

No. SC88430

SUPREME COURT OF MISSOURI

**DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,**

Appellant,

v.

**LITTLE HILLS HEALTHCARE, L.L.C.,
d/b/a CENTERPOINTE HOSPITAL,**

Respondent.

**Appeal from the Administrative Hearing Commission
Commissioner June Striegel Doughty**

APPELLANT'S SUBSTITUTE BRIEF

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Jurisdictional Statement

Following a July 12, 2005 adverse decision by the Administrative Hearing Commission, on August 11, 2005, the Missouri Department of Social Services, Division of Medical Services (“Medical Services”) timely filed its Petition for Judicial Review and Counterclaim for Equitable Set Off in the Circuit Court of Cole County. The Circuit Court entered judgment on March 21, 2006, and on April 21, 2006 Medical Services timely appealed the Circuit Court’s judgment to the Missouri Court of Appeals, Western District. Rule 100.01 and 100.02, and §§ 536.100 - 536.140, 621.055, RSMo (Cum. Supp. 2006).

The Missouri Court of Appeals, Western District reversed and remanded the decision of the Administrative Hearing Commission. This Court ordered the case transferred from the Western District on May 29, 2007 after the Western District issued its final judgment (no dissent) in favor of Appellant Medical Services and denied Respondent Little Hills Healthcare d/b/a Centerpointe Hospital’s (“Centerpointe’s”) Motion for Rehearing or Transfer. Accordingly, this Court has jurisdiction to hear this matter. Mo. Const. art. V, § 10 (as amended, 1982), Rule 83.04.

On appeal, this Court reviews the decision of the Administrative Hearing Commission, not the judgment of the Western District. *Psychare Mgmt., Inc. v. Dep’t of Soc. Servs., Div. of Med. Servs.*, 980 S.W.2d 311, 312 (Mo. banc 1998). Accordingly, Medical Services, though it prevailed at the Western District, is the Appellant in this case because Centerpointe prevailed at the Commission.

Introduction

Medical Services is the state agency charged with administering payments under Missouri's joint federal-state Medicaid program (Title XIX). RSMo §§ 208.201, 208.151,¹ and 208.152 (Cum. Supp. 2006). The services purchased under Missouri Medicaid include hospital services. RSMo § 208.152 (Cum. Supp. 2006) and 13 CSR 70-15.010. Medical Services must: purchase all services mandated by the Missouri statutes, the Social Security Act, and Missouri's federally-approved Medicaid State Plan; assure adequate payments to Medicaid providers under those laws; and, limit its spending to its appropriation. RSMo §§ 21.260, 208.201, 208.151, and 208.152 (Cum. Supp. 2006); 42 U.S.C. 1396-1396a; Mo. Const. art III, §§ 36, 37 and 39; art IV, § 23.

The bulk of the more than \$1 billion Missouri spends annually for hospital services is for two types of payments: per diem payments and Medicaid Add-On payments. Per diem payments are an amount paid on a per patient per day basis to reimburse a hospital for the costs it actually incurs in providing the services. A hospital's per diem rate is based upon cost data contained in cost reports, which the hospital submits to Medical Services. 13 CSR 70-15.010(3). Medicaid Add-On payments are prospective Medicaid payments to hospitals to reimburse for hospitals' projected expenses. 13 CSR 70-15.010. Direct Medicaid payments are one kind of Medicaid Add-On payment. 13 CSR 70-15.010(1)(C)4. Because

¹ All statutory references are to the 2000 Missouri Revised Statutes unless otherwise indicated.

the payments are prospective,² they are based upon estimates of costs incurred by hospitals in prior years. Prospective payments, though based on estimates and projected expenses, do systemically reimburse facilities for the services they perform as the payments change from year to year to reflect the services performed during the prior year or time frame. With prospective payments, hospitals have the added benefit of receiving immediate payments instead of waiting until the services are actually performed.³ Medical Services issues more than \$600,000,000 in prospective direct Medicaid and Add On payments yearly. LF 539.

This case is about one estimate made by Medical Services for Centerpointe Hospital for State Fiscal Year (“SFY”) 2004 and its impact on how much money Centerpointe received in direct Medicaid payments. On September 3, 2003, Medical Services issued a final decision to Centerpointe stating that it would be paid \$1,753,382 in direct Medicaid payments for SFY 2004, based on its estimate of Centerpointe’s Medicaid patient days for SFY 2004 of 2,372. LF 656-659. Patient days is a variable, and a component of the calculation of direct Medicaid payments. 13 CSR 70 15.010(15)(B)(2).

² The only exception to the prospective payment system are payments made to hospitals under 13 CSR 70-15.040, which are not at issue in this case.

³ Regardless of how many actual Medicaid patient days are provided in any State Fiscal Year, the provider retains the entirety of its direct Medicaid payment. Thus, a provider can retain a direct Medicaid payment based upon a 3,000 Medicaid patient day estimate even if the hospital later provides 1,500 actual patient days of service for the year.

Centerpointe had several options after receiving its direct Medicaid payment letter. It could cash its direct Medicaid check and provide services for the year, quit the Medicaid program, or appeal the decision. Centerpointe cashed the check, and did not appeal the September 3, 2003 decision. LF 656-659; § 621.055.3 RSMo, (Cum. Supp. 2006).

