BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	
ALASKA FAMILY HOSPICES, INC.	)	OAH No. 08-0626-DHS
	)	

DECISION

I. Introduction

A. Summary

This is a recoupment case for alleged overcharges to the Medicaid program. The Department of Health and Social Services, Division of Health Care Services (Division) contends that it was billed for, and paid, a higher lodging rate for patients and escorts staying at Alaska Family Hospices (AFH) than AFH was charging ordinary customers. It now seeks to recover the difference.

The case relates to payments made during an "audit period" that spans from September 2, 1997 through September 30, 2000. Its progress toward final resolution has been delayed by a variety of factors, including agency delay in completing the initial audit, delays attendant to a court appeal, and agreed delays to permit the parties to pursue a negotiated solution. Despite the age of the claims, no timeliness defense has been established.

This case went to a formal administrative hearing in November of 2010. The Division showed that Medicaid was generally billed $79 per night for lodging, whereas virtually all non-Medicaid customers were billed at one of various lower rates, the highest of which was $70 per night. AFH then sought to show that the $70 rate and other lower rates fell within regulatory exceptions that made them inappropriate as baseline rates for comparison to the Medicaid rate. AFH did not make a persuasive case regarding these exceptions.

The Division asserted that the net overcharge from the discriminatory rate structure was $164,517.22. This figure was primarily a result of the overcharge of nine or more dollars per night spread across many thousands of nights. There were, however, a few small adjustments in AFH's favor for a handful of occasions on which the audit showed that AFH had mistakenly charged too little. These were supported by testimony at the hearing. More problematically, the Division's figure also included adjustments for alleged double billings and errors in the number of nights charged, on which the Division presented no evidence at the hearing. It has been

necessary to back these adjustments out of the Division's overall calculation, leaving a net overcharge attributable to the differential rate structure of $156,769.82. This is the amount of the recoupment claim that can be sustained.

B. Procedural Status

This case grows out of an audit completed August 9, 2005. The audit reviewed just under $800,000 in payments to AFH over a three-year period, and identified $362,410.54 in alleged overcharges.[1] The Division initiated a recoupment proceeding for that sum on March 8, 2006.[2] AFH timely requested a hearing.[3] The Department of Health and Social Services (DHSS) denied the hearing, leading to a court appeal and, in 2008, to reversal and remand so that the hearing could be conducted.[4] The case was first referred to the Office of Administrative Hearings following the remand.

The present case is not an audit appeal under 7 AAC 160.110 – 130 or the predecessors of those regulations at 7 AAC 43.1440 – 1490, because both the charges and the audit predate the effective date of those regulations. It has followed two other regulatory paths. When it initiated recoupment proceedings in 2006, the Division sought to impose an array of sanctions in addition to direct recoupment of the overpayments, and it relied on its sanction authority under former 7 AAC 43.960.[5] On remand, the Division has limited its case to a simple recoupment proceeding under former 7 AAC 43.081.[6] Moreover, the Division made an election at the hearing to offer proof on only one of the five types of overcharge alleged in the audit. This reduced the Division's total claim to $164,517.22.[7]

The evidentiary hearing provided in this case was a full evidentiary hearing to determine whether the alleged overcharges had occurred. No facts were deemed to have been established by the original audit, nor was any deference accorded to that audit; in other words, this was a *de novo* hearing.[8] The statutes and regulations do not provide for, and this was not, a hearing to

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1 Div. Ex. 1 at 7-33.

2 *Id.* at 1-6.

3 Div. Ex. 2 at 4.

4 Div. Ex. 2.

5 The regulation relied on the Division's sanction claim appeared in Register 139 of the Alaska Administrative Code.

6 This regulation appeared in Register 146 of the Alaska Administrative Code.

7 The Division reports that a portion of this amount has already been withheld under former 7 AAC 43.081(b), with the balance outstanding. Because AFH is no longer in business, prospects for recovering the balance are poor. This explains the decision to forego pursuing a larger award.

8 There has been some uncertainty within DHSS about the scope of hearings arising out of Medicaid audits. In the present case, no ruling on the scope of such hearings was necessary because the parties agreed that in the circumstances a full evidentiary hearing was appropriate. In accepting this approach in this case, the Division's

evaluate whether the Division conducted the original audit correctly or whether AFH has been treated correctly at each stage of its history. Instead, the purpose of this proceeding has been to reach a final agency decision on whether an overcharge occurred and on the amount of any recoupment due.

