IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

HIDDEN HEIGHTS ASSISTED LIVING, INC., Plaintiff, vs. STATE OF ALASKA, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF HEALTH CARE SERVICES, Defendants.	Case No. 3AN-05-11125 CI

MEMORANDUM OF DECISION

I. INTRODUCTION

Appellant Hidden Heights, Inc. ("Hidden Heights") is an assisted living home licensed to provided Medicaid services. Ernest Reeves ("Reeves") is owner and operator of Hidden Heights. Hidden Heights has been licensed since 1999 to house five to six residents. Reeves describes Hidden Heights as a "one man show" with five or six part-time employees.

In 2004, Appellee Department of Health and Social Services (the "Department") contracted with accounting firm Myers & Stauffer, LC (the "Auditor") to conduct audits of Medicaid providers. The Auditor audited Hidden Heights. The Auditor concluded that Hidden Heights had received substantial overpayments from Medicaid. The Auditor based this finding on what it deemed inadequate records to support the Medicaid services for which Hidden Heights billed. Hidden Heights appealed the audit findings.

Following conclusion of an evidentiary hearing, the hearing examiner upheld the Auditor's findings. The Department adopted the hearing examiner's findings.

The matter is now before the court on Hidden Heights's appeal. Hidden Heights questions a number of the hearing examiner's factual findings and legal conclusions, specifically whether standards utilized by the Auditor were appropriate and whether, based on the doctrine of equitable estoppel, the Department should be prohibit from conducting audits and recouping overpayments for the period at issue.

II. BACKGROUND

A. Alaska Medicaid

Under the Medicaid Act, the federal government underwrites part of the costs states spend providing medical care to eligible needy individuals. In order to receive federal support, states must comply with requirements of the Medicaid Act and with regulations promulgated by the federal Department of Health and Human Services.[1] The Medicaid Act mandates that participating states establish or designate a single state agency to administer a state's Medicaid plan.[2] Under the Medicaid Act, a state's plan must establish a scheme for reimbursing health care providers for the medical services provided to eligible individuals and a means of verifying the legitimacy of payment claims.[3] A health care provider receiving Medicaid reimbursements may face various consequences for submitting improper or unsubstantiated claims. A state's Medicaid agency may withhold payments to providers, seek to recover overpayments,

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[1] San Lazaro Ass'n, Inc. v. Connell, 286 F.3d 1088, 1092 (9th Cir. 2002).
[2] Id.
[3] Id. at 1093.

or decertify and bar providers from participation.[4]

The Alaska Legislature has designated the Department of Health and Social Services as its Medicaid agency granting the Department broad statutory authority to manage and regulate Alaska's Medicaid plan.[5] The Department has promulgated regulations, consistent with the Medicaid Act, pertaining to Medicaid funded medical assistance. 7 AAC 43[6] outlines various medical assistance programs funded by Medicaid. One such program is the Home and Community-Based Waiver Services Program ("HCB waiver program").[7] Alaska's HCB waiver program offers eligible aged, blind, physically or developmentally disabled, or mentally retarded persons a choice between home or community-based services instead of an institutional setting such as a nursing home or intermediate care facility.[8] The Department will enroll a provider of residential support living services to provide HCB waiver services if the provider is certified under 7 AAC 43.1090(a) and if the provider has entered into a medical provider agreement pursuant to 7 AAC 43.065.[9]

Under a medical provider agreement, a provider promises "(1) to follow procedures that are consistent with guidance in the applicable Alaska Medicaid Provider Billing Manual as of July 14, 2000; (2) to comply with applicable state and federal Medicaid law; and (3) to cooperate in reports, surveys, reviews, or audits conducted by

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[4] Id.
[5] AS 47.05.010.
[6] The regulations set forth below are contemporaneous with the audit. Many of the regulations were revised after the audit and appeal.
[7] 7 AAC 990 – 1110.
[8] 7 AAC 43.1000.
[9] 7 AAC 42.1090(b).

the department."[10] Further, 7 AAC 43.065 requires a provider to "retain records necessary to disclose fully to the [Department] the extent of services provided to recipients"[11] and must "allow on-site inspection by authorized representatives of both state and federal agencies connected with the Medicaid program."[12]

As the agency responsible for administering the Alaska Medicaid plan, the Department has a fiduciary responsibility to ensure that claims for Medicaid services are paid in accordance with Medicaid program statutes, regulations, Medicaid provider agreements, and Medicaid provider billing manuals. Since 1997, the Department's regulations, specifically 7 AAC 43.067, have provided for auditing of Medicaid providers. Prior to December 2006, 7 AAC 43.067 afforded the Department discretionary authority to conduct reviews or audits to determine the provider's compliance with requirements of 7 AAC 43.030 and other provisions of Alaska medical assistance regulations. 7 AAC 43.030 specifies requirements for provider records.[13] Pursuant to 7 AAC 43.067(g),[14] a

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[10] 7 AAC 43.065(b)(1-3).
[11] 7 AAC 43.067(c).
[12] 7 AAC 43.065(f).
[13] 7 AAC 43.030 provides in part:

> a) A provider shall maintain accurate financial, clinical, and other records necessary to support the care and services for which payment is requested. The provider is responsible to assure that the provider's designated billing service, or other entity responsible for the maintenance of financial, clinical, and other records, meets the requirements of this section.
> (b) A provider's record must identify patient information including
> (1) recipient receiving treatment;
> (2) specific services provided;
> (3) extent of each service provided;
> (4) date on which each service is provided; and
> (5) individual who provided each service.
> (c) A provider's record must identify financial information including

provider must refund to the department any reimbursed claim that the Department finds, after post payment review, does not meet requirements of 7 AAC 43.

