

*This opinion is nonprecedential except as provided by
Minn. R. Civ. App. P. 136.01, subd. 1(c).*

**STATE OF MINNESOTA
IN COURT OF APPEALS
A20-0904**

In the Matter of the SIRS Appeal by 1 Best Care, Inc. and 1 Network Care, Inc.

**Filed April 5, 2021
Affirmed
Reilly, Judge**

Department of Human Services
File No. 36056

Steven Coon, Law Offices of Steven Coon, Minneapolis, Minnesota (for relators 1 Best Care, Inc. and 1 Network Care, Inc.)

Keith Ellison, Attorney General, Zuri Balmakund, Assistant Attorney General, St. Paul, Minnesota (for respondent Minnesota Department of Human Services)

Considered and decided by Reilly, Presiding Judge; Florey, Judge; and Frisch, Judge.

NONPRECEDENTIAL OPINION

REILLY, Judge

In this administrative appeal, relators—providers of personal-care-assistance services in the Minnesota Health Care Programs—challenge the final decision of the Commissioner of Human Services ordering recovery of a more than \$600,000 overpayment and suspending relators’ participation in the program for one year. Relators argue that (1) the commissioner erred by determining that relators committed abuse under department rules, (2) the commissioner’s determination that relators are responsible for an overpayment is not supported by substantial evidence, and (3) the commissioner arbitrarily

or capriciously suspended one relator based on its connection with the other relator. We affirm.

FACTS

Relators 1 Best Care Inc. (Best Care) and 1 Network Care Inc. (Network Care) participate in the Minnesota Health Care Programs, which provide health-care services to individuals. Relators are part of the Personal Care Assistance (PCA) program, through which the Minnesota Department of Human Services (the department) funds entities known as PCA provider agencies, which in turn provide services to recipients to assist them with various daily living activities. *See* Minn. Stat. § 256B.0659, subds. 1(l), 2 (2020). Best Care and Network Care are PCA provider agencies, and are considered “vendors” subject to department regulations. *See* Minn. R. 9505.2165, subp. 16a (2019) (stating that a “vendor” includes a PCA provider). The same person owns the two agencies.

The department’s Surveillance and Integrity Review Section (SIRS) received multiple complaints about Best Care and began investigating it. On October 10, 2016, SIRS notified Best Care that it would conduct an onsite review of Best Care’s records the next day, October 11, 2016. During the scheduled onsite review, Best Care was unable to provide most of the requested documents. The missing and deficient records included care plans and timesheets for the recipients of PCA services. Because Best Care failed to produce the necessary records when requested, SIRS began withholding payments to Best Care and sent a notice of termination of Best Care’s participation in the program.

Best Care appealed the termination decision. It also requested an extension to submit evidence to explain why payments should not be withheld, which the department

granted until November 30, 2016. Best Care submitted several documents to the department on separate dates, although some documents were received after the November 30, 2016 deadline. The records that Best Care submitted included some documents relating to Network Care instead. After receiving these documents, SIRS sent Best Care a notice withdrawing the notice of termination but continuing to withhold payments to Best Care.

SIRS soon discovered that the department was reimbursing Best Care for claims submitted after the October 12, 2016 payment withhold had been put in place. As a result, SIRS conducted a second onsite visit to Best Care on August 29, 2017. As with the first onsite visit, Best Care was unable to provide many of the requested documents. The owner told investigators that, if records were not onsite, then they were located at a different address that he owned. The investigators, though, explained that all records needed to be obtained that day for consideration during the review.

In December 2018, the department sent Best Care a notice of termination, overpayment, and withholding of payments. The notice informed Best Care that the department was seeking to recover an overpayment in the amount of \$608,587.38 for services from January 1, 2014, to October 11, 2016. The overpayment stemmed from multiple issues discovered during the two onsite inspections, including the lack of timesheets and care plans, missing or incorrect information on documents, altered timesheets, claims submitted before signature, and timesheets signed before the end of services. The notice also informed Best Care that the department was terminating Best

Care's participation in the Minnesota Health Care Programs, based on the determination that Best Care's conduct constituted "abuse" under state regulations.

