OAH 82-1800-37176

STATE OF MINNESOTA

OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS Appeal by Best Care, Inc.

AMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION

A hearing in this matter was held before Administrative Law Judge Barbara J. Case on October 5-6, 2021. The parties submitted written closing arguments, and the record closed upon receipt of the parties' final submissions on November 2, 2021.

Molly Beckius, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department).[1] John Kvinge and Matthew W. Bergeron, Larkin Hoffman, appeared on behalf of Best Care, Inc. (Appellant).

On October 10, 2022, the Commissioner remanded this matter "to make additional Findings of Fact and/or Conclusions of Law as necessary…".[2] The Commissioner ordered that the undersigned:

1. Identify the five individuals/recipients by first and last initial that had care plans reviewed during the January 8, 2020, onsite visit to Appellant's office;

2. For each of the recipients identified in No. 1, determine the total overpayment amount proved by the Department for each individual based on the Department's review and list these amounts separately as to each individual identified;

3. For each of the recipients identified in No. 1, determine the applicable overpayment period for each individual at issue and list these time periods separately as to each individual based on the Department's review of the files;

4. Calculate the total amount of overpayment proved by the Department in this matter; and

[1] For the proceedings after the remand the Department was first represented by Assistant Attorney General James Schoeberl and subsequently by Assistant Attorney General Sarah Doktori.

[2] Final Order of the Commissioner of Human services, June 28, 2022. Filed with OAH on October 10, 2022.

5. Based on the calculation in No. 4, calculate the 20% penalty amount.[3]

The parties submitted additional exhibits and arguments and final submissions were received on March 13, 2023. All new or altered Findings of Fact and Conclusions of Law in this Amended Recommended Order are underlined.

STATEMENT OF THE ISSUE

Has the Department established that it may recover an overpayment of Minnesota Health Care Program (MHCP) funds in the amount of $2,229,054.64 and a penalty of $445,810.93 from Appellant?

SUMMARY OF RECOMMENDATION

The Department has not met its burden to prove that it may recover $2,229,054.64 from Appellant as an overpayment of MHCP funds. Therefore, the Administrative Law Judge recommends, as further explained below, that the Commissioner of Human Services (Commissioner) **RESCIND** the Amended Notice of Overpayment issued on October 8, 2020 (Amended Notice of Overpayment) and uphold an overpayment in the amount of 571,456.62 and fine based solely on the care plans that the Department's investigators reviewed. The Department may issue a fine commensurate with that newly determined amount of overpayment in the amount of 114,291.32. The Department may issue a Stipulated Provider Agreement to which Appellant did not object.

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,[4] which funds medical assistance (MA)[5] for eligible individuals who are unable to pay for their medical care.[6] The Department is charged with administering and overseeing this program through the Minnesota Health Care Program (MHCP).[7]

2. The Department's internal unit, called the Surveillance and Integrity Review Section (SIRS) unit, reviews and monitors compliance with federal and state law

[3] *Id.*
[4] *See generally* 42 U.S.C. § 1396-1396v (2020); Minn. Stat. §§ 256B.01-.85 (2020).
[5] *See* Minn. Stat. § 256B.02, subd. 8.
[6] *See* 42 U.S.C. § 1396-1 (2018); 42 C.F.R. § 430.0 (2020).
[7] Minn. Stat. § 256B.04; Minn. R. 9505.0011 (2021); *see also* Minn. Stat. §§ 256B.01-.85; Minn. R. 9505.0295, .0335 (2021).

related to the payment for MA-eligible services by service providers and recipients participating in the MHCP.[8] 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 to impose "sanctions against vendors and recipients of health services."[9]

3. Personal care assistance is one of the services available to MA recipients through the MHCP.[10] Eligible personal care assistance services may include assistance with activities of daily living such as dressing, grooming, bathing, eating, and toileting, among others.[11] Recipients may also receive assistance with health-related procedures and tasks, including exercises, assistance with self-administration of medication, and seizure intervention.[12]

4. Each recipient must be assessed to determine the type and amount of personal care assistance services for which the person qualifies.[13] A public health nurse conducts this assessment and creates a service plan.[14]

5. Services are then provided by a personal care assistant (PCA), who is employed by a personal care assistance provider organization (PCPO).[15] Services provided by PCAs are supervised by a qualified professional (QP).[16]

6. PCAs provide services to recipients pursuant to a personal care assistance care plan (PCA care plan), which is a "written description of personal care assistance services developed by the personal care assistance provider according to the service plan."[17] 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 (RP)."[18] The PCA 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.[19]

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[8] Minn. Stat. § 256B.04, subd. 10; Minn. R. 9505.0180, .2160-.2245 (2021).
[9] Minn. R. 9505.2160, subp. 1.
[10] Minn. Stat. § 256B.0659; Minn. R. 9505.0335.
[11] Minn. Stat. § 256B.0659, subds. 1(b), 2(a)-(b).
[12] *Id.*, subds. 1(h), 2(c).
[13] *Id.*, subds. 3a(a), 4.
[14] *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").
[15] *Id.*, subd. 1(m); Minn. R. 9505.0335, subp. 1(C).
[16] Minn. Stat. §§ 256B.0625, subd. 19c, .0659, subds. 1(k), 14(a).
[17] Minn. Stat. § 256B.0659, subds. 1(n), 7, 12(b).
[18] *Id.*, subd. 7(a).
[19] *Id.*, subd. 7(c). Personal care assistance care plans, also called "care plans" may be confused with a "plan of care." However, these are very different documents. A "plan of care", required to be part of the recipient's record under Minn. R. 9505.2175, subp. 2(G), is defined in Minn. R. 9505.0175, subp. 35; a "care plan" is governed by Minn. R. 9505.2175, subp. 7B, discussing the care plan completed by the supervising QP for the PCA.

