abuse

The Department maintains that Appellant "failed to develop and maintain health-service records as required by law," and that Appellant engaged in abuse, entitling the

Department to recover the overpayment.[159] The Department relies on Minn. Stat. § 256B.0659, subd. 7, which lists the specific required elements of a personal care plan, and Minn. R. 9505.2165, subp. 2A, which defines abuse in the case of a vendor as "a pattern of practices that are inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service."

Appellant presented Mr. Farah Mohamed's unrefuted testimony that all the elements missing from the care plans were available in a document in the recipients' files in their homes. In addition, Mr. Farah Mohamed credibly testified that Appellant makes emergency backup information easily accessible by putting all such information on one sheet of paper for recipients, and then posting that paper on the recipient's refrigerator or in some other easily accessible place. The Department did not offer evidence contradicting that testimony. Instead, the Department insisted there is no substitute, in terms of safety and efficacy, for having all the required information in a single document, the care plan, which is easily identified, regularly updated, and readily accessible in the recipient's file to anyone involved in the recipient's care.

In her testimony regarding the care plans, Ms. Welter repeatedly emphasized the absolute necessity of having up-to-date care plans to protect the health and safety of recipients. Ms. Welter's testimony would lead the listener to believe that the care plans were not updated. This is not true, as all of the care plans examined by the Department were updated. Thus, Ms. Welter's largest concerns are unfounded.

The Department's legal arguments reference only the first portion of Minn. R. 9505.2165, sup. 2A, which defines abuse to be a pattern of practices inconsistent with sound fiscal, business, or health service practices. In response, Appellant focuses on the second half of the definition of abuse. This language adds that, for abuse to be shown, "a pattern of practices . . . inconsistent with sound fiscal, business, or health service practices" must also "result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary, or that fail to meet professionally recognized standards for health service." If both parts of the rule are not satisfied, the practices in question do not meet the definition of "abuse."[160] Appellant acknowledges that this does not leave the Department without a remedy in a case such as this one, because Minn. Stat. § 256B.064, subd. 2(f) authorizes the Department to order a vendor to forfeit a fine "if specific required components of documentation are missing."[161]

The Administrative Law Judge agrees with the Appellant that no evidence in the record shows that the elements missing from the care plan resulted in unnecessary costs to the MHCP, reimbursement for services that were not medically necessary, or that Appellant's care plans for recipients failed to meet professionally recognized standards for health services. This is especially so given Mr. Farah Mohamed's unrefuted testimony

[159] Minn. Stat. § 256B.064, subd. 1c; Minn. R. 9505.0465 (2021).
[160] Appellant's Post-Hearing Memorandum at 2 (Jul. 9, 2021) (Appellant Memorandum).
[161] Minn. Stat. § 256B.064, subd. 2(f) (2020).

that all the information required by the care plans was easily accessible on a form in the recipient's home file, with emergency information on a single sheet even more easily accessible and visible in the recipient's home.

However, Minn. R. 9505.2165, subp. 2A also specifically provides that certain practices are "deemed to be abuse by a vendor." The Department relies on Minn. R. 9505.2165, subp. 2A(1), (7) and Minn. R. 9505.2175, subp. 7, maintaining that "[a]buse . . . includes failing to develop and maintain . . . care plans."[162] Minn. R. 9505.2165, subp. 2A(1) defines such deemed abuse to include circumstances when a vendor submits, or causes to be submitted, claims from which required information is missing or incorrect. Subpart 2A(7) of the rule defines abuse as occurring when a vendor fails "to develop and maintain health service records as required under part 9505.2175."

Minn. R. 9505.2175, subp. 7, specifically applies to personal care provider service records which are generally subject to subparts 1 and 2. Subpart 7, item B accurately names and describes the "care plan" as the document "completed by the supervising qualified professional which details the qualified professional's instruction to the personal care assistant."

But Minn. R. 9505.2175, subp. 1, does not apply to a personal care plan, because it is not a record that includes documentation of each occurrence of a health service provided to a recipient Minn. R. 9505.2175, subp.1, conditions a vendor payment on the vendor's documentation of each occurrence of a health service provided to a recipient, as specified in subpart 2. A care plan is not a record that includes documentation of each occurrence of a health service provided to a recipient.[163] Therefore, Minn. R. 9505.2175, subp. 1, does not apply directly to a personal care plan.

