CAUSE NO. D–1-GN-14-002229

ANTOINE DENTAL CENTER,	§	**IN THE DISTRICT COURT**
Plaintiff	§	
	§	
v.	§	
	§	**OF TRAVIS COUNTY, TEXAS**
TEXAS HEALTH AND HUMAN SERVICES COMMISSION AND OFFICE OF INSPECTOR GENERAL,	§	
	§	
	§	
	§	
Defendants.	§	**200TH JUDICIAL DISTRICT**

DEFENDANTS' TRIAL BRIEF

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CAUSE NO. D–1-GN-14-002229

ANTOINE DENTAL CENTER,	**§**	**IN THE DISTRICT COURT**
Plaintiff	**§**	
	§	
v.	**§**	
	§	**OF TRAVIS COUNTY, TEXAS**
TEXAS HEALTH AND HUMAN SERVICES COMMISSION AND OFFICE OF INSPECTOR GENERAL,	**§**	
	§	
	§	
	§	
Defendants.	**§**	**200TH JUDICIAL DISTRICT**

DEFENDANTS' TRIAL BRIEF

TO THE HONORABLE JUDGE MEACHUM:

Now come the Texas Health and Human Services Commission ("HHSC") and the HHSC Office of Inspector General ("HHSC-OIG") (collectively "Defendants" or "the State"), and file this their trial brief in response to the trial brief filed by Plaintiff, Antoine Dental Center ("Antoine"). Defendants ask the Court to affirm HHSC's Amended Final Order because HHSC Executive Commissioner Dr. Kyle Janek ("Executive Commissioner") acted fully within his lawful authority in entering the Amended Final Order and because the Amended Final Order is in all things supported by substantial evidence.

I. STATEMENT OF THE CASE

The Executive Commissioner, on behalf of HHSC, issued the Amended Final Order, affirming a payment hold imposed by HHSC-OIG on Antoine. Tex.

Hum. Res. Code § 32.0291(c); Tex. Gov't Code § 531.102(g)(2); 42 C.F.R. § 455.23. *See* **Appendix A**, HHSC's Amended Final Order, dated May 2, 2014 (copy also at A.R. 1743-85).[1] Antoine filed this suit for judicial review appealing HHSC's Amended Final Order.

II. ISSUES PRESENTED

A. The Executive Commissioner acted within his sound discretion, and he did not exceed his authority, in entering the Amended Final Order affirming the payment hold issued by HHSC-OIG.

B. The HHSC Amended Final Order is in all things supported by substantial evidence.

III. STATEMENT OF FACTS

A. The Texas Medicaid program, administered by HHSC, provides a health insurance benefit for the indigent, including limited orthodontia services under narrow circumstances.

The federal government enacted the Medicaid program in 1965 as a cooperative undertaking between the federal and state governments to help the states provide medical care to lower income individuals. Medicaid is funded jointly by the United States and each of the fifty states, as mandated by federal law. 42 U.S.C. § 1396. In Texas, the single state agency responsible for the administration

[1] The pleadings and copies of the hearing transcript, contained within HHSC's Administrative Record ("A.R."), are labeled with the Bates prefix "00001" through "2795."

of Medicaid is HHSC. Tex. Gov't Code § 531.0055(b)(1) ("[HHSC] shall "supervise the administration and operation of the Medicaid program.").[2]

1. Medicaid provides a limited benefit for orthodontics.

Texas Medicaid provides coverage for services that include dental and, on a very limited basis, orthodontic services to qualifying children.[3] The law restricts when Texas Medicaid will pay for orthodontic services:

> Orthodontic services for cosmetic reasons only are not a covered Medicaid service. Orthodontic services must be prior authorized and are limited to treatment of **severe handicapping malocclusion** and other related conditions as described and measured by the procedures and standard published in the TMPPM [("Texas Medicaid Provider Procedures Manual")].

25 Tex. Admin. Code § 33.71 (Orthodontic Services and Prior Authorization) (emphasis added). Since 2003, the Texas Medicaid orthodontia benefit policy has covered orthodontic services under three limited scenarios: (i) for children between the ages of 12 and 20 who have a severe handicapping malocclusion (the age requirement was added in 2008) which is defined by a Handicapping Labio-lingual Deviation ("HLD") score of 26 points or greater; (ii) children up to the age of 20 with cleft palate; or (iii) other medically necessary circumstances such as a head

---

[2] Currently more than 4.5 million Texans are enrolled in Medicaid. *See* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html, copy attached at **Appendix B**. In 2013, Medicaid comprised about 26.2 percent of the Texas state budget, amounting to approximately $25.6 billion dollars total for state and federal expenditures. *See* Pink Book, 1-1, at **Appendix C**.

[3] HHSC administers the Medicaid program pursuant to Texas's "Medicaid state plan." The state plan, Texas's blueprint for the Medicaid program, is reviewed and approved by the federal Centers for Medicare & Medicaid Services (CMS). Tex. Gov't Code § 531.097.

injury involving severe traumatic deviation. The Texas Medicaid program does not pay, indeed never has paid, for cosmetic orthodontics. *See, e.g.*, TMPPM (2011) (Ex. R-17), Vol. 2, § 4.2.24, copy at **Appendix D**; TMPPM (2010) (Ex. R-16), Vol. 2, § 5.3.24 (same), copy at **Appendix E**; TMPPM (2009), Vol. 2, § 19.19 (Ex. R-15) (same), copy at **Appendix F**[4]; TMPPM (2008), Vol. 2 § 19.18 (Ex. R-14), copy at **Appendix G**. *See also* 25 Tex. Admin. Code § 33.71 (same). In all cases, comprehensive orthodontic treatment ("full banding" or "full braces," as opposed to more limited orthodontics), is only available for children twelve years of age or older or who have lost their baby teeth. *See* Ex. R-15 at § 19.19.6 (comprehensive

[4] The TMPPM states:

> 19.19 Orthodontic Services (THSteps)
>
> - Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid. Orthodontic services are limited to the treatment of children who are 12 years of age and older with severe handicapping malocclusion, children who are birth through 20 years of age with cleft palate or other special medically necessary circumstances as outlined in Benefits and Limitations below.
>
> 19.19.1 Benefits and Limitations
>
> Orthodontic services include the following:
>
> - Correction of severe handicapping malocclusion as measured on the Handicapping Labiolingual Deviation (HLD) Index. Refer to page 19-4 for information on how to score the HLD. A minimum score of 26 points is required for full banding approval (only permanent dentition cases are considered).
>
> ***
>
> - Crossbite therapy.
> - Head injury involving severe traumatic deviation. The following limitations apply for orthodontic services: Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid or THSteps.

Id. at § 19.19.1 (2009), at **App. F**.

orthodontic treatment, listed as billing procedures code D8080, is "restricted to clients who are 12 years of age or older or clients who have *exfoliated all primary dentition*.") (emphasis added), at **App. F**.

2. Providers must obtain prior authorization representing that their patient has a severe handicapping malocclusion before they may request reimbursement for orthodontic services.

Providers must submit a prior authorization request, and receive approval, before seeking reimbursement from Texas Medicaid for orthodontic services. *See* 25 Tex. Admin. Code § 33.71; *see also* Ex. R-15 at § 19.19.2 ("Prior authorization is required for all THSteps orthodontic services except for procedure code D8660 [this procedure is the initial consultation that pays $15.00 for reimbursement]"), at **App. F**. "Prior authorization is a condition for reimbursement; it is not a guarantee of payment." *Id.* Providers are required to submit truthful and complete information when seeking PA.[5]

[5] Specifically, providers are required to submit:

- An orthodontic treatment plan, which "should incorporate only the minimal number of appliances required to properly treat the case";
- "[c]ephalometric radiograph with tracing models";
- "[c]ompleted and scored HLD score sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases.");
- Facial photographs;
- Full series of radiographs or a panoramic radiograph; diagnostic films are required.

Id., at **App. F**.

The prior authorization application includes the provider's representation that a child has a severe handicapping malocclusion and the treatment necessary to correct this severe handicapping malocclusion. To support a finding that a child has a severe handicapping malocclusion, a provider must, *inter alia*, submit an HLD score sheet with the application for prior authorization. *See* Ex. R-15 at § 19.19.2 (2009), at **App. F**. A prior authorization request is generally *only* approved *if* the child's condition rises to the level of a severe handicapping malocclusion, as indicated by a score of 26 or more on the HLD for non-cleft palate cases. *See id.*[6]

3. "Ectopic eruption" is an exceedingly rare condition, and in the TMPPM the term is afforded the plain meaning generally understood in the practice of dentistry.

"Ectopic eruption" is a rare dental condition – occurring, with only one tooth, in only 1.5 to 9 percent of the population[7] – primarily affecting the first molars, or else upper and then lower canines.[8] Significantly, the scientific literature describes the frequency – the very low frequency – of ectopic eruption occurring even once per patient. *See* R-51, (ectopic eruption only occurring in 1.5-1.6% of a sample population), at **App. H**. The frequency of the same exceedingly rare

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[6] If a provider wishes to obtain treatment for a patient for whom the provider scores less than 26, the provider is required to submit a written narrative. This situation did not occur with any of the patients in this case.

[7] Vol. 1 at 173:3-6, A.R. at 1984; *see also* R-51 at 8 (Thilander article describing ectopic eruption as an "anomaly" occurring in only 1.5-1.6% of a sample population of 4724 patients), copy attached at **Appendix H**.

[8] Vol. 1 at 153:22-24, A.R. at 1964.

condition occurring multiple times and/or bilaterally in the same patient is "infinitesimally smaller."[9] The chance of 100% of the patients in a sample having not only one instance of an exceedingly rare condition, but always at least 6 instances, and always two or more bilateral instances, is "zero. It's not possible."[10]

The Inspector General's expert, Dr. Larry Tadlock, explained that the term ectopic eruption, as explained in the William Proffit textbook *Contemporary Orthodontics*, means a tooth that erupts in the wrong place.[11] The Proffit textbook, which is a standard text used in training orthodontists, explains that ectopic eruption is caused by malposition of a permanent tooth bud and most commonly occurs in the maxillary first molars.[12] "Ectopic eruption of other teeth is rare, but can result in transposition."[13] The following three photographs provide examples of ectopic eruption:

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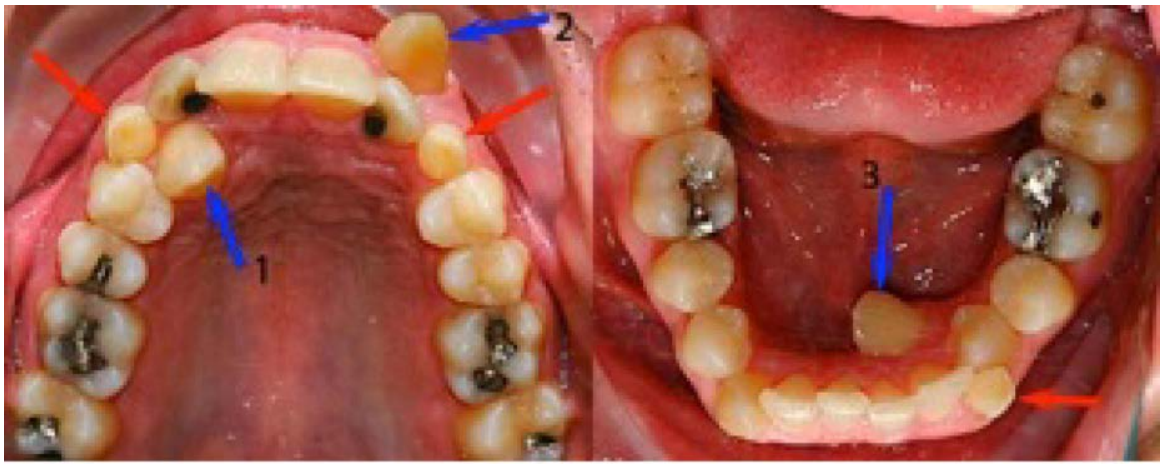
9 Vol. 1 at 174:16-17, A.R. at 1985.

10 *Id.* at 174:1, A.R. at 1985; R-49, Tadlock summary, at A.R. 1097-98, copy attached at **Appendix I**.

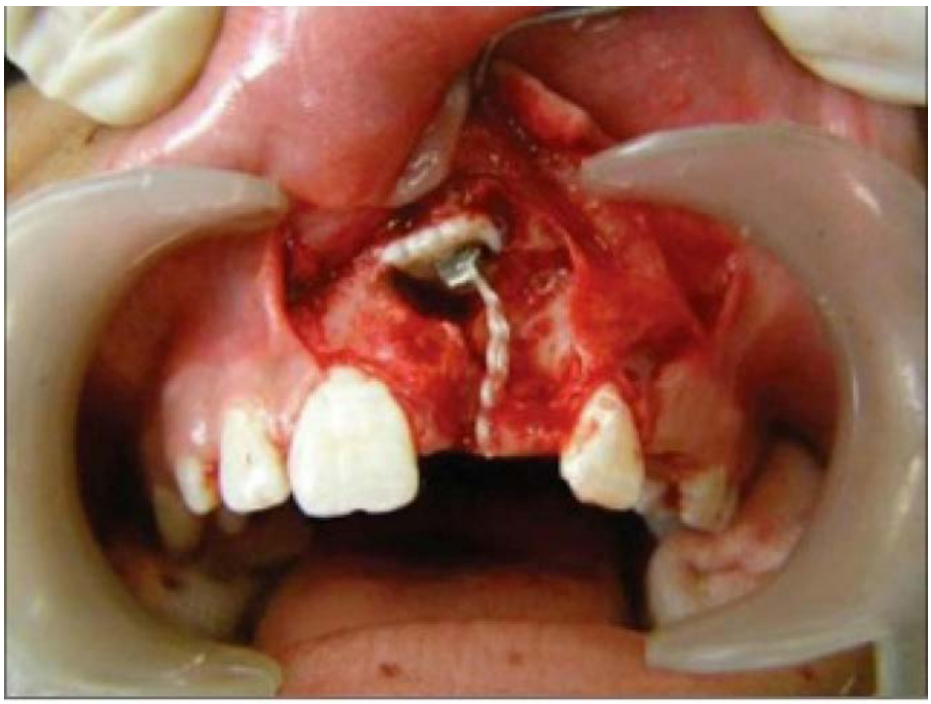
11 *Id.*at 114:18-23, A.R. at 1925.

