STATE OF NORTH CAROLINA

COUNTY OF CUMBERLAND

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
14 DHR 08147

CMS Agency, Inc.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**FINAL DECISION**
	)	
North Carolina Department of Health and Human Services and Eastpointe Human Services LME/PHP,	)	
	)	
Respondents.	)	

This contested case was heard before the Honorable Donald W. Overby, Administrative Law Judge, on July 27, 2015, in Cumberland County, North Carolina.

APPEARANCES

For Petitioner:	J. Scott Flowers and Deanna Coleman Hutchens Law Firm 4317 Ramsey Street Fayetteville, North Carolina 28302
For Respondent NC: Department of Health and Human Services	Rajeev K. Premakumar Assistant Attorney General N.C. Department of Justice Post Office Box 629 Raleigh, North Carolina 27602
For Respondent: Eastpointe Human Services LME/PHP	Jose A. Coker and Dharmi B. Tailor The Charleston Group 201 Hay Street, Suite 2000 Fayetteville, North Carolina 28302

STATUTES AND RULES

42 C.F.R. § 438

N.C.G.S. § 108A

N.C.G.S. § 108C

EXHIBITS

Admitted for Petitioner:

Exhibit No.	Date	Document
1	May 20, 2013	Procurement Contract effective January 1, 2013
2	October 17, 2012	CMS Agency, Inc. Articles of Incorporation
3	May 17, 2013	Procurement Contract Amendment
4		Philadelphia Indemnity Insurance Company, Common Policy Declarations
5		Philadelphia Indemnity Insurance Company, Common Policy Declarations
6	September 16, 2013	Carolina Mutual Insurance, Inc., Worker's Compensation Statement
7	November 11, 2013	Carolina Mutual Insurance, Inc., Policy Cancellation Notice
8	March 27, 2014	Travelers, Workers Compensation and Employers Liability Policy
9	December 11, 2013	ProviderConnect – Billing Statement
10	July 7, 2014	Procurement Contract effective July 1, 2014

11	July 7, 2014	Eastpointe letter to Petitioner
12	July 11, 2014	Petitioner's appeal to Eastpointe
13	July 15, 2014	Email from Tammy Segura to C. Price-Sprague
14	July 14, 2015	Emails between Sheilla Redd, Tammy Segura, and Karen Salacki
15	July 23, 2014	Petitioner's appeal to Eastpointe
16	September 3, 2014	Eastpointe Provider Dispute Resolution Letter to Petitioner
17	February 6, 2015	Acord Certificate of Liability Insurance
18	July 24, 2015	Acord Certificate of Liability Insurance
19	March 4, 2015	Eastpointe's Response to Petitioner's Interrogatories
20	March 4, 2015	Eastpointe's Response to Petitioner's Request for Production of Documents
21	March 4, 2015	Provider Approvals/Payments/ Adjustments by Date of Service for Petitioner
22	September 17, 2014	Eastpointe letter to Petitioner

Admitted for Eastpointe:

Exhibit No.	Date	Document
1	December 12, 2012	Contract between NC DHHS/DMA and Eastpointe
2		Procurement Contract, Appendix G Template from NCDHHS
3	May 17, 2013	Procurement Contract

		Amendment
4	September 25, 2012	Acord Certificate of Liability Insurance 2012-2013
5	June 30, 2014	Acord Certificate of Liability Insurance 2013-2014
6	August 21, 2014	Provider Approvals/Payments/ Adjustments for Petitioner for Dates of Service 9/16/2013-02/14/2014
7	August 13, 2014	Eastpointe Provider Operations Manual

WITNESSES

Called by Petitioner:

Tammy Segura, President of CMS Agency, Inc.

Sheilla Redd, Commercial Lines Account Manager at Insurance Service Center

Called by Eastpointe:

Karen Salacki, Chief of External Operations for Eastpointe

ISSUES

1. Whether Eastpointe deprived Petitioner of property, exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it charged Petitioner $209,515.21 as a result of a lapse in coverage for professional liability insurance, general liability insurance, and worker's compensation insurance as required by Petitioner's procurement contract with Eastpointe and Eastpointe's contract with the Division of Medical Assistance.

2. Whether Eastpointe properly conducted its Reconsideration Review of Petitioner's internal appeal to Eastpointe.

3. Whether Petitioner is entitled to reasonable attorney's fees pursuant to N.C.G.S. § 150B-33(b)(11).

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, along with documents and exhibits received and admitted into evidence and the entire record in this proceeding, the undersigned administrative law judge has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witness, any interests, bias or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony is reasonable, and whether the testimony is consistent with all other believable evidence in the case.

