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

In the Matter of:	)	
	)	
Hearts and Hands of Care, Inc.	)	OAH No. 16-1176/1177-MDA
	)	

FINAL DECISION ADOPTING PROPOSED DECISION IN PART AND REVERSING PROPOSED DECISION IN PART

A proposed decision was issued in this case on December 22, 2017, which reversed the Medicaid Program Integrity Unit's (Program Integrity) conclusion that Hearts and Hands Care Inc. (Hearts and Hands) was not entitled to various Medicaid claims. After consideration of the record and the parties' briefs, the undersigned, by delegation from the Commissioner of Health and Social Services and in accordance with AS 44.64.060(e)(5) partially rejects the proposed decision in this case.

a. Facts

There are several claim denials at issue in this case. But the largest number (sixty-one) involves insufficient timekeeping. Hearts and Hands is a Medicaid provider that provides care services to Medicaid-eligible persons. In October 2010, Hearts and Hands was in the process of recertification with the Department, which allows a provider to remain eligible to provide services under Medicaid. Ms. Smaw – who is the Chief Executive Officer of Hearts and Hands – testified that during recertification, the Provider Certification Staff asked her to provide personal care assistant (PCA) timesheets. Ms. Smaw testified "we did submit a timesheet because, at that point in time, it was

requested, I do believe, from...[Provider Certification Staff]...at the time of our review."[1] Ms. Smaw also pointed to an email between the Provider Certification Staff and Hearts and Hands as proof the Department reviewed the PCA timesheets and found them compliant for all purposes, including auditing.[2] But neither the testimony nor the email established that the Department told Hearts and Hands the submitted timesheet complied with all laws and regulations.

In fact, the timesheets provided during recertification–which reads "Sample"–did not contain both a start time and a stop time for billed services, which is required by regulation. Instead, Hearts and Hands provided a "prefilled" timesheet.[3]

Provider Certification Staff subsequently recertified Hearts and Hands.

The record does not show why the Provider Certification Staff asked Ms. Smaw to provide the PCA timesheets as part of the recertification process. And Ms. Smaw's testimony is that she "believes" the Provider Certification Staff asked for the PCA timesheet.[4] Ms. Smaw did not testify that a member of the Provider Certification Staff or any other employee of the Department represented to her that the PCA timesheets were

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1 Transcript at pg. 172.

2 Agency Record 7290-91.

3 Exhibit AA pg. 53 of 74.

4 Transcript at pg. 172.

acceptable for purposes of billing Medicaid or that this was the reason the Provider Recertification Staff supposedly asked for the PCA timesheets.

Years later, auditors reviewed Hearts and Hands' 2011 and 2012-2014 Medicaid billings. The auditors and the Department's Medicaid Program Integrity Unit denied sixty-one of Hearts and Hands' claims because the aforementioned PCA timesheets did not adequately document both a start time and a stop time for billed services. At hearing, the Administrative Law Judge reviewed the prefilled forms and concluded they did not comply with Department regulations. However, the Administrative Law Judge concluded the Department was equitably estopped from denying the claims because the Provider Certification Staff had reviewed the insufficient timesheets as part of the 2010 recertification process.

The proposed decision also held that Hearts and Hands should be paid on claims where they lacked underlying PCS plans.

b. Discussion

1. The Department does not adopt section III(A)(l) of the proposed decision.

(a) The prefilled timesheets do not adequately document start and stop times for billed services.

Under 7 AAC 125.120, PCAs must maintain a contemporaneous record of services provided for each recipient. The contemporaneous record must include the date, time, and length of each visit, and the services provided during each visit. Here, the

Hearts and Hands' prefilled forms do not comply with the regulation for the reasons stated at pages ten and eleven of the proposed decision.

(b) The Department is not equitably estopped from denying the sixty-one claims related to the prefilled timesheets.

The Department is not equitably estopped in this instance. The proposed decision did not adequately address the elements of equitable estoppel as it relates to claims against a government entity. Private parties may successfully invoke equitable estoppel against the government in exceptional cases.[5]

The first element of equitable estoppel – whether a claimant asserts a position by conduct or words – was not met in this case. In *Municipality of Anchorage v. Schneider,* the claimant was able to show "a position by conduct or words" when the government entered into a settlement agreement and issued a permit, allowing the claimant to construct three housing units on a plot of land.[6] The settlement agreement constituted a "position taken by conduct or words" because it gave the landowner "clear authorization to take the steps they did."[7] In *Schneider,* when the government subsequently tried to

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5 *Alaska Trademark Shellfish, LLC v. State,* 91 P.3d 953, 960 (Alaska 2004) *citing State v. Schnell,* 8 P.3d 351, 356 (Alaska 2000); *Wassink v. Hawkins,* 763 P.2d 971, 975 (Alaska 1988). The elements of equitable estoppel are: (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. *Crum v. Stalnaker,* 936 P.2d 1254, 1256 (Alaska 1997).

6 685 P.2d 94, 96 (Alaska 1984).

7 *Schneider,* 685 P.2d at 98.

deviate from their clear authorization, the Court precluded the government from doing so. Hearts and Hands did not show a similar clear authorization in this case. Instead, Hearts and Hands provided the Provider Certification Staff a sample copy of a timesheet during recertification in 2010 to individuals that are not involved in auditing. The record does not establish if the Provider Certification Staff even asked for the PCA timesheets and if they did, for what purpose. No promises were made that this particular timesheet complied with all relevant regulations. This type of tacit acquiescence has not constituted "a position by conduct or words" in other cases.[8]

Moreover, the proposed decision failed to address instances where the government takes a concrete position by conduct or words but the equities do not merit estoppel. Courts have held that the public interest is best protected through careful application of equitable estoppel, and that decision makers must weigh the prejudice to the public interest.[9] In *Alaska Trademark Shellfish LLC. v. State,* claimants argued that the Department of Fish and Game should be estopped because government officials *specifically* promised permittees they could carry out a certain activity.[10] The Court held that even if the permittees reasonably interpreted the Department of Fish and Games' prior representations as unequivocal promises, the balance of equities fell short of

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8 *Ogar v. City of Haines,* 51 P.3d 333, 335-336 (Alaska 2002) *citing State v. Simpson,* 397 P.2d 288 (Alaska 1964).