Under 7 AAC 43.085(i),[15] a provider could appeal the results of an audit or review conducted under 7 AAC 43.067. 7 AAC 43.085(i) required a appealing provider to submit, to the commissioner of the Department within 30 days after the provider received the audit results, a clear description of the issue or decision being appealed, the reason for the appeal, and all information and materials that the provider request the commissioner consider in resolving the appeal.

In 2003, the Alaska Legislature enacted AS 47.05.200, which made Department audits of medical assistance providers mandatory. The Department must contract for independent audits to identify overpayments and violations of state and federal statues and regulations. AS 47.05.200 not only mandates that the Department contract for these annual audits for the purpose of identifying overpayments, it requires the Department to begin recoupment of an identified overpayment within 90 days of the audit report.[16]

At the time of Hidden Heights's audit and audit appeal, the regulations identifying

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(1) the date of service and charge for each service provided;
(2) each payment source pursued;
(3) the date and amount of all debit and credit billing actions for each date of service provided; and
(4) the amounts billed and paid.

. . .

(e) A provider shall retain the financial, clinical, and other records of a patient for which services have been billed to the Medicaid program for at least seven years from the date the service is provided.

[14] 7 AAC 53.067 (repealed December 2006 relocated to 7 AAC 43.1440).
[15] 7 AAC 43.085 was revised in December 2006.
[16] AS 47.05.200(b).

procedure for these actions were limited. In January 2007, 7 AAC 43.1400 - 1490 became effective. These provisions provide more specific procedure for audits and appeals; however, they are inapplicable to the case before the court.

B. Facts and Proceedings

(1) The audit

In 2004, the Department contracted with Myers & Stauffer, LC (the "Auditor") to conduct desk reviews and onsite field audits of Medicaid providers in Alaska.[17] The purpose of these reviews was to evaluate the accuracy of Medicaid payments made from April 1, 2002 to March 31, 2003.[18] The Auditor selected a random sample of Medicaid claims and notified providers of their selection for desk reviews and on-site field audits.[19] The Auditor chose Hidden Heights to participate in a desk review and requested documentation supporting claims made during the subject time period.[20] After receiving two packets of documentation from Hidden Heights and conducting a desk review, the Auditor notified Hidden Heights of its selection for an on-site field audit.[21] The field audit took place on July 26 and 27, 2004.

During the period under review, Hidden Heights submitted a total of 74 Medicaid claims totally $284,344.41.[22] The Auditor audited 53 of the 74 claims.[23] The Auditor

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[17] Ex. 3 p. 190.
[18] Ex. 5 p. 2.
[19] Ex. 5 p. 3.
[20] Ex. 5 p. 3.
[21] Ex. 5 p. 3.
[22] Ex. 5 p. 17.
[23] Ex. 5 p. 17.

found numerous deficiencies in Hidden Heights's documentation of these claims.[24] The Auditor identified overpayments for 27 claims.[25] The Auditor based findings of overpayment on deficient documentation.[26] The overpayments totaled $74,493.53. Pursuant to 7 AAC 43.068, the Auditor extrapolated the results of the 53 claim sample over the entire population of 74 claims. Consequently, the Auditor calculated that overpayments to Hidden Heights for the audit period totaled $104,009.83.[27]

On September 23, 2004, the Auditor sent Hidden Heights a preliminary audit and allotted Hidden Heights 21 days to respond to the preliminary findings and submit additional documentation.[28] On November 5, 2004, Hidden Heights requested an additional two weeks to respond; however, Hidden Heights submitted no additional documentation.

On February 25, 2005, the Auditor issued its final audit report informing Hidden Heights of its right to appeal by submitting a written request to the commissioner of the Department within 30 days of receiving the audit results.[29] The Auditor informed Hidden Heights of the requirements of 7 AAC 43.085(i) that the appeal request must include: (1) a clear description of the issue of decision being appealed; (2) the reason for the appeal; and (3) all information and materials that Reeves wanted the commissioner to consider in resolving the appeal.[30]

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[24] Ex. 3 p. 192-98.
[25] Ex. 5 p. 17.
[26] Ex. 3 p. 192-98.
[27] Ex. 5 p. 17.
[28] Ex. 3 p. 190.
[29] Ex. 1.
[30] Ex. 1.

