

IN THE MISSOURI SUPREME COURT

BEVERLY ENTERPRISES–MISSOURI,)
INC., et al.,)
)
 Appellants,)
)
 v.) No. SC89737
)
 DEPARTMENT OF SOCIAL SERVICES,)
 DIVISION OF MEDICAL SERVICES,)
)
 Respondent.)

APPEAL FROM THE CIRCUIT COURT OF COLE COUNTY

Honorable Byron L. Kinder

SUBSTITUTE RESPONSE/REPLY BRIEF OF APPELLANTS

HUSCH BLACKWELL SANDERS LLP

HARVEY M. TETTLEBAUM, #20005
ROBERT L. HESS II, #52548
235 East High Street, Suite 200
P. O. Box 1251
Jefferson City, MO 65102-1251
PHONE: 573-635-9118
FAX: 573-634-7854
EMAIL: harvey.tettlebaum@huschblackwell.com
robert.hess@huschblackwell.com

ATTORNEYS FOR APPELLANTS

TABLE OF CONTENTS

	<u>Page</u>
Table of Authorities.....	5
Statement of Facts	9
A. The AHC found that the Department should calculate the administration cost component ceiling from the Department’s data bank of information which is not adjusted for minimum utilization.....	10
B. The Department’s calculation reduces the reimbursement rates of facilities with occupancy rates greater than 85%.....	11
C. In its emergency statement for the March 21 emergency amendment, the Department stated the rule change would only affect facilities with less than 85% occupancy, but then recanted that position at the AHC hearing.....	12
D. The AHC determined that the administration cost component ceiling should be calculated using data that was not adjusted for minimum utilization. ...	13
E. The Department’s Statement of Facts contains inaccuracies and mis-statements.	14
Argument.....	18
I. The Cole County Circuit Court erred in holding that the challenged rules are lawful in that Department’s use of an 85% minimum utilization percentage was arbitrary, capricious, and unreasonable because the Department selected that percentage to solve its funding issue and did not consider whether its Medicaid	

reimbursement rates would cover the costs of efficiently and economically operated nursing home providers as required by the Department’s own regulation (13 CSR 70-10.015(3)(O)) and § 208.152.8, RSMo (Reply in support of Appellants’ First Point Relied On)..... 18

A. The Department was required to consider whether the imposition of an 85% minimum utilization percentage would cover the costs that must be incurred by efficiently and economically operated nursing home providers. 19

B. The Department did not consider whether its rates would reimburse the costs that must be incurred by efficiently and economically operated nursing home providers. 23

C. The rest of the Department’s arguments are red herrings. 25

1. Beverly is not alleging a violation of federal law. 25

2. The Department’s appropriation authority or lack thereof does not excuse the Department from complying with state law. 26

3. Beverly has not challenged the Department’s general authority to promulgate Medicaid reimbursement rules..... 28

II. The Cole County Circuit Court erred in holding that the challenged rules are lawful in that Department’s use of an 85% minimum utilization percentage violated § 536.016, RSMo 2000, because (1) the Department’s selection of that percentage was not based on substantial evidence and did not consider whether its Medicaid reimbursement rates would cover the costs of efficiently and economically operated nursing home providers as required by the Department’s

own regulation (13 CSR 70-10.015(3)(O)), its own practices, and § 208.152.8, RSMo and (2) the Department did not make a finding that the rules are necessary to carry out the purposes of the statute. (Reply in support of Appellants’ Second Point Relied On). 30

III. The Cole County Circuit Court erred in holding that the March 21 and June 20 emergency amendments were lawful in that §§ 536.021 and 536.025, RSMo, required the Department to follow notice and comment procedures to propose its rule changes, because no immediate danger or compelling government interest existed when the Department knew about the anticipated budget shortfall for approximately nine months and knew that it would not receive a supplemental appropriation two months earlier. (Reply in support of Appellants’ Third Point Relied On). 32

IV. The Administrative Hearing Commission’s calculation of the administration cost component ceiling for Beverly’s facilities was supported by substantial and competent evidence and correctly applied the law. (Responds to the Department’s Point Relied On Challenging the AHC’s Decision, pp. 26-32 of its Brief). 34

 A. Standard of Review 34

 B. The AHC correctly determined that the Department’s calculation deviated from the plain language of 13 CSR 70-10.015 and artificially decreased the ceiling applicable to all facilities. 36

 1. The data bank is not adjusted for minimum utilization. 38

2.	The Department ignores the fact that 13 CSR 70-10.015 specifically states when a minimum utilization adjustment should be applied...	41
3.	The Department’s interpretation conflicts with the policies behind both the minimum utilization adjustment and the ceiling.....	43
4.	As in previous cases, the Department argues that the AHC must defer to the Department’s interpretations of its own rules.....	45
V.	The Administrative Hearing Commission properly denied the Department’s offer of proof. (Responds to the Department’s Point Relied On Challenging the AHC’s evidentiary ruling, pp. 49-51 of its Brief).	47
A.	Standard of review.....	47
B.	The Department’s offer of proof was wholly irrelevant, and the AHC properly excluded it.....	48
	Conclusion.....	50
	Certificate of Compliance With Rule 84.06(g)	52
	Certificate of Service	53

TABLE OF AUTHORITIES

	<u>Page</u>
Cases	
Barnes Hosp. v. Mo. Comm'n on Human Rights, 661 S.W.2d 534 (Mo. banc 1983)	34
Barry Serv. Agency Co. v. Manning, 891 S.W.2d 882 (Mo. App. 1995)	18, 19, 28, 29, 30
Budding v. SSM Healthcare Sys., 19 S.W.3d 678 (Mo. banc 2000)	37
Children's Hosp. and Health Ctr. v. Belshe, 188 F.3d 1090 (9th Cir. 1999)	25
Dep't of Soc. Servs. v. Great Plains Hospital, Inc., 930 S.W.2d 429 (Mo. App. W.D. 1996)	23, 28, 30
Dep't of Soc. Servs. v. Little Hills Healthcare, L.L.C., 236 S.W.3d 637 (Mo. banc 2007)	26, 35, 36
Dep't of Soc. Servs. v. Mellas, 220 S.W.3d 778 (Mo. App. W.D. 2007)	35, 46
Dep't of Soc. Servs. v. Senior Citizens of Ray County Nursing Home District, 224 S.W.3d 1 (Mo. App. W.D. 2007)	23, 35, 36, 46, 47
EBG Health Care III, Inc. v. Dep't of Soc. Servs., 882 S.W.2d 143 (Mo. App. W.D. 1994)	34
Foremost-McKesson, Inc. v. Davis, 488 S.W.2d 193 (Mo. banc 1972)	28
Forest Health Systems v. Department of Social Services, 879 S.W.2d 566 (Mo. App. W.D. 1994)	23

Gladstone Special Road Dist. No. 3 of Clay County v. County of Clay, 248	
S.W.3d at 60 (Mo. App. 2008)	45
HCMF Corp. v. Allen, 238 F.3d 273 (4th Cir. 2001).....	25
HCMF Corp. v. Gilmore, 26 F.Supp.2d 873 (W.D. Va. 1998).....	25
Hudson v. Dir. of Revenue, 216 S.W.3d 216 (Mo. App. 2007).....	43
Hundley v. Wenzel, 59 S.W.3d 1 (Mo. App. 2001).....	18, 28
Hyde Park Housing Partnership v. Director of Revenue, 850 S.W.2d 82	
(Mo. banc 1993)	20
Keller v. Marion County Ambulance Dist., 820 S.W.2d 301(Mo. banc	
1991).....	37
Lane v. Lensmeyer, 158 S.W.3d 218 (Mo. banc 2005)	37
Linton v. Mo. Veterinary Med. Bd., 988 S.W. 2d 513 (Mo. banc 1999).....	28
McNeil-Terry v. Roling, 142 S.W.3d 828 (Mo. App. E.D. 2004)	27, 28
Mississippi Hosp. Ass’n Inc. v Heckler, 701 F.2d 511 (5th Cir. 1983)	27
Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29	
(1983)	18, 19, 29, 30, 31
Psychcare Mgmt., Inc. v. Dep’t. of Soc. Servs., 980 S.W.2d 311 (Mo. banc	
1998).....	23, 34, 35, 36
Rees Oil Co. v. Dir. Of Revenue, 992 S.W.2d 354 (Mo. App. 1999).....	20
Roorda v. City of Arnold, 142 S.W.3d 786 (Mo. App. 2004).....	47
St. Louis County v. State Tax Comm’n, 406 S.W.2d 644 (Mo. banc 1966)	34
Teague v. Mo. Gaming Comm’n, 127 S.W.3d 679 (Mo. App. W.D. 2003).....	37