FINDINGS OF FACT

1. Petitioner is a North Carolina corporation organized and existing under the laws of the State of North Carolina that provides mental health, developmental disabilities, and substance abuse services to Medicaid recipients within the catchment area of Eastpointe.

2. Respondent North Carolina Department of Health and Human Services ("DHHS") is the single state agency responsible for operating the State's Medicaid Plan under N.C.G.S. § 180A-54.

3. Respondent Eastpointe Human Services LME/PHP ("Eastpointe") is a managed care organization ("MCO") that manages, coordinates, facilitates, and monitors the provision of state and federal Medicaid-funded mental health, intellectual, and developmental disabilities and substance abuse services for members in Eastpointe's catchment area. The catchment area includes Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson counties.

4. NCDHHS delegates responsibilities to manage the 1915(b)/(c) Medicaid Waiver to MCOs such as Eastpointe.

5. On December 12, 2012, Eastpointe entered into a contract with DHHS's Division of Medical Assistance ("DMA") pursuant to which Eastpointe was to operate a capitated Prepaid Inpatient Health Plan ("PIHP") for Medicaid enrollees in accordance with 42 C.F.R. Part 438 (the "DMA Contract"). The term of the DMA Contract was January 1, 2013 through December 31, 2014.

FIRST AND SECOND CONTRACTS

6. Pursuant to its duties under the DMA Contract, Eastpointe entered into a contract with Care Management Services, a sole proprietorship and CMS's predecessor in interest, on January 18, 2013 for CMS to provide services to Medicare enrollees (the "First CMS Contract"). The term of the First CMS Contract was January 1, 2013 through June 30, 2014. The First CMS Contract was amended on May 17, 2013 to replace Care Management Services with CMS, the corporate entity, as the provider there under.

7. The First CMS Contract is a template contract provided to Eastpointe by DMA. DMA requires Eastpointe to use this contract template in its contracts with providers such as CMS. There is no arm's length negotiation of the terms of the contract. Any provider wanting to participate in Eastpointe's catchment area must accept the terms as presented.

8. Appendix G, paragraph 9, of the First CMS Contract required CMS to purchase and maintain professional liability insurance, comprehensive general liability insurance, automobile liability insurance, workers' compensation insurance, and "tail" coverage in the amounts set forth therein. Appendix G, paragraph 9(e)i. states, "Any loss of insurance shall justify the termination of this Contract in the LME/PIHP's sole discretion." Appendix G of the First CMS Contract sets forth a very specific remedy for Eastpointe in the event there is a lapse in insurance by the provider, and it does not state that Eastpointe is authorized to recoup funds from CMS for a lapse in insurance.

9. The First CMS Contract, Art. I, Section 4(a) through (k) sets forth the "Controlling Authority" which sets forth the laws and regulations governing the First CMS Contract. There is no law or regulation specifically referenced in the Controlling Authority that deals with insurance. The closest it comes is in Section 4(c) which refers to the "State laws and regulations denominated in Appendix G." There are no state laws or regulations specifically referenced in Appendix G that refer to insurance. Thus, any remedy for a lapse of insurance must be set forth in particularity within the confines of the contract itself—and it is.

10. Art. II, Section 5(b) of the First CMS Contract states in part:

> If the LME/PIHP determines CONTRACTOR has failed to comply with Controlling Authority and has been reimbursed for a claim or a portion of a claim that the LME/PIHP determines should be disallowed, or that CONTRACTOR has been paid for a claim that was fraudulently billed to the LME/PIHP, the LME/PIHP will provide thirty (30) days notice to the CONTRACTOR of the intent to recoup funds.

11. Since there has been no showing that Petitioner failed to comply with the laws and regulations of the "Controlling Authority", this provision for recoupment does not apply.

12. The First CMS Contract does not further define which violations of Controlling Authority allow for a recoupment.

13. Neither Eastpointe nor DHHS/DMA has promulgated or published any rules advising which violations of Controlling Authority by a provider shall be deemed to allow or require a recoupment.

14. There is no provision in the First CMS Contract that states that a violation of the First CMS Contract will allow Eastpointe to recoup funds from CMS earned under a future contract between CMS and Eastpointe.