C. Evidence Received

In this case, there were two abortive motions for summary adjudication in which both sides submitted voluminous sets of exhibits designated by numbers. By agreement, these became the core exhibit sets for the hearing, with each side then continuing its numerical series as it offered new exhibits at the hearing. The documents, whenever submitted, were admitted as follows:

Item	Disposition
All affidavits previously submitted with motions	Admitted by agreement as direct testimony
Division Exhibits 1 – 17 (summary adjudication exhibits)	Admitted by agreement without restriction
AFH Exhibits 1 – 20 (summary adjudication exhibits)	Admitted by agreement without restriction
Division Exhibits 18 – 22	Admitted without objection
AFH Exhibit 21	Only chapter 2 of this 5-chapter video was offered. Chapter 2 was admitted over objection solely to show: (i) AFH's position regarding what was on the walls of the facility; (ii) AFH's view of how check-in was conducted; (iii) how AFH promoted its business
AFH Exhibits 22 – 23	Admitted without objection
AFH Exhibit 24 – 25	Excluded (relevance)

position was in keeping with the holding in *Hidden Heights Assisted Living, Inc. v. DHSS*, Case No. 3AN-05-11125 CI (Alaska Superior Court 2008, Rindner, J.), Memorandum of Decision at 27 [Div. Ex. 5].

AFH Exhibit 26	Admitted over objection as illustration of type of guidelines contained in Federal Register, although not applicable to audit period
AFH Exhibit 27	Admitted over objection as illustration that there have been different rates, although not applicable to audit period
AFH Exhibits 28 – 29	Admitted over objection for limited purpose of showing that the auditor was not thinking of 7 AAC 43.040 exceptions

At the hearing, the Division provided a day of testimony from Douglas Jones, the manager of the Program Integrity Section, who was qualified as an expert in Medicaid audits. Seven additional days of hearing time had been set aside, and AFH had the opportunity to present any witnesses it desired, although it did not ultimately use more than a small percentage of the allotted time. AFH offered the testimony of James Sinnett, its general manager (Mr. Sinnett's direct testimony was offered by affidavit, but he submitted to live cross-examination); of economist Anthony Nakazawa; of AFH employees Theresa Moore and Nicole Sinnett; of Department of Health and Social Services employees Cindy Christensen and Terry Hamm; and of Department of Law investigator Rebecca Starry.

II. Regulatory Framework

When Medicaid-eligible patients who live in outlying locations travel to Anchorage for medical treatment, they are often required to stay overnight. When that happens, they can be approved to receive covered lodging with providers such as AFH. Housing may also be provided to an eligible escort who travels with the patient. The provider of these services then seeks payment from Medicaid.

During most of the audit period, the allowable rates for these services were regulated by the Division under 7 AAC 43.040, the pertinent parts of which then read:

> (a) . . . A provider may not charge
>
> . . .
>
> (2) a higher rate for any unit of service provided to a Medicaid recipient than the provider charges others, except for Medicare.
>
> (b) Except as provided in (c) of this section, the department will pay an enrolled provider for a service at the lowest of the

(1) billed charges;

(2) rate identified in the fee schedule established [under this chapter], as applicable for the particular provider type or service; or

(3) provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment; the provider's lowest charge includes any discounted price offered to any other purchaser of services, but does not include

(A) any single contract that contains a discounted rate for a service or group of services and the contract does not exceed 20 percent of a provider's annual gross income;

(B) a reduce rate for a service or group of services the provider offers to the provider's employees . . . ; or

(C) a contract with a federal or state agency.

(c) If a provider establishes in writing a sliding fee scale that is based upon income for families and individuals with income equal to or less that 250 percent of the applicable federal poverty guidelines for this state, the division will not consider the fees applicable to those families or individuals in determining the provider's lowest charge per service under (b)(3) of this section.

(d) For purposes of this section, "federal poverty guidelines for this state" refers to the poverty guidelines for Alaska established by the United States Department of Health and Human Services . . . .

To paraphrase this regulation, a provider may not charge a higher rate for a Medicaid recipient than its lowest rate for others.[9] In determining a provider's lowest rate to others, charges under a sliding scale based upon income are not considered, as long as the sliding-scale rate meets various standards and is established in advance and in writing.[10] Likewise excluded are billings for charges to the provider's own employees or state or federal agencies, and certain other discounted contracts.[11]

For approximately the first nine months of the audit period—until June 26, 1998—the regulation read as above except that (b)(3) was stylistically slightly different and, more importantly, had a period after "purchaser of services," with the three exceptions in subparagraphs (A), (B), and (C) of that paragraph entirely absent.[12] Thus the regulation was less

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9 Former 7 AAC 43.040(a), (b).

10 Former 7 AAC 43.040(c).

11 Former 7 AAC 43.040(b)(3).

12 Until then, paragraph (b)(3) read, in its entirety:

favorable to providers during those months: the only rates excluded from comparison were rates under a sliding scale.

During the audit period, a department regulation authorized the recovery of overpayments to providers through a simple recoupment process.[13] Among the types of payments defined as "overpayments" were "when the division reimburses a provider . . . in an amount that exceeds the maximum dollars . . . allowed under this chapter."[14]

In seeking recoupment, it is the Division's responsibility to prove the basic elements of an overcharge—in this case, that Medicaid has been charged "a higher rate for any unit of service provided to a Medicaid recipient than the provider charges others." This means the Division must prove the actual amount it paid for each Medicaid recipient at issue, and must prove that others were charged a lower rate for the same service.[15] In the present case, AFH does not question the rate paid by the Medicaid program, but it contends that the rate was for a different service from that provided to the clients who were charged lower rates.