12 *Id.* 1 at 143:17-18, 144:13-15, A.R. at 1954.

13 *Id.* at 145:8-10, A.R. at 1956.



R-31A (showing upper and lower ectopically-erupted canines (images of non-Antoine patients provided by Dr. Tadlock)), at A.R. 1031.[14]



See R-31L (showing an ectopically-erupted upper left central incisor (image of non-Antoine patient provided by Dr. Tadlock)).[15]

[14] *See* Vol. 1 at 149 for Dr. Tadlock's description of this non-Antoine patient's condition, at A.R. 1960. *Compare* photos of Antoine patients, included *infra* at pp. 18-19.

Scientific literature explains ectopic eruption.[16] And importantly, all of the articles surveyed by Dr. Tadlock describe ectopically erupted teeth as teeth that have erupted "in the wrong place."[17] Teeth can ectopically erupt in sinus cavities, or through the side of the face.[18]

4. Providers are required to rely on their education and training in making diagnoses and submitting requests for prior authorization and claims for Medicaid reimbursement.

The HLD index allows providers to score nine conditions in a patient's mouth. The nine conditions identified on the HLD index are conditions that are generally recognized in dentistry, including but not limited to cleft palate, ectopic eruption, overbite, and mandibular protrusion ("underbite"). The condition most relevant in this case is ectopic eruption.

The TMPPM includes narrative instructions for providers on how to score patients using the HLD index. The narrative includes a description of ectopic eruption. *See, e.g.*, Ex. R-15 at § 19.21 (2009), at **App. F**. Contrary to the ALJs' conclusion at page 16 of their PFD, the TMPPM does not define *or redefine* ectopic eruption for the purposes of determining Medicaid eligibility for

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15 *Id.* at 150 for Dr. Tadlock's description of this image, at A.R. 1961. *Compare* photos of Antoine patients, included *infra* at pp. 18-19.

16 Vol.1 at 152 (Dr. Tadlock explaining his literature search), A.R. 1963.

17 *Id.* at 153, at A.R. 1964.

18 *Id.* at 146:3-8, at A.R. 1957.

orthodontic benefits. HHSC's policy expert Dr. Altenhoff testified that the terms in the ectopic eruption instruction are not defined, but, rather, are accorded their plain and ordinary meaning in the English language. Vol. 1 at 103:8-12, A.R. at 1914; *see also* R-88, Proffer of Rebuttal Testimony from Dr. Linda Altenhoff (Medicaid did not intend, at any time, for the term "'ectopic eruption' to have a different meaning when used in the evaluation of Medicaid patients than is generally understood in the practice of dentistry" and "dentists [were] expected to employ the training and education they received as dentists in applying the terms used in the Provider Manual"), at copy attached at **Appendix J**; and Vol. 3 at 241:5-11 (where Deputy Inspector General for Enforcement testified to the same proposition), A.R. at 2528.

B. HHSC-OIG is responsible for protecting the Medicaid program from waste, fraud and abuse, and the Inspector General is required by law to impose a payment hold if he receives a credible allegation that a provider has committed fraud against the Medicaid program.

The HHSC-OIG is an independent oversight agency, administratively attached to HHSC. The Inspector General, who is appointed by the Governor, is responsible for investigating instances of waste, fraud and abuse in health care services provided by HHSC, and for enforcing state laws relating to the provision of those services. Tex. Gov't Code § 531.102; *see also* 1 Tex. Admin. Code § 371.1 (Purpose and Scope). Chapter 32 of the Human Resources Code authorizes

the Inspector General to recover damages and penalties from a person who presents or causes to be presented to the department a claim that "contains a statement or representation the person knows or should know to be false." Tex. Hum. Res. Code § 32.032(b)(1).

The statutory authority for the rules governing the Inspector General includes both chapters 32 and 36 of the Human Resources Code, and the Inspector General may take administrative enforcement measures against a person based upon a violation of either chapter. *See* Tex. Gov't Code § 531.001 *et seq*.; 1 Tex. Admin. Code § 371.1605 (2005); 1 Tex. Admin. Code § 371.1617(5)(B) (2005) (which references and incorporates the Texas Medicaid Fraud Prevention Act ("TMFPA")). Therefore, the standard in the TMFPA (ch. 36 of the Human Resources Code) for determining whether a person acts with the requisite scienter to commit an unlawful act is applicable in an enforcement action brought by the Inspector General, including in a payment hold proceeding. *See* Tex. Hum. Res. Code § 36.0011(a) (defining Culpable Mental State).[19]

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[19] The TMFPA establishes the requisite scienter as including either reckless disregard or conscious indifference:

> (a) For purposes of this chapter, a person acts "knowingly" with respect to information if the person:
>
> (1) has knowledge of the information;
>
> (2) acts with conscious indifference to the truth or falsity of the information; or
>
> (3) acts in reckless disregard of the truth or falsity of the information.

The Inspector General is required by law to impose a payment hold "on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or willful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23."[20] Tex. Gov't Code § 531.102(g)(2) (2011). "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." 42 C.F.R. § 455.23(a)(1) (emphasis added).

Fraud is defined in section 531.1011 of the Government Code as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or to another person, *and includes any act that constitutes fraud under applicable* federal or *state law*." Tex. Gov't Code § 531.1011(1) (emphasis supplied). The definition thus incorporates unlawful acts under the TMFPA.

> (b) Proof of the person's specific intent to commit an unlawful act under Section 36.002 is not required in a civil or administrative
>
> proceeding to show that a person acted "knowingly" with respect to information under this chapter.

Id.

[20] The mandatory payment-hold statutory framework was introduced through provisions of the Affordable Care Act, which amended the Social Security Act at sections 1862(o) and 1903(i)(2)(c). Section 1862(o) broadly requires suspension of payments pending an investigation of credible allegations of fraud. 42 U.S.C. § 1396b(i)(2)(c). Section 1903(2)(c) provides for withholding of federal funds where the State fails to implement section 1862(o). 42 U.S.C. § 1395y(o).

A credible allegation of fraud "may be an allegation, which has been verified by the State, from any source, including but not limited to the following: . . . claims data mining[,] . . . patterns identified through provider audits [or] law enforcement investigations." 42 C.F.R. § 455.2. An allegation is credible if it has "indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis." *Id.*

Evidence is presumed to have indicia of reliability and may be adopted by a court "without further inquiry if the defendant fails to demonstrate by competent rebuttal evidence that the information is materially untrue, inaccurate or unreliable." *United States v. Floyd*, 343 F.3d 363, 372-73 (3d Cir. 2003) (citing *United States v. Carbajal*, 290 F.3d 277, 287 (5th Cir. 2002)); *see also California v. Maki*, 704 P.2d 743, 750 (Cal. 1985) (a document will be considered to have a reasonable indicia of reliability where it is "the type relied upon by parties . . .").

The Inspector General also has statutory authority to impose a payment hold if he has "reliable evidence" a provider "committed fraud or willful misrepresentation regarding a claim for reimbursement." Tex. Hum. Res. Code § 32.0291(b) (2003).[21] The authority in chapter 32 of the Human Resources Code is duplicative of the authority in Government Code chapter 531. Importantly,

[21] Effective September 1, 2013 section 32.0291(b) of the Human Resources Code was amended. A new subsection (c) was added to the statute. The changes are prospective and do not apply to this case, which was heard in May 2013.

however section 32.0291(c) includes the standard for maintaining the payment hold: "The department shall discontinue the hold unless the department makes a *prima facie* showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible and material to the issue of fraud or willful misrepresentation." Tex. Hum. Res. Code § 32.0291(c) (emphasis added).[22]

This means that in a payment hold hearing, the Inspector General must present *prima facie* evidence that is relevant, credible and material, that the provider acted: (1) with knowledge of the truth or falsity of its representations to Medicaid; (2) with conscious indifference to the truth or falsity of its representations to Medicaid; or (3) with reckless disregard of the truth or falsity of its representations to Medicaid. Tex. Hum. Res. Code §§ 32.0291(c) (describing standard for maintaining payment hold), 36.011 (defining culpable mental state for violations of the TMFPA).

C. Antoine billed Texas Medicaid for more than $8 million in orthodontia services over a three-year period, and the Inspector General placed Antoine on payment hold.

Antoine voluntarily became a Texas Medicaid orthodontic provider. Between November 1, 2008 and August 1, 2011, the Medicaid program paid Antoine over $8,104,875.00, FoF 3, **App. A** at p. 3, at A.R. 1748. The Inspector

[22] *See In re E.I. DuPont de Nemours & Co.*, 136 S.W.3d 218, 223 (Tex. 2004) ("The prima facie standard requires only the 'minimum quantum of evidence necessary to support a rational inference that the allegation of fact is true.' *Tex. Tech Univ. Health Scis. Ctr. v. Apodaca*, 876 S.W.2d 402, 407 (Tex. App.—El Paso 1994, writ denied). ").

General initiated an investigation of Antoine in 2011. Vol. 3, 195:1, A.R. at 2482. During the time period of the investigation, Antoine treated approximately 6,550 Medicaid patients. Vol. 3 at 200:12, A.R. at 2487. In conducting his investigation, the Inspector General collected from Antoine a statistically valid random sample of 63 patient files from the population of Medicaid patients treated during the time period covered by the investigation (2008-2011). Vol. 3 at 200:20-208:7, A.R. at 2787.[23] The 63 patient files, which included diagnostic materials, such as x-rays, color photographs and three-dimensional models, were independently reviewed by two orthodontic experts: Dr. Charles Evans and Dr. Larry Tadlock. Based on the expert review of the 63-patient sample, HHSC-OIG instituted a 100% payment hold on claims for reimbursement by Antoine.[24] FoF 32, **App. A** at p. 13, at A.R. 1756.

Both orthodontic experts relied upon their education and training in reviewing the diagnostic materials and patient files for each of the 63 patients in the patient sample to evaluate the patients' conditions, and followed the criteria set forth in the TMPPM for the corresponding years of service (2008-2011). Both

[23] The reliability of the Inspector General's statistically valid sampling methodology was not at issue in the payment hold hearing. Antoine does not address it in its briefing and it is not before the Court in this suit for judicial review. In any event, the only evidence in the record regarding the validity of the Inspector General's sampling and extrapolation procedure is uncontroverted. *See* testimony of Deputy Inspector General for Enforcement, Vol 3, at 201-209, A.R. at 2488-96.

[24] Dr. Tadlock reviewed the sample after the payment hold was instituted, for purposes of testifying at the payment hold hearing regarding the patient files.

experts independently concluded Antoine inflated HLD scores submitted to Medicaid as a part of their prior authorization requests. Vol. 3 at 289:23-290:3, 295:22-296:2, A.R. at 2576-77, 2582-83. The Inspector General presented the following evidence, based on the experts' review of the sample of HLD score sheets submitted by Antoine:

- Of the 63 patients in the sample, Antoine dentists scored 61 (or 96.8%) as having severe handicapping malocclusions, *i.e.*, severely extreme deviations from the norm. *See* R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**.
- Antoine certified that every single one of these 61 patients had six or more ectopically-erupted teeth. Ex. P-64.01 through P-64.63; R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**.
- Antoine scored 50% or more of the allowable teeth as ectopic on each and every HLD score sheet Antoine submitted for comprehensive orthodontics authorization. *See* R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**.
- Not a single patient in the sample was eligible for Medicaid-covered comprehensive orthodontics without Antoine's scoring for ectopic eruption; further, Antoine did not submit any narratives for any of the 61 patients, even if services could be justified on other bases. Ex. P-64.01 through P-64.63; Vol. 4 at 70:13-19, A.R. at 2698.
- Dr. Kanaan scored 27 patients of the 63 patient sample. Of the 27 patients he scored, he scored 23 (85%) with the same eight teeth ectopic. Vol. 3 at 43-70, A.R. at 2330-57. Ex. P-64.01 through P-64.63; R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**.
- Antoine submitted prior authorization requests for comprehensive orthodontics under the code D8080 for 61 of the 63 patients. Ex. P-64.01 through P-64.63; Vol. 1, 176:14-20, 177:1-16, A.R. at 1987-88.

