No. 15-7

In the Supreme Court of the United States

UNIVERSAL HEALTH SERVICES, INC.,
Petitioner,

v.

UNITED STATES AND COMMONWEALTH OF MASSACHUSETTS EX REL. JULIO ESCOBAR AND CARMEN CORREA,
Respondents,

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE COMMONWEALTH OF MASSACHUSETTS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the False Claims Act prohibits a claimant from billing the government for goods or services when the claimant knows (and fails to disclose) that the goods or services fail to comply with material statutory, regulatory, or contractual requirements (a theory described by some circuits as "implied false certification" liability).

2. Whether, under an "implied false certification" theory, the material statutory, regulatory, or contractual requirement must expressly state that it is a condition of payment by the government.

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INTERESTS OF *AMICUS CURIAE*

Pursuant to Supreme Court Rule 37.4, the Commonwealth of Massachusetts ("Commonwealth") submits this brief *amicus curiae* in support of respondents.

The Commonwealth is directly interested in this case. At issue is whether petitioner Universal Health Services, Inc. ("UHS") defrauded the Commonwealth by submitting claims to the Massachusetts Medicaid agency ("MassHealth") for mental health services that violated expressly stated conditions of payment in MassHealth's regulations. Contrary to these explicit and longstanding requirements for mental health centers, and without disclosing its violations, UHS sought and obtained reimbursement for services provided by unlicensed and unsupervised mental health counselors in a clinic that lacked an adequately credentialed psychiatrist.[1] This case thus revolves around MassHealth's regulations, in the context of a serious fraud against the Commonwealth that may have led to significant patient harm. The Commonwealth also has a more general interest in maintaining a robust defense against fraud through the Federal False Claims Act, 31 U.S.C. § 3729(a) ("FCA"), and the analogous Massachusetts False Claims Act, Mass. Gen. Laws ch. 12, § 5B ("MFCA").

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[1] Because this case reaches the Court on a motion to dismiss, respondents' allegations are assumed to be true. Moreover, several Massachusetts agencies have already taken action regarding aspects of UHS's alleged conduct. *See* Pet. App. 30-32 (district court's summary of related administrative proceedings resulting from relators' complaints).

The Commonwealth submits this brief (1) to elaborate on the court of appeals' correct holding that MassHealth expressly conditions payment to mental health centers on certain supervision and staffing requirements; (2) to explain *why* MassHealth conditions payment on satisfaction of these requirements; and (3) to describe how destructive it would be to the aims of the FCA (and the MFCA) to carve out as exempt from liability an entire category of fraud against the government.

SUMMARY OF THE ARGUMENT

MassHealth explicitly conditions payment for mental health services on fulfillment of certain requirements set forth in its "Mental Health Center Services" regulations, 130 C.M.R. §§ 429.000 *et seq.* ("Section 429").[2] This case concerns two conditions of payment that apply to facilities like UHS's Arbour Counseling Services in Lawrence, Massachusetts ("Arbour-Lawrence"). Specifically, MassHealth requires such facilities to supervise mental health workers, *id.* § 429.423(B)(2)(c), and to employ a board-certified or board-eligible psychiatrist, *id.* § 429.423(B)(2)(e). MassHealth conditions payment on satisfying these requirements. *Id.* § 429.439.

These longstanding conditions of payment are central to the bargain between MassHealth and mental health centers. The mental health field presents inherent challenges for a Medicaid agency attempting to pay only for medically necessary and

[2] Except where noted, all cited provisions from the Code of Massachusetts Regulations ("C.M.R.") were the same and in effect from October 24, 2003 to January 1, 2014, encompassing the entire time period relevant to this case.

clinically appropriate services. The individualized nature of mental illness and its treatment means that MassHealth lacks fixed objective metrics for evaluating the quality of care provided and merits of each claim submission. And MassHealth cannot monitor each individual patient's private therapy sessions to determine whether the services provided are medically necessary and appropriate. Given these constraints in assessing providers' performance, MassHealth has instead instituted supervision and staffing requirements—requirements that are express conditions of payment and reflected throughout Section 429.