The department also sent Network Care a notice that the department was withholding payments and terminating Network Care's participation in the program. The notice explained that the same person owned Best Care and Network Care, and that the two provider agencies shared a Federal Employer Identification Number. Reasoning that the owner was "directly involved in [Network Care's] operations," the department determined that it was necessary to terminate Network Care's participation "to prevent further abuse." Best Care and Network Care appealed the department's decisions.

The matter came before the Office of Administrative Hearings, and an administrative-law judge (ALJ) conducted an evidentiary hearing in September 2019. The ALJ issued its findings of fact, conclusions of law, and recommendation in December 2019. The ALJ recommended approving recovery of the overpayment, reasoning that Best Care's actions constituted abuse and that it received improper payments as a result. The ALJ also recommended approving termination of Best Care's and Network Care's participation in the program. In an April 13, 2020 final order, the Minnesota Commissioner of Human Services adopted most of the ALJ's recommended findings of fact and conclusions of law. The commissioner agreed that Best Care committed abuse by failing to maintain and disclose health-service records, and that Best Care was responsible for a \$608,587.38 overpayment. But the commissioner did not believe that termination was necessary because the record did not show that Best Care's actions harmed the recipients of the PCA services. The commissioner instead imposed a one-year suspension on Best

Care and Network Care and required them to complete educational sessions that the department provided.

Relators appeal by certiorari from the commissioner's final decision.

DECISION

Relators challenge the commissioner's final decision, which ordered recovery of a \$608,587.38 overpayment to Best Care and suspended both Best Care and Network Care for one year. When reviewing an agency decision, we may affirm the decision or remand for further proceedings, or we may reverse or modify the decision if it is affected by an error of law, not supported by substantial evidence in the record, or arbitrary or capricious. Minn. Stat. § 14.69 (2020). Relators have the burden of proof when challenging an agency decision. *In re Excelsior Energy, Inc.*, 782 N.W.2d 282, 289 (Minn. App. 2010).

Relators raise three arguments on appeal: (1) that the commissioner erred by determining that Best Care's conduct in keeping noncompliant care plans constituted "abuse" under department regulations; (2) that the commissioner's decision to order recovery of the overpayment is not supported by substantial evidence; and (3) that the commissioner's suspension of Network Care based on its common ownership with Best Care was arbitrary or capricious. We examine each argument in turn.

I. The commissioner did not err by determining that Best Care's failure to maintain statutorily compliant care plans constituted "abuse" allowing the department to recover an overpayment.

Relators first argue that the district court erred by determining that Best Care committed abuse. The commissioner's overpayment decision was based in part on the determination that Best Care's PCA care plans and timesheets did not comply with

statutory requirements. Relators argue that these deficiencies do not constitute “abuse” under the department’s regulations and that the department therefore could not rely on this basis to order the overpayment recovery.¹ We agree with the commissioner that Best Care committed abuse by failing to maintain statutorily compliant care plans.

This issue involves the interplay of Minnesota statutes and department rules. The interpretation of statutes and administrative regulations are questions of law, which we review de novo. *J.D. Donovan, Inc. v. Minn. Dep’t of Transp.*, 878 N.W.2d 1, 4-5 (Minn. 2016). Although we generally defer to an agency’s interpretation of its own rules when the language is ambiguous, we need not give any deference when the language is unambiguous. *St. Otto’s Home v. Minn. Dep’t of Human Servs.*, 437 N.W.2d 35, 40 (Minn. 1989). We conclude that the language of the rules at issue is unambiguous.

The commissioner must seek monetary recovery from a vendor of PCA services when the payment “was the result of fraud, theft, abuse, or error on the part of the vendor.” Minn. R. 9505.2215, subp. 1(A) (2019). “Abuse,” in the case of 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 programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service.” Minn. R. 9505.2165, subp. 2(A) (2019). The rule lists many practices that are considered abuse. *See id.*, subp. 2(A)(1)-(22). Relators’ argument

¹ Relators do not dispute the commissioner’s factual findings about the contents of Best Care’s records and argue only that their deficient care plans do not satisfy the definition of “abuse.”

connects to the commissioner's finding that Best Care committed abuse under subpart 2(A)(7): "failing to develop and maintain health service records as required under part 9505.2175." The referenced provision requires vendors to keep health-service records and lists the information that must be included in each record. Minn. R. 9505.2175, subp. 2 (2019). The required information includes recipients' care plans. *Id.*, subp. 2(G). The rule does not specify what information must be included in the care plans.

