OAH 5-1800-38435

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS Appeal by Orion ISO Financial Services, Inc.	**ORDER AND RECOMMENDATION ON CROSS MOTIONS FOR SUMMARY DISPOSITION AND ORDER TO SEAL PORTIONS OF THE RECORD**

This matter came before Administrative Law Judge Jim Mortenson on the parties' cross motions for summary disposition and the Department's motion to seal exhibits.

Paul Ziezulewicz, Assistant Attorney General, represents the Department of Human Services (Department). Sarah E. Bushnell, Arthur Chapman Kettering Smetak & Pikala, P.A., represents Orion ISO Financial Services (Respondent).

The motions were filed on December 14, 2022. Each party timely filed a response opposing the opponent's motion on January 26, 2023. On February 8, 2023, the Department filed a Motion to Seal Exhibits containing care recipients' nonpublic data. On February 9, 2023, the Judge convened a motion hearing and heard arguments from both parties.[1]

Based upon the arguments, record, and proceedings herein, and for the reasons set forth in the accompanying memorandum, the Judge makes the following:

ORDER

Pursuant to Minn. Stat. §§ 14.60, subd. 2, 144.293 (2022) exhibits 1, 4, and 5 in support of the Declaration of Pamela Steffens and exhibits A, B, and C in support of the Declaration of Kelly Merdan, all of which contain identifying information concerning individuals receiving health care services, are **SEALED** from public disclosure.

RECOMMENDATION

The Judge respectfully recommends the Commissioner **GRANT** the Department's Motion and **DENY** Respondent's Motion.

Dated: February 24, 2023

JIM MORTENSON
Administrative Law Judge

[1] Respondent did not object to the Motion to Seal Exhibits.

MEMORANDUM

I. Introduction

The primary question in this matter is whether the Department can recover funds from Respondent which were used to pay personal care assistants (PCAs) who did not provide the services they claimed. This question arises because Respondent is a fiscal intermediary contracted with by the care recipients who hire their own PCAs.

The PCAs and recipients involved here were engaged in fraud. Respondent was not aware of that activity until informed by the Department. The parties do not dispute the material facts, and each seek judgment in their favor as a matter of law.

The Department makes three primary arguments why it may recover the claimed funds from Respondent. First, Respondent is a vendor of medical care pursuant to statute and its provider agreement with the state. Second, Respondent billed the state for services that were not provided. Third, Respondent's lack of knowledge about the fraud that resulted in payment for services that were not provided does not relieve it from recovery.

According to Respondent, the Department can, pursuant to Minn. R. 9505.2215, .0465 (2021), only recover from vendors and recipients who committed fraud. Respondent argues that it is not a vendor, and even if it was, it was not paid as a result of its own conduct or error. Because it is not a vendor, Respondent argues, Minn. R. 9505.2175 (2021) is not applicable justification for recovery. Respondent further argues that its contract with the Department does not authorize recovery for the fraud of others. Finally, Respondent argues that it cannot serve as an insurer for the Department.

II. Undisputed Material Facts

The material facts are:

1. Respondent participates in the Minnesota health care programs (MHCP), providing financial services for care recipients who chose their own care providers.[2]

2. The Department entered into a grant contract with Respondent to complete Respondent's enrollment in the MHCP and to have Respondent provide "Vendor Fiscal/Employer Agent Financial Management Services (VF/FMS) for participants in the STATE's Consumer Support Grant (CSG) program and Consumer Directed Community Supports (CDCS) program."[3]

3. Respondent signed a Provider Agreement with the Department on July 5, 2018.[4] Respondent agreed, in relevant part, to "[a]ssume full responsibility for the

[2] Huldeen Declaration (Decl.) at 1; Steffens Decl., Exhibit (Ex.) 3.
[3] Huldeen Decl., Ex. E; Steffens Decl., Ex. 2.
[4] Steffens Decl., Ex. 3.

accuracy of claims submitted to [the Department]," submit claims "only after the medical care or service has been provided," "submit claims only for services" the Respondent "knows or has reason to know are properly reimbursable," "[m]aintain records that fully disclose the extent of services provided to MHCP recipients," and "[r]efund any overpayments made to [Respondent] by [the Department], including those resulting from payments made by . . . billing errors [or] fraudulent billing."[5]