Disregarding these express conditions of payment, UHS submitted claims for services without acknowledging that Arbour-Lawrence's unlicensed social workers and mental health counselors were unsupervised, and without acknowledging that Arbour-Lawrence lacked a board-certified or even board-eligible psychiatrist. This fraud came to MassHealth's attention only because respondents came forward after the death of their daughter. This case thus demonstrates the continuing need for the FCA as Congress intended it: a broad prohibition of fraud, with incentives for relators to come forward. The Commonwealth respectfully submits that this Court should exempt from liability fraud of the kind committed here.

ARGUMENT

I. MassHealth Expressly Conditioned Payment on Supervision and Adequate Psychiatric Staffing

MassHealth expressly and unequivocally states in Section 429 that it will reimburse services provided at a "satellite" facility of a mental health center only if the satellite meets certain staffing and supervision requirements.[3] These payment conditions, first instituted in 1997, have remained unaltered for nearly 20 years. *See* 130 C.M.R. §§ 429.000 *et seq.* (Feb. 1, 1997); 130 C.M.R. §§ 429.000 *et seq.* (Jan. 1, 2014). As the court of appeals below recognized, Section 429's plain language establishes that these provisions are conditions of payment. *United States ex rel. Escobar v. Universal Health Servs., Inc.*, 780 F.3d 504, 513 (1st Cir. 2011). Moreover, Section 429's entire regulatory scheme reinforces the importance of these supervision and staffing provisions to MassHealth's decision to pay mental health centers and their satellites.

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[3] There is no dispute that Arbour-Lawrence is a "satellite facility" (or "satellite program"), defined by MassHealth as a "mental health center program at a different location from the parent center that operates under the license of and falls under the fiscal, administrative and personnel management of the parent center"; is "open to patients more than 20 hours a week"; and "offers more than 40 person hours a week of services to patients." 130 C.M.R. § 429.402.

A. The Regulation's Text Is Explicit and Unambiguous

The conditions of payment at issue in this case are stated in a subsection of Section 429 titled "Satellite Programs," which has the explicit and sole purpose of stating when "[s]ervices provided by a satellite program are reimbursable." 130 C.M.R. § 429.439. The regulation begins by stating that "[s]ervices provided by a satellite program are *reimbursable only if* the program meets the standards described below." *Id.* (emphasis added). The list of standards that follows includes an unqualified mandate that the parent center's director of clinical services[4] designate a clinical director at the satellite program who "must be employed on a full-time basis and meet *all* of the requirements in 130 C.M.R. § 429.423(B)." *Id.* § 429.439(C) (emphasis added).

Thus designated as "requirements" for reimbursement, the contents of 130 C.M.R. §429.423(B) enumerate the "Position Specifications and Qualifications" that the satellite's clinical director (or "Director of Clinical Services") must meet. The provision begins by stating that the clinical director is "responsible…for the direction and control of all professional staff members and services." 130 C.M.R. § 429.423(B). The provision elaborates on this general requirement in two subsections. Subsection (B)(1) specifies the required professional background for a clinical director and

[4] The MassHealth regulations use "director of clinical services" and "clinical director" interchangeably. *See, e.g.*, 130 C.M.R. § 429.423(B).

the minimum hours the clinical director must spend at the satellite. *Id.* § 429.423(B)(1). Subsection (B)(2) then lists ten "specific responsibilities of the clinical director," including, as relevant here, the "overall supervision of staff performance," *id.* § 429.423(B)(2)(c), and "in conjunction with the medical director, accountability for employing adequate psychiatric staff to meet the psychopharmacological needs of clients," *id.* § 429.423(B)(2)(e).

MassHealth's regulations thus plainly instruct UHS and its satellite Arbour-Lawrence that the satellite's "services…[are] reimbursable only if" the clinical director supervises the staff, and the satellite employs an appropriately credentialed psychiatrist. These requirements are neither surprising nor obscure; they are contained in a provision explicitly devoted to "Satellite Programs" like Arbour-Lawrence, within the discrete section of MassHealth regulations governing all mental health center services.[5] The court of appeals therefore properly found that "the provisions at issue in this case clearly impose conditions of payment." *Escobar*, 780 F.3d at 513.