AFH also contends that the lower rates charged to others fell under the exceptions in subparagraph (b)(3)(A) and subsection (c) of the regulation—the exceptions for certain contract rates and for low-income rates charged under a sliding scale. The existence and use of a sliding scale or qualifying contract that excuses certain billings from consideration is, in effect, an "avoidance" or affirmative defense, on which AFH has the burden of proof.[16] Note also that one

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> (3) provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment, including any discounted price offered to any other purchaser of services.

Alaska Administrative Code, Register 141 (1997). The parties seem to have overlooked this evolution of the regulation and did not make any arguments based on the language changes.

[13] Former 7 AAC 43.081 (Registers 144, 146). The regulation did not take effect until November 29, 1997, about three months into the audit period. Prior to that, recoupment may have had to be undertaken under common law principles or under another, more complex regulatory route such as former 7 AAC 43.955 - 960. In this case, the regulatory gap is immaterial because the two claims that fall in the first three months of the audit period, AFH133 and AFH292, have been resolved below, through Part III-F and Appendix A, to result in a net recoupment during that period of exactly zero (AFH133 is a $140 debit; AFH292 is a $140 credit).

[14] Former 7 AAC 43.081(a)(2).

[15] As noted in Part I-B, the present case is not an audit appeal under 7 AAC 160.110 – 130 or the predecessors of those regulations at 7 AAC 43.1440 – 1490.

[16] *See, e.g., Sloan v. Jefferson*, 758 P.2d 81, 83 ("The party asserting a fact generally bears the burden of proving that fact . . . This is particularly true when the party asserting a fact controls the evidence which bears on that fact."); *Palmer G. Lewis Co. v. ARCO Chemical Co.*, 904 P.2d 1221, 1232 (Alaska 1995) (allocating burden on item that would negate basic claim to defendant, who had best access to and familiarity with contrary evidence). Note that in this case the parties had equal access to AFH's records by the time of the hearing, but AFH had superior access to testimony from those administering its billing structure.

Although the burden of proof has been allocated according to these principles, the preponderance of the evidence is not so closely balanced in this case that allocation of the burden has determined the outcome. Even if the burden were allocated to the Division on all issues, the findings on the key issues of fact would be the same as those made later in this decision.

of these exceptions, the exception for contract rates under (b)(3)(A), did not exist until partway through the audit period.

III. Factual Issues

A. What Rate Was Charged to Medicaid?

The Division's Medicaid audit expert, Douglas Jones, established that during the audit period Medicaid was almost always billed $79 per night for a double room at AFH, and these bills were paid. The rate charged was slightly lower during the first few months of the audit period. On a handful of occasions, sometimes due to apparent bookkeeping errors, Medicaid was charged much lower rates, such as $7.11 per night.

Division Exhibit 7 records the actual amounts paid for the 796 Medicaid lodging transactions during the audit period. AFH's general manager broadly conceded on cross-examination that $79 was the usual rate charged to Medicaid, and AFH neither disputed nor offered contrary evidence regarding any of the individual payments recorded on Division Exhibit 7. The information on Division Exhibit 7 regarding payments to AFH and the nightly rates associated with those payments is adopted as a finding of fact. The total amount paid for the 796 transactions was $499,495.72.[17]

B. What Rate Was Charged to Others?

1. The $70 Rate and Associated Long-Term Rates

The Jones testimony likewise established that, through a sampling process that accords with standard auditing practice, one can discern a rate structure for non-Medicaid clients. In general, throughout the audit period, these clients were charged $70 per night for a double room. There were some variants from this rate. In the early part of the audit period, there was a lower charge for single occupancy. After July of 1998 there was a $50 rate associated with clients designated "low income." Throughout the period there were standard discounts for longer stays, such as a $420 weekly rate used from July of 1998 to November of 1999 and a $50 nightly rate used for stays over six days in ensuing periods. This rate structure is set out in detail in Division Exhibit 8.

This rate structure is generally corroborated by Division Exhibit 18, an AFH brochure quoting "Lodging Rates Effective Until September 15, 2000. For the rental of a private bedroom, single or double occupancy, the brochure lists rates of $70 per night, with lower rates

[17] Div. Ex. 7 at 38.

of $50 per night for weekly stays and $40 per night for monthly stays. It lists special rates as follows: $50 per night for those who are "Low Income Eligible" but ineligible for Medicaid; $35 per night for health care professionals, and $25 per night for students. The structure is also corroborated by the individual invoices offered at the hearing. For example, Division Exhibit 21 shows that a non-Medicaid individual referred by Lutheran Social Services was given a "Low-Income Discount" and charged $50 per night in August of 1998. Pages 4 and 5 of Division Exhibit 17 show two "self-pay" individuals charged $70 per night in April of 2000. Page 17 of the same exhibit shows another such individual charged $70 per night in July of 1999.[18]

AFH, although it had full access to the billing records, did not offer a single example of a non-Medicaid invoice at a rate higher than $70 per night. The company's general manager attempted to elicit testimony from an employee that AFH had charged the president of Bristol Bay Native Association a rate of $79, but the employee could not recall the rate charged and she noted that, in any event, this customer usually took an entire apartment, which is not comparable to the individual rooms in shared apartments that were rented to Medicaid customers.[19] The failure of this effort to provide even a single example of a non-Medicaid rate of $79, much less a generally-applied rate at that level, further confirmed that non-Medicaid customers were billed under a lower rate structure than was used for Medicaid customers.