Medical Services estimated Centerpointe's SFY 2004 Medicaid patient days based upon the actual Medicaid patient days experienced by Centerpointe from August 2002 through March 2003, annualized. LF 676. But during that time, Centerpointe's prior ownership group had downsized the hospital greatly, reducing its Medicaid patient days in preparation for its sale. LF 59, 71-72. Shortly after taking over, Centerpointe's new ownership group increased Medicaid patient days by more than 100 percent. LF 71-72.

Immediately after the September 3, 2003 decision, Medical Services began issuing Centerpointe's direct Medicaid payment. It paid the September 2003 first installment of \$441,558 on or about September 22, 2003.

Centerpointe did not appeal the amount of its direct Medicaid payment (or its estimate of Medicaid patient days) to the Administrative Hearing Commission until June 25, 2004. The Commission, nonetheless, found that it had jurisdiction to hear Centerpointe's challenge after allowing Centerpointe to bootstrap a challenge of a subsequent decision into a challenge of the September 3, 2003 decision setting Centerpointe's estimate of Medicaid patient days.

At hearing, the parties agreed that Medical Services' regulation 13 CSR 70-15.010 sets forth how Medical Services is to calculate direct Medicaid payments to hospitals. LF 122, 498-509. There is also no dispute that the regulation was validly promulgated. LF

122. Accordingly, the Commission found that Medical Services had a rule stating how direct Medicaid payments are to be made, and concluded that estimates of Medicaid patient days were historically reasonable. LF 813, 817. But the Commission found that Medical Services' existing regulation was insufficient, and that Medical Services' estimation process was a policy statement of general applicability for which the Commission determined there was no valid regulation – despite the fact that Medical Services' estimation process cannot apply to unnamed persons or unspecified facts, has no future effect, and only impacts prospective Medicaid payments for which providers have no property rights. The Commission then, paradoxically, created its own method for estimating Medicaid patient days and ordered Medical Services to pay an additional \$1,803,984 in direct Medicaid payments, plus interest, after applying that estimation process. And the Commission's estimate utilized data not even in existence at the time Medical Services made its estimate for Centerpointe.

This case presents three legal issues for the Court's determination. First, did the Commission err in finding that it had jurisdiction to hear Centerpointe's challenge to its September 3, 2003 estimate of Medicaid patient days when Centerpointe filed its Complaint challenging the estimate well in excess of the 30-day statutory deadline? Second, was Medical Services required to promulgate its estimation process for Medicaid patient as a rule? If not, was its estimate reasonable? And third, even if it was required to promulgate its estimation process as a rule, was the remedy fashioned by the Commission – creating its own unpromulgated method and using it to estimate days for Centerpointe based upon data not in existence at the time of Medical Services' estimate – unauthorized by law or unreasonable?

Ultimately this case is about money, and Centerpointe's attempt to carve out a new right. In State Fiscal Year 2003, thousands of children were added to Medicaid's rolls through a legislative enactment. LF 375. As a result of this sudden addition, Medical Services' estimates of Medicaid patient days were off. The Medicaid program was paying out millions more than it collected, and when the money ran out, payments would have stopped to hospitals. The Missouri Hospital Association ("MHA") approached Medical Services about updating the estimate of days for the hospital industry. Medical Services agreed to update its estimate of Medicaid days for the only time in its direct Medicaid payment history – State Fiscal Year 1991-2007 – to keep Medicaid solvent.

In State Fiscal Year 2004, Medical Services' estimates for hospitals were accurate across the industry and there was no funding crisis. Updating the days a second time in SFY 2004 would uniquely help Centerpointe because, as previously mentioned, it greatly reduced days in SFY 2003. Centerpointe does not want to be paid according to its SFY 2004 estimate – based on actual days from SFY 2003. Thus Centerpointe points to the radical action of Medical Services in SFY 2003, and believes it has a right to be paid according to Medical Services' decision in SFY 2003 to update Medicaid patient days, claiming that Medical Services does not have a rule for estimating days, and accordingly, it should be paid according to the method it proposes – one that not surprisingly maximizes its payment.

Centerpointe has no right to be paid according to Medical Services' prior decision in a crisis year, and the law does not support Centerpointe's argument. Indeed, no one supports Centerpointe's challenge, not even its lobbyist Missouri Hospital Association, which testified on behalf of Medical Services at hearing.

Statement of Facts

Parties

Centerpointe is a hospital which provides psychiatric hospital services, and emphasizes services to children and adolescents. LF 55. Centerpointe is located in St. Charles, Missouri, and is a Missouri Medicaid service provider. LF 24, 492 493.

The Department of Social Services is the state agency charged with administering Missouri's Medicaid program, and its Division of Medical Services administers payments under the program. Medical Services is authorized to regulate payments to Medicaid service providers like Centerpointe. RSMo §§ 208.152 (Cum. Supp. 2006), 208.153, 208.201 and 208.471 (Cum. Supp. 2006).

