IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

No. 23-ICA-39

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HOLISTIC, INC.,

Petitioner below, Petitioner,

v.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU OF MEDICAL SERVICES,

Respondent below, Respondent.

PETITIONER'S OPENING BRIEF

J. Zak Ritchie (WVSB #11705)
Counsel of Record
Isaac R. Forman (WVSB #11668)
Skyler A. Matthews (WVSB #13532)
HISSAM FORMAN DONOVAN RITCHIE PLLC
P.O. Box 3983
Charleston, WV 25339
(681) 265-3802 *office*
(304) 982-8056 *fax*
zritchie@hfdrlaw.com
iforman@hfdrlaw.com
smatthews@hfdrlaw.com

Counsel for Petitioner Holistic, Inc.

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INTRODUCTION

This appeal is about government bureaucrats running roughshod over clear legal requirements and abusing the administrative process to the substantial detriment of West Virginia health care providers.

In this case, Respondent West Virginia Department of Health and Human Resources, Bureau for Medical Service ("BMS") unilaterally and with no meaningful explanation indefinitely suspended *all* Medicaid payments to Petitioner Holistic and its providers under a regulation allowing the agency to do so based on a "credible allegation of fraud for which an investigation is pending." These payments are the very lifeblood of Holistic (a family-owned business) and its providers, who supply vital medical services to West Virginia citizens for treatment for substance use disorder. Yet BMS's duty to suspend payments is not only conditioned on a "credible allegation of fraud," *but also* on whether "the agency has good cause to *not* suspend payments or to suspend payment *only in part*."

BMS ignored these legal requirements. It not only failed to explain the "credible allegation of fraud,"[1] BMS critically failed to satisfy the "good cause" element as to whether it should "not" suspend payments or to suspend them "only in part." In so doing, BMS also violated its own Manual, which requires tailoring

[1] During the course of the administrative process below, Petitioner was compelled to file a petition for extraordinary writ against BMS with the Circuit Court of Kanawha County, which was later dismissed for procedural reasons. *See Holistic, Inc. v. W. Va. Dep't of Health and Human Res., Bureau of Med. Servs.*, Case No. 22-P-184 (Kan. Cnty. Cir. Ct.). Even so, the collateral filing smoked out BMS's purported basis for its suspension more than its administrative process ever did (which is to say, not at all).

the payment suspension to the extent of the alleged fraud. Instead of the required scalpel, BMS clumsily used a hammer. Demonstrating BMS's disconnect from the law and the record, the agency wrongly suspended Medicaid payments to Holistic for *all* its Medicaid claims and for the "*entirety*" of the organization—at this point well over a million dollars—based only on concerns with *four-year old paper charts for eight patients*. D.R. 18 (emphasis added). Thus, even if the suspending of some payments is satisfied, there is no support in the facts or the law for the agency's draconian suspension of *all* payments on an indefinite basis. Federal regulation and constitutional due process require far more.

For these reasons and those that follow, this Court should reverse the BMS decision for failure to conduct, much less satisfy, the "good cause" standard not to suspend payments. Alternatively, this Court should vacate the BMS decision and remand with directions to the agency to modify the decision to suspend payments "only in part" consistent with law and its own Manual.

ASSIGNMENTS OF ERROR

1. A court shall reverse, vacate or modify an agency decision if the substantial rights of the petitioner have been prejudiced because the decision is (1) In violation of constitutional or statutory provisions; *or* (2) In excess of the statutory authority or jurisdiction of the agency; *or* (3) Made upon unlawful procedures; *or* (4) Affected by other error of law, *or* (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; *or* (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

   Federal regulation 42 C.F.R. § 455.23 mandates that a state Medicaid agency evaluate the existence of good cause not to suspend, or to suspend in part, Medicaid payments where there is a credible allegation of fraud for which an investigation is pending. Here, BMS failed entirely to even *consider* the "good cause" factors required by 42

C.F.R. 455.23(a)(1), particularly in light of the record demonstrating that nearly all factors are satisfied. Was BMS's unexplained decision to suspend Petitioner's Medicaid payments in their entirety without regard to the required "good cause" analysis contrary to law and otherwise arbitrary and capricious?