It is more likely than not, therefore, that non-Medicaid clients were always or almost always charged according to the rate structure set out in Division Exhibit 8. The rates under this structure did not exceed $70 per night, and an assortment of rates that were still lower were charged to people who stayed for long periods.

2. Were the $70 Rate and the Lower Long-Term Rates for a Different Service?

a. Comparable Rooms

Through questioning, AFH suggested that the lower rates may have been charged for different rooms than the ones used for Medicaid clients. Although AFH did not pursue this as an issue in its closing argument, it will be addressed briefly here.

The invoices used to bill the Medicaid program do not ordinarily allow one to tell which room was assigned to a particular client,[20] and so it generally is not possible to tell if exactly the

[18] As a further check, Mr. Jones "thumbed through" all non-Medicaid billings from the audit period and was unable to find a single one with a billing rate higher than $70 per night.

[19] Direct examination of Theresa Moore.

[20] Examples are collected at Div. Ex. 9 at 3-8.

same rooms were billed at both the Medicaid rate and at the lower rate offered to non-Medicaid clients. Nonetheless, some examples of direct overlap can be found. Room CC-1 was rented to a Medicaid customer at $79 per night in mid-January of 2000.[21] One week later, the same room was rented to a "self-pay" non-Medicaid customer at $70 per night.[22] Likewise in January of 2000, Room A-6 was rented to a Medicaid customer for $79 per night as a "Medicaid:Double Occupancy:Daily" rate.[23] That same month, AFH rented Room A-6 to a self-pay non-Medicaid customer for $50 per night as a "regular daily" rate.[24] Further, to the extent that different rooms may have been used for Medicaid and non-Medicaid customers, there is no evidence in the case that these rooms were different in quality. The evidence in the record makes it more likely than not that the $79 rate and the lower non-Medicaid rates set out in Division Exhibit 8, both for rooms in shared apartments, represent charges for comparable rooms.

b. Different Payment Terms

AFH also suggested during the hearing, but did not pursue in closing argument, a contention that the higher rates charged to Medicaid were not comparable to the lower ones charged to others because regular customers pay in advance, whereas Medicaid does not. Essentially, AFH appears to contend that part of a "service," as that term is used in former 7 AAC 43.040, is the payment terms under which that service is offered, so prepaid services are different services from services paid for upon billing.

This argument turns on interpretation of a word in a regulation. Principles of statutory interpretation carry over to the interpretation of regulations.[25] Statutes—and therefore regulations—are not to be interpreted in a way that leads to an absurd result.[26]

Under AFH's proposed reading of this regulation, 7 AAC 43.040 would be meaningless. The payment terms under which Medicaid pays for services are governed by a highly complex regulatory structure and are essentially unique. It would therefore be impossible to compare rates charged to Medicaid to rates charged to any other customer.

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21 *Id*. at 10. First Health Service Corp., to whom the invoice is addressed, administered Medicaid payments.

22 Div. Ex. 17 at 5.

23 Div. Ex. 15 at 2.

24 Div. Ex. 17 at 7.

25 *State Dep't of Highways v. Green,* 586 P.2d 595, 603 n.24 (Alaska 1978); *Wilson v. State, Dep't of Corrections*, 127 P.3d 826 (Alaska 2006).

26 *E.g., Martinez v. Cape Fox Corp.,* 113 P.3d 1226 (Alaska 2005) ("We will ignore the plain meaning of an enactment . . . where that meaning leads to absurd results or defeats the usefulness of the enactment.") (quoting prior authority).

It is much more reasonable to interpret "service" in 7 AAC 43.040 to mean simply the physical act, privilege, or function delivered to the eligible individual. A provider who wishes to participate in the Medicaid program must charge no more for those services than it charges to others, except pursuant to one of the exceptions listed in (b)(3) and (c) of the regulation. The listed exceptions do not include an exception for prepayment discounts.

C. Were the $70 Rate and the Lower Long-Term Rates Inapplicable Because of a Sliding Scale?

AFH's primary defense from the beginning of this matter has been a contention that the lower rates charged to non-Medicaid clients were charged pursuant to a "sliding scale" under former 7 AAC 43.040(c). To qualify under that regulation, a sliding scale had to be "establishe[d] in writing" and had to be applied "based upon income for families and individuals with income equal to or less that 250 percent of the applicable federal poverty guidelines for this state." The evidence AFH presented on this issue was extraordinarily unconvincing.

At the outset, one must note that AFH never produced a written sliding scale from among its records. AFH suggested that AFH Exhibit 21, a video taken when AFH was open, could show posted documentation of such a rate scale, but nothing that can be seen on that exhibit suggests the existence of such a scale or its use in setting rates for non-Medicaid customers.