The Missouri Hospital Association, ("MHA") is an advocacy organization that represents Missouri's hospitals, including Centerpointe. LF 364-365. MHA represents the industry in discussions regarding the Medicaid program with governmental agencies including Medical Services. LF 365.

General Background

Little Hills Healthcare, L.L.C. acquired BHC Spirit of St. Louis Hospital, now known as Centerpointe Hospital, from Ardent Healthcare on April 1, 2003. LF 67, 72, 492-493. Centerpointe assumed Ardent's Medicaid provider number and provider agreement. LF 55, 67, 492-493. Assuming the provider number and provider agreement enabled Centerpointe to continue to bill for and receive Medicaid payments for services that Ardent Healthcare had already provided but also made it responsible for any accompanying liabilities. 13 CSR 70-3.020(7)

Some changes in board members and officers accompanied the ownership change for Centerpointe. LF 67-68. Tariq Malik became CEO of Centerpointe on April 1, 2003, but Steve Frantz, CFO under Ardent, retained his position. LF 54, 72. Mr. Frantz's duties included dealing with the Medicare and Medicaid programs. LF 72.

During fiscal year 2003, prior to the ownership change, Ardent greatly reduced the Medicaid services it provided, keeping only one of six units of the facility open. LF 59, 71-72. After Little Hills Healthcare purchased the facility, Centerpointe's Medicaid utilization increased by over 100 percent in 2004. LF 60. For a hospital to experience such a large decrease followed by a large increase in Medicaid volume is unusual. LF 72.

Calculating Medicaid Payments

Medical Services issues a series of payments and assessments each year to hospitals enrolled in the Missouri Medicaid program. LF 181-183. The Institutional Reimbursement Unit of Medical Services makes the calculations for the payments and assessments. LF 180-181, 271.

Hospitals enrolled in the Medicaid program receive a per diem Medicaid rate. LF 182. The rate is based upon a hospital's costs. 13 CSR 70-15.010(3). The hospitals submit cost information to Medical Services annually in a cost report. LF 182, 498-509. 13 CSR 70-15.010(5)(A). Facilities receive reimbursement based upon their 1995 cost reports trended forward to 2001. LF 182, 498-509, 13 CSR 70-15.010(3). After receiving a hospital's cost report, Medical Services conducts a desk review of the cost report information. LF 182. This process allows Medical Services to examine the total charges the

hospital billed to Medicaid, through it, Medical Services determines how many Medicaid patient days the facility had for the year. LF 182.

The direct Medicaid Add On payment is a payment made over and above a facility's per diem rate. LF 181. It is designed, in part, to mitigate the impact of the Federal Reimbursement Allowance (a provider tax) on Medicaid providers and to reimburse for other potential and projected costs. LF 793; 13 CSR 70-15.010(15). It is calculated by taking the difference between the facility's estimated costs for the coming SFY – July 1 to June 30 – and its per diem rate, and multiplying this number by an estimate of Medicaid patient days for the coming State Fiscal Year. LF 181, 498-509; 13 CSR 70 15.010(15). Hospitals also receive additional payments, like the uninsured add on. LF 182, 498-509.

Medical Services also oversees the Federal Reimbursement Allowance (“FRA”) assessment. LF 181. The FRA assessment is an amount that is assessed to each hospital for the privilege of doing business in Missouri. LF 181. It is calculated as a percentage of a hospital's total operating revenue less tax revenue and other government appropriations. LF 188; 13 CSR 70-15.110. The percentages of the assessment are set by regulation. 13 CSR 70-15.110.

Direct Medicaid payments are “prospective” payments, made before hospitals incur expenses caring for Medicaid patients. LF 437-438, 498-509. Such payments are generally final, and not subject to retrospective settlement.⁴ LF 437. In calculating a facility's direct

⁴ Medical Services has on rare occasion promulgated regulations that impact payments for a current State Fiscal Year. For example, Medical Services has promulgated

Medicaid payment, Medical Services is required to multiply the difference between the hospital's per diem rate and its per diem costs by an "estimate[]" of "Medicaid patient days for the current SFY." LF 184-188, 498-509; 13 CSR 70-15.010(15)(B)2. The regulation leaves to Medical Services' discretion the data to consult and process to follow in estimating the days for each of Missouri's hospital Medicaid providers. LF 186, 275.

There are three types of Medicaid patient days that a hospital can experience: fee for service ("FFS") days, MC+ days, and out of state days. LF 186. Medical Services' estimate of Medicaid patient days includes all three. LF 186. Out of state days are calculated in accordance with 13 CSR 70-15.010(15)(B)6, which requires Medical Services to use "out of state Medicaid days from the base year cost report." LF 187, 498 509.

