IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

HOLISTIC, INC.,

PETITIONERS BELOW, PETITIONERS,

V.

CASE NO. 23-ICA-39

ON APPEAL FROM THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

THE WEST VIRGINIA DEPARTMENT

OF HEALTH AND HUMAN RESOURCES,

BUREAU FOR MEDICAL SERVICES

RESPONDENT BELOW, RESPONDENT.

RESPONSE BRIEF ON BEHALF OF THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

PATRICK MORRISEY
ATTORNEY GENERAL

BRENT WOLFINGBARGER
SENIOR DEPUTY ATTORNEY GENERAL
1900 Kanawha Boulevard, East
Building 1, Room E-26
Charleston, WV 25305

GARY L. MICHELS
ASSISTANT ATTORNEY GENERAL
W.Va. State Bar #: 10321
350 Capitol Street
Charleston, WV 25301
gary.l.michels@wv.gov
(304) 352-4243

Counsel for Respondent Department of Health and Human Resources

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

STATEMENT OF THE CASE

This appeal arises from a decision of the West Virginia Department of Health and Human Resources, Bureau for Medical Services ("BMS") to suspend Medicaid payments to Holistic, Inc. ("Holistic"), Samantha Burgess, Alyssa Skeens, George Grover, Jessica Halstead, and Sunshine Holstein. ("Petitioners")

Thousands of low-income, elderly, and disabled West Virginians rely on the Respondent, West Virginia Department of Health and Human Resources, Bureau for Medical Services ("BMS"), to administer the State's Medicaid program pursuant to Title XIX of the Social Security Act of 1964. 42 U.S.C. § 1396, *et seq.*, 42 C.F.R. § 400, *et seq*. Holistic is a health care provider enrolled to furnish services to West Virginia Medicaid members. Samantha Burgess, Alyssa Skeens, George Grover, Jessica Halstead, and Sunshine Holstein (collectively referred to as "Individual Providers") are or were employees of Holistic. In response to rising Medicaid losses resulting from fraudulent provider behavior throughout the country, the United States Department of Health and Human Services ("HHS") promulgated a new regulation on July 16, 2012, that requires BMS, as the State's Medicaid administrator, to suspend payments to Medicaid providers if there is a "credible allegation of fraud for which an investigation is pending" against that provider. 42 C.F.R. § 455.23(a)(1) (hereinafter "Section 455.23").

Medicaid is a wide-ranging package of health benefits that are provided to individuals in need through a partnership between the State of West Virginia and the federal government. *See generally* 42 U.S.C. § 1396, *et seq.* The State administers and largely enforces the Medicaid program, and the federal government provides additional funds to pay for the benefits, as long as the State's program maintains certain standards. *Id.* Each State must establish or designate a "single State agency" to administer its Medicaid program, pursuant to 42 U.S.C. §1396a(5). The West Virginia Legislature has designated BMS as the single State agency, responsible for

administering its Medicaid program and providing Medicaid benefits to its eligible residents, pursuant to W.Va. Code §9-1-2(n). BMS subsequently contracts with various providers to furnish particular reimbursable services or goods to Medicaid members, either directly through its fee-for-service (FFS) program or indirectly through one of its three managed care organizations (MCOs). Among these reimbursable services are the healthcare services that BMS has authorized Holistic to provide to eligible Medicaid members.

All Medicaid providers, including Holistic, are paid by submitting claims for services rendered to BMS, either directly through the FFS program or indirectly through an MCO. 42 CFR §447.45. BMS and its MCOs process claims for payment submitted by providers in accordance with established processes, then subsequently audit select claims, which unfortunately can delay the agency's discovery of mistakes or fraud until after the billing provider has been paid. 42 CFR §§431.810 and 431.836.

As West Virginia's single state agency, BMS is required to have policies in place to reduce the risk of Medicaid fraud in order to receive federal funds. 42 C.F.R. §455.13. Moreover, Section 455.23 **requires** BMS to suspend all Medicaid payments to a provider if it determines that there is a credible allegation of fraud against that provider. 42 C.F.R. § 455.23(a)(1). For example, BMS could discover, through a tip or otherwise, that a provider regularly billed for services allegedly rendered to a Medicaid member after that member had passed away. If BMS determines that such an allegation is credible, Section 455.23 **requires** the agency to suspend Medicaid payments to the provider in question, and to notify the provider of its right to appeal the finding by submitting written evidence for BMS' consideration. 42 C.F.R. § 455.23(b). However, Section 455.23 only requires BMS to "set forth the *general allegations* as to the nature of the suspension action," and expressly does not require BMS to disclose "any specific information concerning an ongoing

investigation." 42 C.F.R. §455.23(b)(2)(ii) (emphasis added). This provision is consistent with the MFCU's concurrent duty to protect the privacy rights of individuals who provide the Unit with sensitive information related to its investigations that is established both in the federal regulations and the West Virginia Code. *See* 42 CFR §1007.11(f) and W.Va. Code §9-7-3(d).