Moreover, the record contains a number of billing statements to non-Medicaid clients that use the "regular" $70 rate and the associated long-term rates, but these never indicate that the rates are special low-income charges; nor are the statements accompanied by documentation of any inquiry into the person's income level.[27] Thus, there is no documentation to suggest that the rates the Division has used as comparable to the Medicaid rate were in fact rates charged pursuant to an established, written sliding scale for low-income clients.

In its closing argument, AFH faulted the Division because it did not interview the individuals who were charged lower rates than Medicaid. No statute or regulation requires that recoupment findings be based on interviews with particular clients. Moreover, the premise of this argument is that the Division must prove that each of these examples of lower rates was not offered pursuant to a sliding scale. Instead, it was AFH's responsibility to show, through contemporaneous documentation or other persuasive evidence, that these charges did fit within the sliding scale exception.

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[27] *See, e.g.*, Div. Ex. 15 at 3.

AFH's effort to meet this burden through testimony was disturbing. For example, AFH's front registration desk manager testified by affidavit earlier this year that AFH "provided a published and posted sliding-scale low-income rate."[28] When the manager testified live at the hearing, the company's CEO, James Sinnett, asked a series of highly leading questions, in response to which the desk manager testified that AFH inquired about income at the time of check-in and then charged on a sliding scale from $79 down to zero.[29]

This testimony did not stand up on cross-examination. The manager began the cross-examination by testifying that the sliding scale had "price on one column, and their income on another" and that "sometimes there were columns." Then she said the clients were asked "how much they make a year," but on further questioning backtracked to say that they were only asked if they were "low income." She said the maximum low-income rate was $50, in contrast to her earlier testimony that it went from $79 down to zero. When the cross-examination returned to the issue of a posted sliding scale, she responded as follows:

> Q. Did you ever refer to a sliding scale based on the recipient's income to determine what their room rate was?
>
> A. [long pause] [sharp intake of breath audible] Yes. We may not have it written it, we may not have written down.
>
> Q. Did you not testify in your affidavit, on page 7, that you published and posted a sliding scale income rate?
>
> A. Yes. [voice cracks, sounds crestfallen]
>
> Q. Yes you did? And that's your sworn testimony in the affidavit?
>
> A. Yes. [spoken slowly]
>
> Q. And you just testified under oath that you didn't have it written down?
>
> A. **I** didn't. [emphasizes "I"] They may, I mean--[30]

After this testimony, AFH abandoned the contention that the front desk personnel qualified the individuals as low income on arrival. On redirect examination, Mr. Sinnett asked a new series of leading questions, getting the manager to agree that she relied on the belief that the health providers who referred guests had "prequalified" the individuals as low income.[31]

Similarly, Mr. Sinnett used leading questions to elicit testimony from another employee, his daughter, that $50 per night was the middle rate on a low-income scale.[32] Yet Mr. Sinnett

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28 Affidavit of Theresa Moore at 7.
29 Direct exam of Theresa Moore.
30 Digital recording file 4 at 1:23:00ff.
31 *Id*. at 1:27:15ff.
32 Digital recording file 5 at 12:30.

himself had testified earlier in the hearing that $50 was the top rate of the low-income scale,[33] which would accord with the Division's finding that the $70 rate was not a low-income rate. Moreover, by affidavit, Mr. Sinnett had allowed his daughter to testify that AFH made the sliding scale available to "qualified non-Medicaid low-income healthcare clients."[34] At the hearing, the daughter could not even explain what this phrase meant.[35]

Insofar as a coherent story line survived these contradictions and reversals in the testimony, it was that AFH relied on rural health agencies who referred clients to determine if the clients were low income. AFH did not make any showing, however, that these agencies applied precise income criteria of the type referenced in the regulation, nor that they passed income information on to AFH so that it could fit the person into a sliding scale.

Reviewing the evidence as a whole, it is more likely true than not (1) that no written sliding scale existed, (2) that clients were not required to demonstrate any particular income level to be given the $70 rate and associated long-term rates, and (3) that the $70 rate and associated long-term rates were not charged according to a sliding scale.

D. Were the $70 Rate and the Lower Long-Term Rates Inapplicable Because They Were Contract Rates?

At the end of the hearing, AFH suggested that *every* lower rate charged to a non-Medicaid client would fit under the exception in former 7 AAC 43.040(b)(3)(A), which existed for the last three-quarters of the audit period and excluded from comparison:

> any single contract that contains a discounted rate for a service or group of services and the contract does not exceed 20 percent of a provider's annual gross income[.]

AFH's argument is that every sale of a night's lodging is, in a sense, a "contract" between the lodger and the provider, in which the provider agrees to supply a night's lodging in exchange for an agreed rental.[36]

As discussed in a previous section, regulations are not to be interpreted in a way that leads to an absurd result. Under AFH's proposed reading of this regulation, the exception would in most cases entirely swallow the rule laid down by 7 AAC 43.040. Rates charged to Medicaid could not be compared to rates charged to ordinary individuals because those charges would all

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[33] Digital recording file 3 at 1:31:20.