9 *Schnell,* 8 P.3d at 356.

10 *Alaska Trademark Shellfish, LLC,* 91 P.3d at 955.

justifying equitable estoppel.[11] Here, Hearts and Hands assumed the sample PCA timesheets were essentially "good for all purposes." They weren't. The proposed decision would foreclose the Program Integrity Unit from upholding regulatory requirements in the event a sample PCA timesheet was submitted during a recertification process for unknown reasons. The government would have to pay out claims in instances where it is not at all clear how much time the PCAs devoted to Medicaid patients.

Also, Hearts and Hands' reliance was not reasonable, which is the second element of an estoppel claim. In *Schneider*, the Court found "reasonable reliance," because the claimant relied on concrete statements by the government.[12] Here Hearts and Hands cannot reasonably rely on its submission to the Provider Certification Staff. There is no evidence, for example, Hearts and Hands submitted the PCA timesheets to the State's auditors and asked the auditors if the PCA timesheets were compliant for billing purposes. Hearts and Hands never obtained any assurance from Provider Certification Staff that the sample PCA timesheet complied with all laws and regulations.

Estoppel would not serve the interests of justice in this instance, which is the fourth element of estoppel. Hearts and Hands is essentially asking the State to distribute Medicaid funds for services that have not been adequately documented. Moreover,

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11 *Alaska Trademark Shellfish, LLC,* 91 P.3d at 960.

12 *Schneider,* 685 P.2d at 98.

government auditors would be foreclosed from thoroughly examining Medicaid claims every time a similar form was provided to the government under vague circumstances.

2. The Department does not adopt section III(A)(4) of the proposed decision.

The proposed decision held that Hearts and Hands should be paid on claims where they lacked underlying PCS plans. PCA agencies are required to maintain these service plans. Without service plans, Hearts and Hands would not be able to carry out the function of ensuring the services documented on the timesheets were authorized. It was not an abuse of discretion to make overpayment findings in this instance.

c. Conclusion

The Department rejects section III(A)(1) of the proposed decision. The Department rejects section III(A)(4) of the proposed decision. The remainder of the proposed decision is unchanged and adopted. Program Integrity is to recalculate the overpayment, based upon this decision.

Notice of Appeal Rights

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 5th day of February, 2018.

By: *Signed*
Erin E. Shine
Special Assistant
Department of Health and Social Services

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

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

In the Matter of:	)	Consolidated Cases:
	)	OAH No. 16-1176-MDA
HEARTS AND HANDS OF CARE, INC.	)	OAH No. 16-1177-MDA
	)	

[PARTIALLY REJECTED PROPOSED] DECISION

I. Introduction

Hearts and Hands of Care, Inc. ("Hearts") is a Medicaid provider that provides personal care services (PCS) to Medicaid-eligible persons. The Department of Health and Social Services, Medicaid Program Integrity Unit ("Program Integrity") had Hearts's billings audited for two separate time periods, calendar year 2011, and January 1, 2012 through December 31, 2014, to determine whether Hearts had been overpaid by the Medicaid program. The audit for calendar year 2011 was performed by Meyers & Stauffer, LC ("M & S"). The audit for January 1, 2012 through December 31, 2014 was performed by Health Management Systems ("HMS").

The audits were performed on a random sample of Hearts's billing claims. Each of the audits resulted in the disallowance of a number of the sampled claims. The results of the audited sample were then statistically extrapolated to arrive at a total overpayment figure. The M & S audit identified a total overpayment of $2,536,321.18 for 2011. The HMS audit identified an overpayment of $801,789 for 2012 through 2014.

Hearts requested a hearing to challenge some of the disallowed claims. As discussed in detail below, all the disputed disallowed claims in the M & S audit are allowed, and the overpayment amount must be recalculated. With regard to the HMS audit, one of the disputed disallowed claims continues to be disallowed, and the remaining seven are allowed; the overpayment amount must also be recalculated.

II. Facts[1]

A. Procedural History

After receiving the final results of the audits, Hearts requested an evidentiary hearing to challenge the results of both. The two audit cases were consolidated. An evidentiary hearing

[1] The following facts were established by a preponderance of the evidence.

was held over the course of three days, July 31 through August 2, 2017. Assistant Attorney General Scott Friend represented Program Integrity. Carolyn Heyman represented Hearts.

T. Allen Hansen from M & S, Carmella Jones from HMS, Douglas Jones, the manager of Program Integrity, and Cheri Herman, the program manager for the Medicaid provider certification and compliance unit, testified on Program Integrity's behalf. Kisha Smaw, the owner and chief executive officer of Hearts, Tabitha Alone, Hearts's human resource specialist, and Eddie Astoji, Hearts's program administrator, testified on Hearts's behalf.

B. M & S Audit

In calendar year 2011, Hearts submitted a total of 4,657 PCS claims. The Medicaid program paid Hearts a total of $2,852,001.18 based on those claims.[2] On February 28, 2014, Program Integrity notified Hearts that it had been chosen for an audit.[3] In conjunction with that audit, M & S, which had been selected to perform that audit on behalf of Program Integrity, requested Hearts's records for a designated sample of its Medicaid claims submitted for calendar year 2011.[4] The sample consisted of 64 claims which were selected using a random sample process.[5] Based upon its audit of those 64 claims, and a statistical extrapolation of the errors it found in those claims, M & S found that Medicaid overpaid Hearts a total of $2,536,321.18 in calendar year 2011.[6]

Hearts did not dispute all the audit findings. The disputed audit findings fall into four main categories, each of which is addressed in detail below.

1. PCS individual timesheets that do not contain stop times and in which the frequencies for a particular task were prefilled out.