Estimating FFS Medicaid Patient Days - SFY 1991 2002

Medical Services calculates a hospital's FFS days for facilities with a "base cost report" at the start of each SFY by performing a "regression analysis" to project what the total days for the hospital industry should be for the coming year. LF 191-199, 675-676. The number of days calculated through regression analysis is then compared to the actual number of paid FFS days for the industry from a prior time period. LF 191-200. The prior time period selected is always the most current time period for which Medical Services has

emergency rules changing the FRA assessment percentage prior to the conclusion of a SFY. LF 494-497; 13 CSR70-15.110. With the exception of Medical Services' second estimate of Medicaid days for SFY 2003, however, all payments are final unless altered by regulation.

accurate data. LF 191-198, 200. The time period is annualized if less than a full year is used. LF 191-199. The time period selected for comparison is never older than 36 months. LF 675-676. Medical Services compares the number of days and uses the comparison to know by what factor to inflate the paid days from the prior time period for each hospital for the hospital's estimate. LF 191-192. Hospitals that do not have a base cost report receive their direct Medicaid payments in accordance with 13 CSR 70-15.010(15)(C), based upon industry averages.

SFY 2003 FFS Estimate

Medical Services followed this process for estimating days for each of Missouri's hospital Medicaid providers from SFY 1991 until late in SFY 2003. LF 155, 191-198. In 2003, several thousand children, were added to the Medicaid program through the "SCHIP" program. LF 375. The addition of more recipients created many more actual Medicaid patient days than estimated days for the hospital industry, creating a funding crisis for the Medicaid hospital program. At the request of MHA, Medical Services issued a second estimate of days based upon the actual days reported for August 2002 through March 2003 and annualized the days. LF 375, 556-557. With the exception of SFY 2003, since 1991, Medical Services has only issued one estimate of Medicaid patient days at the beginning of each SFY. LF 135, 155.

SFY 2004-2005 FFS Estimates

In SFY 2004, Medical Services returned to the same process of estimating days that it used from 1991 through the beginning of SFY 2003. LF 378-380, 675-676. Medical

Services noted, however, that the special second estimate of days for SFY 2003 exceeded the number of FFS days obtained by performing the regression analysis. LF 195-198, 675-676. Accordingly, MHA advocated for Medical Services to utilize the second estimate of days in SFY 2003 as the estimate for SFY 2004, and Medical Services agreed. LF 378-379.

In SFY 2005, Medical Services again returned to the same process of estimating days that it used since 1991. LF 196-199, 675-676. Medical Services compared the results of applying its process for each particular hospital with the estimate for the hospital from SFY 2004. Medical Services used either its SFY 2005 estimate for each hospital, or the facility's SFY 2004 estimate if the SFY 2004 estimate was greater and more beneficial for the hospital. LF 198-199.

MC+ Days Estimate

The third type of days, "MC+" days, is calculated by taking the FFS days and dividing by the FFS percentage. The FFS days are subtracted from this number to arrive at the MC+ component. LF 124-125, 189.

Medical Services' Decisions Announcing Estimates

It is important for Medical Services to issue its estimate at or near the beginning of each SFY so that Medicaid payments made on the basis of the estimate can begin to flow to the hospitals. LF 135. Medical Services has always made payments to each of the 140 hospitals in the industry at the beginning of a SFY using the same process industry-wide. LF 200-201, 442.

Medical Services announces the decisions pertaining to direct Medicaid payments, including the estimation of Medicaid days, in decision letters at or near the beginning of each

SFY. LF 558-653, 656-659. The letters contain language informing the recipients of their appeal rights. LF 656-659.

Because payments made on the basis of the estimates are final, Medical Services does not go back and recoup monies where a hospital's actual days were greatly lower than the estimate. LF 142-143. Medical Services did recoup monies in SFY 2003 where Medical Services made two estimates for the year because payments made under the first estimate were no longer final. LF 143.

Hospital Industry Medicaid Utilization - SFY 2003-2004

In SFY 2003, the Hospital Medicaid program experienced a funding crisis. LF 375-376, 543-545. Because the estimation of days directly affects the amount of a provider's FRA assessment, and because the actual number of days greatly exceeded the estimates, the hospital program was out of money. LF 202, 279.

MHA asked Medical Services to increase the FRA assessment percentage, and to update the days to correct the problem. LF 374-378. Medical Services agreed, and issued a second estimate of Medicaid patient days. LF 155. As a result, payments made using the first estimate were adjusted using the second estimate. This adjustment included the assessment of overpayments, including an overpayment against Centerpointe. LF 552-555. Overall, Medical Services assessed or collected \$13 million more from the hospital industry in SFY 2003 than was collected initially. LF 291, 539. Inherent problems with issuing a second estimate of Medicaid patient days for any one SFY include the redistribution of funds paid to hospitals, the assessment of overpayments, and an increased administrative burden on Medical Services. LF 290.

Medical Services did not experience a funding crisis in SFY 2004. LF 294. In fact, when Medical Services compared its estimates of days with the actual days being reported in the industry, its estimate slightly exceeded the actual days being reported. LF 294, 540-542. SFY 2004 was materially dissimilar from SFY 2003, and more similar to SFY 2002 and prior years for purposes of the estimation of Medicaid patient days. LF 300. MHA did not advocate for Medical Services to issue a second estimate of Medicaid patient days for SFY 2004. LF 379.

Centerpointe's Medicaid Payments

On September 3, 2003, Medical Services issued a final decision announcing Centerpointe's direct Medicaid payments, uninsured add on payments, and the FRA assessment for SFY 2004. LF 656-659. The decision also estimated Centerpointe's Projected SFY 2004 Days + 2000 Medicaid out of state days at 2,372. LF 656-659. The September 3, 2003 decision letter was mailed by Medical Services to Centerpointe on September 3, 2003. LF 358-360.