Dr. Larry Tadlock, D.D.S.,[25] testified as follows:

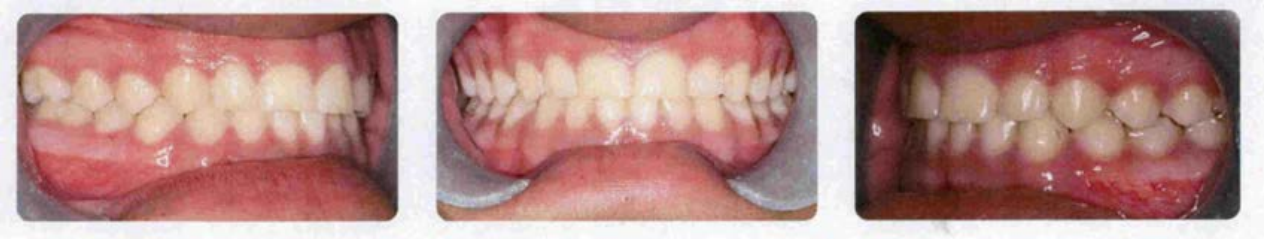
- Antoine submitted HLD score sheets that were false and misrepresented the condition of the patient's teeth. Vol. 1 at 176:14-20, 177:1-16, A.R. at 1987-88.
- 61 of the 63 HLD score sheets were incomprehensible because ectopic eruption is an extremely rare condition. Only between 1.5 and 9% of the population has even one ectopic tooth. Vol. 1 at 173:3-6, A.R. at 1984; *see also* R-51 at 8 (Thilander article describing ectopic eruption as an "anomaly" that occurrs in only 1.5-1.6% of a sample population of 4724 patients), copy at **App. H**.
- For ectopic eruption to occur more than once in the same patient is "infinitesimally smaller." Vol. 1 at 174:16-18, A.R. at 1985. *See also* R-31L, photograph of an actual ectopic eruption, copy, *supra*, at p 8.
- Because ectopic eruption is exceedingly rare, occurring in between 1.5-9% of the population, the chances of 61 patients in the 63-patient sample having 6 or more ectopic teeth in the front of their mouths is "not possible." Vol. 1 at 173:3-6, 175:1, A.R. at 1984, 1986.
- The chance of 100% of patients in a sample having not only one instance of an exceedingly rare condition, but always at least six instances, and always two or more bilateral instances, is "zero. It's not possible." Vol. 1 at 175:1, 176:23, A.R. at 1986-87; R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**.

The following examples show Antoine's scoring of three patients in the 63-patient sample:

[25] Dr. Tadlock has been an orthodontist since 1988 and is a board-certified orthodontist. He is also an Assistant Clinical Professor of Orthodontics at Baylor College of Dentistry, responsible for supervising patient care, teaching orthodontic residents, and performing research on orthodontics. Furthermore, he is one of only eight directors of the American Board of Orthodontics ("ABO") in the United States. As an ABO Director, Dr. Tadlock is responsible for creating, writing, and administering board certification exam for orthodontists. Specific to his experience with Medicaid, Dr. Tadlock has treated Medicaid patients who were accepted and treated at Baylor. He estimates he has assessed "several hundred" HLD score sheets for potential Medicaid patients while at Baylor. Vol. 1 at 146-48, A.R. at 1957-59.

Patient 1:

Pre-treatment intra-oral photos of Antoine Patient 1, P-01-0001:[26]

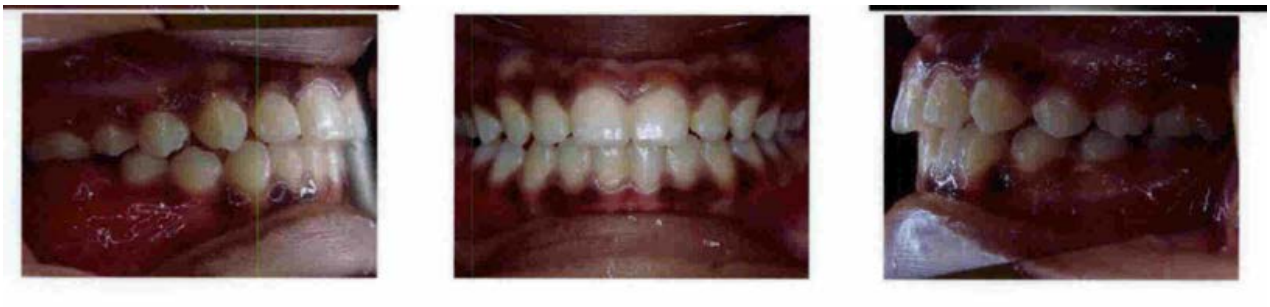


Antoine's HLD score sheet representing that Patient 1 has 8 ectopic teeth. P-01-0013:

See definitions/Instructions to score (previous page)				x5	= 4
Open Bite in mm. *See definitions/Instructions to score (previous page)*				x4	= ϕ
Ectopic Eruption (Anteriors Only) *Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding*	21 | 12 / 21 | 12			Each tooth x3	= 24
Anterior Crowding *10 point maximum total for both arches combined*		*Max.*	*Mand.*	= 5 pts.each arch	= ϕ

Patient 6:

Pre-treatment intra-oral photos of Antoine Patient 6. P-06-0003:[27]



P-06-0001:[27]

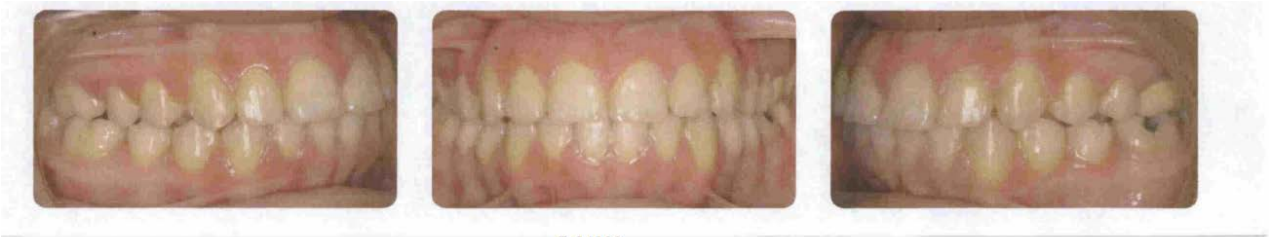
[26] Dr. Tadlock concluded that "[t]his patient's occlusion is near perfect. . . . it might qualify as passing the certification process from the American Board of Orthodonti[cs]. Vol. 1 at 158:18-23. *Compare* photos of true ectopic eruptions, included *supra* at pp. 8.

[27] This patient does not have a single ectopic tooth according to Dr. Tadlock, and does not suffer from a severe handicapping malocclusion. Vol. 1 at 160:14-24, A.R.at 1971.

Ectopic Eruption (Anteriors Only)			x4	=
Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding	21 | 12 21 | 12		Each tooth x3	= 24
Anterior Crowding *10 point maximum total for both arches combined*	*Max.*	*Mand.*	= 5 pts.each arch	=
Labio-Lingual Spread in mm.				=
TOTAL				=
Diagnosis				

Patient 59:

Pre-treatment intra-oral photos of Antoine Patient 59, P-59-0018:



P-01023

Antoine's HLD score sheet representing that Patient 59 has 10 ectopic teeth. P-59-0017:

Open Bite in mm. *See definitions/Instructions to score (previous page)*			x4	= 0
Ectopic Eruption (Anteriors Only) *Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding*	21 | 12 321 | 123		Each tooth x3	= 30
Anterior Crowding *10 point maximum total for both arches combined*	*Max.*	*Mand.*	= 5 pts.each arch	= 0 = 0

The Inspector General based his decision to impose the payment hold on *prima facie* evidence that Antoine fraudulently or willfully misrepresented HLD scores in prior authorization requests, in violation of Tex. Gov't Code § 531.102(a), and 1 Tex. Admin. Code §§ 371.1617(1)(A), (B), (I).[28]

[28] The Inspector General also found that Antoine billed for services not reimbursable, in violation of 1 Tex. Admin. Code § 371.1617(1)(K); and failed to maintain and provide required

D. Antoine requested a hearing on the payment hold, and, after the hearing and the ALJs' recommendation that HHSC order the Inspector General to lift the hold, the Executive Commissioner reversed the PFD and ordered the hold to remain in place.

Antoine requested an administrative hearing to appeal the payment hold. After notice, ALJs Howard Seitzman and Catherine Egan with the State Office of Administrative Hearings ("SOAH") conducted a hearing in May 2013. The issue to be decided was whether the Inspector General presented *prima facie* evidence that was relevant, credible and material that Antoine committed fraud or willful misrepresentations. Tex. Hum. Res. Code § 32.0291(b).

Importantly, the burden was not on the Inspector General to actually prove fraud or willful misrepresentations by a preponderance of evidence; rather, the question was only whether the Inspector General brought forward *prima facie* evidence.[29]

After the hearing, ALJs Seitzman and Egan issued a PFD recommending that HHSC order the Inspector General to lift the payment hold in its entirety. PFD,

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records, in violation of 1 Tex. Admin. Code § 371.1617(2)(A). As a result, Antoine failed to comply with Medicaid program requirements, and a payment hold was authorized under the Inspector General's discretionary authority. However, the Inspector General's authority to impose discretionary payment holds was challenged and then struck in *Harlingen Family Dentistry v. Tex. Health & Human Servs. Comm'n*, 452 S.W.3d 479 (Tex. App.—Austin 2014, pet. filed). Therefore, Defendants confine their arguments to the mandatory payment hold under the credible allegation of fraud standard as codified in 42 C.F.R. § 455.23, Tex. Gov't Code § 531.102(g)(2) (2011), and Tex. Hum. Res. Code § 32.0291(b).

[29] The substantive allegations of Medicaid fraud against Antoine will be addressed in a lawsuit brought by the State of Texas against Antoine and five other groups of provider defendants. *State of Texas v. Nazari*, Cause No. D-1-GN-14-005380 (53rd Dist. Ct., Travis County, Texas).

dated Nov. 4, 2013, A.R. at 1193-1238. The Inspector General timely filed Exceptions to the PFD. Tex. Gov't Code § 2001.062(b); 1 Tex. Admin. Code §§ 155.507(c)(1), 357.497. *See* Exceptions, dated Nov. 22, 2013, A.R. at 1257-1344. Antoine filed a Response to the Inspector General's Exceptions, and the ALJs issued a letter recommending an insignificant modification to their PFD. *See* Letter, dated Jan. 16, 2014, A.R. at 1375-76.[30] HHSC issued a Final Order, adopting the Inspector General's Exceptions and maintaining the payment hold. *See* Order, dated Feb. 27, 2013, A.R. at 1387-1422. HHSC's Final Order was issued by HHSC ALJ Rick Gilpin, who the Executive Commissioner designated to review the PFD and issue the final agency decision. *See* 1 Tex. Admin Code § 371.1617(a)(3); 1 Tex. Admin Code § 357.483(a)(1)-(2). Subsequently, the Inspector General filed a motion for rehearing. Mot., dated Apr. 2, 2014, A.R. at 1552-1650.[31]

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[30] Antoine erroneously states that the ALJs, in their letter of January 16, 2014, "overruled" the Inspector General's Exceptions. Antoine Brief at 6. This is false. Although the Exceptions are served on the ALJ by rule, by statute exceptions are directed to the final agency decision maker, in this case, to the Executive Commissioner. *See* Tex. Gov't Code § 2001.062(a)(2). Regardless, on the face of their letter, the ALJs did not purport to overrule the Exceptions. Rather, they stated that they did not agree with the Exceptions. A.R. at 1375-76.

[31] Antoine also filed a motion for rehearing, erroneously with SOAH instead of with HHSC Appeals Division. Mot., dated Mar. 17, 2014, A.R. at 1423-65; *see also* Tex. Gov't Code § 2001.146 (motions for rehearing procedures); 1 Tex. Admin. Code § 357.488(b) (Filing and Serving of Documents ("Documents are considered filed only when received by the HHSC Appeals Division . . ."); 1 Tex. Admin. Code § 357.497(e) ("When the judge issues a proposal for decision, the referring agency's rules govern final orders and motions for rehearing."). Because Antoine filed the motion for rehearing in the wrong forum, the motion was a nullity, and the Executive Commissioner was free to disregard it.

After reviewing the PFD, the Inspector General's Exceptions, Antoine's Response to the Exceptions, the ALJs' letter, and the additional arguments raised in the Inspector General's motion for rehearing, the Executive Commissioner issued the Amended Final Order at issue in this suit. *See* Am. Final Order, dated, May 2, 2014, at **App. A**, and A.R. at 1744-85.

Antoine filed a motion for rehearing, which HHSC overruled by operation of law. A.R. at 1787-1810. This appeal followed.

IV. STANDARD OF REVIEW

The Court reviews HHSC's Amended Final Order under the substantial evidence rule. Tex. Gov't Code § 2001.174. Specifically, the Administrative Procedure Act ("APA") provides that the Court "may not substitute its judgment for the judgment of the state agency on the weight of the evidence on questions committed to agency discretion but . . . may affirm the agency decision in whole or in part" if the order is supported by substantial evidence. Tex. Gov't Code § 2001.174(1). The APA provides that the Court's review of the agency decision is limited to the administrative record. Tex. Gov't Code § 2001.175(e).

A court reviewing an agency decision may affirm the decision on any grounds that would support the decision, and is not "bound by the reasons given by an agency in its order, provided there is a valid basis for the action taken by the agency." *Tex. Health Facilities Comm'n. v. Charter Med.-Dallas, Inc.*, 665 S.W.2d

446, 452 (Tex. 1984); *see also Tex. Emp't Comm'n v. Hays*, 360 S.W.2d 525, 527 (Tex. 1962). A reviewing court may uphold an agency action based on any legal basis shown in the record. *Bd. of Trs. of the Emps. Ret. Sys. v. Benge*, 942 S.W.2d 742, 744 (Tex. App.—Austin 1997, writ denied). The test for review of an agency action is not whether in the reviewing court's own opinion an agency reached the correct conclusion, but whether some reasonable basis exists in the record for the agency's action. *State v. Pub. Util. Comm'n*, 883 S.W.2d 190, 203 (Tex. 1994). If reasonable minds could have reached the conclusion that the Commission reached on the record presented, then the Court must uphold the Commission's Final Order. *Bd. of Law Exam'rs v. Stevens*, 868 S.W.2d 773, 777-788 (Tex. 1994), *cert. denied, Stevens v. Bd. of Law Exam'rs*, 512 U.S. 1206, 114 S. Ct. 2676 (1994); *Tex. State Bd. of Med. Exam'rs v. Birenbaum*, 891 S.W.2d 333, 337 (Tex. App.—Austin 1995, writ denied).