4. PCAs hired by care recipients under a CSG or CDCS program sign timecards and submit them to Respondent after recipients have also signed the timecard to certify it is accurate.[6] Respondent will then determine whether the services in the timecard are within the recipient's plan and budget, and if so, will pay the PCA.[7] This is the extent of Respondent's monitoring for accuracy of the timecards.[8]

5. Respondent was the FMS provider for L.B. and M.A.[9]

6. L.B., M.A., and their PCAs were engaged in fraudulent billing for services that were not provided to L.B. and M.A.[10]

7. Respondent became aware of suspected fraudulent billing involving M.A. and reported the suspicion to the Department.[11]

8. Respondent was not aware of possible fraud concerning L.B. until so informed by the Department.[12]

9. The Department's Surveillance and Integrity Review Section (SIRS) conducted investigations into these two instances of fraud.[13] In the case of L.B., SIRS found that there was an overpayment of $1,583.60, for services that were not provided between February 1, 2019, to March 31, 2019.[14] In the case of M.B., SIRS found that there was an overpayment of $4,677.00, for services that were not provided between April 1, 2019, and March 15, 2020.[15]

10. The Department provided Respondent a Notice of Overpayment for the L.B. matter on February 9, 2022. The Department sought the entire amount - $1,583.60 - it found was overpaid.[16]

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[5] *Id.*
[6] *Id.*
[7] *Id.*; Ex. C at 6.
[8] *Id.* at 1.
[9] Huldeen Decl. at 2.
[10] *Id.*; Merdan Decl., Ex. B; Steffens Decl., Ex. 1.
[11] Huldeen Decl. at 2-3.
[12] *Id.* at 2.
[13] *Id.*, Ex. 4
[14] Steffens Decl., Ex. 1; Huldeen Decl. at 2.
[15] Merdan Decl., Ex. A.
[16] Steffens Decl., Ex. 1; Huldeen Decl. at 2.

11. The Department provided Respondent a Notice of Overpayment for the M.A. matter on May 4, 2022. The Department sought the entire amount - $4,677.00 - it found was overpaid.[17]

12. Respondent's portion of the $1,583.60 overpayment – its fee for providing finance administrative services – is $292.60.[18]

13. Respondent's portion of the $4,677.00 overpayment – its fee - is $1,359.70.[19]

III. Summary Disposition Standard

Summary disposition is the administrative law equivalent of summary judgment.[20] A judge or commissioner may grant a motion for summary disposition when there is no genuine issue regarding any material fact, and the moving party is entitled to judgment as a matter of law.[21] The Office of Administrative Hearings follows the summary judgment standards developed in the state district courts when considering motions for summary disposition in contested case matters.[22]

The function of an administrative law judge on a motion for summary disposition, like a trial court's function on a motion for summary judgment, is not to decide issues of fact, but to determine whether genuine, material factual issues exist.[23] The judge does not weigh the evidence; instead, the judge views the facts and evidence in a light most favorable to the non-moving party.[24]

Summary disposition cannot be used as a substitute for a hearing or trial on the facts of a case.[25] Thus, summary disposition is only proper when no fact issues need to be resolved.[26]

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[17] Merdan Decl., Ex. A.
[18] Huldeen Decl. at 2.
[19] Huldeen Decl. at 3.
[20] *Pietsch v. Minnesota Bd. of Chiropractic Exam'rs*, 683 N.W.2d 303, 306 (Minn. 2004); *see also* Minn. R. 1400.5500(K) (2021).
[21] *See Sauter v. Sauter*, 70 N.W.2d 351, 353 (Minn. 1955); *Louwagie v. Witco Chemical Corp*., 378 N.W.2d 63, 66 (Minn. Ct. App. 1985).
[22] Minn. R. 1400.6600 (2021).
[23] *See e.g., DLH, Inc. v. Russ*, 566 N.W.2d 60, 70 (Minn. 1997).
[24] *Ostendorf v. Kenyon*, 347 N.W.2d 834, 836 (Minn. Ct. App. 1984).
[25] *Sauter*, 70 N.W.2d at 353.
[26] *Id*.

