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

In the Matter of	)	
	)	
VLADI & ASSOCIATES LLC	)	OAH No. 17-1257-MDA
	)	

FINAL DECISION AFTER REMAND

I. Introduction

Vladi & Associates LLC ("Vladi") is a Medicaid provider that provides personal care services (PCS) and Home and Community-Based Waiver services to Medicaid-eligible persons. The Department of Health and Social Services, Medicaid Program Integrity Unit ("Program Integrity"), through its agent Meyers & Stauffer, LC ("M & S"), audited Vladi's Medicaid billings for calendar year 2012.

M & S audited two random samples of Vladi's billing claims, one covering 2012 PCS services and one covering 2012 Waiver services. Each of the audits resulted in numerous overpayment findings, which were then statistically extrapolated to arrive at a total overpayment figure: $1,473,568.81 for PCS for 2012 and $123,210.13 for Waiver services for 2012.

Vladi requested a hearing to challenge the overpayment findings. An evidentiary hearing was held over the course of four days, June 18 – 21, 2018. Following the hearing, a proposed decision was issued partially affirming and partially reversing Program Integrity's overpayment findings. Both parties filed proposals for action.

After considering the proposals for action, the final decision-maker, Commissioner of Health and Social Services' delegee, remanded the case to the Office of Administrative Hearings (OAH) to reevaluate Part III-E and any associated findings in Part I and IV of the Proposed Decision in light of Program Integrity's proposal for action. Specifically, the final decision-maker remanded the case for consideration of relevant evidence in similar cases and re-evaluation of the finding that Program Integrity was equitably estopped from imposing overpayments for timesheets where providers wrote "live in" instead of start and stop times. Consistent with the September 24, 2018 Order of Remand, this decision re-evaluates and revises Part III-E of the proposed decision.

Given the record and pleadings in this case, and the relevant portions of the record and pleadings in OAH Cases 16-1316-MPC, 16-1490-MDA, 17-1236-MDA, 17-0933-MDA, 16-177-MDA, and 16-

1176-MDA, Program Integrity is equitably estopped from disallowing claims based upon the lack of start and stop times, where the provider noted "live in."

As discussed in detail below, Program Integrity's overpayment findings are partially affirmed and partially reversed. The affirmed findings are summarized in the table below:

Ground	Program	Claims
Timesheets lacked start/stop tir for services provided	Waiver	D262003, D262004, D262012, D262021, D262022, D262023, D262024
No timesheets to document that services were rendered	PCS	D269032, D269049
No timesheets to document that services were rendered	Waiver	D262052
Prepopulated duration of servic not equal the handwritten start stop times documented on the timesheets	PCS	D269057, D269063, D269064, D269065
No documentation that the prov successfully passed criminal background checks before the sampled dates of services	Waiver	D262001, D262011, D262012, D262013

The remaining overpayment findings are reversed. Program Integrity shall recalculate the overpayment, based on this decision.

II. Background[1]

A. PCS Audit Summary

In calendar year 2012, Vladi submitted 1,546 PCS claims for which the Medicaid program paid $1,692,092.88.[2] On June 3, 2016, Program Integrity notified Vladi that it had been chosen for an audit of its PCS claims.[3]

As part of the audit, M & S performed an initial computerized analysis of all claims submitted by Vladi during the audit period.[4] That initial analysis identified one claim as a duplicate payment and

[1] Facts recounted in this decision were established by a preponderance of the evidence. Some factual findings are reserved for Part III, where individual claims are explored in detail.
[2] Agency Record ("AR") at 166.
[3] AR at 418.
[4] AR at 122 – 123; 166, 167; 3004 – 3118; Testimony of T. Allan Hansen.

three claims that conflicted or overlapped with inpatient hospital stays.[5] M & S made overpayment findings for those four claims and removed them from the total population of claims.[6] These overpayment findings were not extrapolated across the entire population of claims.[7] M & S then requested Vladi's records to review a designated sample of 84 randomly selected claims from the remaining 1,542 claims submitted for calendar year 2012.[8]

Based on its audit of those 84 claims, and a statistical extrapolation of the errors it found, M & S found that Medicaid overpaid Vladi a total of $1,471,946.55 for PCS claims in calendar year 2012.[9] The overpayment findings were based on a variety of errors—many claims with concurrent grounds.[10] The grounds for overpayment findings included: (1) timesheets prepopulated with stop and start times, duration of services, and/or tasks performed; (2) writing "live in" instead of documenting start and stop times; (3) no time sheets submitted; (4) discrepancies between duration of services and documented start and stop times; (5) timesheets not signed by the recipient or the recipient's representative; (6) the service rendered was not identified in the recipient's plan of care; and (7) the caregiver had not passed a criminal background check.[11]

B. Waiver Audit Summary

For its Waiver services, Vladi submitted 372 claims for which the Medicaid program paid $131,372.38 in calendar year 2012.[12] On June 3, 2016, Program Integrity notified Vladi that it had also been chosen for an audit of its claims for Waiver services.[13]

As with the PCS audit, M & S performed a computerized analysis of all Waiver claims submitted by Vladi during the audit period.[14] That initial analysis identified one claim with four line-items that conflicted or overlapped with inpatient hospital stays.[15] M & S made an overpayment finding for that

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5 AR at 122 – 123; 166, 167; Hansen Testimony.
6 AR at 166, 167; Hansen Testimony.
7 AR at 166, 167; Hansen Testimony. Vladi repaid Medicaid the overpayment amounts and only disputed the overpayment findings if they were extrapolated across the population of all claims. Because these overpayment findings were not extrapolated, the findings are no longer at issue.
8 AR at 166; Hansen Testimony. These claims are identified in the record as claims D269001 through D269084. *See* AR at 134 – 161.
9 AR at 166; Hansen Testimony. Several overpayment findings were removed during the hearing and the revised overpayment amount will be recalculated.
10 AR at 125 – 127, 134 – 161.
11 AR at 126 – 127; Hansen Testimony.
12 AR at 3317; Hansen Testimony.
13 AR at 3525.
14 AR at 3286 – 3287, 3315; Hansen Testimony.
15 AR at 3287, 3315, 3317, 3318; Hansen Testimony.

claim and removed it from the total population of claims.[16] It was not extrapolated across the population of claims.[17]

Similar to the PCS audit, M & S requested Vladi's records for a designated sample of 65 randomly selected Medicaid Waiver claims from the remaining 371 claims for calendar year 2012.[18] Based on its audit of those 65 claims, and a statistical extrapolation of the errors it found, M & S found that Medicaid overpaid Vladi a total of $131,372.38 for Waiver claims in calendar year 2012.[19] As in the PCS audit, the overpayment findings were based on a variety of errors with concurrent grounds for overpayment findings on many of the claims.[20] The grounds for overpayment findings for Waiver claims included: (1) timesheets prepopulated with stop and start times and duration of services; (2) no start or stop times for services provided; (3) writing "live in" instead of documenting start and stop times; (4) no time sheets submitted; (5) failure to identify the caregiver who was being provided respite (i.e. the recipient's primary care giver who was being relieved); (6) the recipient's plan of care did not cover the sampled dates of service; (7) the units billed to Medicaid exceeded the number of units authorized in the plan of care; and (8) no documentation that the caregiver had passed a criminal background check before the dates of service.[21]

III. Discussion

A. General Overview of Documentation Requirements

Vladi is a Medicaid provider that provides PCS and Waiver services to qualified individuals who need assistance with various tasks. For a business like Vladi to receive payment from the Medicaid system for services provided to Medicaid recipients, that business must be enrolled and certified as a Medicaid provider with the Department.[22] A Medicaid provider is required to comply with all applicable federal and state requirements.[23] They must maintain accurate records to support the services for which payment is requested.[24] A Medicaid provider must record, and be able to document upon

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16 AR at 3317; Hansen Testimony.