In applying the substantial evidence standard to an agency's decision, the reviewing court may not substitute its judgment for that of the agency as to the weight of the evidence on questions committed to agency discretion. *Stevens*, 868 S.W.2d at 778; *Gulf States Utils. Co. v. Pub. Util. Comm'n*, 841 S.W.2d 459, 474 (Tex. App.—Austin 1992, writ denied). Although substantial evidence is more than a mere scintilla, the evidence may actually preponderate against the agency decision and yet still amount to substantial evidence supporting the result reached

by the agency. *State v. Pub. Util. Comm'n*, 883 S.W.2d at 204; *City of El Paso v. Pub. Util. Comm'n*, 883 S.W.2d 179, 185 (Tex. 1994); *see also Tex. State Bd. of Dental Exam'rs v. Sizemore,* 759 S.W.2d 114, 116 (Tex. 1988) (court must consider evidence as a whole).

Under substantial evidence review, the Court presumes that substantial evidence supports an agency's decision, and the appellant has the burden of overcoming this presumption. *Graff Chevrolet Co. v. Tex. Motor Vehicle Bd.*, 60 S.W.3d 154, 159 (Tex. App.—Austin 2001, pet. denied); *Lewis v. Southmore Savings Ass'n*, 480 S.W.2d 180, 183 (Tex. 1972) (plaintiff had "burden of proving" Commissioner's order "was not supported by substantial evidence"); *see also City of El Paso v. Pub. Util. Comm'n*, 883 S.W.2d at 184 ("At its core, the substantial evidence rule is a reasonableness test or a rational basis test. . . . The reviewing court, then, concerns itself with the reasonableness of the administrative order, not the correctness of the order.") (citation omitted).

An agency's decision should be reversed or remanded only if the absence of substantial evidence has prejudiced a party's substantial rights. *Locklear v. Tex. Dep't of Ins.*, 30 S.W.3d 595, 597 (Tex. App.—Austin 2000, no pet.). A court may only reverse or remand a matter "for further proceedings":

> if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
>
> (A) in violation of a constitutional or statutory provision;

> (B) in excess of the agency's statutory authority;
>
> (C) made through unlawful procedure;
>
> (D) affected by other error of law;
>
> (E) not reasonably supported by substantial evidence considering the reliable and probative evidence in the record as a whole; or
>
> (F) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Tex. Gov't Code § 2001.174(2).

Antoine contends that the Executive Commissioner exceeded his authority when he reversed several of the ALJs' findings of fact and conclusions of law. Whether the Executive Commissioner exceeded his authority is a question of law to be decided by this Court *de novo*. *See, e.g.*, *Tex. Ass'n of Psychological Assocs. v. Tex. State Bd. of Exam'rs of Psychologists*, 439 S.W.3d 597, 602 (Tex. App.—Austin 2014, no pet.) (court reviews exercise of authority *de novo*).

Antoine also argues that because the Executive Commissioner exceeded his authority, the Amended Final Order is an abuse of discretion. Antoine Brief, at 19. An agency's exercise of its discretion "may *only* be reversed as being arbitrary and capricious if it constitutes a clear abuse of discretion." *State v. Pub. Util. Comm'n of Tex.*, 883 S.W.2d at 201 (emphasis added); s*ee also City of El Paso v. Pub. Util. Comm'n*, 883 S.W.2d at 184 (citing *Gerst v. Nixon*, 411 S.W.2d 350, 360 (Tex. 1966) ("An agency's decision is arbitrary or results from an abuse of discretion if the agency: (1) failed to consider a factor the legislature directs it to consider; (2)

considers an irrelevant factor; or (3) weighs only relevant factors that the legislature directs it to consider but still reaches a completely unreasonable result."); *Heritage on the San Gabriel v. Tex. Comm'n on Envt'l Quality*, 393 S.W.3d 417, 423 (Tex. App.—Austin 2012, pet denied) (same proposition).

V. SUMMARY OF THE ARGUMENT

This case presents two issues for consideration by the Court. The first issue is whether the Executive Commissioner exceeded his authority in adopting the Amended Final Order on behalf of HHSC. The second is whether the Amended Final Order is supported by substantial evidence.

The Executive Commissioner acted solidly within his lawful authority and within his sound discretion in entering the Amended Final Order. The Executive Commissioner correctly determined that the ALJs failed to properly interpret and apply applicable federal and state law, HHSC rules, and Texas Medicaid policy. Accordingly, the Executive Commissioner was fully authorized to correct the ALJs' errors. *See* Tex. Gov't Code § 2001.058(e)(1) (authorizing an agency to change a finding of fact or conclusion of law in a PFD if ALJ did not properly apply or interpret applicable law, agency rules or written policy); *Froemming v. Tex. State Bd. of Dental Exam'rs*, 380 S.W.3d 787, 793 (Tex. App.—Austin 2012, no pet.) (board met requirements allowing for modification because board explained that ALJ had "failed to properly 'apply or interpret applicable law,

agency rules, and written policies'"); *Sanchez v. Tex. State Bd. of Med. Exam'rs*, 229 S.W.3d 498, 516 (Tex. App.—Austin 2007, no pet.) (agency has discretion to modify ALJ's PFD under 2001.058(e)); *see also Akin v. Tex. State Bd. of Dental Exam'rs*, No. 03-14-00390-CV, 2015 WL 1611803, at *4-5 (Tex. App.—Austin Apr. 9, 2015, no pet. hist.) (same).

The Executive Commissioner was also authorized to change the ALJs' PFD to the extent that they relied on a prior administrative decision that was incorrect or should be changed. Tex. Gov't Code § 2001.058(e)(2).

Antoine spends almost the entirety of its brief arguing the issue that the Executive Commissioner exceeded his authority in adopting the Amended Final Order, and fails to address the issue of substantial evidence. Antoine, therefore, has failed to meet its burden to show that the Amended Final Order is not supported by substantial evidence. *See Graff Chevrolet*, 60 S.W.3d at 159 (plaintiff has burden of proving that agency's order is not supported by substantial evidence). Nevertheless, Defendants will show that the Amended Final Order is fully supported by substantial evidence in the administrative record that: (a) the ALJs misinterpreted and misapplied Texas law and Medicaid policy, and (b) the Inspector General's determination to impose the payment hold was based on *prima facie* evidence that was relevant, credible and material to the question of fraud or willful misrepresentation.

Finally, Antoine presents no evidence or argument in support of its contention that the Executive Commissioner acted arbitrarily and capriciously. This point of error should, therefore, be overruled.

VI. ARGUMENT

A. The Executive Commissioner acted within his sound discretion, and he did not exceed his authority, in entering the Amended Final Order affirming the payment hold issued by HHSC-OIG.

In their PFD, the ALJs misconstrued Medicaid policy, ignored evidence, disregarded competent expert testimony proffered by the Inspector General, and created "expert" testimony that was not offered by Antoine.

The Executive Commissioner, acting within his authority, corrected the ALJs' erroneous policy interpretations, and their flawed findings and conclusions that flowed from their initial errors. The Executive Commissioner fully explained each of his changes, as is required by the APA, and the Amended Final Order should, therefore, be affirmed.

1. The ALJs misunderstood and misapplied Texas Medicaid policy.

The PFD concluded that the Inspector General failed to present *prima facie* evidence that is "credible, reliable, or verifiable, or that has indicia of reliability" that ADC has engaged in fraud or willful misrepresentation in filing its requests for prior authorization with Texas Medicaid, and consequently the ALJs recommended that the Executive Commissioner order the Inspector General to lift the payment

hold in its entirety. *See* PFD proposed FoF Nos. 48-50, at pp. 40-41, A.R. at 1234-35.

The ALJs' findings, conclusions, and ultimate recommendation rested on their erroneous determination that Texas Medicaid adopted a "special" definition of the term "ectopic eruption" that is subjective, and liberal, and broader than the interpretation of the phrase in the general practice of dentistry. In making this determination, the ALJs ignored both the plain language of the policy and the testimony of the HHSC witnesses – the only witnesses qualified to testify what Texas Medicaid policy means. The ALJs' mistaken construction of ectopic eruption effectively destroyed the limitations of Texas law and Medicaid policy which restrict orthodontia to children who suffer from a "severe handicapping malocclusion." 25 Tex. Admin. Code § 33.71.

Rather than concluding that the definition of ectopic eruption is open to subjective interpretation, the ALJs should have adopted the agency's own construction, as presented by agency staff witnesses and by the Inspector General's testifying expert.[32] The record presented by agency staff witnesses and

[32] The ALJs discounted Dr. Tadlock's testimony, stating that he "assisted" in scoring Medicaid patients at Baylor and that "he has no Medicaid patients of his own." PFD at 24. In doing so, the ALJs disregarded evidence: (1) Dr. Tadlock has treated, and supervised treatment by orthodontic residents, of Medicaid patients, (2) has reviewed several hundred HLD score sheets. Vol. 1, at 131:16-23, A.R. at 1942 (stating the faculty makes diagnostic and treatment decisions and treat patients "with the students"). Also, the ALJs ignored the fact Dr. Tadlock is the only board-certified orthodontist who testified in this case; in fact, he is one of only eight directors nationally on the American Board of Orthodontists and is the incoming Chair of the

disinterested experts shows that the TMPPM's instruction regarding ectopic eruption is not vague and is in fact consistent with the widely recognized understanding of ectopic eruption in the dental community. *See* Vol.1, 236:3-15, A.R. at 2047 (Dr. Tadlock testifying that the definition of ectopic eruption is learned at every dental school and in every orthodontic program in the country);[33] *see also* Vol. 2 at 84:23-24, A.R. at 2135 (where Antoine's own expert Dr. Orr acknowledged that "ectopic" means "out of place," and that this meaning is found "in medicine all over.").

The record reflects HHSC's long-standing requirement that medical and dental terms should be interpreted for Medicaid purposes just as those terms are construed by practitioners for their non-Medicaid patients. Ex. R-14, (2008 TMPPM) at § 1.2.5, at **App. G**; Ex. R-15 (2009 TMPPM), at § 1.4.5, at **App. F**;

ABO clinical committee, which administers the clinical exam to orthodontic residents nationally. Vol. 1, at 133:10-134:20, A.R. at 1944-45.

[33] The ALJs apparently concluded Dr. Tadlock relied exclusively on the Proffit textbook in defining "ectopic eruption." PFD, at 17, A.R. at 1211. While the Proffitt textbook is certainly a generally-accepted textbook, Dr. Tadlock also testified regarding his review of medical literature, including nearly 1,300 articles discussing "ectopic eruption." Vol. 1, at 152:1-154:11, A.R. at 1963-65. As Dr. Tadlock noted, discussing medical and scientific literature back to 1938, "The bottom line is this, there are no references to teeth that are rotated or tipped. There *are* -- *ectopic eruption in every article is a tooth that is away from, it is out of place, it is in the wrong place***.** Not most of them, many of -- not most of them, all of them." *Id*. at 153:1-6 (emphasis added), A.R. at 1864; *see also* 154:4-11, A.R. at 1965 ("*But in every case, they are teeth that are out of the position***,** they are not here in turn; they are out, they are somewhere else. *That's the definition of ectopic eruption that existed that started in 1938 or somewhere before then. It has existed in its same form since then, up to '87 when Dr. Proffit wrote its eruption in the wrong place, and that definition has not changed.*") (emphasis added).

Vol. 1, 93:2-9, 94:16-23, 111:11-14, A.R. at 1904-05; Vol. 3, 193:5-194:1, 241:5-11, 249:11-250:19, A.R. at 2480-81, 2528, 2536-37.

Dr. Tadlock's expert testimony that ectopic eruption is generally understood within the dental and orthodontic profession as a "tooth that is out of place," is not only supported by the medical literature and the testimony of the State's Medicaid policy witness, Dr. Altenhoff, it is also the *only* competent expert testimony of record.[34] *See generally* Dr. Tadlock's testimony at Vol. 1, at 152:1-154:11, A.R. at 1963-65; *see also* Vol. 3, 240:22-241:4, A.R. at 2527-28 (Deputy Inspector General for Enforcement testifying that Dr. Altenhoff is the person most knowledgeable about Medicaid policy), and Vol. 3, 174:19-175:7 (Antoine's dentist Dr. Kanaan acknowledging that Dr. Altenhoff is the expert on what Medicaid covers and does not cover), A.R. at 2461-62.[35]

The ALJs' error in disregarding the testimony of Drs. Tadlock and Altenhoff was magnified because they misconstrued what Antoine's orthodontist, Dr. Wael

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[34] The ALJs discussion of other alleged differences between the Medicaid Manual and the general (i.e., non-Medicaid) practice of orthodontics is flawed. *See* PFD, at 18-19, A.R. at 1212-13. The ALJs' analysis is flawed because they rely on excerpts from decades-old articles by Draker (R-37, published in 1958), Parker (P-84, published in 1998), and Andrews (P-83, published in 1972), none of which were admitted into evidence for the truth of the matter. *See, e.g.*, PFD at 19, fn. 101, A.R. at 1213. Moreover, many of the "differences" relate to the measurement of a condition for the purposes of limiting Medicaid eligibility, e.g., open bite, anterior crowding, exclusion of posterior teeth for the purposes of scoring (as opposed to defining) ectopic eruption, not the creation of a Medicaid-only definition for these conditions that expands eligibility far beyond the commonly-recognized meaning of these terms.

[35] When asked by the ALJ if conditions would qualify as ectopic eruption after the January 2012 clarifying amendment, Dr. Kanaan answered: "You would need to ask Dr. Altenhoff." Vol. 3, 174:19-175:4, A.R. at 2461-62.