B. The Regulatory Scheme as a Whole Reflects the Existence of These Conditions of Payment

Beyond the express language of the Satellite Programs regulation, MassHealth's conditioning of payment on proper supervision and adequate

[5] A PDF of Section 429 is available at www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr429.pdf.

staffing is consistent with Section 429's regulatory scheme more broadly. That scheme both instructs satellites as to the types of supervision and staffing that meet the conditions of payment, and links payment to supervision and staffing in other ways.

Section 429 prescribes in detail the supervision and staffing standards that satellites must maintain. With respect to supervision generally, Section 429 provides that "[e]ach staff member must receive supervision appropriate to the person's skills and level of professional development….within the context of a formalized relationship providing for frequent and regularly scheduled personal contact…conform[ing] to the licensing standards of each discipline's Board of Registration[.]" 130 C.M.R. § 429.438(E)(1).

The regulations further elucidate the supervision requirements in a provision titled "Qualifications of Staff by Core Discipline"—the core mental health disciplines being psychiatry, psychology, social work, and psychiatric nursing.[6] *See id.* § 429.424; § 429.402 (defining "core discipline"). This provision includes specific requirements for psychiatric medical residents, who "must be under the direct supervision of a fully qualified psychiatrist," *id.*

[6] During the time period covered by respondents' complaint (2005-2011), this provision's title was "Qualifications of Staff by Core Discipline." On January 1, 2014, MassHealth changed the title of this section to "Qualifications of Professional Staff *Authorized to Render Billable Mental Health Services* by Core Discipline." 130 C.M.R. § 429.424 (emphasis added). (The provision was otherwise unchanged, except for the addition of a subsection covering psychiatric clinical nurse specialists. *See* 130 C.M.R. § 429.424(E).)

§ 429.424(A)(2); for "additional staff members trained in the field of clinical or counseling psychology or a closely related specialty," who "must...be under the direct and continuing supervision of a psychologist meeting" certain requirements, *id.* § 429.424(B)(2)(c); for social workers, who "must provide services under the direct and continuous supervision of an independent clinical social worker," *id.* § 429.424(C)(2); and for "all counselors and unlicensed staff," who "must be under the direct and continuous supervision of a fully qualified professional staff member trained in one of the core disciplines," *id.* § 429.424(E)(1).

Section 429 also elaborates on the condition of payment that satellites must employ adequate psychiatric staff, *see id.* § 429.423(B)(2)(e). Under subsection 429.424(A)(1), MassHealth requires every mental health center to employ "at least one staff psychiatrist" who must be either board-certified or eligible and applying to be certified. This requirement corresponds with a regulation promulgated by MassHealth's sister agency, the Department of Public Health ("DPH"),[7] which oversees the maintenance, licensure, and operation of all clinics in the Commonwealth, including satellites like Arbour-Lawrence. 105 C.M.R. § 140.530; Mass. Gen. Laws ch. 111, § 51. The DPH regulation likewise requires all clinics to maintain a staff that includes a "psychiatrist who is a physician…and who is board certified…or eligible for such certification." 105 C.M.R. § 140.530(C)(1)(a).

[7] *See* Mass. Gen. Laws ch. 6A, § 16 (identifying both the division of medical assistance, otherwise known as MassHealth, and DPH as agencies under the Commonwealth's Executive Office of Health and Human Services).

And "a satellite clinic must meet, independently of its parent clinic, all the requirements imposed on clinics" by DPH. *Id.* § 140.330.

Additional Section 429 provisions also tie MassHealth payment to supervision. Section 429 includes "supervision" among the costs covered by "payment by [MassHealth] for a mental health service[.]" 130 C.M.R. § 429.408(B)(3) (as of October 24, 2003); *id.* § 429.408(C)(3) (as of December 26, 2008). And Section 429 contains supervision-related conditions of payment for other entities. Thus, services provided by an "autonomous satellite program"—*i.e.*, a satellite program that has "sufficient staff and services to substantially assume its own clinical management independent of the parent center," *id.* § 429.402—are "*reimbursable only if*" the satellite "provide[s] supervision and in-service training to all noncore staff employed at the satellite program." *Id.* § 429.439(B) (emphasis added). Likewise, an outreach program operated by a mental health center is "eligible for payment" only if it meets certain standards, including that "staff members must receive supervision and in-service training in accordance with the requirements specified in 130 C.M.R. § 429.438(E)," described above. *Id.* § 429.440(A).

