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

In the Matter of:	)	
	)	
CONSUMER DIRECT CARE NETWORK ALASKA	)	OAH No. 18-1339-MDA
	)	

DECISION BY SUMMARY ADJUDICATION

I. Introduction

This case is a review of a Medicaid audit of a major provider of in-home personal care services. A state contractor conducted the audit on behalf of the department's Medicaid Program Integrity Unit ("Program Integrity"), which now defends it on appeal.

In the audit at issue, Alaska Consumer Direct Personal Care, LLC, doing business as Consumer Direct Care Network of Alaska, was asked to repay $1,228,877.25 of Medicaid payments it received in 2013. Of that amount, $1,227,801.85 was a figure developed by reviewing 90 randomly-selected claims, identifying purported billing errors in 31 of those claims, developing an error rate, and extrapolating that error rate across a population of 45,504 claims that Consumer Direct had submitted during the audited period.[1]

Consumer Direct has challenged 29 of the 31 allegations of improper billings in the extrapolated sample. Because the resolution of these 29 claims turns on legal rather than factual questions, both Program Integrity and Consumer Direct moved for summary adjudication in their favor in lieu of taking the case to a live hearing. This decision grants Consumer Direct's motion, denies Program Integrity's reciprocal motion, and decides the appeal in Consumer Direct's favor. Because not all of the overpayment findings were challenged in the appeal, this result does not quite resolve the audit. The case must be remanded to Program Integrity to have its contractor recalculate the extrapolation using only the remaining overpayment findings.

II. Summary Adjudication

Summary adjudication in an administrative proceeding is the equivalent of summary judgment in a court proceeding.[2] It is a means of resolving disputes without a hearing when the central underlying facts are not in contention, but only the legal implications of those facts. If

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[1] *See* Agency Record ("R.") 0099-0100. The extrapolation procedure, which is not at issue in this appeal, has been described in prior cases such as *In re C Care Services,* OAH Case No. 11-0015-DHS (Comm'r of Health & Soc. Serv. 2012) (published at https://aws.state.ak.us/OAH/Decision/Display?rec=2101).

[2] *See, e.g., Schikora v. State, Dept. of Revenue,* 7 P.3d 938, 940-41, 946 (Alaska 2000); 2 AAC 64.250.

facts that are undisputed establish that one side or the other must prevail, the evidentiary hearing is not required.[3] In evaluating a motion for summary adjudication, if there is any room for differing interpretations, all facts are to be viewed, and inferences drawn, in the light most favorable to the party against whom judgment may be granted.[4]

In this case, only Consumer Direct has presented witness affidavits, and in any event the case turns largely on written communications about which there can be no dispute. The legal implications of those communications are contested. In contrast to factual disputes, legal disputes—such as disputes about the meaning of regulations—do not require a hearing to resolve.

III. Overpayment Findings Based on "Live-In" Entries

1. Undcontroverted Facts Common to Both Grounds for Summary Adjudication

Personal Care Services (PCS) are provided to certain qualifying Medicaid recipients by a Personal Care Assistant, or PCA. An assessment identifies the functional limitations the recipient may have, such as difficulties getting around the house, going to the toilet, preparing meals, shopping, and so on. The PCA's job is to assist the client with those activities. In a highly structured regulatory scheme, a certain number of minutes are assessed for PCA assistance with each required iteration of each task. This leads to a total weekly time award.[5]

An agency such as Consumer Direct employs one or more PCAs to supply the services for which time has been awarded. It then bills the Medicaid program for the service time of the PCAs. For many years these bills have had to be supported by a record of the date, time, and length of each visit and the services performed, which is usually done on a timesheet.[6]

Some PCAs (about a third, in the present audit) live in the same home as their client. Their services may potentially be scattered in many short increments across the course of a 24-hour period. Other PCAs come to the client's home and work a defined shift.

The Division of Senior and Disabilities Services (SDS) is the DHSS division that oversees the PCS program. In late 2009, SDS and its sister divisions were preparing to implement a comprehensive revision of the Medicaid regulations.[7] Among the revisions were

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[3] *See Smith v. State of Alaska,* 790 P.2d 1352, 1353 (Alaska 1990); 2 Davis & Pierce, *Administrative Law Treatise* § 9.5 at 54 (3d ed. 1994).