After BMS suspends payments to a provider, it is also **required** to refer the credible allegations to the MFCU, if it has not already done so. 42 CFR § 455.23(d) (emphasis added). Section 455.23 **expressly indicates** that if the MFCU accepts the fraud referral for investigation, the payment suspension is allowed to continue "until such time as the investigation *and any associated enforcement proceedings* are completed." 42 CFR §455.23(d)(3)(i) (emphasis added); *see also* 42 CFR §455.23(c)(1)(ii). However, if the MFCU declines to investigate the fraud referral from BMS, then the suspension of payments must end. 42 CFR §455.23(d)(4).

Because the West Virginia Medicaid Fraud Control Unit ("MFCU") currently has an open fraud investigation against Holistic, BMS informed Holistic via certified mail on May 2, 2022, that it intended to suspended Medicaid payments to the company as required by federal law, including Section 455.23. (D.R. 18-19) BMS subsequently sent a second letter to Holistic via certified mail on May 16, 2022, clarifying that the MFCU's investigation centered on allegations that Holistic was "knowingly billing for services never rendered," and postponing the effective date of the planned suspension of Medicaid payments until May 23, 2022. (D.R. 25-26) The second letter further informed Holistic that the suspension of payments was temporary, and would end upon either the determination that there is insufficient evidence of fraud, or on the completion of legal proceedings related to the alleged fraud committed by Holistic, Inc. *Id*. Lastly, the second letter informed Holistic that if it disagreed with the Respondent's decision, it could request an

administrative hearing to address the agency's suspension decision pursuant to the provisions of Medicaid Provider Manual, Chapter 800. *Id.*

BMS suspended all Medicaid payments to Holistic, Inc. ("Holistic") and the Individual Providers on May 23, 2022, due to a determination that there were credible allegations of fraud for which an investigation was pending under the Medicaid program against Holistic and the Individual Providers. (D.R. 94-96)

There is no dispute that Holistic and the Individual Providers are currently being investigated by the West Virginia Medicaid Fraud Control Unit ("MFCU") for fraud. Holistic was investigated by UniCare, one of the West Virginia Medicaid program's managed care organizations (MCOs), which investigation identified multiple incidents of apparently fraudulent billing activity. (D.R. 97-99) UniCare also referred those allegations to the MFCU. (D.R. 100-103)

On May 2, 2022, BMS notified Holistic of its intention to suspend Medicaid payments to the company as required by 42 U.S.C. §1396b(i)(2)(C) and 42 CFR §455.23 due to the existence of credible allegations of fraud against Holistic. (D.R. 104). On May 6, 2022, Holistic's counsel sent a letter to BMS seeking to initiate the agency's administrative review process. (D.R. 108-112). Before BMS had an opportunity to respond to the request to begin the administrative review, Holistic filed its *Verified Petition* with the Circuit Court of Kanawha County, West Virginia (D.R. 1-112) On May 20, 2022, the Individual Providers sought to formally join in the *Verified Petition* filed by Holistic. (D.R. 64-82)

On July 7, 2022, Kanawha County Circuit Court Judge Louis "Duke" Bloom entered a Final Order finding that Holistic was not entitled to a writ of prohibition and that a writ of prohibition was inappropriate because Holistic had another adequate remedy in the form of an administrative appeal and dismissed the case. (D.R. 207-211)

On August 12, 2022, BMS issued a document/desk review decision upholding the decision to suspend Medicaid payments to Holistic and the individual providers. (D.R. 212-214).