Minn. R. 9505.2175, subp. 2, lists the required standards for health service records, and applies to a personal care plan, but only as applicable. Not every element listed in Minn. R. 9505.2175, subp. 2, applies to a personal care plan, particularly if that element is not required by Minn. Stat. § 264B.0659, subd. 7. While a particular item must be somewhere in recipient's health service record, that does not necessarily require that it is in the personal care plan. For example, part 9505.2175, subp. 2D(2) requires "the results of all diagnostic tests and examinations." That information is not required by section 264B.0659, subd. 7, and one would not expect it to be in a document prepared for the personal care assistant to use as guidance for providing cares to the recipient. Similarly, part 9505.2175, subp. 2G requires that the record contain the recipient's "plan of care" as defined in part 9505.0175, subp. 35. The definition provided for "plan of care" under part 9505.0175, subp. 35 differs significantly from "personal care plan" as defined by Minn. Stat. § 256B.0659, subd. 7.

Based on the statutorily required personal care plan elements, however, the Department alleged and demonstrated that Appellant failed to develop and maintain the

[162] Department of Human Services', Post-Hearing Memorandum at 9 (Jul.9 2021) (Dept. Memorandum).
[163] *See* Minn. Stat. § 256B.0659, subd. 7.

certain personal care plan elements required by Minn. R. 9505.2175, subp. 2. Specifically, the care plans are missing the following information:

(1) The date the entry is made. To the extent that signatures were not dated, the dates those entries were made were not provided. However, the effective dates of the care plans themselves were provided.[164]

(2) The counter signature of the vendor or supervisor: missing QP signatures are missing supervisor signatures.[165]

(3) The diagnosis: there was no diagnosis on five of the six care plans on which the overpayment was based.[166]

Because these elements are missing from all or most of the care plans, the incomplete care plans constitute abuse pursuant to Minn. R. 9505.2175, subp. 2.

B. Mandatory Monetary Recovery

Minn. R. 9505.2215, subp. 1A, requires the Commissioner to seek monetary recovery from a vendor "if payment for a recipient's health service under a program was the result of . . . abuse . . . on the part of the vendor. . .."[167] The Department maintains that Appellant's failure to properly develop and maintain personal care plans prevented SIRS from carrying out its responsibility "to determine the extent of care actually provided to program recipients" and to "detect instances of improper payment of MA funds due to error." The Department further cites the requirement at Minn. R. 9505.2175, subp. 1, that a vendor must document the services it provides as a condition of payment.

Appellant's personal care plans documented the services it provided, as did the time sheets it retained. The elements that were omitted from the personal care plans were: recipient's birth date, address and telephone number, emergency numbers and procedures, description of measures to address identified safety issues, diagnosis, backup staffing plan, signature and date by recipient or RP, and the signature and date by QP.

While the omitted care plan elements represent required critical information, Appellant maintained the same information in an easily accessible document in the recipients' files at their homes. The information necessary for the Department to verify billing was in the care plans, including the treatment needed, the start and end dates of the care plan, the names of the recipient and RP, the QP, and the PCA. The plans were signed by the PCAs. Moreover, except for one incident, the timesheets themselves were accurate. The only inaccurate timesheet, which covered a two-and-a-half-day period,[168]

[164] Minn. R. 9505.2175, subp. 2C(1).
[165] Minn. R. 9505.2175, subp. 2C(5).
[166] Minn. R. 9505.2175, subp. 2D(3).
[167] Minn. Stat. § 256B.064, subd.1c.
[168] Ex. 17 at 2614, entries for April 10 through 12, 2019.

was part of a record of 718 pages of timesheets representing hours reported over 4,450 days.[169]

The Department has not shown that having information retained on the wrong document prevented it from determining the extent of care actually provided to program recipients or from detecting instances of improper payment of MA funds. There were no allegations that the care provided was inappropriate or substandard. The Department did not show by a preponderance of the evidence that payment under the MA program was the result of the noncompliant care plans. Therefore, while the Appellant's failure to develop and maintain the care plans as required was abuse pursuant to Minn. R. 9505.2165, subp. 2A(1), (7), and Minn. R. 9505.2175, subp. 7, the abuse did not cause MA payments to be made, so repayment was not mandatory.[170]

C. Discretionary Monetary Recovery

Minn. R. 9505.0465 is the only rule or statute dealing with monetary recovery that does not require a causal relationship between the vendor's abuse and the payment of public assistance funds. Nor does Minn. R. 9505.0465 require repayment in all cases:

> Under that rule, monetary recovery under the medical assistance program is permitted for the following:
>
> > intentional and unintentional error on the part of the provider. . . fraudulent or abusive actions on the part of the provider.[171]

Should the Department choose to obtain repayment of its full calculated overpayment amount of $424,564.20, it would have to rely on Minn. R. 9505.0465 for its authority to do so. Based on the same rule, the Department could rescind the remainder of the overpayment, with the exception of the timesheet overlaps for K.K.'s

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[169] Exs. 7 through 17.