[4] *Samaniego v. City of Kodiak,* 2 P.3d 78, 82-83 (Alaska 2000).

[5] A good description of this process is found in *In re G.J.,* OAH Case No. 18-1311-MDA (Comm'r of Health & Soc. Serv. 2018) (https://aws.state.ak.us/OAH/Decision/Display?rec=6344).

[6] *See* 7 AAC 125.120(a); *see also* former 7 AAC 43.775(a) (repealed 2010).

[7] Consumer Direct Ex. JJ.

changes to billing requirements, including a new provision, 7 AAC 105.230(d)(5), requiring "start and stop times for time-based billing codes." Because PCS is a time-based service, this requirement would apply to it, and would affect PCS timesheets. The revisions' final round of public comment closed in October of 2009,[8] making them ripe for adoption. They were subsequently adopted to become effective February 1, 2010.[9]

It is important to note that the specific reference to start and stop times in the incoming regulation created a situation that—as the Commissioner of Health and Social Services has already held in a prior case—was "far from self-explanatory in a situation where the PCA is already in the home when the day begins, and still there when it ends."[10] One "not unreasonable" approach, the Commissioner has held, might be for such PCAs to simply enter "live-in" on the timesheet.[11] Other reasonable approaches can also be imagined.

During the interim between the close of public comment and final adoption, on November 16, 2009, Consumer Direct sought certainty on this and other issues. Its program manager in Alaska (on his own behalf and that of the parent company's Vice President from the Lower 48) requested a meeting with SDS's Division Director, Rebecca Hilgendorf. They asked for "the opportunity to discuss our timesheet auditing practices and see if they meet the State standards."[12]

The meeting took place on December 9, 2009.[13] At the meeting, Consumer Direct presented a one-page set of timesheet auditing procedures.[14] The very first item on the list was labeled "Start Times", and the very first line specified that Consumer Direct would ensure "that either 'Live In' is written or an adequate start time is listed."[15] Consumer Direct said that it would "appreciate the State's feedback" because "it is difficult to know whether our process is satisfactory as time sheet auditing standards are not detailed in regulations."[16]

The day after the meeting, Consumer Direct sent Director Hilgendorf a follow-up email, attaching a copy of the one-page auditing protocol and requesting "a reply letting us know if we

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8 Second Supplemental Notice of Proposed Changes in the Regulations of the Department of Health and Social Services, August 17, 2009. Comments closed in mid-October, with the regulations ripe for adoption from that time forward.

9 Alaska Administrative Code Register 193; Consumer Direct Ex. JJ.

10 *In re U-Care Services,* OAH Case No. 17-1236-MDA (Comm'r of Health & Soc. Serv. 2018).

11 *Id*.

12 R. 0122.

13 Schomaker Affidavit, ¶ 8.

14 *Id*.

15 R. 0127.

16 *Id.* These statements were in writing.

are within the guidelines of the regulations".[17] The SDS Director responded on March 17, 2010, shortly after the new regulations had taken effect. She said, "I believe that your internal auditing protocol will work well."[18] She thanked Consumer Direct for being "so proactive."[19]

In endorsing the entry of "Live In" as being acceptable in place of a start time for live-in PCAs, the SDS Director was apparently in step with the views of staff at lower levels in her division. Other PCS providers perceived that they had obtained a similar go-ahead to use this approach, which they received from SDS quality assurance official Beverly Churchill.[20] And SDS's Chief of Programs, Lisa McGuire, was considering a regulation change as late as 2015 to "Disallow the PCA to write 'Live In' on the timesheet with no documentation of tasks, duration, or scope."[21] The fact that she thought a regulation change should be considered to "disallow" this is evidence that she did not perceive the 2010 regulations as having accomplished that result.[22]

Consumer Direct acted in conformity with the audit protocol it had presented to Director Hilgendorf.[23] Consumer Direct began using a timesheet that had a check box for "Live-In", and explicitly instructed providers to enter "No In/Out Time" if they checked the box.[24]

Discussion of taking some sort of new action in regard to the live-in notation appears to have begun within DHSS by early 2013, as evidenced by an email string encompassing Ms. McGuire, the successors of Churchill and Hilgendorf, Program Integrity's Douglas Jones, and others.[25] There is no evidence that these early discussions went outside DHSS, however, and Program Integrity makes no claim Consumer Direct was notified that Director Hilgendorf's approach to the issue was being reconsidered.