On March 25, 2005, Hidden Heights requested an appeal of the audit and submitted documentation not reviewed by the Auditor.[31] The Department requested the Auditor review the additional documentation. While the Auditor found that the additional daily reports "were often completed by the caregiver initialing once and drawing a line through all of the boxes on the form, rather than initialing each daily activity individually," the Auditor did not make findings of overpayments relating to this practice. However, the Auditor did note "the repeated use of this technique . . . gave diminished assurance that specific activities relating to a resident's plan of care were consistently performed."[32] Ultimately, the Auditor reduced the findings of actual overpayments from $74,493.53 to $45.093.57 and reduced the extrapolated overpayments from $104,009.83 to $62,960.83.[33]

After this recalculation, Hidden Heights submitted more documentation including activity sheets for October 2002 and November 2002 and medication supervision records.[34] The Auditor reviewed the additional documentation. In a letter dated June 24, 2005,[35] the Auditor notified Hidden Heights that the activity logs supported services billed for on most of the days in those months. However, regarding the medication supervision records, the Auditor concluded that while they showed a resident received medication supervision they did not verify that the resident received other required

[31] Ex. 8 p. 1.
[32] Ex. 8 p. 2.
[33] Ex. 8 p. 3.
[34] Ex. 9 p. 1-37.
[35] Ex. 10.

services. Thus, the Auditor did not alter its findings based on these medication logs.[36] Ultimately, the Auditor reduced the actual overpayments from $45,093.57 to $39,111.02 and reduced the extrapolated overpayment from $62,960.83 to $54,607.84.[37]

In an August 5, 2005 letter,[38] the Department offered to compromise $23,273.86 of the outstanding extrapolated liability of $54,607.84 and to settle for $31,333.98. The Department notified Hidden Heights that if it did not accept the compromise and settlement, it could submit a written request for an evidentiary hearing or appeal the findings to the superior court under Appellate Rule 602.

On September 8, 2005, Hidden Heights appealed to the superior court.[39] On the same day, Hidden Heights notified the commissioner that it did not accept the offer of compromise and that it had filed an administrative appeal with the superior court.[40] Hidden Heights expressed a concern about possibly failing to exhaust administrative remedies by not accepting the Department's offered evidentiary hearing, so Hidden Heights requested an evidentiary hearing.[41]

(2) Proceedings before hearing examiner

i. preliminary matters

On September 12, 2005, the commissioner issued a notice of assignment which stated:

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[36] Ex. 10 p. 1-2.
[37] Ex. 10 p. 2.
[38] R. 461.
[39] R. 458-60.
[40] R. 465.
[41] R. 456.

> Pursuant to AS 44.62.350 and 44.62.450, I hereby assign the above appeal to the Hearing Examiners in the Office of Hearings and Appeals, who shall have full authority to conduct an evidentiary hearing and/or such other proceedings as may be appropriate, to submit to me a proposed decision in accordance with AS 44.62.500, and to administer all aspects of the appellate process.[42]

On September 30, 2007, the court stayed proceeds pending the outcome of the evidentiary hearing.

On January 13, 2006, Hidden Height filed, with the hearing examiner, its final statement of points on appeal. Hidden Heights claimed it could prove that residents were in the home and the Medicaid services required by its state-approved Plan of Care were provided.[43] Further, Hidden Height raised the issue that the Department was equitably estopped from requiring production of Medicaid service records at the level of detail and specificity required by the audit, since, according to Hidden Heights, the Department did not require such records until after the Medicaid re-certifications that began July 1, 2004.[44]

ii. summary judgment

On January 24, 2006, the Department moved for summary judgment on both of these issues.[45] The Department noted that Hidden Heights's claims relied on evidence not available to the Auditor. The Department argued that Hidden Heights could not supplement the record with new evidence because the Department's regulations did not

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[42] R. 467.
[43] R. 356.
[44] R. 355-56.
[45] R. 315-344.

allow for the submission of the additional documentation that Hidden Heights's pleading contemplated.[46] The Department relied on 7 AAC 43.085(i) which required the provider to submit "all information and material that the provider requests the commissioner to consider in resolving the appeal" within 30 days of the audit findings.[47] The Department claimed that based on the evidence available to the Auditor, Hidden Heights failed to maintain accurate records necessary to support the care and services for which it received payment.[48] In addition, the Department moved for summary judgment on Hidden Heights's equitable estoppel claim arguing Hidden Heights was unable to meet any of the elements required under the doctrine.[49]

In opposition, Hidden Heights argued that the daily log notes ("daily logs" or "Exhibit D")[50] submitted on January 18, 2006 plus the affidavits of Reeves and Sherry Mettler ("Mettler"), an accountant for assisted living homes, created a genuine issue of material fact whether the overpayment findings were accurate.[51] Hidden Heights claimed that information in Exhibit D was available to the Auditor during the audit.[52] Hidden Heights argued its estoppel defense.

In its reply, the Department argued that Exhibit D was inadmissible because it

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[46] R. 322.
[47] R. 323.
[48] R. 334.
[49] R. 335.
[50] A "daily log" listed the residents with a few lines next to each name for Hidden Heights staff to make notes about the day specific to that resident. In addition, each daily log had a space to make notes about what happened in the house that day. Generally, the daily log notes were signed and dated by staff who completed the log note.
[51] R. 181-82.
[52] R. 181.

was not availab e to the Auditor and because it was not submitted with the appeal to the commissioner or, in the alternative, that Exhibit D did not conform to the requirements of 7 AAC 43.030 and could not create a material factual dispute adequate to preclude summary judgment.[53]

In an order dated March 7, 2006,[54] the hearing examiner made two alternative conclusions. In the first conclusion, the hearing examiner determined that the Department's letter sent February 25, 2005, which notified Hidden Heights of the appellate procedure outlined in 7 AAC 43.085(i), constituted a final audit and that Hidden Heights's March 25, 2005 appeal to the commissioner was the "initial appeal." The hearing examiner concluded this initial appeal ended when the commissioner made the settlement offer and allowed Hidden Heights to request an evidentiary hearing. The hearing examiner concluded that 7 AAC 43.085(i) only applied to this "initial appeal" so it did not bar Exhibit D in the instant matter. The hearing examiner cited nothing in support and did not specify procedure or limitations for submitting evidence in the evidentiary hearing.

