IN THE COURT OF APPEALS OF THE STATE OF NEW MEXICO

STATE OF NEW MEXICO ex rel.
GARY KING, ATTORNEY GENERAL,

Plaintiff-Appellant,

vs.

Ct. App. No. 31,782

ADVANTAGEOUS COMMUNITY
SERVICES, LLC, a New Mexico
limited liability company,

Defendant-Appellee.

STATE OF NEW MEXICO'S BRIEF IN CHIEF

APPEAL FROM THE DISTRICT COURT OF BERNALILLO COUNTY
VALERIE A. HULING, District Judge

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Oral argument is requested.

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REFERENCES

The proceedings below, before the Honorable Valerie A. Huling, were transcribed from the court reporters' notes and reduced to typewritten transcript through Computer-Aided Transcript by New Mexico Certified Court Reporters. References to these proceedings are indicated as "[Tr.#Vol.-pg.: lines]."

References to the Record Proper, filed on February 29, 2012, are indicated as [RP ___]. References to Exhibits admitted at Imagine's *Motion for Sanctions* evidentiary hearings on August 10, 2011 and September 14, 2011, filed May 10, 2012 are indicated as [*NM-Ex. 1-4*] and [*ACS- Ex. A-I*].

REQUEST FOR ORAL ARGUMENT

Oral argument is requested pursuant to Rule 12-214(B) NMRA and Rule 12-213(A)(6) NMRA because of the complexities of Medicaid law and the public importance of these issues on the state's economy as well as on the low income, elderly and severely disabled New Mexico Medicaid recipients, who cannot speak for themselves.

SUMMARY OF PROCEEDINGS

A. Nature of the Case.

Plaintiff-Appellant, the State by and through the New Mexico Attorney General's (NMAG) Medicaid Fraud Control Unit (MFCU), seeks review of the Second Judicial District Court's October 28, 2011 Order granting Defendant's Advantageous Community Services, LLC's (Imagine) *Motion for Sanctions* and *Motion for Summary Judgment* and dismissing the State's Medicaid Fraud Act (MFA) and Medicaid provider contract claims with prejudice. 42 C.F.R. § 1007.5; NMSA 1978, §§ 30-44-1 *et seq.* (1989, as amended through 2004) (MFA); [RP 503-504 (*PTO* 2(a)); 104-137, 204-238, 336-356, 359-393, 407-467, 706-709, 710-711, 721-724, 726-729].

The district court also dismissed the State's action as a sanction due to the unintentional and inadvertent use in a deposition of a 2011 "re-printed" Department of Health (DOH) Caregivers Criminal History Screening Program (CCHSP) criminal history (CH) clearance letter containing 2006 CH data and 2011 "updated" data fields. *ACS-Ex. D*; [RP 706-711, 726-729]. Because the court's Order is not supported by the facts and/or the law, it must be reversed here.

Medicaid is authorized as a grant to the states under Title XIX of the Social Security Act (Act) and provides medical assistance to low income and

developmentally disabled (DD) individuals. Federal and state governments jointly fund and administer the Medicaid program. 42 U.S.C. §§ 1396 *et seq.* At the federal level, the Centers for Medicare & Medicaid Services (CMS) administer the program. www.cms.gov; www.medicaid.gov.

At the state level, the Human Services Department (HSD) Medical Assistance Division (MAD) administers the program in accordance with a CMS approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, its must comply with federal requirements. *Lewis v. New Mexico Dept. of Health*, 275 F.Supp.2d 1319 (D.N.M. 2003). New Mexico's ongoing receipt of Medicaid federal funds (FFP) is contingent upon the State's continuing compliance with Title XIX requirements and the CMS approved state plan. 42 C.F.R. § 400.203; *Atkins v. Rivera*, 477 U.S. 154, 156, 106 S.Ct. 2456, 91 L.Ed.2d 131 (1986).

Section 1915(c) [42 U.S.C. § 1396n] of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. HCBS are "state optional" services provided to vulnerable DD individuals, who would otherwise require institutionalization. 42 C.F.R. § 441.300. *Cf. OIG Quality in HCBS Waiver Programs*, June 2012, pg. 10 (two States allowed caregivers to provide services before ... [receipt] of CH results), oig.hhs.gov/oei/reports/oei-02-08-00170.pdf; VTCA, Texas Health & Safety Code, Section 250 (2011); *State*

Policies on Criminal Background Checks for Medicaid Supported In-Home Direct Care Workers, Chart & Summaries (12/18/2008), www.ncsl.org. CMS approval, compliance and oversight of the DD Waiver program are also prerequisites for federal Medicaid funds reimbursement.

The State must document that there are safeguards in place, such as the Caregivers Criminal History Screening Act (CCHSA) to protect DD Waiver recipients. 42 U.S.C. § 1396n(e); NMSA 1978, §§ 29-17-2 *et seq.*, (1998, as amended through 1998); NMSA 1978 § 29-17-3 (1998). DOH's DD Services Division (DDSD) administers the DD Waiver program which provides a wide range of in-home unlicensed direct access caregiver services. hsd.state.nm.us/mad/CHomeCommunityWaiversDetail.html.

In May 2004, Imagine executed the HSD MAD 335 Provider Participation Agreement (9/9/03) (PPA or provider contract) in order to become a provider and be paid with federal and state health care funds. [RP 504 (*PTO*, 2(c))]. Imagine also executed a DDSD Provider Agreement (DDSD contract) to provide HCBS for DD Waiver recipients. [RP 504 (*PTO*, 2(d)]. The DDSD contract explicitly incorporated the MAD 335 PPA and the Caregivers Criminal History Screening Requirements (CCHSA/CCHSR) (7.1.9. NMAC). *See* 42 U.S.C. § 1396d(a)(6)-(16), (18), (20), (22-25); [RP 427-440].

Imagine's "home health services" are delivered at the recipient's home, and includes unsupervised and unlicensed direct access personal care services. 42 C.F.R. §§ 440.70, 440.167 and 440.180. For the State to receive the approximately seventy-five percent federal fund (FFP) contribution for Imagine's DD Waiver home based care services, Imagine's T2032 payments at issue here, must have been authorized or not prohibited by State or local laws or regulations. 2 C.F.R. § 225, App. A, § C.1.c.

For Imagine to have provided a valid and payable program service, its HBCS caregivers were required to be "qualified" as defined by federal program regulations and meet State caregiver requirements. *See HHS OIG, Review of NM Medicaid Personal Care Services Provided by Heritage Home Healthcare*, May 2012, i-iii, 6-7, oig.hhs.gov/oas/reports/region6/60900063.asp.

The DD Waiver regulations relating to Imagine's duties and its caregivers' mandatory qualifications were enacted pursuant to NMSA 1978, Sections 27-2-12 *et seq.* (1973, as amended through 2010) (NM Medicaid) and federal law promulgated under Title XIX. Because the care of DD waiver recipients outside of licensed facilities is so complex, the NM DD Waiver program uses NMAC regulations and the *DD Waiver Service Standards* (*DD Standards*) to "clarify, interpret, and further enforce the HSD regulations governing the DD Waiver." *See* MAD-736, effective 7/1/02, as amended; 8.314.5 NMAC (7-1-02);

nmaging.state.nm.us/D&E_Waiver_pdf_files/Revised_D&E_Service_Standards.pdf (8-1-06). The *DD Standards* address each DD Waiver service and all DD Waiver providers were required to [must] comply with all "applicable standards," including all personnel requirements for caregiver employees. *Id.* The *DD Standards* required Imagine to comply with the CCHSA and the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) when providing HBCS. *Id.* at pg. 7, General Provider Requirements, IX.

Under CCHSA Section 29-17-4(C) (1999 and 2005), *Definitions*, Imagine was a "care provider" subject to Section 29-17-5 (1999 and 2005). Imagine was required in general, to submit applications for criminal history screenings for direct access caregivers within thirty (30) days of a specific caregiver starting employment with Imagine. 7.1.9.8.F NMAC (8/15/02); [RP 506-508 (*PTO*, 2(j), (k) & (l)].

Between October 2004 and May 2007 Imagine knowingly submitted 270 DD Waiver HCBS claims for seven (7) DD recipients (cared for by six (6) caregivers) under billing code T2032 (residential direct access caregiver services) and was paid for those claims by the DD Waiver program. [RP 1-18; 506 (*PTO* 2(i)); 527-540]. For the six (6) Imagine caregivers, Imagine had not submitted and/or obtained CH clearances as required by CCCHA when filing its claims [RP 527-540].