During the first three quarters of 2013, while these internal discussions were going on, Consumer Direct was consistently using the live-in timesheet notation, without start and stop

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17 Schomaker Affidavit, ¶ 9; R. 0124-5.

18 R. 0124.

19 *Id*.

20 *U-Care, supra*, at 6-12; *In re Consumer Care Network, Inc.*, OAH Case No. 17-0933-MDA (Comm'r of Health & Soc. Serv. 2018) at 3-5, 8-10;

21 Consumer Direct Ex. K-1, K-2.

22 I recognize that this evidence might not be conclusive on the issue of what she believed, if contrary evidence were offered at hearing.

23 Schomaker Affidavit, ¶ 11.

24 *E.g.,* R. 0959, 1322, 1681, 1859, 2176, 2445, 2762, 3985, 4619, 5071.

25 Consumer Direct Ex. J. Program Integrity has heavily redacted the email string, perhaps based on an expansive interpretation of deliberative process privilege.

times, for resident PCAs. All of the disallowed billings at issue in this case occurred during that period.

On March 11, 2014, a mid-level SDS manager informed Consumer Direct in writing that its use of a "live-in" notation was insufficient to comply with the billing regulations.[26] The letter declined to renew Consumer Direct's certification as a PCS provider unless the practice was changed, and required corrective action by April 10, 2014.[27] On April 3, 2014, Consumer Direct responded, discussing the practical difficulty of having live-in providers clock in and out but promising to either adopt a universal PCA timesheet that SDS was proposing to circulate, or to change the live-in practice on its own as of a date in May.[28] On April 21, 2014, SDS closed out the review and thanked Consumer Direct "for your diligence in correcting the identified deficiencies."[29]

Three years later, on April 10, 2017, Program Integrity initiated an audit of Consumer Direct's PCS billings between January 1, 2013 and September 30, 2013.[30] The audit letter listed 90 claims selected at random that would serve as a sample for the audit period.[31] From that sample, 29 claims were determined to be invalid because the time sheet reported the PCA as "live-in" rather than providing specific start and stop times.[32] These were 29 of the 31 overpayment findings that—when extrapolated across a population of 45,504 claims in the audit period—produced a total demand for repayment of $1,227,801.85.

2. Regulatory Reinterpretation Not Applicable Until After Audit Period

As noted above, when DHSS adopted the start-and-stop time regulation in 2010, it was "far from self-explanatory" how it would operate in the unique context of live-in PCAs.[33] Perhaps these providers might just be expected to write "live in" as a way of indicating that they did not arrive or leave, but rather were there all the time. The Commissioner has already held this interpretation of the regulation, in the PCA context, to be "not unreasonable."[34] Perhaps they should enter a start time of midnight on the timesheet and a stop time of the following midnight. Perhaps they should clock in and out dozens of times a day, recording that they began

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26 R. 0131.
27 R. 0130-0131.
28 R. 0134-0135; Schomaker Affidavit, ¶ 14.
29 Consumer Direct Ex. U.
30 R. 0997-1002.
31 R. 1003-1006.
32 R. 0514.
33 *U-Care Services* at 12.
34 *Id*.

work at 4:03 a.m. and finished at 4:09 a.m. to assist with one trip to the toilet, then began work again at 6:07 a.m. and finished at 6:12 a.m. for assistance with locomotion to the breakfast table, and so on. Perhaps they should be expected to identify one or two defined multi-hour blocks in the day, during which they would perform (or claim to perform) all of their tasks.