2. A court shall reverse, vacate or modify an agency decision if the substantial rights of the petitioner have been prejudiced because the decision is (1) In violation of constitutional or statutory provisions; *or* (2) In excess of the statutory authority or jurisdiction of the agency; *or* (3) Made upon unlawful procedures; *or* (4) Affected by other error of law, *or* (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; *or* (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

   Federal regulation 42 C.F.R. § 455.23(b)(2)(ii) requires a state Medicaid agency to give sufficient notice of the allegations of the alleged fraud to the suspended party so that it may be contested. Moreover, constitutional due process requires the agency to provide substantive information about the purported fraud on which the suspension was based. Here, however, when Holistic sought clarification on the nature of the allegations against it that were identified as the basis of the indefinite and total suspension of its Medicaid payments, BMS only provided a conclusory assertion that the pending investigation "concerns allegations of knowingly billing services never rendered." Was BMS's barebones statement of alleged fraud sufficient to satisfy § 455.23(b)(2)(ii) and constitutional due process requirements before depriving Petitioner of all of its Medicaid payments on an indefinite basis?

STATEMENT OF THE CASE

Petitioner Holistic, Inc. provides comprehensive services to its patients, including primary care, addiction treatment, and counseling. D.R. at 2.[2] In addition to providing family practice services, Holistic provides medically assisted treatment for substance use disorder to over 350 patients from two offices located in St. Albans and Charleston, West Virginia. *Id*. Many of Holistic's patients receive and rely on

[2] References to "D.R." are to the designated record lodged in this appeal.

Medicaid benefits to pay for the necessary medical treatment that they receive. *Id*. To that end, the decision to suspend Medicaid payments can have a devastating effect upon the economic viability of healthcare practices or individual practitioners, even if the suspension is ultimately lifted. *Id*. This is especially true in West Virginia where so many low-income patients receive insurance through this program and the bulk of many practices often includes patients on Medicaid. *Id*.

Because of this potential drastic effect, it is therefore critical that the State, in making a decision to suspend a provider's access to Medicaid reimbursement, do so only upon a thorough consideration of whether good cause exists to stay a decision to suspend and to only suspend when adequate and specific pre-suspension notice has been given to providers. D.R. 108–111. To allow otherwise could result in further reducing the number of available providers in the state, thereby eliminating access to much needed care for vulnerable West Virginians. *Id*.

On May 2, 2022, BMS, then a division of DHHR, notified Holistic that it intended to suspend Medicaid payments to Holistic in their entirety on May 16, 2022. D.R. 18–19. The suspension applied to *all* of Holistic's Medicaid claims and to the entirety of the organization. D.R. at 3, 18. BMS stated that the suspension was due to an ongoing investigation by the West Virginia Medicaid Fraud Unit but wholly failed to explain any specific findings of wrongdoing on behalf of Holistic. *Id*. Six current and former providers from Holistic also received identical letters from

BMS (collectively, the "Individual Providers"), who are petitioners in a related appeal. D.R. at 27.[3]

Holistic immediately notified BMS of their intention to contest the suspension, requested a hearing, and demanded that BMS provide notice of its specific findings of against Holistic. D.R. at 20; D.R. at 27-28. BMS's notice provided *no substance* as to a finding of a credible allegation of fraud that would have even permitted Holistic to be able to respond or challenge. D.R. 18-19. Likewise, the notice failed to include general allegations as to the nature of the suspension action, as required by federal law and precedent. D.R. at 28; *see also* 42 C.F.R. § 455.23(b)(2). Because of BMS's insufficient notice, Holistic was unable to provide BMS with any explanation of specific billing patterns or practices that were allegedly problematic and the supposed basis for the draconian suspension. D.R. at 28. BMS also neglected to consider the "good cause" factors outlined in 42 C.F.R. § 455.23 prior to suspending Medicaid payments to Holistic. D.R. 28-29.

On May 16, 2022, BMS issued a second letter to Holistic that was nearly identical to the first but extended the suspension deadline to May 23, 2022. D.R. 25-26. Neither letter contained adequate or specific details about the allegation of

[3] Five past and/or present employees are also subject to the BMS decision and are petitioners in a related appeal before the ICA raising substantially identical arguments and seeking substantially similar relief, based on the same administrative record. *See Samantha Burgess, et al. v. W. Va. Dep't of Health and Human Res., Bureau of Med. Servs.*, Case No. 23-ICA-11. Petitioner anticipates moving to consolidate the cases for argument and decision. And for that same reason, Petitioner in this appeal also incorporates by reference the arguments raised by Petitioners in the *Burgess* case to ensure the cases can be efficiently considered and resolved by this Court.

wrongdoing against Holistic so that they could prepare a meaningful defense. D.R. 25-31. After extending the suspension deadlines, BMS ultimately issued an expedited Desk Review Decision on August 12, upholding the suspension of Medicaid payments by the Individual Providers and Holistic. D.R. 212-214. Holistic and the Individual Providers then requested an evidentiary hearing before the Commissioner of the Bureau of Medical Services, which was held on August 19. D.R. 217-219.