Kanaan actually said. The ALJs incorrectly asserted that Dr. Kanaan concluded that Patients 36, 37, 42, 43, and 47 each presented a "severe handicapping malocclusion." *See* PFD at 26-27, A.R. at 1220-21. This statement is not supported by the evidentiary record. Out of these patients, the only ones for which Dr. Kanaan made such statement were Patients 36 and 47. Vol. 3, at 149:3-4, A.R. at 2436 (describing Patient 36 as a "100 percent dysfunctional handicapping case"); Vol. 3, at 161:23-162:6, A.R. at 2448-49 (opining that Patient 47 presented "dental necessity, medical necessity, hundred -- hundred percent handicap malocclusion"). For each of the other patients, Dr. Kanaan merely stated that the patient, in his opinion, needed orthodontic treatment. Vol. 3, at 156:16-19 (Patient 37) (answering "100 percent, 120 percent" when asked patient had a "true orthodontic need"), A.R. at 2443; Vol. 3, at 155:1-6 (Patient 42) (answering "correct, hundred percent" when asked if case was an example of "true orthodontic need"), A.R. at 2442; Vol. 3, at 159:12-16 (Patient 43) (agreeing that the patient had a "true orthodontic need for braces"), A.R. at 2446. This distinction is more than a semantic one, as the standard for Medicaid coverage is "severe handicapping malocclusion" and not merely "true orthodontic need." *See* 25 Tex. Admin. Code § 33.71.

2. The proper interpretation of Texas Medicaid policy is a question of law to be determined by the Executive Commissioner.

The proper interpretation and application of statutory provisions governing Medicaid, and Medicaid policy are questions of law committed to the discretion of the Executive Commissioner - not the ALJs. Thus, the Executive Commissioner was not bound to accept the ALJs' determinations regarding Medicaid's use of the phrase "ectopic eruption." *See, e.g.*, *R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W. 3d 619, 629 (Tex. 2011) ("We must uphold the enforcing agency's construction if it is reasonable and in harmony with the statute."); *Sw. Pharm. Solutions, Inc., v. Tex. Health & Human Servs. Comm'n*, 408 S.W.3d 549, 557-58 (Tex. App.—Austin 2013, pet. denied) ("As the agency designated to administer Medicaid, HHSC is charged with overseeing a complex regulatory scheme, and deference to its construction is particularly important.") (citing *Texas Citizens*, 336 S.W.3d at 629)); *Froemming*, 380 S.W.3d at 793 (board met requirements allowing for modification where board explained that ALJ had "failed to properly 'apply or interpret applicable law, agency rules, and written policies'"); *Akin*, 2015 WL 1611803, at *4-5.

In *Akin*, the district court approved the board's modifications of the ALJ's proposed finding and conclusion because the ALJ failed to properly interpret or apply the statute to facts in evidence. *Id.* While the ALJ in *Akin* found Akin did not commit a dishonest act, the board provided examples of evidence that showed the

dentist was dishonest or practicing dentistry illegally, and the district court upheld 34the board's order reversing the ALJ's PFD. *Id.* The *Akin* court also quoted with approval *Smith v. Montemayor*, 03-02-00466-CV, 2003 WL 21401591, at *8 (Tex. App.—Austin June 19, 2003, no pet.). *Akin*, 2015 WL 1611803, at *5 n.6 ("'An agency enjoys ***complete discretion*** in modifying an ALJ's findings and conclusions when those findings and conclusions reflect a lack of understanding or misapplication of the existing laws, rules, or policies.'") (emphasis added).

a. The rules of statutory construction govern questions of agency policy and administrative rules.

In determining the proper scope and limitations of Medicaid policy, and the administrative rules of HHSC implementing Medicaid policy, the Executive Commissioner – and this Court on judicial review – are guided by the rules governing statutory construction. *See*, *Boswell v. Brazos Electric Power*, 910 S.W.2d 593, 599-600 (Tex. App.—Fort Worth 1995, writ denied) ("Rules of statutory construction apply equally to the construction of an administrative order."); Tex. Gov't Code § 311.002(4).

In construing a statute, the primary objective is to ascertain and give effect to the intent of the legislature. *Cont'l Cas. Ins. Co. v. Functional Restoration Assocs.*, 19 S.W.3d 393, 402 (Tex. 2000) (citing *Liberty Mut. Ins. Co. v. Garrison Contractors, Inc.*, 966 S.W.2d 482, 484 (Tex.1998)); *Texas Citizens*, 336 S.W.3d at 624; Tex. Gov't Code § 312.005. In so doing, courts look first to the plain and

common meaning of the statute's words. *See* Tex. Gov't Code § 311.005; *Fitzgerald v. Advanced Spine Fixation Sys., Inc.*, 996 S.W.2d 864, 865 (Tex.1999). Courts will consider the entire statute, not simply the disputed portions. *State v. Terrell*, 588 S.W.2d 784, 786 (Tex.1979). Each provision must be construed in the context of the entire statute of which it is a part. *Bridgestone/Firestone, Inc. v. Glyn-Jones*, 878 S.W.2d 132, 133 (Tex.1994) ("Only in the context of the remainder of the statute can the true meaning of a single provision be made clear.").

The Code Construction Act, Government Code chapter 311, provides additional guidelines for statutory interpretation. For instance, words and phrases should be read in context, not in isolation. Tex. Gov't Code § 311.011(a). Words and phrases that have acquired a technical or particular meaning shall be construed accordingly. Tex. Gov't Code § 311.011(b). The entire statute is intended to be effective. Tex. Gov't Code § 311.021(2). A just and reasonable result is intended; one that is feasible of execution. Tex. Gov't Code §§ 311.021(3), (4). The public interest is favored over any private interest. Tex. Gov't Code § 311.021(5).

In construing a statute a court may consider: (1) the object sought to be obtained; (2) the consequences of a particular construction; and (3) an agency's construction of a statute that is committed to the agency for enforcement. Tex. Gov't Code §§ 311.023(1), (5), (6).

b. The ALJs ignored statute, rules, and evidence and made three fundamental errors in interpreting and applying Texas Medicaid policy.

The Executive Commissioner acted solidly within his authority and sound discretion when he applied principles of statutory construction and declined to adopt the ALJs' and Antoine's misconstruction of Texas Medicaid policy. The Executive Commissioner corrected three fundamental errors in the ALJs' interpretation of Texas Medicaid Policy. First, the ALJs erroneously determined that the TMPPM somehow includes a special definition of ectopic eruption, a definition wide open to various subjective professional opinions and capable of different interpretations in different circumstances. Under this interpretation, the ALJs found that Antoine's scoring of twisted and rotated teeth as ectopic was acceptable. However twisted and rotated teeth are normal and do not impair function. *See, e.g.*, note 36, *infra*. Therefore, the ALJs' misinterpretation runs afoul of the plain language of Texas Medicaid policy, as set forth in the TMPPM and in HHSC rules, which clearly states the Medicaid orthodontia benefit is limited to cases where the patient presents a "severe handicapping malocclusion." 25 Tex. Admin. Code § 33.71; Ex. R-15 at § 19.19, at **App. F**. Thus, the ALJs' erroneous interpretation of Medicaid policy violates a fundamental requirement that law and agency policy should be construed consistently with their plain language. *Texas Citizens*, 336 S.W.3d at 624.

Second, the specific instruction regarding "ectopic eruption" should have been construed by the ALJs in the overall context of Medicaid's limited orthodontia benefit. Tex. Gov't Code § 311.011(a). Instead, the ALJs examined the ectopic eruption discussion in the TMPPM in isolation, and without regard to the overall objectives of Texas Medicaid policy. In fact, the ALJs applied an interpretation of the meaning of ectopic eruption that was not only contrary to plain language of Medicaid law and policy, it was also fundamentally at cross-purposes with the overall objective of the policy. The ALJs' impermissibly liberal interpretation of the meaning of ectopic eruption[36] was erroneous because it violated the TMPPM's clear direction that providers should be *conservative* in scoring the HLD. *See, e.g.*, Ex. R-15 at § 19.21, at **App. F**. ("Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case.").[37]

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[36] The absurdity of the ALJs' construction of the instruction is illustrated by Antoine's own expert, Dr. Orr, who testified that in his broad reading of the Manual's instruction ". . . to me, semantically it has a limitless interpretation as far as the recognition by competent dentists of teeth out of position." Vol. 2, 148:23-149:2, A.R. at 2199-2200. The ALJs' interpretation of the instruction renders the word "unusual" in the instruction meaningless, a result that violates canons of statutory construction. *See, e.g.*, *TGS-NOPEC Geophysical Co. v. Combs*, 340 S.W.3d 432, 439 (Tex. 2011) ("We presume that the Legislature chooses a statute's language with care, including each word chosen for a purpose, while purposefully omitting words not chosen."). As Dr. Tadlock testified, based on medical literature, nearly 80 percent of the population has teeth that are crooked to some degree, and therefore there is nothing "unusual" for teeth to erupt in a manner that is not straight or ideal. Vol. 1, at 157, A.R. at 1968.

[37] The idea that HHSC would eviscerate Medicaid orthodontic policy and regulatory benefit limitations by promulgating a new and more liberal definition of a widely understood term – one of eight on the HLD index – is, at best counterintuitive. At worst, the notion is absurd and contrary to state and federal law.

Indeed, the ALJs' construction of "ectopic eruption" in isolation from the overall context of Medicaid's policy directives also violated the requirement to consider the disputed portions of the policy within the policy as a whole. *Bridgestone/Firestone, Inc. v. Glyn-Jones*, 878 S.W.2d 132, 133 (Tex. 1994).

The ALJs' construction of Medicaid policy violated several additional tenets of statutory construction in the Code Construction Act:

- The ALJs ignored the meaning of ectopic eruption that is generally understood in the dental profession, in violation of Tex. Gov't Code § 311.011(b);
- The ALJs' broad interpretation of ectopic eruption rendered the limiting language in State regulations (e.g., 25 Tex. Admin. Code § 33.71) and in Medicaid policy (*e.g.*, Ex. R-15, at § 19.19, at **App. F**) ineffective, in violation of Tex. Gov't Code § 311.021(2);
- The ALJs' interpretation leads inevitably to an "ectopic eruption in the eye of the beholder" standard, which is absurd given scarce Medicaid resources and HHSC statements regarding the limited nature of the orthodontic benefit. Opening the definition to the subjective interpretation of providers ("if the provider says its ectopic eruption, then it's ectopic eruption") also deprives Medicaid policy makers of their statutory and regulatory responsibility for defining the scope of the benefit. Thus the ALJs' interpretation violates Tex. Gov't Code § 311.021(3) (a just and reasonable result is intended), and Tex. Gov't Code § 311.021(4) (a result feasible of execution is intended);
- The ALJs' construction favors only the private pecuniary interests of unscrupulous providers, at the expense of taxpayers and truly eligible Medicaid recipients. Thus, the ALJs' interpretation violates Tex. Gov't Code § 311.021(5) (public interest is favored over any private interest);
- The ALJs failed to consider the purposes of Medicaid policy: their construction does not advance the goal of preserving scarce Medicaid dollars by limiting orthodontic reimbursements to cases of severe

handicapping malocclusion. Thus, the ALJs' interpretation violates Tex. Gov't Code § 311.023(1); and

- The ALJs failed to consider the consequences of their interpretation. Under their interpretation, any provider's prior authorization request for comprehensive orthodontia will be approved, so long as the provider scores the HLD with a 26 or greater – without regard to the true condition of the patient. This has far reaching implications for the Medicaid program, particularly in light of the ALJs' acknowledgement (proposed FoF No. 25) that HHSC's Medicaid claims processing contractor, TMHP, abrogated its responsibility to review clinical data submitted with prior authorization requests. The ALJs' interpretation violates Tex. Gov't Code § 311.023(5).

Third, the ALJs' interpretation of the Medicaid meaning of ectopic eruption was contrary to HHSC's long-held and consistent construction of the phrase. The Inspector General presented evidence in the hearing that a January 2012 amendment to the TMPPM language addressing ectopic eruption was intended to clarify the Medicaid program's long-standing interpretation, not to implement a substantive change in policy. *See* testimony of Dr. Linda Altenhoff, Vol, 1 at 93:2-9, 94:16-23, A.R. at 1904-05; and testimony of Deputy Inspector General for Enforcement, Vol. 3 at 193:5-194:1, 294:21-23, A.R. at 2480-81, 2581. This testimony from Medicaid program officials – the only witnesses competent to testify to the meaning of Medicaid policy – was uncontroverted.

Nevertheless, the ALJs erroneously concluded that the January 2012 language was intended to effect a substantive change to the "definition" of ectopic eruption. On appeal, Antoine characterizes the ALJs' determinations regarding the

effect of the January 2012 language change as finding of adjudicative fact that the Executive Commissioner was not allowed to alter. Antoine Trial Brief, at 9-10. Antoine is wrong. Whether the language change in the TMPPM was intended to be substantive or clarifying is a question of law, committed to the discretion of the Executive Commissioner. *Sw. Pharm. Solutions*, 408 S.W.3d at 561-62; *Boswell*, 910 S.W.2d at 599-600. The Executive Commissioner was fully authorized to correct the ALJs' error of law.

c. The Executive Commissioner was fully authorized to find error in the ALJs' reliance on incorrectly decided prior findings.

The Executive Commissioner correctly found that the ALJs erred to the extent that they relied on certain findings of fact in HHSC's final order in *Harlingen Family Dental v. Tex. Health & Human Servs. Comm'n*. The Executive Commissioner expressly disapproved of *Harlingen* Findings of Fact Nos. 29, 31, and 33 and declared that these findings were incorrectly decided and should not be relied on in this case or any other case. *See* Tex. Gov't Code § 200l.058(e)(2) (authorizing an agency to modify a PFD when it relies on a prior administrative decision that is "incorrect or should be changed").[38] Specifically, the Executive

[38] Antoine has waived its argument regarding the *Harlingen* case. Antoine Brief at 15-18. Antoine failed to raise this point in its motion for rehearing. Rather, in its motion for rehearing, Antoine only argued, in Point of Error 5, that by disavowing the *Harlingen* findings the Executive Commissioner applied a new policy and failed to give Antoine notice. Antoine failed to raise this particular point in its Brief. Therefore, Antoine has waived both arguments and neither are properly before the Court.