This category covers 61 out of the 64 audited claims.[7] The weekly timesheets which form the basis for each of these claims are a standardized form. These indicate the name of the recipient, the name of the personal care assistant (PCA), and the dates of service, and contain a list of the services the recipient receives on a daily basis. For example, the timesheet might record that the recipient received assistance with toileting four times daily, and bathing once daily. They contain a start time. They do not contain a stop time but indicate the total number of

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2 AR 121.
3 AR 238.
4 AR 239 – 258.
5 These claims are identified in the record as claims D853001 – D853064. *See* AR 19 – 41. They will be referred to as claims 1 – 64.
6 AR 121.
7 Claims 1 – 5, 7 – 9, 11 – 20, 22 – 64. AR 13.

minutes of services provided each day.[8] Some of these timesheets are prefilled out with the number of times a particular service is provided each day, along with the corresponding number of minutes.[9]

M & S found that all 61 claims should be disallowed in their entirety. The finding was based upon the fact that none of the 61 timesheets supporting the claims complied with the regulatory requirement that the timesheet completed by the PCA must contain both a start time and a stop time.[10] In addition, M & S found that the practice of having the timesheets prefilled with regard to each service item and the number of minutes expended for that service did not satisfy the regulatory requirement that the provider agency, here Hearts, provide contemporaneous billing records.[11]

Hearts is required to be recertified as a Medicaid provider every two years. In October 2010, Hearts was engaged in the recertification process. As part of that process, Ms. Smaw, Hearts's principal, was contacted by either Beverly Churchill or Gail Clinch, both of whom worked for the Department's Provider Certification Unit. Ms. Smaw was specifically asked to provide a copy of the PCA timesheet form as part of the recertification process. Ms. Smaw provided a copy of the timesheet form, which is the same form that is at issue in this case: it contains start times for each day but no stop times, only total number of minutes per day. No one contacted her to tell her that the form was not proper or that it needed to be changed.[12] On November 4, 2010, Hearts was recertified as a PCS provider, for January 1, 2011 through December 31, 2012.[13]

2. Illegible timesheets.

This category covers one claim.[14] It is for a single timesheet covering a one-week time period. The auditor disallowed this claim based upon its finding that the timesheet was illegible.[15] The auditor's written comment on this timesheet is that the "submitted time sheets are not readable."[16] A review of that timesheet, a copy of which is contained in the record,

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8 For a representative copy of a timesheet, see AR 6148.
9 *See, e.g.*, AR 6145.
10 Mr. Hansen's testimony; AR 13.
11 Mr. Hansen's testimony; AR 13.
12 Ms. Smaw's testimony; Ex. AA, pp. 5, 53.
13 Ex. AA, p. 14.
14 Claim 6. AR 13, 20.
15 Mr. Hansen's testimony.
16 AR 20.

shows that it is not the model of clarity. It should be noted that the record contains a scanned copy of the timesheet, which would itself be less legible than the original. However, it is possible, even when reviewing the scanned copy, to make out the entries of the timesheet, *i.e.*, the name of the consumer/recipient, the name of the PCA, the date the services were provided, the services provided, the PCA's daily notes, and the signatures and date of the signatures on that timesheet.[17]

3. Timesheets where M & S found the PCA was also the power-of-attorney for the recipient.

This category covers one claim.[18] The auditor disallowed this claim because the applicable PCA regulation does not allow a legal representative of a recipient to also serve as that recipient's PCA, absent court authorization. The auditor's written comment on this timesheet is that the "signature of the personal care assistant on the time sheet was from the recipient's agent under power-of-attorney that was documented on the Consumer Assessment Tool (CAT)."[19] The timesheet is for the period from October 23 – 29, 2011. The PCA on the timesheet is Q. L.[20]

It is undisputed that Q. L. held the recipient's power-of-attorney at one time. However, on March 17, 2010, Hearts faxed a number of documents to the Division pertaining to this recipient. Those documents included a notice dated March 13, 2010, revoking Q. L.'s power-of-attorney, and a new "Health Care Agent" document, dated March 15, 2010, giving authority to another person to make medical decisions for the recipient.[21]

Mr. Hansen essentially testified that the revocation of Q. L.'s power-of-attorney should be disregarded because he thought the recipient's signature on the revocation was different from her signature on other documents, implying that the signature on the revocation was forged. Mr. Hansen acknowledged that he is not a handwriting expert.[22]

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17 AR 6177.
18 Claim 31. AR 13 – 14, 29.
19 AR 29.
20 AR 1026.
21 Ex. V.
22 Mr. Hansen's testimony.

A review of the timesheet in question shows that the recipient printed her name.[23] A review of the new "Health Care Agent" document shows that the recipient printed her name.[24] However, the revocation contains a cursive signature.[25]

4. Incomplete documentation, where Hearts did not have a copy of the PCS authorized plan in its records.

This category covers three claims.[26] The auditor disallowed these claims because Hearts did not have a copy of the PCA service plan authorizing the services it billed for.[27] Mr. Hansen testified that Hearts not having a copy of the PCA service plan was a violation of PCA regulation 7 AAC 125.120(a)(3), which specifically requires the provider to keep a copy of the PCA service plan, and the regulation 7 AAC 125.240, which allows the Department to seek repayment of a paid claim when the provider does not produce copies of records which it is required to maintain.

Sometime on or before March 9, 2016, Hearts requested copies of PCS plans for at least two of Hearts's PCS clients.[28] In response, Mr. Fromm, a Health Program Manager II with Senior and Disabilities Services, emailed Hearts on March 9, 2016, stating that he was providing the service plan for one of the recipients, and that he was "having trouble finding" the service plans for another requested recipient. That email also states that all requests for service plans should be directed to him, and that he would "not look up records older then (sic) 7 years."[29] The person whose plans he identified as "having trouble finding" was the recipient for whom two of three disallowed claims applied.[30] Both of the recipients involved in these three claims were operating under 2006 PCS plans in 2011,[31] which made their service plans more than seven years old in 2016. The record does not contain any reference indicating what other recipients, if any, for whom service plans were requested.

C. HMS Audit

HMS audited Hearts for three calendar years: 2012, 2013, and 2014. Hearts billed Medicaid a total of $16,737,609.92 for service rendered during those three years. HMS selected

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23 AR 1026.
24 Ex. V, p.11.
25 Ex. V, p. 3.
26 Claims 29, 55, and 56. AR 11.
27 AR 11, 28, 38.
28 The record does not contain a copy of the actual request for records.
29 AR 7296.
30 The individual identified in Mr. Fromm's email as someone whose plan he was having "trouble finding," is the same recipient identified in claims 55 and 56. See AR 7296, 7335.
31 AR 7303, 7305.

a 250-claim sample, out of the 119,768 claims filed during the three years, for audit purposes.[32] Based upon its review of those claims, and the subsequent statistical extrapolation, HMS found that Hearts had been overpaid a total of $801,789 during those three years.[33] Hearts is contesting eight of the disallowed claims: 93938, 16929, 89140, 1887, 84965, 24090, 1293, and 23516.