United Pharmacal Co. of Mo., Inc. v. Mo. Bd. of Pharmacy, 159 S.W.3d

361 (Mo. banc 2005) 36

Wisconsin Hosp. Ass’n v. Reivitz, 733 F.2d 1226 (7th Cir. 1984)..... 27

Willard v. Red Lobster, 926 S.W.2d 550 (Mo. App. E.D. 1996) 35

Statutes

5 U.S.C. § 553 21

42 U.S.C. § 1396a..... 20, 21

Section 208.152.8, RSMo..... 18, 19, 20, 21, 22, 25, 27, 29, 30

Section 536.014, RSMo..... 32

Section 536.016, RSMo..... 30, 31, 50

Section 536.016.1, RSMo..... 30, 31, 32

Section 536.016.2, RSMo..... 30

Section 536.021, RSMo..... 32, 47

Section 536.021.7, RSMo..... 47, 48

Section 536.025, RSMo..... 32, 33, 50

Section 536.070(7), RSMo 48

Section 536.140, RSMo..... 34

Rules

Rule 55.03..... 52

Rule 84.04(f)..... 28

Rule 84.06(b) 52

Rule 84.06(b)(2) 52

Rule 84.06(c) 52

Rule 84.06(g) 52, 53

Regulations

42 C.F.R. § 447.250..... 20, 21

13 CSR 70-10.015*passim*

13 CSR 70-10.015(3)..... 18

13 CSR 70-10.015(3)(O) 19, 21, 22, 25, 27, 29, 30

13 CSR 70-10.015(4)(L)..... 10

13 CSR 70-10.015(11)(C) 41, 42

13 CSR 70-10.015(11)(C)(1)..... 43, 46

13 CSR 70-10.015(11)(C)(2)..... 42, 43

Constitutional Provisions

Mo. Const. art. V, § 18 34

STATEMENT OF FACTS

Beverly¹ filed Administrative Hearing Commission (AHC) complaints to challenge the validity of certain changes to 13 CSR 70-10.015. The AHC made findings of fact, but did not enter conclusions of law on those claims. In its brief, Beverly has raised three points relied on challenging the validity of those changes. The Department has responded to those arguments in its brief. In sections I-III of this Brief, Beverly replies to the Department's arguments in support of the rule change.

At the AHC, Beverly also argued that, even assuming the amendments were valid, the Department had incorrectly applied the regulation. The AHC considered the merits of this claim, and determined that the Department incorrectly calculated the administration cost component portion of Beverly's rates. Now, the Department has separately challenged the AHC's decision on that issue in its brief. Dept. Br. 26-32. Beverly responds to that argument in section IV of this brief. In addition, the Department's Statement of Facts does not summarize the AHC's factual findings as they relate to the calculation of the administration cost component. Dept. Br. 10-20. Accordingly, Beverly is setting forth the facts that support the AHC's decision.

By way of background, the nursing facility reimbursement rate is comprised of four components: administration, ancillary, patient care, and capital. AHC Dec. ¶ 33 (LF

¹ As in the first brief, the term "Beverly" is used to collectively refer to Beverly Enterprises-Missouri, Inc., and Commercial Management, Inc. – the operators of the 17 long term care facilities that brought these appeals.

282). The capital cost component is not subject to a ceiling. J. Ex. 1, 13 CSR 70-10.015(4)(L). However, the other components are subject to a ceiling. Id. Of those three other components, the ancillary and patient care components are not adjusted for minimum utilization. AHC Dec. ¶40 (LF 283).

The issue is whether 13 CSR 70-10.015 requires the ceiling to be calculated without applying a minimum utilization adjustment. The AHC held that the minimum utilization requirement should not be applied when making this calculation. AHC Dec. ¶ 78 (LF 292). The AHC calculated the administration ceiling as \$23.96 per patient per day. Id. On the other hand, the Department argues that the ceiling should be based on data which is adjusted for minimum utilization, and has calculated an administration cost component ceiling of \$21.40. AHC Dec. ¶¶ 76, 77 (LF 292). Since the administration cost component is the only component to which a ceiling and minimum utilization both apply, it is the only cost component implicated by the Department's allegation of AHC error.

A. The AHC found that the Department should calculate the administration cost component ceiling from the Department's data bank of information which is not adjusted for minimum utilization.

For the administration cost component, the ceiling is 110% of the median per diem. AHC Dec. ¶ 38 (LF 282-83). The median is “the middle value in the distribution, above and below which lie an equal number of values. This distribution is based on the data bank.” AHC Dec. ¶ 39 (LF 283; emphasis added). The “data bank” is the Medicaid cost report information that the Department uses to calculate reimbursement rates. AHC

Dec. ¶ 30 (LF 281). The data bank consists of the audited 2001 cost report data for all facilities, except for hospital-based, state operated, and pediatric nursing facilities. AHC Dec. ¶ 31 (LF 281). The 2001 cost report data in the data bank is trended for the years following the cost report, meaning it is adjusted to update for cost increases due to time (e.g., inflation). AHC Dec. ¶ 32 (LF 281). No other adjustments are applied to the audited cost report data in the data bank.

B. The Department's calculation reduces the reimbursement rates of facilities with occupancy rates greater than 85%.

By calculating the ceiling using data that has been adjusted for minimum utilization, the Department's calculation has the effect of reducing facilities' rates for minimum utilization twice: the first time, for the facilities with less than 85% occupancy, and the second time, for all facilities by using minimum utilization adjusted rates to lower the ceiling that applies to all facilities. See AHC Dec. ¶ 77 (LF 292). Petitioner New Haven Facility exemplifies the practical differences between the two calculations. The New Haven facility had an occupancy rate of 91.53%. AHC Dec. ¶ 45 (LF 284). Since its occupancy rate was greater than 85%, its administration costs of \$28.59 per patient per day were not reduced for minimum utilization. P. Ex. 143 (separately filed exhibit); Tr. 1237, l. 24–1238, l. 13. Under the AHC's calculation, the ceiling is \$23.96 per patient per day and New Haven's administration cost component per diem would also be \$23.96. AHC Dec. ¶ 78 (LF 292). But, if the ceiling were to be calculated as the Department suggests, the ceiling would only be \$21.40. AHC Dec. ¶ 76 (LF 292). The difference results because the Department would calculate the median from a distribution

of data that has already been adjusted for minimum utilization. AHC Dec. ¶ 77 (LF 292). Thus, the New Haven facility – which had an occupancy rate of 91.53% – would have \$2.56 of allowable costs per patient day subtracted from its per diem because other facilities had occupancy rates that were below 85%.

C. In its emergency statement for the March 21 emergency amendment, the Department stated the rule change would only affect facilities with less than 85% occupancy, but then recanted that position at the AHC hearing.

In its emergency statement for the March 21 emergency amendment, the Department expressly stated that it only intended to reduce the rates for facilities with less than 85% occupancy: “This emergency amendment, that reduces payments to some nursing facility providers with an occupancy of less than eighty-five percent (85%), will ensure continued payment at the end of State Fiscal Year 2005 for nursing facility services.” J. Ex. 4 (EF 85; emphasis added). But, by the time of the hearing, the Department claimed that all facilities – including facilities that have greater than 85% occupancy like New Haven – should have their rates decreased for the industry-wide trend of decreasing occupancy rates. AHC Dec. at 27-28 (LF 301-02). In its decision, the AHC characterized the parties’ competing positions: (1) “Beverly Enterprises complains that well-run facilities that maintain occupancy at or above 85% are being punished when the ceiling is depressed by the inclusion of administration per diems that were reduced by the minimum utilization adjustment” and (2) “The Department readily admits that this is the purpose and effect of its Plan.” Id.

D. The AHC determined that the administration cost component ceiling should be calculated using data that was not adjusted for minimum utilization.

The AHC held that the ceiling should be calculated from administration cost component data that has not been adjusted for minimum utilization. AHC Dec. at 28 (LF. 302). The AHC thus determined that the administrative per diem ceiling should have been \$23.96 per patient per day. AHC Dec. ¶ 78 (LF 292). The AHC specifically refused to find that the data bank includes data that has been adjusted for minimum utilization, as advocated by the Department. AHC Dec. at 23-25 (LF 297-99). The AHC's factual finding that the "data bank" does not include adjustments for minimum utilization was supported by hearing testimony and exhibits. J. Ex. 1 at (4)(S), (10), (20) (EF 002, 007, 015); J. Exs. 4-5 (EF 084-090); Tr. 462 l. 5-12, 1181, l. 23 – 1182, l. 3, 1197 l. 14 – 1199 l. 2. See also R. Ex. CC (2001 Cost Report for Glennon Place Nursing Center) (EF 675); R. Ex. GG-1 (2001 Cost Report for Beverly Health & Rehab Center – Jefferson City) (EF 733).

By regulation, the data bank consists of the audited 2001 cost report data for all Medicaid-certified skilled nursing facilities, except for hospital-based, state-operated, and pediatric nursing facilities. AHC Dec. ¶¶ 30-32 (LF 281); J. Ex. 1 at (4)(S), (20) (EF 002, 015); J. Exs. 4-5 (EF 084-090). Accordingly, to determine whether the data bank includes data that has been adjusted for minimum utilization, the AHC heard testimony on the process for submitting and auditing cost reports. The audited 2001 cost report data comes from the cost report that each facility is required to submitted annually. The

reported costs are reviewed by and, if necessary, adjusted by the Department's auditors. J. Ex. 1 at (4)(S), (10), (20) (EF 002, 007, 015); J. Exs. 4-5 (EF 84-90); Tr. 462, l. 5-12; AHC Dec. ¶¶ 29, 31 (LF 281). The costs in the last column of a facility's cost report reflect the facility's allowable costs according to 13 CSR 70-10.015 and go into the data bank. See, e.g., Tr. 1181, l. 23 – 1182, l. 3, 1197, l. 14 – 1199, l. 2; R. Ex. CC (EF 675); R. Ex. GG-1 (EF 733). These are the costs that the Department reviews and adjusts to reflect allowable costs located in the last column of the audited cost report. See AHC Dec. at 7 (LF 281); Tr. 462, l. 5-12; see, e.g., R. Ex. CC (EF 675); R. Ex. GG-1 (EF 733). The costs in the last column of the audit adjustment report have not been adjusted for minimum utilization. See, e.g., R. Ex. CC (EF 675); R. Ex. GG-1 (EF 733). Since the data bank includes "only . . . allowable cost data" which is taken directly from the cost reports, the AHC concluded that the data bank does not include "the products of the Department's calculations." AHC Dec. at 24-25 (LF 298-99).