17 AR at 3317; Hansen Testimony. Vladi repaid Medicaid the overpayment amounts and only disputed the overpayment findings if they were extrapolated across the population of all claims. Because these overpayment findings were not extrapolated, the findings are no longer at issue.

18 AR at 3317, 3526 – 3546; Hansen Testimony. These claims are identified in the record as claims D262001 through D262065. *See* AR at 3533 – 3546.

19 AR at 3317; Hansen Testimony. Several overpayment findings were removed during the hearing and the revised overpayment amount will be recalculated.

20 AR at 3288 – 3291, 3297 – 3314.

21 AR at 3288 –3291; Hansen Testimony.

22 7 AAC 105.210(a).

23 *See* 7 AAC 105.220.

24 7 AAC 105.230; 7 AAC 105.220.

audit, the name of the recipient receiving treatment, the service provided, the extent of the service provided, the date it was provided, and the individual providing the service.[25]

> The point of the documentation requirements is to allow the department to audit individual claims and cross-check them against other information that may be available. In the case of PCA services, for example, the combination of a vulnerable clientele and a lack of close supervision creates significant opportunities for fraud. By requiring providers to specify exactly when they were with the client, the department can check a particular claim against observations of the provider in other locations, or shifts worked on other jobs. This helps to pin down malefactors, who might otherwise be able to answer any challenge by claiming, after the fact, that they simply worked different hours. Moreover, by making enforcement possible, it deters misconduct in the first place.[26]

The provider must retain the records for seven years, and if the provider is unable to produce the records on demand, the Department "may deny payment or may initiate a recoupment."[27] The Department may also impose sanctions for failure "to maintain for each recipient a contemporaneous and accurate record of the services provided."[28]

It is well settled that Medicaid payments will be denied if the required documentation has not been maintained. This is so even if one might be able to infer that it is more likely than not that the services billed, or at least some services, were actually rendered. In *In re Alaska Children's Services, Inc.*, [29] the Commissioner of Health and Social Services affirmed Program Integrity's recoupment of funds from a conscientious provider on the basis of substandard documentation, even though most, and perhaps all, of the claimed services had probably been performed. The single potential exception to this principle is where failure to comply with some nuance of a documentation requirement is "so insubstantial that the department must consider the records complete." [30]

An overpayment occurs when the department pays a provider incorrectly for services that do not meet standards established for payment of services.[31] Federal law requires the Department to seek recoupment of overpayments.[32] Because Program Integrity is seeking affirmative financial relief against Vladi, based upon its allegation that Vladi has not complied with Medicaid requirements, it has

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25 7 AAC 105.230; 7 AAC 105.220(b).

26 *In re Eben-Ezer Homecare, LLC*, OAH No. 13-1605-MDA at 7 (Comm'r of Health & Soc. Serv. 2015) (http://aws.state.ak.us/officeof administrative hearings/Documents/MDA/MDA131605.pdf).

27 7 AAC 105.240(d).

28 7 AAC 105.400(41).

29 OAH No. 13-0182-MDA (Comm'r of Health & Soc. Serv. 2014) (published at http://aws.state.ak.us/officeofadministrativehearings/Documents/MDA/MDA130182.pdf).

30 *Id.* at 12.

31 7 AAC 105.260.

32 42 CFR § 431.1002.

the burden of proving by a preponderance of the evidence that Vladi did not comply with the Medicaid requirements.[33] The central issue in this case, that applies to all claims, is whether Vladi failed to provide the required documentation.

B. Vladi's Equitable Estoppel Defense in General

Vladi generally argues that many of the overpayment findings are barred by equitable estoppel. 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."[34]

Vladi asserts several theories for the equitable estoppel defense. In several contexts, Vladi's equitable estoppel claims can be rejected out of hand, but in one context it will need to be revisited in more detail later in this decision.

First, relying on 7 AAC 125.190—which requires the Department to conduct compliance audits "on a biennial basis"—Vladi argues that if the Department had conducted an audit before July of 2014, he would have been informed of any procedural errors and could have rectified them. But equitable estoppel requires a governmental agency to "assert[ ] a position by either conduct or words."[35] So if such an audit had been performed, and the Department had told Vladi that his practices were acceptable, then this argument would have some merit. However, the failure of a governmental agency to conduct a compliance audit cannot be said to amount to an assertion of a governmental position. Accordingly, this argument is not persuasive.

Next, Vladi relies on a 2008 audit conducted by M & S and argues that because its documentation has remained unchanged since 2007, Program Integrity is estopped from making overpayment findings for failing to maintain contemporaneous records of services, times in and times out, and duration of services. However, as of February 1, 2010, the regulations that were applied to Vladi's record-keeping in the 2008 audit were revised. Before 2010, the general Medicaid regulations required provider records to show the date services were rendered.[36] They did not, however, require providers to record start and stop times for time-based billings. Beginning February 1, 2010, a provider

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33 *See In re Accredo Health Group,* OAH No. 13-0622-MDA (Comm'r Health & Soc. Services, 2014).
34 *Wassink v. Hawkins,* 763 P.3d 971, 975 (Alaska 1988).
35 *Wassink,* 763 P.3d at 975.
36 7 AAC 43.030(b)(4) (repealed effective 2/1/2010, Register 193).

billing for such time-based services was required to "maintain a clinical record" recording "start and stop times."[37] Moreover, the Department adopted a very specific recordkeeping responsibility for PCS. The new regulation requires that "a personal care assistant shall maintain a contemporaneous service record for Medicaid billing [including] (4) a time sheet recording the date, time, and length of each visit and the services provided during each visit . . .."[38] To the extent that the regulations have changed, assertions made about compliance with record-keeping requirements under the old regulations are irrelevant to the 2012 audit. In other words, the 2008 audit findings—insofar as they were based on entirely different regulations—cannot be deemed an assertion of governmental position with regard to the applicable regulations in 2012. Accordingly, this argument likewise lacks merit.

Finally, Vladi argues that an audit conducted of its 2012-2013 claims by Xerox found no overpayments, and thus, Program Integrity is estopped from finding overpayments for its 2012 billings in this case. The Xerox audit was targeted, however—limited to an audit of the billings by one PCS caregiver.[39] The audit was never completed.[40] Because of another investigation into Vladi's billings, Xerox closed its case and forwarded its records to the other agency.[41] The auditors did not make any findings about Vladi's record-keeping—either favorable or unfavorable.[42] Although an agency's silence may in some cases be relied on to satisfy the first element of estoppel,[43] the fact that Xerox never issued findings was not an assertion that Vladi's audit had been or would have been favorably resolved. Silence is not sufficient to bar state action in this situation.[44] Lastly, and most fundamentally, Vladi could not have relied on a post-2012 audit in selecting a documentation protocol in 2010.

Because Vladi has not satisfied the first two elements of the equitable estoppel test, it is not necessary to address the other elements as to the three estoppel claims described above. Vladi has also raised estoppel because of a very specific representation made to him by a department official. That estoppel issue will be addressed in Part III-E below.

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37 7 AAC 105.230(d)(5) (eff. 2/1/2010).
38 7 AAC 125.120(a) (eff. 2/1/2010, Reg. 193).
39 Testimony of Jason Ball.
40 Ball Testimony.
41 Ball Testimony.
42 Ball Testimony.
43 *Crum v. Stalnaker*, 936 P.2d 1254, 1257 (Alaska 1997) (.
44 *See State, Dept. of Commerce and Economic Development, Div. of Ins. v. Schnell,* 8 P.3d 351, 357 (Alaska 2000) (concluding that silence was not sufficient to satisfy the first element of estoppel where Division failed to issue a decision in an administrative disciplinary proceeding in a heavily regulated profession).