Commissioner concluded that Finding of Fact No. 29 in the *Harlingen* case was erroneous to the extent that it suggested that the Inspector General's retained expert Dr. Charles Evans was not qualified to be an expert because he did not treat Medicaid patients. This erroneous finding could not be relied on in this case because state and federal laws require Medicaid patients to be treated to the same standard of care as patients in the general population. That Dr. Evans did not treat Medicaid patients in his practice could not be used in properly evaluating his qualifications as an expert in this case. To the extent that the ALJs relied on Finding of Fact No. 29 from *Harlingen* in their PFD, they erred.

Finding of Fact No. 31 in the *Harlingen* case misinterpreted and misapplied Texas law and Medicaid policy, suggesting that Medicaid policy interprets "ectopic eruption" differently and more expansively (or more liberally) than the condition is interpreted in the general practice of dentistry. Because this finding misapplied the law and policy, the Executive Commissioner correctly determined that the finding could not be relied on in this case. Tex. Gov't Code § 2001.058(e)(2).

The Executive Commissioner also determined that *Harlingen* Finding of Fact No. 33 was erroneous to the extent it explained away evidence of fraud by impermissibly claiming Dr. Evans was not a qualified expert witness. The *Harlingen* ALJ opined that Dr. Evans had not treated Medicaid patients in his

private practice and that Dr. Evans scored the HLD indices in the *Harlingen* sample in accordance with the common interpretation in the general practice of dentistry, as opposed to the "more expansive" interpretation that the *Harlingen* ALJ erroneously claimed had been adopted by HHSC. Thus, because the *Harlingen* ALJ relied on these faulty premises, *Harlingen* Finding of Fact No. 33 was a misapplication of law. To the extent that the ALJs relied on the *Harlingen* case for their understanding of Medicaid policy, they erred. Tex. Gov't Code § 2001.058(e)(2).

Because the Executive Commissioner determined that certain of the findings in the *Harlingen* case incorrectly stated the law, rules, and Medicaid policy, he correctly determined that these findings and conclusions could not be relied on in this case. Tex. Gov't Code § 2001.058(e)(2).

d. The Executive Commissioner's corrections of the ALJs' errors in interpreting Texas Medicaid policy are entitled to respect by this Court.

The Executive Commissioner's interpretation of the proper scope and limitations of Texas Medicaid policy is entitled to respect from this Court. *See Texas Citizens*, 336 S.W.3d at 624 (court will defer to agency's long-standing construction of statute that is committed to agency for enforcement, as long as the interpretation is reasonable and not contrary to the statute's plain language); *see also Atascosa Cnty. v. Atascosa Cnty. Appraisal Dist.*, 990 S.W. 2d 255, 258 (Tex.

1999) (courts may not accept interpretations of a statute that defeat the purpose of the legislation so long as another reasonable interpretation exists); *Gomez v. Tex. Educ. Agency*, 354 S.W.3d 905, 913-17 (Tex. App.—Austin 2011, pet. denied) (giving deference to agency's interpretation of a term); *Sw. Pharm.*, 408 S.W.3d at 562 ("[W]e must uphold an enforcing agency's construction if it is reasonable and in harmony with the statute . . . This deference is particularly important in construing a complex statutory scheme like Medicaid.") Tex. Gov't Code § 311.023(6); (in construing statute, court considers agency construction).

Southwest Pharmacy is particularly instructive regarding this point. The plaintiff pharmacy providers challenged HHSC rules pertaining to pharmacy reimbursements under Medicaid's managed care program. The outcome of the dispute turned, in part, on construction of the phrase "medical assistance" as defined in Government Code chapter 531, Human Resources Code chapter 32, and the rules adopted thereunder. *Sw. Pharm.*, 408 S.W.3d at 560-61. In siding with HHSC, the court noted that the disputed statutory language must not be read in isolation, but rather, must be analyzed "in the context of the statutes as a whole." *Id.* "We must consider the role of the provisions in the full Medicaid statutory scheme and in . . . context. . . And we must construe the provisions in a way that is consistent with their underlying purpose and the policies they are intended to promote." *Id*. at 561. The court further noted:

> Even if we were to conclude that there is vagueness, ambiguity, or room for policy determinations in these statute and rules, we would conclude that HHSC's interpretation of the relevant code provisions and agency rules is reasonable, in harmony with the statutes and rules, and entitled to deference. *See Texas Citizens*, 336 S.W.3d at 629. We defer to the agency's interpretation unless it is plainly erroneous or inconsistent with the language of the statute or rule. *See TGS-NOPEC Geophysical Co.*, 340 S.W.3d at 438. ***As the agency designated to administer Medicaid, HHSC is charged with overseeing a complex regulatory scheme, and deference to its construction is particularly important***. *See Texas Citizens*, 336 S.W.3d at 629. An agency's construction does not have to be "the only--or the best--interpretation in order to warrant . . . deference." *Id.* at 628. Considering the entire statutory scheme, the goals and policies behind it, and the legislative history and intent, we would conclude that HHSC's interpretation is reasonable, does not conflict with the provisions' language, and is entitled to deference.

Id. at 561-62 (emphasis added). Here, the Executive Commissioner's understanding of the meaning of ectopic eruption is reasonable, and is consistent with Medicaid policy and applicable laws. Therefore, it is entitled to deference by this Court. *Texas Citizens*, 336 S.W. at 629; *Sw. Pharm.*, 408 S.W.3d at 561-62.

e. Providers have a duty to know and follow law and policy.

In reaching their flawed interpretation of Medicaid policy, the ALJs ignored the duty placed on Antoine, as a matter of law, to understand and comply with Medicaid requirements, standards, and procedures. *See Heckler v. Community Health Servs.*, 467 U.S. 51, 63-65 (1984). *Heckler* involved the Government's recovery of payments incorrectly made to a Medicare provider, who contended the Government was estopped from recovering because the provider relied on authorization by a fiscal intermediary. *Id*. at 53, 60. The Court rejected the

availability of estoppel ("When the Government is unable to enforce the law because the conduct of its agents has given rise to an estoppel, the interest of the citizenry as a whole in obedience to the rule of law is undermined."). The Court found that the provider had lost no legal right because it was never entitled to the money in the first place. *Id*. at 61-62.[39] And, the court found that the provider had a duty to know the provisions under which it received government funds. *Id*. at 64 ("As a participant in the Medicare program, respondent had a duty to familiarize itself with the legal requirements for cost reimbursement."). The Court noted:

> Justice Holmes wrote: "Men must turn square corners when they deal with the Government" (citing *Rock Island, A. & L.R. Co. v. United States*, 254 U.S. 141, 143 (1920)). This observation has its greatest force when a private party seeks to spend the Government's money. Protections of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law; respondent could expect no less than to be held to the most demanding standards in its quest for public funds. This is consistent with the general rule that those who deal with the Government are expected to know the law and may not rely on the conduct of Government agents contrary to law.

Id. at 63; *see also N. Mem'l Med. Ctr. v. Gomez*, 59 F. 3d 735, 739 (8th Cir. 1995) (participants in the Medicaid program have a "duty to familiarize themselves with the legal requirements" of Medicaid procedures). Providers may not claim after getting caught in a lie that they interpreted a term in a manner that contradicts

[39] *See also Personal Care Products, Inc. v. Hawkins*, 635 F. 3d 155 (5th Cir. 2001) (noting that providers have no property interest in Medicaid reimbursement receivables).

Medicaid policy, federal and state law, and the industry-wide understanding of the term.[40] Likewise, Antoine's misrepresentations were not excused.

3. The evidence shows that Antoine committed fraud or made willful misrepresentations.

The ALJs erroneously determined that there exists a special definition for ectopic eruption under the Medicaid Program different from any other definition. As a result, they found that none of the HLD score sheets Antoine submitted included false statements or misrepresentations. Consequently, they wrongly concluded that Antoine's conduct was neither fraudulent nor willfully misrepresentative.

In reaching this conclusion, the ALJs ignored evidence of Antoine's conduct, disregarded the testimony of the Inspector General's expert, and impermissibly created "expert" opinions from the testimony of Antoine's treating dentists, Drs. Nazari and Kanaan.

Antoine does not address the issue of substantial evidence in its Trial Brief. Accordingly, Antoine has waived any argument that the Amended Final Order is not supported by substantial evidence. *See Akin*, 2015 WL 1611803, at *3 n.1

[40] The ALJs' incorrect evaluation of Medicaid policy, and their faulty companion conclusion - the so-called "definition" is subjective - reflected a gross misinterpretation of Texas law and misapplication of Medicaid policy. That gross misunderstanding existed not simply in an academic environment but in a very real financial environment as well. This misinterpretation, if maintained, would have represented an expenditure of more than *one billion* Medicaid dollars – hardly an expenditure where any reasonable person could expect the State to be vague about whether it intended to authorize that type of Medicaid benefit.

(plaintiff "waived any argument" as to remainder of modifications where he failed to provide "any argument or cite to any authority or to the record"). Nevertheless, Defendants will show that the Amended Final Order is fully supported by substantial evidence.

a. Dr. Kanaan's scoring pattern shows, at a minimum, he acted with conscious disregard or reckless indifference to the truth or falsity of his representations of patient conditions.

Dr. Kanaan's scoring pattern shows reliable evidence of fraud: he scored 27 of the 63 patients in the sample, and of those 27 patients, Dr. Kanaan scored 23 (85%) as having the *same eight teeth ectopic*. Vol. 3 at 43-70, A.R. at 2330-57. Ex. P-64.01 through P-64.63; R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**. The rate of occurrence of ectopic eruption in the cases scored by Dr. Kanaan flies in the face of expert testimony that, according to the scientific literature, ectopic eruption is rare and the incidence of **even one tooth** ectopic occurs only in between 1.5 and 9 percent of the population.[41] The chances that 85%

[41] Dr. Kanaan testified the ectopic eruption is so rare that he has never treated a private-pay patient for a single ectopically-erupted tooth. Vol. 3 at 96:6-9, A.R. at 2383. Yet, he also testified that he does not diagnose Medicaid and private-pay patients differently. *Id.* at 17:22-25, A.R. at 2304. Dr. Kanaan even testified that the very same mouth that has ectopically-erupted teeth for Medicaid purposes is a prime example – the very example he uses on his other practice's website – of crowding. Vol. 3 at 20:25-21:1, A.R. at 2307-08 (the photo on his website is an example of crowding), 21:5-20, A.R. at 2308 (explaining that the photo is of ADC's Medicaid patient), 25:5-25:8, A.R. at 2312 (stating that he scored this patient as ectopic). He nevertheless scored each of his patients in the sample as having 7 or more ectopic teeth. This testimony, despite his protestations to the contrary, demonstrates that Dr. Kanaan scores his private pay patients one way and his Medicaid patients completely differently.

of Dr. Kanaan's patients would each have the same eight ectopic teeth, when less than 10% percent of the population has even one ectopic tooth, is infinitesimal. *See* Dr. Tadlock's testimony, Vol. 1 at 174-175, A.R. at 1985-86. Although the ALJs made passing note of Dr. Kanaan's scoring pattern, they failed to draw any inferences from this objectively observed conduct, nor did they explain how this evidence relates to the Inspector General's burden to continue the payment hold.[42] *See* 42 C.F.R. § 455.2 (a Medicaid agency may receive credible allegations of fraud from any source, including "patterns identified through provider audits.").[43]

Additionally, the Inspector General presented reliable evidence that Antoine submitted fraudulently scored HLD score sheets for 61 of the 63 patients in the sample by falsely representing that each of these 61 patients had six or more ectopically-erupted teeth. *See* R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**. In light of the commonly understood meaning of ectopic eruption as established by the testimony of Dr. Tadlock and Dr. Altenhoff, the egregiousness of Antoine's scoring pattern shows reliable *prima facie* evidence of

[42] Indeed, not a single one of the patients in the sample was eligible for Medicaid-covered comprehensive orthodontics without Antoine's score for ectopic eruption: excluding those ectopic eruption scores, Antoine's sample HLD scores ranged from 0 (9 patients) to 19 (1 patient). *See* R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**. Further, even assuming that each of these patients had not one, but two instances of the very rare phenomena of ectopic eruption in their anterior teeth, they still would not have been eligible for Medicaid-covered comprehensive orthodontics, as they could not achieve the qualifying score of 26.

[43] The evidentiary burden on the Inspector General in this proceeding is not particularly onerous. The evidence must have "indicia of reliability." In other words, it is reliable unless rebutted and shown to be immaterial, untrue, inaccurate or unreliable.

fraud or willful misrepresentations and satisfied the Inspector General's burden to maintain the payment hold. Tex. Gov't Code § 531.102(g)(2).

b. The ALJs compounded their errors by relying on "experts" who misunderstood and misapplied Texas Medicaid policy.