On August 17, 2022, Holistic and the Individual Providers requested an administrative hearing to contest the document/desk review decision. (D.R. 215-219)

An administrative hearing with Hearing Examiner Lewis Brewer was conducted on August 18, 2022. On September 7, 2022, Hearing Examiner Brewer issued a recommended decision recommending that BMS deny the request of Holistic and the Individual Providers to rescind or suspend, in whole or in part, the current suspension of all Medicaid payments, pending completion of a fraud investigation by the MFCU. (D.R. 265-285). Hearing Examiner Brewer specifically found that BMS provided the Petitioners with detailed information contained in the Report of Investigation prepared by Investigator Young and that it was permissible to base an allegation on the data analysis that revealed aberrant billing practices that appeared unjustifiable based on normal business practices. (D.R. 281) Hearing Examiner Brewer also found that BMS had satisfied the requirements of 42 C.F.R. § 455.23(e) and that the Petitioners' argument that BMS failed to properly consider all of the good cause exceptions to continue payment without merit. (D.R. 281) On December 7, 2022, BMS Commissioner Cynthia Beane adopted the recommendation of Hearing Examiner Brewer. (D.R. 307)

On May 17, 2023, counsel for Holistic filed a Petition for a Writ of Certiorari with the Kanawha County Circuit Court and argue that the Intermediate Court of Appeals lacks jurisdiction to hear this appeal. The Writ of Certiorari makes very similar arguments that are contained in the Petitioner's Opening Brief.

JURISDICTION

West Virginia Code § 51-11-4(b)(4) provides that the Intermediate Court of Appeals ("ICA") has appellate jurisdiction over "final judgments, orders, or 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." It is not contested that BMS is an agency under the code or that the decision being appealed was a decision of BMS. BMS does not contest that previously this decision would have been excluded from the West Virginia Administrative Procedures Act. However, W.Va. Code § 51-11-4(b)(4) makes no mention of the West Virginia Administrative Procedures Act and simply states that the ICA has appellate jurisdiction over final judgments, orders, or decisions or an agency. That plain language makes it clear that the ICA has appellate jurisdiction over this case.

SUMMARY OF ARGUMENT

Contrary to the Petitioners' claims, the Respondent did not act arbitrarily or capriciously in suspending Petitioners' Medicaid payments.

BMS is not obligated to refrain from suspending payments to a provider against whom a credible allegation of fraud has been made simply because some "good cause" to continue making payments arguably may exist. Instead, Section 455.23 expressly vests BMS with the **discretion** to do so under circumstances where it believes one of the eleven factors set forth in 42 CFR §455.23(e)-(f) warrants such action. *See* 42 C.F.R. § 455.23(e)-(f) (noting in applicable part that "a State **may** find that good cause exists not to suspend payments...") (emphasis added). As stated in a letter to the Petitioners from Andrew Pack on May 16, 2022, BMS reviewed all good cause exceptions to the payment suspension and found that none were applicable, thereby satisfying the requirements on 42 C.F.R. §455.23(e)-(f). (D.R. 25)

BMS suspended all Medicaid payments to Holistic and the Individual Providers on May 23, 2022, due to a determination that there were credible allegations of fraud for which an investigation was pending under the Medicaid program against Holistic and the Individual Providers.

After BMS suspends payments to a provider, it is also **required** to refer the credible allegations to the MFCU, if it has not already done so. 42 CFR § 455.23(d) (emphasis added). Section 455.23 **expressly indicates** that if the MFCU accepts the fraud referral for investigation, the payment suspension is allowed to continue "until such time as the investigation *and any associated enforcement proceedings* are completed." 42 CFR §455.23(d)(3)(i) (emphasis added); *see also* 42 CFR §455.23(c)(1)(ii). However, if the MFCU declines to investigate the fraud referral from BMS, then the suspension of payments must end. 42 CFR §455.23(d)(4). There is no dispute that Holistic and the Individual Providers are currently being investigated by the West Virginia Medicaid Fraud Control Unit ("MFCU") for fraud.

42 C.F.R. § 455.23 only requires BMS to "set forth the *general allegations* as to the nature of the suspension action," and expressly does not require BMS to disclose "any specific information concerning an ongoing investigation." 42 CFR §455.23(b)(2)(ii) (emphasis added). This provision is consistent with the MFCU's concurrent duty to protect the privacy rights of individuals who provide the Unit with sensitive information related to its investigations that is established both in the federal regulations and the West Virginia Code. *See* 42 CFR §1007.11(f) and W.Va. Code §9-7-3(d). BMS has satisfied the requirements set forth in 42 C.F.R. § 455.23.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

It is the belief of the Respondent that oral argument is unnecessary in this matter, as the facts and legal arguments are adequately presented in Petitioners' and Respondent's briefs and the

Record of this appeal, and the decisional process would not be significantly aided by oral argument.