7. PCA care plans contain certain specific information, including a start and end date of the PCA care plan, and 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."[20] The PCA care plan must be signed and dated by the recipient or responsible party and the QP,[21] and, according to Minn. Stat. § 256B.0659, subd. 7, a copy is kept in the recipient's home and in the recipient's file at the provider agency.[22] However, Minn. Stat. § 256B.0659, subd. 28(a), states that "required documentation must be completed and kept in the personal care assistance agency file **or** the recipient's home residence." PCA care plans are included in this section of the statute as required documentation.[23]

8. A QP may be a mental health professional, registered nurse, licensed social worker, or a qualified designated coordinator.[24] The QP works for the provider agency, and must train, supervise, and evaluate PCAs.[25] Among their duties, QPs develop and monitor the recipient's PCA care plan, and document all training, communication, evaluations, and actions needed to improve the performance of the PCAs who provide services.[26]

9. To obtain payment for services provided, each occurrence of a health service provided to a recipient must be documented. [27]

10. 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.[28] Health service and financial records must be available at the provider's place of business on the day on which investigators request access.[29] A provider must store records in a manner that allows review by investigators at the provider's place of business during business hours.[30]

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[20] *Id.*, subd. 7(b)(1), (5).
[21] *Id.*, subd. 7(b)(6).
[22] *Id.*, subd. 7(a).
[23] Minn. Stat. § 256B.0659, subd. 28 (a) (2)(iii).
[24] Minn. Stat. §§ 256B.0625, subd. 19c, .0659, subd. 1(k).
[25] Minn. Stat. § 256B.0659, subds. 13(a)-(b), 14.
[26] *Id.*, subd. 13(b)(1), (5).
[27] Minn. R. 9505.2175, subp. 1 and 2.
[28] Minn. Stat. § 256B.0659, subd. 31.
[29] Minn. R. 9505.2185, subp. 2.
[30] Minn. R. 9505.2190, subp. 1.

II. Factual Background

A. Appellant's Operations

11. Best Care, Inc. (Best Care or Appellant) is solely owned by Nazneen Khatoon, who has been in the health care provider business for approximately 30 years. Best Care has existed for the same length of time.[31]

12. Ms. Khatoon also has an ownership interest in Best Care Home Health, Inc. (Provider ID # 7668228000) which provides skilled nursing care.[32]

13. There is no evidence in the record, and the Department does not contend, that Appellant has failed to provide services to recipients, had complaints filed against it by other than Department personnel in the circumstances related to this case, or previously had been cited for violations of the laws governing care providers.[33]

B. The Department's Investigation

14. On August 8, 2017, Department Provider Screeners (Screeners) conducted an approximately one-hour long revalidation visit to Best Care. The Screeners noticed that Best Care's care plans did not contain recipient signatures and that Best Care did not have a QP on staff from October 15, 2016, through April 23, 2017.[34] An Investigator, Hua Vang, noted that Best Care did have QP and PCA billing during the same timeframe and so referred the case to SIRS.[35]

15. Appellant was not informed about the alleged violations found by the screeners.[36]

16. Another Investigator, Stephanie Widing, reviewed the "intake materials" which indicated concerns regarding no recipient signatures on the care plans and no QP affiliation from October 15, 2016, to April 23, 2017. Ms. Widing ran a query on the same timeframe and found there were QP visits billed during these dates.[37] Ms. Widing also sent a records request to Best Care. Ms. Widing found that each of the care plans provided in response to her request were missing Recipient or Responsible Party signatures and end dates.[38]

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[31] Testimony (Test.) of Nazneen Khatoon; Exhibit (Ex.) 6 (On Site Review Report).
[32] Test. of N. Khatoon; Ex. 6.
[33] Test. of Jake Shadis.
[34] Ex. 4 (Investigative Report).
[35] Test. of N. Khatoon; Ex. 4.
[36] Test. N. Khatoon. Although Department witnesses testified that education was expected to be provided by Screeners, there is no evidence that Best Care was ever informed of the Screeners' findings or educated by the Screeners on the deficiencies they found.
[37] Ex. 4 at 771-72.
[38] *Id.* at DHS 772. Neither the dates for which Ms. Widing requested care plans or the number of care plans she requested is referenced in the report.

17. A SIRS Investigator, Jake Shadis, was assigned to the case, although the Investigative Report does not indicate the date of this assignment or commencement of the investigation. Upon being assigned to the Best Care case, Mr. Shadis ran two queries in SIRS's electronic systems. One query looked for times when Best Care did not have an active QP "affiliation" and the other query searched for claims from October 1, 2016, through November 30, 2019.[39]

18. As part of his investigation, Mr. Shadis selected a sample of five recipients and the six PCAs who provided care from October 15, 2016, through April 23, 2017, to review the timeframe SIRS believed Best Care did not have a QP affiliation.[40]

19. A screen shot from a Medicaid Management Information System (MMIS) shows the following regarding when there were QPs employed by, and affiliated with, Appellant:[41]

Initials of QP	Begin Employment Date	End Employment Date
A.M.	04/24/2017	continuing
C.V.	10/04/2010	02/03/2013
S.G.	03/25/2002	09/24/2014
I.K.	02/25/2016	10/14/2016

20. The Department has a document it calls "form 4022," which is used by PCPOs to inform the Department when the PCPO is "affiliating" a QP with the agency, and when a QP is terminated from affiliation.[42] Best Care submitted this form for I.K. on or about October 23, 2015. There is a place on the form for indicating that "the affiliation has ended" that was never checked to indicate I.K.'s affiliation ended. The Department's MMIS system and the form are in conflict.[43]

21. To determine whether the issues identified by the Screeners were continuing, Mr. Shadis and another investigator, Rachel Lewis, conducted an onsite visit at Best Care's office in Minneapolis, on January 8, 2020.[44]

[39] *Id.*
[40] *Id.*
[41] Test. of J. Shadis; Ex. 14.
[42] Ex.18 (Qualified Professional Acknowledgement Forms).
[43] *Id.* at DHS 2596.
[44] Ex. 4 at 772.