15. Pursuant to Eastpointe's duties under its Contract with DMA, Eastpointe entered into a second contract with CMS on July 7, 2014 for CMS to provide services to Medicare enrollees (the "Second CMS Contract"). The term of the Second CMS Contract was July 1, 2014 through June 30, 2015.

16. Like the First CMS Contract, the Second CMS Contract was the same template contract provided to Eastpointe by DMA, and included all of the same material terms without arm's length negotiation. There is no provision in the Second CMS Contract authorizing Eastpointe to recoup funds due under the Second CMS Contract for a breach of the First CMS Contract.

17. On July 7, 2014, Eastpointe gave CMS a notice of recoupment. The notice provided in part:

> After review of your insurance coverage it is the determination of Eastpointe that you had the following gap(s) in your insurance: General Liability, Professional Liability and Worker's Comp from July 1, 2013 through February 15, 2014.
>
> Attached you will see a payment detail for these timeframes. The total recoupment due to Eastpointe is $324,312.70. Failure to submit payment for this full amount within thirty (30) days of receipt of this communication will result in recoupments of future payments for your organization.

18. The July 7, 2014 notice advised CMS that it could appeal this decision by sending written notice of appeal to Eastpointe within twenty-one (21) calendar days of receipt. The notice stated that CMS must "submit in writing any supporting documentation as to why this decision should be reversed."

19. The July 7, 2014 notice did not inform CMS that Eastpointe would only consider Certificates of Insurance as proper evidence of insurance coverage.

20. Eastpointe had entered into a contract with DHHS/DMA on December 2012 ("DMA Contract"). (R. Ex. 1) That contract provided in part "EASTPOINTE shall require Network Providers to submit certificates of coverage to EASTPOINTE." (Emphasis added)

21. Testimony from Respondent stated that DMA had previously specifically advised Eastpointe that Eastpointe could not accept insurance declarations from providers and that certificates of insurance coverage ("COIs") are required. (T. p. 148:15-22; 163:15-18)

22. The small but perceptible distinction between the DMA contract and what Eastpointe was allegedly told is the distinction between certificates of coverage and certificates of insurance. It would seem that the critical point would be for the provider to demonstrate that indeed it has the required insurance coverage without regard to what label is placed on it, much like courts accept Orders with findings of fact that are more conclusions of law, but are usually accepted without regard to label.

23. The distinction is of no consequence because whether it is a more generic certificate of coverage or the specific certificate of insurance, neither was communicated to the Petitioner. Petitioner was not privy to nor a party to the contract nor conversations between Respondent and DMA. Petitioner was sending what she thought was sufficient to answer the question of insurance, but was being rejected by Respondent. There was no way for Petitioner to know that what was being sent to Respondent was not sufficient.

24. The First CMS Contract uses the specific language of "Certificates of Insurance" in Appendix G, Section 9 (c)(i). That proviso requires the Petitioner to provide the COI to show that Eastpointe has been named as an additional insured, and that it must be provided prior to entering into the contract. There is no evidence that such COIs were ever provided prior to entering the contracts or that there was ever any problem in this regard.

25. Appendix G, Section 9 is the same section that provides the specific remedy for a violation of the insurance requirements, which is termination in the sole discretion of Eastpointe.

26. The recoupment amount set forth in the July 7, 2014 notice was the entire amount paid by Eastpointe to CMS during the period of the alleged insurance lapse. There is no question that all services were provided and provided adequately by CMS for which it had previously been paid by Eastpointe during the alleged lapse period.

27. Upon receipt of the July 7, 2014 notice, Tammy Segura ("Ms. Segura"), principal of CMS, contacted her insurance agent, Sheilla Redd of Insurance Service Center ("Ms. Redd"), and requested Ms. Redd provide her with evidence of insurance during the alleged lapse period.

28. In response, Ms. Redd sent the following documents to Ms. Segura (the "Insurance Documents") as proof of insurance:

(a) A Declaration Page from Travelers Property Casualty Company ("Travelers") for a workers' compensation policy, with the policy period being March 8, 2014 to March 8, 2015;

(b) A Declaration Page from Philadelphia Insurance Companies ("Philadelphia") for an insurance policy that provided insurance for commercial property, commercial general liability, commercial auto, and professional liability coverage for the policy period December 4, 2012 to December 4, 2013;

(c) A Declaration Page from Philadelphia for an insurance policy that provided insurance for commercial property, commercial general liability, commercial auto, and

professional liability coverage for the policy period December 4, 2013 to December 4, 2014; and,

(d) A Notice of Cancellation of a workers' compensation policy from Isurity effective November 4, 2013.