ARGUMENT

I. Standard of Review

The Petitioner's appeal arises from a Recommended Decision of a Hearing Examiner for BMS. Under *Alcan Rolled Products Ravenswood, LLC v. McCarthy*, 234 W.Va. 312, 318, 765 S.E.2d 201, 207 (2013), the Court is to review an administrative body's findings of fact under a clearly erroneous standard, and employ a *de novo* standard of review on its legal determinations. But above all else, the Court must conduct its review with "conscientious awareness of [judicial review]'s limited nature" in this context. *Amedisys W. Virginia, LLC v. Pers. Touch Home Care of W.Va., Inc.*, 245 W. Va. 398, 414, 859 S.E.2d 341, 357 (2021). The Court should always give "due deference" to the agency and avoid acting as a "superagency that can supplant the agency's expert decision-maker." *Id.*

II. BMS properly suspended all Medicaid payments to the Petitioners.

Contrary to the Petitioner's arguments, BMS is not obligated to refrain from suspending payments to a provider against whom a credible allegation of fraud has been made simply because some "good cause" to continue making payments arguably may exist. Instead, Section 455.23 expressly vests BMS with the **discretion** to do so under circumstances where it believes one of the eleven factors set forth in 42 CFR §455.23(e)-(f) warrants such action. *See* 42 C.F.R. § 455.23(e)-(f) (noting in applicable part that "a State **may** find that good cause exists not to suspend payments...") (emphasis added); *see also Pioneer Pipe, Inc. v. Swain*, 237 W. Va. 722, 725, 791 S.E.2d 168, 171 (2016) ("An elementary principle of statutory construction is that the word 'may' is inherently permissive in nature and connotes discretion."). Factors potentially constituting "good

cause" that BMS is permitted to consider in making its payment suspension decision include, *inter alia,* whether law enforcement officials have specifically requested that payments not be suspended because such action could compromise or jeopardize an ongoing investigation; whether other remedies available to BMS would "more effectively or quickly protect" Medicaid funds; whether Medicaid members' access to needed services could be compromised by a payment suspension; and whether "the submission of written evidence" by the provider subject to the payment suspension convinces BMS that the suspension should be removed. *Id.*

BMS suspended all Medicaid payments to Holistic, Inc. ("Holistic") and the Individual Providers on May 23, 2022, due to its determination that there were credible allegations of fraud for which an investigation was pending under the Medicaid program against Holistic and the Individual Providers. (D.R. 94-96). **Section 455.23 states in relevant part that:**

> "(a) Basis for suspension.
> (1) The State Medicaid agency **must** suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
> (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
> (3) A provider may request, and must be granted, administrative review where State law so requires."

42 CFR §455.23 (emphasis added).

There is no dispute that Holistic and the Individual Providers are currently being investigated by the West Virginia Medicaid Fraud Control Unit ("MFCU") for fraud. Holistic was investigated by UniCare, one of the West Virginia Medicaid program's MCOs, which investigation identified multiple incidents of apparently fraudulent billing activity. (D.R. 97-99) UniCare also referred those allegations to the MFCU. (D.R. 100-103) Thus, by default, federal law

required BMS to suspend Petitioners; the lone exception *might* apply *if* BMS decided to exercise its discretion after finding good cause otherwise.

42 C.F.R. § 455.23(e)-(f) provides guidelines that BMS uses in determining whether good cause not to suspend Medicaid payments exist and states that:

> "*E. Good Cause Not To Suspend Payments.* A State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
> (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.
>
> *F. Good cause to suspend payment only in part.* A State may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are other applicable:
> (1) beneficiary access to items or services would be jeopardized by a payment suspension in whole or part 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.
> (2) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
> (3)

> (i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
> (ii) The State determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
> (4) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
> (5) The State determines that payment suspension only in part is in the best interests of the Medicaid program."