Contemporaneously with the adoption of the regulation, the Director of the division responsible for PCS opted for the first interpretation of the regulation, and she so informed at least one provider, Consumer Direct. Her choice was reasonable. The provider relied on it in setting up a documentation protocol for millions of dollars in billable services. That, then, is what the regulation meant.

An agency can change its interpretation of its own regulation. But the change cannot run roughshod over industry reliance on the prior interpretation. Courts have indicated that they will decline to apply such a change retroactively when the new interpretation would impose "some new liability . . . on individuals for past actions that were taken in good faith reliance."[35] One federal court summarized the rule as follows:

> As a general matter, when an adjudicating agency retroactively applies a new legal standard that departs radically from the agency's previous interpretation of the law, the agency must give entities regulated by the agency proper notice and a meaningful opportunity to adjust.[36]

This rule has been cited with approval and followed by the Alaska Superior Court[37] and by the Office of Administrative Hearings acting as the state tax court.[38] It will be followed here.

Based on the evidence in the record, the earliest date on which the changed interpretation of 7 AAC 105.230(d)(5) could be applied would be sometime after April of 2014, when SDS informed Consumer Direct that it would no longer accept the "live in" notation as compliant. All services at issue in this audit predate April of 2014. Therefore, the agency's prior interpretation of the regulation was, in fact, what the regulation meant at the time those services were performed. Since Consumer Direct documented the services in a manner consistent with that interpretation, the overpayment findings based on a different interpretation must be overturned.

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35 *NLRB v. Bell Aerospace Co.,* 416 U.S. 267, 295 (1974). *See also, e.g., Baptist Health v. Thompson,* 458 F.3d 768, 777 (8th Cir. 2006) (change in interpretation applied to cost years 1991-94 was valid because "HHS notified Baptist Memorial and its sister hospitals beforehand . . . in an August 1990 letter").

36 *Alabama v. Shalala,* 124 F. Supp. 2d 1250, 1264 (M.D. Ala. 2000).

37 *State, DHSS v. Valley Hosp. Ass'n,* No. 3AN-01-12301 (2003), *aff'd on other grounds*, 116 P.3d 580 (Alaska 2005).

38 *In re Sodexo Inc.,* OAH No. 18-0397-TAX (March 4, 2019).

3. Equitable Estoppel

Even if Program Integrity's current interpretation of 7 AAC 105.230(d)(5) had been effective in 2013, that interpretation could not be enforced against Consumer Direct in the present context. Under certain circumstances, regulations cannot be strictly applied because of the doctrine of equitable estoppel. This doctrine is conceptually related to, but not quite the same as, the one discussed in the previous section.

In order to prevail on this theory, the citizen must prove each one of four separate elements:

> [E]stoppel may apply against the government and in favor of a private party if four elements are present: (1) the governmental body asserts a position by conduct or words; (2) the private party acts in reasonable reliance thereon; (3) the private party suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to limit public injury.[39]

When these four elements are met, the government may be estopped or partially estopped (that is, limited or prevented) from applying a restriction as written. For example, in *In re M.B.,*[40] a case decided by the Department of Health and Social Services in 2012, an eligibility technician inadvertently misled a Medicaid applicant into putting too little money into her Medicaid Qualifying Income Trust. The agency was found to be estopped from denying Medicaid coverage for that individual for the period when the trust was underfunded as a result of the error.

This principle has been found in two previous cases to prevent Program Integrity from insisting on start and stop times in the live-in context. That result was reached in *In re Consumer Care Network, Inc.*[41] and *In re U-Care Services*,[42] both cases involving oral approvals of the "live-in" timesheet entry in place of specific start and stop times. The approvals were given by an SDS quality assurance reviewer soon after the new regulations went into effect. However, Consumer Direct did not have the same interactions with SDS as U-Care Services or Consumer Care Network, and thus the evaluation of the four elements of estoppel must largely be done anew in this case, although one subsidiary finding in the two prior cases carries over to this case.

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39 *Crum v. Stalnaker*, 936 P.2d 1254, 1256 (Alaska 1997).