[170] Minn. Stat. § 256B.064, subd.1c; Minn. R. 9505.0465, subp. 1. The Department cited 1 Best Care, Inc., 2021 WL 1245294 at *4 (Minn. App. 2021), a nonprecedential opinion from the Court of Appeals, contending that a vendor's failure to include information required by statute in care plans constitutes a failure to develop and maintain health service records, and therefore constitutes abuse. While the Administrative Law Judge agrees with this conclusion, she respectfully notes that the Court reached its conclusion by looking to Minn. R. 9505.2175, subp. 2(G), and notes that that provision does not say what is required in a care plan. The Court appears not to have considered the difference between "plan of care" which is required to be part the recipient's record under Minn. R. 9505.2175, subp. 2(G), and the reference to Minn. R. 9505.0175, subp. 35 for its definition, and "care plan" which is referred to under 9505.2175, subp.7B, discussing the care plan completed by the supervising QP for the PCA. Minn. R. 9505.0175, subp. 35 requires that a "plan of care"

> A. states with specificity the recipient's condition, functional level, treatment objectives, the physician's orders, plans for continuing care, modifications to the plan, and the plans for discharge from treatment; and
>
> B. except in an emergency, is reviewed and approved, before implementation, by the recipient's attending physician in a hospital or long-term care facility or by the provider of a covered service as required in parts 9505.0170 to 9505.0475.

This is not the same document as the personal care assistance plan defined by Minn. Stat. § 256B.0659, subd. 7, which is the document at issue in this case.

[171] Emphasis provided.

hospitalization.[172] In addition, the Department could still consider a fine pursuant to Minn. Stat. § 256B.064. subd. 2(f).

Ms. Welter testified that a fine is not an available sanction except as an add-on to an overpayment. There is no legal support for this statement. Section 256B.064 concerns both sanctions and monetary recovery, as well as procedures related to the imposition of these remedies. Subdivision 1a sets forth the grounds for sanctions, including for "abuse in connection with the provision of medical care to recipients. . .."[173] Subdivision 1b sets forth the sanctions available, including suspension or withholding of payments. . . and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f)."[174]

Subdivision 2(f) permits the Commissioner to order a vendor to forfeit a fine "for failure to fully document services according to the standards of statute and rule. The Commissioner may assess fines if specific required components of documentation are missing."[175] Nothing in this language, however, links imposition of a fine to requiring payment of an overpayment. The value of the claims at issue may come into play in determining the fine:

> 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. If the commissioner determines that a vendor repeatedly violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order a vendor to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

Thus, the Department has two significantly different options for imposing a fine. It could be as little as $5,000, or, based on a nature, severity, and chronicity analysis, it could be as much as $84,912.84.[176]

The statutes and rules governing the SIRS program, its vendors and providers, recipients and the Department, weave a complex web that is often difficult to follow, let alone find sense in. But careful study reveals certain concepts that go beyond the often-simplistic reading the Department applies to these laws. While the Administrative Law Judge understands and supports the Department's mission to ensure that Medicaid dollars are well- and appropriately-spent, at times the Department appears to paint all vendors with a devious brush.

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[172] Ex. 17 at 2614.
[173] Minn. Stat. § 256B.04, subd. 1a.
[174] Minn. Stat. § 256B.04, subd. 1b.
[175] Minn. Stat. § 256B.04, subd. 2(f).
[176] Minn. Stat. § 256B.04, subd. 1b.

On one hand, the Department may argue that the recovery of an overpayment is not a form of penalty, that it is simply the Department's mandate to recoup money for services that were not properly provided, or not provided at all. On the other hand, imposition of a $424,560.20 overpayment, with a two-year suspension for what really amounts to a documentation error, amplified by the creation of a form, is utterly disproportionate. This is particularly so where there is neither an allegation, nor any proof, that the information missing from the care plans was unavailable in the recipient files, or that the missing elements caused any inappropriate payments to be made or substandard care to be provided. This is not a case where there were missing time sheets or care plans, or where the vendor was uncooperative in any sense, despite the repeated admonitions from the Department of the importance of a timely response to a request for records.[177]

The Administrative Law Judge recognizes that this is the second time in a few years that Appellant has made mistakes. From the Department's point of view, Appellant was given a chance with the SPA to make things right, but failed to do so. At the same time, the Administrative Law Judge also notes that care plans were not an issue in the earlier case. Appellant should have been more mindful as to whether the care plans met the requirements established by statute and the SPA. For that reason, because Appellant did not discover the problem on its own over a period of years, and since care plans are important documents, the Administrative Law Judge recommends the larger fine of $84,912.20, be imposed. This is no small fine, by any means. However, it is more proportional to the seriousness of the violation, and is a more proper application of the law, than the original overpayment order. The overpayment for the timesheet overlap for K.K. would be added to the fine.