At the evidentiary hearing, Holistic and the Individual Providers requested that BMS reverse its pay-hold assessed across the entirety of Medicaid claims filed by Holistic and the Individual Providers due, in part, to BMS's failure to comply with its own policies, conduct the required good cause analysis, or provide sufficient notice to Holistic regarding the existence of any credible allegation(s) of fraud. D.R. 248-249. Remarkably, *after* Commissioner designee Brewer concluded that the factual, evidentiary record was closed, BMS submitted an untimely, post-hearing Affidavit of Andrew Pack, the Director of Program Integrity. D.R. 224-225. The tardy Affidavit *purported* to address the good cause exception factors—which, again, came long after the suspension had been made. *Id.*

On September 7, Mr. Brewer issued the Hearing Examiner's Recommended Decision, recommending the denial of Holistic's and the Individual Providers' requests to rescind or suspend the current suspension of all Medicaid payments, pending completion of an investigation. D.R. 265-285. The recommended decision stated that BMS's determination of a credible allegation of fraud was made in good

faith. D.R. at 283. To that end, the Hearing Examiner found that Holistic and the Individual Providers failed to demonstrate that BMS's determination to completely suspend Medicaid payments resulted from arbitrary and capricious decision-making. *Id*.

By letter dated December 7, 2022, BMS formally accepted, without modification, Mr. Brewer's recommended decision. D.R. at 307. The letter was not delivered to Holistic's counsel until over a month later. This appeal followed.

SUMMARY OF ARGUMENT

The decision below is legally flawed in numerous respects. Assuming this Court has appellate jurisdiction to review the order, it should be reversed.

First, BMS acted unlawfully by suspending Petitioner's Medicaid payments without considering the existence of good cause not to suspend, or to suspend in part, such payments. Here, BMS failed entirely to even *consider* the "good cause" factors required by 42 C.F.R. 455.23(a)(1), particularly in light of the record demonstrating that nearly all factors are satisfied. Therefore, BMS's decision to suspend Petitioner's Medicaid payments in their entirety without regard to the required "good cause" analysis was contrary to law and otherwise arbitrary and capricious. D.R. 18.

Second, BMS violated 42 C.F.R. § 455.23(b)(2)(ii), which requires a state Medicaid agency to give sufficient notice of the allegations of the alleged fraud to the suspended party so that it may be contested. Moreover, the agency violated constitutional due process, which required BMS to provide substantive information about the purported fraud on which the suspension was based. Here, however, when

Holistic sought clarification on the nature of the allegations against it that were identified as the basis of the indefinite and total suspension of its Medicaid payments, BMS only provided a conclusory assertion that the pending investigation "concerns allegations of knowingly billing services never rendered." Therefore, BMS's unexplained statement of alleged fraud was insufficient to satisfy § 455.23(b)(2)(ii) and constitutional due process requirements before depriving Petitioner of all of its Medicaid payments on an indefinite basis.

Accordingly, this Court should reverse the BMS decision for failure to satisfy the "good cause" standard not to suspend payments and to even explain with any meaningful respect the "credible allegations of fraud" in the first place necessary to satisfy regulatory requirements and constitutional due process. Alternatively, this Court should vacate the BMS decision and remand with directions to the agency to modify the decision to suspend payments "only in part" narrowly tailored to the specific allegations of fraud subject to the ongoing investigation.

STATEMENT REGARDING ORAL ARGUMENT

This appeal is suitable for Rule 20 argument because it involves legal issues of first impression in this Court (the application of 42 C.F.R. § 455.23) and issues fundamental public importance (the public need for drug abuse treatment providers and constitutional due process).

ARGUMENT

I. This Court may lack appellate jurisdiction.

In all candor to the tribunal, it is debatable whether the Intermediate Court of Appeals has appellate jurisdiction to review the BMS's decision in this case,

which Petitioner has appealed to this Court out of an abundance of caution to protect its appellate rights.

West Virginia Code § 51-11-4(b)(4) provides that the ICA has appellate jurisdiction over, among other things, "decisions of an agency or an administrative law judge entered after June 30, 2022, *heretofore appealable to the Circuit Court of Kanawha County pursuant to § 29A-5-4* or any other provision of this code." (emphasis added). Here, the question is whether the BMS decision was (prior to the ICA) previously appealable under the West Virginia Administrative Procedures Act (Chapter 29A) ("WVAPA") or any other provision of law. In Petitioner's view, the ICA may lack appellate jurisdiction because the BMS decision arguably falls under an express statutory *exclusion* from the WVAPA as a "contested case[] involving . . . the receipt of public assistance." W. Va. Code § 29A-1-3(c).