29. The Declaration Pages contained in the Insurance documents were issued by Travelers and Philadelphia. The declaration pages are only issued after CMS had paid the policy premium and contemporaneous with the policy being issued. At least one half of the total premium must be paid before the declaration pages are issued.

30. According to Ms. Segura, the declaration pages are more accurate and more reliable than the COIs.

31. Ms. Redd sent Ms. Segura an email dated July 11, 2014 attaching the policy declarations. Ms. Segura forwarded this email to Karen Salacki ("Salacki") at Eastpointe. (P. Ex. 14) Ms. Salacki responded to Ms. Segura stating she needed to follow the appeal instructions contained in the letter. (P. Ex. 14) Ms. Salacki did not forward the information to Eastpointe's Grievance and Appeals Department. (T. p. 154:21-23) According to Respondent, typically Ms. Salacki does not forward that information because there is a "firewall" between her department and the Grievance and Appeals Department (T. p. 155:2-7; 159:24-25, 160:1-4) At some point apparently Eastpointe's Grievance and Appeals Department did receive and consider, but reject, the information attached to Ms. Segura's email. (T. p. 205:14-25, 206, 207:1; P. Ex. 16)

32. Ms. Segura had been in contact with Ms. Salacki previously and used that contact as the person to whom she felt the information should go. A firewall might be a useful and necessary part of the procedure, but it is hard to understand how merely forwarding information received by one department to another department can be any form of officious interloping with the affairs of the other. There does not seem to be anything that could be read into the giving of information from one department to the other. Such a hard and fast internal process "rule" means that the left hand does not know what the right hand of the same body is doing, which has the potential for causing serious consequences for providers, and which could be avoided by merely passing the information along.

33. CMS did not have a lapse in its insurance coverage for its commercial property, commercial general liability, commercial auto, or professional liability coverage. CMS did have a lapse in its workers' compensation policy from November 4, 2013 to March 8, 2014.

34. The total amount paid to CMS by Eastpointe from November 4, 2013 to March 7, 2014 was $159,923.92

35. On July 23, 2014, CMS timely appealed the July 7, 2014 notice of recoupment in accord with instructions provided in the letter. Eastpointe received CMS's appeal on July 25, 2014. Included in its appeal, CMS provided Eastpointe with the Insurance Documents received from Ms. Redd.

36. Eastpointe did not request any further information from Ms. Segura. Eastpointe never specifically asked CMS for a Certificate of Insurance.

37. On September 3, 2014, Eastpointe gave notice to CMS of its final decision with regard to the recoupment. In the September 3, 2014 notice, Eastpointe advised CMS that the recoupment amount had been adjusted to $209,515.21.

38. Although Eastpointe claimed that it reviewed the Insurance Documents in its September 3, 2014 notice, Eastpointe, refused to consider any document other than a Certificate of Insurance as evidence of insurance. CMS had no way of knowing that a Certificate of Insurance was the only documentation that Eastpointe would consider.

39. In the September 3, 2014 notice, Eastpointe did not advise CMS how it determined the amount of $209,515.21 was owed. Eastpointe did not advise which insurance policies had allegedly lapsed or the period of time in which the alleged lapse occurred.

SEPTEMBER 3, 2014 AMENDED CONTRACT

40. Together with the September 3, 2014 notice, Eastpointe provided CMS with an Amended Contract, which purported to unilaterally amend the First CMS Contract to eliminate September 16, 2013 through February 14, 2014 from the contract period. The September 3, 2014 notice stated, "Enclosed you will find your agency's amended contract to reflect the date adjustment for non-coverage of insurance."

41. CMS never approved or executed the Amended Contract.

42. Eastpointe's witness at first said that the reason for this amended contract was to minimize Eastpointe's potential liability. (Tr. pps. 244-252) Section 12.3 of the contract between DMA and Eastpointe allows for DMA to sanction Eastpointe in the event Eastpointe or one of its providers substantially fails to comply with the terms of the contract between Eastpointe and DMA. Sanctions include the possibility of Eastpointe being terminated from the contract with DMA.

43. Thus, the after-the-fact contract amendment that Eastpointe is trying to put in place is primarily to protect Eastpointe.