II. Two-Year Suspension

The Department based the two-year suspension on Appellant's alleged violations of four terms of the SPA, in addition to an analysis by the NSC group of Appellant's conduct, and considering the effect of the conduct on the health and safety of the recipients Appellant serves.[178] The Administrative Law Judge concludes that the Department has proved by a preponderance of the evidence that Appellant violated two of the SPA terms.

A. SPA Term 10 – Internal Controls

The Department failed to show that Appellant violated term 10 requiring it to develop internal controls to ensure that time records submitted for clients reflect the actual care provided. Of the 718 pages of timesheets Appellant submitted in the investigation in this matter, representing hours worked over 4,450 days,[179] there was only one incident of improperly recorded time.[180] The Department viewed that incident as proof by a

[177] Test. of Welter. Department Memorandum at 8.
[178] Ex. 1 at 353. The 4,450 days are days on which at least one provider worked, not consecutive working days. Providers worked on the same days, either for the same recipient or for different recipients.
[179] Exs. 7-17.
[180] Ex. 17 at 2614, entries for April 10 through 12, 2019.

preponderance of the evidence that Appellant had failed to develop internal controls ensuring that time records submitted for clients reflect the actual care provided. At no time did the Department recommend or require that any particular type of internal controls be used. Nor did the Department ask Appellant during the investigation whether they had implemented any kind of internal controls, or to submit any records concerning such internal controls. Considering the significant improvement in timesheet accuracy from the Department's 2019 investigation to the investigation in this case, with no other evidence offered by the Department regarding a lack of internal controls, the Administrative Law Judge concludes the Department failed to demonstrate by a preponderance of the evidence that Appellant did not develop internal controls to ensure timesheet accuracy following the 2019 SPA. Thus, there is no basis to conclude that Smart Choice violated term 10 of the SPA.

B. SPA Term 15 – Missing Care Plan and QP Reports

Term 15 of the SPA requires Appellant to ensure that care plans are on file for each recipient. On November 7, 2019, Katherine Isaacson, SIRS' preliminary investigator, faxed Appellant a document request. Ms. Isaacson asked for care plans, time sheets, and QP supervisory visit documentation for dates of service from March 1, 2019, through October 31, 2019, for the 11 recipients chosen in this matter. The documents were to be provided no later than November 15, 2019.[181] Smart Choice faxed the requested records on November 12, 2019, three days before the deadline.[182] For each recipient, there was a fax cover page stating the number of pages in that particular packet, including the cover page. With the exception of H.N.'s records, the first batch of pages for each packet contained the time sheets, and the last few pages of each packet were the care plans and QP supervisory reports.[183] H.N.'s records were faxed in a packet with a cover page indicating there were 122 pages in the fax.[184] Instead, the packet only included 118 pages.[185] Unbeknownst to Mr. Farah Mohamed, the final pages of H.N.'s records had not gone through with the rest of H.N.'s faxed records.

On the evening of November 12, 2019, Mr. Farah Mohamed emailed Ms. Isaacson to alert her that he had faxed the paperwork. He told her that he planned to send the submission again by mail on November 13, 2019. He asked whether she could confirm that she had received the fax and whether she needed the paperwork mailed as well. Ms. Isaacson responded early in the morning on November 13, 2019, saying "It appears I have received it all. At this time there is no need to mail the records. If I have any questions I will contact you."[186] During the course of the ensuing investigation, Mr. Farah Mohamed attempted to contact Ms. Isaacson or Ms. Pha several times, leaving telephone

[181] Ex. 18 at 1250.
[182] Exs. 7-17.
[183] Exs. 7, 9-17.
[184] Ex. 8 at 1114.
[185] Ex. 8.
[186] Ex. 102

messages to find out whether they needed any additional documents. His phone calls were not returned, although Ms. Pha did return his calls about an unrelated matter.[187]

According to the Notice and Order for Prehearing Conference and Hearing, SIRS investigators determined that Appellant violated SPA term 15, that care plans be on file for each recipient.[188] SIRS found that H.N.'s file did not contain a care plan or QP supervisory visit form.[189]

At the hearing, Appellant offered into evidence copies of H.N.'s care plan, dated December 1, 2018, through November 30, 2019, and QP supervisory visit reports from May 5, 2019, and September 30, 2019.[190] Appellant claimed that the care plan and QP reports were the last three pages missing from H.N.'s records as received by the Department, and were part of the fax sent on November 12, 2019. The Department claimed that could not be the case because, according to Ms. Welter, the SIRS fax machine never lost any pages. While she did not suspect Appellant manufactured the missing pages or accuse Appellant of wrong-doing, she did not believe they were part of the original fax and was unwilling to accept what she considered to be late-filed documents.