IV. Analysis

A. Respondent is a PCA choice agency and, therefore, a vendor of medical care.

PCA services are medical assistance (MA) services authorized by state law.[27] PCA services cover a wide range of tasks that are provided in care recipient's homes and are to assist them with a range of needs from mundane activities of daily living to more involved medical care which does not rise to the level requiring a licensed nurse or therapist.[28]

The Commissioner may "allow a recipient of [PCA] services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered [PCA] services."[29] All the requirements for PCA services apply to the recipient "[u]nless otherwise provided in [Minn. Stat. § 256B.0659]."[30]

Providers of PCA services are referred to as "personal care assistance provider agenc[ies]."[31] PCA agencies are defined by statute as:

> a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, *personal care assistance choice agency*, class A licensed nursing agency, and Medicare-certified home health agency.[32]

A PCA choice agency is a component of the PCA choice option for care recipients.[33] Under the PCA choice option, a recipient is "responsible for the hiring, training, scheduling, and firing of [PCAs] according to the terms of the written agreement with the personal care assistance choice agency."[34] The terms of the written agreement are prescribed by the statute.[35] The Department administers PCA choice options through "consumer directed community supports (CDCS)" and Consumer Support Grants (CSG).[36]

Because a PCA choice agency is a provider of statutorily authorized medical services, it is a vendor of medical care. A "vendor of medical care" includes a person or persons who provide "such other services or supplies provided or prescribed by persons authorized by state law to give such services and supplies."[37]

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[27] Minn. Stat. §§ 256B.0625, subd. 19a, .0659 (2022).
[28] Minn. Stat. § 256B.0659, subds. 2, 3.
[29] Minn. Stat. § 256B.0659, subd. 18(a).
[30] *Id.*, subd. 18(b).
[31] Minn. Stat. § 256B.0659, subd. 1(l).
[32] *Id.* (emphasis added).
[33] *Id.* at subd. 18.
[34] *Id.* at subd. 18(b).
[35] *Id.* at subd. 20.
[36] Exhibit A.
[37] Minn. Stat. § 256B.02, subd. 7(a) (2022).

A PCA choice agency must act as the fiscal intermediary.[38] The fiscal intermediary "manages payroll, invoices the state, is responsible for all payroll-related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's [PCA] services."[39] When relying on the PCA choice option, a recipient must, among other things, "monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the [PCA]."[40] The fiscal intermediary must, among other things, "meet all personal care assistant provider agency standards" found at subdivisions 24, 25, 26, 27, and 28.[41] The fiscal intermediary must also:

- be the PCA's employer "for employment law and related regulations including but not limited to purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance . . .;"

- "bill the medical assistance program for personal care assistance services . . .;"

- pay PCAs "based on actual hours of services provided;"

- "verify and keep records of hours worked by the" PCAs;

- "enroll in the medical assistance program as a personal care assistance choice agency," which means the fiscal intermediary is a "vendor of medical care" under Minn. Stat. § 256B.02, subd. 7 (2022).[42]

  All reports as to the costs of operations or of medical care provided which are submitted by vendors of medical care for use in determining their rates or reimbursement shall be submitted under oath as to the truthfulness of their contents by the vendor or an officer or authorized representative of the vendor.[43]

To implement these requirements, the Department refers to the fiscal intermediaries as "financial management services" providers (FMS).[44] Respondent is a contracted FMS for the Department.[45] Therefore, Respondent is a fiscal intermediary with statutorily required responsibilities and a vendor for purposes of Minn. Stat. § 256B.064. The contracts and other agreements the Department may have with Respondent are not

[38] Minn. Stat. § 256B.0659, subd. 18(b).
[39] Minn. Stat. § 256B.0659, subd. 18(b).
[40] *Id.* at subd. 19(a)(5).
[41] *Id.* at subd. 19(b)(1); Minn. Stat. § 256B.0659, subds. 24, 25, 26, 27, 28.
[42] Minn. Stat. § 256B.0659. subd. 19(c)(1), (2), (4), (6), (8), .21(b).
[43] Minn. Stat. § 256B.027, subd. 2 (2022).
[44] Ex. A; Ex. 2.
[45] Ex. E; Ex. 2.

controlling for purposes of this analysis, because the statutory scheme makes clear the Respondent is a vendor of medical services for purposes of fiscal accountability.

B. The Department may recover funds paid to Respondent for services claimed by PCAs and their care recipients which were never provided.