E. The Department's Statement of Facts contains inaccuracies and mis-statements.

The Department's Statement of Facts pertain almost wholly to the validity of the rules. There are several inaccuracies and mis-statements in it. At page 13, the Department refers to "running various cost assessment scenarios." In the hearing testimony, the Department's witnesses never used the term "cost assessment" at all, nor did they use that term when referring to the act of "running scenarios." As the AHC explained in its decision, "running scenarios" was the phrase that the Department's witnesses used to describe instances when they changed a variable in their nursing home

reimbursement spreadsheet: “As used by the Department’s witnesses throughout the hearing, ‘running a scenario’ refers to calculating a reimbursement rate based on a hypothetical set of criteria. When running multiple scenarios, the Department would use different criteria in the Plan or vary the same criterion to determine and compare the results of different hypothetical situations.” AHC Dec. at 6 n.7 (LF 280).

Likewise, at page 15, the Department refers to examining the “impact” of “each scenario” on nursing facilities. For all three of the transcript cites, the witnesses were referring to the “impact” on the variables of the nursing facilities’ reimbursement rate as set forth in the spreadsheet that the Department uses to calculate rates. Tr. 235 l. 9-25, 236 l. 1-2 (referring to the impact on the cost components of the reimbursement rates); Tr. 351 l. 3-10 (referring to impact on nursing home rates); Tr. 356 l. 10-13 (referring to impacts on rate calculations). The Department’s witnesses did not examine the impact on the nursing homes themselves, their ability to provide care, or their patients. Their only conclusion in that regard was that facilities had not been “going out of business or being de-certified because of patient care deficiencies” and that the rate reduction would not result in a “mass exodus” from the Medicaid program. AHC Dec. ¶ 86 (LF 294); Dept. Br. 16 (citing testimony of the Department’s witness at Tr. 413).

The Department asserts that it had nine years of experience with the 85% minimum utilization rate. Dept. Br. 15, 16. However, that assertion is very misleading. Rates were originally set in 1995, using the average occupancy of all facilities at that time (85%) as the minimum utilization percentage. AHC Dec. ¶ 24 (LF 280). Between 1995 and 2004, the Department did not rebase rates and medians and ceilings were “frozen”

for facilities participating in Medicaid as of January 1, 1995. AHC Dec. ¶ 25 (LF 280). Thus, the AHC found that “the minimum utilization adjustment would not have affected reimbursement rates despite any subsequent decrease in occupancy” for facilities participating in the program through 2004. *Id.* In 2004, when the Department finally rebased rates, it again used the average occupancy rate. AHC Dec. ¶ 48 (LF 285). Thus, the Department used 85% one time in 1995 because it was the average occupancy rate at that time. After that, the Department had no experience with the 85% minimum utilization percentage because it did not rebase rates again until 2004. AHC Dec. ¶ 48 (LF 285). In 2004, the Department again used the average occupancy rate to set minimum utilization, as it did in 1995. AHC Dec. ¶ 48 (LF 285). In 2004, the average occupancy rate for all nursing facilities was 73%. *Id.*

On page 19, the Department says the AHC “did not hold that resetting the minimum utilization to 85% was improper.” The statement is ambiguous, but suggests that the AHC refused to invalidate its rules. Later, the Department expressly states that the AHC upheld its rules against challenge:

- “The AHC did not invalidate the Department’s rules, finding that the rules did not directly and expressly conflict with any statute,” Dept. Br. 21;
- “The AHC found that the Department’s setting minimum utilization at an 85% figure was acceptable,” Dept. Br. 25;
- “As found by the AHC . . . , the Division’s regulation complies with both federal and state law, and were [*sic*] properly promulgated under Missouri law,” Dept. Br. 33; and

- The AHC did not find “a problem with the Division’s promulgation of an emergency amendment to 13 CSR 70-10,” Dept. Br. 45.

All four of these statements incorrectly state that the AHC decided the merits of those issues in its favor. Regarding the validity of the rules and the emergency amendment, the AHC made findings of fact only and determined that it did not have jurisdiction to determine the validity of the rules or the emergency amendment:

- “Consistent with the *Monroe County Nursing Home Dist.* decision, we determine that we have no jurisdiction to declare invalid the March 21 emergency and March 29 proposed amendments,” AHC Dec. at 31 (LF 305); and
- “[W]e found the relevant facts and, consistent with *Monroe County Nursing Home Dist.*, determine that we have no jurisdiction to declare the emergency amendment invalid,” *id.*

ARGUMENT

I. The Cole County Circuit Court erred in holding that the challenged rules are lawful in that Department's use of an 85% minimum utilization percentage was arbitrary, capricious, and unreasonable because the Department selected that percentage to solve its funding issue and did not consider whether its Medicaid reimbursement rates would cover the costs of efficiently and economically operated nursing home providers as required by the Department's own regulation (13 CSR 70-10.015(3)(O)) and § 208.152.8, RSMo (Reply in support of Appellants' First Point Relied On).

On the merits of Beverly's first claim, the Department makes only passing responses. Dept. Br. 36-37, 38, 42-44. Since the Department's response addresses several arguments that Beverly has not made, Beverly briefly restates its argument:

1. In promulgating rules, agencies act arbitrarily and capriciously if they fail to consider an important factor or aspect of the problem in their decision-making process, such as the factors that state laws require them to consider, see Beverly's First Br. 23-26 (citing and discussing Barry Serv. Agency Co. v. Manning, 891 S.W.2d 882, 892, 894 (Mo. App. 1995); Hundley v. Wenzel, 59 S.W.3d 1, 8, 13 (Mo. App. 2001); Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983)).

2. When setting Medicaid reimbursement rates, state law requires the Department to consider whether its Medicaid rates reimburse the costs that efficiently and economically nursing facilities must incur, see Beverly's First Br. 26-33 (citing and

discussing § 208.152.8, RSMo Supp. 2008 and 13 CSR 70-10.015(3)(O) and previous court interpretations of the standard that they adopt); and

3. The Department failed to engage in the analysis required by § 208.152.8, RSMo and 13 CSR 70-10.015(3)(O), to determine what the costs of an efficiently and economically operated facility are. Instead it arbitrarily selected as 85% the minimum utilization percentage to solve its funding issue, see Beverly's First Br. 33-37.

Beverly will first reply to the responsive material in the Department's brief and then address the non-responsive portions of the Department's brief.

A. The Department was required to consider whether the imposition of an 85% minimum utilization percentage would cover the costs that must be incurred by efficiently and economically operated nursing home providers.

The Department makes only passing reference to Beverly's actual arguments. First, Beverly identified the Barry Service Agency Co. and Motor Vehicle Manufacturers' Association cases as principal authorities supporting its Point Relied On. Beverly's First Br. 20. The Department discusses Barry Service Agency Co. in two sentences on page 41 of its Brief and never cites or discusses the Motor Vehicle Manufactures Association case. The Department never expressly agrees that agencies must consider the important factors and aspects of a problem before it, including those factors that statutes and regulations require it to consider. However, it never disputes that legal proposition either. Moreover, the Department does argue about the factors that the Department did consider and what it may or may not have been required to consider.

Accordingly, it appears that the Department is conceding that it is required to consider important factors and aspects of the problem before it, including those factors that it is required to consider by state law.

Second, the Department acknowledges that § 208.152.8, RSMo, incorporates “Section 1902(a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.” Dept. Br. 36 (emphasis added). The Department further acknowledges that the “implementing regulation, 42 C.F.R. § 447.250, remains.” Dept. Br. 36 (emphasis added). Finally, the Department agrees that 42 C.F.R. § 447.250 directs states to consider whether their Medicaid rates are reimbursing the costs of efficiently and economically operated providers and that this standard requires specific studies and findings reflecting that consideration. Dept. Br. 36, 43.

The Department contends, however, that the standard should not apply because the federal statute was amended. Dept. Br. 37-38. This contention ignores the plain text of § 208.152.8, which incorporates both the federal statute and the “regulations promulgated thereunder.” Since the federal regulation “remains” and it is expressly incorporated by § 208.152.8, it is the same as if that regulation “had been written into the adopting statute.” Rees Oil Co. v. Dir. Of Revenue, 992 S.W.2d 354, 359, n. 6 (Mo. App. 1999). To accept the Department’s position, the Court would have to ignore or read the words “and regulations promulgated thereunder” out of the statute. But, in interpreting statutes, every word should be given meaning and effect, if possible, and courts will not construe legislative text as idle verbiage. See, e.g., Hyde Park Housing Partnership v. Director of Revenue, 850 S.W.2d 82, 84 (Mo. banc 1993). The plain text of § 208.152.8 confirms

that regulations promulgated under 42 U.S.C. 1396a are incorporated into state law and 42 C.F.R. § 447.250 is just such a regulation.