The State's *Complaint* seeks recovery of $361,193.18 paid Imagine for the 270 DD Waiver claims Imagine submitted that violated federal/state DD Waiver statutes and regulations, the MFA, *DD Standards*, Imagine's provider contracts, and the CCHSA. [RP 1-18; 510 (*PTO* 2(u) & (v)]. The State's *Complaint* contained three Counts: 1) *Recovery of Medicaid Overpayments* under the Medicaid Fraud Act (MFA), NMSA 1978, Sections 30-44-1 *et seq.* (1989, as amended through 2004); 2) Civil Penalties under MFA Sections 30-44-8(A)(1), (2), (3) and (4) (1997); and, 3) Breach of Contract under Imagine's Medicaid provider agreements (MAD 335 PPA & DDSD contract). *Complaint Ex. A* listed each claim and payment by transaction control number (TCN). [RP 6-18]. The TCN is used to track each claim and confirm electronic funds transfers (EFT) of each payment made to Imagine through a print out known as a remittance advice (RA). [RP 103; 427-440]. "It is undisputed that Imagine made the claims." [RP 460]. Imagine admitted receipt of the Medicaid funds at issue. [RP 506 (*PTO* 2(i))].

Federal regulations define an overpayment as "the amount paid to a provider which is in excess of the amount that is allowable for services furnished under section 1902 [42 U.S.C. § 1396a] of the Act and which is refunded [to the federal government] under section 1903 [42 U.S.C. § 1396b] of the Act." 42 C.F.R. § 433.304 (1989). *West Virginia Dept. of Health & Human Resources v.*

Sebelius, 649 F.3d 217, 218-220 (4th Cir.2011). When an overpayment is discovered, the State has one (1) year in which to recover the overpayment before the Federal payment to the State is adjusted to account for the overpayment. 42 U.S.C. § 1396b(d)(2)(C). After one year, the federal government's right to collect overpaid funds operates independent of a state's recovery of funds wrongfully disbursed. 42 C.F.R. § 433.312(a); 42 C.F.R. § 433.316(c, h); *West Virginia*, *supra* at 218-220, 225.

The MFCU is approximately seventy-five percent federally funded. Its authority and duties are defined by federal statutes and regulations. Under the CMS approved State plan, the MFCU is required to investigate and prosecute violations of all applicable State laws by providers. 42 U.S.C. §§ 1396b(a)(6), 1396b(b)(3) and 1396b(q); 42 C.F.R. §§ 1007.1 *et seq.* If provider overpayments are discovered, the MFCU is required to collect the overpayments or refer the matter to an appropriate State agency for collection. § 1396b(q)(5); § 1007.11(c); 8.351.2.13 NMAC (7/1/03).

The Medicaid Fraud Act (MFA) was enacted within this federal/state statutory and regulatory framework. The MFA statutorily authorizes the MFCU "to investigate MFA violations and bring actions to enforce the civil remedies established in the MFA." NMSA 1978, Section 30-44-3(A) (1989). Section 30-

44-8, *Civil penalties; created; enumerated; presumption; limitation of action*, at paragraph A states:

> A. Any person who receives payment for furnishing treatment, services or goods under the program, which payment the person is not entitled to receive by reason of a violation of the Medicaid Fraud Act [30-44-1 NMSA 1978], **shall, in addition to any other penalties or amounts provided by law**, be liable for:
>
> (1) payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to the state;
>
> (2) a civil penalty in an amount of up to three times the amount of excess payments;
>
> (3) payment of a civil penalty of up to ten thousand dollars ($10,000) for each false or fraudulent claim submitted or representation made for providing treatment, services or goods; and
>
> (4) payment of legal fees and costs of investigation and enforcement of civil remedies. [Emphasis added.] NMSA 1978, Sections 30-44-8(A)(1), (2), (3) and (4) (1989 as amended through 1997).

[Emphasis added.]

Filing a criminal action is not a condition precedent to MFA civil liability. NMSA 1978, Section 30-44-8(D) (1989). And the [30-44-8] civil remedies "are separate from and cumulative to any other administrative and civil remedies available under federal or state law or regulation." NMSA 1978, Section 30-44-8(E) (1989).

B. Course of Proceedings.

On June 10, 2011, the State identified Arminder Kaur as a witness to be called at the evidentiary hearing. [RP 400-404]. On July 26, 2011, the State subpoenaed Kaur for the hearing. [RP 491-496]. Nonetheless on August 10, 2011, Kaur was in India. Tr.#1. On August 10, 2011, the district court denied Imagine's *Motion to Dismiss* and began an evidentiary hearing on Imagine's *Motion for Sanctions*. Tr.#1-7:21-23; 7:24-74:23; [RP 064-073; 084-103; 162-170; 581-582; 104-137; 204-238; 336-356]. To allow for Kaur's return and testimony, the district court continued the evidentiary hearing on Imagine's *Motion for Sanctions* and vacated the September 19, 2011 Trailing Docket setting. Tr.#1-73:7-74:15; Tr#2-32:12-33:1-8; Tr.#3. [RP 400-404; 470-473; 491-496; 583-585].

On August 15, 2011, the court heard Imagine's *Motion for Summary Judgment* and took it under advisement. Tr.#2-29:11-33:9; [RP 359-393; 407-467]. On September 14, 2011, the court concluded the evidentiary hearing on Imagine's *Motion for Sanctions* and stated: "This case is dismissed. Summary Judgment is granted." The court initially denied Imagine's *Motion for Sanctions*, while granting the *Motion for Summary Judgment*. The court then denied Imagine's request for attorneys' fees and granted summary judgment as a sanction, stating: "... it pretty much doesn't matter what the reason is, if it's

granted for any reason, it [summary judgment] should be granted;" and "if the State accepts the ruling of this Court, I do not need to make detailed findings." Tr.#3-74:12-77:25.

On September 14, 2011, the court proceeded to hear Imagine's September 9, 2011 unverified *Motion for an Injunction* against the NMAG, without any NMAG written *Response*. AAG Landau objected to being "blindsided" by Imagine's *Motion* against the DOH but orally against the NMAG. The MFCU had not known that DOH decided to not renew Imagine's contract. DOH DDSD had not been served, was not present and was not a party to the action. Required by federal regulation to be legally separate and distinct from MAD and DOH DDSD, the MFCU only prosecutes MFA and provider contract violations. Therefore Imagine's attempt to enjoin the NMAG, which went far beyond the scope of Imagine's contract renewal, would have been void. § 1007.9. Tr.#3-65:7-25; 78:1-86:2. [RP 618-626; 632-652; 688-689].

On September 23, 2011, the State filed separate *Proposed Findings of Fact & Conclusions of Law on Defendant's Motion for Sanctions* and on *Defendant's Motion for Summary Judgment.* [RP 655-683]. Thereafter Imagine filed its *Findings of Fact and Conclusions of Law.* [RP 690-695]. On October 25, 2011, the State filed its *Objections to Imagine's FFCL.* [RP 696-705]. After receiving the court's October 28, 2011 *Order*, the State filed a *Motion to Amend.*

[RP 706-720]. On November 17, 2011 the court denied the State's *Motion to Amend* without a hearing and the State filed its *Notice of Appeal*. [RP 721-725].

C. Summary of the Facts.

Defendant Advantageous Community Services, LLC, is a New Mexico limited liability company with its principal place of business in Bernalillo County, New Mexico and does business as Imagine, LLC. [RP 1, 22, 504 (*PTO* 2(b))]. Kaur executed Imagine's MAD 335 PPA (9/9/03) which stated at Art. I:

> The ... provider shall: 1.1. Abide by all federal, state, and local laws, rules, and regulations, including but not limited to, those laws, regulations, and policies applicable to providers of medical services under Title XIX [Medicaid] . . . and other health care programs administered by HSD. [RP 429];

and at Art. VIII - *Imposition of Sanctions for Fraud or Misconduct*, ¶ 8.1:

> If the provider obtains an excess payment or benefit willfully, by means of false statement, representation, concealment of any material fact, or other fraudulent scheme or devise with the intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the MFA, 42 U.S.C. § 1320a-7b, and 42 C.F.R. § 455.23. [RP 431].

Cf. [RP 511-512 (*PTO*, 3(a), (b) & (c))].

In 2004, in 2005, and in 2008, Imagine executed three additional provider agreements to function as a DD Waiver provider. [RP 1-2; 22 admitting ¶¶ 2, 3, 4, & 6; 433-440; 504-505 (*PTO* 2(d), (e) & (f)); 643-648]. Imagine admits that it agreed in its Electronic Claim Submission Agreement (ECA), *inter alia*, that

all claims submitted electronically "... shall contain, true, accurate, and complete information." [RP 1-2, 22, 506 (*PTO* 2(g))].

Imagine's DDSD contracts explicitly incorporated the MAD 335 PPA provisions "by reference;" and required Imagine to submit claims for reimbursement for Medicaid services in accordance with all applicable state and federal laws, and the regulations and standards of the New Mexico Medicaid program, including without limitation the *DD Standards*, the CCHSA and 7.1.9 NMAC. [RP 417-440, 506 (*PTO* 2(h)); 643-648]. As a DD Waiver provider, Imagine was also required to comply with the Medicaid Provider Act (MPA), NMSA 1978, Sections 27-11-1 *et seq.* (1998, as amended through 1999).