After the three pages were received into evidence over the Department's objection, the parties stipulated that, if the Department were to consider them timely provided, the contents of the care plan would still not meet the statutory or SPA standards. However, the Department tried to use this both ways – arguing that all eleven care plans were inadequate, and that the Department never received the eleventh care plan. The Administrative Law Judge rejects this argument – the Department cannot have it both ways. Either it accepts that, to the extent it did not receive the missing care plan, the Department was responsible for not responding to, or following up with, Mr. Farah Mohamed; or the Department sticks with its position that it never received the missing care plan due to Appellant's fault and responsibility. If it chooses the latter, it cannot then argue that there were eleven faulty care plans.

The Administrative Law Judge finds it is more likely than not that the three missing pages from H.N.'s records were faxed on November 12, 2019, with the rest of H.N.'s file. It is the most likely explanation of what became of the last three of the four missing pages of the fax. It is more likely than not that Appellants indicated there were 122 pages included in the fax because Appellants believed that was the number of pages they were faxing. The PCA Supervision Reports and a Care Plan page would logically have been the final three pages of the fax, because that would be consistent with all of the other recipient records faxed on that day.

Furthermore, Mr. Mohamed made a good faith effort to determine whether the Department had received a complete faxed set of records. The Department's absolute refusal to accept any responsibility to confirm that a fax was received is unreasonable,

[187] Test. of Farah Mohamed.
[188] Notice and Order at 2. Ex. 1 at 352.
[189] Test. of M. Pha.
[190] Ex. 101.

especially when a provider makes the effort to inquire. Ms. Welter's testimony that she has never experienced or heard of missing pages from a fax during her time working at the Department is not credible. Ms. Pha testified that she felt some sense of responsibility to check about the fax, but that she never did. The one inconsistency – that the three pages of documents leave one missing page from the fax unexplained – is less troubling than allowing the Department to disregard what were very likely the last three, critically important, pages of the fax. The Department presented no basis for its general presumption that late-filed documents are likely to have been fabricated. Nor did the Department present any evidence to show that Exhibit 101, or any part of it, was fabricated.[191] Therefore, the Administrative Law Judge concludes Appellant did not violate term 15 of the SPA based on a missing care plan and QP supervisory sheets.

C. SPA Term 15 – Incomplete Care Plans

As discussed above, the Administrative Law Judge and the Appellant agree with the Department that the care plans in this matter did not meet the standards required by Minn. Stat. § 256B.0659, subd. 7, and term 15 of the SPA. The Department focused its testimony and arguments on the safety concerns that can arise with inadequate care plans. The Department argued that "anytime" care plans are missing information "it calls into question whether that individual is receiving the proper cares and services."[192] In making this argument, the Department weighs all of the risks due to missing information in a care plan equally. Thus, a telephone number or address, or even a birthdate that is on a separate document is, according to the Department, just as concerning as a plan with no QP identified, no beginning or end dates, or no clear treatment plan. While a lack of emergency plan or backup plan could be concerning, the unrefuted testimony was that Appellant had systems and documentation in place to ensure its recipients were safe and their care was covered. Ms. Welter repeatedly expressed concerns that care plans with missing elements meant care plans that would not have the most up-to-date information about the recipient's needed care. But the evidence in this matter demonstrates that Appellant was very consistent about updating its care plans. Mr. Farah Mohamed testified that he developed new care plan forms with legal advice as soon as he became aware of the problems with his forms. He did not presume to say that he should not comply with the law.

The Administrative Law Judge agrees that incomplete care plans, by their nature, are a serious concern, and that the care plans involved in this case were chronically incomplete. The Administrative Law Judge cannot characterize the care plan documentation violations as severe in this case, especially in light of a lack of any occurrences of health or safety concerns in connection with the missing elements, and the testimony offered by Appellant regarding its alternative placement of the missing information.

D. SPA Term 17 - Submit Accurate Billings

[191] Test. of T. Welter.
[192] Dept. Memorandum at 16.

Appellant violated term 17 of the SPA when it processed a timesheet billing for PCA services for K.K. at a time when K.K. was hospitalized. Appellant agrees that it should repay the amount it was paid for PCA services during the two-and-a-half days K.K. was hospitalized. This single timesheet problem does not add to the nature, chronicity, or severity of the SPA violations.