In the alternative, the hearing examiner concluded that if the matter before her constituted a continuation of the March 25, 2005 appeal, then 7 AAC 43.085(i) still did not apply because the Department constructively waived its right to strict adherence to 7 AAC 43.087 by accepting supplemental documents after the 30-day deadline.

Ultimately, the hearing examiner denied the motion for summary judgment. The hearing examiner concluded issues of fact existed regarding the admissibility of Exhibit

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[53] R. 148.
[54] R. 300.

D stating, "I will weigh the credibility of each party's witnesses and make the final determination of admissibility at hearing." Further, the hearing examiner found, based on the affidavits of Reeves and Mettler and the possible admittance of Exhibit D, that genuine issues of fact existed regarding the overpayment calculations. The hearing examiner did not address the estoppel issue but denied summary judgment in whole.

iii. evidentiary hearing

The hearing examiner conducted an evidentiary hearing from March 28 through March 30, 2006.

The parties established that the Department had the burden of proof by a preponderance of the evidence, but it is unclear what the Department had to prove.[55]

Fran Arseneau ("Arseneau") and Allen Hansen ("Hansen") testified for the Department.

Arseneau testified that as manager of the Quality Assurance Unit of the Division of Senior and Disability Services, her duties included reviewing program methods, overseeing audits, and monitoring billing practice. Arseneau concluded Hidden Heights's documentation was not sufficient; however, on cross-examination Arseneau could not firmly establish how specific records needed to be.[56]

Hansen testified, as manager for Myers & Stauffer, that he had been part of the team that preformed the desk review and the field audit. He testified that Hidden Heights's records were highly disorganized. He testified that his auditing standard was lenient to the extreme in favor of Hidden Heights. He testified any identifiable marks

[55] R. 133.
[56] Tr. 47-51.

that showed Hidden Heights substantially performed the required daily services constituted adequate documentation; however, an unidentifiable mark (for example "stars") did not support such a finding.[57] Hansen testified that he had not seen the daily logs during the audit but that had he seen the daily logs they would not have made a difference in his audit. Hansen testified that the daily logs where inadequate because they did not indicate that appropriate services were provided, only that the resident was in the home. Hansen testified that under the Auditor's lenient review standard, evidence merely showing a resident was in the house was inadequate because such evidence failed to show Hidden Heights performed services.[58] Hansen stated, "I don't think it is really a matter for us to speculate were they in the home or were services provided. It's a matter of . . . is there a record. 43.030 defines the records that must be kept and that's irregardless . . . of the service being preformed, it's a matter of documenting the services."[59]

Reeves and Mettler testified for Hidden Heights.

Reeves testified that the Department never imposed Medicaid record keeping requirements and never conduct record examinations before 2004.[60] Reeves testified that Hidden Heights preformed all the services for which it billed Medicaid.[61] Reeves went through each entry in Exhibit D[62] and claimed the daily logs were available or "somewhere in the office" but stated that he did not submit the daily logs with the

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[57] Tr. 169-70.
[58] Tr. 184.
[59] Tr. 184-85.
[60] Tr. 198-99.
[61] Tr. 263-64.
[62] Tr. 220-50.

appeal.[63]

Mettler testified that she had been an accountant for 42 years and involved in the assisted living business since 2001. She testified that she was not aware of Medicaid audits prior to 2004 and that she was not aware of standards.

At the hearing, the parties offered the following documents as evidence: (1) plans of care for various residents;[64] (2) activity sheets for various residents;[65] (3) medication supervision records,[66] and (4) daily logs. The hearing examiner admitted the plans of care, activity sheets, and medication supervision records.[67] The hearing examiner refused to admit the daily log notes.

A "plan of care" set forth the day to day needs of each resident.

An "activity sheet" listed the required daily services for each resident with a place for the care giver to initial when the resident received the service. The staff person that initialized daily activities was required to initial and sign the bottom of the sheet to identify the initials. The activity sheet included standard services – nutrition, bathing and hygiene, toileting/incontinence, skin care, dressing, grooming, medication management, and laundry/chores – and services specific to the resident.

A "medication supervision record" tracked the type of medication and times medication was administered to the residents.

A "daily log" listed the residents with a few lines next to each name for a staff

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[63] Tr. 215.
[64] Ex. 2 p. 3-7, 19-21, 29-35, 40-44, 48-49, 52-54, 66-70, and 75-80.
[65] Ex. 2.
[66] Ex. 9.
[67] R. 2.

person to make notes about the day specific to that resident. In addition, each daily log had a space to make general notes about what happened in the house that day. Generally, the daily log notes were signed and dated by staff who completed the log note.