The Supreme Court has long interpreted this statutory exclusion broadly, including to challenges to DHHR decisions that suspended the ability of providers to receive direct payments of public funds given to them as providers of products or services "to people eligible for welfare benefits." *State ex rel. Ginsberg v. Watt*, 168 W. Va. 503, 505, 285 S.E.2d 367, 369 (1981); *see also id.* ("[DHHR] is not subject to the Administrative Procedures Act. . . . Certiorari is the proper means for obtaining judicial review of a decision made by a state agency not covered by the Administrative Procedures Act."); *see* Syl. Pt. 2, *Bills v. Hardy*, 228 W. Va. 341, 342, 719 S.E.2d 811, 812 (2011) ("Under West Virginia Code § 29A-1-3(c) (2007), the Administrative Procedures Act does not apply to contested cases involving the

receipt of public assistance."). For example, the Supreme Court approved of a party challenging the DHHR's denial of its application for participation in a Medicaid waiver program through a writ of certiorari filed in circuit court. *See Wysong ex rel. Ramsey v. Walker*, 224 W. Va. 437, 441 & n.2, 686 S.E.2d 219, 223 & n.2 (2009).

The grant of appellate jurisdiction to the ICA did not change the exclusion in Chapter 29A; it simply incorporated it. Perhaps the Legislature should repeal the exclusion for "public assistance" decisions, W. Va. Code § 29A-1-3(c), but until it does, certiorari to Kanawha County Circuit Court is arguably the only available path for appeal.

Under binding precedent, therefore, the BMS decision in this case arguably "involve[es]. . . the receipt of public assistance," and therefore may fall beyond the bounds of the judicial review process set forth in the WVAPA. If so, the ICA does not have appellate jurisdiction under W. Va. Code § 51-11-4(b)(4) to hear the appeal directly from the agency. Instead, under precedent, the decision would only be reviewable via petition for writ of certiorari in Kanawha County Circuit Court, where petitioner resides, or where the cause of action arose. *See* W. Va. § 14-2-2(a).

For this reason, and to avoid any loss of its appellate rights, Petitioner will be making a concurrent filing of a petition for writ of certiorari to challenge the agency's decision here in Circuit Court (and then would appeal the final order from the Circuit Court to the ICA, if need be).

II. The standard of review.

Assuming this Court concludes that it has appellate jurisdiction over the decision as a "contested case" under Chapter 29A, *see* W. Va. Code § 51-11-4(b)(4), the standard of review is as follows:

> Upon judicial review of a contested case under the West Virginia Administrative Procedure Act, Chapter 29A, Article 5, Section 4(g), the [ICA] may affirm the order or decision of the agency or remand the case for further proceedings. The [ICA] shall reverse, vacate or modify the order or decision of the agency if the substantial rights of the petitioner or petitioners have been prejudiced because the administrative findings, inferences, conclusions, decisions or order are: (1) In violation of constitutional or statutory provisions; or (2) In excess of the statutory authority or jurisdiction of the agency; or (3) Made upon unlawful procedures; or (4) Affected by other error of law, or (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; or (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Syl. Pt. 1, *Amedisys W. Virginia, LLC v. Pers. Touch Home Care of W.Va., Inc.*, 245 W. Va. 398, 859 S.E.2d 341, 344 (2021) (quotation marks and citations omitted).

III. The BMS decision should be reversed.

The substantial rights of Petitioner Holistic have been significantly prejudiced by the BMS decision in numerous respects, any one of which is grounds for reversal, vacatur, or modification of the decision. *See* Syl. Pt. 1, *Amedisys W. Virginia, LLC v. Pers. Touch Home Care of W.Va., Inc.*, 245 W. Va. 398, 859 S.E.2d 341, 344 (2021). The BMS decision was made in violation of constitutional and regulatory provisions and upon unlawful procedures; is affected by error of law and clearly wrong in light of the record as a whole; and is otherwise arbitrary and capricious and characterized by abuse of discretion or clearly unwarranted exercise

of discretion. *See id*. The decision should be reversed, or at least vacated and remanded to require the agency to do its job as the law requires.