E. SPA term 18 – "Steps for Success" Training

SPA term 18 required six of Appellant's owners, managers, billers, and QPs to attend the Department's "Steps for Success" training program in person, within six months of the date of the SPA.[193] Mr. Farah Mohamed signed the SPA on February 7, 2019, and the Department's Deputy Inspector General signed it on February 14, 2019.[194]

Mr. Farah Mohamed contacted Ms. Ripperton, the investigator in that matter, at some point before he signed the SPA, asking her whether term 18, the Steps for Success attendance requirement, could be waived, because the employees named in the SPA to attend the training had attended it in mid-May of 2018.[195] These employees had taken the Steps for Success online approximately nine months before the SPA was to be signed.[196]

Mr. Farah Mohamed repeated his inquiry to Ms. Ripperton on February 11, 2019.[197] Ms. Ripperton responded about 15 minutes later, saying she would "look in the provider enrollment documents where you send the information about who has attended the Steps for Success." Noting that there are delays in that information, she stated if she did not see the information, Mr. Farah Mohamed could send her copies of the attendance certificates. Finally, Ms. Ripperton's email said, "That will fulfill that portion of the Stipulated Provider Agreement."[198]

Mr. Farah Mohamed then faxed copies of the Steps for Success certificates to Ms. Ripperton for each of the employees required by the SPA to take the training.[199] Ms. Ripperton acknowledged the fax, saying "Thank you, you saved me a step."[200] Given the progression of emails and actions - from Ms. Ripperton's statement that term 18 of the SPA would be fulfilled if either she found the certificates in Department records or he sent copies of the certificates; to Mr. Farah Mohamed pre-empting her search by faxing the certificates to her; to Ms. Ripperton replying "Thank you, you saved me a step," it was reasonable for Mr. Mohamed to believe that Appellant had fulfilled term 18 of the SPA.

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[193] Ex. 19 at 939.
[194] Mr. Mohamed's signature is dated February 7, 2018. Given that the Department's signature is dated 2019, and that is consistent with the other evidence in this case, the Administrative Law Judge will treat the year associated with Farah Mohamed's signature on the SPA as a clerical error.
[195] Ex. 100 at 001.
[196] *Id.*at 003-008.
[197] *Id.* at 001.
[198] *Id.*
[199] *Id.* at 001-008.
[200] *Id.* at 001.

The Department argues that Ms. Ripperton "never confirmed that the training certificates were sufficient or that the training did not need to be completed again."[201] That argument defies any sensible reading of the email chain. The Department also claims that, regardless of the certificates provided, term 18 was still violated because it required that the training be taken "within 6 months" of the agreement and that it be completed in person, rather than online. Ms. Welter testified that the in-person requirement ensures that the person signed up for training is actually present and paying attention. Given the documentation errors following the SPA, the Department argues that the Administrative Law Judge should conclude that term 18 of the SPA was violated.[202]

The Administrative Law Judge concludes that Appellant could not have known that the Department did not consider it to have fulfilled the training requirement in the SPA. Appellant had a written approval to waive the SPA term 18 requirement based on its fairly recent participation in the same training. The approval came from the investigator with whom Appellant had worked throughout the process.

Neither party has argued that Appellant could not rely on Ms. Ripperton's statements, however, even if that were true, Appellant's violation of term 18, if there was one, was innocent and inadvertent. Therefore, the Administrative Law Judge finds that it does not add to the nature, chronicity, or severity of the violations of the SPA and should not add to the weight of the violations when considering how the SPA should be enforced. It would be appropriate for the Department, if it does not suspend Appellant, to require that relevant staff take the Steps for Success training with whatever conditions the Department deems fit.

F. Nature, Severity, and Chronicity

Having already concluded that the nature of the violations was serious, and that they were chronic, but not severe, the Administrative Law Judge re-examines the question of sanctions in light of the SPA violations. The Department argued that Appellant's conduct was severe because it continued to have documentation problems, even after having previous documentation issues and entering into a SPA to try to correct those issues. The Department overlooks the fact that the documentation problems in this matter were completely different than the ones in the previous matter, and that there was no evidence that care plans were a concern in the previous case. The Department counted four violations of the SPA as contributing to chronicity. The Administrative Law Judge finds two violations occurred, one of which is the incomplete care plans, which has

[201] Dept. Memorandum at 15.