1. Duplicate billings for the same service: claim 93938

Claim 93938 involves an issue where it is undisputed that Hearts filed duplicate claims for the same service: once as a Medicaid Home and Community-based Waiver service, and once as a Medicaid PCS billing. The Waiver program pays for services at a higher rate than the PCS program. HMS disallowed the Waiver claim, and allowed payment at the rate for the PCS program.

2. Respite services: claims 16929, 89140, 1887, 24090, 1293, and 23516

In each of these claims, HMS disallowed a claim for the reason that respite services were provided for a non-eligible person. The regulatory basis for the disallowance in each was 7 AAC 130.280(b)(1).

a. Claim 16929

The recipient is an elderly woman. Her approved Medicaid Waiver Plan of Care (POC) provides that she lives with her older daughter and family, and that the "older daughter is mostly responsible for her care."[34] The POC specifically provides for both daily and hourly respite care. It says that the hourly respite and daily respite will be provided to give the daughter relief, and identifies the daughter as the primary caregiver.[35] G. T. is the older daughter with whom the recipient resides. According to the recipient's August 2012 Medicaid assessment (Consumer Assessment Tool, generally referred to as the CAT), G. T. is also the recipient's PCA.[36]

During the week of February 24, 2013, Hearts filed a claim for hourly respite services for the recipient to provide relief for B. T., who was identified as the recipient's primary caregiver on the respite claim form. The recipient signed the respite service timesheet.[37]

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32 AR 7426.
33 *See* HMS Final Audit Report dated July 29, 2016. AR 11049 – 11077.
34 AR 15272.
35 AR 15274.
36 AR 15218.
37 AR 15214.

HMS disallowed claim 16929 for respite care because it found there was no information showing that B. T. was the recipient's primary unpaid caregiver.[38] No evidence was presented showing that B. T. was not the recipient's primary unpaid caregiver. Eddie Astoji was the recipient's care coordinator and is familiar with the recipient.[39] He testified that, to his knowledge, B. T. had never been a paid caregiver for the recipient.[40]

b. Claim 89140

This was a claim for respite provided to a C. T. The respite services were provided the week of March 25, 2012. The respite provider was U. T. The respite timesheet was signed by C. T.[41] C. T. has a limited power-of-attorney for the recipient.[42] The recipient's approved POC provides for respite care, but does not specify the primary caregiver for whom respite is provided.[43]

HMS disallowed the claim because there was no showing that C. T. lived with the recipient as her primary caregiver.[44] Mr. Astoji with Hearts was familiar with the recipient and testified that he thought C. T. was a family member, and that he was providing support to the recipient.[45]

c. Claim 1887

This recipient has two daughters, B. N. and Q. N. This was a claim for respite provided to the recipient for Q. N. during the week of April 7, 2013. The respite care timesheet was signed by the recipient.[46] The recipient's approved POC states that she lives with her daughter B. N., who is also her PCA, and that respite services were provided to give her daughter relief. [47] The recipient's March 14, 2013 CAT also indicates that B. N. was the recipient's PCA.[48]

HMS disallowed this claim because there was documentation showing that Q. N. was a third-backup PCA and there was no documentation showing that she was the recipient's primary

38 AR 10947.
39 Mr. Astoji's testimony; AR 15269.
40 Mr. Astoji's testimony, Trans. Vol. III, pp. 396 – 397.
41 AR 16103.
42 AR 16105 – 16110.
43 AR 14162.
44 AR 10949.
45 Mr. Astoji's testimony, Trans. Vol. III, p. 397 – 398.
46 AR 16391.
47 AR 16448, 16452.
48 AR 16749.

unpaid caregiver in need of respite.[49] Mr. Astoji testified that a backup PCA was not necessarily paid, and that he was unaware of Q. N. ever being a paid caregiver for the recipient.[50]

d. Claim 24090

This claim involves respite provided to the recipient for a W. H. for the week of September 22, 2014.[51] W. H. is the recipient's daughter and holds her power-of-attorney.[52] The recipient's POC provides for respite services and specifically notes that N. N. resides with the recipient and is her primary care provider, who is to receive respite services.[53]

HMS's notes provide that the recipient's primary unpaid caregiver, identified in the recipient's plan of care is N. N., who lives with the recipient, whereas W. H. is the recipient's daughter, who does not live with the recipient. The respite care timesheet is also not signed by the recipient. HMS disallowed this claim because N. N. is the primary unpaid caregiver.[54] Mr. Astoji testified that he knew W. H. was a primary caregiver for the recipient.[55]

e. Claim 1293

This claim involves respite provided to the recipient for a J. D. during the week of April 8, 2012. The timesheet was signed by the recipient.[56] The recipient's approved POC states that she has a roommate, and that respite is being provided to her "roommate/family."[57] The roommate is not identified by name. Mr. Astoji was the recipient's care coordinator and knew that J. D. was the recipient's roommate.[58]

HMS disallowed this claim because there was no indication as to who J. D. was, and if she was the recipient's primary caregiver.[59]

f. Claim 23516

This claim involves respite provided to the recipient for a W. D., who is the recipient's son and power-of-attorney, the week of January 27, 2014. The recipient did not sign the

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49 AR 10950.
50 Mr. Astoji's testimony; Trans. Vol. III, pp. 400 – 401.
51 AR 17097.
52 AR 17072.
53 AR 17077 – 17078.
54 AR 10952.
55 Mr. Astoji's testimony; Trans. Vol. III, pp. 399 – 401.
56 AR 17506.
57 AR 17723.
58 Mr. Astoji's testimony; Trans. Vol. III, pp. 402 – 404.
59 AR 10952.

timesheet. W. D. signed it.[60] The recipient's approved POC provides that respite services are provided to give the recipient's family relief.[61] The recipient's daughter, with whom she resides, is the recipient's PCA.[62]