As a result of the extensive evidence review, the parties realized that the Auditor had overlooked an activity sheet for the month of November 2002.[68] The hearing examiner allowed the Auditor to revise the payment calculation which reduced the actual overpayments from $39,111.02 to $34,154.05 and reduced the extrapolated overpayments from $54,607.84 to $47,686.70.[69]

iv. hearing officer's decision

On August 2, 2006, the hearing examiner issued her Revised Purposed Decision. The hearing examiner did not admit the daily logs or Exhibit D into evidence. The hearing examiner, relying heavily on Hansen's "credible" testimony, concluded "the documents were not presented nor reasonably made available to the auditors. . . ." and stated that "[i]f new evidence was to be allowed to be introduced after the audit, that would place the hearing examiner in the role of the Auditor, reviewing documentation for purposes of making an audit finding. Rather, [the] hearing examiner's role is to determine if the Auditor's findings were correct, given the documentation submitted during the course of the audit."[70] The hearing examiner noted that even if the daily logs were admitted they only indicate that the resident was present, not that the resident

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[68] Tr. 248.
[69] Tr. 186; Ex. 15.
[70] R. 25.

received services.

Regarding the propriety of the audit calculation, the hearing examiner stated:

> 7 AAC 43.030(b) requires a provider to maintain accurate records of the following: the recipient receiving treatment, the specific service and extent of that service provided, the date on which each service is provided, and the individual who provided each service. 7 AAC 43.030(b) is clear on its face. Hidden Heights signed a[n] enrollment form acknowledging compliance with this regulation. (Ex. 12). Hidden Heights failed to document the services it billed the Department for. Because of this failure, the Department is correct in recouping the amount of those services.[71]

Regarding Hidden Heights's argument that proof the resident was in the home is sufficient to prove the resident received the required care, the hearing examiner stated:

> Services provided must be documented. The regulations state that services must be documented to support billing for that care and service. In addition, common sense alone would dictate a payment will not be forthcoming for services that are not documented. It would be unconscionable for the Department to pay for services under the assumption that if a person is present in a facility, then that facility must be providing services required.[72]

The hearing examiner did not accept Hidden Heights's argument that lack of knowledge of record requirements and inconsistency during the audit and appeal regarding the Department's record requirements alleviate a provider's obligation to keep records. The hearing examiner conclude: (1) that 7 AAC 43.030(b) set forth specific requirements; (2) that while the Auditor did not strictly adhere to these requirements Hidden Heights was not injured because the Auditor accepted documentation markedly less detailed then 7 AAC 43.030(b) requires; and (3) that Hidden Heights did have

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[71] R. 21-22.
[72] R. 22.

knowledge of record requirements evidenced by the daily activity sheets Hidden Heights required employees to complete.[73]

Further, the hearing examiner decided the equitable estoppel argument posed by the Department in its motion for summary judgment. The hearing examiner denied Hidden Heights's use of equitable estoppel because she deemed Hidden Heights failed to establish the elements. The hearing examiner stated that she granted the summary judgment motion but did not rely on a summary judgment standard of review because in her analysis she referred to evidence entered at the hearing.[74]

On August 2, 2006, the commissioner adopted the hearing examiner's Revised Proposed Decision.

(3) Administrative appeal before the court

On September 8, 2006, the court lifted the stay imposed on Hidden Heights's superior court appeal. On October 12, 2006, Hidden Height submitted its Second Amended Statement of Points on Appeal. Hidden Heights appeals the Departments decision to accept the Auditor's findings, to deny application of equitable estoppel, and to adopt the hearing examiner's decision.

Essentially, Hidden Height makes three claims. First, Hidden Heights claims the findings of overpayment where incorrect because: (1) Exhibit D should have been admitted and it proves that patients received care;[75] (2) concluding that the use of stars with no description was incorrect because Reeves testified he remembered who made

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[73] R. 23-24.
[74] R. 19-20 (hearing examiner mention of Exhibit 12 and Exhibit 2).
[75] Appellant's Br. 31-34.

the stars;[76] (3) concluding that Hidden Heights did not comply with 7 AAC 43.030, because Hidden Heights failed to comply with its own record keeping requirements, was incorrect because "Mr. Reeves was clear that Hidden Heights met any reasonable standard of Medicaid documentations, and thus met his own standards";[77] and (4) the Auditor's decision to recoup for everyday that Hidden Heights did not document was incorrect because lack of documentation does not mean the services were not performed.[78]

Second, Hidden Heights claims that the hearing examiner should have applied the doctrine of equitable estoppel. Hidden Heights notes the unorthodox approach the hearing examiner took in deciding this issue on summary judgment after the evidentiary hearing. Hidden Heights argues estoppel applies because: (1) the Department did not conduct regular audits until after the enactment of AS 47.05.200 and never notified Medicaid providers that it required strict compliance with 7 AAC 43.030, thus the Department asserted a position that providers did not have to adhere to 7 AAC 43.030;[79] (2) Hidden Heights relied on this position;[80] (3) Hidden Heights is prejudiced by having to pay $47,686.70;[81] and (4) estoppel serves the interest of justice because recouping payments for services that were provided would be a "substantial and unfair hardship."

Third, Hidden Heights claims, "[t]he state's after-the-fact audits also violate the

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[76] Appellant's Br. 32.
[77] Appellant's Br. 34-35.
[78] Appellant's Br. 35-37.
[79] Appellant's Br. 39-41.
[80] Appellant's Br. 42.
[81] Appellant's Br. 42.