A. The legal background.

Federal regulations require a state's Medicaid agency, like BMS, to suspend Medicaid payments to providers where the agency determines that a "credible allegation of fraud for which an investigation is pending" exists. 42 U.S.C. § 455.23(a)(1).

However, this mandate comes with a very important caveat: the agency is required to suspend payments "*unless* the agency has good cause to not suspend payments or to suspend payment only in part." *Id*. (emphasis added). Properly read, the regulation holds that an agency seeking to suspend a provider's Medicaid payments *must* first consider whether good cause exists *before* implementing the suspension. *See Victoria Transcultural Clinical Center, VTCC v. Kimsey*, 477 F. Supp. 3d 457, 464 (E.D. Va. 2020) ("Pursuant to 42 C.F.R. § 455.23, where, as here, there is a credible allegation of fraud, [the state Medicaid agency] is required to suspend Medicaid payments, *unless one of the regulatory good cause exceptions is found to exist*." (emphasis added). Put differently, while the decision of whether a good cause exception *justifies* a decision not to suspend payments might be discretionary, the actual *performance of the evaluation* of whether good cause exists is *mandatory*. Indeed, the BMS Provider Manual states, "OPI *will* determine if good cause exception exists to not suspend payment." BMS Manual § 800.9 (emphasis added).

The same regulation also provides six specific favors that the agency *must* consider whether good cause not to suspend exists in a given case, even if the agency' is entitled to exercise discretion in *actually applying* the factors. They are set forth as follows:

> (1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
>
> (2) Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.
>
> (3) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
>
> (4) Beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:
>
> > (i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
> >
> > (ii) The individual or entity serves a large number of beneficiaries within a HRSA–designated medically underserved area.
>
> (5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
>
> (6) The State determines that payment suspension is not in the best interests of the Medicaid program.

Id.

But even when the agency purports to undertake consideration of these factors as an exercise of discretion, BMS still cannot "entirely ignore aspects of the problem." *Bedford*, 769 F.2d at 1022; *see also In re Queen*, 196 W. Va. 442, 446, 473 S.E.2d 483, 487 (1996) (a court may reverse an agency's discretionary decision if the agency "used a misapplication of the law, entirely failed to consider an important aspect of the problem, offered an explanation that ran counter to the evidence

before the [agency], or offered one that is so implausible that it could not be ascribed to a difference in view or the product of [agency] expertise"). As explained below, BMS has "ignored the problem" at every stage of the proceedings by refusing to recognize, or even consider, clear evidence of good cause to withhold suspension under five of the above six factors (or to at least make such suspension partial).

B. BMS's decision is a result of numerous legal errors and abuses of discretion by the agency.

1. BMS committed legal error by indefinitely suspending Medicaid payments to Holistic in direct violation of the text of the controlling regulation, 42 C.F.R. § 455.23. This provision directs BMS to suspend Medicaid payments "unless the agency has good cause to not suspend payments or to suspend payments only in part" under the factors set forth in § 455.23(e)-(f). *Id.* § 455.23(a), (e)-(f). Indeed, BMS repeatedly committed clear legal errors in the application of these provisions that lead to the resulting decision now on appeal. By not even purporting to conduct the analysis until after the evidentiary hearing below was closed, BMS gave away the game, as it had not undertaken the required analysis before suspending the payments months earlier.

To begin with, BMS has repeatedly insisted that it has a mandatory obligation to suspend payments, and that the payment suspension was "mandated" by federal law. D.R. 123. But in making these blanket assertions, BMS has completely ignored its concomitant—and equally mandatory—obligation under the same regulation "to not suspend payments or to suspend payments only in part" if enumerated "good cause" factors are met.

Yet BMS ignored this provision every step of the administrative process, despite repeated requests by Petitioner's counsel that the agency follow the law. Indeed, BMS's refusal to even try to apply this mandatory provision is acutely illustrated by the agency's implementation of the inordinate, sweeping suspension of the "entirety" of Medicaid payments to Holistic. D.R. 18. The only basis of which is apparently an analysis of eight patient records from four years ago, and despite the plain regulatory alternative to either forego suspension altogether or to tailor it to the specific allegations under investigation.

Demonstrating BMS's arbitrary approach was their actions at the beginning. The agency's first letter to Holistic offered zero discussion, much less application, of the mandatory "good cause" factors. After Holistic's counsel pointed out this glaring legal deficiency, BMS's second letter merely added the conclusory (and obviously hollow) statement that "BMS reviewed all good cause exceptions to payment suspension allowed by statute and determined none are applicable in this instance." D.R. 25.