C. Prepopulated Timesheets

M & S identified overpayments for 60 of the 84 sampled PCS claims and 33 of the 65 sampled Waiver claims because the submitted timesheets were prepopulated with times in, times out, tasks performed, frequency and duration of services, or total hours as allowed under the recipients' service plan authorizations or plans of care (POC).[45] Program Integrity argues that prefilling timesheets means that they are not contemporaneous records of the actual times and services rendered.

The timesheets for each of the contested PCS claims are on a computer-generated, standardized form that indicates the name of the recipient, the name of the personal care assistant, the services or activities of daily living (ADLs) the recipient receives on a daily basis, the dates of service spanning a two-week period, frequency and duration of tasks, total minutes spent on each task, and the number of daily hours.[46] Vladi incorporated each recipient's approved Medicaid service plan, including the approved frequency, scope, and duration for each task, into the timesheets.[47] The timesheets for 50 of the PCS claims had handwritten notes indicating the dates, but were otherwise prefilled with times in, times out, tasks performed, frequency and duration of services, and total hours as allowed under the recipients' service plan authorizations.[48] Similarly, timesheets for 10 PCS claims in this category are prefilled with the duration of services and tasks that were authorized under the recipients' service plan authorizations, but the dates and times in and out are handwritten.[49] On one timesheet, the provider also made handwritten entries for the number of hours each day and the total time for the week.[50] Three timesheets contained hand-written notes about the recipient's care.[51] And on three timesheets, the providers crossed out days or made hand-written corrections to the information that was prefilled in the timesheet.[52] The timesheets were signed and dated by both the providers and the recipients at the end of the two-week period covered by the time sheets with the following acknowledgment: "By signing this page, I acknowledge that the above tasks were completed and the times are correct[.]"[53]

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45 AR at 125, 3289; Hansen Testimony.

46 *See for example* AR at 486 – 487.

47 Testimony of Vladimir Vishnevetski.

48 Vishnevetski Testimony. *For example, compare* AR at 486 – 487 *with* AR at 482 – 485 (D269001).

49 *For example, Compare* AR at 543 – 544 *with* AR at 529 – 534 (D269003).

50 *See* AR at 486 – 487.

51 *See* AR at 1547 – 1548 (D269035), 2456 (D269077), 2544 – 2545 (D269081).

52 *See* AR at 1631 – 1633 (D269037), 1634 – 1635 (D269038), 1850 (D269048). Vladi did not submit claims for payment for days that were crossed out on the timesheets for Claim D269038 or D269048. *Compare* AR at 146 *with* AR at 1634 – 1635; *Compare* AR at 149 *with* AR at 1850. Vladi did, however, submit claims for payment for days that were crossed out on the timesheet for Claim D269037. *Compare* AR at 145 *with* AR at 1631 – 1633.

53 *See for example* AR at 487.

Similarly, the timesheets for each of the contested Waiver claims are on a computer-generated, standardized form that indicates the name of the recipient and the name of the service provider; has rows for the times in, times out, and daily total time; and has columns for dates of service over a two-week period as well as weekly total time.[54] The timesheets for 33 of the Waiver claims were prefilled with times in and times out.[55] The timesheets for all but 2 of the 33 claims in this category were also prefilled with duration of services and total weekly hours as allowed under the recipients' plans of care.[56] For one timesheet, the provider crossed out days and times, corrected the number of daily and weekly hours, and added handwritten times in and out.[57] Like the PCS timesheets, the Waiver timesheets were signed and dated by both the providers and the recipients at the end of the two-week period covered by the time sheets.[58] The following warning is next to the signature lines on each timesheet: "By signing this timesheet, you certify the hours recorded above were worked. Misrepresentation constitutes fraud."[59]

At the outset, one should note that the regulations applied to these audits, as written, do not expressly prohibit Vladi's prefilling practice. Program Integrity nonetheless argues that the overpayment findings should be upheld because timesheets prepopulated with the number of daily/weekly units allotted from the service plan or plan of care are simply a reiteration of what services were authorized and thus, they are not a credible record of what services were actually rendered. Program Integrity's position is based primarily on the auditor's speculation that "[c]reating a time sheet prepopulated with the number of daily/weekly units allotted from the plan of care does not allow the rendering provider to contemporaneously document actual times, durations, or services performed."[60] But Program Integrity has failed to present any evidence that the timesheets were not signed contemporaneously with the service being provided. And skepticism or speculation that those services might not actually have been provided at the times indicated is not a basis for a factual finding. Moreover, Mr. Vishnevetski (who goes by "Vladi" and is the company's principal officer) explained

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54 *See for example* AR at 3625.

55 Vishnevetski Testimony.

56 Vishnevetski Testimony. *For example, compare* AR at 3625, 3631, & 3633 *with* AR at 3583 (D262007, D262008, & D262009).

57 AR at 3686 (Claim D262018).

58 *See for example* AR at 3895. One timesheet was not signed by the recipient. AR at 3842 (Claim D262031).

59 *See for example* AR at 3895.

60 AR at 3289. *See also* AR at 126 ("Creating a time sheet prepopulated with the number of daily/weekly units allotted from the service plan does not allow the rendering provider to contemporaneously document actual times, durations, or services performed as required by 7 AAC 105.230(b), 7 AAC 105.230(d)(5) and 7 AAC 125.120(a).")

that most of the providers work many more hours than what is authorized by Medicaid, and the hours and services allowed under the recipients' service authorizations are "default" for the timesheets—that the prefilling of services, duration, etc., makes clear what services and extent of services were authorized by Medicaid.[61] Mr. Vishnevetski instructed providers to make corrections and initial the timesheets if there were any variations to the prepopulated information.[62] Mr. Vishnevetski's testimony was credible on this point, and indeed was corroborated by examples in the record.[63]

For these reasons, Program Integrity has failed to show that the timesheets at issue were not contemporaneous records. Overpayment findings on this basis should be removed.

D. No Start and Stop Times for Services Provided

M & S identified overpayments for seven of the sampled Waiver claims because the submitted timesheets did not have a start and stop time for services provided.[64] Like the timesheets discussed above, each of the contested Waiver claims in this category is based on a computer-generated, standardized form that indicates the name of the recipient and the name of the service provider; has rows for the times in, times out, and daily total time; and has columns for dates of service and weekly total time.[65] The timesheets have spaces for documenting start and stop times. Six of the timesheets in this category do not contain any start or stop times—those sections are left blank.[66] And the time sheet for Claim D262003 contains the times in and times out for three days, but does not have times in or times out for two days for which claims were submitted.[67] All of the Waiver timesheets provide the total number of hours of services provided each day.[68]

Medicaid regulations specifically require provider records to show the date the services were provided and include the "stop and start times for time-based billing codes."[69] PCS and Waiver services are time-based: services are authorized on a service plan, which provides for a certain number of

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61 Vishnevetski Testimony.
62 Vishnevetski Testimony.
63 Vishnevetski Testimony; Ex. V; *see also* AR at 1631 – 1635, 1850, & 3686.
64 AR at 3289; Hansen Testimony, D262003, D262004, D262012, D262021, D262022, D262023, and D262024. AR at 3289 n. 2.
65 *See for example* AR at 3608.
66 AR at 3611 (D262004); AR at 3651 (D262012); AR at 3704 (D262021); AR at 3705 (D262022); AR at 3706 (D262023); and AR at 3707 (D262024).
67 AR at 3608 (D262003). The times for the days documented on the timesheet do not match the claims submitted. Vladi submitted claims for 2 hours per day for 5 days for a total of 10 hours; however, the timesheet submitted to support those claims reflects times in and out for 3 days—4 hours on two days and 2 hours on one day for a total of 10 hours. *Compare* AR at 3298 *with* AR at 3608.
68 AR at 3608 (D262003); AR at 3611 (D262004); AR at 3651 (D262012); AR at 3704 (D262021); AR at 3705 (D262022); AR at 3706 (D262023); and AR at 3707 (D262024).
69 7 AAC 105.230(d)(5).

services per day or week. Consequently, a timesheet must include not only the date, but must also contain a start and stop time for the services. For PCS, the timesheet must include the date, time, length of each visit, and a start and stop time for the services.[70]

Because Vladi failed to meet the regulatory requirements for documenting times in and times out, the overpayment findings on these grounds are affirmed.