For each of the 270 DD Waiver HBCS claims submitted under procedure code T2032 (residential care) for clients FB, CD, MH, JN, DO, JS and KV, whose caregivers were AC, RD, AO, TM, SS, and DC, Imagine admitted that it made the claims and received payments. [RP 5-18; 460, 506 (*PTO* 2(i))]. Imagine admitted that the *Complaint Ex. "A"* accounting correctly reflected the caregiver/client correlation, caregiver start dates, claim dates, and the payment received for each claim. [RP 1-18, 23, 508-510 (*PTO* 2(m), (n), (o), (p), (q), (r) & (s)); 527-540].

Imagine admitted it was a "care provider" and its six caregivers, AC, RD, TM, SS and DC were "caregivers" whose CH applications were required to have

been submitted within thirty (30) days from the first day Imagine employed the caregiver under the DD Waiver statutes, regulations, *DD Standards*, the CCHSA, and 7.9.1 NMAC. NMSA 1978, Section 29-17-5 (1999); [RP 506-510 (*PTO* 2(j), (k), (l) & (t))].

The State contends that Imagine's claims violated the MFA because they constituted: 1) Falsification of Documents under Sections 30-44-4(A)(1) and/or 30-44-4(A)(2); and/or, 2) Medicaid fraud under Sections 30-44-7(A)(1)(c) and/or 30-44-7(A)(1)(d) and/or 30-44-7(A)(3) and/or 30-44-7(A)(4)(b). Because Imagine's HCBS claims violated the CCHSA, federal/state program statutes and regulations and the MFA, the MFCU is authorized to recover for the benefit of State, all *Complaint Ex. A* overpayments ("excess amounts") and civil penalties. Sections 30-44-8(A) and 30-44-8(A)(1), (2), (3) and (4). [RP 1-4; 84-103; 407-458; 497-567; 669-683].

The State's filed its *Complaint* within five years of Imagine's earliest billing date. The two MFA causes of action, *Overpayments* and *Civil Penalties*, and the third cause of action, *Breach of Contract* [MAD and DDSD provider agreements], rely upon the same facts and involve the same $361,193.18 (270 claims). *Cf.* NMSA 1978, Section 30-44-8(G) (1989) to NMSA 1978, 37-1-3(A) (1978); [RP 1-18]. Imagine contractually authorized the State's MFA

enforcement and recovery of the $361,193.18 for its CCHSA violations. [RP 427-440; 643-648].

The court's Sanction Dismissal relates to Assistant Attorney General Landau asking Kaur about a 2011 "updated" CH clearance letter. Tr.#1; Tr.#3; *ACS-Ex. D*; *ACS-Ex. A*, pgs 138-148; [RP 116-137; 204-238]. After the deposition AAG Landau discovered that prior to the deposition and unbeknownst to her at the deposition, MFCU investigator, Marc Workman could not find copies of two 2006 DOH CH letters in the MFCU's files and that the NM DOH did not retain copies. Without informing AAG Landau, Marc Workman obtained faxes of the two DOH CH clearance letters which contained the 2006 CH data, along with "updated data" fields. *Cf. ACS-Ex. C & E to D & NM-Ex. 1*; [RP 215-234].

After the deposition, AAG Landau discovered that CCHSP had faxed a cover sheet explaining the DOH computer program limitations and that "re-printing" the two 2006 CH clearance letters would result in updated fields and/or "discrepancies." However Workman did not provide the fax cover sheet to AAG Landau and/or inform her of the situation and/or understand the implications of the updated data fields under the Rules of Evidence prior to the Kaur deposition. On March 14, 2011, the MFCU provided an explanation of the facts surrounding the use of the DOH 2011 "updated" CH letters to Imagine. [RP 133-137].

ARGUMENT

I. THE TRIAL COURT ABUSED ITS DISCRETION BY DISMISSING THE STATE'S COMPLAINT AS A SANCTION.

A. Standard of Review.

Dismissal is a severe sanction imposed for intentional, willful and/or bad faith misrepresentations in violation of a court order and/or rule. *Lopez. v. Wal-Mart Stores, Inc.*, 108 N.M. 259, 261, 771 P.2d 192, 194 (Ct.App.1989). The severe sanction of dismissal is only proper where the opposing party suffered tangible prejudice. *State v. Harper*, 2011-NMSC-044 ¶ 19, 150 N.M. 745, 266 P.3d 25.

Appellate courts review dismissal of a plaintiff's case for abuse of discretion. *Reed v. Furr's Supermarkets*, 2000-NMCA-091 ¶ 10, 129 N.M. 639, 643, 11 P.3d 603, 607; *Medina v. Foundation Reserve Insurance Company, Inc.*, 117 N.M. 163, 166, 870 P.2d 125, 128 (1994), *rehearing denied.; United Nuclear Corp. v. General Atomic Co.*, 96 N.M. 155, 239, 629 P.2d 231, 315 (1980), *cert. denied.* When reviewing an order for abuse of discretion, this Court reviews the application of the law to the facts de novo. *N.M. Right to Choose/NARAL v. Johnson*, 1999-NMSC-028, ¶ 7, 127 N.M. 654, 986 P.2d 450.

B. THE COURT'S DISMISSAL IS UNWARRANTED BECAUSE IT RESTS UPON THE ROUTINE OPERATION OF THE DOH'S COMPUTER SYSTEMS, NOT WILLFUL AND/OR BAD FAITH MISREPRESENTATIONS.

The Kaur deposition took place on March 9, 2011. On March 14, 2011 the MFCU provided Imagine's attorney, Dennis Jontz, with an explanation and copies of the 2011 DOH CCHSP cover sheet and fax. [RP 133-137]. Nonetheless, Imagine filed its *Motion for Sanctions* in which it contends that the 2011 DOH "updated" data fields in *ACS-Ex. B* were part of the State's strategy to damage Imagine for its "alleged technical paperwork errors [CCHSA violations]." [RP 69; 105-106; 112; 120; 342; 362]. Imagine's *Motion* and *Reply*, and other Imagine pleadings in this action, demonstrate that Imagine's allegations regarding the State's alleged litigation strategies are peremptory projections resulting from the State's refusal to accept Imagine's defenses to its strict liability, including: 1) Kaur's insistence that others, not she and/or Imagine, violated the MFA, *DD Standards* and CCHSA; 2) that Imagine didn't make any money from the Medicaid payments; and, 3) that none of the DD recipients were injured and/or died and none of the caregivers were convicted felons. [RP 64-73; 104-137; 162-170; 173-182; 185-195; 198-201; 204-241; 280-301; 308-331; 336-356; 359-393; 459-467].

Imagine insists that the MFCU's inadvertent oversight and mistake relating to the DOH 2011 "updated" CH clearance letters, which have been

repudiated, should be subject to dismissal sanctions. Tr.#1; Tr.#3; [RP 64-73; 104-137; 690-695]. However in an ironic twist, Imagine's $361,193.18 in DD Waiver HCBS payments which violated the CCHSA are "alleged technical paperwork errors" that "affected nobody." *Cf.* Tr.#2-20:22-23:4; [RP 162].

At the August 10, 2011 hearing, Orlando Sanchez, the DOH Caregivers Criminal History Screening Program (CCHSP) application (software) developer testified that: 1) he accessed and reviewed the underlying data base that produced the 2011 "reprinted" CH clearance letters; 2) he personally verified that the 2011 data in the critical fields conformed to the data in the CCHSP system and on the 2006 CH letters; 3) the CCHSP computer program did not, and does not, have the capability to reprint the 2006 CH letters without updated fields; and, 4) the CCHSP did not keep copies of the two 2006 CH clearance letters. *Cf.* Imagine *ACS-Ex. C & E* to *ACS-Ex. D*; Tr #1, 36:18-71:15; 45:1-46:4. The court directly questioned Mr. Sanchez regarding these facts "because [she needed] to understand what happened." Tr.#1, 8:9-53:4.

Mr. Sanchez testified that the 2011 "updating" of the two CH clearance letters resulted from the routine operation of the CCHSP computer system which did not allow printing of an exact copy of the 2006 CH letters and caused the alteration and overwriting [updated data fields] of information in the 2011 letters. *Cf.* RP 133-137 to 225-234]. The 2011 CCHSP computer program

updating of "non-essential" data fields did not result in the loss of critical data because the caregiver name, fact of clearance, and date of clearance in the 2011 and 2006 versions were the same. CCHSP's computer program's "updating of data fields" does not have a direct counterpart in hard copy documents. *Federal 2006 Rule Committee Notes on F.R.C.P. 1-037(f).*

Mr. Sanchez also testified that the 2006 CH essential clearance data for the two caregivers shown on the 2011 "updated" CH clearance letters was independently accessible and verifiable by Imagine through the CCHSP Consolidated Online Registry (COR), a web based system. Tr. #1-36:18-71:19; *NM-Ex. 2 & 3* printed by Imagine on 5/5/2011; *ACS-Ex. C, D, & E.* Therefore the 2011 "updated" CH clearance letters cannot reasonably be considered "false and/or fake and/or fraudulent" as alleged by Imagine and its counsel. *Cf.* Rules 11-1001, 11-1002, 11-1003, 11-1004, and 11-803(H) & (J) NMRA.