22. On January 7, 2020, they sent a letter by facsimile to Ms. Khatoon stating that they would be making the onsite visit on January 8, 2020, and listing the documents they would need available for review. The letter instructed Ms. Khatoon to have certain documents available for the service dates of October 1, 2016, through April 30, 2017. The list of documents did not specifically include PCA care plans, but asked for "[a]ll supporting documentation for services billed by Best Care or its contractors."[45]

23. During the January 8, 2020, onsite visit, Mr. Shadis gave Ms. Khatoon a list of five recipient files he wanted to review from October 2016 through April 2017. Ms. Khatoon was cooperative and worked to assemble the requested materials. She explained that Best Care uses paper timecards but maintains care plans and QP notes in an electronic system.[46]

24. Mr. Shadis reviewed a total of eight PCA care plans.[47] The five 2016-2017 PCA care plans reviewed contained electronic signatures from a QP but no other signatures.[48] Mr. Shadis then requested the current PCA care plans for the same five recipients.[49] In response, Ms. Khatoon provided three additional PCA care plans.[50] These three plans also contained electronic QP signatures but no other signatures.[51] Mr. Shadis testified that that he did not have time to check the SIRS internal system to see whether all five of the original recipients were continuing to receive services.[52]

25. For each of the care plans reviewed by Mr. Shadis, the identities of the individuals by initials, the overpayments amounts per individual as determined by the Department's review and the commensurate overpayment calculation determined by the Department is as follows:[53]

Initials	Date Range of Overpayment Reviewed and Claimed	Overpayment	Fine Based on Overpayment
J.W.	10/01/2016-03/31/2019	$83,130.28	$16,626.06
A.M.	10/01/2016-11/28/2019	191.888.02	$38,377.60

[45] Ex. 5 (Letter).
[46] Test. N. Khatoon.
[47] Exs. 8-13.
[48] Exs. 9-13 (2016-27 Care Plans for five different recipients).
[49] Ex. 6 (On Site Review Report).
[50] Ex. 8 at 775-79.
[51] Ex. 6 at 1211.
[52] Test. of J. Shadis.
[53] Aff. of J. Shadis (Feb. 15, 2023); Amended Ex. 20; Letter from Department, March 13, 2023.

Initials	Date Range of Overpayment Reviewed and Claimed	Overpayment	Fine Based on Overpayment
A.A.	6/10/2016-6/10/2017	$47,552.00	$9,510.40
E.C.	10/11/2016-4/08/2017	$30,014.79	$6,002.96
M.J.	10/1/2016-11/28/2019	$218,871.53	$43,774.31
TOTAL		$571,456.62	$114,291.32

26. Mr. Shadis asked Ms. Khatoon to explain Best Care's PCA care plan process. She explained that Best Care uses the assessments provided by the public health nurses and "Minnesota Choice Assessment." According to Mr. Shadis and Ms. Lewis, Ms. Khatoon said that none of Best Care's PCA care plans are signed by anyone other than the QP. Mr. Shadis asked if recipients or RPs sign the PCA care plans. He understood Ms. Khatoon to say that Best Care did not have the PCA care plans signed. According to Mr. Shadis, Ms. Khatoon assured Mr. Shadis that the QP typically leaves a copy of the PCA care plan with the recipient so the PCA can follow the care plan.[54]

27. Mr. Shadis documented the conversation at the end of a standard SIRS' interview form. No evidence demonstrates that Ms. Khatoon was asked to confirm his understanding.[55]

28. Ms. Khatoon testified that Best Care has QPs develop the PCA care plan with the client or RP and then leaves the PCA care plan with the client to be signed and sent to Best Care.[56]

29. Based on his understanding of Ms. Khatoon's statements during the site visit, Mr. Shadis concluded that none of the claims the Department paid to Best Care for any of its 53 clients between October 1, 2016, and November 30, 2019, were supported by signed PCA care plans. He reached that conclusion without requesting or reviewing any other records.[57]

[54] Ex. 6 at 1211; Ex. 7 at 1377 (Interview form); Test. J. Shadis; Test. of Rachel Lewis.
[55] Ex. 7 at DHS 1377.
[56] Test. of N. Khatoon.
[57] Test. of J. Shadis.

30. During the site visit and in testimony, Ms. Khatoon explained that when Best Care lacked a QP, she borrowed one from her other company to cover that position.[58]

31. Mr. Shadis presented his findings and conclusions about Best Care's PCA care plans to SIRS legal counsel and management, and recommended recovering all payments made to Best Care between October 1, 2016, through November 30, 2019, imposing a fine, and placing Best Care on a stipulated provider agreement.[59]

32. Mr. Shadis' supervisor, Kimberly Ralidak, explained that the Department is not required to consider the nature, chronicity or severity of violations before recouping an overpayment but that these factors are considered when imposing fines.[60] Department staff thought that the nature of Appellant's violation was that PCA care plans had no recipient or RP signatures and, for certain periods, there were no QPs. They also considered the amount paid to Appellant to be high. The Department deemed the violations chronic because the violations continued after being identified by the Screeners. The Department considered the violations severe because the failure to obtain required signatures on PCA care plans could mean that recipients did not receive needed services, negatively impacting their health and safety.[61] The Department agreed that there was no evidence that services had not been received.[62]

33. On June 29, 2020, SIRS sent a Notice of Overpayment, Stipulated Provider Agreement, and Order to Forfeit a Fine (Notice of Overpayment) to Best Care setting out an overpayment amount of $2,229,054.64 and a fine of $445,810.93. The Notice stated the overpayment was for services from October 1, 2016, to November 30, 2019, because (1) the PCA Care Plans do not contain a signature from the recipient or the RP, and (2) the agency had not a QP during certain times.[63]

34. On July 29, 2020, counsel for Best Care sent an appeal letter to the Department.[64]

35. On October 8, 2020, SIRS sent an Amended Notice of Overpayment, Stipulated Provider Agreement and Order to Forfeit a Fine (Amended Notice).[65] The Amended Notice stated that Best Care's July 29, 2020, Notice of Appeal was considered ongoing and that Best Care did not have to renew its appeal.[66]