Section 429 is thus replete with provisions tying payment by MassHealth to proper supervision and staffing by mental health centers. Considered as a whole, these provisions demonstrate that supervision and adequate psychiatric staffing not only are express conditions of payment, but also are at the heart of the bargain between the Commonwealth and satellite providers like Arbour-Lawrence. By making

claims for reimbursement despite UHS and Arbour-Lawrence's ongoing, knowing failure to comply with these conditions of payment, UHS and Arbour-Lawrence violated the FCA and MFCA.

II. Supervision and Adequate Psychiatric Staffing Are Necessarily Central to MassHealth's Bargain with Mental Health Centers

MassHealth conditions reimbursement for mental health services on proper supervision and adequate psychiatric staffing because those requirements are the baseline means by which it ensures that taxpayer monies are spent on appropriate care for its members. The mental health care field presents particular challenges for monitoring and evaluating both the quality of care provided and the merits of each claim submission. As a result, MassHealth must rely heavily on mental health centers and their satellites' compliance with supervision and staffing requirements to ensure that the Commonwealth receives the benefit of its bargain.

MassHealth cannot engage in real-time observation of the therapeutic services provided by mental health center staff. As a practical matter, "social workers perform their functions under conditions that do not permit direct observation"; they "hold interviews in private and discourage observation as an obstruction on the privacy of the encounter." Alfred Kadushin, *Supervision in Social Work* 37 (4th ed. 2002) (hereinafter "Kadushin"). Because of the complex nature of mental illness and its treatment, MassHealth members frequently are ill-equipped to evaluate critically the quality and

appropriateness of services that they are receiving. *See* Institute of Medicine, *Psychosocial Interventions for Mental and Substance Abuse Disorders: A Framework for Establishing Evidence-based Standards* 15 (2015) (hereinafter "Psychosocial Interventions") (noting that "consumers have limited involvement in the development and implementation of quality measures in this arena"). In the absence of supervision by appropriate staff during therapy, MassHealth has few ways, if any, of contemporaneously ensuring that it is paying only for treatment that is medically necessary and appropriate to address a MassHealth member's needs.

Although MassHealth can engage in retrospective review of documentation maintained by mental health center staff after therapy sessions, *see* 130 C.M.R. § 450.205(A), there are significant limits to the effectiveness of review after the fact. Without additional context, MassHealth members' records often do not provide a complete picture of whether the patients' diagnoses are accurate or their treatment plans are appropriately designed and implemented. "[T]he best forms fail to collect a good deal of significant information about the [mental health] worker's activity." Kadushin, at 37. There is also a real risk that the records may be altered or destroyed in an effort to conceal fraudulent behavior.[8] Even absent such risk, reliance on an

[8] *See, e.g.*, Press Release, "Owner of In-Home Care Business Sentenced to Jail, Company to Pay $3.3 Million for Billing MassHealth for Services not Provided," (October 30, 2013) at http://www.mass.gov/ago/news-and-updates/press-releases/2013/2013-10-30-richardson-sentence.html (reporting Commonwealth's prosecution of defendants who falsified and

audit conducted months or years after treatment cannot provide the immediate oversight necessary to ensure the quality of service provided to MassHealth members, for whom inadequate care can have devastating consequences. Nor can retrospective review prevent the needless additional expenditure of public funds over the long term caused by substandard care.

Moreover, when conducting either contemporaneous or retrospective review of claims for mental health services, MassHealth currently lacks reliable qualitative or quantitative metrics to determine whether reimbursement claims for mental health services are based on necessary and appropriate medical therapy. Mental health services are "nonroutine, nonstandardized, unpredictable, [and] highly individualized." Kadushin, at 36. Whether delivered in an individual or group setting, therapy is a process that varies in approach and frequency for each patient, depending on the nature of the patient's condition and rate of improvement

