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

In the Matter of:	)	
	)	
McKINLEY SERVICES	)	OAH No. 16-1154-MDA
	)	
Audit/Case Tracking No. 2015-759-1417244468-Comp-03-13	)	

FINAL DECISION

In accordance with AS 44.64.060(e)(1), (4), and (5), I adopt the attached proposed decision with the following modifications:

1. On page 8, the fourth paragraph is stricken and replaced with new text reading as follows:

   "Program Integrity advocates disallowance of Claim 4185A on two grounds. The second of these is wholly dispositive of the claim, resulting in its disallowance for the reasons explained below. Program Integrity's first basis for disallowing Claim 4185A need not be addressed."

2. Subsection II-C-1 of the proposed decision (found on pages 8-10) is stricken in its entirety.

The outcome of the decision, as summarized in the conclusion, is unchanged.

This is the final decision of the Department of Health and Social Services. 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 24 day of January, 2018.

By: *Signed*
Erin Shine
Special Assistant to the Commissioner
Commissioner's Delegate

[This document has been modified to conform to the technical standards for publication.]

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[PARTIALLY REJECTED PROPOSED] DECISION

I. Introduction

A. Summary

This is an appeal under 7 AAC 160.130 of the findings of a Medicaid provider audit. McKinley Services of Alaska, LLC (which does business simply as McKinley Services) offers personal care assistant (PCA) services to elderly and disabled Alaskans who are on Medicaid. The Department of Health and Social Services' Program Integrity Unit (Program Integrity) audited McKinley's billings to the program for the period from January 1, 2012 to December 1, 2013, during which McKinley submitted 43,461 claims and received $3,813,021.04 from the program. Based on this audit, Program Integrity contends that the department was overcharged by $303,060.00, and it has demanded reimbursement in that amount.[1]

Program Integrity arrived at this figure through a process of statistical sampling and extrapolation in which 250 randomly-selected claims were evaluated. The auditor disallowed 32 claims on a variety of grounds. The auditor's extrapolation technique, which applies a statistical confidence interval that is highly favorable to providers, translated this failure rate into disallowance of about seven percent of the overall volume of claims for the audit period.[2]

In the present case, the audit methodology is not in dispute. McKinley appeals nine of the 32 overpayment findings on the merits, contending that they were not overpayments at all. Additionally, McKinley seeks to have four findings thrown out of the sample, even though they concededly were overpayments. Insofar as McKinley prevails on any of the appealed findings, a new extrapolation can be performed that would yield a smaller total repayment amount.

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[1] Letter from Douglas Jones to McKinley Services, August 29, 2016.

[2] This technique is discussed in *In re C Care Services LLC*, OAH No. 11-0015-DHS (Commissioner of Health & Soc. Serv. 2012) (http://aws.state.ak.us/officeofadminhearings/Documents/MDA/DHS110015.pdf). The technique used by the auditor in this case was like the one described in that case, but had an even higher confidence interval. Testimony of D. Jones; Agency Record (A.R.) 0040.

This case was heard in three hearing sessions held on March 27 and 29 and June 22, 2017. Between the March and June sessions, one issue was addressed through a dispositive motion. This decision addresses both the matters developed through a live hearing and the matter handled by motion. The nine claims at issue on the merits are resolved as follows:

Claim	Primary Issue	Disposition
4325A	Not presented	Conceded by McKinley. Affirmed.
4369A	Whether service provided/data entry error	Overturned.
4185A	Line through all tasks/noted unauthorized task	Affirmed.
9171A	Data entry error	Conceded by agency. Overturned.
16666A	No out time	Affirmed.
19302A	Data entry error	Conceded by agency. Overturned.
32115A	Line through all tasks/specifically marked unauthorized task	Affirmed.
33766A	Line through all tasks/specifically marked unauthorized task	Affirmed.
33771A	Line through all tasks/specifically marked unauthorized task	Affirmed.

As to the additional four claims that McKinley sought to exclude from the sample, this decision finds that the sample was valid and should not be disturbed.