[202] The Department called no witness to testify regarding Ms. Ripperton's authority, or lack thereof, to tell Mr. Farah Mohamed that Appellant had fulfilled the term 18 requirement. Ms. Welter testified that Ms. Ripperton lacked such authority, but Ms. Welter was not employed by the Department at the time, nor was she ever Ms. Ripperton's supervisor. Ms. Welter testified incorrectly about the legality of other matters during this hearing. Therefore, without more to support what appeared to be an off-the-cuff remark during her testimony regarding this question, her testimony carries no weight.

already been counted in the NSC analysis. That leaves one violation – the single timesheet error, which is not enough to add to the NSC analysis.

The Administrative Law Judge finds that Appellant's conduct in this matter was of a serious nature, and chronic, but not severe, because it had no impact on the health and safety of any recipients, and only a very minor impact on a Medicaid payment, which the Appellant has not disputed.

G. SPA as a Contract

The Department also maintained that it views the SPA as a contract, binding on the Department and the vendor.[203] The SPA is more a regulatory tool than a contract. It is authorized by Minn. R. 9505.0175, subp. 39, which permits the department to enter into a "provider agreement" with a provider. The rule characterizes the "provider agreement" as a "written contract between a provider and the Department in which the provider agrees to comply with the provisions of the contract as a condition of participation in the medical assistance program." Since, by definition, the provider agreement sets certain essential terms (the provider must agree with the Department's provisions in order to participate in the MA program), it is apparent from the definition that the provider agreement authorized by Minn. R. 9505.0175, subp. 39 is an unconventional contract, with all of the bargaining power on the side of the Department. The lopsidedness of the bargaining power is demonstrated in this case, for example, by the Department's response to the Appellant's attempt to have some of the requirements of Term 18 – Steps for Success training – amended.[204]

Most of the SPA's terms are restatements of statutory or rule provisions that already apply to a vendor. The remaining terms are primarily about consequences of failure to comply with the SPA – in particular, in this case, a two-year suspension. The Department does not treat the SPA as completely unyielding. While it might choose not to sanction a provider under the SPA for an insignificant violation, for any other violation

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[203] Test. of M. Pha and T. Welter. Dept. Memorandum at 16. Citing In re the SIRS Appeal of Caring Professionals Homecare, LLC, Matthew Dewey and Flavianna Tesha, 2012 WL 6568303 (April 23, 2012).

[204] *Interfund Corp. v. O'Byrne*, 462 N.W. 2d 86, 89 (Minn. Ct. App.1990). A clause in a contract is unreasonable if it is contained within an adhesion contract. An adhesion contract is one which is the product of disparate bargaining power, the "opportunity for negotiation, the availability of the service for which the parties contracted, whether the service was a public necessity, and the business sophistication of the parties." In this situation, all of the *Interfund* factors weigh in favor of finding the SPA is an adhesion contract. The Department had all the bargaining power. It likely presented the Appellant with a fully written document and no apparent opportunity for negotiation. The availability of the service for which the parties contracted is generally one where providers are needed, as Appellant's quickly-growing clientele has shown. PCA agencies do provide a service that is a public necessity. The provider number is required in order to pursue that business, and is only available through the Department. Finally, the Department is much more sophisticated, particularly with regard to this heavily regulated industry, than is Appellant. At the time the agreement was signed, Mr. Mohamed had only owned a PCA agency for three years, at most. He is not a native English speaker. The Department literally wrote the book about PCA agency regulation. For the Department to interpret the SPA as a contract which is binding in such a way as to prevent the parties from adjusting the terms to be more favorable to Appellant, but while consistent with governing laws, is unreasonable.

it views the SPA as a contract, binding to both the Department and the vendor.[205]The Department witnesses had no doubts that if a violation of the SPA was more significant, it was absolutely subject to the full suspension set forth in the SPA. The witnesses who spoke to this point were not able to describe what makes a violation significant enough to warrant a suspension under the SPA.[206]The Department is free to refrain from relying on the SPA, and instead rely on its statutory authority to impose sanctions, including a shorter suspension or a fine. Alternatively, it could i enforce the SPA in a way that is less burdensome to the provider than the two years spelled out in the agreement.

This SPA was not fairly bargained-for. Appellant will always be bound by the applicable laws, whether or not they are in the SPA. The Department is not bound by the SPA to impose a two-year suspension and is free to impose lesser sanctions than those set forth in the SPA.

H. Application of a Suspension to Mr. Farah Mohamed

The Department applied a two-year suspension to Mr. Farah Mohamed individually as well as to Appellant, alleging that it was legally required to do so.[207] When recalled to testify at the end of the hearing, Ms. Welter cited Minn. Stat. § 256B.0659, subd. 23, as the statutory authority for the Department's position regarding his individual suspension.[208] That statute applies only when a PCA agency is terminated from MHCP, not when it is suspended. The Administrative Law Judge is unaware of any basis for the Department's position that it is required to suspend Mr. Mohamed's separate, individual provider number.