Only when sued in a collateral, writ proceeding—outside the administrative process—did BMS offer any substantive explanation to Petitioner as to the factual basis of the suspension. The agency asserted that the suspension is supported by an alleged overutilization of ten codes related to components of medication assisted therapy for substance use disorder from four-year-old patient records—the brief window of time after Holistic opened and before it switched from paper charts to electronic medical recordkeeping. D.R. 269. Only then did it become apparent that

BMS's wholesale payment suspension for Holistic is completely disproportionate to any supposed "credible allegations of fraud." No wonder BMS refused throughout the entire administrative process to apply the regulation requiring it "to not suspend payments or to suspend payments only in part," because the regulation would surely compel it to do so. At the barest of minimums, the agency should have made a good-faith effort to apply that provision and explain why it believed no "good cause" to be found. Here, there can be no deference to the agency's consideration of the "good cause" factors because they refused to consider them at all. This was a fundamental legal error that infected the entire administrative process, from start to finish.

Faced with continued arbitrary actions and no explanation from the bureaucratic forces driving the administrative process to its inevitable conclusion, Petitioner Holistic was compelled to commence collateral writ proceedings to seek relief. Although the Circuit Court in that case ultimately concluded that exhaustion of the administrative process was required, BMS's response in that proceeding still demonstrated a shocking unwillingness to engage and apply the required law—here, the "good cause" factors for determining whether payments should not be suspended or only in part.

Despite Holistic repeatedly setting forth why multiple of the "good cause" factors are fully satisfied and must be applied here to negate suspension, or at least tailor it, BMS continued to ignore every single good cause factor in dereliction of its statutory and regulatory obligations. This includes BMS' own commitment to its

beneficiaries to ensure access to critical care that is clearly in the best interests of the Medicaid program and West Virginia citizens.

Perhaps BMS's most glaring legal error was the agency's unequivocal failure to consider good cause factor § 455.23(e)(3): whether, "based upon the submission of written evidence by the individual or entity that is subject of the payment suspend, . . . the suspension should be removed." In fact, BMS has not considered this factor (it could not) because until its response in the writ proceeding (again, outside the administrative process), BMS had not even provided Holistic with a single example of a fraud allegation *to which Holistic could respond*. That this took the filing of a writ proceeding to force the agency to even try to follow the law shows just how badly the administrative process suffered from even basic failures of constitutionally required due process (notice and opportunity to be heard, etc.) and mandatory regulatory requirements.

BMS's failure to follow even the most fundamental legal requirements of the administrative process is alone ample justification to reverse the decision. If not, BMS will be emboldened to drag other West Virginia providers through a similar arbitrary process with no hope until an appeal can reach the judicial branch months or even years after.

Although this Court cannot rewrite the administrative record, there is no doubt that Holistic satisfies nearly all of the "good cause" factors, which, again, went entirely—and unlawfully—*ignored* by the agency. As to the first factor, law enforcement officers did at one stage recommend that the suspension not be

imposed, though this recommendation was later lifted. D.R. 220. While the Fraud Control Unit may have later rescinded its recommendation, it is an indication that the Unit, at least initially, believed that this was a case where suspension was not warranted. The Unit had it right the first time.

As to the second factor, BMS states that, due to the "nature of the allegations of fraud," there are no alternative remedies to suspension. *Id*. Nonsense. As a preliminary matter, if BMS did indeed have information as to the "nature of the allegations of fraud," as the (improper) affidavit stated, then the agency was required to share that information with Petitioner in its Notice Letters.

As noted, no such thing occurred—yet another process violation. In any event, however, the agency's assertion is false. As Holistic has repeatedly explained to BMS to no avail, alternative remedies to a suspension certainly existed and continue to exist. Indeed, Holistic demonstrated its willingness and ability to submit to prepayment review processes (as opposed to wholesale suspension) with The Health Plan. D.R. 30, 43, 183–84, 229, 237, 248. Indeed, it appears that BMS's Medicaid suspension practices have grown even more draconian since its suspension decisions were overturned by Judge Haden in *Pressley Ridge Schools, Inc. v. Stottlemeyer*, 947 F. Supp. 929, 940 (S.D. W. Va. 1996).

Rather than use the pre- or post-payment review processes available to it under 42 C.F.R. § 447.45, it appears that BMS now prefers the "scorched earth" approach to suspensions and has instead opted to just suspend first and ask

questions later. But the law does not allow that sort of arbitrary decisionmaking by government bureaucrats.