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destroyed records to conceal a failure to provide services); Press Release, "Owner and Recruiter for Louisiana and Texas Mental Health Clinics Convicted as Part of $258 Million Health Care Fraud Scheme in Baton Rouge, Louisiana," (May 22, 2014) at https://www.justice.gov/opa/pr/owner-and-recruiter-louisiana-and-texas-mental-health-clinics-convicted-part-258-million (reporting U.S. Department of Justice's prosecution of owner and recruiter of mental health clinics who "falsif[ied] patient treatment records for services that had not been provided"); Colleen Heild, *AG: Behavioral Health Boss Falsified Records*, Albuquerque Journal (Oct. 10, 2014), at http://www.abqjournal.com/477521/news/ag-behavioral-health-records-falsified.html (reporting New Mexico's prosecution for falsification and destruction of records by behavioral health provider).

over time. There are no universally accepted metrics for incorporating performance measures based on patient-reported outcomes; the field lacks "consensus on which outcomes should have priority and what tools are practical and feasible for use in guiding ongoing clinical care." Psychosocial Interventions, at 15. As a result of these uncertainties, MassHealth simply cannot say, as a general rule, that diagnosis of a particular condition should result in a course of therapy lasting a specific number of sessions over a predictable period of time, covering a fixed set of issues during the sessions.

This variability prevents MassHealth from conducting the kinds of contemporaneous claims oversight available in other medical contexts. In the pharmacy context, for example, MassHealth can determine instantaneously whether a prescription is for a "covered" drug for which MassHealth is authorized to make payment, *see* 130 C.M.R. § 406.412, and the proper amount to be paid for the strength and quantity of the drug dispensed, *see id.* § 406.431. Similarly, for acute inpatient hospital admissions and stays, MassHealth can apply standardized tools in its review of a patient's medical record to determine— "prior to, concurrently or retrospectively"—whether a hospital admission is medically necessary and appropriate, and how long a stay should last. *See id.* § 415.414(B).

Without analogous qualitative and quantitative metrics in the mental health center context, MassHealth needs, and conditions payment on, oversight in the form of clinics' adequate supervision and psychiatric staffing. "The cause-and-effect relationship between social work activity and

changes in the client's situation is…subtle and difficult to define. Because the damaging effects of poor practice are not so self-evident and observable, protection of the client requires a procedure for explicit periodic review of worker activity and practice outcomes." Kadushin, at 38; *accord* Janine Bernard & Rodney Goodyear, *Fundamentals of Clinical Supervision* 7 (1992) (hereinafter "Bernard & Goodyear") (describing origins of clinical supervision in monitoring quality of care).

In other words, lacking reliable or readily-available standards for performance or outcomes, MassHealth has chosen to use a design-based regulatory standard that focuses on the process by which therapy is to be given—*i.e.*, by sufficiently credentialed staff, under adequate supervision by licensed professionals. *See* Jonathan Mant, *Process Versus Outcome Indicators in the Assessment of Quality of Health Care*, 13 Int'l J. for Quality in Health Care 6 (2001) (describing challenges of measuring performance in healthcare generally and noting that process-based standards are often more appropriate); *see generally* Stephen Breyer, *Regulation and Its Reform* 105-6 (1982) (contrasting design and performance standards and noting that "in principle, design standards are easier to enforce than performance standards").

MassHealth's regulations conditioning payment on supervision and adequate psychiatric staffing are an efficient and substantial regulatory check, relying on widely-accepted best practices in the mental health field. *See* Bernard & Goodyear, at 2 (describing centrality of supervision to the field); *see also* Jeanne Marie Hughes, *The Role of Supervision*

in Social Work: A Critical Analysis, 2 Critical Social Thinking: Policy and Practice 59, 63 (2010) (noting "[s]upervision has been recognized as an integral part of social work since the early 1900s"). Requiring clinically appropriate professional supervision helps ensure that MassHealth's members receive services consistent with the standard of care. *See* Robert Cohen, *Clinical Supervision* 3 (2004) ("Clinical supervisors, at minimum, monitor the quality of their supervisees' work on behalf of their clients to ensure sound practice according to professional ethical standards and the law of the land."); Bernard & Goodyear, at 1 ("The helping professional who has gained experience *without* the benefit of supervision is likely to have acquired skills and work habits that are at variance with usual standards of practice."). In this way, MassHealth also increases the likelihood of positive patient outcomes. *See generally* Nat'l Ass'n of Social Workers & Ass'n of Social Work Boards, *Best Practice Standards in Social Work Supervision* 6 (2013) ("During supervision, services received by the client are evaluated and adjusted, as needed, to increase the benefit to the client."). Without regular supervision and oversight by experienced and licensed staff, including board-certified or board-eligible psychiatrists, MassHealth members "would be left without effective protection from practice that might be damaging[.]" Kadushin, at 37.