E. Timesheets With "Live In" Instead of Start and Stop Times

1. Medicaid regulations, effective February 1, 2010, require documentation of the extent of each service provided and start times and stop times for services, and writing "live in" in lieu of start and stop times does not sufficiently document when the provider delivered services

M & S found overpayments for 23 of the 84 audited PCS claims and four of the audited Waiver claims because the timesheets noted "live in" instead of start and stop times.[71] The finding was based on the conclusion that the timesheets were insufficient to verify the amount of service provided to the recipient, and none of the timesheets supporting the claims complied with the regulations requiring a start time and a stop time or a contemporaneous service record.[72]

As discussed above, before 2010, the general Medicaid regulations required provider records to show the date services were rendered.[73] The pre-2010 Medicaid regulations also required PCS timesheets to note the "date, time and length of each visit and the services provided during each visit."[74] It was a common, accepted practice for providers who resided with PCS recipients to write "live in" on their timesheets.[75]

In 2010, a significant part of the Medicaid regulations was revised and renumbered.[76] The revised regulations, effective February 1, 2010, introduced 7 AAC 105.230(d)(5), which specifically requires provider records to show not only the date the services were provided, but also to include the

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70 7 AAC 125.120.

71 AR at 126 & 3289, 3290. Hansen Testimony. PCS Claims: AR at 496 – 497 (D269002); AR at 669 – 670 (D269006); AR at 1011 – 1014 (D269015 & D269016); AR at 1151 – 1152 (D269022); AR at 1194 – 1251 (D269025, D269026, & D269027); AR at 1350 – 1351 (D269030); AR 1636 – 1641 (D269039, D269040, & D269041); AR at 1895 (D269049); AR at 2281 – 2284 (D269068 & D269069); AR at 2363 – 2370 (D269071, D269072, D269073, & D269074); AR at 2458 – 2461 (D269078 & D269079); AR at 2501 – 2502 (D269080); and AR at 2647 – 2648 (D269084). Waiver Claims: AR at 3565 (D262001); AR at 3581 (D262002); AR at 3687 (D262019); and AR at 3803 (D262035).

72 Hansen testimony.

73 7 AAC 43.030(b)(4) (repealed effective 2/1/2010, Register 193).

74 7 AAC 43.775(a)(4) (effective 2/9/2007) and (effective 4/1/2006) (renumbered to 7 AAC 125.120).

75 Vishnevetski Testimony; *see also* Kisha Smaw Testimony, *ITMO Hearts and Hands of Care, Inc.*, OAH 16-1176-MDA/ 16-1177-MDA (consolidated), Exc. 329-330.

76 *See, e.g.,* 7 AAC 105 (effective 2/1/2010, Register 193) *and* 7 AAC 125 (effective 2/1/2010, Register 193).

"stop and start times for time-based billing codes."[77] PCS and Waiver services are time-based. Accordingly, the Medicaid program expressly requires a PCS caregiver's timesheet to contain a start time, a stop time, and a duration.[78] For both PCS and Waiver services, the general regulation requires documentation of the extent of each service provided *and* start times and stop times for services. Vladi's timesheets, which contain only one of those elements, the duration or extent of services, do not satisfy the regulatory requirements.

Although noting "live in" on the time-sheet indicates that the recipient and the caregiver live together, it does not provide any information about when services were provided or how much time the caregiver spent with the recipient. Just because individuals live together does not mean that they spend 24 hours, 7 days a week with each other. As discussed, the purpose of the start and stop times requirement is to pinpoint when Medicaid-paid services are provided. The requirement is intended to give the Division oversight tools to ensure accountability and to detect and prevent fraud. Writing "live in" instead of start and stop times does not sufficiently document when the provider delivered services.

2. *Vladi has established that equitable estoppel precludes Program Integrity from imposing overpayments based on the lack of start and stop times, where the provider noted "live in"*

Vladi argues that equitable estoppel precludes the Division from using the lack of a start and stop time on its timesheets as a basis for denying payment when the timesheets note that it is a live-in provider. As discussed above, Vladi must prove four elements to successfully invoke estoppel against a governmental agency: the assertion of a governmental position by either conduct or words; an act which reasonably relied upon the governmental position; resulting prejudice; and "estoppel serves the interest of justice so as to limit public injury."[79]

a. SDS authorized Vladi to write "live-in" in lieu of start and stop times on timesheets where the Medicaid recipient and caregiver resided together.

The evidence on the first element of equitable estoppel consists of testimony from Mr. Vishnevetski and other Medicaid service providers, Kisha Smaw, owner and administrator of Hearts and Hands of Care, Inc., Fue Yang, owner and operator of U-Care Services, LLC, Steve Ulufoshio,

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77 7 AAC 105.230(d)(5).
78 7 AAC 125.120; 7 AAC 105.230(d)(5).
79 *Wassink,* 763 P.3d at 975.

administrator of Consumer Care Network, and Patricia Stringer, administrator of Consumer Care Network's Kenai Office.[80]

When the regulations were changed in 2010, Mr. Vishnevetski and other Medicaid service providers were concerned about the time-in and time-out requirements for live-in providers.[81] Specifically, they were concerned about Department of Labor enforcement of wage and hour laws for services provided by live-in caregivers over a 24-hour period.[82] Many of Vladi's live-in providers are family members, who provide care sporadically, 24 hours per day, seven days per week.[83] Most provide more services and work more hours than the number authorized for payment by Medicaid.[84] The timesheets are designed only to support Medicaid billing—they do not generally reflect the number of hours live-in caregivers actually work.[85] Additionally, because the regulation requires a time in and time out for "each visit," and live-in providers do not "visit" Medicaid recipients that they live with, Mr. Vishnevetski found the regulation confusing and wondered whether it applied to live-in providers.[86] Mr. Vishnevetski discussed the issue with other service providers and learned that other providers were using prepopulated timesheets, and it was routine for live-in providers to write "live in" on the timesheets instead of time in and time out.[87]

Mr. Vishnevetski and several other Medicaid service providers also discussed the issue with Beverly Churchill, a staff member of SDS, Medicaid Provider Certification and Quality Assurance

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[80] Vishnevetski Testimony; Testimony of Kisha Smaw; *see also* Exc. 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Owner/Administrator of U-Care Services, LLC, Kisha Smaw, Owner/Administrator for Hearts and Hands of Care, Inc., and Steve Ulufoshio, Administrator for Consumer Care Network, Inc.)); Exc. 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, Kisha Smaw, and Patricia Stringer, Administrator for Consumer Care Network's Kenai Office)).

[81] Vishnevetski Testimony; Testimony of Kisha Smaw; *see also* Exc. 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Kisha Smaw, and Steve Ulufoshio)); Exc. 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, Kisha Smaw, and Patricia Stringer, Administrator for Consumer Care Network's Kenai Office)).

[82] Vishnevetski Testimony; Smaw Testimony; *see also* Exc. 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, and Kisha Smaw)).

[83] Vishnevetski Testimony.

[84] Vishnevetski Testimony.