Alaska Constitution's due process clause, Art. I § 7 as interpreted in State, DHSS v. Valley Hospital Association, Inc., 116 P.3d 580 (Alaska 2005)."[82] Hidden Heights says. "the state changed standards for enforcement of 7 ACC 43.030, so the factual scenario is parallel to Valley Hospital. The state needs to generate meaningful standards for Medicaid documentation . . . That did not happen here."[83]

In response to issues regarding the propriety of the audit, the Department argues: (1) that 7 AAC 43.030 requires a provider to maintain documentation to support the specific services provided to Medicaid recipients, the extent of each service provided, the date on which each service is provided, and the individual who provided each service;[84] (2) that, as evidenced by his Alaska Medicaid Provider Enrollment Form,[85] Reeves knew he must comply with this regulation and, as evidenced by his own testimony he new documentation was need;[86] (3) that Hidden Heights failed to provide evidence to refute findings of overpayment on days when no documentation existed even though they had numerous opportunities to do so;[87] (4) that the issue was never the sufficiency of documentation, but the simple existence of documentation;[88] (5) that substantial evidence in the record supports the Department's findings of overpayment, irrespective of the hearing examiner's ruling on the admissibility of Exhibit D;[89] and (6) even if the court, in apply its independent judgment, finds that Exhibit D should have

[82] Appellant's Br. 45.
[83] Appellant's Br. 46.
[84] Br. Appellee 14.
[85] Ex. 12 p. 2.
[86] Br. Appellee 15.
[87] Br. Appellee 18.
[88] Br. Appellee 19.
[89] Br. Appellee 21.

been admitted as a matter of law, substantial evidence demonstrates that its admission would not have affected the final outcome in this matter for the reasons cited by the hearing examiners.[90]

In response to issues regarding application of equitable estoppel, the Department argues that Hidden Heights meets none of the elements.[91] The Department argues that "the commissioner's decision to reject the equitable estoppel defense presents a question of law pursuant to the Department's use of its audit functions" so the court should review under the reasonable basis test which applies to questions of law involving agency expertise.[92]

In response to the due process claims, the Department delineates the issue in Valley Hospital arguing that Valley Hospital applied to the retroactive application of a statute and in the instant case "the due process issue (assuming one exists) is whether Hidden Heights was on notice of applicable Medicaid law and had the opportunity be heard with respect to the Department's findings of overpayment."[93]

III. STANDARD OF REVIEW

Judicial review of action taken by an administrative body is to ensure that the body "has given reasoned discretion to all the material facts and issues."[94] Alaska courts employ four recognized standards to review administrative decisions: (1) substantial evidence test for questions of fact; (2) reasonable basis test for questions of

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[90] Br. Appellee 21.
[91] Br. Appellee 23-30.
[92] Br. Appellee 21.
[93] Br. Appellee 30.
[94] Area G Home and Landowners Org., Inc. (HALO) v. Anchorage, 927 P.2d 728, 744 - 745 (Alaska 1996).

law involving agency expertise; (3) substitution of judgment test for questions of law where no expertise is involved; and (4) reasonable and not arbitrary test for review of administrative regulations.[95]

Alaska courts apply independent judgment to questions of constitutional law.[96]

Because this case addresses multiple types of administrative determinations, the court will discuss the respective standards of review in context of each issue.

IV. DISCUSSION

A. Doctrine of Equitable Estoppel Does Not Precluded Department From Requiring Medicaid Providers Comply With 7 AAC 43.030 Record Requirements.

The decision to postpone deciding the summary judgment issue regarding equitable estoppel until after the hearing was procedurally challenged. Originally, the hearing officer denied the Department's motion for summary judgment without addressing the issue; however, after the hearing concluded the hearing examiner addressed the issue as a summary judgment motion. While the hearing officer stated in her Revised Purposed Decision that "the Department's motion for summary judgment is granted" and dismissed Hidden Heights's equitable estoppel claim, the hearing examiner did not apply a summary judgment standard. Throughout the hearing examiner's analysis and conclusion, the hearing examiner referenced testimony or lack

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[95] Municipality of Anchorage, Police and Fire Retire. Bd. v. Coffey, 893 P.2d 722, 726 (Alaska 1995).

[96] Rollins v. State, Dept. of Revenue, Alcoholic Beverage Control Bd., 991 P.2d 202, 206 (Alaska 1999).

of testimony and exhibits admitted at the hearing.[97] In effect, the hearing officer decided the issue, which was one of Hidden Heights's issues on appeal, appropriately. After denying summary judgment, the hearing examiner should have decided whether estoppel was appropriate based on the entire record. The court will review this matter as a legal conclusion based on all evidence in the record and not as a summary judgment determination.

While the Department claims the court should review this matter under the reasonable basis test appropriate to questions of law involving agency expertise because it involves the Department's audit function, the Department fails to show how its audit function aids in deciding the applicability of the doctrine of equitable estoppel. In reviewing legal questions not aided by agency expertise, the court applies the substitution of judgment or independent judgment standard of review.[98] Under this standard, the court substitutes its own judgment for that of the Department's, even if the Department's decision had a reasonable basis in law.[99] Ultimately, the court must adopt the rule of law most persuasive in light of precedent, reason, and policy.[100]

A litigant may invoke equitable estoppel as a defense against the government where four elements are present: (1) the governmental body asserts a position by conduct or words; (2) the person acts in reasonable reliance thereon; (3) the person suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to