44. But this ruse also gives Eastpointe another avenue as a means to try to collect money from CMS. By voiding out the contract, then Eastpointe says that CMS received money improperly because there is no contract for that period of time. There is no question the services were rendered. There is no question about the quality of services. Eastpointe is trying to create a hole where none previously existed with the two-pronged purpose of covering its own behind with DMA, as well as creating a hole when there was no contract and ordering the provider to pay that money back.

45. Perhaps most interesting of all, Eastpointe's representative says that by voiding out the contract in this manner for the time that CMS allegedly did not have insurance, actually means that there is no time in which CMS is out of compliance. More succinctly—CMS is in compliance at all times the contract is in effect. This creates a very strange dichotomy: on the one hand, Eastpointe spends considerable effort to convince this Tribunal that the terms of the contract allow for recoupment, but on the other hand Eastpointe says that CMS is actually in compliance for the entire time the contract is in effect because Eastpointe has created a hole.

46. There is nothing in law or contract to allow this unilateral un-doing of a contract. This attempt to amend the contract after the fact is void *ab initio*. This unilateral un-doing is a very conscious effort to deceive by creating a situation to its own benefit after the fact. Such an act and its implications are very, very concerning legally to this Tribunal.

47. To say that this is just the way Eastpointe has done business is of no consequence. It merely means that somehow it has been allowed to get away with this ruse for some time without having been called on it. It does not make such a process okay. Eastpointe, in essence, adopted and implemented an un-promulgated policy whereby Eastpointe sought to unilaterally amend its contracts with providers.

48. Subsequent to the filing of CMS' petition, and prior to a Preliminary Injunction being issued by this Court, Eastpointe deducted $6,647.84 from payments due CMS under the Second CMS Contract as part of the claimed recoupment.

49. Eastpointe properly conducted its Reconsideration Review of Petitioner's internal appeal to Eastpointe. No procedural questions were raised by Petitioner.

BASED UPON the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the subject matter of this contested case and over the parties named therein pursuant to Chapters 108C and 150B of the North Carolina General Statutes.

2. To the extent the Findings of Fact contain Conclusions of Law, or the Conclusions of Law contain Findings of Fact, they should be so considered without regard to the given labels.

3. N.C.G.S. § 108C-12 requires this Court to issue a "final decision within 180 days of the date of filing of the appeal with the Office of Administrative Hearings." *See* N.C.G.S. § 108C-12. "The time to make a final decision shall be extended in the event of delays caused or requested by the Department." *Id.*

4. Because Eastpointe requested a continuance, the time for making the final agency decision was extended by request of the Department. *See* N.C. Gen. Stat. § 108C-12. Therefore, this final decision is timely. *See id.*

5. At all times relevant herein, Eastpointe acted as the agent of DHHS, within the course and scope of its authority, with regard to its actions towards CMS set forth above.

6. The First CMS Contract does not authorize Eastpointe to recoup funds from CMS for a lapse in insurance coverage.

7. The First CMS Contract does not authorize Eastpointe to recoup funds due and owing under the Second CMS Contract for a lapse in insurance that occurred during the First CMS Contract.

8. The Second CMS Contract does not authorize Eastpointe to recoup funds from CMS for a lapse in insurance coverage.

9. The Second CMS Contract does not authorize Eastpointe to recoup funds due and owing under the Second CMS Contract for a lapse in insurance that occurred during the First CMS Contract.

10. Eastpointe's unilateral amendment of the First CMS Contract to allow Eastpointe to recoup funds from CMS was not authorized by the First or Second CMS Contract.

11. A unilateral amendment to a contract is generally not allowed by basic principles of contract law.

12. Because Eastpointe determined that CMS had a lapse in insurance, Eastpointe has attempted to unilaterally amend its contract with CMS to eliminate from the contract the period during which Eastpointe believed CMS had a lapse in insurance, then initiated recoupment from CMS on the basis that the payments made to CMS were paid during a period where no contract existed between the parties.

13. Respondents have not promulgated a rule to implement Respondent's interpretation of any controlling authority that would allow for a unilateral amendment of its provider contracts, nor followed the procedures required for public hearing, determination of fiscal costs, or review by the Rules Review Commission before a rule becomes effective and codified.