40 Case No. 11-FH-496 (Office of Hearings & Appeals 2012).

41 OAH No. 17-0933-MDA (Comm'r of Health & Soc. Serv. 2018) (published at https://aws.state.ak.us/OAH/Decision/Display?rec=2119).

42 OAH No. 17-1236-MDA (Comm'r of Health & Soc. Serv. 2018) (published at https://aws.state.ak.us/OAH/Decision/Display?rec=6361).

The first element is whether the government body has expressed a position by conduct or words. Here, the chief of the division responsible for PCS met with a provider before the new regulations went into effect and reviewed a one-page audit protocol, in which the first line of the first item made it clear that the "live-in" entry would be used in place of specific times for PCAs who were not coming to the home from outside.[43] The division chief then said, in writing, that she thought this would "work well." That is an expression of a position that the "live-in" entry would meet the regulatory requirements for documentation.

Program Integrity asserts, without evidence, that "Ms. Hilgendorf did not intend her reply to expressly authorize anything."[44] Even if there were evidence, such as an affidavit from Ms. Hilgendorf, to back up this speculation, it would not matter.[45] It does not matter what the SDS director intended; it matters what she conveyed. She held a pre-arranged meeting with high-level management of a major provider to give them "the opportunity to discuss our timesheet auditing practices and see if they meet the State standards."[46] In that context, her statement that the protocol they discussed would "work well" conveyed that the protocol met the standards.

The second element has two dimensions—whether the member of the public acted in reliance on the advice, and whether the reliance was reasonable. Consumer Direct did use the "live-in" entry, explicitly instructing its PCAs not to give start and stop times if they had checked the box for that entry. It did so until it was told to stop, at which point it immediately changed to a different practice. Was Consumer Direct reasonable to rely on the signoff from Director Hilgendorf? Surely, it is reasonable to rely on a written sign-off from the highest official with direct responsibility over the matter, after a meeting expressly devoted to reviewing the timesheet issue. There were no caveats with the advice, no suggestion that Consumer Direct should check with anyone else or should proceed at its own risk. Instead, Consumer Direct was congratulated on being proactive in ensuring it was in compliance. This is the kind of feedback that reasonable members of the public can be expected to rely on, and do rely on.

The third element is whether the private party has suffered prejudice (harm) on account of its reliance. Program Integrity does not dispute this element. By proceeding with the "live-

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43 The protocol did not specifically mention stop times, but the clear implication was that "live-in" would supplant both start and stop times. It would be absurd to require stop times without start times.

44 Opposition and Cross-Motion at 9.

45 The speculation is difficult to square with Rebecca Hilgendorf's reputation as a highly competent executive. The suggestion that she would not have appreciated the significance of a written communication sent in this context, in her capacity as SDS Director, may sell her short.

46 R. 0122.

in" entry it had proposed for the resident PCAs, Consumer Direct wound up with a third of its PCS claims, totaling more than a million dollars, being disallowed after the fact.

The fourth element is whether estoppel serves the interests of justice so as to limit public injury. This element has already been decided by the prior cases, *U-Care* and *Consumer Care Network,* which held in nearly identical circumstances that the fourth element is satisfied. As pointed out in *Consumer Care Network*:

> Regulated businesses should be able to rely upon the basic competence of the governmental regulators to provide correct guidance when incorrect guidance could invalidate all their billings. This is especially true in a case like this, where the business actively sought guidance from the governmental agency, the governmental agency gave consistent guidance to several businesses, and then, after determining that the practice was in error, the governmental agency failed to notify the business and other businesses that the practice was inadequate.[47]

Because the four elements of estoppel are met, Program Integrity must honor Director Hilgendorf's approval of the "live in" entry at least until that approval was rescinded in 2014. Since this audit relates to 2013, all of the overpayment findings in this audit that were based on the "live in" issue must be overturned.

IV. Overpayment Finding Based on Power of Attorney

There was one claim in the sample, D392083, for which a dual overpayment finding was made, one based on the "live in" ground and another one based on the PCA holding a power of attorney in purported violation of the regulation at 7 AAC 125.010(b)(4). The "live in" finding must be reversed for the reasons discussed in Part III. The other finding must be reversed as well, and the elimination of both grounds makes D392083 a payable claim.