The Department also attempts to characterize 42 C.F.R. § 447.250 as a “vacated” regulation. Dept. Br. 38. The Department makes that assertion without citing any evidence or legal authority in support. Id. 42 C.F.R. § 447.250 has not been vacated. The latest version of the Code of Federal Regulations still includes the regulation. 42 C.F.R. § 447.250 (2008). Like Missouri, federal agencies must publish notice of proposed rule changes. See 5 U.S.C. § 553. The Department has not cited to any proceeding whereby the federal government vacated or otherwise repealed the regulations promulgated under the Boren Amendment. Since those regulations were promulgated under § 1902(a)(13)(A) of the Social Security Act and continue to be published in the Code of Federal Regulations, they are properly incorporated into § 208.152.8 by reference and must be used by the Department when setting provider reimbursement rates (“in accordance with . . . regulations promulgated thereunder”).

Further, the Department’s incorporation of the efficiency and economy standard into 13 CSR 70-10.015(3)(O) shows that the Department also believed that standard was required by state law (and not simply a byproduct of federal requirements). The Department acknowledges that its own regulation is still in effect and directs an analysis of whether its Medicaid rates reimburse the costs incurred by efficiently and economically operated providers. Dept. Br. 38. However, the Department argues that “type of analysis [is] permissive, not an absolute requirement.” Id. The Department emphasizes the words “may be” in subsection (3)(O) : “The reimbursement rates

authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustment needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers." Id. The word "may" in this sentence refers to the decision to re-evaluate rates and makes the decision whether to undertake such a re-evaluation permissive. However, once the Department chooses to re-evaluate rates, subsection (3)(O) directs the factors that the Department must consider in its analysis.

Those factors were originally requirements of the Boren Amendment, were incorporated and continue in effect as state law by § 208.152.8, and have also been adopted by the Department in its own regulation without repeal or amendment. If the Department's interpretation of subsection (3)(O) is correct, that subsection is meaningless because the Department is free to use any standard it wishes even after it decides to reevaluate rates. That was certainly not the intent of the regulation when it was adopted in 1995. Proposed Rule, 13 CSR 70-10.015, 20 Mo. Register 351, 352 (Jan. 17, 1995); Order of Rulemaking, 13 CSR 70-10.015, 20 Mo. Register 1880 (June 15, 1995) (originally codified as Subsection (3)(N)). The regulatory text has not changed since the Boren Amendment was repealed, and the Department's latest re-interpretation is not a fair or reasonable reading of the regulation. Rather, it appears to be an attempt by the Department to evade regulatory requirements that it imposed on itself without going through notice and comment rulemaking. This Court and the Court of Appeals have repeatedly rejected such attempts by the Department. See, e.g., Dep't of Soc. Servs. v. Senior Citizens of Ray County Nursing Home District, 224 S.W.3d 1, 16 (Mo. App.

W.D. 2007) (rejecting an attempt by the Department to re-interpret the meaning of the Plan when the Department “simply does not like what the Plan says”); Psychcare Mgmt., Inc. v. Dep’t. of Soc. Servs., 980 S.W.2d 311, 314 (Mo. banc 1998) (refusing to enforce an unpromulgated Missouri Medicaid manual provision).

B. The Department did not consider whether its rates would reimburse the costs that must be incurred by efficiently and economically operated nursing home providers.

The Department does not argue that it considered whether its rates would reimburse the costs that must be incurred by efficiently and economically operated nursing home providers. Dept. Br. 43-44, 49-51. Rather, it claims Beverly failed to meet its burden of proof, citing Forest Health Systems v. Department of Social Services, 879 S.W.2d 566 (Mo. App. W.D. 1994). Dept. Br. at 43. In that case, the Department “argued” that the State had not satisfied the procedural requirements of the Boren Amendment, but the record contained no evidence to support that argument. Forest Health Systems, 879 S.W.2d at 570. Thus, the Court rejected the claim for lack of evidence. By way of contrast, Beverly proved its case by showing that the Department did not consider whether its rates would reimburse the costs of efficiently and economically operated nursing home providers. Dep’t of Soc. Servs. v. Great Plains Hospital, Inc., 930 S.W.2d 429, 436 (Mo. App. W.D. 1996) (holding that a hospital established a procedural Boren Amendment violation based on evidence that the Department did not consider whether its rates would reimburse costs of efficiently and

economically operated providers). Once Beverly did that, the burden shifted to the Department to rebut that evidence. The Department has not met its burden in that regard.

In this case, there were seven days of hearing resulting in over 1200 pages of transcript. The trial exhibits consisted of more than 1600 pages of documents and comprise nine exhibit files that have been filed with this Court as part of the record on appeal. All of that evidence related to the process by which the Department implemented the challenged rules. The extensive and voluminous evidence culminated in an AHC decision with 90 findings of fact on the issues presented, including the factors that were and were not considered by the Department.

To briefly summarize, the Department's investigation was so cursory that it reached only the vaguest conclusions about the effect of the rate change. The AHC found that the Department does not know the cost of taking care of a Medicaid resident in Missouri. AHC Dec. ¶ 65 (LF 289). Accordingly, the Department has no idea whether its rates reimburse long term care providers for the costs that must be incurred to care for such residents. The AHC further found that the Department believed its rates were sufficient if "facilities [were not] going out of business or being decertified because of patient care deficiencies." AHC Dec. ¶ 86 (LF 294). In the contemporaneously published emergency statement, the Department expressly stated the change was made as a "solution to this funding issue." J. Ex. 4 (EF 085). Regarding the effect that its budget-driven cuts would have on long term care providers, the Department concluded only that "no mass exodus" from the Medicaid program would occur. Dept. Br.16 (citing testimony of its witness at Tr. 413). The Department's vague determination that

reimbursement rates were not so low that they would cause a “mass exodus” from the program hardly fulfills the obligation to determine whether those rates reimburse the costs that must be incurred by efficiently and economically operated providers.

C. The rest of the Department’s arguments are red herrings.

The Department responds to legal challenges that Beverly has not asserted by arguing (1) the challenged rules comply with federal law, (2) the Department lacked appropriation authority, and (3) the challenged rules were within the scope of rulemaking authority delegated to the Department. All three of these arguments are non-responsive to Beverly’s brief.

1. Beverly is not alleging a violation of federal law.

The Department’s assertion that the State complied with federal law does not respond to any argument in Beverly’s brief. Dept. Br. 33-38. As the State acknowledges, “Medicaid is a joint state and federal program . . . and the Department’s rules must comply with both state and federal law.” Dept. Br. 34 (emphasis added). Beverly is challenging their compliance with state law. The efficiently and economically operated facility standard is a matter of state law because it is incorporated into both § 208.152.8, RSMo, and 13 CSR 70-10.015(3)(O) as the standard for reimbursement of the costs incurred by a nursing home. The repeal of the federal Boren Amendment did not affect the authority of states to adopt the same standard as matter of state law. HCMF Corp. v. Gilmore, 26 F.Supp.2d 873, 878-880 (W.D. Va. 1998), aff’d HCMF Corp. v. Allen, 238 F.3d 273 (4th Cir. 2001); Children’s Hosp. and Health Ctr. v. Belshe, 188 F.3d 1090, 1100-01 (9th Cir. 1999).

In discussing compliance with federal law, Beverly refers to CMS's approval of the proposed state Plan amendment. Dept. Br. 33-38. However, since Beverly is not alleging a violation of federal law, that fact is completely irrelevant. To the extent the Department believes that CMS approval demonstrates compliance with state law, the Missouri Supreme Court recently considered and rejected this exact same argument by the Department. Dep't of Soc. Servs. v. Little Hills Healthcare, L.L.C., 236 S.W.3d 637, 643 (Mo. banc 2007). In the Little Hills case, the Department argued that its procedure for estimating a component of Medicaid reimbursement for hospitals did not need to be promulgated as a rule because the federal government approved the reimbursement change without requiring that procedure to be specified. Id. at 643. This Court held that the federal government's approval did not alleviate the Department's responsibility to comply with state law. Id. Likewise, in this case, CMS's approval of the challenged rules has no bearing on whether those rules comply with state law.

2. The Department's appropriation authority or lack thereof does not excuse the Department from complying with state law.

In responding to Beverly's first point relied on and throughout its Brief, the Department emphasizes the appropriation shortfall for 2005. Dept. Br. 40-41, 44. This argument is another red herring. In setting Medicaid reimbursement rates, the State is not precluded from considering its financial situation. However, mere lack of appropriation authority does not justify failure to comply with other legal requirements.