Relators argue that Best Care did not commit "abuse" under subpart 2(A)(7) because its care plans met the minimum requirements under rule 9505.2175, which does not require the information that was missing from Best Care's care plans. Rather, relators note, the commissioner's finding of abuse rested on Best Care's failure to include information in the care plans that was required by a separate *statutory* provision. Under that statute, a PCA care plan must include various information pursuant to statute, including the start and end date of the plan, the recipient's demographic information, emergency information, contact information, a description of the recipient's individualized needs, and dated signatures. Minn. Stat. § 256B.0659, subd. 7 (2020). The commissioner, reading the statute and the rule together, determined that Best Care's failure to include some of the statutorily required information in the care plans showed a failure to maintain health-service records under rule 9505.2165, subpart 2(A)(7). Relators maintain that the commissioner's interpretation improperly expanded the definition of "abuse," while the department argues that the commissioner appropriately read the statute and the rule in conjunction.

We agree with the commissioner’s interpretation. The department rules mandate that they be read together with relevant statutory provisions. See Minn. R. 9505.2160, subp. 1 (2019) (“Parts 9505.2160 to 9505.2245 must be read in conjunction with . . . Minnesota Statutes, chapter[] . . . 256B . . .”). This follows the general principle that courts interpret a statute “to give effect to all of its provisions” and consider its “placement and purpose in the statutory scheme.” *In re Schmalz*, 945 N.W.2d 46, 50 (Minn. 2020) (quotations omitted). Here, we conclude that the statute and the rule must be read together to give full effect to the provisions in both. Rule 9505.2175 lays out the required information that vendors must include in their health-service records. This provision refers to what a care plan is, but does not specify what information must be included in the care plans. Minn. R. 9505.2175, subp. 2(G). The required information for care plans is instead found in the statute, Minn. Stat. § 256B.0659, subd. 7. When reading the rule to incorporate the requirements of the statute, the provisions unambiguously provide that a vendor’s failure to include the statutorily required information in the care plans constitutes a failure to develop and maintain health-service records under the rules.

We also note that this interpretation adheres to the rules’ broad definition of abuse as “a pattern of practices that are inconsistent with sound fiscal, business, or health service practices.” Minn. R. 9505.2165, subp. 2(A). Best Care’s practice of maintaining care plans missing statutorily required information—including start and end dates for the plans, complete demographic information, emergency numbers, and contact information—goes against sound business and health-service practices. Moreover, if we were to disregard the statutory requirements, as relators urge, then the department would be unable to sanction

provider agencies for failing to include statutorily required information in their care plans. This result would contradict the overall purpose of the statutory scheme and the rules. Instead, the statutes and the rules are best furthered by reading them together to mean that failure to comply with the statute constitutes abuse under the rule.

Relators also argue that, even if the failure to comply with the requirements under Minn. Stat. § 256B.0659, subd. 7, could constitute abuse, the commissioner's decision was erroneous because not all of Best Care's care plans are covered by that statutory provision. Relators maintain that subdivision 7 governs only traditional PCA programs, while some of Best Care's services were PCA choice programs, which are governed by a separate statutory provision, Minn. Stat. § 256B.0659, subd. 19 (2020). Because the record did not reveal which recipients were in PCA choice programs, relators argue that we should either reverse the commissioner's order or remand for more findings on the issue of the PCA choice recipients.