[34] Affidavit of Brandi Nicole Sinnett at 3.

[35] Cross-exam of Ms. Sinnnett.

[36] Notably, AFH did not advance this argument until the final day of the hearing in 2010; for many years prior to that, the company does not seem to have been under any illusion that 7 AAC 43.040(b)(3)(A) could effectively serve as a license to charge discriminatory rates to Medicaid because all lodging arrangements are "contracts."

be deemed to fall under single-stay "contracts" for lodging. This result would reduce the regulation to an absurdity. The word "contract" in the regulation plainly refers to discounted contracts with, for example, a health insurer that provide for a special rate to be charged for a particular service or group of services to a class of eligible members, subscribers, or clients. AFH does not contend that all of the non-Medicaid billings fell under such broad discount contracts.[37]

E. Is the Recoupment Action Too Late?

A striking feature of this case is its age. The audit period began in 1997 and ended in 2000. The Division did not complete an audit of the period until August 2005, five to eight years after the charges at issue.[38] It initiated administrative proceedings to recoup the alleged overpayments on March 8, 2006.[39] Those proceedings and an associated court appeal have continued to the present.[40]

The first question is whether any statute of limitations applies to bar this case. The general statutes of limitation in Title 9 of the Alaska Statutes do not ordinarily apply to administrative proceedings.[41] There is one provision in the statutes applicable to Medicaid audits that does appear to impose a time limit in some respects: AS 47.05.200(b) provides that "[w]ithin 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments . . . and shall allocate the . . . necessary financial and human resources to ensure prompt recovery . . . ." The context and history of this provision, however, show it to be a direction pressing the agency to

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[37] AFH did suggest through questioning that *some* of the lower charges were applied in connection with a contract with Alaska Native Medical Center. AFH, which has the burden of proof to establish any defense under 7 AAC 43.040(b)(3)(A), never supplied a copy of the ANMC contract and never showed that it would have accounted for less than 20% of the company's gross income.

[38] Div. Ex. 2 at 3.

[39] *Id*.

[40] *Id*. at 6, 9. The Office of Administrative Hearings first became involved in the case upon remand from the Superior Court in late 2008. All delays since that time have been by agreement of the parties.

[41] Those statutes apply to "civil actions," which are civil cases in court, wheres the present proceeding is not a "civil action." *See, e.g., Smith v. State, Bd. of Dental Examiners*, 1984 WL 908389 (Alaska 1984) (court observed that "civil and criminal statutes of limitations are not applicable to license revocation proceedings"); *Nims v. Board of Registration*, 53 P.3d 52, 56 (Wash. App. 2002) (same*); In re C. V.*, OAH No. 04-0322-TAX (Order on Pending Dispositive Motions, 2007); *In re B.A.*, OAH No. 06-0829-PER (2007).

act vigorously, not a time limit intended to create a new defense for private parties.[42] The regulation that specifically provided for recoupment of overpayments during the audit period, former 7 AAC 43.081, likewise imposed no time limit.

Even where no statute or regulation imposes a time limit, a long delay in pursuing enforcement of a right can bar recovery on second basis, the equitable defense of laches. The person asserting laches—here, AFH—must prove two principal elements: unreasonable delay and resulting prejudice. These are evaluated on a sliding scale, such that the longer the delay, the "lesser degree of prejudice . . . required."[43] The public interest can also be weighed in evaluating laches. The public interest can sometimes help to tilt the balance for enforcement, such as where it is important to protect the public from fraudulent loss of its assets. On the other hand, there is a public interest in accurate results, and since long delays can greatly compromise the accuracy of the factfinding system, the public interest factor can tip the scales against enforcement.

In this case, AFH did not make a serious effort to bring out the facts that would be necessary to support a laches claim. In a case that fundamentally turns on documentation, it identified no documents that are unavailable for review in 2010. On the key issue of documentation of the low income status of clients receiving rates lower than those charged to Medicaid, AFH admitted that no such documents had ever been in its records.[44] AFH did not demonstrate that any witness with key knowledge is unavailable in 2010. The witnesses it did not show a fundamental lack of recall about AFH's billing structure; while some of their testimony was not credible, the lack of credibility stemmed primarily from a willingness to offer contradictory accounts fed to them by their former boss rather than from lack of recollection. Moreover, AFH did not explore the reasons for the delay in the recoupment action. The most

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[42] The 90-day provision itself reads like an exhortation to the department, and it was enacted in a short bill that also added language to the purpose clause of the Medicaid chapter, with all of the new language aimed enhancing cost containment. The main passage of the new purpose language reads:

> It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures . . . .

§ 4, ch 66 SLA 2003. *See also* Remarks of Sen. Green to Senate Judiciary Committee re SB 41, April 14, 2003; Remarks of Sen. Green to Senate Finance Committee re SB 41, April 15, 2003.

In the present case, the audit report was issued in late 2005 and the administrative proceedings appear to have been initiated a little beyond the 90-day target. AFH has not tried to rely on AS 47.05.200(b) as a defense, but because the firm has vaguely articulated a timeliness objection to recoupment, the potential defense has been reviewed here.