In 2009, the Rules Committee chose not to incorporate into Rule 1-037 NMRA, the Federal Rule 37(f) "safe harbor" provision which states:

> **(f) Electronically Stored Information.** (ESI) Absent exceptional circumstances, a court may not impose sanctions under these rules on a party for failing to provide electronically stored information lost as a result of the routine, good-faith operation of an electronic information system. *See current 37(e).*
>
> However the *Committee Commentary* stated:
>
> New Mexico's civil discovery rules should not treat the routine, good-faith purging of electronic files any differently than the good-

> faith, routine destruction of paper files according to an established records retention schedule. The destruction of electronic information pursuant to the routine, good-faith operation of an electronic information system is ... something the district court can take into account when considering a request for discovery sanctions. *Rule 1-037 NMRA. Failure To Make Discovery; Sanctions, 2009 AMENDMENTS.*

Fed.R.Civ.P. 37(f) 2006 *COMMITTEE NOTES* state:

> The ordinary operation of computer systems creates a risk that a party may lose potentially discoverable information without culpable conduct on its part ... absent exceptional circumstances, sanctions cannot be imposed for loss of ESI resulting from the routine, good-faith operation of an electronic information system. Rule 37(f) ... includes the alteration and overwriting of information ... a feature with no direct counterpart in hard-copy documents ... [and] applies to information lost due to the routine operation ... if the operation was in good faith.

The "updating" of the two 2011 CH clearance letters was not the result of any culpable conduct on the part of DOH CCHSP and/or the MFCU and/or MFCU employees. The "updated" printing resulted from the routine, good faith operation of the CCHSP's computer system and its ESI stored information limitations. Based upon the State's repudiation of the two 2011 "updated" CH clearance letters and these facts, judicial treatment of the CCHSP's computer system limitations should not be any different from the judicial treatment accorded the good faith, routine destruction of paper files according to an established retention schedule. *2009 Comments, supra*; Fed.R.Civ.P. 37(e) fka

(f). Therefore the district court's dismissal sanction relating to the two 2011 "updated" CH clearance letters is unwarranted and should be reversed.

C. DISMISSAL OF THE STATE'S CASE AS A SANCTION IS A DRASTIC REMEDY CONTRARY TO LOGIC AND REASON.

A court has discretion to impose sanctions for the violation of a discovery order that result in prejudice to the opposing party. *State v. Bartlett*, 109 N.M. 679, 680, 789 P.2d 627, 628 (Ct. App. 1990). A court abuses its discretion when its "ruling is clearly against the logic and effect of the circumstances of the case." *State v. Lopez*, 2011-NMSC-035, ¶ 14, 150 N.M. 179, 258 P.3d 458. Any assessment of sanctions should consider the extent of the government's culpability, weighed against the amount of prejudice to the defense. *State v. Chouinard*, 96 N.M. 658, 661, 634 P.2d 680, 683 (1981).

Throughout this litigation, Imagine has contended that the MFCU has acted improperly. [RP 64-73; 104-137; 162-170; 173-182; 185-195; 198-201; 239-241; 244-269; 280-301; 336-356; 359-393; 459-467; 501-503 (*PTO Imagine Claims*)]. Imagine's *Motion for Sanctions* refused to accept the MFCU's explanation and documentation regarding how the inadvertent oversight and mistake occurred and Imagine's attacks on the MFCU increased. [RP 104-137; 204-238; 336-356; 359-368]. *See State's Response to Defendant's Motion for Protective Order,* wherein Imagine misrepresented facts relating to a

case manager's objections to Imagine's dangerous transport of a severely impaired DD consumer during feeding. [RP 308-331].

The State's *Response* documents the facts relating to the creation and use of *ACS-Ex. B*. [RP 204-238]. The *ACS-Ex. A* [Dep. AK 138-148] documents that when the issue arose [address change - Susan Martinez letterhead], AAG Landau stopped asking about *ACS-Ex. B*. *See ACS-Ex. B*; *ACS-Ex. A* [Dep. AK 138-148]; Tr.#1-18:4-21:3; 45:19-55:1; Tr.#3-8:15-9:17; 47:. Nonetheless, Imagine's *Reply* still insists that *ACS-Ex. D* contained intentionally fabricated documents, which is not true. [RP 336-356].

At the September 14, 2011 hearing, Mr. Jontz called *ACS-Ex. B* a "mistake" and admitted that [even] he didn't notice the difference in the address and the addressee. Tr.#3-61:24-62:20. Kaur "totally agreed" that AAG Landau never realized [the updated fields]. Tr.#3-11:5-6. The district court stated: "Personally, no I don't think you [AAG Landau] created it." Tr.#3-74:1-2; 58:13-61:17; 65:7-74:14. Nonetheless Imagine incorrectly still wrongly contends, without any grounds, that "the State" intentionally created *ACS-Ex. B* to deceive, mislead, and prejudice Imagine. [RP 690-695].

Before choosing dismissal as a just sanction, the federal courts consider (1) the degree of actual prejudice to the defendant; (2) the amount of interference with the judicial process; ... (3) the culpability of the litigant.

Ocelot Oil Corp. v. Sparrow Indus., 847 F.2d 1458, 1465 (10th Cir. 1988). The New Mexico appellate courts have stated that before imposing sanctions, a court should consider (1) the degree of fault of the party who altered or destroyed the evidence; (2) the degree of prejudice suffered by the opposing party; and (3) whether there is a lesser sanction that will avoid substantial unfairness to the opposing party. *Restaurant Management Co. v. Kidde-Fenwal, Inc.*, 1999-NMCA-101, ¶ 13, 127 N.M. 708, 986 P.2d 504. Considering all of these factors, dismissal is not a just sanction here.

At the evidentiary hearings, there was no testimony to support Imagine's contentions that the MFCU intentionally fabricated and/or falsified *ACS-Ex. B*, and/or that any of the information in the 2011 CCHSP "updated" data fields on *ACS-Ex. D* were relevant to the State's claims and/or prejudiced and/or damaged Imagine. Tr.#1; Tr.#3.

The MFCU's inadvertent error arose from a combination of over 4,000 documents in Imagine's case, the MFCU's investigator's inexperience and lack of training in evidentiary principles, and the CCHSP's inherent computer limitations and inability to "reprint" exact copies of the original two 2006 CH clearance letters sent to Imagine. There is no dispute as to the essential data in the two 2006 CH clearance letters, copies of which Imagine admits were, and are, in its possession. [RP 204-238; 336-356].

The trial court has inherent power to impose a variety of sanctions on both litigants and attorneys in order to regulate their dockets and promote judicial efficiency. *State ex rel. N.M. State Highway & Trans. Dep't v. Baca*, 116 N.M. 751, 754, 867 P.2d 421, 424 (Ct.App.1993). However, this is not an exceptional case where the extreme sanction of dismissal should be applied. *Bartlett, supra* at 293, 628.

Even applying a criminal suppression of evidence test here, the evidence shows: 1) the MFCU made a mistake but did not intentionally breach any duty toward Imagine or deprive Imagine of any evidence; 2) the 2011 "updated" CH clearance letters were not material and have been repudiated; and 3) Imagine was not, and has not, been prejudiced by the 2011 "updated" CH clearance letters because Imagine possessed the 2006 copies and could independently access COR to verify the CH data. *State v. Lovato*, 94 N.M. 780, 782, 617 P.2d 169, 171 (Ct. App. 1980).

The State did not defy any court order and/or intentionally breach any duty and/or intentionally deprive Imagine of any evidence and/or otherwise prejudice Imagine. Tr.#1; Tr.#3.

Review of the pleadings, hearing transcripts, and exhibits demonstrates that despite Imagine's claims of prejudice, no prejudice occurred and/or was proven despite Imagine's deeply held and constantly voiced belief that the State

should never have sued Imagine. *State v. McDaniel*, 2004-NMCA-022, ¶ 6, 135 N.M. 84, 84 P.3d 701; Tr.#3-61:24-69:4; [RP 112; 120; 162; 342; 362].

Even if the CCHSP printing 2011 "updating" involved more than an inadvertent oversight and mistake by the MFCU, which it did not, the severe sanction of dismissal is only proper where the opposing party suffered tangible prejudice. *Cf. State v. Duarte*, 2007-NMCA-012, ¶ 15, 140 N.M. 930, 149 P.3d 1027 (affirming dismissal) with *Bartlett, supra* at 680-681, 628-629. (holding dismissal was not warranted).

This case does not involve any missing evidence. Imagine's ability to prepare and present its case has not been adversely impacted. Imagine's *Motion for Sanctions* relied upon speculative and unproven claims of prejudice. *McDaniel supra* at ¶ 6. Balancing the facts against the extreme sanction of dismissal, dismissal is not warranted, is clearly untenable, and is not justified by reason. *State v. Dominguez*, 2007-NMSC-060, ¶ 16, 142 N.M. 811, 171 P.3d 750. The court's Order granting the dismissal sanction defies the logic and effect of the facts and circumstances here. Therefore the court's Order must be reversed for abuse of discretion.