When the estimate of days was multiplied by the difference between the "estimated cost per day" and Centerpointe's per diem rate, Centerpointe's direct Medicaid payment was \$1,753,382. LF 656-659. Medical Services began making payments on the basis of this decision in September, 2003. LF 488-491.

On June 4, 2004, Medical Services issued a final decision to Centerpointe informing it that the FRA assessment percentage would be increased from 5.23% to 5.32%. LF 664-667. This change corresponded to a change in the regulations. *See* 13 CSR 70 15.110(11), as *Ex. C* and *DI* (LF 494-497, 534-537) were not current enough to show the change in the

regulation. Medical Services sent its decision to Centerpointe via first class mail, not via certified or registered mail. LF 320. The decision had nothing to do with Centerpointe's estimation of Medicaid patient days. LF 236.

Appeal

Centerpointe filed its Complaint with the Commission appealing Medical Services' June 4, 2004 decision changing Centerpointe's FRA assessment percentage. LF 1-19. Centerpointe never appealed Medical Services' September 3, 2003 decision. LF 1-19.

On January 31 and February 1, 2005, the Commission held a hearing on Centerpointe's Complaint. Both sides were represented by counsel, called witnesses, introduced exhibits, and presented oral and written arguments. LF 1-421.

On July 12, 2005 the Commission issued its decision changing Centerpointe's estimate of Medicaid days for SFY 2004. The Commission ordered Medical Services to pay \$1,803,984 in additional direct Medicaid payments, plus interest, after multiplying Centerpointe's new estimate of days by the difference between its projected expenses and its Medicaid per diem rate. LF 197.

Medical Services timely appealed to the Circuit Court of Cole County on August 11, 2005, and included a counterclaim for equitable set off with its Petition for Judicial Review. LF 822-837. By order dated October 31, 2005, the Cole County Circuit Court dismissed Medical Services' counterclaim for equitable set off. LF 842. On March 21, 2006, the court issued its Final Judgment affirming the decision of the Commission. LF 843.

Medical Services timely filed its Notice of Appeal with the Circuit Court of Cole County on April 21, 2006, and appealed the Circuit Court's Final Judgment to the Missouri

Court of Appeals, Western District. LF 4, 844-846. The Western District reversed the decision of the Commission, holding that Medical Services did not need to promulgate its process for estimating Medicaid patient days as a rule. It remanded the case to the Commission to determine whether Medical Services' estimate of Medicaid patient days for Centerpointe for SFY 2004 was an abuse of discretion. *Department of Social Services, Division of Medical Services v. Little Hills Healthcare*, 2007 WL 505658 at 18 (Mo. App. W.D., February 20, 2007).

On March 5, 2007, Centerpointe filed a Motion for Rehearing or Transfer to the Missouri Supreme Court with the Western District. The Western District denied the motion on March 27, 2007.

On or about April 10, 2007 Centerpointe filed its Application for Transfer with this Court. On May 29, 2007, the Court granted Centerpointe's Application.

Points Relied On

I. The Commission erred in holding that it had jurisdiction to hear Centerpointe's Complaint because its decision was in excess of its statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious or unreasonable under RSMo § 536.140.2 in that Centerpointe failed to timely appeal Medical Services' decision setting Centerpointe's estimate of Medicaid patient days, Centerpointe may not collaterally attack a prior decision through a challenge of a subsequent decision, and the Commission's finding that Centerpointe did not receive Medical Services' September 3, 2003 decision letter is contrary to the overwhelming weight of the evidence.

1. *Mo. Dep't of Soc. Serv's, Div. of Med. Serv's v. NME Hospitals, Inc.*, 11 S.W.3d 776 (Mo. App. 1999).
2. *Clear v. Missouri Coordinating Bd. for Higher Educ.*, 23 S.W.3d 896 (Mo. App. 2000).
3. Section 621.055.3, RSMo (Cum. Supp. 2006).

II. The Commission erred in holding that Medical Services was required to promulgate a rule setting forth its process for estimating Medicaid patient days because its process does not meet the definition of a rule under RSMo § 536.010(6) and does not have to be promulgated according to state and federal case law in that the process does not apply to unnamed persons or unspecified

facts, has no future effect, does not impact the property rights of providers, and is not a payment method or standard requiring promulgation.

1. *Missouri Soybean Ass'n v. Missouri Clean Water Comm'n*, 102 S.W.3d 10 (Mo. banc 2003).
2. *Indiana Ass'n of Homes for Aging Inc., v. Ind. Office of Medicaid Policy & Planning*, 60 F.3d 262 (7th Cir. 1995).
3. Section 536.010(5-6), RSMo (Cum. Supp. 2006).