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[97] R. 19-21.
[98] N. Alaska Envtl. Ctr. v. State, Dept. of Natural Res., 2 P.3d 629, 633 (Alaska 2000).
[99] Fraiman v. State, Dept. of Admin., Div. of Motor Vehicles, 49 P.3d 241, 243 - 244 (Alaska 2002).
[100] Chugach Electric Ass'n, Inc. v. Regulatory Com'n of Alaska, 49 P.3d 246, 249 (Alaska 2002).

limit public injury.[101]

Hidden Heights asks the court to concluded: (1) that, since the Department did not conduct regular audits until after the enactment of AS 47.05.200 and never notified Medicaid providers that it required strict compliance with 7 ACC 43.030, the Department asserted a position that providers did not have to strictly adhere to 7 AAC 43.030; (2) that Hidden Heights reasonably relied on this position so it did not maintain the records which the Department now requires; (3) that Hidden Heights is prejudiced by having to pay $47,686.70 for failing to document services for which it received Medicaid payments; and (4) that estoppel serves the interest of justice because recouping payments for services that were provided would be a "substantial and unfair hardship."

Hidden Heights fails to satisfy the first element.

While Hidden Heights may be correct asserting that the Department conducted fewer audits before the July 1, 2004 enactment of AS 47.05.200, which mandated the Department conduct annual audits, the increase in audits does not effect the record keeping obligations of Medicaid providers or prove that prior to the increase in audits the Department accepted records less in compliance with regulations. 7 AAC 43.030, not AS 47.05.200, sets forth requirements for provider records. As outline above, 7 AAC 43.030, last amended in 1997, requires HCB waiver program providers, pursuant to their medical provider agreement,[102] to maintain detailed records necessary to support the care and services for which the provider received payment. These records

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[101] State, Dept. of Commerce and Economic Dev., Div. of Ins. v. Schnell, 8 P.3d 351, 355 -356 (Alaska 2000).
[102] 7 AAC 43.065.

must include specific patient and billing information. This regulation did not change with the enactment of AS 47.05.200 or with what Hidden Heights refers to as "a sea change in the regulation of assisted living homes." Hidden Heights's argument that the legislative mandate to audit a mere 0.75% of medical assistance providers prompted the Department to more strictly adhere to the requirements of 7 AAC 43.030 lacks merit.

Further, Hidden Heights had, at the very least, constructive notice of its obligation to maintain records according to 7 AAC 43.030. As a condition to provider enrollment into HCB wavier program, Hidden Heights agreed to abide by Medicaid regulations, including 7 AAC 43.030. The Alaska Medicaid Provider Enrollment Form, signed by Reeves on October 7, 1999, specified that the provider agrees to abide by all Alaska Medicaid Regulations and to comply with review, audit, and recoupment regulations.[103] Even if the court was to accept that Hidden Heights did not know of record keeping requirements for Medicaid providers, a company's purported ignorance of specific regulations governing its conduct does not eliminate a company's obligation to abide by such regulations.

Hidden Heights has failed to show that the Department asserted, by conduct or words, that adherence to requirements of 7 AAC 43.030 was unnecessary. Since Hidden Heights has failed to satisfy the first element, the court need not address the other elements of Hidden Heights's estoppel argument.

B. Department Should Have Admitted Exhibit D.

The proceedings before the hearing examiner, what the Department referred to

[103] Exhibit 12 p. 2.

as an "evidentiary hearing", have greatly confused the court's review of this matter. 7 AAC 43 does not afford providers the option of receiving a post-audit/post intra-agency appeal "evidentiary hearing." Thus, procedure applicable to such proceedings does not exist. Further, at oral argument, council for the Department stated that this is the only instance a provider was given such a hearing.

Problems seem to have arisen due to the parties' and the hearing examiner's confusion regarding the scope and purpose of the evidentiary hearing and the role of the hearing examiner. Hidden Heights approached the evidentiary hearing as an opportunity to refute the Auditor's findings of overpayment by proving, primarily via circumstantial evidence, that residents received the services for which Hidden Heights billed. The Department, as evident by its motion for summary judgment and arguments before the hearing examiner regarding the admissibility of evidence, viewed the evidentiary hearing as a limited opportunity for Hidden Heights to refute the findings based solely on documents available to the Auditor.

In deciding not to admit Exhibit D, which constitutes Hidden Heights's primary evidence supporting its argument that residents received services, the hearing examiner concluded that Exhibit D was not available to the Auditors and that her role was limited to determining if the Auditor's findings were correct based on the documentation submitted during the audit. While the hearing examiner did not admit Exhibit D, she allowed Hidden Heights to present the evidence and took testimony from both parties regarding the evidence. In the decision, the hearing examiner made an alternative conclusion, based on Hansen's testimony, that if Exhibit D had been admitted it would

only indicate that a resident was present, not that a resident received services.

The court declines to accept the hearing examiners rationale for not admitting Exhibit D. The court believes that the proper approach would have been to admit all relevant evidence. First, an appeal to the commissioner pursuant to 7 AAC 43.085 is not limited to evidence reviewed by the Auditor. 7 AAC 43.085 specifically allows for the submission of "all information and materials" that the provider requests the commissioner consider in resolving the appeal. Second, the commissioner offered Hidden Heights an "evidentiary hearing." To limit evidence to documents considered by the Auditor effectually defeats the purpose of holding an evidentiary hearing. If the Department was not going to allow Hidden Heights to submit all relevant evidence to what the Department called an unbiased decision maker, the Department should have simply allowed Hidden Heights to appeal to the superior court. However, what the court perceives as error will not limit the court's further review of this matter since the hearing examiner allowed testimony regarding Exhibit D and made an alternative finding that Exhibit D did not satisfy the Auditor's standard for determining adequate records.