[43] *Pavlik v. State, Dep't of Commuity & Reg. Affairs*, 637 P.2d 1045, 1047-8 (Alaska 1981).

[44] Cross-exam of James Sinnett.

significant delay seems to have occurred because AFH's records were being reviewed for possible criminal prosecution,[45] but no questions were asked and no evidence was offered about the reasons, if any, for the slow progress of the criminal investigation.

Under these circumstances, a laches defense cannot be sustained.

F. What Was the Total Overcharge from the Excessive Rates?

The Division has proved that the Medicaid program was overcharged by the use of the $79 rate. It is necessary to assign a dollar figure to this single type of overcharge over the course of the audit period. At the hearing, the Division did not seek to prove, and did not prove, any other type of overcharge. Indeed, the Division expressly stated that it would not seek to recoup funds on the basis of any other type of overcharge.[46]

The Division's calculation to supply the necessary dollar figure is Division Exhibit 7. This exhibit shows a total overcharge of $164,517.22.

Regrettably, Exhibit 7 purports to make adjustments for a second type of overcharge, in addition to the use of an excessive rate: it adjusts for the charging of excessive numbers of nights on certain occasions. To give one example, line AFH05, found on the first page of Exhibit 7, reduces a 24-night billing to 23 nights on the premise that one of the nights was double-billed. There is no proof on the double-billing allegation—no foundational testimony, no underlying documentation. To give a second example, line AFH27 purports to reduce a 15-night stay to 13 nights because on two of the nights the same patient was in the hospital. There is, however, no proof in this case regarding charging for a room while the patient is in the hospital, nor any legal argument about whether such charges would be improper in all circumstances.

The reductions in number of nights play only a small role in the total overcharge figure yielded by Division Exhibit 7. Nonetheless, to be fair to AFH, these cannot be included in any recoupment amount.

To reach a figure for the single claim that has been proved, the ALJ has "backed out" the excessive nights adjustments, so as to generate a figure for overcharges solely based on an excessive nightly *rate*. This has required two main types of corrections.[47]

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[45] *See* Div. Ex. 2 at 2.

[46] This was presented as a tactical decision based on the belief that AFH does not have assets to satisfy a large recoupment obligation.

[47] Because this case has gone on too long, the ALJ elected not to remand it to the DHSS accountants to perform this task. If either party objects to the corrections, the AS 44.64.060 process provides a mechanism for doing so.

First, where the number of nights has been reduced by the auditor who prepared Division Exhibit 7, the number of nights has been restored to the number billed by AFH, and the figure in the column for "Nml & Cust Rate" has been adjusted where necessary to reflect the higher number of nights. The normal and customary rate used for this adjustment is the one given by Division Exhibit 8 for the applicable date span. To give an example, claim reference AFH04 entailed a billing by AFH for 22 nights. The auditor reduced the number of nights to 20, and using the rates in Exhibit 8 he calculated a normal and customary total bill of $1260, consisting of two full weeks at the weekly rate of $420 and six nights at the nightly rate of $70. When the number of nights is restored to 22, the normal and customary billing amount rises to $1330, consisting of three full weeks at the weekly rate of $420 and one additional night at the nightly rate of $70.

Note that, because of weekly and monthly rates, the higher number of individual nights does not lead to an upward adjustment to "Nml & Cust Rate" for every claim. When the number in the "Nml & Cust Rate" column does go up, there is a downward effect on the number in the "Overpmt" column. The overpayment column is simply the result of subtracting "Nml & Cust Rate" from the figure in the "Payment" column.

The second common adjustment has been a correction of a repetitive error in Division Exhibit 7. It is best illustrated by an example. For claim AFH49, the auditor noted that Medicaid paid $158 for two nights. He determined that the number of nights should be only one. He calculated the normal and customary billing for that number of nights as $70. This ought to have yielded a net overpayment of $158 (the amount actually paid) minus $70 (the amount the auditor thought should have been paid), or $88. What the auditor then seems to have done, inexplicably, was to go back and subtract $79 (the amount AFH billed for the night the auditor had disallowed) *from the "Overpmt" column*. He entered a total overpayment of only $9. In recalculating claims where the number of nights has been reduced by the auditor, the ALJ has not repeated this erroneous subtraction in the calculations.

To reach the right result, it is often necessary to make both types of corrections. For claim AFH49, the number of nights has to be restored to two. The normal and customary rate for two nights at that time would have been $140. AFH charged $158. Therefore, the overpayment is $18. In this particular example, the overpayment is actually a little higher than the figure the auditor entered on Exhibit 7, although it is much lower than what the auditor's entry would have been had he performed the calculation correctly.

In making these adjustments, it is occasionally necessary to apply a different rate, either because the altered number of nights places the rate in a different category or, more rarely, because the auditor applied the wrong rate to begin with.