Thus, in McNeil-Terry v. Roling, the Department filed an emergency amendment to curtail dental services for Medicaid beneficiaries when funding was eliminated. 142 S.W.3d 828, 831 (Mo. App. E.D. 2004). Though the funding was eliminated, state statute still required some of those services to be provided. Id. As in this case, the Department argued in that case that “budgetary constraints” and the lack of appropriation authority justified the Medicaid program cuts. Id. at 834. The Court of Appeals rejected those arguments, holding that “the legislature’s failure to appropriate funds for dental services for Medicaid-eligible adults” did not confer “on the Division the right to limit such dental services.” Id. at 834-35. The cases cited on pages 34 and 35 of the Department’s brief reach the same conclusion. States can consider the budget in setting Medicaid rates, but budgetary constraints do not justify failure to comply with other Medicaid program requirements. Mississippi Hosp. Ass’n Inc. v Heckler, 701 F.2d 511, 518 (5th Cir. 1983); Wisconsin Hosp. Ass’n v. Reivitz, 733 F.2d 1226, 1235-36 (7th Cir. 1984).

The logic of these cases is sound. If a budget shortfall justified ignoring all other Medicaid requirements, Medicaid services and benefits would be left to the whim of the budget process and could be slashed every time the State’s revenue dips. To guard against improvident cuts, the Medicaid program statutes and regulations contain procedural constraints – like § 208.152.8 and 13 CSR 70-10.015(3)(O) – that require a reasoned analysis of important factors before such rate cuts are implemented. A budget shortfall cannot excuse the Department’s failure to comply with those requirements. Since the Department did not analyze whether its new rates would reimburse those costs,

they are invalid. Great Plains Hosp., Inc., 930 S.W.2d at 437; Mc-Neil-Terry, 142 S.W.3d at 834-35.

3. Beverly has not challenged the Department's general authority to promulgate Medicaid reimbursement rules.

The Department includes a lengthy discussion of the statutes authorizing it to promulgate Medicaid reimbursement rules. Dept. Br. 39-42. Again, the Department is responding to a straw-man argument that Beverly is not making. Beverly's challenge is very specific. Beverly's claim is brought under a settled line of administrative law cases. See, e.g., Barry Serv., 891 S.W.2d at 892; Hundley v. Wenzel, 59 S.W.3d 1, 8 (Mo. App. 2001). The Department's failure to respond to the actual arguments being made hinders this Court in its duty to decide the issues being raised on appeal and reflects a misuse of a Respondent's brief, which should respond to the arguments being made by the Appellants. Rule 84.04(f).

The Department does not articulate any affirmative standard that guided its decision-making process, and instead quotes the standard for a challenge to the substantive reasonableness of a rule. Dept. Br. 39-40 (quoting Foremost-McKesson, Inc. v. Davis, 488 S.W.2d 193, 200 (Mo. banc 1972); Linton v. Mo. Veterinary Med. Bd., 988 S.W. 2d 513, 517 (Mo. banc 1999)). Likewise, the Department describes the 2005 rate decrease in relation to the 2004 rate increase. Dept. Br. 13, 17, 25, 44, 50. The Department then argues that, since the cumulative effect of the 2004 and 2005 rate adjustments was a net increase for nursing facilities, its rules are justified. Id. The Department does not put the rate adjustments in broader context. For example, it neglects

to mention that the State Auditor determined that nursing facilities were being paid \$9.80 per resident per day less than their allowable costs as of 2001. P. Ex. 107 (EF 475). And, it cannot ultimately justify whether it was (or was not) appropriately reimbursing nursing facilities because the AHC found that the Department “never requested information regarding, and does not know, the average cost of taking care of a Medicaid resident in Missouri.” AHC Dec. ¶ 65.b (LF 289; emphasis added).

The overall reasonableness of the reimbursement rates, however, is irrelevant for purposes of this lawsuit, because Beverly has not brought a “substantive” challenge to the rates as expressly stated in Beverly’s brief. Beverly’s First Br. 24 (“This case does not concern the substantive reasonableness of the challenged rules.”). For purposes of this lawsuit, Beverly is not contesting that the Department could choose not to reimburse facilities for certain costs if it had done an analysis and determined that those costs need not be incurred by an efficiently and economically operated facility.

The Department’s decision-making process was arbitrary, capricious or unreasonable because it did not evaluate whether its rates would reimburse the costs of efficiently and economically operated nursing home providers as required by § 208.152.8 and 13 CSR 70-10.015(3)(O). “[A]n agency which completely fails to consider an important aspect or factor of the issue before it may . . . be found to have acted arbitrarily and capriciously.” Barry Serv. Agency Co. v. Manning, 891 S.W.2d 882, 892 (Mo. App. 1995) (quoting Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983)). Accordingly, the Department’s rule change is invalid and Beverly is

entitled to be reimbursed under the previous unamended Plan until the Plan is changed according to the applicable procedures. Great Plains Hosp., Inc., 930 S.W.2d at 438.

II. The Cole County Circuit Court erred in holding that the challenged rules are lawful in that Department’s use of an 85% minimum utilization percentage violated § 536.016, RSMo 2000, because (1) the Department’s selection of that percentage was not based on substantial evidence and did not consider whether its Medicaid reimbursement rates would cover the costs of efficiently and economically operated nursing home providers as required by the Department’s own regulation (13 CSR 70-10.015(3)(O)), its own practices, and § 208.152.8, RSMo and (2) the Department did not make a finding that the rules are necessary to carry out the purposes of the statute. (Reply in support of Appellants’ Second Point Relied On).

Section 536.016 codifies the rational decision-making requirements of the Motor Vehicle Manufacturers Association and Barry Service cases. For the same reasons that the Department’s decision-making process was arbitrary, capricious, or unreasonable, it violated § 536.016’s requirement that rulemakings must be based on substantial evidence.

But, § 536.016.1 also requires agencies to make a specific “finding by the agency that the rule is necessary to carry out the purposes of the statute that granted such rulemaking authority.” The finding requirement is an important procedural component of the rulemaking process. Section 536.016.2 requires agencies to adopt procedures for determining whether a rule is necessary, which must include an evaluation of reasonably available empirical data and an assessment of the cost of the rules both to the state and

private entities. At the conclusion of this process, they must make a finding that the rule is necessary. § 536.016.1, RSMo. The finding informs the public of the reasons the rule was found to be necessary. It provides a basis for judicial review of the agency's compliance with § 536.016. A formal finding is required and cannot simply be inferred from the fact that the agency promulgated a rule. If it could, the requirement would be meaningless. The Department made no such finding, and its brief does not cite to any evidence of such a finding. See Dept. Br. 40. Rather, the Department notes the looming "budget shortfall" as the cause for the rule change. Id. But, the Department did not do the evaluation or cost assessment required by § 536.016, RSMo, and made no finding that the rule was necessary for any reason.

The Department's justification is insufficient for two reasons. First, it is a classic, post hoc rationalization. The Department did not make the required finding during its decision-making process and now effectively argues that its failure to do so should be excused because it could have made such a finding. Decision-making requirements such as the finding requirement are meant to discipline the agency's decision-making process and ensure that its rules consider the important factors as directed by state law. Allowing the agency to make after-the-fact claims about findings it could have made, but did not, would eviscerate the procedural requirements. Motor Vehicle Mfrs. Ass'n, 463 U.S. at 50 ("the courts may not accept appellate counsel's post hoc rationalizations for agency action").

Second, as noted above, the alleged looming "budget shortfall" only existed for a portion of state fiscal year 2004-2005. So, even accepting the Department's post hoc

rationalization, the shortfall would only show a need for a rule change in state fiscal year 2004-2005. The Proposed Amendment and June 20 emergency amendment were rule changes effective for state fiscal year 2005-2006 and beyond. In those years, no looming “budget shortfall” existed and the Department’s post hoc postulation of a “need” which could have supported the Proposed Amendment and June 20 emergency amendment did not exist.

Since the Department did not make findings that the challenged rules were necessary to carry out the purposes of the rulemaking statutes, those rules violated § 536.016.1. The challenged rules are therefore unlawful and invalid because they lack statutory authority and conflict with state law. *Id.*; § 536.014, RSMo 2000.

III. The Cole County Circuit Court erred in holding that the March 21 and June 20 emergency amendments were lawful in that §§ 536.021 and 536.025, RSMo, required the Department to follow notice and comment procedures to propose its rule changes, because no immediate danger or compelling government interest existed when the Department knew about the anticipated budget shortfall for approximately nine months and knew that it would not receive a supplemental appropriation two months earlier. (Reply in support of Appellants’ Third Point Relied On).

The Department alleges that the budget shortfall was the “emergency” that allowed it to change its reimbursement rule without following notice-and-comment rulemaking procedures in § 536.021, RSMo. Dept. Br. 45-48. The Department had more than six months’ notice of the potential shortfall before it promulgated the March 21

emergency amendment. AHC Dec. ¶ 57 (LF 287). The circumstances that the Department claims supported the June 20 emergency amendment were known to the Department nine months in advance of the date of promulgation. AHC Dec. ¶ 57 (LF 287). Moreover, the June 20 emergency amendment pertained to the 2005-2006 fiscal year, which had not even started at that time.