II. THE TRIAL COURT ERRED IN DISMISSING THE STATE'S MFA CIVIL OVERPAYMENT AND PENALTY CLAIMS (COUNTS I & II) BECAUSE GENUINE ISSUES OF MATERIAL FACT PRECLUDE JUDGMENT AS A MATTER OF LAW.

A. Standard of Review.

Summary judgment is appropriate where there are no genuine issues of material fact and the movant is entitled to judgment as a matter of law. *Romero v. Philip Morris, Inc.*, 2010-NMSC-035, ¶ 7, 148 N.M. 713, 720, 242 P.3d 280, 287, citing *Montgomery v. Lomas Altos, Inc.*, 2007-NMSC-002, ¶ 16, 141 N.M. 121, 150 P.3d 971. An appeal from the grant of a motion for summary judgment presents a question of law and is reviewed de novo. *Id.*

All interpretations of law made by the district court are reviewed de novo. New Mexico courts view summary judgment with disfavor, preferring trial on the merits. *Romero, supra* at ¶ 8. Here the filter of federal and state Medicaid law must be used to determine if a fact is material. *Id.* at ¶ 11.

B. DISPUTED ISSUES OF MATERIAL FACT AND THEIR APPLICATION TO THE MFA PRECLUDE ENTRY OF SUMMARY JUDGMENT AS A MATTER OF LAW.

The court did not disclose the factual and legal grounds for its grant of Imagine's *Motion for Summary Judgment*. *Cf.* Tr.#3-75:24-77:25 to *FFCL* to *Order*; [RP 706-711; 669-683; 696-705; 706-711]. The court failed to inquire whether under substantive Medicaid law, there were disputed facts which gave rise to, and supported the State's claims as a matter of law. *Id.*

In the August 4, 2011 *Final Joint Pretrial Order* (*PTO*) signed by the court, the parties' stipulated that there were genuine issues of material fact. [RP 497-567]. The *Contested Issues of Fact* include [partial list]: *a)* whether under the MFA and provider contracts Imagine was strictly liable for the claims filed under its provider number [*cf.* RP 706 (FOF 5)]; *b)* whether Imagine's contracts required strict compliance with federal/state Medicaid provisions; *c)* whether Imagine contractually agreed to comply with the CCHSA when providing and billing for HCBS; *d)* whether Imagine was required to submit CH clearance applications for the six DD caregivers prior to billing Medicaid; and, *o & p)* whether Imagine's 270 claims for caregivers whose CH applications did not comply with CCHSA requirements are overpayments recoverable under the MFA/PPA. [RP 511-514].

The *Contested Issues of Law* include [partial list]: *a)* whether Imagine's submission of the 270 unqualified HCBS claims violated the MFA; *u)* whether the State is required to prove Imagine's intent to defraud for each of the 270 claims in order to recover the $361,193.18; *w & x)* whether an employee's and/or partner's conduct and/or legal relationship to Imagine relieves Imagine of MFA/contract liability; and, *y)* whether the State must prove common law contract damages to recover under Imagine's provider agreements. Tr.#2-6:22-8:20; 8:21-33:8; [RP 514-521].

The *Contested Issues of Fact* applied to the *Contested Issues of Law* filtered through federal/state Medicaid law, preclude entry of summary judgment in Imagine's favor as a matter of law. Rule 1-056; [RP 497-567].

The Order effectively repeals the MFCU's statutory authority to enforce MFA civil remedies against Imagine for its CCHSA violations, as well as the MFCU's related federally mandated duties under the State plan. Tr.#1, Tr.#2; Tr.#3. Preventing the MFCU from prosecuting MFA civil cases against providers, constitutes "a serious encroachment on the executive branch." §§ 1396a-b, 1396b(q); §§ 1007 *et seq.*; *State v. Armijo*, 118 N.M. 802, 816, 887 P.2d 1269, 1283 (Ct. App. 1994); NMSA 1978, § 8-5-2(B) (1975); §§ 400-403, 430 - 456, 460 - 585, 1000 - 1008.

Without the MFCU's MFA civil enforcement authority against providers, Medicaid recipients and the federal funds that flow to the State, will be severely impacted. In the fiscal year ending June 2011, joint federal and state health care funds spent in New Mexico (approximately 75% federal to 25% state) were approximately 3.2 billion dollars ($3,200,000,000). Sections 27-2-12 *et seq.* and 27-11-1 *et seq.*; statehealthfacts.org.

Section 30-44-8 Paragraph A expressly authorizes the MFCU to recover Imagine's overpayments ("other penalties or amounts provided by law") if, as here, Imagine violated the MFA "by receiving payments it was not entitled to,"

and all four civil penalties listed in subparagraphs (1), (2) (3) and (4). The mandatory word "shall," before the parenthetical reference employing the conjunctive "in addition to," followed by "be liable for," listing each "and" every "civil penalty," requires statutory construction that gives effect to the plain meaning of the words and the conjunctive which reflects the legislative's objective to civilly recover provider overpayments and penalties. § 433.316 (2001).

The crucial phrase of the Section 30-44-8(A) is that [i]f Imagine receives program payments it is not entitled to receive because of MFA violations, [Imagine] "shall, in addition to" [the overpayments], "be liable for" civil penalties. Imagine received program payments in violation of the MFA, because its HCBS [false] claims were for "unqualified" [false] DD caregivers as defined under federal/state Medicaid law. Therefore the MFCU may recover the overpayments under the MFA.

Once the total amount and number of claims comprising Imagine's overpayments is calculated and proven, Imagine "shall" be liable for: 1) those "amounts provided by law" [overpayments]; **AND**, 2) all four civil penalties, three of which are calculated based upon the total amount and total number of claims. The total due back to the State is the sum of the overpayments or amounts provided by law added to the four types of civil penalties. Section 30-

44-8(A). Using the words "any other penalties or amounts provided by law," the "excess amounts" upon which the MFA civil penalties are based need not only be due under the MFA. "Those amounts provided by law" could include overpayments under the provider contracts and/or 8.351.2.13 and/or § 433.316. If the Legislature did not want recovery of "overpayments" under "any other amounts provided by law," it would not have included those terms within the statute. Part 433, Subpart F, *Refunding of Federal Share of Medicaid Overpayments to Providers.*

Construing Section 30-44-8(A) as not authorizing recovery of overpayments and the four types civil penalties, also ignores the mandatory use of the word "shall," exorcises the directional wording "in addition to," and abrogates the interwoven federal and state Medicaid scheme under which the State enacted the MFA.

The Section 30-44-8(A) four civil penalties for which Imagine "shall be liable," is stated in the conjunctive using the word "and" after subparagraph A(3), not the disjunctive particle "or." All four Section 30-44-8(A)(1), (2), (3), and (4) MFA civil penalties are mandatory, **NOT** alternative choices to be picked by the judge and/or jury. [Emphasis added.]

The legislative intent in authorizing MFA civil actions is to compensate the federal/state governments for losses incurred through fraud, waste, and

abuse. *Cf.* Part 455--Program Integrity: Medicaid. Title XIX federal provisions enacting the State plan, also authorize the MFCU to civilly recover "overpayments" and/or "excess amounts" "AND" penalties arising from Imagine's unqualified HCBS billing. § 1396b(q); Part 1007. Thus, any MFA statutory construction that is inconsistent with other applicable federal/state provisions cannot, and must not, be upheld. *See West Virginia, supra.*

In ascertaining the legislative intent of the MFA, the courts must look "not only to the language used in the statute but also to the object sought to be accomplished and the wrong to be remedied." *Starko v. Presbyterian Health Plan, Inc. (Starko III)* ¶ 20, 2011-NMCA-053, 276 P.3d 252. This Court must look to the plain language of the statute, harmonizing and construing together multiple statutes in a manner that facilitates their operation and achievement of their goals. *Alliance Health of Santa Teresa, Inc. v. National Presto*, 2007-NMCA-157, ¶ 19, 173 P.3d 55.

Had the legislature not intended that the MFA apply to the MFCU's civil recovery of overpayments, excess amounts, and penalties for Imagine's MFA and CCHSA violations, independent of HSD's and the CCHSA's administrative remedies, the legislature would have **NOT** have included such authority in the MFA. [Emphasis added.] Section 30-44-8(E). This Court must give effect to

the MFA's clear and unambiguous language, because it makes sense as written. *Starko III* at ¶ 47; Tr.#1, Tr.#2, Tr.#3.

The Order also ignores the MFCU's express federal mandate to recover federal and state health care overpayments and civil penalties for false, fraudulent, and excessive claims containing misrepresentations of material facts through judicial action. §§ 1396a(42) & (61), 1396b(q); § 1007 *et seq.* *Cf.* "abuse" at §§ 433.304; § 1007.9 (1992) requiring the MFCU be "separate and distinct" from HSD.