We disagree with relators' argument, based on a plain-language reading of the statute. The statute does impose some requirements specific to PCA choice programs. Minn. Stat. § 256B.0659, subsd. 18-19 (2020). But "[u]nless otherwise provided in this section, all other statutory and regulatory provisions relating to personal care assistance services apply to a recipient using the personal care assistance choice option." *Id.*, subd. 18(a). It is true, as relators note, that the recipient or responsible party, rather than the vendor, is responsible for developing the care plans in the PCA choice program. *Id.*, subd. 19(a)(2). But regardless of which parties create the care plans, subdivision 19 does not specify any more information that must be included in the care plans. Because the

statute does not require different information for PCA choice care plans, then those types of care plans must include the required information under subdivision 7. In other words, PCA choice care plans are bound by the same requirements as traditional care plans. The distinctions between traditional PCA recipients and PCA choice recipients are not relevant here.

For these reasons, the commissioner did not err by determining that Best Care's failure to include information in the care plans as required by Minn. Stat. § 256B.0659, subd. 7, showed a failure to develop and maintain health-service records under rule 9505.2175. The commissioner correctly concluded that Best Care's practices constituted abuse under rule 9505.2165, subp. 2(A)(7), thereby allowing the department to recover an overpayment.

II. The commissioner did not err by ordering recovery of an overpayment based on Best Care's failure to make its records available to the department.

Relators next argue that there was not substantial evidence in the record to support the commissioner's determination that Best Care was responsible for a \$608,587.38 overpayment. The overpayment decision rested on the determination that the department had a right to recover the full amount of funds that it paid to Best Care during the time that Best Care committed abuse. Besides finding abuse based on Best Care's deficient care plans (as discussed in the previous section), the commissioner concluded that Best Care committed abuse by failing to make its care plans and timesheets available to the

department upon request. Relators argue that this determination is not supported by substantial evidence. We are not persuaded.²

We will sustain the commissioner's factual findings unless they are not supported by substantial evidence in the record. See Minn. Stat. § 14.69(e); *Excelsior Energy*, 782 N.W.2d at 290. The substantial-evidence test "requires such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Excelsior Energy*, 782 N.W.2d at 290 (quotation omitted). We defer to an agency's conclusions on the inferences to be drawn from the evidence. *In re Excess Surplus Status of Blue Cross & Blue Shield of Minn.*, 624 N.W.2d 264, 278 (Minn. 2001).

Relators challenge the district court's determination that Best Care committed abuse by failing to make all its care plans and timesheets available to the department. Department rules require vendors to provide the department with access to health-service records:

A vendor shall grant the department access during the department's normal business hours to examine health service and financial records related to a health service billed to a program. A vendor shall make its records available at the vendor's place of business on the day for which access was requested, unless the vendor and the department both agree that the records will be viewed at another location.

Minn. R. 9505.2185, subp. 2 (2019). The department must provide the vendor at least 24 hours' notice before seeking access to the records. *Id.* The failure to comply with this

² The department argues that relators forfeited this argument because they failed to order a transcript of the evidentiary hearing, meaning that only a limited portion of the record is available for this court's review. Because we conclude that, even without the transcript, there is substantial evidence in the record to support the commissioner's determination, we need not consider the department's alternative argument.

provision is listed as a practice found to be abuse—“failing to disclose or make available to the department the recipient’s health service records or the vendor’s financial records as required by part 9505.2185.” Minn. R. 9505.2165, subp. 2(A)(9).

Here, substantial evidence in the record supports the commissioner’s finding that Best Care violated this rule. Relators do not dispute the facts. SIRS conducted its first onsite inspection of Best Care on October 11, 2016, after providing notice the day before. The investigator noted that Best Care “was unable to produce the majority of the requested documentation” and that there were “no care plans or supervisory notes in the recipient or PCA files.” SIRS allowed Best Care to submit additional records after the onsite inspection. Best Care submitted some records after the agreed-upon November 30, 2016 deadline, and many documents were still missing or deficient. During a second onsite inspection on August 29, 2017, SIRS investigators encountered the same problems, as Best Care was unable to provide many of the requested documents. Best Care’s failure to make the required documents available to investigators during the two onsite inspections shows that it did not comply with rule 9505.2185.