B. Evidence Admitted

At the hearing, the numbered agency record, consisting of 7,319 pages, was admitted in its entirety without objection. McKinley Exhibit A was also admitted without objection. McKinley Exhibits B and C were submitted during supplemental proceedings in response to a request from the tribunal. Program Integrity argued that they should be disregarded based on an unusual argument addressed in footnote 15 below; insofar as this was an objection to *admission,* it is overruled and the two exhibits are taken into evidence. At hearing, Program Integrity presented its case through a single witness, Carmella Jones, who had been part of the audit team based in Kansas. McKinley presented testimony from Program Integrity Manager Douglas Jones, from McKinley's owner, Angela Jimenez, and from its acting General Manager, Darcie

Shaffer. Program Integrity accepted the burden of proof to show that McKinley failed to meet the program's documentation requirements.[3]

II. Disputed Overpayment Findings (Claims 4369A, 4185A, 16666A, 32115A, 33766A, and 33771A)

With respect to the individual overpayment findings on appeal, this case is about documentation, not fraud. In all cases, there does not seem to be much practical doubt that the PCA worked the hours billed, and the likelihood seems high that real, approved services were rendered while the PCA was there. However, the mere fact that services were rendered does not entitle a provider to Medicaid reimbursement.

For a Medicaid billing, payment will be denied if the required documentation has not been maintained. This is so even if it seems likely that the services billed, or at least some services, were actually rendered. This principle was explained in a prior decision of the Commissioner of Health and Social Services, *In re Alaska Children's Services, Inc.,*[4] in which funds were recouped from a conscientious provider on the basis of substandard documentation, even though most, and possibly all, of the billed services had probably been performed. The only potential exception to strict adherence to documentation requirements is where failure to comply with some nuance of a documentation requirement is "so insubstantial that the department must consider the records complete."[5]

Of the nine individual claims that were placed at issue in this case, three have been resolved by concession as noted on the table in the introduction. The other six are addressed below.

A. Claim 4369A: Code for Wrong Provider Entered

Claim 4369A sought payment of $41.72 for seven 15-minute units (1.75 hours) of PCA services for patient C.U. on November 12, 2013. The auditor disallowed the claim on the basis of "Service Not Provided."[6]

For all services, a Medicaid provider must record, and be able to document upon audit, the name of the recipient receiving treatment, the service provided, the extent of the service

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[3] The burden to establish any affirmative defenses remained with McKinley.

[4] OAH No. 13-0182-MDA (2014) (published at http://aws.state.ak.us/officeofadminhearings/Documents/MDA/MDA130182.pdf).

[5] *Alaska Children's Services,* Decision at 11.

[6] A.R. 0033, 0630.

provided, the date it was provided, and the individual providing the service.[7] (As will be discussed later in this decision, for PCA services there is an additional requirement to record start and stop times for the PCA's shift, but that requirement is not at issue for Claim 4369A). The difficulty with Claim 4369A arose from an alleged failure to provide any relevant documentation at all. This happened because of a typographical error that made it appear that the documentation of these elements did not match up to the service for which Medicaid was billed. The way this problem arose was explored in depth at the hearing, and is not genuinely disputed at this point in the case. It happened as follows:

On November 21, 2013, McKinley generated an invoice for seven units of PCA services to C.U. on each of six consecutive days, November 11 through November 16. The clerk generating the invoice entered (or failed to change, from a prior invoice) the provider code for PCA E.T., making it appear that each of these six daily sessions was provided by E.T.[8] In fact, the PCA who worked six 1.75-hour sessions with C.U. that week was L.U., and when the seven-unit/1.75-hour charge on November 12 was selected for audit, it was L.U.'s weekly time sheet that McKinley produced.[9]

At the time, C.U. was receiving 3.75 hours of PCA services most days, divided between a two-hour session from 9:00 to 11:00 every morning and a 1.75-hour session from 6:00 to 7:45 every evening.[10] E.T., who is not one of the regular providers for C.U., had in fact only worked a single shift at C.U.'s home the week in question, one of the two-hour morning sessions. That session was worked on November 13.[11]

As the outlines of this sequence of events began to emerge at the hearing, I wanted to audit the document trail further to make sure McKinley had billed in a manner fully consistent with the above scenario—that is, the 1.75 hours being actually worked by L.U. on November 12, but then inadvertently billed with an erroneous provider code for E.T.[12] I wanted to see if the same error appeared elsewhere in the week. I asked McKinley to find the claims data for

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7 7 AAC 105.230.