The version of 7 AAC 125.010(b)(4) in effect in 2013 provided that PCS may only be provided "by an individual . . . who is not . . . a legal representative of the recipient." Among the ways to be a "legal representative" is to be an "an agent under a power of attorney authorizing the person to make health care decisions."[48] On the date of service in question, February 21, 2013, the recipient's PCA was Roger F. Mr. F was listed as the recipient's designated "agent to make health care decisions for me" in a "Durable Power of Attorney for Health Care Decisions" the recipient had signed several years previously.[49] The existence of this document is the single

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47 *Consumer Care Network* at 10.
48 Former 7 AAC 125.199(8) (superseded in 2017).
49 R. 0449-0453.

additional ground on which the Program Integrity has made an overpayment finding on Claim D392083.[50]

However, the power of attorney was not effective on February 21, 2013. It would only become effective if a physician or court determined the recipient was unable to make her own decisions.[51] The only evidence in the record indicates that the recipient herself retained decision-making authority on medical matters, with the medical POA not in effect at the time of service.[52]

Program Integrity concedes that the POA was ineffective at the time of service, but argues that "the regulations do not make the distinction" between powers of attorney that are effective versus powers of attorney that are not yet effective.[53] That may be true, but the regulation on this issue is utterly simple: it only disqualifies someone who "is"—present tense—a legal representative. On February 21, 2013, Mr. F could not take any legal action or make any decision on behalf of the recipient. That is the end of the matter.

Program Integrity advances policy arguments suggesting the regulations ought to prohibit PCAs from being named in contingent POA documents that might become effective in the future.[54] If the Division of Senior and Disabilities Services finds those arguments persuasive, it could easily write a regulation so providing. But it has not done so yet.

V. Claims Resolved in Favor of Program Integrity

Consumer Direct did not appeal 16 overpayment findings which the auditor disallowed based on duplicate payments and conflicting inpatient hospital stays. These were not part of the extrapolation population, but instead were assessed for direct reimbursement with a total amount owing of just over a thousand dollars.[55] This decision does not affect that liability.

Consumer Direct also did not appeal two overpayment findings *within* the extrapolation population (D392044 and D392023), which were based on timesheet deficiencies other than the

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50 The 2013 version of 7 AAC 125.010(b)(4) also says that an "immediate family member" may not be a PCA, and Mr. F was the recipient's son. However, Program Integrity correctly refrained from asserting this as a basis for disallowance. A son is not an "immediate family member" as that term is defined in former 7 AAC 125.199(7).

51 R. 450.

52 R 4672, 4665. There does seem to have been a POA in effect for financial decisions, but there is no information in the record about who held that POA and, in any event, such a POA would apparently not be disqualifying. *See* former 7 AAC 125.199(8). It has not been asserted as a basis for denial of Claim D392083.

53 Program Integrity Opposition and Cross-Motion at 25.

54 *Id.*

55 *See* Appendices A-2 and A-3 to M&S Report.

"live in" entry.[56] These overpayment findings therefore remain in place for the new extrapolation to be performed on remand.

VI. Conclusion and Order

Consumer Direct's Motion for Summary Adjudication is granted. Program Integrity's Cross-Motion for Summary Adjudication is denied. Consumer Direct's appeal is sustained, and all overpayment findings within the audit sample are overturned with the exception of D392044 and D392023. Upon adoption by the final decisionmaker, this matter is remanded to Program Integrity for recalculation of the amount owing based on the reduced number of overpayment findings. Jurisdiction is not retained. If Consumer Direct contests the recalculation, it will have separate appeal rights from that determination.

DATED this 31st day of May, 2019.

By: *Signed*
Christopher Kennedy
Administrative Law Judge

Adoption

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

DATED this 2nd day of July, 2019.

By: *Signed*
Jillian Gellings
Policy Analyst
Alaska Department of Health & Social Services

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

[56] *See* Consumer Direct Motion for Summary Adjudication at 1; Consumer Direct Appeal Table of Contents.