BMS is not obligated to refrain from suspending payments to a provider against whom a credible allegation of fraud has been made simply because some "good cause" to continue making payments arguably may exist. Instead, Section 455.23 expressly vests BMS with the **discretion** to do so under circumstances where it believes one of the factors set forth in 42 CFR §455.23(e)-(f) warrants such action. *See* 42 C.F.R. § 455.23(e)-(f) (noting in applicable part that "a State **may** find that good cause exists not to suspend payments...") (emphasis added). Many other courts have recognized as much. *See, e.g., Victoria Transcultural Clinical Ctr., VTCC, LLC v. Kimsey*, 477 F. Supp. 3d 457, 464 (E.D. Va. 2020) ("[W]hether a good cause exception justifies not suspending payments is left to the discretion of the state."); *Rehab Ariz., LLC v. Ariz. Health Care Cost Containment Sys.*, No. 1 CA-CV 18-0511, 2019 WL 1530112, at *3 (Ariz. Ct. App. Apr. 9, 2019) ("[T]he State has discretion to forego the suspension."); *Bergeron v. Dep't of Health Servs.*, 71 Cal. App. 4th 17, 20, 83 Cal. Rptr. 2d 481, 483 (1999) ("Under federal law (42 C.F.R. § 455.23), the Department has the discretion to withhold payments upon a showing of reliable evidence the circumstances involve fraud or willful misrepresentation.").

Counsel for the Petitioners argues at length that BMS should not have suspended all Medicaid payments under the above factors. However, BMS is expressly vested with the discretion to determine if good cause exists to continue making Medicaid payments. The Petitioners also fail to cite any law or regulations that deprives BMS of its regulatory discretion to

determine if the suspension of Medicaid payments to providers against whom a credible allegation of fraud has been made is warranted under such circumstances. On May 16, 2022, Andrew Pack sent a letter from BMS to the Petitioners notifying them that "BMS reviewed all good cause exceptions to payments suspension allowed by statute and determined none are applicable in this instance." (D.R. 25) The good-cause exception analysis performed by Andrew Pack satisfies the requirements the good cause not to suspend payments and good cause to partially suspend payments as outlined in 42 C.F.R. § 455.23(e)-(f). Counsel for the Petitioner argues that even if the Court finds that the suspension was proper the decision should be vacated with directions to modify for only suspension in part. The good cause exceptions for a partial suspension are contained in 42 C.F.R. § 455.23(f) and were considered by Andrew Pack as stated in his May 16, 2022, letter to Holistic. (D.R. 25) The facts shows his analysis was reasonable; for example, law enforcement did not request that a suspension be withheld (as Petitioners concede), beneficiary access was not specifically jeopardized in ways contemplated by the regulations (as Petitioners effectively admit by speaking only generally about the opioid crisis), no written evidence showed that a suspension was improper (as Petitioners recognize by not citing any), and the interests of the Medicaid program are best served by preventing those investigated for fraud from continuing to draw payments from the defrauded system (as the federal regulations recognize by making full suspension the default). And at bottom, Petitioners' arguments amount to an attempt to reweigh the evidence, invite different credibility determinations, and prefer Petitioners' favored policy considerations. None of those acts are appropriate on appellate review. *See W. Va. Div. of Highways v. Scott*, No. 22-ICA-135, 2023 WL 2365786, at *4 (W. Va. App. Ct. Mar. 6, 2023) (memorandum decision) ("We are not in a position to reweigh said evidence at the appellate stage."); *Curry v. W. Va. Consol. Pub. Ret. Bd.*, 236 W. Va. 188, 191, 778 S.E.2d 637, 640 (2015)

("Pursuant to the arbitrary and capricious standard, a … court reviewing the factual findings of an administrative agency must 'not substitute its judgment for that of the hearing examiner.'"). Therefore, the decision of the Hearing Examiner should not be disturbed on appeal.

III. BMS did not act arbitrarily or capriciously by suspending Medicaid Payments and the suspension is not an indefinite suspension.

Counsel for the Petitioners argues that the suspension of Medicaid payments is an indefinite suspension. However, that is simply not the case. 42 CFR § 455.23(d) (emphasis added). **expressly indicates** that if the MFCU accepts the fraud referral for investigation, the payment suspension is allowed to continue "until such time as the investigation *and any associated enforcement proceedings* are completed." 42 CFR §455.23(d)(3)(i) (emphasis added); *see also* 42 CFR §455.23(c)(1)(ii). However, if the MFCU declines to investigate the fraud referral from BMS, then the suspension of payments must end. 42 CFR §455.23(d)(4). There is no dispute that Holistic and the Individual Providers are currently being investigated by the West Virginia Medicaid Fraud Control Unit ("MFCU") for fraud and that the investigation is still ongoing.