As to the third factor, Holistic is effectively prevented from submitting any written documentation rebutting said allegations because BMS repeatedly refuses to sufficiently elaborate on the allegations of fraud. Put simply, if BMS does not provide Petitioner something to respond to, then its ability to respond at all is completely hamstrung.

It is this factor that most accurately captures Petitioner's entire argument: how can it contest the specific findings in dispute, which BMS informed them it was their right to do, if they do not even know what the specific findings are? This also demonstrates that BMS failed to consider this factor *before* it suspended the payments. If Holistic was not afforded the opportunity to provide "written documentation" for BMS to evaluate and either accept or reject, then this factor could not have been considered when BMS made the suspension decision.

Fourth, Holistic and its staff provides much-needed medical services to a consistently vulnerable and needy population of West Virginia citizens. Petitioner can hardly believe that they have to point this out to the Bureau for *Medical* Services, but West Virginia has *far and above* the highest mortality rate in the nation in the nation for drug overdoses, and this crisis has only gotten worse in recent years.[4]

[4]*See* Centers for Disease Control, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm (last visited March 30, 2023). According to the 2020 data, West Virginia's

Fifth and finally, suspension of Holistic's Medicaid payments is certainly not in the best interests of the Medicaid program writ large. Indeed, BMS's own mission statement expresses the sentiment that BMS "is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically necessary, and quality health care services for all members . . ."[5]

BMS's "shoot-first, ask-questions-later" approach to the blanket suspension that it has directed toward Petitioner demonstrates the agency's willingness to remove access to care for some of West Virginia's most vulnerable populations on a whole-sale, no exceptions basis—all in the name of "accountability." The Medicaid program's purpose is to provide a means for society's less fortunate to receive necessary medical care. Holistic takes its role in providing that needed care very seriously, but, because of BMS's unlawful administrative action, they can no longer do so.

2. BMS also violated Petitioner's substantial rights by failing to adhere to the legal requirement that it disclose sufficient information about the alleged credible allegation of fraud to permit Holistic to meaningfully defend itself. This amounted to not only a violation of regulatory provisions but also fundamental constitutional due process requirements.

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opioid mortality rate is 81.4, almost double that of Kentucky, which has the next-highest rate at 49.2.

[5] https://dhhr.wv.gov/bms/Pages/default.aspx (emphasis added) (last visited 4/21/2023).

Although BMS argues that it is not required to provide Holistic and the individual providers with specific information regarding the alleged credible allegation of fraud, such argument is directly contravened by the requirements of BMS' own administrative review process which requires a suspended provider to submit "supportive documentation" of its reasons for appeal and to rebut BMS' specific findings. BMS Manual § 800.11. BMS's notice letters each require Holistic to submit "a statement as to the specific findings in dispute and the bases for the provider's contention that the specific findings were incorrect." *See* D.R. 18, 25.

Likewise, the Document/Desk Review Decision states that a provider requesting an evidentiary hearing "shall set forth the specific issues or findings of fact and conclusions of law with which the party disagrees and the basis for its contention that the specific issues and/or findings and conclusions are incorrect" and the BMS Manual similarly requires that a request for a hearing "shall contain a statement as to the specific issues of findings of fact and/or conclusions of law in the preceding determination with which the provider disagrees and basis for its contention that the specific issues and/or findings and conclusions were incorrect." BMS Manual § 800.11.3; *see* D.R. 213. Indeed, basic tenets of constitutional due process require that an accused be informed of the accusations made against him/her, and this is further confirmed by the structure and requirements of BMS's own administrative review process.

Similar action by Illinois' Medicaid agency has been deemed insufficient by a federal court under analogous circumstances:

> The parties here have shed little light on the question of what process is constitutionally required in a case such as this one. *But it is difficult to see how the minimal process Dr. Alexandre has received to date can be considered sufficient.* The January 28, 2020 letter that Dr. Alexandre received from the State told her only that HFS would be temporarily withholding Medicaid payments because a preliminary audit of her business revealed "billing irregularities." The letter stated that the State could withhold all of her reimbursements for "up to three years" so long as the department did not determine before then that there was insufficient evidence of fraud to support the withholding. The letter also informed Dr. Alexandre that she could "submit written evidence for reconsideration of the withholding of payments" and request "full or partial release of withheld payments," but provided her with no information about what the irregularities were or why they had been flagged. *In Dr. Alexandre's words, she was left "wrestling with a ghost," because the letter provided no details as to the nature of the identified billing irregularities or why they had been flagged.*

Alexandre v. Illinois Dep't of Healthcare & Fam. Servs., No. 20 C 6745, 2021 WL 4206792, at *9 (N.D. Ill. Sept. 15, 2021) (citations omitted; emphasis added).