III. The Commission erred in failing to defer to Medical Services' estimate of Medicaid patient days for Centerpointe of 2,372 for SFY 2004 and in requiring Medical Services to issue a second estimate of Medicaid patient days because it applied the wrong standard of review in violation of RSMo § 536.140.2 and contrary to state and federal case law in that Medical Services' estimate was based upon Centerpointe's own objective data, Centerpointe's expert conceded there was nothing "unreasonable" about Medical Services' SFY 2004 estimation process, and SFY 2004 was not an extraordinary year like SFY 2003 in which thousands of Medicaid recipients were suddenly added to Missouri Medicaid's rolls requiring a second update of Medicaid patient days to be done to keep the Medicaid program solvent.

1. *KV Pharm. Co. v. Missouri State Board of Pharmacy*, 43 S.W.3d 306 (Mo. banc 2001).
2. *SSM Healthcare System v. Reagan*, 681 F.Supp. 625 (W.D.Mo. 1988).

3. *Citizens for Rural Preservation, Inc. v. Robinett*, 648 S.W.2d 117 (Mo. App. 1983).

IV. The Commission erred in ordering Medical Services to pay more than \$1.8 million in additional direct Medicaid payments to Centerpointe and in refusing to consider proffered evidence by Medical Services because those decisions were in excess of the Commission's statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious or unreasonable under RSMo § 536.140.2 in that the Commission's Decision by its very terms applies an unpromulgated method of estimating Medicaid patient days, superintends Medical Services' procedures, incorrectly applies the Missouri case law to the facts, and is unreasonable in applying the Commission's new method of estimating Medicaid patient days to the only year which results in additional payments to Centerpointe and not to other years in which Medical Services would be owed additional money.

1. *Soars v. Soars Lovelace, Inc.*, 142 S.W.2d 866 (Mo. 1940).
2. *Mo. Health Fac. Review Comm. v. Admin. Hearing Comm'n*, 641 S.W.2d 69 (Mo. banc 1982).
3. *Monroe County Nursing Home Dist. v. Dep't of Soc. Serv's*, 884 S.W.2d 291 (Mo. App. 1994).

Standard of Review

The standard of review for this matter is set by RSMo § 536.140.2. This Court reviews the decision of the Commission to determine whether it was: (1) unconstitutional, (2) in excess of statutory authority, (3) unsupported by competent and substantial evidence upon the whole record, (4) unauthorized by law, (5) made upon unlawful procedure or without fair trial, (6) arbitrary, capricious or unreasonable, or (7) involves an abuse of discretion. RSMo § 536.140.2(1) (7).⁵

This Court's review of the Administrative Hearing Commission's conclusions of law is de novo. Medical Services' interpretation of its regulation is entitled to deference, *Collins v. Department of Social Services*, 141 S.W.3d 501, 504 (Mo. App. 2004), as an agency's interpretation of a law it administers is entitled to great weight. *Foremost McKesson v. Davis*, 488 S.W.2d 193, 197 (Mo. banc 1972). Conversely, the Commission's interpretation of Medical Services' regulation is not entitled to deference as decisions based on interpretations of law are for the independent judgment of the reviewing court. *Golde's Department Stores, Inc. v. Director of Revenue*, 791 S.W.2d 478, 480 (Mo. App. 1990). In reviewing the decision of the Commission, the Court will draw from the Commission's

⁵ This case was originally appealed as a petition for judicial review of a contested case under § 536.100-140, RSMo. After Medical Services filed its Petition for Judicial Review with the Circuit Court of Cole County, paragraph 3 of § 536.140, RSMo was amended by House Bill 576 (93rd General Assembly, 2005).

findings of fact, its own conclusions of law. *Concerned Services, Inc. v. Department of Social Services*, 834 S.W.2d 908 (Mo. App. 1992).

The standard of review for questions of fact is substantial evidence. If the Commission's findings are contrary to determinative undisputed facts, the decision is arbitrary and unreasonable and must be reversed. *Dueker v. Missouri Div. of Family Services*, 841 S.W.2d 772 (Mo. App. 1992). A finding of the Commission is arbitrary and unreasonable where it is not based on substantial evidence, and can only be affirmed if supported by substantial and competent evidence in the record. *Edmonds v. McNeal*, 596 S.W.2d 403 (Mo. banc 1980). Decisions contrary to the overwhelming weight of the evidence must be reversed. *Miller v. Dunn*, 184 S.W.3d 122, 124 (Mo. App. 2006).

Argument

I. The Commission erred in holding that it had jurisdiction to hear Centerpointe’s Complaint because its decision was in excess of its statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious or unreasonable under RSMo § 536.140.2 in that Centerpointe failed to timely appeal Medical Services’ decision setting Centerpointe’s estimate of Medicaid patient days, Centerpointe may not collaterally attack a prior decision through a challenge of a subsequent decision, and the Commission’s finding that Centerpointe did not receive Medical Services’ September 3, 2003 decision letter is contrary to the overwhelming weight of the evidence.

A. The Commission misinterpreted the law in allowing Centerpointe to collaterally attack a previous decision through a subsequent one.