8 A.R. 5742; C. Jones and Jimenez testimony.

9 A.R. 5744.

10 *See* A.R. 5850, 5744; testimony of Jimenez.

11 A.R. 0155.

12 This seemed necessary because the Division's auditor testified that she could see only one claim for the 13th, coinciding with E.T.'s 2.0-hour timesheet. If that had been true, it would have made the overall documentary record inconsistent with the emerging explanation: that all time on L.U.'s weekly time sheet (A.R. 5744) had been billed erroneously under E.T.'s code as a result of a single, simple data entry error. However, the auditor did not have access to all claims.

November 13. This was done, and it showed that for the 13th, McKinley submitted two claims: one for 1.75 hours (corresponding to the evening shift, actually worked by L.U.) and one for 2.0 hours (corresponding to the morning shift that was, in fact, worked by E.T.). McKinley billed both claims under E.T.'s provider number and, as a result, the 1.75-hour claim was denied by the automated payment system under code 6600 for "duplicate." This denial occurred many months later, and McKinley did not pursue it.[13] Hence, for the 13th, McKinley has suffered a consequence for its coding error, having actually supplied 3.75 hours of PCA services but been paid for only 2.0.

The question in this case, however, is whether claim line 4369A on November 12, 2013 should be deemed an overpayment on the basis of "Service Not Provided." If the service was not provided, McKinley was overpaid for that claim and it becomes part of McKinley's error rate to be extrapolated across the universe of claims. If the service was provided (and can, albeit belatedly, be documented in all the ways required by regulation), McKinley was not overpaid and line 4369A does not become part of the error rate. This is the way the department traditionally approaches typographical errors: in fact, in this case, the department originally disallowed, then decided to allow, claim line 19302A, which likewise involved a PCA service that was actually provided but submitted under the wrong PCA code.[14]

The service was provided. There is no longer any dispute that L.U. performed the 1.75-hour shift referred to on that claim line and that this shift was billed—just once—under a mistaken PCA code. Further, with the full array of documents now assembled, it is possible to ascertain the name of the recipient receiving treatment, the service provided, the extent of the service provided, the date it was provided, the individual providing the service, and the PCA's start and stop times, which are the items the provider must be able to document to comply with the record-keeping regulation. Claim line 4369A should be allowed, and the audit finding to the contrary overturned.[15]

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13 The two claims can be traced in McKinley Exhibits B and C.

14 C. Jones testimony ("For the date of service in review, there's no difference.").

15 Program Integrity's argument that this result is barred by the appeal deadline in 7 AAC 105.270(a) is inventive but unavailing. Program Integrity contends that the full documentary trail of the typographical error at issue involves looking at the unpaid claim for November 13, and that McKinley failed to appeal that nonpayment, thus leaving in place an administrative finding that it was a duplicate. The main trouble with this argument is that McKinley is not seeking reimbursement for November 13. That claim will remain unpaid, with McKinley required to live by its decision not to invest resources in pursuing the $41.72 it was denied for that date. The November 13 claim was simply context that helped to confirm what happened on November 12. Moreover, the November 13