HMS disallowed the claim because W. D. did not reside with the recipient, and because the recipient's daughter was her primary caregiver.[63] Mr. Astoji was the recipient's care coordinator. He testified that V.C. was a member of the recipient's family, and that he met with W. D. regarding the recipient's care. To his knowledge, W. D. was not compensated for his services.[64]

3. Day habilitation services – Claim 84965

This was a claim for day habilitation services provided on January 31, 2014. The comments on the timesheet read:

> 1-31-14- [recipient] had a very good evening. He listened very well, with only one cue to wash up and to say "excuse me" when he burped. He was prompt in the bathroom and needed only a little cue to stop his homework and play.[65]

HMS denied this claim because the timesheet did not demonstrate that the day habilitation services were provided, as required by 7 AAC 130.260(b)(1) outside the recipient's home in the community, and that the items on the timesheet (recipient washed up, was prompted to use the restroom, and was prompted to do his homework) did not meet the recipient's day habilitation goals.[66]

The recipient is an intellectually disabled young man who lives in an assisted living home. His approved POC provides for day habilitation services, with goals of increasing his social interaction skills, community involvement, increasing his community safety skills, engaging in physical fitness activities, and increasing his financial independence and shopping skills.[67] The recipient goes to play Bingo as part of his day habilitation. Hearts submitted a mileage claim showing that the recipient had gone to Bingo. However, HMS deemed that

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60 AR 18029; Ms. Jones's testimony; Trans. Vol. III, p. 319.
61 AR 18044.
62 Ms. Jones's testimony; Trans. Vol. III, p. 320.
63 AR 10953.
64 Mr. Astoji's testimony; Trans. Vol. III, pp. 404 – 406.
65 AR 16672 – 16673.
66 AR 10951.
67 AR 16678, 16681, 16693 – 16697.

inadequate. HMS specifically noted that the timesheet notes do not refer to the recipient attending Bingo.[68]

III. Discussion

In order for a business to receive payment from the Medicaid system for services provided to Medicaid recipients, that business must be enrolled as a Medicaid provider with the Department.[69] A Medicaid provider is required to comply with all applicable federal and state requirements.[70] In this case, because Program Integrity is seeking affirmative financial relief against Hearts, based upon its allegation that Hearts has not complied with Medicaid requirements. It has the burden of proof by a preponderance of the evidence to establish the requisite non-compliance.

A. M & S Audit[71]

1. PCA timesheets that do not contain stop times, and in which the frequencies for a particular task were prefilled out.

PCS program regulation 7 AAC 125.120 requires that there must be a "contemporaneous service record" which includes "a time sheet recording the date, time, and length of each visit."[72] Prior to 2010, the general Medicaid regulations contained the requirement that provider records show the date services were rendered.[73] Revised Medicaid regulations were adopted, effective February 1, 2010, which specifically requires that provider records not only show the date the services were provided, but also that they include the "stop and start times for time-based billing codes."[74] PCS are time-based: services are authorized on a service plan, which provides for a certain number of services per day or week, *e.g.*, a recipient may have assistance for toileting up to six times daily, and the amount of time for each time toileting assistance is provided is a set amount of time, based upon the level of physical assistance that the recipient requires.[75] Consequently, a timesheet for a PCA must include not only the date, time, and length of each visit, but must also contain a start and stop time for the services.

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68 AR 10951.
69 7 AAC 105.210(a).
70 *See* 7 AAC 105.220.
71 Unless otherwise specified, the regulations cited to are those that were in effect in calendar year 2011.
72 7 AAC 125.120(a) and (a)(4).
73 7 AAC 43.030(b)(4) (repealed effective 2/1/2010, Register 193).
74 7 AAC 105.230(d)(5).
75 *See* 7 AAC 125.020 for a description of how a PCS plan is developed and authorized for a recipient.

It is undisputed that Hearts's individual PCA timesheets contained the date, time, and length of each visit. It is also undisputed that they contained a starting time, but did not contain a stopping time. The timesheets, while they were compliant with regulatory requirements prior to February 1, 2010, did not comply with the change instituted effective February 1, 2010, which required a stop time. Hearts argued that its timesheets, which recorded a duration, supplied a reasonable basis from which to infer the stop time of the PCA services on a particular day. However, this argument is not persuasive. When the specific PCS regulation, 7 AAC 125.120, is read in conjunction with the general Medical regulation for time-based billing units, 7 AAC 105.230(d)(5), the Medicaid program requires that a PCA's timesheet must contain a start time, a stop time, and a duration. Hearts's timesheet, which only contains two of those elements, the start time and the duration, does not satisfy the regulatory requirements.

Hearts raised another argument, which was that equitable estoppel precludes the Division from using the lack of a stop time on its timesheet form as a basis for denying payment. In order to successfully invoke estoppel against a governmental agency, four elements must be established:

1. the assertion of a governmental position by either conduct or words;
2. an act which reasonably relied upon the governmental position;
3. resulting prejudice; and
4. "estoppel serves the interest of justice so as to limit public injury."[76]

The evidence on the first element consists of Ms. Smaw's testimony that she was asked by Division of Senior and Disabilities (Division) Medicaid Provider Certification staff for Hearts's standard timesheet form as part of Hearts's recertification process, that she provided the timesheet, which does not show a stop time, merely a start time and the duration, and that she was recertified without the Division objecting to the timesheet form. This occurred in October 2010. The regulation which requires a stop time was effective February 1, 2010. There is nothing in the evidence that suggests that Ms. Smaw was not credible. Nor was there any meaningful evidence controverting Ms. Smaw's account.

Program Integrity presented a witness stating that the office which conducts recertifications would not have asked for a copy of a timesheet. However, she had no personal knowledge of what was done in this case. Indeed, she did not work for the certification office in

[76] *Wassink v. Hawkins*, 763 P.3d 971, 975 (Alaska 1988).

2010 or 2011, and did not even work for the Division at the time.[77] While the recertification process apparently does not require that a provider submit a copy of its timesheet, the fact that the Division asked for one demonstrates that it was a factor in Hearts's recertification. Accordingly, Hearts has shown that the Division asked for and implicitly approved Hearts's timesheet form in late 2010 when it approved Hearts's recertification, which was well after the time the regulatory requirement that timesheets must show a stop time became effective. This satisfies the first element of the estoppel test, the assertion of a governmental position.