The ALJs expressly declined to rely on Antoine's proffered experts, Orr and Ornish, for their determinations regarding ectopic eruption. PFD at 28, A.R. at 1222. Instead the ALJs attempted to refute Dr. Tadlock's expert testimony by citing to the testimony of Drs. Nazari and Kanaan. However, Antoine did not proffer or qualify either Dr. Nazari or Dr. Kanaan as an expert in this hearing, and the ALJs erred in considering them as experts.[44] *See also Petitioner's Expert Designations* (listing only Dr. Orr and Dr. Ornish), A.R. at 356-74. The ALJs also failed to note in their PFD Dr. Nazari's testimony that he learned how to score the

[44] The Defendants objected to Dr. Kanaan being treated as an expert witness. Vol. 3 at 128:2-5, A.R. at 2415. The ALJs abused their discretion when they considered Dr. Kanaan's testimony as an expert. Vol. 3 at 128:6-16 (ALJ: "Well he [Dr. Kanaan] may not have been offered as an expert but he certainly is qualified as an expert as much as any other."). The ALJs, *sua sponte* designated Dr. Kanaan as an expert. Vol. 3 at 129: 3-5, 19-22, A.R. at 2416 (allowing a treatise to be shown to Dr. Kanaan to show "what the expert relied on" and "showing in part what Dr. Kanaan relied upon in forming his expert opinions"). Nor did Antoine ever offer or qualify Dr. Kanaan as an expert witness. Because of the ALJs' abuse of discretion in designating on their own volition a party opponent as an expert, the Executive Commissioner acted well within his discretion in correcting any proposed findings or conclusions that were predicated on the ALJs' erroneous ruling.

As for Dr. Nazari, Antoine never offered him as an expert. Vol. 4, A.R. 2633-2794 (showing that neither Antoine nor the ALJs ever offered or qualified Dr. Nazari as an expert during the hearing). The ALJs in their PFD, again *sua sponte*, and unilaterally of their own accord, designated Dr. Nazari as an expert. *See* PFD at 28 (discussing Dr. Nazari's testimony as an expert), A.R. at 1222. The Executive Commissioner correctly modified any findings or conclusions relying on the ALJs' erroneous designation of Dr. Nazari as an "expert."

HLD index "for Medicaid" from Dr. Orr. Vol. 4 at 137:17-25, A.R. at 2765.[45] Thus, even though the ALJs putatively did not rely on Orr and Ornish, their reliance on Dr. Nazari is misplaced because his opinions are entirely derivative of Dr. Orr, who incorrectly opined that Texas Medicaid adopted a special liberal definition of ectopic eruption.[46] The ALJs therefore erred by relying on providers, who in turn relied on Dr. Orr, for their interpretation of Medicaid policy; and the ALJs erred by disregarding the testimony of Medicaid policy witnesses and qualified experts. *See Sw. Pharm.*, 408 S.W.3d at 561-62; *Wood v. Tex. Comm'n Envtl. Quality*, No. 13-13-00189-CV, 2015 WL 1089492, at *6 (Tex. App.—Corpus Christi, Mar. 5, 2015, no pet. hist.) (affirming TCEQ order, after

[45] Dr. Nazari testified the methodology he applied for ectopic eruption was to include any teeth that were "rotated, the slanted leaning teeth" based on what he learned from Dr. Orr a decade prior. Vol. 4, at 102:22-103:4, 138:18-23, A.R. at 2730-31, 2766 (including any teeth that are "twisted or turned or crooked"). This description, however, does not comport with either the generally-accepted scientific understanding of the term "ectopic eruption" or in the instruction of the TMPPM which refers to "an unusual pattern of eruption."

[46] The ALJs summarily, and incorrectly, stated that the HLD scores of Dr. Orr and Dr. Ornish, Antoine's experts, were "generally similar" to Antoine's scores and that their testimony was "cumulative" of the testimony of Drs. Nazari and Kanaan; the ALJs asserted that they did not rely upon the testimony of either Dr. Orr or Dr. Ornish. PFD at 28, A.R. at 1222. The Inspector General objected to this supposed cursory treatment of Antoine's experts for two reasons. First, the evidence shows Dr. Nazari's understanding of HLD score sheets was directly based on training he received from Dr. Orr. Vol. 4, at 137-38, A.R. at 2765-66 (testifying that he learned the theory that "ectopic eruption means any tooth that is twisted or turned or crooked" from Dr. Orr). *See also* Respondent's Closing Brief at 13, 33-37, A.R. at 1001, 1021-22. Second, it is factually incorrect to conclude that Dr. Ornish's scores were "generally similar" to Antoine's – in fact, Dr. Ornish, the only expert orthodontist retained by Antoine, scored 13 of the 63 Antoine patients as having an HLD score less than 26. Thus, *Antoine's own expert* opined that nearly 21 percent of the Antoine patients did not qualify for Medicaid based on the HLD score.

Commission determined that ALJ's reliance on expert was inappropriate when expert misinterpreted policy).

4. The Executive Commissioner did not re-weigh the evidence, and each of his changes to the PFD is authorized by the APA.

Antoine complains that the Executive Commissioner erred in modifying the ALJs' proposed findings of fact ("FoF") 45 through 50, and conclusion of law ("CoL") 13.[47] Antoine Brief at 9. Specifically, Antoine contends that the Executive Commissioner exceeded his authority in changing FoF Nos. 45-50 and CoL No. 13 because he impermissibly re-weighed the evidence adduced in the hearing. Antoine is mistaken.

The Administrative Procedure Act (APA), chapter 2001, Government Code, governs contested proceedings before HHSC. The APA expressly defines the Executive Commissioner's discretion to change proposed findings of fact and conclusions of law prepared by ALJs after contested case hearings. The APA provides, in pertinent part:

> (e) A state agency may change a finding of fact or conclusion of law made by the administrative law judge, or may *vacate* or

[47] In passing, Antoine contends that the Executive Commissioner's modifications to FoF Nos. 10, 21, 26, 29, 54, 55, and 57, and CoL Nos. 4 and 16 were also not permitted by law. However, Antoine provides no argument on these points and has effectively waived any contention of error. *See Akin*, 2015 WL 1611803, at *3 n.1 (addressing only findings and conclusions actually briefed because Akin "waived any argument" as to remainder of modifications where he failed to provide "any argument or cite to any authority or to the record").

> *modify* an order issued by the administrative law judge, only if the agency determines:
>
> (1) *that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies provided under Subsection (c), or prior administrative decisions;*
>
> (2) *that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed*; or
>
> (3) that a technical error in a finding of fact should be changed.

Tex. Gov't Code § 2001.058(e) (emphasis added). Thus, the Executive Commissioner was authorized to change the ALJs' incorrect legal and policy determinations. *See* Tex. Gov't Code § 2001.058(e)(1); *see also Froemming*, 380 S.W.3d at 793; *Akin*, 2015 WL 1611803, at *4-5, *5 n.6; *Smith v. Montemayor*, 2003 WL 21401591, at *8; *Wood v. Tex. Comm'n Envtl. Quality*, 2015 WL 1089492, at *11 (approving of agency's modification under 2001.058(e)(1) when ALJ "did not properly apply the correct . . . standard to review" evidence).

Consistent with the concept that agencies determine the meaning of their policies and the laws they are committed to enforce, agencies have broad discretion to modify "legislative facts" in PFDs.[48] *See Tex. State Bd. of Med. Exam'rs v.*

[48] A "legislative fact" is a mixed question of fact and law and defining terms is an agency function. F. Scott McCown & Monica Leo, *When Can an Agency Change the Findings of Conclusions of an ALJ?: Part Two*, 51 Baylor L. Rev. 63, 69-70 (1999) (hereinafter "McCown & Leo"). A finding of fact is a "legislative fact" where the finding affects not just one specific case, but is actually an explication of agency policy and therefore may be applied to other cases or implicates agency policy. *Id.*

Dunn, 03-03-00180-CV, 2003 WL 22721659, at *3 (Tex. App.—Austin Nov. 20, 2003, no pet.) ("agencies are 'relatively' free to review and correct an ALJ's 'legislative facts,' which 'provide a foundation for developing law, rules, or policies and, consequently, affect the outcome of many cases.'") (quoting McCown & Leo, at 68-69); *see also Sanchez*, 229 S.W.3d at 515-16 (holding that board acted within its discretion to modify a conclusion where ALJ's proposed conclusion "did not accurately reflect agency policy") (citing McCown & Leo); *Exxon Corp. v. Railroad Comm'n*, 993 S.W.2d 704, 710 (Tex. App.—Austin 1999, no pet.) (determining that certain determinations were "'legislative facts'" because agency "was authorized" to determine a unit of measurement "based on its judgment and expertise in light of what the evidence showed" where the agency had to establish some baseline measurement for the distance between wells in individual cases); *Montemayor*, 2003 WL 2140151, *8 (citing McCown & Leo).

For each modification, the Executive Commissioner met the requirements to support his changes to the PFD in his Amended Final Order. *See e.g.*, *Flores v. Emps. Ret. Sys. of Tex.*, 74 S.W.3d 532, 540 (Tex. App.—Austin 2002, pet. denied) (APA requires "a reasoned explanation for each change"); *Pierce v. Tex. Racing Comm'n*, 212 S.W.3d 745, 755 (Tex. App.—Austin 2006, pet. denied) (an agency must state in writing "the specific reason and legal basis for" each change of the ALJ's order, findings of fact, or conclusions of law); s*ee also Dunn*, 2003 WL

22721659, at *1 (board must "establish a reasonable evidentiary basis for rejecting the ALJ's findings and conclusions"). There must be a rational connection between an underlying agency policy and the altered finding of fact or conclusion of law. *See, e.g.*, *Heritage on the San Gabriel Homeowners Assoc. v. TCEQ*, 393 S.W.3d at 440-4; *State v. Mid-South Pavers, Inc.*, 246 S.W.3d 711, 728 (Tex. App.–Austin 2007, pet. denied); *Levy v. Tex. State Bd. of Medical Exam'rs*, 966 S.W.2d 813, 816 (Tex. App.–Austin 1998, no pet.).

a. Finding of Fact No. 45

Finding of Fact No. 45 reads:

> **In reviewing the 63 ADC patient files in the statistically valid random sample, Dr. Tadlock applied the definition of ectopic eruption that is generally recognized within the dental profession and scored the patients as instructed by the Manuals. Dr. Tadlock properly applied Medicaid policy.**

As proposed by the ALJs, proposed FoF No. 45 read: "*Dr. Tadlock did not apply the Manual's definition of ectopic eruption in scoring the HLD index for the 63 patients*." A.R. at 1234.

The Executive Commissioner was authorized by law to modify proposed FoF No. 45 because it addresses a mixed question of fact and law, and is therefore a "legislative finding."[49] *See Sanchez*, 229 S.W.3d at 515-16 (holding that board

[49] *See* McCown & Leo, *supra* note 48.

acted within its discretion to modify a conclusion where ALJs proposed conclusion "did not accurately reflect agency policy") (citing McCown & Leo); *Dunn*, 2003 WL 22721659, at *3 ("agencies are 'relatively' free to review and correct an ALJ's 'legislative facts,' which 'provide a foundation for developing law, rules, or policies and, consequently, affect the outcome of many cases.'") (quoting McCown & Leo, at 68-69); *Montemayor*, 2003 WL 2140151, *8 (citing McCown & Leo).

The ALJs' proposed FoF No. 45 was a legislative finding because it was expressly premised on the erroneous and impermissible interpretation that Texas Medicaid policy incorporates a special definition for ectopic eruption. The ALJs' proposed FoF No. 45 had two incorrect assumptions: (1) Medicaid had a special definition for ectopic eruption; and (2) Dr. Tadlock failed to apply Medicaid policy. Neither element of the proposed finding of fact is accurate.

The Executive Commissioner fully explained the reasons for his modification of FoF No. 45 in his Amended Final Order. *See* **App. A**, at pp. 21-23, A.R. at 1764-66.

b. Finding of Fact No. 46.

Finding of Fact No. 46 reads:

> **Despite the SOAH ALJs finding Dr. Nazari's testimony to be credible, Dr. Nazari did not properly follow Medicaid policy in his identification of ectopic eruptions; the overwhelming evidence of the consistent pattern of inflated HLD scores submitted by ADC establishes prima facie evidence that is reliable, relevant and material that ADC's**

misrepresentations of medical necessity constitute willful misrepresentations.

As proposed by the ALJs FoF No. 46 stated: *Dr. Nazari was a credible witness and properly utilized the Manuals' definition in scoring the HLD index.*

Finding of Fact No. 46 is a legislative finding because it is implicitly founded on the (erroneous) presumption that Texas Medicaid policy incorporates a special definition for ectopic eruption. The ALJs' proposed finding had two components: (1) Medicaid had a special definition for ectopic eruption; and (2) Dr. Nazari properly followed Medicaid policy in scoring his patients. Neither element of the proposed finding of fact was accurate.

The Executive Commissioner modified the ALJs' proposed FoF No. 46 because the ALJs relied on the faulty proposition that Medicaid adopted a special definition for ectopic eruption. Further, Dr. Nazari's own testimony reveals that he did not properly apply Medicaid policy to the scoring of his patients. Vol. 4, at 103:13-16, 104:1-4, 145:9-10, A.R. at 2731-32, 2773, where Dr. Nazari testified that orthodontics for Medicaid patients is different than orthodontics for non-Medicaid patients.[50] Further, Dr. Nazari was unable to define a "severe handicapping malocclusion." *Id.*, at 144:17-145:6, A.R. at 2772-73.

[50] In this regard, Dr. Nazari's testimony differed from Dr. Kanaan's. Dr. Kanaan testified that Medicaid patients and non-Medicaid patients should be diagnosed and treated to the same standard; yet, in practice he did not follow that guidance. *See supra* note 41.

The Executive Commissioner fully explained his reasons for modifying FoF No. 46. *See* **App. A**, at pp. 23-24, A.R. at 1766-67.

c. Finding of Fact No. 47.