Although *Pressley Ridge Schools, Inc. v. Stottlemeyer*, 947 F. Supp. 929 (S.D. W.Va. 1996), is cited by the Petitioners it simply does not apply to the current case. In *Pressley Ridge*, the U.S. District Court for the Southern District of West Virginia found that BMS had violated an older version of 42 C.F.R. § 455.23 by using the prepayment and postpayment provisions in 42 CFR § 447.45(f) to suspend payments to the provider indefinitely. The Court also held that BMS violated 42 U.S.C. § 1396(a)(37)(B) and Section 764.1 of its own Medicaid Regulations when it refused to grant Pressley Ridge an administrative hearing that Pressley Ridge had requested on the "Bureau's decision to impose prepayment review of Pressley Ridge's Behavioral Management Services claims and to pend payments indefinitely for those services represented by the claims." *Id.*, at 939. Moreover, the Court held that BMS violated 42 U.S.C. §1396(a)(30) by retroactively

applying a prepayment review process to Pressley Ridge's claims that materially differed from the process that was spelled out in the BMS manual.

The language set forth in 42 C.F.R. § 455.23 has been substantially amended during the 27 years since the *Pressley Ridge* case was decided. Most importantly, the language contained in 42 C.F.R. § 455.23(a) that was cited in the *Pressley Ridge* case indicated that BMS State Medicaid agencies "**may** withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program."[1] Based on the use of the word "may" in the older version of the regulation, BMS was vested in 1996 with the *discretion* to withhold payments or not withhold payments to providers even if it was in receipt of "reliable evidence" that "fraud or willful misrepresentation" was involved.

By comparison, the language currently set forth in 42 C.F.R. § 455.23(a) clearly demonstrates that BMS had a mandatory legal **obligation** to suspend payments to Holistic and the Individual Providers after it determined that there was "a credible allegation of fraud" against them. This regulatory change was promulgated by the HHS Office of the Inspector General ("OIG") on February 2, 2011,[2] as part of its implementation of the Patient Protection and Affordable Care Act (Public Law 111-148) ("ACA"), which Congress had passed in March 2010. As the OIG noted in announcing its Final Rule, "We proposed to implement section 6402(h)(2) of the ACA by modifying the existing § 455.23(a) **to make payment suspensions mandatory** where an investigation of a credible allegation of fraud under the Medicaid program exists."[3]

---

[1] *Pressley Ridge*, at 940, *quoting* 42 C.F.R. §455.23 (emphasis added).
[2] *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 FR 5862-01 (February 2, 2011).
[3] *Id.*, at 5932.

Although the language currently found in 42 C.F.R. § 455.23(e) vests BMS with the **discretion** not to suspend such payments to providers if it determines that "good cause" exists not to do so, as noted above, the agency has no legal obligation to do so. And as the OIG noted in its Final Rule in discussing this subsection of the amended regulation: "Consistent with the new ACA provision, we also proposed to create several "good cause" exceptions by which States **may** determine good cause exists not to suspend payments or to suspend payments only in part."[4] In short, even if "good cause" not to suspend payments to Holistic and the Individual Providers arguably existed in the case at bar despite the existence of an investigation of a credible allegation of fraud, BMS was vested with the discretion to suspend the payments anyway.

In the case at bar, the suspension is not an indefinite one and has only continued because the MFCU investigation is still ongoing. It also must be noted that, unlike what transpired in the *Pressley Ridge* case, BMS did not refuse to grant the Petitioners an administrative hearing. As stated in the Final Order from Judge Bloom, BMS voluntarily agreed to fast track the administrative review process and to conduct an administrative hearing in early August 2022. (D.R. 207-208). The first step of the administrative review process is a document desk review ("DDR") which was conducted by BMS on August 12, 2022. (D.R. 212-214) The Petitioners disagreed with the DDR decision and requested an administrative hearing which was conducted on August 18, 2022. (D.R. 265)

Therefore, BMS has complied with all the requirements of 42 C.F.R. § 455.23 in suspending the Medicaid payments to the Petitioner.

[4] *Id.*, at 5933.

IV. BMS did not act arbitrarily or capriciously and provided Petitioners with the required detail of the allegations that led to the suspension of Medicaid Payments.

42 C.F.R. § 455.23 only requires BMS to "set forth the *general allegations* as to the nature of the suspension action," and expressly does not require BMS to disclose "any specific information concerning an ongoing investigation." 42 CFR §455.23(b)(2)(ii) (emphasis added). This provision is consistent with the MFCU's concurrent duty to protect the privacy rights of individuals who provide the Unit with sensitive information related to its investigations that is established both in the federal regulations and the West Virginia Code. *See* 42 C.F.R. §1007.11(f) and W.Va. Code §9-7-3(d).