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[58] Ex. 4 at DHS 772; Test. of J. Shadis; Test. of N. Khatoon.
[59] Test. of J. Shadis.
[60] Test. Kimberly Ralidak.
[61] *Id.*
[62] *Id*.
[63] Notice and Order for Prehearing Conference and Hearing (Notice and Order for Hearing) (Nov. 13, 2020), Ex. 1 (Notice of Overpayment, Stipulated Provider Agreement, and Order to Forfeit a Fine).
[64] Ex. 2 (Appeal Letter).
[65] Ex. 1 (Amended Notice).
[66] *Id.*

36. The overpayment amount of $2,229,054.64 and the fine of $445,810.93 remained the same in the Amended Notice of Overpayment as in the October 8, 2020, Notice. The amendments consisted of adding a violation for the lack of an affiliated QP to the Notice.[67] The Amended Notice included an updated spreadsheet, detailing the Department's "findings" for the individual claim lines sought to be recovered by the Department.[68] The spreadsheet noted for each claim that the PCA Care Plan was not signed by a recipient or a responsible party and, for certain claim lines, that Appellant had not had an "affiliated QP". Except for the eight records reviewed during the site visit, none of these claim lines resulted from a review of Best Care's records. The spreadsheet only serves to document the amount of money paid to Appellant between October 1, 2016, and November 30, 2019. [69]

37. Best Care's July 29, 2020, appeal letter stated that Best Care maintains signed copies of care plans in each client's paper file and that "[d]uring the SIRS onsite inspection, Best Care inadvertently provided DHS staff with unsigned copies of the care plans from its electronic records system instead of the signed copies it keeps in each client's hard file."[70] The appeal letter further asserted that "Best Care has in its possession, and available to DHS, signed care plans outlining the PCA services its clients received during the relevant period . . ."[71] These signed care plans were received into evidence at the hearing.[72]

38. The appeal letter also addressed SIRS' determination that Best Care did not have affiliated QPs during relevant periods. Specifically, Best Care stated that services were overseen by QPs as follows:

- I. K., R.N. (Pre-October 2016 to April 2017)
- E. M., RN (April 2017 to June 2018)
- J.G., LSW (July 2018 to Present)

39. The Department acknowledged Best Care's appeal on August 3, 2020, by letter which explained, among other things, that the Department would continue to pay for services Best Care provided to MHCP recipients during the appeal period.[73]

40. Any fact referenced in the Memorandum below that is not specifically referenced in these Findings of Fact is incorporated herein.

41. Any Conclusion of Law more properly deemed to be a Finding of Fact is incorporated herein.

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[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] Ex. 2 (Appeal Letter).
[71] *Id.*
[72] Exs. 100-02 (Signed Care Plans).
[73] Ex. 3 (Letter).

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

CONCLUSIONS OF LAW

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

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

3. Appellant is a "personal care assistance provider agency,"[74] and a "vendor of medical care."[75]

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.[76]

5. To obtain monetary recovery, the Department has the burden to establish by a preponderance of the evidence, that Appellant was improperly paid funds from the MHCP as a result of fraud, theft, abuse, or error.[77]

6. A "preponderance of the evidence" means that the ultimate facts must be established by a greater weight of the evidence.[78]

7. 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.[79]

8. 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.[80] Specific practices deemed by rule to be abuse by a vendor include failing to develop and maintain health service records as required under Minn. R. 9505.2175 (2021), and repeatedly failing to comply with the requirements of

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[74] *See* Minn. Stat. § 256B.0659, subd. 1(l); Minn. R. 9505.0335, subp. 1(D).
[75] *See* Minn. Stat, § 256B.02, subd. 7(a); Minn. R. 9505.0175, subp. 50, .2165, subp. 16a (2021).
[76] *Id.*, subd. 1c(a).
[77] Minn. R. 1400.7300, subd. 5 (2021).
[78] 4 Minnesota Practice, CIV JIG 14.15 (2014).
[79] Minn. Stat. § 256B.064, subd. 1a.
[80] Minn. R. 9505.2165, subp. 2(A).

the provider agreement that relate to the programs covered by Minn. R. 9505.2160-.2245.[81]

9. 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.[82] 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.[83]

10. The Commissioner may order a vendor to forfeit a fine for failing to document services fully according to standards in Minn. R. ch. 9505 (2021), and if specific required components of documentation are missing.[84]

11. 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 Minn. Stat. ch. 256B (2020), or Minn. R. ch. 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.[85]

12. A recipient of PCA services must have a current PCA care plan, developed by the QP with the recipient and the RP. The PCA care plan is based on the service plan completed on a form determined by the Commissioner, pursuant to Minn. Stat. § 256B.0659, subd. 6.[86]

13. Minn. R. 9505.2175, subp. 7, requires that personal care provider service records include the PCA 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. 1-2.

14. 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 Minn. R. 9505.2175, subp. 2 items A through I.

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

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[81] *Id.*, subp. 2(A)(7), (18).
[82] Minn. Stat. § 256B.064, subd. 1b.
[83] *Id.*
[84] Minn. Stat. § 256B.064, subd. 2(f).
[85] *Id.*
[86] Minn. Stat. § 256B.0659, subd. 7(a) (2020).

16. According to Minn. Stat. § 256B.0659, subd. 7, "[a] copy of the most current personal care assistance plan is required to be in the recipient's home and in the recipient's file at the provider agency."