The evidence on the second element is that Hearts continued to use its standard, approved, timesheet form throughout 2011. This was a reasonable reliance upon the asserted governmental position, which satisfies the second element of the estoppel test. In considering the reasonable reliance element, it is important to note that the requirement for a stop time is not contained in the general PCS regulations, but is instead contained in the general Medicaid regulations. A PCS provider, while aware of the specific requirements contained in the PCS regulations, might not be aware of the overarching Medicaid record-keeping requirements.

The evidence on the third element is that Hearts has been substantially prejudiced by its reliance on the governmental position. If it had been advised that its timesheets did not comport with regulatory requirements at the time of its recertification, it could have rectified the deficiency, and avoided findings in an audit conducted five years later that result in a disallowance of the majority of its billings.

The fourth element is also satisfied. Regulated businesses should be able to rely upon the basic competence of the governmental reviewers to point out errors that might invalidate all of their billings. This is especially true in this case, where the government agency actively sought out information, the timesheet, and then failed to notify the business that the timesheet was inadequate.

Hearts has therefore established that equitable estoppel precludes Program Integrity from disallowing the 61 claims M & S identified in its audit based upon the lack of a stop time in the timesheets.

Program Integrity also presented an argument that these 61 claims should be disallowed based upon the fact that most of Hearts's timesheets were forms where the number of times a particular service was provided each day, along with the corresponding number of minutes, were

[77] Ms. Herman's testimony.

filled out in advance.[78] Program Integrity's specific argument was that the practice of prefilling out the timesheets meant that the timesheets were not contemporaneous billing records. However, there was absolutely no evidence presented that the timesheets were not signed contemporaneously with the service having been provided. Although Mr. Hansen from M & S speculated that the prefilling out of the specific services meant that those specific services might not actually have been provided, [79] this was purely speculative and cannot be used as a basis for a factual finding. Hearts's principal, Ms. Smaw, provided a very reasonable explanation that the prefilling of the services let both the client and the PCA know what services were authorized, and that the practice of prefilling was instituted because of difficulties with the PCAs providing more services than were authorized.[80] As a result, Program Integrity's argument is not persuasive.

Although Program Integrity demonstrated that Hearts's timesheets were not in compliance with regulatory requirements, it failed to show that they were not contemporaneous records. Hearts also established that equitable estoppel barred Program Integrity from using the lack of regulatory compliance for disallowing these 61 claims. Accordingly, the audit results must be adjusted to allow these 61 claims.

2. Illegible timesheets.

This category covers one claim.[81] It is for a single timesheet covering a one-week time period. The auditor disallowed this claim based upon its finding that the timesheet was illegible.[82] As found above, the timesheet, although less than ideal, is intelligible with effort. Accordingly, Program Integrity has not met its burden with regard to this claim. The audit results must be adjusted to allow this claim.

3. Timesheet where M & S found the PCA was also the power-of-attorney for the recipient.

This category covers one claim.[83] The auditor disallowed this claim because the applicable PCA regulation does not allow a legal representative of a recipient to also serve as that recipient's PCA, absent court authorization. Program Integrity is correct that the applicable

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78 *See, e.g.*, AR 6145.

79 Mr. Hansen's testimony; AR 13.

80 This decision does not suggest in any way that the prefilling out of service frequencies is a best practice in any way. However, it was not an unreasonable practice in 2011.

81 Claim 6. AR 13, 20.

82 Mr. Hansen's testimony.

83 Claim 31. AR 13 – 14, 29.

regulation, 7 AAC 125.010(b)(4), does not allow PCS to "be provided by an individual who is. . . a legal representative." The evidence in this case shows that the PCA in question was previously the recipient's legal representative (power-of-attorney). However, that power-of-attorney was revoked on March 13, 2010, which was over a year prior to the week of October 23 – 29, 2011.

The auditor discounted the revocation of the power-of-attorney because the signature on it was markedly different from other documents signed by the recipient. The signature was in cursive, whereas the recipient's other signatures were printed. This is comparing apples and oranges. There was no handwriting analysis presented stating that the cursive signature was not from the same person who had printed her name on other documents. In addition, the recipient executed a new "Health Care Agent" document, dated March 15, 2010, only two days after the revocation document, giving authority to another person for making medical decisions for the recipient, a change which is consistent with the removal of a prior legal representative.

Program Integrity had the burden of proof. It did not meet it. Accordingly, this claim should be allowed, rather than disallowed, and the audit results adjusted.

4. Incomplete documentation, where Hearts did not have a copy of the PCA authorized service plan in its records.

Medicaid providers are required to keep a copy of their records for a period of seven years from the date of service.[84] If a Medicaid provider does not supply a copy of a record, after it is requested, the record "may [be] consider[ed] . . . to be nonexistent."[85] A recoupment action "may" then be brought to "recover an overpayment . . . based on a determination of the record's nonexistence."[86]

M & S requested copies of Hearts's records for this audit. Hearts did not have a copy of the PCS authorized plan for three of the sampled claims.[87] Based upon their nonavailability, the auditor disallowed the three claims. Hearts, referring to the class action suit that essentially placed the PCS program on hold in 2009, argued that the PCS plans were more than seven years old, and that it was therefore in compliance with retention requirements. This argument is nonavailing. The record retention period is seven years from the date of service, not from the date the PCS plan was created.

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84 7 AAC 105.230(e).
85 7 AAC 105.240(d)(1).
86 7 AAC 105.240(d)(2).
87 Claims 29, 55, and 56. AR 11.

Regardless, there are two independent grounds that favor Hearts on this issue. The first is that the Medicaid regulations do not specifically require the PCS agency to retain copies of the PCS plan. The second is, assuming for the sake of argument that a PCS agency is required to retain copies of the PCS plan, it is an abuse of discretion for these claims to be disallowed, given the specific circumstances of this case.

a. Medicaid Regulations

A review of the general Medicaid regulations that govern all providers shows that they require a provider to maintain records that identify the recipient, the specific services provided, the date of the services, and for time-based billing services, start and stop times.[88] The provider must also "retain records necessary to disclose fully to the department the extent of services provided to recipients."[89] The general Medicaid regulations, however, do not require that a provider maintain a copy of the Division's approval, which a PCS plan would be, for the provision of a specific service or services. The PCA timesheets would therefore meet these general requirements.