B. Claim 16666: No Out Time Noted at End of Shift

Claim 16666A relates to a billing for 12 units (3.0 hours) of PCA services for patient N.S. on Monday, October 15, 2012. The supporting documentation for this claim is a PCA timesheet for the whole week. On each day, including the 15th, it records that the PCA clocked in at 8:30 a.m., but the "out" time is left blank. For services performed, the PCA has checked the box for every service for which PCA time was authorized for this patient, for every day of the week (with the single exception of shopping, which is marked only on Thursday). Thus, if the sheet is read literally, the PCA claims to have helped the recipient get to a medical appointment on every day of the week, to have done laundry every day of the week, and so forth.[16] McKinley billed 12 units on two of the days and 14 units on the other three. The different numbers of units do not match up to any particular set of checked services; for example, the same set of services was checked for Friday, October 19 as for Monday, October 15, but the number of units billed was different.[17]

The single basis for disallowing claim 16666A is the lack of an "out" time. Regulation 7 AAC 105.230(d)(5) requires providers to maintain clinical records that contain "stop and start times for time-based billing codes." PCA time is billed under a time-based billing code, and the clinical record for October 15 contains no stop time.

The reason for the requirement of start and stop times was explained in a recent case involving similar issues:

> The point of the documentation requirements is to allow the department to audit individual claims and cross-check them against other information that may be available. In the case of PCA services, for example, the combination of a vulnerable clientele and a lack of close supervision creates significant opportunities for fraud. By requiring providers to specify *exactly when* they were with the client, the department can check a particular claim against observations of the provider in other locations, or shifts worked on other jobs. This helps to pin down malefactors, who might otherwise be able to answer any challenge by

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documents came in at the ALJ's request, not McKinley's. They functioned only as a double-check to verify an impression created by other evidence.

[16] For the benefit of readers who are unfamiliar with PCA services, I note that this certainly did not happen. Like all or nearly all Personal Care Services (PCS) patients, this patient would have been awarded an annual amount of time associated with medical appointments that was then divided by 52. The resulting weekly amount for this patient is consistent with much less frequent trips for medical treatment. A patient needing daily medical attention outside the home would not ordinarily be a candidate for the type of services N.S. has received for many years.

[17] The whole paragraph is drawn from A.R. 0147 and the testimony of C. Jones.

claiming, after the fact, that they simply worked different hours. Moreover, by making enforcement possible, it deters misconduct in the first place.[18]

McKinley established that the PCA in question works the same schedule every day, consisting of two hours of chore (documented on a separate sheet) and three or three-and-a-half of PCA. N.S. is authorized for more hours of PCA, and those additional hours are done by a different PCA.[19] But McKinley could not fully defend the time sheet for Claim 16666A. McKinley's owner felt that on days when the same number of services were checked, the billing should be the same, and on days when more services were checked, more units should be billed—and yet there was no such correlation. She conceded that the agency needs start and stop times in order to be able to cross-check against the other jobs PCAs may hold, as a check against fraud. [20] McKinley presented no basis to overturn the audit finding entirely and allow the 12-unit billing notwithstanding the failure to record the hours worked.

As a fallback, however, McKinley argued that the agency should allow one unit for Claim 16666A, rather than zero, thus only partially denying the claim instead of wholly denying it (this would have some benefit to McKinley's overall result when extrapolated across the whole claim population of 43,461 billings). The rationale would be that the PCA must have worked at least 15 minutes after arriving at the client's home. McKinley established that Program Integrity has done something similar in the past (under a different regulation, which did not require start and stop times), when it allowed one unit of time under a time-based billing even though no overall time duration had been documented. In the example discussed during the hearing, this was done because there was written work product associated with the billed time—a multi-page behavioral health assessment—that established that something had been done, justifying a minimum unit charge.[21]

The present case, however, is not the same. In the behavioral health case, the provider needed only to establish that hours had been worked, not which hours during the day had been worked. Thus, it was rational to treat a multi-page assessment report as *de facto* documentation that at least one minimum billing unit must have been worked to create it. Here, there is no written work product that can serve as documentation that services were performed, and there is

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[18] *In re Eben-Ezer Homecare, LLC,* OAH No. 13-1605-MDA (Comm'r of Health & Soc. Serv. 2015), at 7 (http://aws.state.ak.us/officeofadminhearings/Documents/MDA/MDA131605.pdf).
[19] Testimony of Jimenez.
[20] Cross-exam of Jimenez.
[21] Testimony of D. Jones.

a specific requirement for start and stop times showing *when* they were performed. The audit finding disallowing Claim 16666A in its entirety should be upheld.