17. According to Minn. Stat. § 256B.0659, subd. 28, required documentation, including PCA care plans, must be "kept in the personal care assistance provider agency file or the recipient's home residence."[87]

18. According to Minn. R. 9505.0175, subp. 35, a "Plan of Care" 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.

19. PCA services provided to a recipient must be performed under the supervision of a QP.[88]

20. 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."[89]

21. The Department "shall notify the vendor no less than 24 hours before obtaining access" to a health service record.[90]

22. The Commissioner may require a vendor to sign a Stipulated Provider Agreement as a condition of participating in MHCP that may require "specific conditions of participation" in MHCP.[91]

23. The Department bears the burden of proof to show, by a preponderance of the evidence, that Appellant should be subject to monetary recovery and sanctioned under Minn. Stat. §§ 256B.064, .0659, subd. 7; Minn. R. 9505.0465, subp. 1, .2165, subps. 2(A)(1), (3), .2175, subps. 2, 7, and .2215, subp. 1 (2021). If the evidence is

[87] Minn. Stat. § 256B.0659, subd. 28 (a)(2)(iii).
[88] *Id.*, subd. 14.
[89] Minn. R. 9505.2185, subp. 2.
[90] *Id.*
[91] Minn. R. 9505.2210, subp. 2B.

equally balanced, then that fact or issue has not been proven by a preponderance of the evidence.[92]

24. The Department established, by a preponderance of the evidence, for eight PCA care plans developed between October 1, 2016, and November 30, 2019, that Appellant failed to ensure that those PCA care plans were signed by the recipient or RP. The Department failed to establish it is entitled to recover any other payments made to Best Care for the timeframe in question.

25. The Department offered no evidence to support its contention that QPs must be "affiliated" as that term is used by the Department.

26. The Department failed to prove by a preponderance of the evidence, that Appellant did not have a Qualified Professional to supervise the provision of PCA services as required by statute.

27. The Commissioner's ~~authority to~~ may recover from Appellant an overpayment ~~limited to the amount~~ of $571, 456.62 calculated from the eight care plans the Department reviewed.[93]

28. The Commissioner has the authority to levy a fine for 20 percent of $114,291.32 ~~the amount~~ calculated from the eight care plans.

29. The individual amounts for each recipient and for the dates of the plans that were reviewed are:[94]

Initials	Date Range of Overpayment Reviewed and Claimed	Overpayment	Fine Based on Overpayment
J.W.	10/01/2016-03/31/2019	$83,130.28	$16,626.06
A.M.	10/01/2016-11/28/2019	191.888.02	$38,377.60
A.A.	6/10/2016-6/10/2017	$47,552.00	$9,510.40
E.C.	10/11/2016-4/08/2017	$30,014.79	$6,002.96

[92] *Id.*
[93] Amended Ex. 20.
[94] Amended Ex. 20.

Initials	Date Range of Overpayment Reviewed and Claimed	Overpayment	Fine Based on Overpayment
M.J.	10/1/2016-11/28/2019	$218,871.53	$43,774.31
TOTAL		$571,456.62	$114,291.32

30. The total of the recommended recovery and recommended fine is $685,747.94.[95]

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

32. Any portion of the Memorandum below that constitutes a Conclusion of Law is incorporated herein.

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

RECOMMENDATION

1. The Department has established by a preponderance of the evidence that it may recover an overpayment from Appellant in an amount calculated from the eight claims the Department reviewed.

2. The Administrative Law Judge respectfully recommends that the Commissioner **AFFIRM** the Amended Notice of Overpayment in accordance with the conclusions above along with a corresponding fine of 20 percent of the newly calculated amount. The Administrative Law Judge further respectfully recommends the implementation of the proposed Stipulated Provider Agreement.

Dated: April 13, 2023

BARBARA J. CASE
Administrative Law Judge

[95] Amended Ex. 20.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Department of Human Services (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. Introduction

The Department seeks to recover an overpayment from Appellant of $2,229,054.64 for every claim for PCA services provided to Appellant's clients from October 1, 2016, to November 30, 2019.[96] The Department's overpayment claim is based on the Department's determination that Appellant submitted claims for PCA services that lacked PCA care plans signed by recipients or, where appropriate, RPs.[97] In addition, the Department found that Appellant did not have an affiliated QP from October 15, 2016, through April 23, 2017, and again from June 16, 2018, through July 10, 2018. However, this violation did not increase the amount of the overpayment sought because it overlaps with the periods for which the Department seeks recovery based on unsigned care plans.[98]

In addition to retrieving every penny paid to Appellant over almost three years, the Department seeks to impose a $445,810.93 fine. This is 20 percent of the total claims paid and the highest sanction the Department is permitted to levy for this type of

[96] Ex. 86.
[97] *Id.*
[98] Test. of J. Shadis.

alleged violation.[99] Finally, the Department is requiring Appellant to enter into a Stipulated Provider Agreement (SPA) which essentially restates rules that providers are required to follow. Appellant did not oppose the imposition of the SPA.

The Department bears the burden to prove its claims by a preponderance of the evidence.[100] To establish a fact by a preponderance of the evidence, "it must be more probable that the fact exists than that the contrary exists."[101] If the evidence is equally balanced, then that fact or issue has not been proven by a preponderance of the evidence.[102] The Administrative Law Judge concludes that the Department has not established that it may recover the bulk of the claimed overpayment for reasons discussed below. However, if the Department concludes that it is entitled to the entire amount set forth in the notice, then the addition of the fine is needless. If the purpose of a fine is to focus Appellant's attention on its responsibilities, thus improving its practices, recovering two and a half million dollars, representing three years' worth of payments, would be just as effective.

II. Background

Minnesota participates in the Medicaid program,[103] which funds medical assistance (MA)[104] for eligible individuals who are unable to pay for their medical care.[105] The Department is charged with administering and overseeing this program through the MHCP.[106] As shown by the amount at issue for just 53 recipients in this matter, the cost to the MHCP for PCA services is significant.

Recipients are entitled to choose any state-enrolled PCPO.[107] PCPOs are regulated in certain ways that can be easily validated, such as proof of bond coverage, workers' compensation insurance, other kinds of insurance, and training for agency owners and staff.[108] However, given the vast number of PCPOs, recipients, and daily services, the state must rely on PCPOs to comply with state laws in lieu of close surveillance of the provision of services, service standards and the minimization of fraud, waste and abuse.