The court will review the decision based on all the testimony and evidence submitted at the hearing.

C. Department Did Not Err In Accepting Auditor's Findings that Hidden Heights Received Overpayments.

Hidden Heights argues that the standard utilized by the Auditor to determine overpayments was incorrect and that Exhibit D proves patients received care on days the Auditor calculated an overpayment.

Hidden Heights fails to understand the basis for the Departments findings. At issue is not whether the residents received care nor does the Department's grounds for recoupment hinge on whether the residents received care. The findings are based simply on the fact that Hidden Heights failed to document the care provided.

Medicaid regulations, specifically 7 AAC 43.065, require a provider to refund to the Department any reimbursed claim that the Department deems does not meet requirements of 7 AAC 43. 7 AAC 43.030 sets out requirements for provider records. These requirements contemplate providers keeping thorough, exact, and detailed records consisting of patient and financial information. The Auditor concluded that a substantial number of Hidden Heights's records were insufficient to support the claims for which Hidden Heights received reimbursement, thus where inadequate under 7 AAC 43.030. The standard utilized by the Auditor was extremely lenient in light of the stringent requirements of 7 AAC 43.030. The Auditor accepted as adequate any record that showed Hidden Heights substantially performed the required daily services. However, the Auditor did not accept documentation that merely showed a resident was in the facility and may have received only some of the required daily services. For days that the Auditor deemed documentation was inadequate to satisfy this standard and thus failed to satisfy the record keeping requirements of 7 AAC 43.030, the Auditor concluded an overpayment.

Where an agency is creating a standard to be used in evaluating a case before it, the court must employ the reasonable basis standard of review because the question at

issue implicates special agency expertise.[104] When applying the rational basis test, the court determines whether the facts support the agency's decision and has a reasonable basis in law, even if the court may not agree with the agency's ultimate determination.[105] While significantly less stringent, the Auditor's standard was clearly based on 7 AAC 43.030. The court will not interfere with the Department's decision to alleviate some of the burden impcsed by its regulation by utilizing a less stringent standard.

Whether documentation from days the Auditor found overpayment was inadequate to meet the Auditor's standard and whether the hearing examiner's conclusion that Exhibit D did not meet the Auditor's standard present questions of fact that the court must review under the substantial evidence test. The court must determine whether the quantum of evidence is substantial enough to support these conclusions in the contemplation of a reasonable mind.[106] The findings of overpayment based on the Auditor's standard are support by substantial evidence in the record. Exhibit 3, which shows the results of the field audit, illustrates the deficiencies in Hidden Heights's records and supports the Auditor's conclusion. Exhibit D, while presenting circumstantial evidence supporting the Hidden Heights's contention that residents where at the facility, does not show the residents received the required daily services. The hearing examiner's finding that Exhibit D did not show that the residents received care and thus did not satisfy the Auditor's standard is supported by the document itself and testimony by Hanson.

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[104] Tesoro Alaska Petroleum Co., v. Kenai Pipe Line Co., 746 P.2d 896, 903 (Alaska 1987).
[105] Id.
[106] Coffey, 893 P.2d at 726.

D. Hidden Heights's Due Process Argument is Ineffective In Showing a Constitutional Violation.

Hidden Heights claims that the audit violated Article 1 section 7 of the Alaska Constitution as interpreted in State, DHSS v. Valley Hospital Association, Inc.[107] In Valley Hospital, the Alaska Supreme Court faced the issue whether a Medicaid regulation should have retroactive or prospective application. While the superior court found that the regulation violated procedural due process rights of the hospital, the Supreme Court avoided the constitutional holding by finding that the regulation was arbitrary and capricious.[108] Hidden Heights contends that in the instant case the state changed standards for enforcement of 7 AAC 43.030, so the factual scenario parallels Valley Hospital.

This case does not parallel Valley Hospital. Valley Hospital dealt with a newly enacted regulation. The Department has not generated new regulations and to any extent the Department generated a new standard for the enforcement of 7 AAC 43.030, by imposing an extremely lenient record requirement standard, it was to Hidden Heights's benefit.

Hidden Heights seems to attempt a due process argument based on insufficient notice. Hidden Heights has not developed its due process argument beyond reference to Valley Hospital. The court need not address such an inadequately briefed argument.[109]

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[107] P.3d 580 (Alaska 2005).
[108] Id. at 584.
[109] Jurgens v. City of North Pole, 153 P.3d 321, 326 (Alaska 2007).

V. CONCLUSION

The Department did not err in concluding that Hidden Heights's records were insufficient to support services for which Hidden Heights received reimbursement. The standard utilized by the Auditor has a reasonable basis in law and findings of the Department are supported by substantial evidence. The Department's decision is AFFIRMED.

DATED at Anchorage, Alaska, this 31st day of January 2008.

Mark Rindner

MARK RINDNER
Superior Court Judge

I certify that on 1/31/08 *a copy was mailed to:*

V. Ulmer
Administrative Assistant

R. Polizzotto
J. Pharr