C. Claim 4185A: Swirly Line Through All Tasks, Plus Entry for "Daily Massage"

Claim 4185A is a billing for 6 units (1.5 hours) of PCA services to patient B.P. on Friday, November 15, 2013. B.P. was a 77-year-old woman suffering from diabetes, arthritis, asthma, renal disease and insufficiency, incontinence, and many other medical afflictions.[22]

The services billed were rendered by a PCA named L.F. The supporting timesheet has a grid in which the left margin lists all of the services for which B.P. had apparently, at one time, received authorization, including range of motion work and walking for exercise. The top margin sets up seven columns for the seven days of the week. For each day, including November 15, L.F. has recorded in and out times, listed the total number of hours, and drawn a curvy line down the whole column, suggesting that all services were performed. At the bottom, she has also written "DAILY MASSAGE."[23]

Providing context for L.F.'s November 15 timesheet are other timesheets prepared by L.F. and by different PCAs who worked different shifts in the same patient's day. All of the other timesheets (including another by L.F.) show a different list of authorized tasks. All of these other timesheets match up with the list of tasks for which B.P. was approved in an assessment that took place in the spring of 2013. That approval authorized a PCA service level of 29 hours per week between April of 2013 to March of 2014, including no time for range of motion work nor any time for walking for exercise. Throughout the fall of 2013, the hours worked were consistent with this service level.[24]

However, in the second week of November, L.F. seems to have entered her time on an old time sheet, one based on the 59.5 hours per week that B.P. had prior to the 2013 assessment. The earlier allotment included time for range of motion and walking for exercise. L.F.'s mistaken use of an old timesheet did not result in extra time being billed, but it did mean that when she drew her customary swirly line down each column, she was marking tasks for which B.P. was no longer approved.

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[22] A.R. 3731.

[23] A.R. 1605.

[24] This account is apparent from a careful review of A.R. 1601-1605 and 3681-3718. Although Carmella Jones did not provide all of this background, she did confirm in her cross-examination that B.P. no longer had an authorization for range of motion work in November of 2013.

Program Integrity advocates disallowance of Claim 4185A on two grounds. The first is unpersuasive, but the second is meritorious.

1. First Basis: Notation Regarding Massage

First, Program Integrity points to the handwritten entry for daily massage. All parties agree that this establishes that L.F. provided a massage on November 15. Massage is not one of the services provided by the PCA program. Although McKinley has suggested that massage might be a way of providing range of motion therapy, that is not so,[25] and in any case range of motion work was not approved for patient B.P. on the date at issue. Thus, by providing massage on that date, L.F. was providing an extra service. Program Integrity contends that it has therefore been billed for an unauthorized service.

I am not persuaded by this approach to reviewing PCA billings, because in adopting it, Program Integrity ignores the realities of the PCA program as it is currently administered in Alaska. To see where the auditors have gone astray, let us take a simplified, hypothetical patient, "Joe," who has paralysis in both arms. Let us imagine that Joe requires hands-on assistance with only one activity of daily living, toilet use, for which he has the same assessed need that B.P. did at one time: 12 times per day, 9 minutes per usage, 7 days per week.[26] This would result in a weekly allotment of 756 minutes of PCA time. In addition, like B.P., he needs 56 minutes per week of help with medications. These two awards, after rounding, would add up to approximately 14 hours per week.