To oversee the PCPOs and to assure they oversee their PCAs, the state has in place certain record keeping requirements.[109] PCPOs are required to use 72.5 percent

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[99] Minn. Stat. § 256B.064, subd. 2(f).
[100] Minn. R. 1400.7300, subp. 5.
[101] *City of Lake Elmo v. Metropolitan Council*, 685 N.W.2d 1, 4 (Minn. 2004).
[102] *Id.*
[103] *See generally* 42 U.S.C. § 1396-1396v (2021); Minn. Stat. §§ 256B.01-.85 (2020).
[104] *See* Minn. Stat. § 256B.02, subd. 8.
[105] *See* 42 U.S.C. § 1396-1; 42 C.F.R. § 430.0 (2021).
[106] Minn. Stat. § 256B.04; Minn. R. 9505.0011 (2021); *see also* Minn. Stat. §§ 256B.01-.85; Minn. R. 9505.0295, .0335 (2021).
[107] Minn. Stat. § 256B.01.
[108] Minn. Stat. § 256B.0659, subd. 21.
[109] *Id.*

of revenue paid by medical assistance for the PCA's wages and benefits.[110] The remaining revenue is available to run the PCPO in a way that complies with state requirements, including administrative tasks like record keeping, overhead costs and other business requirements, and the payment of QPs.[111]

It is understandable that reviewing PCPO record-keeping is the only practical way the state has to prevent most fraud, waste, and abuse. Other means, such as interviewing recipients, would likely prove inaccurate as well as being overly burdensome in most cases. PCPOs are required to maintain copies, or have access to copies, of all of the forms the agency uses in the course of daily business such as time sheets, training records,[112] and copies of each recipient's current PCA care plan.[113] However, in this matter the Department did not avail itself of its authority to review all fifty-three of the records for which it seeks recovery. Furthermore, precisely where the PCA care plans must be maintained is not clear.

III. Overpayment Recovery for Unsigned Care Plans

A. The Investigation and Findings

On or about July 17, 2017, a Screener conducted a "re-validation screening" onsite at Best Care.[114] The Screener found that none of five recipient files reviewed contained signed care plans. According to the Department, typically Screeners would have explained the signed care plan requirement to a PCPO owner at the screening.[115] Ms. Khatoon denies that the Screener took the time to explain the errors or anything else.[116] Nothing in the record supports the contention that Ms. Khatoon was informed of the Screener's finding except the Department's assertion that this is its standard practice.[117] It is reasonable to expect that the Department would have communicated its findings in a letter to Appellant, but it did not. In addition to providing a clear record that findings were given to a PCPO, maintaining a record via a letter would model the documentation standards the Department expects of providers.

On January 8, 2020, investigators Mr. Shadis and Ms. Lewis, followed up on the Screener's findings. They requested the care plans for the same five recipients the Screener had reviewed two years earlier.[118] Appellant produced the five requested care plans from Appellant's electronic filing system, but they lacked the signatures of either

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[110] *Id.*
[111] *Id.* The revenue generated by the qualified professionals and the reasonable costs associated with the qualified professionals shall not be used in calculating the 72.5 percent that flows to the PCAs.
[112] *Id.*
[113] *Id.*, subd. 7. A copy of the most current personal care assistance care plan is required to be in the recipient's home and in the recipient's file at the provider agency.
[114] Ex. 4 at DHS 773.
[115] Test. of K. Ralidak.
[116] Test. of N. Khatoon.
[117] Test. of K. Ralidak.
[118] Test. of J. Shadis.

an RP or a recipient. Both investigators assert that Ms. Khatoon told them that Appellant did not require recipients or RPs to sign care plans.[119] On the basis of that admission, Mr. Shadis expanded both the time and the number of recipients for whom the Department sought an overpayment from 5 to 53. Despite the dramatic expansion of his investigation, Mr. Shadis apparently found no reason to request or review records beyond the original five recipient files. Instead, Mr. Shadis based his overpayment determination applicable to the other 48 recipients on what he viewed as Ms. Khatoon's admission.

Ms. Khatoon recalls her conversation with Mr. Shadis differently. According to her, she was responding to the investigators' request for copies of the five care plans, which she could only retrieve from Appellant's electronic system in which there are no signed care plans. Precisely why the electronic system used by Appellant is unable to store signatures is unclear but also undisputed. Ms. Khatoon recounts that the SIRS investigators did not specifically request signed care plans. Appellant asserted that Best Care had difficulty obtaining signed care plans, blaming a difficult-to-serve clientele and the underfunding of the MHCP system.[120] She described a process by which the RP or recipient was expected to sign the care plan after it was developed with the QP.

Best Care's practice, according to Ms. Khatoon, is to keep signed care plans at each recipient's home. According to Minn. Stat. § 256B.0659, subd. 28(a)(2)(iv), this is an acceptable manner in which to maintain care plans.[121] However, she also claimed at the hearing that Best Care has QPs develop the care plan with the client or responsible party and then leaves the care plan with the client to be signed and sent to Best Care.[122]

B. Overpayments

1. The Parties' Arguments

Appellant contends that the Department's grounds for seeking monetary recovery turn on whether the Department can demonstrate, by a preponderance of the evidence, that Appellant's noncompliance constitutes abuse.[123] Appellant argues that the Department has failed to demonstrate abuse in part because the Department's regulations define abuse as a pattern of practices that are inconsistent with sound fiscal, business, or health service practices and those practices result in unnecessary costs to