The regulations specific to PCS require the individual PCAs to keep a copy of the PCS plan: the PCA is required to maintain a record, which includes "a copy of the PCAT authorized services plan."[90] The PCA is also supposed to turn his or her records over to the PCS agency if the PCA is replaced or otherwise stops providing services to a recipient.[91] Interestingly enough, while the PCS agency is required to "collect and verify consumer-directed personal care assistants' timesheets and submit claims to the department," the regulations do not require the PCS agency to hold onto a copy of the PCS plan.[92] The regulations also do not allow a PCS agency to be compensated for billing in excess of services authorized in the PCS plan.[93]

Reading the regulations as a whole, the PCA, not the PCS agency, is the primary custodian of the PCS plan. It is the PCA's responsibility to make sure that it travels with the recipient by returning it to the PCS agency, in the event the PCA is replaced or terminated. While the PCS agency must obviously be aware of the PCS plan's contents, because it is required to verify the PCA's timesheet and submits the claims and may only be compensated for

88 7 AAC 105.230(a) – (d).
89 7 AAC 105.220(b).
90 7 AAC 125.120(a)(3).
91 7 AAC 125.120(b) – (c).
92 7 AAC 125.130.
93 7 AAC 125.195(b) and (c).

services authorized by the PCS plan, the regulations do not require the PCS to actually maintain a copy of the plan in its records. The intent of the regulations in force in 2011 might have been that PCS agencies were required to keep a copy of the PCS plan; however they do not expressly require it. Interestingly enough, the PCS regulation changes which took effect in July 2017 rectify this apparent oversight: "a personal care services agency … shall (3) maintain a service record for each recipient that includes (A) a copy of each service level authorization . . ."[94] As a result, these three claims may not be disallowed due to the PCS's failure to maintain a copy of the PCS plan, because that was not required in 2011.

b. Disallowing the claims is discretionary, and the facts of this case support exercising discretion in favor of allowing the claims.

Even if Program Integrity is correct and the regulations do require a PCS agency to maintain copies of the PCS plan, the facts of this case demonstrate that the Department should exercise its discretion in favor of allowing the claims.

The Division would have copies of recipients' PCS plans, since it is the agency that authorizes the plans and sends the recipients copies of their plans. After M & S issued its preliminary audit findings, specifically identifying the lack of service plan on three claims, two of which related to the same recipient, Hearts asked for a copy of the service plan for the recipient on two of the claims. The Division did not supply a copy of the service plan because it was "having trouble finding it." The Division also notified Hearts that it would not even look for plans that were more than seven years old. These three claims involve two recipients, both of whose service plans were from 2006, *i.e.*, more than seven years old.

In two hospital Medicaid rate-setting cases, the Alaska Supreme Court overturned decisions issued in strict adherence to regulatory requirements when the Department of Health and Social Services had information in its possession which indicated that strict compliance should not be enforced. The first of these cases, *Valley Hospital*, involved the Department setting the hospital's Medicaid payment rate using an interim cost report, which the Department knew was historically inaccurate, when the Department had within its possession a more accurate report based upon the hospital's own Medicaid billings.[95] The second of these cases, *North Star Hospital*, involved the Department setting the hospital's Medicaid payment rate using financial

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94 7 AAC 125.130(a) (regulation changes effective July 22, 2017, Register 223).

95 *State, DHSS v. Valley Hospital Association, Inc.* 116 P.3d 580 (Alaska 2005).

data for 2005, when it had in its possession an unaudited financial report which showed the hospital's costs had greatly increased in 2006:

> In summary, the present case and *Valley Hospital* are similar in a most important respect: At the time DHSS calculated both hospitals' reimbursement rates, DHSS's Medicaid staff appeared to have known that there was a significant discrepancy between the most current date available and the outdated data it relied on, and that using outdated data 'would result in a lower reimbursement rate.'[96]

The *Valley Hospital* and *North Star Hospital* cases are instructive. They demonstrate that it is an abuse of discretion for a governmental agency to take action based upon incomplete/outdated documentation provided by a party, when the agency already has the necessary information in its possession.

As discussed above, PCS plans are generated and authorized by the Division. The Division would have therefore had them in its position. Assuming that the regulation mandates that the PCS provider is required to keep copies of its documents for seven years after the date of service, it being undisputed that Hearts did not have the service plans in its possession at the time of the audit, the regulation is clear that presuming non-existence of the documents is discretionary:

> [i]f, in a response to a request for a record . . ., the provider does not produce the record on or before the deadline specified in the request or the deadline modified or extended under (c) of this section,
>
> (1) for purposes of an audit . . ., the person making the request **may** consider the record to be nonexistent; and
>
> (2) the department . . . **may** initiate a recoupment, another procedure to recover an overpayment, . . . based on a determination of the record's nonexistence under (1) of this subsection.[97]

The regulation is also clear that, even if a document is presumed to be non-existent, initiating recovery is itself discretionary. The facts of this case support the exercise of discretion in Hearts's favor for the following reasons:

1. These plans date back to 2006. The audit process was begun in 2014, eight years after the plans were authorized.

2. The plans authorized and developed in 2006 were apparently unaltered and remained the same in 2011, the year of service.

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[96] *State, DHSSS v. North Star Hospital*, 280 P.3d 575, 582 (Alaska, 2012) (quoting from *Valley Hospital* at 587).

[97] 7 AAC 105.250(d) (emphasis supplied).

3. The Division, which developed and authorized the plans, either could not locate the plans itself or was unwilling to locate them.

4. It was not argued, nor was any evidence presented suggesting, that Hearts billed for services that were not rendered or that it billed for services not authorized by the PCS plans.

B. HMS Audit

1. Duplicate billings – Claim 93938

Hearts does not dispute that it submitted duplicate claims for the same service. One claim was made for Waiver services. The other was for PCS. The Division argues that payment should be made at the lesser rate paid for PCS, rather than for the higher rate paid for Waiver services. Hearts argues the contrary. Neither side has presented any authority in support of its position. The undersigned is unaware of any authority on this point.