From a policy perspective, Ms. Welter testified that individually suspending Mr. Mohamed was necessary to prevent him from opening a new PCA agency and re-engaging in similar unsafe conduct that led to Appellant's suspension. The Administrative Law Judge is not persuaded by this argument. To the extent Mr. Mohamed's conduct was inconsistent with the statute, it was inadvertent. There is no evidence that he put anyone at risk. and he immediately tried to rectify Appellant's mistakes. Furthermore, Mr. Mohamed relies on his individual provider number to his part time work at Mayo. There is no evidence that Mr. Mohamed ever engaged in any violations of law in connection with that work. If the Department suspends his business and imposes a significant repayment obligation, Mr. Mohamed will be unable to work. Allowing him to work for another employer, using his individual provider number will allow him to provide for his family while he addresses debts owed by Appellant.

III. Suspension and Repayment Recommendations

The Administrative Law Judge is well-aware that fraud and abuse are serious concerns in the MHCP, and that public resources must be preserved for those who are in

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[205] Test. of M. Pha and T. Welter. Dept. Memorandum at 16. Citing *In re the SIRS Appeal of Caring Professionals Homecare, LLC, Matthew Dewey and Flavianna Tesha,* 2012 WL 6568303 (April 23, 2012).
[206] Test. of M. Pha and T. Welter.
[207] Test. of T. Welter.
[208] *Id*.

need, and who qualify for them. Nonetheless, it is also concerning that the Department at times appears to paint providers of MA services with a broad and ill-meaning brush, clawing back sums of money that far exceed any actual losses incurred by the program, and exponentially outweighing any proportionate penalty for errors. This appears to be one such case.

A close examination demonstrates that there is causality built into the statutes and rules dealing with repayment – a fact that the Department tends to overlook. Furthermore, sanctions are discretionary, especially where there is no fraud at issue. Here, there is no causal link between any of the documentary errors with Appellant's care plans and inappropriate reimbursement by the program to Appellant.[209] The only inappropriate reimbursement is based on the inaccurate billing for K.K.'s hospital stay, and Appellant agrees that should be repaid.

Appellant is one of the largest agencies in Olmsted County, and a suspension will leave it unable to serve recipients. Appellant serves members of the community who speak multiple languages, based in part on Mr. Mohamed's background as an immigrant and refugee. According to Appellant, a suspension will result in 173 employees losing their jobs and over 130 vulnerable adult PCA recipients losing their care providers.

If permitting Appellant to continue to serve its clients posed a risk to them, the Administrative Law Judge would not recommend rescinding the suspension. But in this case, the Administrative Law Judge finds that despite the nature and chronicity of the violations, the relatively low severity of those violations, combined with the Appellant's strong credibility regarding changes it has already made to comply with the care plan requirements, supports rescission of the suspension. Should the Commissioner leave a suspension in place, of two years or some other time period, the Administrative Law Judge recommends that the Commissioner apply the suspension only to Appellant, and not to Mr. Mohamed.

As explained above, the Administrative Law Judge also recommends that the Commissioner rescind the overpayment of $424,540.20. Instead, the Administrative Law Judge recommends that the Commissioner recover an overpayment reflecting the improper billing for PCA services during the time that K.K. was hospitalized. In addition, the Administrative Law Judge recommends that the Commissioner impose a fine of $84,912.80, or 20 percent of the claims for reimbursement, based on a finding of incomplete documentation, related to the provision of services to program recipients, and the submission of claims for payment, based on a finding that the nature and chronicity of the violations were serious, and that there was a real potential for severity.

IV. Conclusion

For all of the reasons discussed in this report, the Administrative Law Judge respectfully recommends that the Commissioner **RESCIND** the overpayment order requiring Appellant to repay $424,540.20 and **RESCIND** the two-year suspension of the

[209] In addition to paying the various providers, Smart Choice has paid unemployment, workers' compensation and appropriate employer taxes for all of its staff. Test. of Farah Mohamed.

MHCP provider identification numbers of Appellant and Mr. Mohamed. The Administrative Law Judge further respectfully recommends that the Commissioner **ISSUE** an overpayment order requiring Appellant to repay amounts inappropriately billed for PCA services provided to K.K. on April 10-12, 2019. Finally, the Administrative Law Judge respectfully recommends that the Commissioner **IMPOSE** a fine of $84,912.84, pursuant to Minn. Stat. § 256B.064, subd. 2(f).

L. S.