Finding of Fact No. 47 reads:

> **Despite the SOAH ALJs finding Dr. Kanaan's testimony to be credible, Dr. Kanaan did not properly follow Medicaid policy in his identification of ectopic eruptions; the overwhelming evidence of the consistent pattern of inflated HLD scores submitted by ADC establishes prima facie evidence that is reliable, relevant and material that ADC's misrepresentations of medical necessity constitute willful misrepresentations.**

As proposed by the ALJs FoF No. 23 stated: *Wael Kanaan, D.D.S. an orthodontist who worked with ADC was a credible witness and properly utilized the Manuals' definition of ectopic eruption in scoring the HLD index.*

Finding of Fact No. 47 is a legislative finding because it is implicitly founded on the (erroneous) presumption that Texas Medicaid policy incorporates a special definition for ectopic eruption. The ALJs proposed finding had two components: (1) Medicaid had a special definition for ectopic eruption; and (2) Dr. Kanaan properly followed Medicaid policy in scoring his patients. Neither element of the proposed finding of fact was accurate.

First, the Executive Commissioner corrected the ALJs' error of law regarding Medicaid policy. Then, he appropriately applied the law to the uncontested facts in the record. In their PFD, the ALJs acknowledged that Dr.

Kanaan scored 23 of 27 patients exactly the same way—with the same eight teeth being scored as ectopic in all 23 patients. PFD at p.25, A.R. at 1219.

Although they recognized this pattern by Dr. Kanaan, the ALJs failed to correctly apply the law to the uncontested facts. Dr. Kanaan's cookie cutter approach to scoring Medicaid patients, at the very least, indicates that Dr. Kanaan was reckless in his scoring, or indifferent to the actual standards for qualifying a patient under Medicaid. Dr. Kanaan's pattern of scoring 23 out of 27 patients exactly the same way thus constitutes prima facie evidence that he acted with the requisite scienter to commit fraud or willful misrepresentations. *See* Tex. Hum. Res. Code § 36.0011(b), defining Culpable Mental State:

> A person acts knowingly with respect to information if the person:
>
> (1) has knowledge of the information;
> (2) acts with conscious indifference to the truth or falsity of the information; or
> (3) acts in reckless disregard of the truth or falsity of the information.

Tex. Hum. Res. Code § 36.0011(a).

In his Amended Final Order the Executive Commissioner fully explained the reasons for his changes to FoF No. 47. *See* **App. A**, at pp. 24-26, A.R. at 1767-69.

d. Finding of Fact No. 48.

Finding of Fact No. 48 reads:

> **HHSC-OIG presented evidence that is credible, reliable, and verified, and that has indicia of reliability when analyzed consistently with Texas law and Medicaid policy, that ADC knowingly incorrectly scored the HLD index on orthodontic prior approval requests submitted to Texas Medicaid.**

As proposed by the ALJs, FoF No. 48 stated: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC incorrectly scored the HLD Index to obtain Texas Medicaid benefits for patients or to obtain Texas Medicaid payments.*

The Executive Commissioner was authorized to change FoF No. 48 because it is a mixed finding of fact and law. The finding incorporates two components: (1) a statement regarding whether Antoine properly scored the HLD index ("*There is no evidence . . . that ADC incorrectly scored the HLD . . .*"); and (2) a statement regarding Antoine's intent (". . . *to obtain Texas Medicaid benefits for parents or to obtain Texas Medicaid benefits.*"). As to both components, the ALJs' proposed finding reflected the ALJs' misunderstanding of: (a) Texas Medicaid policy; (b) the Inspector General's burden of proof in a payment hold proceeding; and (c) the standard for proving scienter under the TMFPA.

In contravention of HHSC policy, the ALJs erroneously determined that Texas Medicaid adopted a special, liberal interpretation of Medicaid policy,

particularly with respect to ascertaining whether a patient exhibits ectopic eruption. Upon accepting the wildly subjective "anything goes" standard propounded by Drs. Orr, Nazari and Kanaan, the ALJs then found no error, much less a willful error in Antoine's scoring. The lynch-pin to this finding, and almost all of the ALJs' findings and conclusions, was their misunderstanding, and misapplication, of the limits of Texas Medicaid policy. The ALJs compounded their error by misapplying Texas law: specifically, the ALJs misapplied the Inspector General's burden of proof in the payment hold proceeding, and they ignored the TMFPA standard for scienter of conscious indifference or reckless disregard. *See* Tex. Hum. Res. Code § 36.0011(a).

At the payment hold hearing, the Inspector General bore the burden of presenting *prima facie* evidence of fraud or wilfull misconduct. *Prima facie* evidence is "evidence that, until its effect is overcome by other evidence, will suffice as proof of a fact in issue." *Rehak Creative Servs. v. Witt*, 404 S.W.3d 716, 726 (Tex. App.—Houston [l4th Dist.] 2013, pet. denied). The Inspector General satisfied his burden by presenting evidence of Antoine's scoring pattern for the HLD score sheets. *See* R-49, Tadlock summary, at A.R. 1097-98, copy attached at **App. I**. Section 36.0011 of the TMFPA, as noted supra at note 19, defines the culpable mental state the State must establish to prove unlawful acts. The State must only show that the person acted with knowledge of the truth or falsity of

information; with conscious indifference to the truth or falsity of the information; or with reckless disregard of the truth or falsity. Tex. Gov't Code § 36.0011(a). Importantly, the State is not required to show the person's specific intent to commit an unlawful act. *Id.*, § 36.0011(b).

Therefore, in correctly applying Medicaid policy and Texas law to the evidence, the Executive Commissioner was fully authorized to correct the ALJs' erroneous finding: (1) that there was not credible, reliable, verified evidence with indicia of reliability that Antoine incorrectly scored HLD indices; (2) that there was no evidence Antoine did so for the purpose of obtaining Medicaid benefits.

As required by law, the Executive Commissioner fully explained the rationale for his changes. *See* **App. A**, at pp. 26-28, A.R. at 1769-71.

e. Finding of Fact No. 49.

Finding of Fact No. 49 reads:

> **HHSC-OIG presented *prima facie* evidence that is credible, reliable, and verified, and that has indicia of reliability when analyzed consistently with Texas law and Medicaid policy, that ADC committed fraud or wilful misrepresentations to Texas Medicaid.**

As proposed by the ALJs, FoF No. 49 stated: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC committed fraud or engaged in willful misrepresentation with respect to the 63 ADC patients in this case.*

The Executive Commissioner was authorized to change FoF No. 49 because it is a mixed finding of fact and law. The ALJs' proposed finding incorporated their misunderstanding of Medicaid policy, and misapplication of Texas law, to the uncontested evidence of record. The Executive Commissioner explained the reasons for his changes to FoF No. 49. *See* **App. A**, at pp. 28-30, A.R. at 1771-73.

f. Finding of Fact No. 50.

Finding of Fact No. 50 reads:

> **HHSC-OIG presented *prima facie* evidence that is credible, reliable, and verified, and that has indicia of reliability when analyzed consistently with Texas law and Medicaid policy, that ADC committed fraud or wilful misrepresentations in filing requests for prior authorization with TMHP for a substantial majority of patients in the OIG audit sample.**

As proposed by the ALJs, FoF No. 50 stated: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC committed fraud or misrepresentation in filing requests for prior authorization with TMHP for the 63 patients at issue in this case.*

The Executive Commissioner was authorized to change FoF No. 50 because it is a mixed finding of fact and law. The ALJs' proposed finding incorporated their misunderstanding of Medicaid policy, and misapplication of Texas law, to the uncontested evidence of record. As with FoF No. 49, the Executive Commissioner explained the rationale for his changes. *See* **App. A**, at pp. 30-31, A.R. at 1773-74.

g. Conclusion of Law No. 13.

Conclusion of Law

No. 13 in the Amended Final Order reads:

> **HHSC-OIG should maintain the payment hold against ADC for alleged fraud or willful misrepresentation, and program violations. Tex. Gov't Code § 531.102(g) (2011); 42 CFR § 455.23 (2011); Tex. Hum. Res. Code § 32.091(c) (2003); 1 Tex. Admin. Code §§ 371.1703(b)(3), and (b)(5), 371.1617(a)(1)(A)-(C), (I), (K), (2)(A), (5)(A), (5)(G) (2005).**

As proposed by the ALJs, CoL No. 13 stated: *HHSC-OIG lacks authority to maintain the payment hold against ADC for alleged fraud or misrepresentation. Tex. Gov't Code § 531.102(g) (2011); 42 CFR § 455.23 (2011); Tex. Hum. Res. Code § 32.091(c) (2003); 1 Tex. Admin. Code §§ 371.1703(b)(3), 371.1617(a)(1)(A)-(C) (2005).)*

The Executive Commissioner was authorized to change CoL No. 13 because it was a pure question of law committed to the discretion of the agency. Further, to the extent that CoL No. 13 was actually a recommendation from the ALJs, and not a true conclusion of law, the Executive Commissioner was fully authorized to modify it. *See Granek v. Texas State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex. App.—Austin 2005, no pet.) ("We agree with the Board that it is not required to give presumptively binding effect to an ALJ's recommendations regarding sanctions in the same manner as other findings of fact or conclusions of

law."); *Akin*, 2015 WL 1611803, *5 (approving of board's reclassification of conclusion to a recommendation); *see also Pierce v. Tex. Racing Comm'n*, 212 S.W.3d at 754 n.7 ("We need not decide, however, whether the ALJ had authority to recommend a penalty in a racing commission case because, regardless of whether the ALJ's conclusion of law was authorized, the Commission was statutorily authorized to modify or reject it." (citing Tex. Gov't Code § 2001.058(e))).

As required by the APA and black letter Texas law, the Executive Commissioner fully explained the reasons for his change to CoL No. 13. *See* **App. A**, at pp. 39-40, A.R. at 1782-83.

5. The Executive Commissioner did not abuse his discretion in ordering the Inspector General to maintain the payment hold.

The standard of review for an abuse of discretion by a state agency is whether the agency's final decision: (1) ignores the factual record; (2) relies on facts not in evidence; or (3) is not rationally connected to the factual record. *City of El Paso*, 883 S.W.2d at 184; *State v. Pub. Util. Comm'n*, 883 S.W.2d at 201; *Heritage*, 393 S.W.3d at 423 ("we must remand for arbitrariness if we conclude that the agency has not 'genuinely engaged in reasoned decision-making'" (quoting *City of Waco v. Tex. Comm'n Envtl. Quality*, 346 S.W.3d 781, 819-20 (Tex. App.—Austin 2011, pet. denied))).

The HHSC Amended Final Order is squarely based on the factual record from the SOAH hearing. The Amended Final Order is 42 pages long and is replete with references to the uncontested evidence from the hearing. **App. 1**. Further, no reasonable argument can be made that the Amended Final Order relies on facts not in evidence or that it is rationally unrelated to the evidence. In short, there is no credible argument that the Executive Commissioner abused his discretion and this point of error should be overruled.

B. Substantial evidence supports the Amended Final Order.

In its Trial Brief, Antoine barely addresses the issue of substantial evidence, devoting the overwhelming majority of its argument to the contention that the Executive Commissioner exceeded his authority. Because Antoine bears the burden on the issue of substantial evidence, the Court could summarily determine that Antoine has failed to meet its burden and affirm the Amended Final Order without further inquiry. Nevertheless, the discussion of the Executive Commissioner's changes to the findings of fact and conclusion of law, above, demonstrates that each of the contested findings and conclusions are fully supported by substantial evidence in the record. Accordingly, the Court should overrule this point of error.

C. The remainder of Antoine's points lack merit.

Without citation to any authority, Antoine complains that after the Executive

Commissioner granted the Inspector General's motion for rehearing, he *did not actually hold a new hearing* before issuing the Amended Final Order. Antoine Brief at 19, Point of Error "D." Antoine cannot cite to any authority supporting the proposition that the Executive Commissioner was actually required to hold another hearing, because none exists.

Antoine also complains that it was deprived of the opportunity to respond to the Inspector General's motion for rehearing. This complaint is also specious. Antoine had ample opportunity to file briefing in response to the Inspector General's motion for rehearing, which was filed March 17, 2014. The Amended Final Order was not issued until May 2, 2014. It is no one's fault but Antoine's that it failed to brief the issues in the month and half after the Inspector General filed his motion for rehearing and before the Amended Final Order was issued.

Finally, Antoine spends several pages complaining about the first final order, issued by HHSC ALJ Rick Gilpin. The Amended Final Order, issued by the Executive Commissioner, superseded the final order issued by ALJ Gilpin. These complaints, which are a retread of tired and discredited arguments,[51] are moot because the Gilpin order is not at issue. *See, e.g.*, *Williams v. Lara*, 52 S.W.3d 171,

[51] Antoine, and other dental providers, moved to strike ALJ Gilpin from presiding in contested administrative cases. The Honorable Tim Sulak presiding, dismissed the providers' suit. *See* Order Granting Defs.' Plea to the Jurisdiction and, in the Alternative, Granting Defs.' Mot. for Summ. J., D-1-GN-14-001109 (345th Dist. Ct., Travis County, Tex. Aug. 7, 2014), copy attached at **Appendix K**.

184 (Tex. 2000) ("If a controversy ceases to exist—'the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome'" the issue becomes moot.).

VII. PRAYER

WHEREFORE PREMISES CONSIDERED, upon notice and hearing, Defendants pray that the Court find that the Executive Commissioner acted fully within his lawful authority and sound discretion in entering the Amended Final Order; and further that the Court find the Amended Final Order is supported by substantial evidence; and further request the Court to affirm the Amended Final Order in all respects.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify, that in accordance with Travis County Local Rule 10.5, this Defendant's Trial Brief complies with the requirements of Texas Rules of Appellate Procedure applicable to appellate court review of administrative decisions. The word count for this brief is 13,413 words.

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Defendant's Brief on the Merits*, has been served, on May 29, 2015, by e-service, fax or certified mail, return receipt requested, to the following attorney-in-charge:

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