In practice, Joe's PCS agency would likely give him a PCA two hours per day, seven days per week. The two hours would be continuous, because almost no one will work—and the department does not expect anyone to work—twelve nine-minute shifts spread across a 24-hour period.[27] In the two continuous hours Joe's PCA would actually be with him, a few minutes would be spent on medications, and perhaps two toilet uses would occur. These would not use up the whole two hours. There would be some unused time. A compassionate, industrious PCA might use that time for other useful therapies, such as massaging Joe's paralyzed limbs, or laundering soiled clothing (another unauthorized service, in Joe's case) from the toilet uses when the PCA was not present. It does not follow that the department would then be "billed" for an

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[25] Cross-exam of C. Jones.

[26] *Cf.* A.R. 3687.

[27] The only kind of PCA who can be present for all such scattered services is a live-in PCA. While these exist, B.P. did not have a live-in PCA, and most patients like her do not.

unauthorized service. Assuming the PCA does perform the approved services *as needed,* the department is being billed for the time the PCA is present to cover those needs, not for every individual thing the PCA does while present.

The same is true of patient B.P., even though she had a more complex set of approved PCA tasks. In the mid-day hour-and-a-half that L.F. was with B.P. on November 15, many of the tasks for which she was approved might not ordinarily occur (dressing, personal hygiene, bathing), and the locomotion, transfers, and toileting would come up only intermittently. That the PCA managed to fit in a massage is not an indication of fraud or abuse of the system. A really savvy PCA, knowledgeable about the risk that an auditor might misunderstand, might elect not to put the notation on her timesheet. But the fact that it is there is not a basis, in itself, to disallow payment for the 1.5 hours of PCA time.

2. Second Basis: Line Through All Tasks

The second concern the auditors had about L.F.'s timesheet was that, instead of checking off or listing the PCA tasks she performed during her shift, she drew a wavy line down all the tasks. This could be read as a claim that she performed all the tasks, but that is plainly not true, because to do—even once—all the tasks listed on the erroneous timesheet template she used, she would have needed far more than the hour and a half she was present in the home. Moreover, some of those tasks are things that do not occur every day, such as escorting to a medical appointment. Yet she has marked the sheet as though she took B.P. to a medical appointment all seven days of the week, including Saturday and Sunday, and managed to do so in the same hour and a half she was giving B.P. a 30-minute bath, taking her for a 15-minute walk, and feeding her a light meal.

If the wavy line through all the task boxes cannot be interpreted as an indication that all the tasks were performed, it is simply meaningless. It is as though L.F. had left all the boxes blank and turned in a timesheet documenting only "DAILY MASSAGE." We have just seen that documenting an unauthorized service, such as massage, is not, in and of itself, disqualifying. But the fact remains that documentation required to support a billing for PCA services must show "the service provided."[28] If the *only* service provided that has been documented is an unauthorized, non-PCA service, the program cannot pay for it.

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[28] 7 AAC 105.230(b)(2).

McKinley's owner, Angela Jimenez, points out that the PCAs fill out the timesheets very fast. Nonetheless, they need to take a moment, at the end of each shift, to note or check off the services they performed that day. That is what a checklist is for—to document what was done—and for November 15, 2013 L.F. turned in a checklist that documented no PCA services at all.

McKinley has suggested that this and other "line through everything" timesheets should support a partial payment for a minimum increment of one unit of PCA time. Again, however, there is simply no documentation to support that a single authorized PCA service was performed. Thus, a minimum single-unit payment would not be appropriate.

The audit finding disallowing Claim 4185A in its entirety must be upheld.

D. Claims 32115A, 33766A, 33771A: Straight Line Through All Tasks Including Unauthorized Ones

Claims 32115A, 33766A, and 33771A all relate to a single patient, F.C., served by PCA S.S. The random audit sample brought up three dates of service, and on each of them, S.S. had completed a timesheet that contained a grid with boxes under the date corresponding to all 27 types of assistance for which PCA time can be granted.[29] Next to some of the services, the pre-printed form listed minutes, apparently corresponding to the number of weekly minutes that had been awarded for that service.[30] Other services had no minutes next to them on the preprinted listing. In filling out this template timesheet, S.S. would put an "X" in the box for foot care on each day, and draw a line through all the other 26 boxes to the top of the sheet. On one occasion, she also put an "X" in the top box, corresponding to body mobility. F.C. was not approved for foot care or body mobility services.[31] The line through the boxes that did not have an "X" passed indiscriminately through services F.C. was not approved for and surely would not receive as an elective matter (such as oxygen, oxygen maintenance), services she was not approved for but might conceivably receive (such as main meal prep), services she was approved for but would not be expected to receive most days (such as escort, locomotion to medical appointments), and services she was approved for that she likely would need every day.