If the Department can create its own “emergency” by delaying rulemaking until the last possible moment, the notice-and-comment rulemaking procedures can be evaded simply through inaction. Moreover, for the June 20 emergency amendment, absolutely no emergency existed. The amendment was proposed before the next fiscal year even started, no budget shortfall could have yet existed for that fiscal year, and the Department clearly could have gone through the regular notice-and-comment rulemaking process to effect those changes in the law. In fact, a final order of rulemaking for the March 29 Proposed Amendment was published in the Missouri Register on August 15, 2005, and was effective 30 days thereafter. Thus, the Department could have and did promulgate a regular rule change to be effective three months into the 2005-2006 state fiscal year. The Department completely failed to demonstrate an emergency existed to justify promulgating the June 20 emergency amendment without following notice-and-comment procedures.

This Court should hold that the March 21 and June 20 emergency amendments were unlawful because no emergency existed. § 536.025, RSMo 2000.

IV. The Administrative Hearing Commission’s calculation of the administration cost component ceiling for Beverly’s facilities was supported by substantial and competent evidence and correctly applied the law. (Responds to the Department’s Point Relied On Challenging the AHC’s Decision, pp. 26-32 of its Brief).

A. Standard of Review

The AHC determined this issue in favor of Beverly. In an appeal following judicial review of a decision of the AHC, the Court reviews the decision of the AHC and not that of the circuit court. Psychcare Mgmt., 980 S.W.2d at 312. The Court does not determine the weight of the evidence or substitute its discretion for that of the AHC. Id. Rather, the Court determines whether the decision involves an abuse of discretion and whether it is supported by competent and substantial evidence upon the whole record; unauthorized by law; made upon unlawful procedure; or arbitrary, capricious, or unreasonable. § 536.140, RSMo Supp. 2008; see Mo. Const. art. V, § 18 (judicial review involves determining whether agency decisions are authorized by law and supported by competent and substantial evidence upon the whole record). The Court defers to the AHC’s factual findings. See EBG Health Care III, Inc. v. Dep’t of Soc. Servs., 882 S.W.2d 143, 145 (Mo. App. W.D. 1994) (citing Barnes Hosp. v. Mo. Comm’n on Human Rights, 661 S.W.2d 534, 535 (Mo. banc 1983)). The AHC, and not the Court, judges the credibility of the witnesses. Id. (citing St. Louis County v. State Tax Comm’n, 406 S.W.2d 644, 649 (Mo. banc 1966)). If the evidence would establish either of two opposing findings, the Court must uphold the factual determination of the AHC. Id.

When an agency's decision is based upon an interpretation, application, or conclusion of law, the Court's review is de novo. Psychcare Mgmt., 980 S.W.2d at 312.

When the AHC adjudicates an agency dispute, it "actually steps into the Department's shoes" and "render[s] the agency's decision." Little Hills, 236 S.W.3d at 644; Dep't of Soc. Servs. v. Mellas, 220 S.W.3d 778, 783 (Mo. App. W.D. 2007).

The AHC exercises any discretion that the Department would exercise. Mellas, 220 S.W.3d at 783; Senior Citizens, 224 S.W.3d at 15. The AHC is not obligated to defer to the Department. Senior Citizens, 224 S.W.3d at 15. Rather, the Department must use its administrative expertise to "persuade the commission of the soundness of its policy." Id. On appeal, the reviewing Court defers to the AHC's decision – not that of the Department. Little Hills, 236 S.W.3d at 644.

When the case involves interpretation of a regulation, "the Commission determines the proper interpretation of the agency regulation, and that becomes the agency's interpretation of its regulation." Senior Citizens, 224 S.W.3d at 16. The Department, however, claims that its interpretations of its rules are entitled to deference, as it has in other recent Medicaid reimbursement cases. Dept. Br. 27. In support, it cites Willard v. Red Lobster, 926 S.W.2d 550 (Mo. App. E.D. 1996). Dept. Br. 27. But, in the Senior Citizens case, the Department made the exact same argument, citing the same cases. 224 S.W.3d at 14-15. In that case, the Court of Appeals noted that some cases (e.g., the cases cited on page 27 of the Department's brief) do state that agency interpretations of rules may receive deference, but that those decisions appear to be importing principles of federal law that conflict with Missouri administrative law or

misinterpret the principle that agency interpretations of statute are entitled to deference if duly promulgated as regulations. Id. at 15. The Court noted that “it would be inappropriate for a court to defer to an agency’s interpretation of its own regulation” that added to, subtracted from, or in any way varied from the regulation’s plain text. Id. at 15. The Court distinguished the Department’s citations and rejected the Department’s arguments, concluding that it misunderstood the role of the AHC. Id. at 15. In Little Hills, this Court was squarely presented with the same issue and reaffirmed its consistent stance that unpromulgated agency interpretations cannot be enforced and are not entitled to deference. Id. The Department’s “interpretation” of its regulation is not entitled to deference. See, e.g., United Pharmacal Co. of Mo., Inc. v. Mo. Bd. of Pharmacy, 159 S.W.3d 361, 365 (Mo. banc 2005) (holding that an unpromulgated agency FAQ had no “force or legal effect”); Psychare Mgmt., Inc. v. Dep’t. of Soc. Servs., 980 S.W.2d 311, 314 (Mo. banc 1998) (refusing to enforce an unpromulgated Missouri Medicaid manual provision).

B. The AHC correctly determined that the Department’s calculation deviated from the plain language of 13 CSR 70-10.015 and artificially decreased the ceiling applicable to all facilities.

The AHC followed the plain language of 13 CSR 70-10.015 to calculate the cost component ceiling. See AHC Dec. at 21-29 (LF 295-304). The AHC concluded that the Department’s methodology of calculating the administration cost component median using data that had been adjusted for minimum utilization was contrary to 13 CSR 70-10.015. AHC Dec. at 24 (LF at 298).

The issue of regulatory interpretation is quite simple. The Department applies a “ceiling” to the administration cost component. That ceiling is 110% of the “median” determined from the “data bank.” The issue is: should the median be determined from administration cost component data that has or has not been adjusted for minimum utilization?

Regulations are interpreted according to the same rules as statutes. Teague v. Mo. Gaming Comm’n, 127 S.W.3d 679, 685 (Mo. App. W.D. 2003). In interpreting regulations, the words must be given their plain and ordinary meaning and read in context. Id. at 686. Context determines meaning. Keller v. Marion County Ambulance Dist., 820 S.W.2d 301, 302 (Mo. banc 1991). Regulations should be interpreted reasonably. Absurd interpretations should not be adopted. Budding v. SSM Healthcare Sys., 19 S.W.3d 678, 681 (Mo. banc 2000). The Department lists Lane v. Lensmeyer, 158 S.W.3d 218 (Mo. banc 2005) as a principal authority supporting its Point Relied On and cites it for the proposition that regulations should be read as a whole and effect should be given to all language used in the regulation. Dept. Br. 23, 27. Beverly does not disagree with this proposition of law. The question in this case is which interpretation best reflects the meaning of the text.

The AHC held that 13 CSR 70-10.015 plainly states that the median is determined from the data bank and found as a matter of fact that the data bank does not include information that has been adjusted for minimum utilization. AHC Dec. ¶¶ 30-32 (LF 281); AHC Dec. at 24-25 (LF 298-99). Accordingly, it held that the ceiling should be calculated using data that has not been adjusted for minimum utilization, and calculated

that amount to be \$23.96 per patient day. AHC Dec. ¶ 78 (LF 292); AHC Dec. at 28 (LF 302). The Department would first adjust the data for minimum utilization, then identify the median, and finally calculate the ceiling. Dept. Br. 38. Under the Department's calculation, the ceiling would be \$21.40 per patient per day. AHC Dec. ¶ 76 (LF 292).

The Department's calculation ignores and/or varies the plain text of the rule in order to artificially decrease the rates of all facilities. Its interpretation is wrong because (1) it assumes the data bank includes data that has been adjusted for minimum utilization (contrary to the AHC's findings of fact), (2) ignores the fact that the regulation specifies when the minimum utilization shall be applied and does not specify that it should be applied in calculating the ceiling or the median, (3) contradicts the policy for the minimum utilization adjustment (as expressed in the emergency statement for the March 21 emergency amendment) by penalizing facilities with greater than 85% occupancy for the low occupancy rates of other facilities, and (4) depends on the court "deferring" to the Department's unpromulgated interpretation that ambiguities in its rule should be resolved in the Department's favor.

1. The data bank is not adjusted for minimum utilization.

As an initial matter, 13 CSR 70-10.015 provides that the "ceiling" is 110% of the median. J. Ex. 1 at (4)(L) (EF 002).² The median is "[t]he middle value in a distribution,

² The 2005 version of 13 CSR 70-10.015 (Joint Exhibit 1) is included in the Appendix and this discussion cites to it for ease of reference. Appendix to Substitute Brief of Appellants, A00065–A00081 (Mar. 26, 2009). The March 21 emergency amendment, the

above and below which lie an equal number of values. This distribution is based on the data bank.” J. Ex. 1 at (4)(KK) (EF 003; emphasis added). 13 CSR 70-10.015 re-emphasizes that the ceiling is calculated from the data bank in assigning a facility its final per diem, which shall be the lower of the facility (1) administration costs adjusted for minimum utilization, or (2) “[t]he per diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank.” J. Ex. 1 at (11)(C) (EF 009; emphasis added).