[85] Vishnevetski Testimony; *see also* Kisha Smaw Testimony, *ITMO Hearts and Hands of Care, Inc.*, OAH 16-1176-MDA/ 16-1177-MDA (consolidated), Exc. 329-330.

[86] Vishnevetski Testimony.

[87] Vishnevetski Testimony; *see also* Exc. 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, and Kisha Smaw)); *see also* Kisha Smaw Testimony, *ITMO Hearts and Hands of Care, Inc.*, OAH 16-1176-MDA/ 16-1177-MDA (consolidated), Exc. 329-330.

Program.[88] Ms. Churchill had the authority to certify Medicaid providers, and Mr. Vishnevetski and other providers routinely communicated with Ms. Churchill with questions about compliance with Medicaid regulations.[89] Ms. Churchill reportedly told Mr. Vishnevetski, Ms. Smaw, Mr. Yang, and Mr. Ulofoshio that if the provider lived with the recipient, then the provider could write "live-in" on the timesheets instead of time in and time out.[90]

Ms. Smaw, owner and administrator of Hearts and Hands of Care, stated that when the regulation changed in 2010, she received a few calls from other providers about the issue of writing "live in" on timesheets.[91] After learning that another agency was writing "live in" on its timesheets, Ms. Smaw, who described Ms. Churchill as one of her main contacts for compliance questions, specifically asked Ms. Churchill if live-in providers could write "live in" instead of times in and times out.[92] Ms. Churchill told Ms. Smaw that as long as the provider and recipient lived in the same household, the caregiver could write "live in" on the timesheets.[93] And in the M & S audit for Ms. Smaw's agency, Hearts and Hands of Care, M & S made findings that three timesheets with "live in" written under the block for start time did not have start and stop times, but it did not assess overpayment findings.[94]

Mr. Yang, owner and administrator of U-Care Services, likewise sought guidance from Ms. Churchill about the issue.[95] Mr. Yang showed Ms. Churchill the timesheet used by his agency and

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[88] Vishnevetski Testimony; Smaw Testimony; *see also* Exc. at 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Owner/Administrator of U-Care Services, LLC, Kisha Smaw, Owner/Administrator for Hearts and Hands of Care, Inc., and Steve Ulufoshio, Administrator for Consumer Care Network, Inc.)); Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, Kisha Smaw, and Patricia Stringer, Administrator for Consumer Care Network's Kenai Office)).

[89] Vishnevetski Testimony; Smaw Testimony; *see also* Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, and Kisha Smaw)).

[90] Vishnevetski Testimony; Smaw Testimony; *see also* Exc. at 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Kisha Smaw, and Steve Ulufoshio)); Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 & n. 66 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, Kisha Smaw) (noting testimony of Patricia Stringer that she spoke to someone in the SDS Personal Care Assistance Unit in 2010, who told her to continue doing what they were doing—i.e. writing "live in" on timesheets—as long as the tasks were signed by the recipient).

[91] Smaw Testimony; *see also* Exc. 7 (*In re U-Care Services*, OAH No. 17-1236-MDA at 7 (2018) (summarizing testimony of Kisha Smaw)); Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5).

[92] Smaw Testimony; Exc. 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 5).

[93] Smaw Testimony; Exc. 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 5).

[94] Exc. 7 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 7).

[95] Exc. at 7 (*In re U-Care Services*, OAH No. 17-1236-MDA at 7 (2018) (summarizing Fue Yang's testimony); Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 5) (summarizing Fue Yang's testimony).

explained his plan for documenting services provided by live-in caregivers.[96] Indeed, Mr. Yang testified that he discussed the issue with Ms. Churchill twice, and on both occasions, Ms. Churchill told him it was okay to fill the timesheets out this way when the caregiver was living with the client.[97] Mr. Yang testified that he did not begin to use the "live in" phrase on timesheets until Ms. Churchill reviewed it and told him that it was okay.[98]

Similarly, Mr. Ulufoshio, the administrator for Consumer Care Network, testified about his concerns about Department of Labor enforcement for live-in caregivers and discussions he had with other Medicaid service providers.[99] After learning that several providers were writing "live in" on the timesheets in lieu of time in and time out, he contacted Ms. Churchill to discuss his concerns.[100] Mr. Ulofoshio, who routinely communicated with Ms. Churchill via telephone and email with questions about compliance with Medicaid regulations, asked Ms. Churchill if live-in providers could write "live in" on timesheets rather than time in and time out.[101] Consistent with the testimony of the other providers, Mr. Ulofoshio—who is not an owner of Consumer Care Network—testified that Ms. Churchill told him that providers could write "live-in" on the timesheets instead of times in and times out. [102]

Despite the consistent testimony by numerous Medicaid service providers, Ms. Churchill did not recall having *any* conversations with providers about timesheets.[103] She repeatedly stated that it was not her job to review or approve timesheets, and she does not believe that she would have given advice to providers about how to complete timesheets.[104] Yet she acknowledged that when the PCS regulations were rewritten, she attended meetings with providers, and timesheets in general was one of the topics discussed at those meetings.[105] According to Ms. Churchill, timesheets were a controversial topic and

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96 Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 5) (summarizing Fue Yang's testimony).
97 Exc. at 7 (*In re U-Care Services*, OAH No. 17-1236-MDA at 7 (2018) (summarizing Fue Yang's testimony).
98 Exc. at 7 (*In re U-Care Services*, OAH No. 17-1236-MDA at 7 (2018) (summarizing Fue Yang's testimony).
99 Exc. at 62 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4) (summarizing Steve Ulofoshio's testimony).
100 Exc. at 62 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4) (summarizing Steve Ulofoshio's testimony).
101 Exc. at 62 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4) (summarizing Steve Ulofoshio's testimony).
102 Exc. at 62 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4) (summarizing Steve Ulofoshio's testimony).
103 Churchill Testimony.
104 Churchill Testimony.
105 Churchill Testimony.

there was some internal discussion about whether the Division would provide a template for timesheets.[106] Because of the tension, Ms. Churchill claims that she was instructed not to deal with timesheets—that provider agencies were responsible for their own timesheets.[107]

The live-in provider issue was significant enough that sometime in 2010 or 2011, Program Integrity had meetings with other Department of Health and Social Services staff, including SDS staff, to discuss it.[108] They determined that writing "live in" instead of times in and times out was not sufficient to comply with the regulation.[109] Ms. Churchill was not included in those discussions.[110] Although Program Integrity Manager Doug Jones and SDS Health Program Manager Lynne Keilman-Cruz knew that several providers were writing "live in" instead of time in and time out for live-in caregivers, they concluded that the regulation was clear, and that the error by a limited number of providers did not warrant a policy statement or other notice to providers.[111] Neither Mr. Jones nor Ms. Keilman-Cruz discussed the issue with Ms. Churchill.[112]

Although it may not have been Ms. Churchill's job to approve timesheets or approve how providers completed their timesheets, Ms. Churchill was a primary point of contact for many provider agencies with questions about the Medicaid regulations.[113] Given the Wage and Hour issues resulting from the 2010 change in regulations, Mr. Vishnevetski's, Ms. Smaw's, Mr. Yang's, and Mr. Ulofoshio's testimony that they contacted Ms. Churchill for a solution is credible. The common-sense plausibility of the advice reportedly given in the unique context of a live-in caregiver bolsters that credibility.[114] On the other hand, Ms. Churchill's testimony that she never reviewed timesheets is undermined by a January 2012 email exchange between her and Hearts and Hands of Care's Executive Director, Pauline

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106 Churchill Testimony.

107 Churchill Testimony.

108 Exc. 10 (*In re U-Care Services*, OAH No. 17-1236-MDA at 10); Exc. 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4).