Appendix A to this decision shows the line-by-line adjustments to Division Exhibit 7 necessary to remove the unproven "excessive nights" allegation. The total adjustment is a downward one of $7747.40. Accordingly, the overcharge from excessive rates alone is as follows:

$164,517.22	(total from Div. Ex. 7 for excessive nights + excessive rates)
- 7,747.40	(portion attributable to excessive nights allegations)
$156,769.82	

G. Is the Result Prevented by Irregularities in the Original Audit?

Much of AFH's closing argument is a contention that the original audit and surrounding criminal investigation were conducted improperly. Because the present proceeding is a *de novo* hearing designed to reach, for the first time, a final, commissioner-level decision on whether recoupment is due, the audit's findings have no special standing in this proceeding and it is irrelevant *in this proceeding* whether those findings were arrived at correctly. The Division has had to prove its allegations anew, and it has been able to do so, in part.

IV. Conclusion

The Division has shown that AFH charged a higher rate to Medicaid for lodging units than AFH charged other. The lower charges to others did not fit within any of the permissible exceptions written into former 7 AAC 43.040. No untimeliness defense or other defense has been established. Accordingly, the amount charged in excess of the rates charged to others, a total of $156,769.82, may be recouped from AFH.

DATED this 21st day of December, 2010.

By: *Signed*
Christopher Kennedy
Administrative Law Judge

APPENDIX A

Claim Ref.	Adjustment type(s)	Nml & Cust	Overpayment	Net change
AFH03	A, B	350	45	+18
AFH04	A	1330	408	-70
AFH05	A	1470	426	-70
AFH24	A, B	210	27	+18
AFH27	A, B, C	770	415	+228
AFH36	A, B	980	284	+18
AFH46	A	210	27	-70
AFH49	A, B	140	18	+9
AFH69	B	1200	1170	+158
AFH75	A, B	1820	550	+18
AFH90	A	490	142	-70
AFH97	A, B	1050	609	+58
AFH102	A, D	2480	2418	-250
AFH105	A	490	70	-35
AFH112	A, B	420	54	+9
AFH136	A, B	210	27	+9
AFH150	A	1540	435	-585
AFH151	A, B	2270	2075	+133
AFH164	A	550	319	-50
AFH167	A	1250	567	-350
AFH168	A, E	1040	1014	-140
AFH172	A, B, C	420	133	+88
AFH191	A, E	840	719	-190
AFH202	A, B	210	27	+9
AFH207	A, E	1000	975	+197
AFH218	A	1600	1002.36	-400
AFH219	A, E	1480	1048	-330
AFH220	A	3960	985	-720.40
AFH241	A, B, F	490	142	-43
AFH259	A, C	840	266	-190
AFH287	A, B	79	9	+9
AFH292	A	1610	(140)	-735
AFH299	A	910	275	-70
AFH303	A	2200	2145	-280
AFH316	A	1190	311	-140
AFH339	A	800	464	-150
AFH361	A, B	1120	302	+18
AFH377	A, B	910	275	+88
AFH389	A, B	400	232	+29
AFH391	A, B	350	45	+9
AFH393	A, B	420	54	+9
AFH399	A, B	3520	3432	+117

AFH415	A	950	551	-300
AFH418	A, B	140	18	+9
AFH427	A, B	700	406	+116
AFH450	A	3480	3393	-1480
AFH466	A, B	700	406	+58
AFH478	A, B	550	319	+58
AFH484	A, B	210	27	+9
AFH493	A, B	560	151	+9
AFH502	A, B	650	377	+58
AFH507	A, B	700	406	+29
AFH514	A	1320	1287	-320
AFH515	A	1120	1092	-280
AFH520	A, B	1540	435	0
AFH564	A, B, G	450	261	+243
AFH585	A	350	(86.66)	-140
AFH598	H	210	27	0
AFH604	A	280	(43)	-70
AFH618	A	1840	1557	-640
AFH620	A, B, G	450	261	+225
AFH621	A, B	1310	1692	+68
AFH630	A, B	850	497	+33
AFH644	A, B	840	187	+18
AFH646	A, B, I	630	160	-14
AFH650	A, B	1190	311	+18
AFH663	A	600	348	-100
AFH670	A, B	880	858	+39
AFH680	A, B	210	27	+9
AFH684	A, B	140	18	+9
AFH693	A, B	700	169	+9
AFH706	A, B	500	290	+87
AFH707	A, C	700	90	-350
AFH718	A, B, C	450	261	+128
AFH740	A, B	700	169	+18
AFH752	A	350	286.80	-210
AFH765	A, B, I	2030	573	-1002
AFH766	A	1920	1872	-280
AFH789	A, B	210	27	+18
AFH793	A	350	(113)	-140
TOTAL				-7747.40

Key to adjustments:

A Restore number of nights to number billed
B Do not subtract overpayment from overpayment column
C Auditor used wrong rate for date span (see Exhibit 8)
D Auditor miscounted days; auditor said should be 61 days but allowed only 56
E Rate shifts to 21+

F Rate shifts to weekly
G Rate shifts to 6+
H Auditor stated he was reducing nights but did not make the change
I Discontinuous dates. Quantity discount applied only to continuous periods.

Adoption

The undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 20th day of January, 2011.

By: *Signed*
Signature
William J. Streur
Name
Acting Commissioner
Title