Since the median must be determined from the data bank, the Department’s argument assumes that the data bank information has been adjusted for minimum utilization. The AHC, however, expressly found as a matter of fact and law that the data bank information is not adjusted for minimum utilization based on the plain text of the regulation, the text of the challenged rules, and hearing testimony. AHC Dec. ¶¶ 30-32

March 29 proposed amendment (as adopted in the August 15 order of rulemaking), and June 20 emergency amendment all adopted changes that affected the data set used to perform these calculations. See J. Ex. 4 at 20(D)1.A. (EF 0085); J. Ex. 7 at (21)(A) (EF 094); J. Ex. 5 at (20)(D), (21)(A) (EF 086-87). The methodology for calculating the ceiling remained the same under all of these rules. None of these rules changed the definitions for “ceiling,” “median,” or “data bank.” Like the 2005 version of 13 CSR 70-10.015, they state that the data bank consists of cost report data with certain trends applied. Id. None of these rules allow the Department to adjust the data bank information for minimum utilization.

(LF 281); AHC Dec. at 24-25 (LF 298-99).

That factual finding was supported by substantial and competent evidence. The data bank consists of the audited 2001 cost report data for all Medicaid-certified skilled nursing facilities, except for hospital-based, state-operated, and pediatric nursing facilities. AHC Dec. ¶¶ 30-32 (LF 281); J. Ex. 1 at (4)(S), (20) (EF 002, 015); J. Exs. 4-5 (EF 084-090). The audited 2001 cost report data comes from the cost report that each facility is required to submit annually that is reviewed by and, if necessary, adjusted by the Department's auditors. J. Ex. 1 at (4)(S), (10), (20) (EF 002, 007, 015); J. Exs. 4-5 (EF 84-90); Tr. 462, l. 5-12; AHC Dec. ¶¶ 29, 31 (LF 281). The costs in the last column of an audit adjustment report are allowable costs and go into the data bank. Tr. 1181, l. 23 – 1182, l. 3; see Tr. 1197, l. 14 – 1199, l. 2. The costs in the last column of a facility's cost report reflect the facility's allowable costs according to 13 CSR 70-10.015. See, e.g., R. Ex. CC (2001 Cost Report for Glennon Place Nursing Center) (EF 675); R. Ex. GG-1 (2001 Cost Report for Beverly Health & Rehab Center – Jefferson City) (EF 733). These are the costs that the Department reviews and adjusts to reflect allowable costs located in the last column of the audited cost report. See AHC Dec. at 7 (LF 281); Tr. 462, l. 5-12; see, e.g., R. Ex. CC (EF 675); R. Ex. GG-1 (EF 733). The data bank includes “only . . . allowable cost data” which is taken directly from the cost reports. AHC Dec. at 24 (LF 298). It does not include “the products of the Department's calculations.” AHC Dec. at 25 (LF 299).

At the AHC and in its Brief, the Department also argues that the minimum utilization adjustment should be considered part of the data bank because changes to the

desk audited and/or field audited cost reports are included. Dept. Br. 31. But, audited information is specifically defined as part of the data bank. J. Ex. 1 at (4)(S), (10), (20) (EF 002, 007, 015). By way of contrast, the AHC specifically refused to find that minimum utilization adjustments are made as part of the desk audit or field audit process, and noted that the regulation does not provide for them to be incorporated into the “data bank.” AHC Dec. at 24-25 (LF 298-99). Thus, the AHC rightly rejected this argument as an effort to modify 13 CSR 70-10.015 by “interpretation” and without going through the notice-and-comment procedures. AHC Dec. at 28 (LF 302) (refusing to “amend the Plan to make it work in a way that the Department considers better”).

2. The Department ignores the fact that 13 CSR 70-10.015 specifically states when a minimum utilization adjustment should be applied.

13 CSR 70-10.015 expressly states when a minimum utilization should be applied.

13 CSR 70-10.015(11)(C) provides:

Each nursing facility’s administration per diem shall be the lower of –

1. Allowable cost per patient day for administration as determined by the division from the 1992 cost report data, trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4%, and nine months of 1995 of 3.3%, for a total of 10.6% and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or
2. The per diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank.

J. Ex. 1. at (11)(C) (EF 009; emphasis added).

Subparagraph 11(C)(1) is the only place where 13 CSR 70-10.015 directs the Department to perform a minimum utilization adjustment. That adjustment is not required to calculate the ceiling under subparagraph 11(C)(2), and is not mandated in the definitions of “ceiling,” “median,” or “data bank.”

The Department argues that the use of the phrase “median per diem” in the definition of “ceiling” necessarily implies that the median is determined from data that has been adjusted for minimum utilization, and apparently believes this implication should override the express direction to calculate the median from data that has not been adjusted for minimum utilization (i.e., the data bank). Dept. Br. 30. This interpretation is not consistent with the regulation’s plain text. First, the definition of “per diem” is silent as to the application of the minimum utilization percentage. See J. Ex. 1 at (4)(PP) (EF 003). A “per diem” is simply a “daily rate calculated using [the Plan’s] cost components and used in the determination of a facility’s prospective and/or interim rate.” Id. The definition includes no mention of a minimum utilization adjustment.

Second, the Department’s argument contradicts 13 CSR 70-10.015 because a facility’s per diem rate cannot be calculated before the ceiling is calculated. J. Ex. 1 at (11)(C) (EF 009). The median must also be calculated before the per diem rate is calculated in order to determine whether the facility is even subject to the ceiling. Tr. 1041, l. 4-20.

Finally, the Department’s interpretation would directly contradict either the definition of “median” or “data bank,” because the Court would either have to find that

the data bank includes information that has been adjusted for minimum utilization (in direct contravention of the definition in paragraph (4)(S)) or that the median is calculated from some set of information other than the data bank (in direct contravention of (4)(KK) and (11)(C)(2)). In interpreting provisions of a regulation, the Court should harmonize and give effect to all of its provisions, if possible. See, e.g., Hudson v. Dir. of Revenue, 216 S.W.3d 216, 222 (Mo. App. 2007). All of these provisions of 13 CSR 70-10.015 can be reconciled by recognizing that the minimum utilization adjustment is specifically required under subparagraph 11(C)(1), but is not authorized in the directions for calculating the ceiling under subparagraph (11)(C)(2), is not mentioned in the definitions of “ceiling,” “median,” or “data bank,” and should not be implied into the calculation of the ceiling because to do so would directly contradict other portions of the regulation. Thus, the data bank information should not be adjusted for minimum utilization in calculating the ceiling under subparagraph (11)(C)(2) .

3. The Department’s interpretation conflicts with the policies behind both the minimum utilization adjustment and the ceiling.

When it promulgated the first emergency amendment, the Department stated that it would only be reducing the rates of facilities with occupancy rates less than 85%: “This emergency amendment, that reduces payments to some nursing facility providers with an occupancy of less than eighty-five percent (85), will ensure continued payment at the end of State Fiscal Year 2005 for nursing facility services.” J. Ex. 4 (EF 085; emphasis added). But, in its arguments to the AHC, the Department conceded that the effect of its interpretation was that “well-run facilities that maintain occupancy at or above 85% are

being punished when the [calculation of the administration cost component] ceiling is depressed by the inclusion of administration per diems that were reduced by the minimum utilization adjustment.” AHC Dec. at 27-28 (LF 301-02). The effect of the Department’s interpretation is to adjust for minimum utilization twice. First, it directly reduces the rates of facilities with less than 85% occupancy. Second, it reduces the rates of all facilities by calculating the ceiling using the minimum utilization adjusted data. See AHC Dec. ¶ 77 (LF 292).

For example, Petitioner New Haven Nursing Home has an occupancy rate of greater than 85 percent. P. Ex. 145 (separately filed exhibit); AHC Dec. ¶ 45 (LF 284). Its trended, allowable administration costs for its rate effective April 1, 2005, were \$573,054. P. Ex. 145 (separately filed exhibit); Tr. 1236 l. 21 - 1237 l. 4. The facility’s administration costs, \$573,054, divided by its patient days, 20,046, equals \$28.59. P. Ex. 143 (separately filed exhibit); Tr. 1237, l. 24 – 1238, l.13. This means that the facility spent \$28.59 per patient day on its administration costs. P. Ex. 143 (separately filed exhibit); Tr. 1237, l. 24 – 1238, l. 13. When the ceiling is correctly calculated with unadjusted data, New Haven receives \$23.96 per patient day for its administration cost component resulting in a shortfall of \$4.63 per patient per day. Tr. 1238, l. 9-14; AHC Dec. ¶ 78 (LF 292). Because the ceiling calculated by the Department was only \$21.40, New Haven was not reimbursed \$7.19 in otherwise allowable administration costs. P. Exs. 143, 145 (separately filed exhibit). Therefore, because of the Department’s erroneous methodology, New Haven failed to receive and have available to spend for its care of residents \$2.56 per patient per day in otherwise allowable costs for a facility with

greater than 85 percent occupancy. Tr. 1238, l. 13-24.