The Commission based its jurisdiction upon Medical Services’ June 4, 2004 decision. That conclusion is unsupported by law. The Missouri Court of Appeals in *Missouri Department of Social Services, Division of Medical Services v. NME Hospitals, Inc.*, 11 S.W.3d 776, 782 (Mo. App. 1999) (“*NME I*”), held that a subsequent decision cannot be used to reopen the timely filing deadline for a prior decision. Under the *NME II* holding, an appeal of the June 4, 2004 decision cannot reopen an issue decided in the September 3, 2003 decision because “a new decision denying the claims, which would provide the basis for a new appeal period under section 208.156.2, would have the [e]ffect of negating the 30-day requirement of section 208.156.8.” *NME II*, 11 S.W.3d at 782.

Medical Services' June 4, 2004 decision had nothing to do with its estimation of Medicaid patient days under 13 CSR 70-15.010(15). The June 4, 2004 final decision changed the FRA assessment percentage, a tax arising under 13 CSR 70-15.110, from 5.23% to 5.32%. The Commission held that because the June 4, 2004 decision referenced a prior decision and showed the impact of the change on the hospital's Medicaid payments it could be used to reopen the prior decision for appeal. LF 805-809. This holding effectively precludes Medical Services from referencing prior decisions in any subsequent letters. This would be extremely detrimental to providers who would have difficulty assessing the impact of any changes absent the reference to prior decisions and the inclusion of charts showing the impact. And if Medical Services does reference or rely on prior decisions, it eliminates filing deadlines or dramatically lengthens the time in which challenges can be made – delaying finality, in many cases, until future fiscal years.

The Commission cites *BHCA of Kansas City v. Department of Social Services*, No 96-0020 (Mo. Admin. Hearing Comm'n Nov. 3, 1997) and *Psychiatric Healthcare Corporation v. Department of Social Services*, 996 S.W.2d 733 (Mo. App. 1999), as legal authority for its exercise of jurisdiction in this matter, stating that Medical Services left Centerpointe with the impression that the issue of the estimate of Medicaid patient days was still a live issue that could be appealed. LF 805-809.

Since the decisions in those two cases, the legislature enacted RSMo § 621.055.3 (Cum. Supp. 2006)⁶ which renders their holdings obsolete. The statute now specifically

⁶ A.L. 2001 H.B. 693.

dictates the language Medical Services must include in a “decision” to clearly convey that any issue is no longer a live issue:

3. Any decision of the department of social services that is subject to appeal to the administrative hearing commission pursuant to subsection 1 of this section shall contain a notice of the right to appeal in substantially the following language:

If you were adversely affected by this decision, you may appeal this decision to the administrative hearing commission. To appeal, you must file a petition with the administrative hearing commission within thirty days from the date of mailing or delivery of this decision, whichever is earlier; except that claims of less than five hundred dollars may be accumulated until such claims total that sum and, at which time, you have ninety days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the commission.

RSMo § 621.055.3 (Cum. Supp. 2006).

This statute and its requirements dictate how Medical Services must provide notice of a final decision. Medical Services’ September 3, 2003 final decision letter followed the statute and contained the requisite language. It informed Centerpointe of its right to appeal, and, unequivocally conveyed Centerpointe’s appeal rights. LF 656-659. Centerpointe did

not appeal Medical Services' September 3, 2003 decision. The June 4, 2004 final decision, unrelated to the estimation of patient days, did not reopen the earlier decision to a tardy challenge.

Accordingly, the Commission was without jurisdiction to hear Centerpointe's Complaint, and the case must be dismissed.

B. The evidence does not support the conclusion that Centerpointe did not receive Medical Services' September 3, 2003 decision.

Alternatively, the Commission concluded that it had jurisdiction over Centerpointe's Complaint because Centerpointe never received Medical Services' September 3, 2003 decision. But Centerpointe failed to rebut the presumption that a letter duly mailed was received, and accordingly, the Commission's decision is in error.

On September 3, 2003, Medical Services issued its final decision estimating the Medicaid patient days for Centerpointe for SFY 2004. LF 656-659. The letter explained Centerpointe's appeal rights. LF 656-659.

The timely filing deadline for filing an appealing Medical Service's September 3, 2003 of the decision letter to the Commission is set by RSMo §§ 208.156.8 and 621.055.3 (Cum. Supp. 2006). Section § 208.156.8 states:

8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review

with the administrative hearing commission except that claims of less than five hundred dollars may be accumulated until they total that sum and at which time the provider shall have ninety days to file his petition.

A letter duly mailed is presumed to be received by the addressee. *Clear v. Missouri Coordinating Bd. for Higher Educ.*, 23 S.W.3d 896, 900 (Mo. App. 2000). When proof of proper mailing is adduced, the presumption may be rebutted by evidence showing that the mailing was not received. *Id.* Evidence of non-receipt does not nullify the presumption but leaves the question for the determination of the finder of fact under all the facts and circumstances of the case. *Id.*

Centerpointe asserts that it that it never received Medical Services' September 3, 2003 letter. But Centerpointe did not rebut the presumption of receipt, because: (1) Centerpointe's CFO was aware that Medical Services issued final decisions concerning direct Medicaid payments every fall accompanying the issuance of the first payment for the SFY (LF 575); (2) Centerpointe had actual notice that Medical Services issued its decision concerning direct Medicaid payments when it received a \$441,558 direct Medicaid payment from Medical Services on September 22, 2003 (LF 488-491, 656-659); and (3) Centerpointe's CEO candidly admitted that other important documents from Medical Services were stored in other files that were not searched despite Medical Services' discovery request demanding the documents. LF 70-72.