Imagine violated the MFA by falsifying documents under section 30-44-4(A)(1989). ACS program computers automatically paid Imagine for its invalid HCBS claims relying upon the T2032 procedure code, applicable Medicaid regulations requiring reimbursement for "billing errors," and Imagine's PPA which required compliance under penalty of perjury. [RP 432]. Imagine's own provider policies required CCHSA compliance when delivering HCBS. [RP 417-426]. Imagine misrepresented material facts and/or provided false and/or incomplete information upon which the program relied when paying the "invalid" (falsely obtained) claims. Sections 30-44-2(A)(1997) and 30-44-4(A)(1989); *Fischer v. U.S.*, 120 S. Ct. 395, 145 L.Ed.2d 308 (1999).

Imagine also committed Medicaid fraud under section 30-44-7(A). As OIG has made clear, in order for Imagine's services to be valid payable services,

its HCBS were required to meet federal/state CCHSA regulations when billed. Imagine had a mandatory duty to only bill for caregivers whose CH applications had been submitted. *OIG Heritage Review*, *supra* at 1-7. On a physical and compassionate level, the State cannot afford to overlook Imagine's violations and put DD Waiver recipients at risk. On a financial level, the state cannot afford to overlook Imagine's HCBS CCHSA violations because the unqualified HCBS Imagine billed for, and was paid for, were not payable under federal/state Medicaid law. § 433.304.

Imagine received and retained payments which were in excess of rates and amounts authorized to be paid for "qualified" DD Waiver caregivers whose CH applications had to be submitted. Submission of CH applications was a precondition for Imagine billing the HCBS services. 8.315.4 NMAC; Section 30-44-7(A)(1)(c). Alternatively, Imagine's HCBS claims containing CCHSA violations were false, fraudulent, excessive and/or incomplete as defined by federal/state law. *See* also Sections 30-44-7(A)(1)(d) and/or 30-44-7(A)(3).

Under Section 30-44-7(A)(3), because Imagine presented, received and retained the overpayments, it committed Medicaid fraud and violated MFA, entitling the State to recover the overpayments. "Knowingly" is not defined in the MFA. However the Fraud Against Taxpayers Act (FATA) Section 44-9-

2(C) (2007) defines "knowingly" as meaning that a person with respect to information, acts:

> (1) with actual knowledge of the truth or falsity of the information;
> (2) in deliberate ignorance of the truth or falsity of the information; or
> (3) in reckless disregard of the truth or falsity of the information.

See "false claims" defined in MFCA Section 27-14-4 (2004); FATA Section 44-9-3 (2007). *Cf.* FCA, 31 U.S.C. § 3729 (a) and (b) to UJI 13-1633 NMRA (proof of "fraudulent misrepresentation" elements requires clear and convincing evidence).

The record, the facts and the law do not support Imagine's contention that that the filing of 270 claims, each of which required entry of at least 10 computer data fields [a minimum of 2,700 keystrokes] was done without any knowledge and/or intent. See *New Mexico Medicaid Portal* at nmmedicaid.acs-inc.com/nm/general/home.do, *CMS-1500 Professional Claim Form* for Billing Instructions (PDF). Having hit the computer buttons to submit its electronic unqualified HCBS claims a minimum of 2,700 times over five years, and thereafter retaining the $361,193.18 in program funds, Imagine "knowingly" [44-9-2(C)] violated the CCHSA and the MFA. *See* Sections 30-44-7(A)(1)(c) and (d).

Should this Court uphold the court's Order, the MFA's remedial purpose to recover overpayments [amounts provided by law] in order to make the

government whole for monies paid, interest lost, investigation costs and legal fees, AND to impose civil penalties to deter future CCHSA violations, fraud, waste, and abuse will fail, and the MFA civil remedies will have been judicially repealed in violation of Medicaid law. *State v. Kirby*, *supra* at ¶¶ 5-6, 23-41; *Espinosa v. Roswell Tower, Inc.*, 1996-NMCA-006, ¶ 8, 121 N.M. 306, 311-314, 910 P.2d 940, 945-948.

C. IMAGINE'S DEFENSES TO MFA CIVIL LIABILITY REST UPON DISPUTED FACTS.

The court's summary judgment decision upholds Imagine's defenses to MFA enforcement, in derogation of the MFA's express statutory provisions and legislative intent. The Order upholds Imagine's defense that the State must prove "intent" and/or knowledge to commit "Medicaid fraud" for each of the 270 prohibited claims under the MFA and Imagine's provider contracts, despite Imagine's express provider policies requiring CH clearance applications and admission that it submitted and was paid for each claim. *Cf.* Section 30-44-7(A). [RP 359-393].

Summary judgment also sustains Imagine's defense that its submission of DD Waiver service claims for "unqualified" caregivers constitute "mere late paperwork submission," not statutory and/or regulatory violations. Tr.#2-3:12-6:21; [RP 362; RP 461-464]. This ruling is directly contrary to three 2012 HHS OIG published reviews of NM Medicaid personal care (PC) providers that state,

"to provide a valid and payable service, personal care services must meet Federal requirements which require personal care services to be provided by a qualified attendant." 42 U.S.C. 1905(a)(24(B); 42 C.F.R. 167; *HHS OIG Review of NM Medicaid PC Services by Ambercare Home Health* (A-06-09-00062), i-iii, 7-8, oig.hhs.gov/oas/reports/region6/60900062.asp; *OIG Heritage Review, supra* at i-iii, 6-7; *HHS OIG Review of NM Medicaid PC Services Provided by Clovis Homecare, Inc.* (A-06-09-00117), i-iii, 1-7, /60900117.asp.

OIG also refused to accept defenses similar to Imagine's defenses that the court upheld here, including providers' insistence that attendant qualifications are conditions of participation, not payment, and that substantial regulatory compliance is sufficient. OIG has made clear that in order to be paid with federal health care funds, the attendant must meet the NMAC [7.1.9] attendant qualifications requirements, which include the CCHSA compliance, "because an attendant who is not qualified cannot provide valid personal care [HCBS] services as defined by Federal statutes and regulations." *Id.*

The Order also upholds Imagine's untenable defenses without verified facts and/or supporting statutes and regulations and/or case law, including: 1) CCHSA compliance is excused by CCHSP's alleged loss of Imagine's applications; 2) CCHHSA violations are permissible because the State's enforcement motive is financial; 3) Imagine [thinking] "that they were in

compliance," relieves it of liability (Tr.#2-24:12-15; 27:19-29:10); and, 4) Imagine's ongoing CCHSA violations after the State filed this action, are irrelevant. [RP 459-467]. Because the facts and the law supporting Imagine's defenses are disputed by the State, summary judgment here is improper as a matter of law.

Consistent with HHS OIG, the State maintains that Imagine was, and is, strictly liable for complying with the CCHSA under the MFA and its provider contracts when billing Medicaid. Tr.#2-8:21-33:8. Conversely, the court believed that the State was relying upon "some type of technicality to get the money back ... and found it disturbing." Tr.#2-23:3-4. Ignoring the statutory definition of Medicaid fraud, the court stated that without proof of harm to the DD recipients, *e.g.* no deaths and no convicted felon caregivers, there could be "no fraud." Section 30-44-7(A); Tr.#2-18:5-32:11.

The court did not consider either Congress's and/or the legislature's intent when enacting the federal/state Medicaid scheme and the MFA. The court failed to apply any statutory construction canons and/or look at the plain language of the MFA statutory provisions. *See* Section 30-44-(A) providing civil remedies against "persons" who "receive payments in violation of the MFA."

The court's Order only appears to reflect its unsupported extrajudicial opinion that the State should simply not be allowed to recover $361,193.18 from

Imagine for its CCHSA violations. Tr.#2-27:19-32:2; Tr.#3. Therefore the Order must be reversed, as a matter of law.

III. THE TRIAL COURT ERRED IN DISMISSING THE STATE'S BREACH OF CONTRACT CLAIMS (COUNT III) BECAUSE GENUINE ISSUES OF MATERIAL FACT PRECLUDE JUDGMENT AS A MATTER OF LAW.

A. Standard of Review.

Interpretation of a contract is a question of law, reviewed de novo. *McNeill v. Rice Engineering and Operating, Inc.*, 2003-NMCA-078, ¶ 13, 133 N.M. 804, 70 P.3d 794. When a contract dispute "depends upon the interpretation of documentary evidence, this Court is in as good a position as the trial court to interpret the evidence." *Lencrafters, Inc. v. Kehoe*, 2012-NMSC-____, ¶ 13. The parties' disagreement on construction of the CCHSA requirements incorporated by reference into Imagine's MAD 335 PPA and DDSD contract, does not necessarily establish ambiguity. *Vickers v. N. Am. Land Devs., Inc.*, 94 N.M. 65, 68, 607 P.2d 603, 606 (1980).

B. IMAGINE'S CONTRACTS REQUIRED COMPLIANCE WITH HCBS CCHSA STATUTES AND REGULATIONS AS A CONDITION OF PAYMENT.

Imagine's Medicaid provider contracts were not transactional, bargained for contracts. They are uniform pre-printed agreements that recite the responsibilities imposed on providers by federal/state Medicaid statutes and regulations. *Astra, USA, Inc. v. Santa Clara County, Cal.*, 131 S.Ct. 1342, 1345,

179 L.Ed.2d 457 (2011). A provider's eligibility to participate in the Medicaid program is conditioned upon execution of the provider contracts. The NM form contract PPA implements and incorporates by reference the federal/state statutes and regulations, in compliance with the CMS state approved plan. *See e.g.* Parts 434, 455, and 489. Civil actions to enforce the MFA and to enforce Imagine's provider contracts are in substance one and the same. Their treatment, therefore, must be the same, "[n]o matter the clothing in which [a Medicaid provider] dresses its claims." *Astra, supra* at 1345.