The Department's interpretation is also inconsistent with the purpose for the ceiling. The AHC found that, calculated without the application of the minimum utilization percentage, the administration *median* is \$21.78, which results in a ceiling of \$23.96. AHC Dec. ¶ 78 (LF 292); Tr. 1152, l. 7-21. In contrast, the *ceiling* calculated using the Department's methodology is \$21.40. AHC Dec. ¶¶ 76, 77 (LF 292); Tr. 1152, l. 7-21. Thus, the Department's method of calculating the median does not even reimburse facilities for allowable costs below the actual median. Tr. 1164, l. 20-22. It only reimburses facilities for 98 percent of the median. *Id.*

Accordingly, the Department's interpretation results in an absurd and unreasonable outcome in that the rates of facilities with greater than 85% occupancy are being reduced and the "ceiling" – as calculated by the Department – is less than the true median of the administration costs. Tr. 1038, l. 25 – 1039, l. 3. Interpretations that result in absurd or unreasonable outcomes should not be adopted, if another reasonable construction is possible. See, e.g., Gladstone Special Road Dist. No. 3 of Clay County v. County of Clay, 248 S.W.3d at 60, 63-64 (Mo. App. 2008).

4. As in previous cases, the Department argues that the AHC must defer to the Department's interpretations of its own rules.

As the discussion above shows, the Department's argument depends on manufacturing ambiguities in its own rules and then commanding "deference" to its resolution of those ambiguities. The Department's assertion that it is merely following the "plain text" of its rule is belied by the fact that it ignores the AHC's factual finding

that the data bank is not adjusted for minimum utilization, argues for a result that contradicts the emergency statement for the March 21 emergency amendment and the very policy underlying the use of the minimum utilization adjustment, and asserts that this Court must defer to its interpretation of its regulation. Dept. Br. 27.

As in other recent cases, in challenging the AHC's conclusion that the Department improperly calculated the ceiling for the administration cost component, "DMS is actually complaining of . . . the Commission's unwillingness to apply its regulation, the Plan, in the manner DMS wants it to be applied. But DMS's desired application of the Plan is contrary to the Plan's plain language," and the Department "simply does not like what the Plan says." Senior Citizens, 224 S.W.3d at 16. As those previous cases recognize, the Department's Plan is not a model of clarity. But, "[v]ague or even inept drafting does not permit [the Court] to simply read the language out of the regulation." Id. at 18. Rather, the AHC, the Court, and the regulated community must harmonize the plain text of the regulation to decipher its meaning. The Department cannot amend its regulation by interpretation when the plain text leads to a conclusion it does not like.

Standing in the shoes of the Department, the AHC determined that the Department's methodology in calculating the administration cost component median and ceiling lacks authority in 13 CSR 70-10.015. See Mellas, 220 S.W.3d at 783; AHC Dec. at 23-244 (LF 297-98). In calculating the reimbursement rates, the Department has contravened the statements in (7)(O) and (11)(C)1 that the minimum utilization percentage should only be applied "if applicable." Instead, the Department has applied that percentage to every facility and has applied it twice to some facilities. By applying

the minimum utilization percentage to facilities in this manner, the AHC determined that the Department artificially decreased facilities' rates regardless of a facility's occupancy percentage. AHC Dec. at 27-28 (LF 301-02). The Department's improper methodology has resulted in decreased reimbursement rates for eight of Beverly's facilities. AHC Dec. ¶ 75 (LF 291-92); see P. Ex. 143 (separately filed exhibit). This methodology is void under § 536.021.7 since it represents a policy of statewide applicability that was not promulgated and adopted pursuant to § 536.021. AHC Dec. at 22 (LF 296). The Department had its opportunity to persuade the AHC of the correctness of its interpretation and failed. The AHC's interpretation of the regulation is the agency's interpretation. Senior Citizens, 224 S.W.3d at 16. Because it correctly interprets 13 CSR 70-10.015, this Court should affirm the AHC's calculation of the administration cost component ceiling.

V. The Administrative Hearing Commission properly denied the Department's offer of proof. (Responds to the Department's Point Relied On Challenging the AHC's evidentiary ruling, pp. 49-51 of its Brief).

A. Standard of review

The Department's brief omits the standard of appellate review of a decision to exclude evidence. See Dept. Br. 21-22, 49. Trial courts and administrative agencies are afforded substantial latitude in considering evidentiary issues. Their rulings are reversed only if they abuse their discretion. See, e.g., Roorda v. City of Arnold, 142 S.W.3d 786, 799 (Mo. App. 2004).

B. The Department's offer of proof was wholly irrelevant, and the AHC properly excluded it.

The Department submitted a supplemental legal file to this Court, which contains certain documents that were not admitted into evidence before the AHC. Moreover, the AHC exercised its discretion and refused to accept those documents even as an offer of proof, because they were wholly irrelevant to the issues being litigated. Tr. 699, 959-60, 973-77, 1276; LF 393-94. Beverly has previously moved to strike the supplemental legal file, because the documents it contains constitute non-record material that should not be considered by this Court. Motion to Strike (March 26, 2009). That motion is still pending as of the filing of this brief.

The AHC properly denied the offer of proof. The AHC has discretion to refuse offers of proof that are “wholly irrelevant.” § 536.070(7), RSMo 2000. The transcript of the AHC hearing spanned seven days and produced more than 1,200 pages of transcript, including the admission of more than 100 exhibits. Throughout the hearing, the Department unnecessarily protracted the proceedings by attempting to probe and ascertain the overall financial status of the facilities. But, Beverly's challenge was limited to the reasonableness of the Department's decision-making process. Allegations regarding factors that Beverly considers in its business operations, its overall financial status, etc., have absolutely no probative value regarding whether the Department considered the required factors under state law. In fact, such evidence only tended to confuse the issues. The Department's obligation pertains only to the procedural methods used to determine Medicaid reimbursement. The issue in this case does not involve the

Department's substantive obligations, i.e., the adequacy of reimbursement. The overall financial situation of long term care providers depends on a broader range of conditions – for example, reimbursement from other sources (Medicare, private pay patients, and third party insurers). The kinds of material that the Department attempted to clutter the record with provided absolutely no probative evidence of whether the Department determined if its Medicaid rates would compensate long term care providers for the costs that must be incurred by efficiently and economically operated facilities. Since the Department persisted in submitting the evidence through offers of proof, the AHC exercised control over the case and managed its own docket by excluding the irrelevant offers of proof. Tr. 699, 959-60, 973-77, 1276; LF 393-94.

Second, even if the AHC could have accepted the documents as an offer of proof, for the same reasons the Department has not demonstrated that the AHC abused its discretion in refusing to admit them into evidence. The Department's brief shows that it fundamentally misunderstands the difference between a substantive challenge to the reasonableness of a rule and a procedural challenge to the process followed to adopt a rule. Beverly's claim is the latter, and evidence showing that Beverly's facilities are or are not financially solvent – in spite of the Department's unfamiliarity with the costs of taking care of Medicaid residents and whether its Medicaid rules reimburse those costs – is simply irrelevant.

Accordingly, Beverly respectfully requests that this Court strike the supplemental legal file, reject Beverly's second Point Relied On, refuse to remand the case as requested by the Department, and declare the challenged rules unlawful.

CONCLUSION

Accordingly, the Appellants respectfully request that this Court reverse the Circuit Court's judgment and declare that:

1. The challenged rules are arbitrary, capricious, and unreasonable because the decision-making process followed to select 85% as the minimum utilization percentage did not consider whether that standard would reimburse the costs of efficiently and economically operated providers;
2. The selection of 85% as the minimum utilization percentage was not based on substantial evidence and the challenged rules therefore violate § 536.016, RSMo 2000;
3. The Department did not make a finding that the challenged rules were necessary to carry out the purposes of the statutes and the challenged rules therefore violate § 536.016, RSMo 2000;
4. No emergency existed to justify the March 21 and June 20 emergency amendments and those emergency amendments therefore violated § 536.025, RSMo 2000;
5. The AHC properly calculated the administration cost component ceiling;
and
6. The AHC properly excluded the Department's offers of proof.

Respectfully submitted,

HUSCH BLACKWELL SANDERS LLP

By: _____
HARVEY M. TETTLEBAUM #20005
ROBERT L. HESS II #52548

HUSCH BLACKWELL SANDERS LLP
235 East High Street, Suite 200
P. O. Box 1251
Jefferson City, MO 65102-1251
PHONE: 573-635-9118
FAX: 573-634-7854
EMAIL: harvey.tettlebaum@huschblackwell.com
robert.hess@huschblackwell.com

ATTORNEYS FOR APPELLANTS

CERTIFICATE OF COMPLIANCE WITH RULE 84.06(g)

The undersigned counsel hereby certifies pursuant to Rule 84.06(c) that this brief (1) contains the information required by Rule 55.03; (2) complies with the limitations contained in Rule 84.06(b); and (3) contains 12,653 words, exclusive of the sections exempted by Rule 84.06(b)(2) of the Missouri Supreme Court Rules, based on the word count that is part of Microsoft Word 2003 SP-2. The undersigned counsel further certifies that the diskette has been scanned and is free of viruses.

CERTIFICATE OF SERVICE

I certify that two copies of this brief and one copy on floppy disk, as required by Missouri Supreme Court Rule 84.06(g), were served on each of the counsel identified below by placement in the United States mail, postage paid, on this 5th day of May, 2009, to:

Mark Long
J. Scott Stacey
Assistant Attorneys General
Broadway State Office Building, 6th Floor
221 West High Street
Jefferson City, MO 65102

Richard D. Watters
Lashly & Baer
714 Locust Street
St. Louis, MO 63101