14. Pursuant to the North Carolina Administrative Procedure Act, Chapter 150B (the "APA"), and specifically G.S. 150B-2(8a), "Rule" means any agency regulation, standard, or statement of general applicability that implements or interprets an enactment of the General Assembly or Congress or a regulation adopted by a federal agency or that describes the procedure or practice requirements of an agency." G.S.150B-(8a)(c) defines nonbinding interpretive statements as "statements within the delegated authority of an agency that merely define, interpret, or explain the meaning of a statute or rule." Respondents' interpretations that were not adopted as

a rule are "nonbinding." Respondents' interpretation of the provider contractual provisions and the "Controlling Authority" set forth therein are nonbinding interpretative statements.

15. Respondents are not exempted from Article 2A of Chapter 150B.

16. Pursuant to N.C. Gen. Stat. § 150B-18, an interpretative statement made by Respondents is not valid unless it is adopted in substantial compliance with the APA. G.S. 150B-18 specifically and affirmatively prohibits the enforcement of a nonbinding interpretative statement. It is quoted as follows:

> An agency shall not seek to implement or enforce against any person a policy, guideline, or other nonbinding interpretive statement that meets the definition of a rule contained in G.S. 150B-2(8a) if the policy, guideline, or other nonbinding interpretive statement has not been adopted as a rule in accordance with this Article.

17. To the extent a unilateral amendment of provider contracts to allow for redefining the contract period and recoupment of payments made during the amended non-contract period is not prescribed by applicable federal or North Carolina law, and not allowed by the terms of the contract itself, such methods must be adopted as a rule as defined in G.S. 150B-2(8a).

18. To the extent a unilateral amendment of provider contracts to allow for redefining the contract period and recoupment of payments made during the amended non-contract period is not prescribed by applicable federal or North Carolina law, allowed by the terms of the contract, or properly adopted as a rule pursuant to the APA, such method does not carry the force of law.

19. To the extent a unilateral amendment of provider contracts to allow for redefining the contract period and recoupment of payments made during the amended non-contract period is not prescribed by applicable federal or North Carolina law, allowed by the terms of the contract, or properly adopted as a rule, such denial is invalid as contrary to law.

20. There is nothing in law or contract to allow this unilateral amendment of the contract. This attempt to amend the contract after the fact is void *ab initio*.

21. Because Eastpointe attempted to recoup payments from CMS by unilaterally amending the First CMS Contract to remove the lapse period from the contract without legal authority to do so, such amendment and recoupment was erroneous.

22. There is no unjust enrichment for Petitioner by the ruling in this Decision. There is no windfall.

22. Respondents, in seeking to bind CMS to their interpretation and a unilateral amendment to the First CMS Contract, exceeded Respondents' authority, failed to use proper procedure, and failed to act as required by law.

23. Eastpointe acted erroneously by seeking to unilaterally amend the First CMS Contract, by seeking to recoup payments due under the Second CMS Contract, by failing to promulgate APA rules to determine when a provider contract may be unilaterally amended and when Eastpointe may recoup funds from a provider, and by recouping from CMS $6,647.84. Petitioner is entitled to receive $6,647.84 from Eastpointe as reimbursement for the unlawful recoupment.

24. Petitioner failed to show that Respondent acted arbitrarily or capriciously and is therefore not entitled to reasonable attorney fees.

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the Undersigned makes the following:

DECISION

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned determines Respondent did deprive Petitioner of property, exceeded its authority or jurisdiction, failed to act as required by law or rule in its decision to charge Petitioner in the amount of $209,515.21 as the result of a lapse in coverage for professional liability insurance, general liability insurance, and worker's compensation insurance. Respondent's decision is hereby **REVERSED.**

Respondents shall not recoup any funds from Petitioner for the alleged lapse of insurance. Respondent Eastpointe shall pay to Petitioner the amount of $6,647.84 for the funds already recouped by Eastpointe from Petitioner. Respondent Eastpointe shall reimburse to Petitioner its filing fees as Petitioner is the prevailing party. Petitioner's request for reasonable attorney fees is **DENIED**.

IT IS SO ORDERED.

NOTICE

Pursuant to N.C.G.S. § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge may commence such appeal by filing a Petition for Judicial Review in the Superior Court of the county in which the person aggrieved by the administrative decision resides. The appealing party must file the petition within thirty (30) days after being served with a written copy of the Administrative Law Judge's Final Decision. In conformity with the Office of Administrative Hearings' rule, 26 NCAC 03.012, and the Rules of Civil Procedure, N.C.G.S. lA-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision. N.C.G.S. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Pursuant to N.C.G.S. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within thirty (30) days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent

to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

This the 30th day of October, 2015.

_____
Hon. Donald W. Overby
Administrative Law Judge