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Oregon Health Authority
Medicaid Division
500 Summer Street, N.E., E-36
Salem, Oregon 97301-1118

In the Matter of:

Rever Grand, Inc.
fka Rever Grand, LLC

To: Rever Grand, Inc. c/o Kristi Bonham, Chief Operating Office

Address(es): 1553 NE F Street, Grants Pass, OR 97526

eXPRS ID: [redacted].

Pursuant to ORS 413.032, the Oregon Health Authority (OHA), Medicaid Division (MD) (the Division) is the state Medicaid agency authorized to administer funds from Titles XIX and XXI of the Social Security Act and to administer medical assistance under ORS Chapter 414. The Division regulates providers participating in Oregon's medical assistance programs as provided by ORS 414.065.

Rever Grand Inc. fka Rever Grand LLC (Provider) is certified as a provider agency under OAR Chapter 411 Division 323 and is endorsed to provide Community Living Services pursuant OAR Chapter 411 Division 450. Provider has no other endorsements. Provider provides community living supports as a standard model agency as defined in OAR 411-450-0020(44). Provider participates in Oregon's medical assistance program under a Provider Enrollment Agreement (PEA) with the Oregon Department of Human Services (ODHS).

Determination of Credible Allegation of Fraud

On or about September 3, 2024, the Oregon Medicaid Fraud Control Unit (MFCU) provided a copy of an indictment of Provider issued in the Josephine County

Circuit Court in Case No. 24CR42893 on June 11, 2024 and filed August 16, 2024 (the Indictment).

The Division reviewed the allegations in the Indictment and sought and reviewed all available information and evidence related to the allegations.

The Indictment alleges that Rever Grand, Inc. (Provider) engaged in fraud by "unlawfully, knowingly, and with the intent to obtain a health care payment to which [Provider] was not entitled, conceal from and fail to disclose to the Department of Human Services, a health care payor, the existence of information." The Indictment covers all claims submitted for payment in several specific timeframes.[1]

The Division finds that the Indictment contains allegations with an indicia of reliability because the Indictment is based on evidence presented to a grand jury and is the result of a law enforcement investigation by the MFCU. Therefore, the Division has determined in this case that there is a credible allegation of fraud[2] with respect to Provider, effective September 11, 2024.

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[1] The Indictment lists the following timeframes:
August 13, 2019 to January 15, 2020
January 16, 2020 to June 12, 2020
June 16, 2020 to November 13, 2020
November 16, 2020 to April 14, 2021
April 16, 2021 to September 15, 2021
September 16, 2021 to February 14, 2022
February 18, 2022 to July 15, 2022
July 18, 2022 to December 14, 2022
December 16, 2022 to May 15, 2023
May 17, 2023 to October 13, 2023
October 16, 2023 to March 15, 2024
March 18, 2024 to May 31, 2024

[2] According to 45 CFR 455.2: "Credible allegation of fraud. 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: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis."
According to OAR 410-120-0000 (97): "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law."
According to OAR 410-120-1510(1)(a): "(1) This rule sets forth requirements for reporting, detecting and investigating fraud and abuse. The terms fraud and abuse are defined in OAR 410-120-0000. For the purpose of these rules, the following definitions apply:
(a) "Credible allegation of fraud" means an allegation of fraud, that has been verified by the state and has indicia of reliability that comes from any source as defined in 42 CFR 455.2"

The Division acknowledges that it is obligated to suspend Medicaid payments to Provider [3] unless it determines there is good cause not to suspend such payments in accordance with federal regulations.[4]

Determination of Good Cause Not to Suspend Medicaid Payments

The Division finds that there is good cause not to suspend Medicaid payments to Provider pursuant to 42 CFR 455.23(e)(4)(ii). Beneficiary access to personal care services would be jeopardized by a payment suspension because Provider serves a large number of beneficiaries within one or more HRSA-designated medically underserved areas.