This pattern puts the S.S. timesheets in essentially the same class as the one at issue for Claim 4185A. Although there is no notation for "massage," every sheet has a specific "X" for foot care. This alone would not be disqualifying, since it might be permissible for a PCA to

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[29] A.R. 1118, 1122, 1129.

[30] Angela Jimenez so testified.

[31] Inferred from Jimenez testimony.

render foot care during down time between other tasks, even though it was not itself an authorized task. However, the only potential indication that S.S. performed *any* of the tasks for which F.C. received PCA time is an indiscriminate line that is meaningless because it covers both events that may have occurred and events that certainly could not have occurred. The line provides no evidence that S.S. did any particular task, and as such, the documentation fails to meet the requirement for a record of "the service provided" in order to qualify for payment. The audit findings disallowing Claims 32115A, 33766A, and 33771A are appropriate as a matter of regulatory compliance.

McKinley argues that the regulatory requirement should not be enforced, however, because a department employee named Patrick Walker visited McKinley's offices, saw timesheets that had been filled out this way, and raised no concerns at the time. Under certain circumstances, the Medicaid regulations cannot be strictly applied because of the doctrine of equitable estoppel. To prevail on this basis, the citizen must prove each one of four separate elements:

> [E]stoppel may apply against the government and in favor of a private party if four elements are present: (1) the governmental body asserts a position by conduct or words; (2) the private party acts in reasonable reliance thereon; (3) the private party suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to limit public injury.[32]

When these four elements are met, the government may be estopped or partially estopped (that is, limited or prevented) from applying a restriction as written. This doctrine cannot avail McKinley, however, because of the second element, reliance. Mr. Walker's visit was in 2013 or 2014.[33] The timesheets we are reviewing are from 2012. Thus, McKinley could not have been relying on Mr. Walker's advice when it permitted S.S. to do her documentation this way.

The audit findings disallowing Claims 32115A, 33766A, and 33771A are upheld.

III. Disputes Over Sample Composition (Out-of-Country Overpayment Claims 7079A, 21052A, 29992A, and 32966A)

Among the 250 sampled claims, the department's auditor identified four claims for services supposedly rendered when the recipient or the caregiver was out of the country on the date billed. This was determined by running an "ICE report"[34] on the caregivers and patients in

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32 *Crum v. Stalnaker*, 936 P.2d 1254, 1256 (Alaska 1997).
33 Jimenez testimony.
34 "ICE" stands for Immigration and Customs Enforcement.

the sample, to determine whether dates of claims coincided with periods when they were out of the country.[35] Obviously, Medicaid payments to McKinley for these services were overpayments, because no services were performed: as McKinley acknowledges, "the service providers were not physically able to provide those services due to the location of the provider or the client."[36] The presence of these four overpayment findings in the sample suggests that there were about $59,623 in total overpayments in the total claim population for which this problem would be found in a complete audit. However, because of the provider-friendly confidence interval used by the department in extrapolating from audit samples, the department seeks to recoup only $38,755 of this amount.[37]

The out-of-country findings do not suggest fraud by McKinley. Insofar as we have any evidence on the subject, it seems likely that McKinley did not know that a few of its PCAs were billing for shifts when they or their clients were abroad, and in a sense McKinley is a victim of the fraud, along with the Medicaid program. It does not follow, however, that McKinley was necessarily blameless: there may be controls or random checks that an employer could devise to limit or prevent this kind of fraud. We simply do not know whether McKinley bore any blame for the overpayments, and as a legal proposition, it does not matter.