109 Exc. 10 (*In re U-Care Services*, OAH No. 17-1236-MDA at 10); Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4).

110 Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4).

111 Exc. 10 (*In re U-Care Services*, OAH No. 17-1236-MDA at 10); Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4).

112 Exc. at 63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4).

113 Vishnevetski Testimony; Smaw Testimony; *see also* Exc. at 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Owner/Administrator of U-Care Services, LLC, Kisha Smaw, Owner/Administrator for Hearts and Hands of Care, Inc., and Steve Ulufoshio, Administrator for Consumer Care Network, Inc.)); Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, Kisha Smaw, and Patricia Stringer, Administrator for Consumer Care Network's Kenai Office)).

114 *See* Exc. 8-9 (*In re U-Care Services*, OAH No. 17-1236-MDA at 8-9 (2018) (discussing unique circumstances for live in providers and the reasonableness of such advice).

Jeffrey, and an April 2013 email exchange between her and Ms. Smaw, which suggest that Ms. Churchill did indeed—at least on two occasions—review timesheets as part of the certification process.[115] To the extent that Ms. Churchill claims or suggests that she never talked to *any* providers about timesheets after the 2010 change in regulations, that claim is inconsistent with her own testimony, and simply not credible. Just because Ms. Churchill may not have been the person at SDS with knowledge about timesheets, does not mean that providers would not have contacted her with their questions. Moreover, Ms. Churchill's testimony that she does not remember any conversations about writing "live in" on timesheets does not squarely controvert Mr. Vishnevetski's, Ms. Smaw's, Mr. Yang's, or Mr. Ulofoshio's accounts.

Mr. Vishnevetsky's testimony about guidance he received from Ms. Churchill is credible and well-corroborated. Accordingly, the preponderance of the evidence shows that the Division, through Ms. Churchill, approved Vladi's practice of writing "live in" in lieu of start and stop times.

b. Vladi's reliance on Ms. Churchill's guidance was reasonable.

The Medicaid regulation, 7 AAC 105.230(d)(5) is far from self-explanatory in a situation where a caregiver lives with the Medicaid recipient. Mr. Vishnevetski was confused about the time in and time out requirement for each "visit" because live-in providers do not "visit" the Medicaid recipients that they live with. His doubt about whether a time-in and time-out requirement for visits applies to live-in providers, was reasonable. For a caregiver who comes from someplace else and works a specified shift, the arrival and departure time for each visit can be readily recorded. But with a live-in caregiver, it is much more difficult, as the person does not arrive or leave, but instead may perform services in many small increments, as needed, throughout a 24-hour period. It was not unreasonable to conclude that requiring start and stop times in this context was not workable or necessary.

As stated, Ms. Churchill was a primary point of contact at SDS for guidance about complying with the regulations for Mr. Vishnevetski and other providers.[116] Ms. Churchill was not a file clerk or other administrative assistant.[117] She was, instead, an SDS employee known to be responsive and to

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115 *See* Exc. at 136-137; Vladi's Second Supplementation of Record.

116 Vishnevetski Testimony; Smaw Testimony; Exc. at 6-8 (*In re U-Care Services*, OAH No. 17-1236-MDA at 6-8 (2018) (summarizing testimony of Fue Yang, Owner/Administrator of U-Care Services, LLC, Kisha Smaw, Owner/Administrator for Hearts and Hands of Care, Inc., and Steve Ulufoshio, Administrator for Consumer Care Network, Inc.)); Exc. at 62-63 (*In re Consumer Care Network, Inc.*, OAH No. 17-0933-MDA/17-0983-MDA at 4-5 (2018) (summarizing testimony of Steve Ulufoshio, Fue Yang, and Kisha Smaw)).

117 Vishnevetski Testimony; Smaw Testimony; Churchill Testimony.

have knowledge of the regulatory requirements.[118] Ms. Churchill had the authority to certify Medicaid providers.[119] Mr. Vishnevetski routinely contacted Ms. Churchill about regulatory requirements.[120] Given the course of conduct and Ms. Churchill's position, it was reasonable for Mr. Vishnevetski to believe that Ms. Churchill had the authority to answer questions about compliance with the regulations. Although it would have been prudent for Mr. Vishnevetski to get Ms. Churchill's statement reduced to writing, there is no requirement under the equitable estoppel test for a government employee's statement to be in writing for the principal to apply. Nor was it unreasonable for Vladi to rely on Ms. Churchill's guidance without getting her responses in writing. And despite the fact that the Division had knowledge of and actually discussed the "live in" provider issue, it took no action to inform providers that the practice was not acceptable until years later.

Given that this was a common practice among providers, combined with the common-sense plausibility of the advice, it was reasonable for Vladi to rely on Ms. Churchill's response as the Division's position on the matter.

c. Vladi has been substantially prejudiced by its reliance.

Vladi has shown that it was substantially prejudiced by its reliance on the governmental position. Vladi has been subjected to years of potential overpayment findings for a significant percentage of its billings. If Vladi had not been advised by Ms. Churchill that writing "live in" instead of time in and time out was acceptable, and if Vladi had been advised at any time during the 2012 calendar year, or when Mr. Vishnevetsky asked SDS for specific advice on this issue, Vladi could have rectified the alleged deficiency and avoided overpayment findings in an audit conducted years later.

d. Estoppel serves the interest of justice so as to limit public injury.

The regulations at issue here are difficult to apply to live-in providers, and they appeared to conflict with Department of Labor regulations. Vladi acted reasonably when it sought clarification on how to apply the regulations in a way that would keep it in compliance with both regulatory schemes. Regulated businesses should be able to rely upon the basic competence of the governmental official in the agency overseeing certification and quality assurance to provide correct guidance when incorrect guidance could invalidate all their billings. This is especially true in a case like this, where several businesses actively sought guidance from the governmental agency; the governmental agency apparently

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118 Vishnevetski Testimony; Smaw Testimony.
119 Vishnevetski Testimony; Smaw Testimony.
120 Vishnevetski Testimony.

gave a number of providers the same advice; and the governmental agency was aware that several providers were writing "live in" on their timesheets instead of times in and out but took no action to notify the providers that their timesheets would result in overpayment findings.

Vladi has therefore established that equitable estoppel precludes Program Integrity from imposing overpayments for the 23 PCS claims and four Waiver claims M & S identified in its audit based upon the lack of start and stop times, where the provider noted "live in."[121] And thus, the overpayment findings on this basis should be removed.

F. No Timesheets Submitted

M & S found overpayments for two PCS claims and one Waiver claim because Vladi did not submit any timesheets to document that the services were rendered.[122] Mr. Vishnevetski did not dispute that he did not submit the timesheets for these claims.[123] Instead, he testified that he misplaced the records.[124] He explained that it is easy to put timesheets in wrong folders, and he may have inadvertently destroyed them.[125]

A Medicaid provider must record, and be able to document upon audit, the name of the recipient receiving treatment, the service provided, the extent of the service provided, the date it was provided, and the individual providing the service.[126] The provider must retain the records for seven years, and if the provider is unable to produce the records on demand, the Department "may deny payment or may initiate a recoupment."[127] Because Vladi failed to submit complete timesheets, the overpayment findings on these grounds are affirmed.

G. Discrepancies Between Duration of Services and Documented Start and Stop Times

M & S made overpayment findings for four PCS claims because the prepopulated duration of service did not equal the handwritten start and stop times documented on the timesheets.[128] Vladi billed

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121 AR at 126 & 3289. Hansen Testimony. D269002, D269006, D269015, D269016, D269022, D269025, D269026, D269027, D269030, D269039, D269040, D269041, D269049, D269068, D269069, D269071, D269072, D269073, D269074, D269078, D269079, D269080, and D269084. AR at 126 n. 3. D262001, D262002, D262019, and D262035. AR at 3290.