As a condition for payment, a vendor of medical care must document each occurrence of a service provided.[46] The requirements for health records to be kept by a vendor, including a fiscal agent like Respondent, are listed at Minn. R. 9505.2175, subps. 2, 7. Entries into health records must contain, among other things, the recipient's name, the date on which a health service is provided, and the length of time of the service when payment is based on time.[47]

Abuse and error which result in improper payment are bases for monetary recovery.[48] Abuse, in the case of a vendor, is "a pattern of practices that are inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the programs."[49] Abuse includes: "submitting repeated claims . . . from which required information is missing or incorrect," "submitting repeated claims . . . that overstate the level or amount of health service provided," and "repeatedly failing to comply with the requirements of the provider agreement."[50] Claim or payment errors committed by the vendor or the Department need not be intentional in order to result in recovery of improperly paid funds.[51]

Here, the fraud committed by the PCAs and their recipients resulted in erroneous claims submitted to the Department by Respondent. This is sufficient for monetary recovery. The bad claims are also properly considered abuse – and likewise eligible for recovery – because they were based on incorrect information (dates and times services were not actually provided), overstated the amount of health service provided (hours of claimed service were impossible because the PCAs were documented being at other jobs at the same time they claimed to be providing services to Respondent's client care recipients), and failure to comply with the provider agreement (by not ensuring the claims were accurate). No matter the cause of the bad claims, Respondent had a duty to ensure the claims were accurate. The Department can recover the money paid for services which did not go toward services for recipients as claimed.

Respondent argues that the Department can only seek recovery from the PCAs or recipients who committed the fraud. Minn. R. 9505.2215 specifically requires the Commissioner to seek monetary recovery from a vendor or recipient if the payment to the vendor was the result of fraud, theft, abuse, or error on the part of the vendor or recipient, or Department or local agency.[52] Respondent's argument has some basis in law, but the

[46] Minn. R. 9505.2175, subp. 1.
[47] *Id.* at subp. 2.
[48] Minn. Stat. § 256B.064, subd. 1c (2022).
[49] Minn. R. 9505.2165, subp. 2(A) (2021).
[50] Minn. R. 9505.2165, subp. 2(A)(1), (2), (18).
[51] Minn. Stat. § 256B.064, subd. 1c(a).
[52] Minn. R. 9505.2215, subp. 1.

applicable regulations and Minn. Stat. §§ 256B.001 – 256B.851 (2022) must be read together.[53] In light of the Commissioner's broad authority when looking at the statute and rules together, the requirement is Minn. R. 9505.2215, subp. 1 that the Commissioner "shall seek monetary recovery" from certain parties does not limit the Commissioner's authority in the present case. Respondent has an obligation to ensure abuse and errors with regard to claims do not occur in order to obtain payments from MHCP.[54] It does not follow that there are no repercussions for failing in that obligation. Respondent not only received the funds from the Department for the fraudulent claims, but Respondent also kept a portion of those funds. Respondent's responsibility as a fiscal agent goes further than simply being a pass-through organization. It must ensure the funds are appropriately used.

Respondent also argues that it cannot act as an insurer for the Department by being the source of monetary recovery for the fraud of others. This argument is unpersuasive. The statute requires Respondent to carry fidelity and surety bonds to protect it (and the MHCP) from problems arising from dishonest employees and the liabilities resulting from the actions of others.[55] Thus, any recovery sought by the Department for the fraud committed by the PCAs and care recipients is required to be covered by properly purchased insurance.[56] The risk Respondent speaks of was accounted for by the legislature and is not a persuasive reason to interpret the regulatory scheme in the manner argued by Respondent and contrary to its plain meaning.

V. Conclusion

Respondent, a fiscal agent, is a provider of medical care under the MHCP. As a provider of medical care who erroneously submitted claims for reimbursement which were based on the fraud of Respondent's associated PCAs and care recipients, the Commissioner may recover those funds from Respondent. As a result, the Judge respectfully recommends the Commissioner **GRANT** the Department's motion for summary disposition and **DENY** the Respondent's motion.

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J. R. M.

[53] Minn. R. 9505.2160, subp. 1.
[54] Minn. Stat. § 256B.0659, subds. 19(c), 20, 24.
[55] *Id.*, subd. 21(a)(2), (3).
[56] Facts concerning this insurance were not presented by the parties. Such facts are irrelevant for this analysis.