This matter is analogous to *Alexandre*. As explained in Holistic's May 6, 2022, letter to BMS, without detailed information about the allegations made against it and the individual providers, Holistic was unable to provide supporting documentation or specific detail regarding in its defense as contemplated as required by administrative review process. *See* D.R. 27.

Like Dr. Alexandre, Holistic and its providers have been left "wrestling with a ghost" as they attempted a losing battle to defend their actions and continue to provide essential health care services to beneficiaries who will be adversely impacted when Holistic is forced to cease operating. Because of BMS's willful refusal to follow the law, the arbitrary process has resulted in substantial harm to BMS and the West Virginians it would otherwise be able to serve.

IV. Alternatively, the BMS decision should be vacated with directions to modify for only suspension in part.

BMS also failed to consider the factors relating to good cause to suspend payments *only in part*. The "good cause" inquiry does not end after consideration of a whether a full suspension is warranted—the state Medicaid agency must also consider whether good cause exists to implement only a *partial* suspension of Medicaid payments before arriving at a decision. *See* 42 C.F.R. § 455.23(a), (f).

Almost identical to the good cause considerations related to a full suspension, there are several factors the agency must evaluate in determining whether a partial suspension is warranted. And based on these factors, BMS ignored clear evidence of good cause to suspend Medicaid payments only partially. In addition to the reasons provided in the preceding section in regard to the full suspension good cause factors, there are, specific to the partial suspension factors, several reasons why only a partial suspension would be warranted.

To the first and fifth factors, while no suspension is warranted in this case, a partial suspension would certainly be in closer alignment with the best interests of the Medicaid program instead of a full one. As has been expressed repeatedly, the bulk of Petitioner's practice is directed toward the vulnerable and underserved populations of West Virginia, particularly those suffering from the ravages of substance abuse. Restricting Petitioner's access to Medicaid payments will result in disruptions in continuity of care and will restrict access to needed services for these patients.

As to the third factor, the Investigation Report flagged multiple specific CPT codes during the investigator's review of Holistic's records, did not contain any indication of widespread fraudulent billing practices, and Shawn Blankenship (without counsel) provided detailed explanations in response to the investigator. D.R. 97, 174, 236, 269, There is therefore no reason why, if BMS truly remains concerned about Holistic's billing practices concerning these codes, that the payments for just these particular codes could not be suspended.

Accordingly, if the Court does not believe that reversal is warranted, at minimum, it should vacate the BMS decision and remand to the agency with instructions that the agency modify the suspension to be only in part, so any partial suspension be narrowly tailored to address only what is necessary to account for the alleged credible allegations of fraud for which the investigation is pending. In short, the agency should be instructed to mitigate the pay-hold with a partial suspension narrowly tailored to the billing codes in question.[6]

CONCLUSION

For these reasons, this Court should reverse the DHHR's decision for failure to satisfy the "good cause" standard not to suspend payments. Alternatively, this

[6] Again assuming this Court concludes that it has appellate jurisdiction over the decision as a "contested case" under Chapter 29A (the WVAPA), *see* W. Va. Code § 51-11-4(b)(4), the WVAPA gives the reviewing court broad equitable authority to conform the remedy to the circumstances of the case. See Syl. Pt. 1, *Amedisys W. Virginia, LLC v. Pers. Touch Home Care of W.Va., Inc.*, 245 W. Va. 398, 859 S.E.2d 341, 344 (2021) (the reviewing court may "reverse, vacate, or modify the order or decision of the agency") (citations omitted).

Court should vacate the DHHR's decision and remand with directions to the agency to modify the decision to suspend payments "only in part."

HOLISTIC, INC.,

By Counsel:

/s/ J. Zak Ritchie
J. Zak Ritchie (WVSB #11705)
Counsel of Record
Isaac R. Forman (WVSB #11668)
Skyler A. Matthews (WVSB #13532)
HISSAM FORMAN DONOVAN RITCHIE PLLC
P.O. Box 3983
Charleston, WV 25339
(681) 265-3802 *office*
(304) 982-8056 *fax*
zritchie@hfdrlaw.com
iforman@hfdrlaw.com
smatthews@hfdrlaw.com

CERTIFICATE OF SERVICE

I hereby certify that on April 21, 2023, *Petitioner's Opening Brief* was filed and served via File&ServeXpress on all counsel of record.

/s/ J. Zak Ritchie
J. Zak Ritchie (WVSB #11705)