Petitioners insist that BMS should have provided them more information, but the Court of Appeals of Mississippi has explained well why more substantial information is not required to be disclosed in a case like this one. In *NSCH Rural Health Clinic v. Snyder*, 321 So. 3d 565, 571–72 (Miss. Ct. App. 2020), that court held that:

> "the fraud allegations were referred to the Medicaid fraud unit at the Mississippi Attorney General's Office. Further, there is no authority within the relevant federal or state regulations that requires the ((Mississippi Division of Medicaid (DOM)) to provide an administrative hearing concerning the sufficiency of the initial allegations of fraud or to disclose any specific information regarding the fraud allegations under investigation. Pursuant to 42 C.F.R. § 455.23(b)(2), the DOM was required to give North Sunflower notice of the suspension to include **only** general allegations but not to disclose any specific allegations concerning the ongoing investigation. **The regulation's obvious goal was to protect the integrity and confidentiality of an ongoing criminal investigation.** To hold otherwise could potentially undermine the ongoing criminal investigation being conducted by the Attorney General's Office. Pursuant to both federal and state regulations, the DOM referred the allegations of fraud to the MFCU, gave North Sunflower the appropriate notice, and suspended reimbursements pending the outcome of that investigation. North Sunflower's assertion that the DOM's actual decision to refer the allegations of fraud was subject to judicial review is without merit. Given the fact that both federal and state regulations mandated the DOM's referral of the allegations to the MFCU, its actions in that regard were certainly within the

parameters set forth in the law." *NSCH Rural Health Clinic v. Snyder*, 321 So. 3d 565, 571–72 (Miss. Ct. App. 2020)(emphasis added).

The facts in *NSCH* are very similar to the instant case in that both cases started with fraud allegations being referred to MFCU and ultimately ended with Medicaid payments to the provider being stopped while the fraud investigation was ongoing. However, BMS went a step further than the DOM took in *NSCH* by providing the Petitioners with detailed information contained in the Report of Investigation Case Summary prepared by Investigator Young, as noted by the Hearing Examiner on page 17 of his recommended decision. (D.R. 281) *See also Consumer Directed Choices, Inc. v. N.Y. State Off. of Medicaid Inspector Gen.*, 90 A.D.3d 1271, 1272, 935 N.Y.S.2d 352, 353 (2011) (holding that a suspension notice contained "a proper description of the reason for the withholding" where the notice merely informed the entity that it was under investigation for claims that resulted in a substantial overpayment).

Petitioners think this case is a repeat of *Alexandre v. Ill. Dept. of Healthcare & Family Services,* No. 20 C 6745, 2021 WL 4206792, (N.D. Ill. Sept. 15, 2021), but that case is distinguishable. There, the Illinois' Medicaid agency ("HFS") suspended Dr. Alexendre Medicaid payments for approximately three years pending an investigation for fraud. *Id* at 1. The court held that HFS had violated Dr. Alexandre's due process rights by suspending her payments "without providing any substantive information about the purported 'billing irregularities' on which the suspension [was] based." *Id.* at 10. It appears that the only information HFS provided to Dr. Alexandre was a notification that billing irregularities had been detected in her practice. *Id.* at 1. Dr. Alexandre filed suit against HFS in regards to the lack of information concerning the allegations, and HFS responded with a short email stating that "the investigation remains actively ongoing and pertains to a variety of fraud allegations, including allegations of receiving kickbacks and administering expired vaccines." *Id* at 1-2.