The court failed to consider Imagine's PPA agreement "under penalty of perjury" to "abide by and be held to" all Medicaid federal, state and local laws, rules, and regulations. [RP 432]. Directly above Kaur's signature, this PPA provision made Imagine's compliance with "all Medicaid federal and state laws and regulations" mandatory and allows for perjury prosecution for the making any false statements material to the Medicaid law. NMSA 1978, Section 30-25-1 (1978). *Cf. Bhandari v. VHA Southwest Community Health Corp.*, D.N.M., 2011 WL 1336512, at *3, n.1, reiterating the 10th Circuit's recognition that an unsworn statement made in compliance with 28 U.S.C. § 1746 (1976) may be submitted in lieu of affidavits. *Thomas v. U.S. Dept. of Energy*, 719 F.2d 342, 344 n. 3 (10th Cir. 1983).

Imagine disputes whether under the PPA, Art. I, *Obligations of the Provider* that uses the words "The Medicaid Provider shall," whether it had a mandatory duty to only bill for HCBS qualified caregivers under its name and provider number or face recoupment. See PPA at Art. 1.3 and 1.11; [RP 511 (*PTO* 3(b)); 429-432].

The State contends that in addition to Imagine's contractual agreement to the imposition of the MFA civil penalties for its PPA breaches, Imagine also agreed that "in addition to the [8.1] criminal civil penalties," HSD could impose monetary and non-monetary sanctions, including civil penalties for its misconduct or breaches. Art. VIII, *Imposition of Sanctions for Fraud or Misconduct*, Art. 8.1 to 8.4; [RP 431]. Imagine also contractually agreed to HSD's authority to elect to pursue one or a combination of "all of the PPA delineated "sanctions" (penalties)," which included MFA enforcement, federal sanctions and penalties, and recovery of overpayments for its breaches. *Id.* at Art. 8.4. By executing the PPA under "penalty of perjury," Imagine contractually consented to the MFCU's MFA statutory authority to recover overpayments and civil penalties if Imagine failed to comply with the CCHSA statutes when billing, as occurred here. Imagine's contract breaches and its MFA violations are one and the same. *Astra supra,* at 1348. [RP 1-18].

Imagine's PPA and DDSD contract(s) also incorporated *General Provider Policies*, 8.302.1; *Billing for Medicaid Services*, 8.302.2; *Sanctions and Remedies*, 351.2 (incorporating the MFA), and "all other regulations, standards, policies, and procedures, guidelines and interpretative memorandum of the DDSD and DOH" [RP 438-439; 644-645]; all of which also incorporated Title XIX federal/state Medicaid provisions. 42 C.F.R. Part 434 Contracts; 7.26.3, 7.26.5, and 7.26.6 NMAC; [RP 427-440; 648-648 (portions of DDSD contracts)].

Imagine's DDSD contracts required Imagine to comply with the "DHI/DOH Criminal Records Screening for Caregivers (7 NMAC 1.9)." [RP 439(#19); 645(#t)]. Imagine admitted that it understood its claims would be paid with federal and state funds and that federal law applied. Imagine contractually agreed that all of its electronically transmitted claims [shall] contained true, accurate, and complete information and breached that agreement by submitting the 270 unqualified HCBS claims. [RP 1-2, ¶ 4; 22 ¶ 2].

Consistent with OIG's position, a federal appellate court reversed a lower court 12(b)(6) dismissal of New Mexico's state law MFCA claims against Amgen relating to payments made by the NM Medicaid program. Bypassing the "precondition" argument, the *Amgen* court held that the New Mexico MAD 335 PPA, Article VIII, which incorporates the MFA and is the same contract

provision at issue here, was "more than sufficient" to establish FCA liability. *New York v. Amgen, Inc.*, 652 F.3d 103, 114 (1st Cir. 2011), *cert denied.*

The federal appellate court found that the MAD 335 PPA's, Article VIII, *Imposition of Sanctions for Fraud or Misconduct* directly referred to provider compliance, that the conditions of payment versus conditions of participation distinction were irrelevant, and that the NM PPA required providers to acknowledge that non-compliance with anti-kickback laws vitiates a provider's ability to get [its] claims paid. *Id.* at 115. *Cf.* Section 30-44-7(a)(1)(a), an MFA anti-kickback provision.

Although *Amgen* involved anti-kickback statutes under the MCFA [27-14-1 to 27-14-15], the same reasoning applies under the MFA here. *Cf.* 30-44-7(a)(1)(a). Pursuant to federal/state statutes and regulations and the PPA, Imagine's HCBS CCHSA violations vitiate Imagine's ability to be paid with federal/state health care funds. Because Imagine's claims when made were for invalid [false] and not payable [false] HCBS claims, the distinction between conditions of participation and conditions of payments, including any argument regarding what Imagine "certified" to when hitting the electronic claim submission button over 2,700 times, is irrelevant. *OIG Heritage Review*, *supra.*

Imagine claimed and was paid for federally defined "unqualified" HCBS claims, which were invalid services when billed. The State would not, and

should not have paid Imagine had it known of Imagine's HCBS CCHSA violations at time of payment. Sections 30-44-4(A), 30-44-7(A); 30-44-8(A); 27-14-1 *et seq.* (2004); 44-9-1 *et seq.* (2007). Therefore the full amount of Imagine's "unqualified" 270 payments is recoupable by the state as a civil remedy under the MFA as "amounts provided by law" and under the PPA. [RP 428 (Art. 1.3)].

C. IMAGINE GRANTED THE STATE CONTRACTUAL AUTHORITY TO RECOVER OVERPAYMENTS AND SANCTIONS FOR ITS BREACHES, MISCONDUCT, AND FRAUD.

Similar to the Managed Care Organization (MCO) Medicaid contracts, Imagine's provider contracts incorporated "[a]ll applicable statutes, regulations and rules implemented by the [f]ederal [g]overnment, the State of New Mexico ..., and [HSD], concerning Medicaid services[.]" *Starko III,* at ¶ 6; Section 27-11-2(B)(1998); [RP 427-440; 643-648]. The PPAs are form contracts which by their terms are meant to contain and implement all Medicaid laws and regulations. *Astra, supra* at 1345. Therefore the provider contracts must be construed to harmonize with the federal/state Medicaid provisions which they incorporate. *Id.*

Any construction of the provider contracts creating more, new and/or different rights beyond those specified in Medicaid law cannot be upheld under federal preemption. *Id.* at 1345. Congress did not authorize a common law

contract damage measure for breaches of Medicaid provider agreements (PPA). § 1396b; § 433.316 42; Part 434 Contracts. *See Americare Properties, Inc. v. State Dept. of Social and Rehab. Serv.*, 241 Kan. 607, 612-613, 738 P.2d 450, 453-455 (1987) (federal law [statutes and regulations] preempts state law to the extent state law conflicts with federal Medicaid law).

State agencies, such as HSD, regularly overpay providers for services rendered because of incomplete paperwork, inadvertent errors or fraud. *Personal Care Products, Inc. v. Hawkins*, 635 F.3d 156-158 (5th Cir. 2011), *cert. denied,* citing 1 Tex. Admin. Code § 371.1703. Therefore federal statutes mandate that states "provide for procedures of prepayment and postpayment claims review ... to ensure the proper payment of claims." 42 U.S.C. §§ 1396a(a)(37) and 1396b(q)(5); *Personal Care Products, supra,* at 156-158.

New Mexico's regulatory scheme provides "at least" two civil avenues for overpayment recovery, the HSD administrative routine payment correction process and a MFCU MFA civil suit. Neither process is exclusive for the State's recovery of civil overpayments, excess amounts and penalties. § 1003 *et seq.*; Section 30-44-8(E). If an overpayment investigation is complex with the potential for uncovering fraud and abuse and/or criminal activity, it is likely to be handled by the MFCU. §§ 455.2, 455.18, 455.19, 455.21, 455.23, 1007 *et*

seq.; NMSA 1978, Sections 30-44-3(B)(1991), 30-44-4(B)(1989), 30-44-5(C)(1989), 30-44-6(B)(1989), 30-44-7(B) & (C)(1997).

The MFCU's investigation involved review of Imagine's billing records, personnel records, and COR data. MFCU investigators correlated specific caregivers to Imagine's failure to submit the individual CH clearance applications as documented in the COR online database to determine whether the 270 paid Imagine HCBS claims involved unqualified caregivers. *See* Art. 1.14, PPA. [RP 429; 84-103]. Without Imagine's files and timesheets, the MFCU could not have identified and/or correlated Imagine's claims and overpayments because Imagine was not, and is not required to disclose the individual caregiver who cares for a specific DD consumer, when submitting and being paid for HCBS claims. NMSA 1978, Sections 30-44-5 (1989) and 27-11-4(1999), 8.302.1.17 NMAC (7/1/01).