122 Hansen Testimony; AR at 127, 144, & 149; AR at 3290. PCS Claims: D269032 & D269049; Waiver Claim D262052.

123 Vishnevetski Testimony.

124 Vishnevetski Testimony.

125 Vishnevetski Testimony.

126 7 AAC 105.230; 7 AAC 105.220(b).

127 7 AAC 105.240(d).

128 Hansen Testimony; AR at 127, 152, & 154; AR at 1988 – 1989 (D269057); AR at 2195 – 2196 (D269063); AR at 2197 – 2198 (D269064); & AR at 2199 – 2200 (D269065).

Medicaid based on the prepopulated duration of services which was more than the start and stop times.[129] For these claims, the overpayment was limited to the difference between handwritten stop and start times and the prepopulated duration of services.

Vladi submitted a handwritten note dated November 14, 2017 from the Medicaid recipient claiming that "PCA Service on 10-3-12 was provided from 8:00 AM until 10:15 AM" and "PCA Service on 10-10-12 was provided from 9:00 AM until 11:15 AM."[130] Vladi also provided a handwritten note from the PCS provider asserting that she made an error "converting minutes into decimals" for October 3, 2012 and October 10, 2012.[131]

Because the timesheets for these claims were prefilled with the duration of service, Program Integrity's decision to reconcile the discrepancy in favor of the handwritten start and stop times and the provider's and the recipient's signatures acknowledging "that the above tasks were completed and the times are correct," was reasonable.[132] The subsequently submitted notes from the recipient and the provider—notes dated more than five years after services were purportedly provided—do not meet the Medicaid documentation standards. Accordingly, the overpayment findings on these grounds are affirmed.

H. Time Sheet Not Signed by the Recipient or the Recipient's Representative

M & S made an overpayment finding for one PCS claim because the timesheet submitted by Vladi does not include the signature of the recipient or the recipient's legal representative.[133]

Alaska regulation 7 AAC 125.120(a)(5) requires PCS agency records of service to include the recipient's, the recipient's representative's, or the representative's designee's signature verifying that the services were provided as reported by the personal care assistant. In this case, however, the recipient became critically ill and suddenly passed away.[134] The recipient did not have a legal representative, and there is no evidence in the record that anyone else was authorized to sign on her behalf.[135] Vladi provided handwritten notes verifying that the personal care assistant provided services as reported to the

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129 Hansen Testimony; AR at 127, 152, & 154; AR at 1988 – 1989 (D269057); AR at 2195 – 2196 (D269063); AR at 2197 – 2198 (D269064); & AR at 2199 – 2200 (D269065).

130 Ex. V at 5.

131 Ex. V at 5. In its closing brief, Vladi references a settlement of a 2008 audit. That settlement is not admissible evidence in this case. Accordingly, Vladi's Exhibit BB is excluded.

132 *See* AR at 1988 – 1989 (D269057); AR at 2195 – 2196 (D269063); AR at 2197 – 2198 (D269064); & AR at 2199 – 2200 (D269065).

133 AR at 127, 138 (DR269014). *See also* AR at 963 – 964.

134 Ex. D at 6 – 7, 12 – 13.

135 *See for example* AR at 915.

recipient.[136] Given that it would have been impossible for the recipient to sign the timesheet, combined with the fact that Vladi has provided some evidence to verify that the services were provided, it would be fundamentally unfair to make an overpayment finding for this claim. Given the unusual circumstances surrounding this claim, that fundamental unfairness would be compounded by extrapolating the overpayment finding across the entire population of claims. Moreover, where a citizen has supplied a service in good faith—thereby acquiring a property right in payment for that service—and a subsequent event out of the citizen's control makes literal compliance with a documentation requirement impossible, it would be a violation of due process to *apply* the documentation regulation literally to deprive the citizen of an opportunity for payment.[137] Accordingly, the overpayment finding for Claim D269014 on this basis should be removed.

I. The Recipient's Service Plan Did Not Include the Rendered Service

M & S identified an overpayment for one PCS claim because the recipient's service plan did not include the rendered service.[138] The auditors concluded that Vladi did not provide sufficient documentation to support the need for the billed service.[139]

The recipient was authorized for 16.75 hours of PCS time per week.[140] The timesheet for this claim was pre-filled with time and tasks authorized by the PCAT Authorized Service Plan.[141] In addition to the time and tasks authorized in the recipient's service plan, the timesheet was also prefilled with 5 minutes per day for passive range of motion exercise.[142] Even so, Vladi charged for only 16.75 hours of PCS time per week—time that is consistent with the recipient's service authorization.[143]

In short, Program Integrity has failed to prove that Vladi charged for any services or time that were not authorized under the recipient's plan. Accordingly, the overpayment finding for Claim D269011 on this basis should be removed.

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136 Ex. D at 12 – 13.

137 The Commissioner of Health and Social Services may, and indeed, should consider such constitutional limitations on the outer boundaries of when an otherwise valid regulation can be applied. *See, e.g., In re S.D.,* OAH Case No. 13-1398-MDE (Comm'r of Health & Soc. Serv. 2014) at 7 & n.44.

138 AR at 127, 137 (D262011).

139 AR at 127.

140 AR at 836.

141 AR at 838 – 839.

142 R at 838 – 839.

143 AR at 137. (9 + 10 + 10 + 9 + 10 + 10 + 9) units * 15 minutes = 1,005 / 60 = 16.75 hours per week. AR at 838 – 839.

J. Plans of Care did not Cover the Dates of Service

M & S made overpayment findings for two Waiver claims because the recipients' plans of care did not cover the sampled dates of service.[144]

The dates of service for Claim D262024 were December 10, 2012 through December 21, 2012.[145] The last Plan of Care on file for the Medicaid recipient covered the period from December 5, 2011 through December 4, 2012.[146] However, the recipient experienced a lapse in care coordination services after November 19, 2012.[147] So, on December 4, 2012, SDS sent the recipient a list of care coordinators and asked her to select a new one.[148] After receiving no response from the recipient, SDS sent a second letter requesting the recipient to select a care coordinator with the warning that her Waiver services would be closed if she did not select a care coordinator within 30 days.[149] Due to health and safety and due process rights, the recipient's services were extended until the notification period was complete.[150] The recipient's case was not closed until February 14, 2013.[151] Because the services were extended, the overpayment findings for Claim D262024 should be removed.

Similarly, the dates of service for Claim D262063 were October 29, 2012 to November 9, 2012.[152] The plans of care on file for the recipient covered the periods from October 28, 2011 through October 27, 2012 and from November 15, 2012 through November 14, 2013.[153] Although the recipient's assessment was assigned on August 31, 2012, an interpreter was not requested until October 30, 2012, and the assessment was not completed until November 15, 2012.[154] Meanwhile, the Division of Public Assistance (DPA) extended services for the recipient.[155] And the same services were approved before and after the missing date span.[156] Accordingly, Program Integrity opined (and SDS agreed) that an overpayment finding would "likely not be held up in an appeal" and "this should be a technical

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144 AR at 3291, 3303, & 3313 (D262024 & D262063). *See also* AR at 3689 & 3917 *compared with* AR at 3707 (D262024); AR at 3897 & 3913 *compared with* AR at 3928 (D262063).
145 AR at 3291, 3303, 3707.
146 AR at 3689 & 3917.
147 AR at 3917.
148 AR at 3917.
149 AR at 3917.
150 AR at 3917.
151 AR at 3917.
152 AR at 3291, 3313, 3928.
153 AR at 3897 & 3913.
154 AR at 3914.
155 AR at 3914.
156 AR at 3913.

finding."[157] Because the services were extended and the same services were approved, the overpayment findings for Claim D262063 should also be removed.