It is clear that Hearts cannot be paid twice for the same service. Given there is a substantial (25%) disparity between the rate paid for Medicaid Waiver services ($41.80) and PCS ($30.50), it follows that the Division as the payer should pay the lesser of the charges. To do otherwise, would unjustly enrich Hearts. Accordingly, this overpayment finding is upheld.

2. Respite care services

Respite care services are provided to relieve unpaid primary caregivers of Medicaid recipients. The applicable regulation specifically provides that they are to relieve "primary unpaid caregivers, including family members and court-appointed guardians."[98] Respite care services must be approved as part of a Medicaid recipient's POC.[99] Neither the respite care service regulation nor the regulation that contains the requirement for a POC require that a POC identify the primary unpaid caregiver by name, specify that a recipient may only have one primary unpaid caregiver, that the primary unpaid caregiver must reside with the recipient, or that the primary unpaid caregiver cannot change.[100]

a. Claim 16929

HMS disallowed Claim 16929 because B. T. was not the recipient's primary caregiver. However, Program Integrity failed to present any evidence that B. T. was not a primary

98 7 AAC 130.280(b)(1).
99 7 AAC 130.230(a)(1).
100 7 AAC 130.230; 7 AAC 130.280.

caregiver. In addition, the recipient actually signed the timesheet for the respite care provider, which listed B. T. as the primary caregiver. Program Integrity's head, Douglas Jones, testified:

> Q. So if the timesheet identified an unpaid primary caregiver and the consumer, the recipient signed off on that timesheet, they would essentially be identified by their primary caregiver?
>
> A. As long as they're --- are they unpaid?
>
> Q. Yes.
>
> A. Okay.[101]

Mr. Astoji who was the recipient's care coordinator, testified that, to his knowledge, B. T. had never been a paid caregiver for the recipient. No evidence was presented to controvert his testimony. Consistent with Mr. Jones's testimony, and because Program Integrity failed to provide any evidence that B. T. was not a primary caregiver for the recipient, Program Integrity's disallowance of this claim was based upon speculation. It failed to meet its burden of proof. Accordingly, this claim should be allowed.

b. Claim 89140

This is similar to Claim 16929 with one critical difference. The person receiving the respite care services, not the recipient, signed the timesheet. However, there was no indication that C. T. was not a primary caregiver for the recipient. There was also a legal relationship between the recipient and C. T. C. T. held a limited power-of-attorney for the recipient. Program Integrity's disallowance of this claim was based on speculation. It did not meet its burden of proof. This claim should be allowed.

c. Claim 1887

This is virtually identical to Claim 16929. The timesheet was signed by the recipient. The unpaid primary caregiver listed on the timesheet, Q. N., is the recipient's daughter. While Q. N. is not the daughter with whom the recipient resides, the daughter, B. N. with whom the recipient resides, is the recipient's PCA. B. N. cannot receive respite care because she is a paid caregiver. The disallowance of this claim was speculative. Program Integrity has not met its burden of proof. The claim should be allowed.

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[101] Mr. Jones's testimony; Trans. Vol. III, p. 380.

d. Claim 24090

This claim involves respite provided to the recipient for a W. H. for the week of September 22, 2014. The evidence shows that W. H. is the recipient's daughter, who does not live with her, and holds her power-of-attorney. However, the recipient's POC specifically notes that N. N. resides with the recipient and is her primary care provider, who is to receive respite services.

HMS disallowed this claim because N. N. is the primary unpaid caregiver. However, there is no evidence showing that W. H. was not the primary caregiver at the time of the billing claim. In addition, Mr. Astoji testified that he knew W. H. was a primary caregiver for the recipient. Consequently, Program Integrity failed to meet its burden of proof, and this claim should be allowed.

e Claim 1293

This involves a claim for respite care afforded J. D. The timesheet was signed by the recipient. The evidence shows that J. D. was the recipient's roommate. The recipient's plan of care identifies a "roommate" as a respite care recipient. There is no evidence that J. D. was not the roommate, nor that J. D. was not the recipient's unpaid primary caregiver. Accordingly, Program Integrity has failed to meet its burden of proof and this claim should be allowed.

f. Claim 23516

This involves a claim for respite care afforded W. D., the recipient's son and power-of-attorney. While W. D. does not reside with the recipient, the daughter with whom she resides is the recipient's PCA, who cannot receive respite care because she is a paid caregiver. The recipient's POC states respite care is to be provided to family. It does not specify an individual. W. D., per Mr. Astoji's testimony, was involved with the recipient's care. There is no evidence showing that W. D. was not a primary unpaid caregiver for the recipient. Program Integrity has therefore failed to meet its burden of proof and this claim should be allowed.

3. Day habilitation services – Claim 84965

It is undisputed that the recipient goes to Bingo as part of his day habilitation services. The timesheet that was filed does not say he went to Bingo on the day in question. However, it does refer to him being prompted to stop his homework and to play. It also refers to him being cued to wash, and to say excuse me. His goals include increasing his social interaction skills: washing up, excusing oneself, and participating in group activities all fall in this area. While it

would be preferable if the timesheet actually indicated that the recipient was at Bingo, Program Integrity is required to demonstrate that he was not. It has not met its burden of proof, and this claim should be allowed.

IV. Conclusion

The M & S audit's disallowance of claims pertaining to defective timesheets is reversed under the doctrine of equitable estoppel. The M & S audit's disallowance of claims pertaining to a lack of PCS service plans is reversed because the regulations give the Department the discretion to allow these claims, and the facts support the exercise of that discretion in Hearts's favor. With regard to the other two disallowed claims in the M & S audit, being the one for an illegible timesheet and the one where Program Integrity alleged that the PCA was not eligible to be a paid caregiver, Program Integrity has not met its burden of proof. Accordingly, each of these disallowed claims is allowed. Program Integrity is to recalculate the overpayment, based upon this decision.

The HMS audit's disallowance of the duplicate claim (Claim 93938) is upheld. The disallowance of the remaining seven disputed claims in the HMS audit is reversed, because Program Integrity failed to meet its burden of proof on each of these claims. Program Integrity is to recalculate the overpayment, based upon this decision. If Hearts disputes the recalculation, it will have new appeal rights confined to that issue alone. Jurisdiction is not retained.

DATED this 22nd day of December, 2017.

By: *Signed*
Lawrence A. Pederson
Administrative Law Judge

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