The Division further finds that there is good cause not to suspend Medicaid payments to Provider pursuant to 42 CFR 455.23(e)(6) because the Division has determined that payment suspension is not in the best interests of the Medicaid

[3] According to 42 USC 1396b(i)(2)(C):
"(i) Payment under the preceding provisions of this section shall not be made—(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments."
According to 42 CFR 455.23(a)(1):
"(a) Basis for Suspension (1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part."

[4] According to 42 CFR 455.23(e)(1)-(6): "(e) Good cause not to suspend payments. A State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
(2) Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.
(3) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
(4) beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:
(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.
(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
(6) The State determines that payment suspension is not in the best interests of the Medicaid program."

program because suspension could disrupt the continuity of services to many vulnerable beneficiaries over a large area of the state. As of a recent count, Provider had Medicaid reimbursement authorizations for approximately 2,148 beneficiaries who reside in most or all of Oregon's 36 counties and includes beneficiaries in rural and other hard-to-serve areas.

Beneficiaries enrolled with Provider receive critical in-home services to meet their attendant care needs. Provider assumes all related responsibilities including employing caregivers, providing coverage when a caregiver is unavailable, and other extensive care coordination necessary to maintain the health and safety for individuals with developmental and intellectual disabilities living in the community. An immediate withdrawal of Medicaid payment reimbursing Provider for these services would place vulnerable individuals at serious risk of neglect or hospitalization. ODHS has estimated that it will need approximately 90 days to give beneficiaries the opportunity to make alternate arrangements through the Medicaid mandated process of Choice Advising (see OAR 411-415-0020(7); 42 CFR 441.540).

Some portion of the beneficiaries receive services from family members who are also employees of Provider. For those beneficiaries, ODHS has expressed concern for the unique challenges of simultaneously losing income and necessary care that further demonstrates good cause to delay suspension. The additional time will allow those families to make alternate arrangements.

Duration or Conditions Under Which Good Cause Will Continue

The Division has determined that good cause will exist for such time period as there remains a substantial number of beneficiaries who are actively seeking alternate arrangements but have not been able to access a suitable alternative.[5] Good cause will be evaluated on an ongoing basis, including, but not limited to evaluation of these factors:

- ODHS' ability to contact beneficiaries without interference from Provider.

[5] According to 42 CFR 455.23(g)(2)(i) and (ii): "(g) Documentation and record retention. State Medicaid agencies must meet the following requirements: (2)(i) Maintain for a minimum of 5 years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause. (ii) This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the State anticipates such good cause will exist."

- Provider's engagement in assisting individuals to explore choices and enroll with alternate providers.

- Provider not otherwise interfering with the individual's choice by taking actions that impede or obstruct care transition.

- Provider facilitates and ensures that all documentation and support documents are made available to ODHS and to any new provider, and takes any other actions necessary to facilitate a beneficiary's choice to change providers, within three (3) business days of ODHS' request for the same.

- Provider or Provider agent dissemination of any false or misleading statements regarding the status of Provider's pending Medicaid payment suspension.

- Any other actions taken by Provider that pose a greater risk to beneficiaries or the Medicaid program when viewed on balance, outweigh the basis for the good cause finding not to suspend payment in whole or in part.

- Beneficiaries in some or all service areas are no longer enrolled with Rever Grand or have indicated their choice to remain with Rever Grand.[6]

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[6] According to 42 CFR 455.23(f): "Good cause to suspend payment only in part. A State may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
(1) beneficiary access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.
(2) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
(3)
(i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
(ii) The State determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
(4) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
(5) The State determines that payment suspension only in part is in the best interests of the Medicaid program."

Statement of Non-Final Determinations

The foregoing determinations are subject to further consideration. If the conditions under which good cause will continue are no longer met, and a credible allegation of fraud continues to exist, the Division is required to issue an order suspending Medicaid payments to Provider, which will include appeal rights under ORS Chapter 183.

DATED this 11 day of September, 2024.

Fritz Jenkins
Office of Program Integrity
Fiscal and Operations Division
On Behalf of Medicaid Division
Oregon Health Authority