In the case at bar, BMS provided the Petitioners with a Report of Investigation Case Summary ("Investigation Report") prepared by Investigator Audrey Young and the Medicaid Fraud Referral Form. (D.R. 97-103). The Investigation Report reviews eight medical records with eight hundred and sixty two dates of service with the data "showing a consistent trend of billing patients a drug screen test (80307, alcohol breath screen test (82075), E&M (99213, 99214), preventative medicine counseling, (99401, 99402) and tobacco cessation counseling (99406, 99407." (D.R. 97) Investigator Young noted that the above referenced billing codes were repeated weekly for the eight patients and that there appeared to be a high trend of high daily volume for time-based codes and potential for impossible day billing. (D.R. 97) The Investigation Report also noted that there were occasions where a female patient who had previously undergone a hysterectomy had pregnancy test performed and another patient that was tested for pregnancy weekly. (D.R. 98) Investigator Young reached the conclusion that "a review of the eight, (8) individual spreadsheets will show occasions where there were two, (2) E&M codes billed on the same date of service for the same patient by two, (2) different provider, Dr. Bacha and Mr. Blankenship." (D.R. 98) Lastly, Investigator Young found that "there will also be numerous dates of services for counseling services where there is no documentation at all, no date documented, no time documented, no topic of counseling documented, and no signature of who provided the counseling….On many occasion, the documentation provided by Mr. Blankenship did not support the claims that Holistic billed." (D.R. 98-99) Thus, unlike the agency in *Alexandre*, BMS has provided detailed information regarding the billing irregularities and allegations of fraud. While this information was provided after the May 16, 2022, informing the Petitioners that payments would be suspended effective May 23, 2022 it was provided to the Petitioners as an exhibit to BMS' Response in Opposition to the Verified Petition For Writ Of Prohibition that was filed on

June 10, 2022, well before the document desk review and evidentiary hearing took place. (D.R. 97-103). Petitioners' argument that BMS Manual § 800.11 requirements that the Petitioner submit a "statement as to the specific findings in dispute and the bases for the provider's contention that the specific findings were incorrect" require BMS to provide specific information regarding the credible allegations of fraud is incorrect. If BMS were required to provide specific information regarding the credible allegations of fraud all investigations of MCFU would be undermined by divulging sensitive information that is still being investigated. This point was outlined in *NSCH Rural Health Clinic.*

As the Hearing Examiner correctly stated in his recommended decision, BMS' determination "that there has been a credible allegation of fraud must be made in good faith, and nor arbitrarily and capriciously." (D.R. 280).

Again, BMS provided the Petitioners with detailed information from Investigator Young and the Hearing Examiner correctly found that Director Andrew Pack's determination that there was a credible allegation of fraud was not arbitrary or capricious in any regard. (D.R. 281) The Hearing Examiner also found that "it is permissible to base an allegation on data analysis that reveals aberrant billing practices that appear unjustifiable based upon normal business practices" (D.R. 281). Further, as noted by the Hearing Examiner, "nothing in federal law extends a property right in Medicaid reimbursements to a provider that is the subject of a fraud investigation." *quoting Personal Care Products, Inc. v. Hawkins,* 635 F.3d 155, 159 (5th Cir. 2011); *See also ABA, Inc. v. Dist. Of Columbia,* 40 F. Supp 3d 153, 167 (D.D.C. 2014). 42 C.F.R. § 455.23 gives BMS sole discretion to decide if Medicaid payments may continue while an investigation of a credible allegation of fraud is ongoing.

At bottom, Petitioners vehemently disagree with the allegations against them. So be it. But BMS is not required at this early stage to prove all the facts that might ultimately support the allegations against Petitioners; the idea that Petitioners should receive "particularized" allegations, for example, is not supported by one bit of cited authority. It is enough that Petitioners be informed of the sort of "general" information upon which the allegations rest. Questions like those Petitioners press here can be answered during the course of the investigation and, if necessary, at the time of any appropriate trial. The only question here is whether Petitioners have received the minimal notice required to institute this preliminary suspension process.

Therefore, the Hearing Examiner's recommended decision should not be disturbed on appeal.

CONCLUSION

For the reasons set forth herein, Respondent prays that this Honorable Court will deny the Petition for Appeal and prays for such further relief as this Honorable Court deems fit and proper.

Respectfully Submitted,

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

By Counsel,

PATRICK MORRISEY
ATTORNEY GENERAL

/s/ *Brent Wolfingbarger*
BRENT WOLFINGBARGER (WVSB #6402)
SENIOR DEPUTY ATTORNEY GENERAL
1900 Kanawha Boulevard, East

Building 1, Room E-26
Charleston, West Virginia 25305
(304) 558-2021

/s/ *Gary L. Michels*
GARY L. MICHELS (WVSB #10321)
ASSISTANT ATTORNEY GENERAL
812 Quarrier St., 6th Floor
Charleston, WV 25301
(304) 558-2131

CERTIFICATE OF SERVICE

I hereby certify that on May 24, 2023, *Response Brief On Behalf Of The West Virginia Department of Health and Human Resources, Bureau For Medical Services* was filed and served via File&ServeXpress on all counsel of record.

/s/ Gary L. Michels
Gary L. Michels (WVSB #10321)