The facts of the present case highlight this danger. For many years, a significant number of mental health workers provided unsupervised, unlicensed therapy and services at Arbour-Lawrence. Among the patients personally affected was the respondents' late daughter. Reducing the risk of

substandard care and its potentially tragic consequences is a critical objective underlying MassHealth's choice to require supervision and adequate staffing as conditions of payment.

In short, adequate licensing and supervision of mental health center staff are essential to MassHealth's bargain with these providers and their satellite programs. The inability to enforce—or incentivize private enforcement of—these payment conditions under the FCA and MFCA would leave MassHealth and its members more vulnerable to the harms these regulations seek to prevent.

III. Narrowing the FCA Would Frustrate Congress' Intent and Impede Efforts to Combat Fraud

Eliminating an entire category of fraud from the scope of FCA liability would place a substantial roadblock in front of federal and state law enforcement officials in their uphill battle to protect the public fisc. The fraudulent conduct at issue in the current case is but one of a vast and complex range of fraudulent schemes to obtain government funds. While MassHealth regulations expressly advised UHS and Arbour-Lawrence that payment was conditioned upon compliance with Section 429's staffing and supervision regulations, not even a clairvoyant government official could foresee every potential fraudulent scenario in order to draw up a complete list of conditions of payment to be explicitly identified at the moment a claim is submitted.

Nor is this a burden the government bears or should bear. Government contractors have a duty to

know and comply with the terms of their bargains. As this Court has previously stated, "[p]rotection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law," and they should "expect no less than to be held to the most demanding standards in [the] quest for public funds." *Heckler v. Cmty. Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63 (1984).

Such was Congress' intent in drafting the FCA. "Congress wrote [the FCA] expansively, meaning to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Cook County, Ill. v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (citations omitted). This is not to suggest, as petitioners and their *amici* contend, that any regulatory violation, however insignificant, is subject to liability under the FCA (and MFCA) if viewed through the prism of "implied certification." The paramount requirements that a claim be *materially* false, and that it be *knowingly* false when made, determine whether a false claim justifies liability. The pleading requirements of Fed. R. Civ. P. 9(b) also provide adequate and effective safeguards against unwarranted litigation under the FCA.

Abolishing liability for a broad swath of knowing, materially false claims, whose falsity goes to the heart of the bargain between a contractor and the government, would deprive the government of an important weapon against fraud. It would also undermine the FCA's whistleblower provisions. The present case provides a perfect example of a serious fraud exposed by a *qui tam* relator. Making the

scope of liability turn on technical drafting questions of "express" versus "implied" conditions would increase the level of risk and uncertainty in FCA litigation, particularly for relators, thus diminishing their incentive and willingness to come forward. While alternate administrative procedures may be useful to discover and address fraud in some cases, government payors, particularly at the state level, often have limited resources with which to identify a fraud against the public fisc in the first instance. Indeed, the existence of these resource constraints motivated Congress to enact the FCA in the first place. *See Marcus v. Hess,* 317 U.S. 537, 547 (1943) ("large rewards were offered [under the FCA] to stimulate actions by private parties should the prosecuting officers be tardy in bringing the suits").

In essence, the various judicially-constructed FCA "certification" theories are simply means of conceptualizing how a person commits fraud by submitting claims for payment while knowingly failing to comply with material payment terms. To carve out these acts of fraud from the FCA's reach would create a loophole through which unscrupulous contractors would surely aim their schemes, empowered to increase their profits by secretly and knowingly ignoring material obligations. Without a strong and effective FCA to protect vulnerable government programs like Medicaid, the United States and the Commonwealth would be challenged even further in their attempts to ensure that taxpayer funds are spent to provide medically necessary and critically needed services.

The Commonwealth respectfully submits that this Court should not narrow Congress' broad prohibition of such fraud.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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