Likewise irrelevant is the possibility that McKinley may have already repaid these claims.[38] If it did so, McKinley repaid them only after they were identified on audit. An audit target cannot defeat the extrapolation process by cherry-picking the overpayments identified in the sample, repaying those, and thereby avoid repaying the hundreds of similar overpayments that likely exist in the overall population being audited. Of course, McKinley is entitled to a dollar-for-dollar credit for any reimbursements it has made since the audit was done with respect to *any* claims in the audit population (whether inside or outside the sample). The extrapolated audit figure is intended to be a proxy for the total amount McKinley would owe if all 43,461 claims in the population were examined individually and completely, and to the extent McKinley has already reimbursed some of those claims, it must be given an offset.

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[35] C. Jones testimony.

[36] McKinley Prehearing Brief.at 9.

[37] In other words, $38,755 of the $303,060 sought from this audit relates to this particular issue. The calculations behind these figures are found in Program Integrity's Response to McKinley Services' Motion for Summary Adjudication.

[38] As of the time of the hearing, Ms. Jimenez's testimony indicated that McKinley had not yet done so, but her counsel seemed to think she might be mistaken. Hearing recording, part 5, 1:32:00 and following.

Going beyond these basic observations, however, McKinley argues that the four out-of-country items should be removed from the sample entirely. McKinley's main argument is that there is a better way to address the out-of-country problem: McKinley would propose that an ICE report be run on the entirety of the claim population (not just the sample of 250 claims), and a precise overpayment amount be calculated, rather than an extrapolated estimate. When this kind of global report can be run, the exact figure substitutes for extrapolation and all claims in that class are removed from the audit sample. Through testimony from Program Integrity Manager Douglas Jones, McKinley was able to establish that this has been done in the past, with the department able to run a check on an entire population of claims for out-of-country overpayments with the assistance of the Immigration and Customs Enforcement agency.[39] However, Mr. Jones testified that this was a labor-intensive effort, with the information keyed in by hand by a Homeland Security employee one provider at a time, and the resulting delay makes this approach impractical for a population as large as 43,461 claims. Given this reality, sampling and extrapolation—which are authorized by 7 AAC 160.120—are an appropriate tool for addressing the out-of-country issue. One should bear in mind that the likelihood that extrapolation has produced a less favorable result for McKinley than a global ICE report is extremely small, because the statistical confidence interval used by the auditor in this case was so provider-friendly.[40]

McKinley also points out that there is a Fraud Control Unit action against the caregivers themselves, which could result in repayment of some of the out-of-country overpayments by the primary malefactors, the individual caregivers. There is no evidence of such reimbursement in the claim population at issue in this case, however. Insofar as any are made, McKinley is undoubtedly entitled to a dollar-for-dollar offset against its own liability, just as it would be for any payments it has made itself against that liability, because these would be payments by another party to satisfy a joint obligation.[41] However, the availability of such an offset is not a basis to change the sample composition.

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[39] D. Jones Testimony.

[40] This auditor calculated the recoupment amount at the lower bound of a two-sided 95% confidence interval, apparently using a normal distribution. A.R. 0040.

[41] To be clear, this would be an offset against the total liability after extrapolation, not against the liability within the sample. The department should be forthcoming about whether any such payments have been received, but if it is not, McKinley can obtain the information by public records request.

This inclusion of Claims 7079A, 21052A, 29992A, and 32966A in the audit sample will not be disturbed.

IV. Conclusion

The overpayment findings with respect to Claims 4369A, 9171A, and 19302A are overturned. Program integrity shall recalculate the sample and extrapolation with these overpayments removed. If there is a dispute about the recalculation methodology, McKinley may file a new appeal related to that limited issue. In all other respects, the final audit findings in Audit Case 2015-759-1417244468-Comp-03-13 are upheld.

DATED this 12th day of December, 2017.

By: *Signed*
Christopher Kennedy
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]