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[119] *Id.*; Test of R. Lewis; Ex.4 at DHS 773; Ex. 7 (Provider Questionnaire).
[120] Test. of N. Khatoon.
[121] Minn. Stat. § 256B.0659, subds. 7(a) and 28(a)(2)(iv), appear to be at odds with one another. Subdivision 7(a) requires that personal care assistance care plans be maintained in the recipient's home and in the recipient's file at the provider agency. Subdivision 28(a)(2)(iv) permits personal care assistance care plans to be maintained either in the recipient's home or the recipient's file at the provider agency. This conflict in the statutes does not appear to be reconcilable and is likely to have caused confusion among conscientious providers who took time to read through the statutes.
[122] Test. of N. Khatoon.
[123] Appellant's Closing Argument at 13.

the program.[124] Appellant further argues that the Department failed to prove the second part of a two part test: that the abuse resulted in any unnecessary costs.[125] Similarly, Appellant asserts the Department should not recover all of the money paid to Appellant for PCA care because there is no evidence that the care was not needed or not provided.[126]

Appellant also contends that the Administrative Law Judge should consider its later-submitted documentation, rather than the care plans and information provided to the inspectors on January 8, 2020.[127]

Lastly, Appellant implies that the Department erred by engaging in "random sample extrapolation."[128] The investigators looked at only five care plans but then extrapolated, based on Ms. Khatoon's statements, to apply their conclusion that Appellant did not maintain signed care plans to all 53 recipients served by Appellant.

The Department claimed that Best Care's failure to keep copies of all of the PCA care plans at Best Care's office rendered the plans unavailable for the Department to review. Citing Minn. Stat. § 256B.0659, subd. 7, and Minn. R. 9505.2190, subp. 1, the Department argued that keeping care plans only at recipients' homes is insufficient.

2. Analysis

Appellant's arguments regarding abuse are unavailing. 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.[129] However, the Department may recover money paid to a vendor without proving that there were unnecessary costs to the MHCP if the recovery is the result of a specific practice defined as abuse. Specific practices deemed by rule to be abuse by a vendor include failing to develop and maintain health service records as required under Minn. R. 9505.2175.[130] In short, failure to maintain plans which are unsigned care plans or plans which otherwise fail to contain all the elements set forth at Minn. Stat. § 256B.0659, subd. 7(b), is abuse. The Department need not prove that the failure resulted in unnecessary costs.[131]

Appellant also argues that the Administrative Law Judge should rely on its later-submitted care plans, rather than on the absence of signed care plans on the day of the inspectors' visit. The Administrative Law Judge agrees that the later-submitted plans should be considered. Not only did the inspectors never ask for these documents, but Appellant would not have known until receiving the June 29, 2020, Notice of

[124] Minn. R. 9505.2165, subp. 2.; Appellant's Closing Argument at 18-19.
[125] Appellant's Closing Argument at 13-14.
[126] *Id.* at 14-18.
[127] *Id.*
[128] *Id.*
[129] Minn. R. 9505.2165, subp. 2(A).
[130] *Id.*, subp. 2(A)(7).
[131] *Id.*

Overpayment, Stipulated Provider Agreement, and Order to Forfeit a Fine (Notice of Overpayment) that the scope of the investigation went beyond the original five files Ms. Khatoon had been asked to produce. Thus, there would have been no reason for Appellant to even offer to provide the additional 48 care plans before responding to the Notice of Overpayment. For these reasons, it is appropriate for the Administrative Law Judge to consider the later-submitted care plans, giving them the appropriate weight considering the circumstances.

The Department's argument that Appellant failed to maintain all of the PCA care plans at its office does not resolve this case for several reasons. Minn. Stat. § 256B.0659, subd. 7(a), does require that an agency keep of copies personal care assistance care plans both at the agency itself, and at the recipient's residence. Minn. R. 9505.2190, subp. 1, requires vendors to "maintain and store records in a manner that will allow for review by the department within the times set forth in part 9505.2185, subpart 2."[132]

The Department's position regarding the legal requirement that recipient's personal assistance care plans be maintained both at the provider's office and at the recipient's home is undermined by the language of Minn. Stat. § 256B.0659, subd. 28(a)(2)(iv). In apparent contradiction to the requirements at Minn. Stat. § 256B.0659, 7(a), subd. 28(a)(2)(iv) permits personal care assistance care plans to be maintained either in the recipient's home or the recipient's file at the provider agency. This conflict in the statutes does not appear to be reconcilable. If subdivision 28(a)(2)(iv) establishes a "minimum standard" and the provider meets that standard, there is no requirement that the provider also meet the more difficult standard set forth at subdivision 7(a). Nor does the cited rule prevent a provider who keeps a particular version of the personal care assistance care plan only at the recipient's home from obtaining the document on request, given the 24 hour required notice, which is also a part of Minn. R. 9505.2185, subp. 2. Had Mr. Shadis requested the additional 48 files, Ms. Khatoon would have had 24 hours to produce them. But he never asked for those care plans. Instead, he presumed that they lacked the same element missing from the five care plans he had seen.

Mr. Shadis and the Department made their decision that 53 care plans were incomplete based on looking at a sample of five, and on Ms. Khatoon's statement that she did not require recipients or a responsible party to sign care plans. Particularly given Ms. Khatoon's long years in business as a PCA provider agency and her lack of a previous record of overpayment situations, along with the cultural and language differences between investigators and Ms. Khatoon, further clarifying discussion would have been helpful.[133] But lacking that, Mr. Shadis certainly could have followed up on

[132] Minn. R. 9505.2185, subp. 2 requires the department to provide at least "24 hours notice before obtaining access to a health service or financial record, unless the vendor waives notice."