K. Insufficient Documentation for Respite Services

M & S made overpayment findings for 50 Waiver claims because the timesheets submitted by Vladi do not "document the provision for respite support."[158] Program Integrity argues that Vladi failed to document the need for services or what services were provided.[159] In particular, the auditors found overpayments because the timesheets for respite care services do not identify the primary caregivers who were being relieved.[160]

For all the claims in this category, Vladi submitted the recipients' plans of care authorizing respite care.[161] Vladi also submitted computer-generated, standardized forms that say "Respite Timesheet" handwritten or pre-typed at the top of the page. Each timesheet indicates the name of the recipient and the name of the service provider, but neither the plans of care nor the timesheets identify the recipient's primary unpaid caregivers.[162]

Respite care services are provided to relieve "primary unpaid caregivers, including family members and court-appointed guardians."[163] Respite care services must be approved as part of a Medicaid recipient's POC.[164] None of the applicable regulations require that a POC or timesheet identify the primary unpaid caregiver.[165] Yet Program Integrity faults Vladi for failing to identify the primary unpaid caregivers and assessed overpayment findings, reasoning that the auditors were unable to determine that unpaid caregivers were the ones being relieved.

Program Integrity's rationale is unpersuasive. For one thing, if someone else is providing respite services, then the primary unpaid caregiver is being relieved. Moreover, Program Integrity, who bears the burden of proof here, presented no evidence that the respite care services were being provided for

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157 AR at 3913.

158 AR at 3290. D262001, D262002, D262003, D262004, D262005, D262006, D262010, D262011, D262013, D262015, D262016, D262017, D262018, D262019, D262020, D262021, D262022, D262023, D262024, D262025, D262026, D262027, D262028, D262029, D262030, D262031, D262032, D262033, D262034, D262035, D262036, D262037, D262038, D262039, 40, D262041, D262042, D262043, D262044, D262045, D262046, D262047, D262048, D262050, D262053, D262057, D262060, D262061, D262063, and D262064. AR at 3290 n. 3.

159 AR at 3290.

160 AR at 3290.

161 Documentation provided by Vladi for each Waiver claim begins at page 3548 of the agency record.

162 Concurrent grounds for lack of start and stop times or writing "live in" instead of start and stop times are addressed separately.

163 7 AAC 130.280(b)(1).

164 7 AAC 130.230(a)(1).

165 7 AAC 130.230; 7 AAC 280.

anyone other than the unpaid primary caregivers. Nor did Program Integrity present any evidence that the paid service providers identified on the timesheets were the recipients' primary unpaid caregivers. Instead, Program Integrity's overpayment findings in this category are based purely on speculation, and thus it has failed to meet its burden of proof. For these reasons, the overpayment findings on this basis should be removed.

L. Insufficient Documentation that Provider Successfully Passed a Criminal Background Check

M & S made overpayment findings for four PCS claims and six Waiver claims because Vladi failed to submit documentation that the providers successfully passed criminal background checks before the sampled dates of services.[166] At the hearing Program Integrity removed the overpayment findings for all of the PCS claims and two of the Waiver claims.[167] Accordingly, four Waiver claims remain at issue in this category: D262001, D262011, D262012, and D262013.

Individuals and businesses that must be licensed or certified by the Department, or that will be paid by the Department to provide services to individuals served by the Department's programs, are required to undergo a criminal history check.[168] This criminal history check is mandatory and applies to owners, officers, directors, partners, members, principals, employees, and independent contractors who have regular contact with service recipients or their personal or financial records.[169] A Medicaid-enrolled provider may not have a person who has been convicted of a barrier crime as an owner, officer, director, partner, member, principal, employee, or independent contractor of the business.[170] A business entity that is subject to the background check requirement must request a criminal history background check for a prospective employee: "the criminal history check must be completed *before* hiring unless the department issues notice of a provisional valid criminal history check under 7 AAC 10.920."[171]

The billings for Claim 262001 included services provided by Aumua Arona on November 26, 2012 through December 7, 2012.[172] But Vladi did not receive a provisional background check clearance

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166 Hansen Testimony; AR at 127; AR at 3291. PCS Claims: D269017, D269035, D269075, and D269076. Waiver Claims: D262001, D262011, D262012, D262013, D262048, and D262065.

167 Program Integrity removed overpayment findings on this ground for PCS Claims D269017, D269035, D269075, and D269076; and Waiver Claims D262048 and D262065.

168 AS 47.05.300; AS 47.05.310; 7 AAC 10.900(b).

169 AS 47.05.300; 7 AAC 10.905; 7 AAC 10.910.

170 AS 47.05.310(a); 7 AAC 10.905.

171 7 AAC 10.910(a)(3). All references to regulations are to those in effect at the time of the alleged acts that gave rise to this case.

172 AR at 3297, 3565.

for this provider until January 10, 2013.[173] Similarly, the billings for Claims D262011, D262012, and D262013 included services provided by Faamalolo Misa on October 1 through October 12, 2012, October 15 through October 26, 2012, and October 29, 2012,[174] even though Vladi did not receive a provisional background check clearance until October 30, 2012.[175]

Vladi did not dispute the basic facts. Instead, Vladi argued that the billings were valid because it hired the providers "retroactively."[176] Mr. Vishnevetski believed that the Department of Labor required him to pay providers before the background clearances were received because the providers—who are usually family members—began working as soon as the recipients' service authorizations were completed.[177]

The regulations are clear, however, that "the criminal history check must be completed *before* hiring unless the department issues notice of a provisional valid criminal history check under 7 AAC 10.920,"[178] and a provider "must pass a criminal history check . . . unless the department grants a variance."[179] The underlying purpose behind the background check requirement is to protect recipients from unsafe providers. Allowing a provider to work for a recipient before his or her background check is completed defeats that purpose. Accordingly, Medicaid service providers cannot perform services for Medicaid recipients until they obtain either a provisional or final background check, and the provider cannot bill for those services. Vladi's practice of allowing providers to work and submitting Medicaid claims for such services before the date of their approval was a violation of the Medicaid program requirements. Further, because Vladi was not required to *hire* providers before receiving background check clearances, its argument that the Department of Labor required it to pay providers for services rendered before receiving background check clearances lacks merit.

Accordingly, the overpayment findings on these grounds are affirmed.

IV. Conclusion

Program Integrity's overpayment findings are partially affirmed and partially reversed. Specifically, the overpayment findings for the following grounds are affirmed: the submitted timesheets

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173 Testimony of Karen Benson.
174 AR at 3300, 3650, 3651, & 3652. The overpayment finding is limited to Line 1 of Claim D262013.
175 Benson Testimony; Ex. 45.
176 Vishnevetski Testimony.
177 Vishnevetski Testimony.
178 7 AAC 10.910(a)(3). All references to regulations are to those in effect at the time of the alleged acts that gave rise to this case.
179 7 AAC 125.090(a).

did not have a start and stop time for services provided (Waiver Claims D262003, D262004, D262012, D262021, D262022, D262023, and D262024); no timesheets to document that the services were rendered (PCS Claims D269032 and D269049 and Waiver Claim D262052); prepopulated duration of service did not equal the handwritten start and stop times documented on the timesheets (PCS Claims D269057, D269063, D269064, and D269065); and no documentation that the providers successfully passed criminal background checks before the sampled dates of services (Waiver Claims D262001, D262011, D262012, and D262013). The remaining overpayment findings are reversed. Program Integrity shall recalculate the overpayment, based on this decision.

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: April 5, 2019

RECOMMENDED BY:

Signed
Jessica Leeah
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

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 2nd day of July, 2019.

By: *Signed*
Name: Jillian Gellings
Title: Project Analyst
Agency: Office of the Commissioner, DHSS

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]