Relators acknowledge that Best Care failed to comply with the rule but insist that it was unreasonable for the commissioner to order recovery of an overpayment. They highlight that Best Care eventually provided the department with most of the records in the months after the October 2016 inspection and that it provided “the majority of the records” at the August 2017 inspection. The flaw in relators’ argument is that the rule requires the vendor to provide *immediate* access to all records “during” the inspection. Minn. R. 9505.2185, subp. 2. There is no provision for substantial compliance. The statute

requires vendors to keep the necessary documents in either the provider agency's file or at the recipient's home address. Minn. Stat. § 256.0659, subd. 28(a) (2020). For this reason, Best Care's alleged practice of keeping some documents at another office does not excuse the failure to produce the documents during the inspections. Although SIRS granted Best Care an extension to produce the documents after the first inspection, it was not legally obligated to do so. And even with the extension, Best Care failed to submit some of the documents. Whether based on the failure to provide requested documents timely, or to provide them altogether, there is substantial evidence in the record to show that Best Care failed to disclose its records as required by the rule.

While the commissioner's ordering the recovery of such a large overpayment on this basis may seem harsh, Best Care's failure to make its records available to the department fell within the definition of abuse, for which the commissioner could order monetary recovery. See Minn. R. 9505.2215, subp. 1(A). The commissioner did not err by ordering recovery of the \$608,587.38 overpayment.

III. The commissioner's suspension of Network Care was not arbitrary or capricious.

Finally, relators challenge the commissioner's imposition of a one-year suspension to Network Care in addition to Best Care. Although the department's investigations related only to Best Care, it sought to sanction Network Care as well. The commissioner did not provide specific reasoning in relation to suspending Network Care; the only mention of Network Care is in one of the ALJ's findings, which says that because Network Care "is also under [Best Care's owner's] control, it has been implicated in the Department's

sanctions arising from the violations attributed to [Best Care], even though its services to its recipients were not specifically investigated.” Relators argue that this decision was arbitrary or capricious because the commissioner’s order included few findings relating to Network Care specifically and because Network Care could not be sanctioned based solely on its common ownership with Best Care. We reject relators’ argument for two reasons.

First, as the department notes, relators did not raise this argument before either the ALJ or the commissioner. We rarely address issues not raised and considered below. *Thiele v. Stich*, 425 N.W.2d 580, 582 (Minn. 1988). At oral argument, Best Care maintained that it raised the issue below because it asked the ALJ and the commissioner not to terminate or suspend either Best Care or Network Care. But a party cannot raise “the same general issue litigated below but under a different theory.” *Id.* Before the ALJ and the commissioner, relators argued generally against the department’s sanctioning of Network Care, but they did not raise the specific argument that they do here—that it was improper to sanction Network Care based on its common ownership with Best Care. Because relators failed to make this argument before the commissioner, they cannot raise it for the first time here.

Second, even if we address relators’ argument on the merits, we conclude that the commissioner’s decision to suspend Network Care was not arbitrary or capricious. An agency’s decision is arbitrary or capricious if the decision “represents the will of the agency and not its judgment.” *Excelsior Energy*, 782 N.W.2d at 290. Its conclusions are not arbitrary or capricious, however, if there is a “rational connection between the facts found and the choice made.” *Blue Cross & Blue Shield*, 624 N.W.2d at 277.

Relators argue that the ownership of Best Care and Network Care by the same person does not show that Network Care committed abuse based on Best Care's conduct. We are inclined to agree, in general, that a provider agency should not be sanctioned just because of its connection to a different provider agency that has committed abuse. But here, the record shows that the similarities between Best Care and Network Care went beyond common ownership. Best Care and Network Care have the same listed address, and they share a Federal Employer Identification Number, showing that they are treated the same for tax purposes. In fact, when the department asked for records for recipients under Best Care following the first onsite inspection, some of the documents the owner provided were for recipients under Network Care. This evidence showing a similar structure and operations between Best Care and Network Care suggests that the owner essentially treated the two provider agencies as the same entity. *Cf. Johns v. Harborage I, Ltd.*, 585 N.W.2d 853, 858 (Minn. App. 1998) (holding that two entities could be treated as the same for purposes of a Title VII discrimination claim based on interrelated operations, common management, centralized control of labor relations, and common ownership or control over finances). The commissioner therefore did not act arbitrarily or capriciously in determining that it was necessary to sanction Network Care in order to address the abuse committed by Best Care.

Affirmed.