[133] Although no translator was requested or required for Ms. Khatoon's testimony, she did speak with the accent of a non-native English speaker and sometimes needed to clarify her statements due to difficulty

his concerns by requesting the care plans of the remaining 48 recipients served by Best Care. Ms. Khatoon would have had 24 hours to produce the requested documents, and a careful examination of those documents would have formed the basis for whatever Notice of Overpayment the Department ultimately issued. Ms. Khatoon offered the signed care plans to the Department a number of times after receiving the Department's notice.[134] The Department declined to review the proffered care plans, but they were received into evidence at the hearing because of their obvious probative value. The care plans do not appear uniform, identical or unbelievably consistent such that they would be assumed to have been created for purposes of Appellant's appeal. These care plans support Ms. Khatoon's description of Best Care's care plan practices.[135]

Mr. Shadis reviewed the additional 48 plans apparently after they were submitted as exhibits for the hearing. He testified at the hearing that none of the additional 48 plans contained the required statutory components. He stated, without foundation, that some care plans appeared to have signatures that were not there at the time of review; and observed that others were signed after the start date of the plans. The spreadsheet that the Department offered did not specify, for each care plan, why the document was insufficient. They were all listed as lacking recipient or RP signatures when it is obvious that most of them do have such signatures.

The Administrative Law Judge cannot treat the 53 recipient's personal care assistance care plans as a single piece of evidence, where five or even 25 inadequate plans mean that the entire batch is flawed. Each plan must be supported by the Department's evidence, showing why the plan is inadequate. That is what it means to bear the burden of proof. The Department is claiming that the Appellant owes over $2.5 million, and it may be that Appellant does. However, at this time, the Department has only met its burden of proof as it applies to the eight recipients' care plans the investigators actually reviewed.

Appellant's argument about the application of Minn. R. 9505.2220, regarding the random sample extrapolation rule, is simply misplaced. That rule applies when the Department seeks to estimate the amount of an unknown overpayment by projecting with a calculated margin of error. The rule does not apply in a situation like this one, where the Department is claiming all of the funds paid to a PCPO based upon alleged record deficiencies without having reviewed the majority of the care plans for which it seeks recovery. The Department did not assert the rule to this matter and its sampling in this case bears no resemblance to an appropriate application of the rule because, among other reasons, the "sample" chosen was not random. To the contrary Mr. Shadis chose the same five recipient files that had been reviewed by the Screeners.

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expressing herself. It would be important when interviewing her to be certain of one's understanding and to double-check assumptions or critical statements.

[134] *See* Ex. 2 (Appeal Letter).

[135] Exs. 100-02 (Signed Care Plans).

The Department has failed to meet its burden with regard to establishing that 53 care plans from October 1, 2016, to November 30, 2019, were unsigned by a recipient or RP. The Department has met its burden with regard to the five care plans reviewed by the investigators for the dates reviewed and submitted into evidence.

C. Qualified Professionals

Under Minn. Stat. § 256B.0659, subd. 14, all PCAs must be supervised by a qualified professional. The QP must work for a PCPO, meet the definition of qualified professional under Minn. Stat. § 256B.0625, subd. 19(c), and enroll with the department as a qualified professional after clearing a background study. Minn. Stat. § 256B.0659, subd. 13(a).

Mr. Shadis testified that the Medicaid Management Information System (MMIS) showed Best Care did not have a QP on staff from October 15, 2016, through April 23, 2017.[136] Ms. Ralidak testified that Appellant also lacked a registered QP from June 16, 2018, through July 10, 2018.[137] The evidence presented to support their testimony is a screen shot from the MMIS system.[138] This document indicates that one QP, with the initials IK, terminated his affiliation with Best Care on October 14, 2016, and another, with initials MA, was not employed until April 24, 2017.[139] The Department did not present evidence regarding the sources for the MMIS information. Furthermore, there is nothing in the statutes cited by the Department on "form 4022" requiring "affiliation" or the use of the form. There is nothing in the evidence or in statute that supports the Department's "affiliation" requirement as being different from a PCPO using a QP who is properly trained, has passed a background study, and is employed by the PCPO.

The Department has failed to meet its burden with regard to this issue. Appellant acknowledged that Best Care failed to file a Form 4022C with the Department from June 16, 2018, through July 10, 2018. However, with respect to the period of October 15, 2016, through April 23, 2017, Form 4022C was filed with the Department, reflects that I.K. was employed beginning February 25, 2016, and was not terminated.[140] Appellant testified that she did not send in any paperwork terminating I.K.'s affiliation prior to April 2017.[141]

In addition, the Department did not meet its burden on this issue because it cites no statute or rule that requires form 4022C or the "affiliation" of QPs as that term was applied in this matter by the Department. If the requirement for "affiliation" of a QP is required in the Department's guidance to PCPOs, the Department did not produce that guidance. The applicable statute states:

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[136] Ex. 14; Test. of J. Shadis.
[137] Test. of R. Ralidak; Ex. 14.
[138] Ex. 14.
[139] *Id.*
[140] Ex. 18 at 2596.
[141] Ex. 18 at 544; Test. of N. Khatoon.

> The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:
>
> (1) is not disqualified under section 245C.14; or
>
> (2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.[142]

Appellant complied with this standard. The Department did not prove by a preponderance of the evidence that Appellant's QPs, even the ones borrowed from Ms. Khatoon's other health care agency, did not meet the qualifications of a QP, have a background study or fail to meet training requirements. The Department also did not meet its burden of proof for this allegation because it did not review the records at issue.

IV. Conclusion

The law states the Department may recover funds from a vendor who has been improperly paid "as a result of a vendor or department error, regardless of whether the error was intentional."[143] Moreover, the Department "shall recover" program funds paid for services that are not documented in the manner required by law.[144]

Therefore, the Administrative Law Judge determines that the Department established by a preponderance of the evidence that it may recover an overpayment from Appellant as it applies to the eight recipient files reviewed by the Department. The Administrative Law Judge respectfully recommends that the Commissioner **AFFIRM** the Stipulated provider Agreement, **AFFIRM** the overpayment for the eight files reviewed by the investigators and a fine in the amount of 20 percent of the recalculated total. The Administrative Law Judge also recommends that the Department **RESCIND** overpayments stemming from the 48 recipients whose care plans were not reviewed and from its allegation that Appellant failed to have affiliated QPs.

B. J. C.

[142] Minn. Stat. § 256B.0659, subd. 13.
[143] Minn. Stat. § 256B.064, subd. 1c.
[144] Minn. R. 9505.2175, subp. 1.