Once MFCU determined that Imagine's unqualified HCBS claims violated the CCHSA and were therefore invalid and should not have been paid, Imagine was required to return the monies to the State with interest. PPA, Art.1.3; 8.351.2 NMAC (7/1/03); [RP 429]. Imagine's refusal to correct and/or refund the "overpayments," created ongoing breaches and MFA violations. Art. 8.1, PPA. [RP 431]. The MFA incorporated into the PPA, authorized the MFCU to recover the overpayments and all four civil penalties for Imagine's contractual

breaches and MFA violations. Section 30-44-8(A), 8.351.2.13 NMAC. [RP 427-440; 634-648].

In addition to the MFA "criminal civil penalties," HSD may require repayment of all monies received for Imagine's invalid HCBS claims, plus civil penalties of: 1) interest; 2) up to two times the amount of the excess payments; 3) $500 for each claim [$135,000]; and, 4) legal fees and costs of investigation and enforcement of civil remedies. 8.351.2.11.F NMAC; [RP 431 (PPA, Art. VIII)]. Therefore any court ordered common law contract damage calculation used to calculate the State's recovery for Imagine's breaches violates the provider agreements' terms and the NMAC, underestimates the government's loss, and is preempted by federal mandate. Part 433.300, *Subpart F--Refunding of Federal Share of Medicaid Overpayments To Providers.*

Imagine's PPA contractually requires the imposition [shall] of "civil monetary penalties" pursuant to the MFA and C.F.R. 444.23, using the word "sanctions" to include "remedies" and "penalties" to be imposed for Imagine's fraud or misconduct for "breach of any of the terms of this Agreement." *See* [RP 431 (Art. 8.1 & 8.2)]. The court ignored these express contractual provisions.

Measuring the State's damages using Imagine's net gain after paying the unqualified caregivers, ignores the provider contracts' terms and the mandatory statutory civil monetary penalties to be imposed, consistent with the federal

definition of "overpayments," requiring the State repay the full amount due back to the federal government for the unqualified HCBS caregivers. 42 C.F.R. Part 433.300; *OIG Heritage Review, supra.*

The MFA and provider agreement sanctions and remedial remedies for recovery of state/federal health care funds are generally consistent with other statutes relating to the improper use of government funds. *Cf.* MFA § 30-44-8(A); MPA § 27-11-3(C); MCFA § 27-14-4 (2004); FATA § 44-9-3 (2007); (Civil Monetary Penalties (CMP)), 42 U.S.C. §§ 1320a-7a, 42 C.F.R. §§ 1003.103(a)(2)(2004) and 103.102(a)(2004); and, FCA, 31 U.S.C. § 3729.

The express incorporation by reference of explicit Medicaid remedies for breaches and invalid receipt of federal/state health care funds arising from Imagine's CCHSA violations, precludes and prevents the application of a common law damage measure to calculate the government's Medicaid losses. *See Hasse Contracting Company Inc. v. KBK Financial, Inc.*, 1999-NMSC-023, ¶ 21, 980 P.2d 641 holding [a] statutory section incorporated into a contract provides an adequate basis for enforcing [actions] under the contract; *Albuquerque Commons P'ship v. City of Albuquerque*, 2011-NMSC-002, ¶ 16, 248 P.3d 856 holding [A] federal statute, incorporated by state statute is applied when interpretation of a state statute is enacted against federal legislative backdrop allowing similar interpretation.); *Starko III, supra* at ¶ 73 holding

[s]tatutes incorporated into Medicaid provider agreements are relevant and applicable to the contract [PPA] commitments involved; *Amgen supra*, at 111, 114-116.

Whether or not the MFA and/or Imagine's Medicaid provider contracts authorize the MFCU to recover civil overpayments ["amounts provided by law"] and penalties under Section 30-44-8(A), is a matter of first impression in New Mexico. *But see*, *State ex rel. King v. Behavioral Home Care*, NMCA #31,682. However, the Supreme Court has held that when transactions are governed by both federal and state statutes [Truth in Lending Act (TILA), 15 U.S.C. §§ 1601-1693r (1993) and Sections 56-8-7 to 8 (1986)], and both contain remedial enforcement schemes designed to protect the public interest, [TILA] is to be liberally construed." *Equity Plus Consumer Finance and Mortg. Co., Ltd. v. Howes*, 116 N.M. 151, 152, 861 P.2d 214, 216 (1993).

Here, as in the TILA scheme, the MFA's and provider contract's mandatory imposition of civil penalties was intended by Congress to create a remedial enforcement framework allowing the MFCU to collect both the federal and state share of improperly paid health care funds (overpayments) and civil penalties to pay for the collection efforts, before CMS withheld the FFP from the State. 433 Subpart F. As in TILA litigation, the State is not required to consider the provider's net gain and/or loss after paying the caregiver, because statutory

penalties strictly apply if the provider received the health care funds in violation of federal/state Medicaid law and its contracts. *Equity*, at 861 P.2d 216. *See U.S. v. Gupta (Gupta II)*, 463 F.3d 1182, 1200 (11th Cir. 2006) discussing appropriate measure of loss relating to federal and state health care funds. See also *State v. McCall*, 101 N.M. 32, 33, 677 P.2d 1068, 1069 (1984), a New Mexico fraud and securities prosecution where proof of pecuniary loss and/or calculation of common law contract damages was not required. The elements necessary to prove Imagine's breaches and the State's entitlement to recover overpayments and civil penalties are explicitly delineated in the MFA, provider contracts and applicable Medicaid law. *Id.*

The case law on the improper receipt of federal and state health care funds includes consideration and the application of an enormous range of varying federal/state criminal and civil laws. No New Mexico cases have been found construing 30-44-8(A) and/or which could be argued as directly controlling here. But in a federal appeal involving a home health agency's criminal conviction for conspiracy to submit false Medicare claims under 18 U.S.C. § 286, the court refused to accept a "no harm, no foul" argument alleging no loss to the government. Holding that the full amount the government paid for the false claims is the measure of damages, the court remanded the case to district court to revise its improper damage calculations. *Gupta II, supra* at 1200.

Here too, this Court must remand and direct the district court to award the State the MFA's and provider contracts' statutory remedial sanctions [amounts provided by law, overpayments, and civil penalties] arising from Imagine's MFA and CCHSA violations and contract breaches, using the statutorily defined measure of damages, the full amount Imagine received for the unqualified HCBS plus all four MFA civil penalties. *Cf. U.S. v. Triana*, 468 F.3d 308, 319-324 (6th Cir.2006) holding [c]ourts have consistently held that calculating loss, using defendant's gain [UJI 13-843], underestimates the government's loss. *Kirby, supra* at ¶ 37.

Most importantly, this Court must construe the MFA's and provider contracts' measure of loss [overpayments and penalties] for Imagine's HCBS CCHSA violations in compliance with the federal method used to calculate overpayments due back from the State. §§ 1396a-b, 42 C.F.R. Parts 433 and 455; Section 30-44-8(A). To rule otherwise, creates a hazardous conundrum where the federal government still recovers the overpayments from the State by withholding the FFP based upon Imagine's "overpayments," leaving the State and its taxpayers out of pocket without any statutory or contractual remedy at law to recover those monies; while Imagine retains $361,193.18 for providing unqualified DD Waiver HCBS which violated the CCHSA and federal/state

Medicaid law and putting vulnerable DD consumers at unreasonable risk for abuse, neglect, and exploitation.

CONCLUSION

For the foregoing reasons, Attorney General King on behalf of the State, respectfully requests that this Court hold that the Medicaid Fraud Act, §§ 30-44-1 *et seq.* confers statutory authority to recover overpayments, excess payments, and other amounts provided by law under Section 30-44-8(A) and civil penalties under Sections 30-44-8(A)(1), (2), (3) and (4) and in the alternative, civil monetary penalties under the MAD 335 Provider Participation Agreement for Imagine's Medicaid DD Waiver HBCS CCHSA statutory and regulatory violations under Sections 29-17-2 *et seq.* (1999) and 7.1.9 *et seq.* NMAC; reverse the court's Order granting Defendant's *Motion for Sanctions* and *Motion for Summary Judgment*; remand this case back to the district court with directions for trial on the merits; and for such other and further relief as this Court deems just and proper under the circumstances.

Respectfully submitted,

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STATEMENT OF COMPLIANCE

Pursuant to Rule 12-213(G) NMRA, I hereby certify that this Brief in Chief complies with the limitations of Paragraph F of Rule 12-213 NMRA. It was created using Microsoft Word 97-2003 and that the body of this petition using Times New Roman 14 point font consists of 10,694 words as shown on the program word count. Rule 12-213(F)(3) NMRA.

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was mailed with first-class postage, pre-paid to Defendant-Appellee's counsel of record, Dennis E. Jontz & Jason Bousilman, P.O. Box 1027, Albuquerque, NM 87103, the 25th day of June, 2012.

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