Medical Services mailed its September 3, 2003 decision letter on September 3, 2003, as Medical Services' policy is to mail letters on the date of the letter or the next morning. LF 358-360. Patricia Barnes mailed the letter. LF 359. According to standard practice, Ms.

Barnes made a copy of the letter for Medical Services' file and stamped "COPY" on the document when she mailed the original. LF 360. Ms. Barnes physically took the decision letter to Medical Services' mail room and mailed it leaving only the "COPY" stamped September 3, 2003 decision letter for Centerpointe in the file. LF 359-360.

As a standard practice, Medical Services also takes additional steps to insure that addressees receive decision letters – additional steps which were followed in this case. First, prior to sending the September 3 letter to Centerpointe, Ms. Barnes sent a letter to Centerpointe on August 8, 2003 asking Centerpointe to update its address information. LF 358-359, 654-655. Centerpointe responded to the letter with updated information, and Ms. Barnes updated Medical Services' addressee records. LF 358, 654-659. Second, if Medical Services' letters are undeliverable as addressed, they are returned to Medical Services and placed into Medical Services' file for the facility. LF 360. There are no returned letters for Centerpointe. LF 360.

Additional facts suggest that Centerpointe received the letter. First, Centerpointe's CFO at the time of the September 3, 2003 decision letter, Steve Frantz, admitted that he knew from experience that Medical Services issued "some kind of letter or announcement when [Medicaid] payments started." LF 575.

Second, Centerpointe received a payment of \$441,558 from Medical Services on September 22, 2003 and then received a check for \$73,593 on the very next payment. LF 656-659. Centerpointe's testimony that the hospital was unaware of Medical Services' decision because the payments "didn't change significantly[,] is not supported by the facts. LF 402.

Third, Centerpointe was unable to produce other “fairly important” records when, in discovery, Medical Services requested all correspondence between the parties “between the dates of June 1, 2003 and June 10, 2004.” LF 70, 679-688. For example, Tariq Malik, CEO of Centerpointe, stated that Centerpointe’s desk review report – correspondence between the parties dated October 17, 2003 – was in “a different filing area,” and was not turned over in discovery despite Medical Services’ request. LF 71. Further, Mr. Malik candidly admitted that there could be other documents from Medical Services in “different filing area[s]” at Centerpointe. LF 71. Perhaps most important Mr. Malik’s March 10, 2004 and March 19, 2004 letters to Medical Services show that he was aware that a decision had been made concerning the estimation of Medicaid days. LF 403- 407, 660-662.

The Commission’s finding that Centerpointe did not receive Medical Services letter is contrary to the overwhelming weight of the evidence. The mere assertions of Centerpointe’s CEO – premised upon an incomplete review of Centerpointe’s files and inexperience in working with Medicaid – do not rebut the documentary evidence that supports the conclusion that Centerpointe received Medical Services’ September 3, 2003 decision letter. Accordingly, the Commission erred in ruling it had subject matter jurisdiction over Centerpointe’s Complaint and its decision should be reversed. The Court should reverse the Commission’s decision and remand the case to the Commission for dismissal.

II. The Commission erred in holding that Medical Services was required to promulgate a rule setting forth its process for estimating Medicaid patient days because its process does not meet the definition of a rule under RSMo § 536.010(6) and does not have to be promulgated according to state and federal case law in that the process does not apply to unnamed persons or unspecified facts, has no future effect, does not impact the property rights of providers, and is not a payment method or standard requiring promulgation.

The pivotal question for this Court’s determination is whether the process Medical Services’ personnel follow for estimating Medicaid patient days must be promulgated as a rule. The estimate of patient days is a variable in the calculation of direct Medicaid payments. 13 CSR 70-15.010(15)(B)(2). Medical Services has promulgated a rule detailing how it will make direct Medicaid payments to hospitals. LF 122. Thus, the question becomes whether the process by which Medical Services’ estimates – guesses – a variable in a validly promulgated rule must itself be promulgated as a rule. But because Medical Services’ estimates do not apply to unnamed persons or unspecified facts and have no future effect, Medical Services’ yearly estimates fit squarely within RSMo § 536.010(6)(b)’s exception to the definition of a rule.

The Missouri Administrative Procedure Act defines “rule” as:

(6) “Rule” means each agency statement of general applicability that implements, interprets, or prescribes law or policy ... of an agency. The term includes the amendment or repeal of an existing rule, but does not include:

* * *

(b) A declaratory ruling issued pursuant to section 536.050, *or* an interpretation issued by an agency with respect to a specific set of facts and intended to apply only to that specific set of facts[.]

RSMo § 536.010(6) (Cum. Supp. 2006), (emphasis added).⁷

Under MAPA, the term “decision” includes “decisions and orders whether negative or affirmative in form.” RSMo § 536.010(5) (Cum. Supp. 2006).

This Court, in noting the failings of MAPA’s definition of rule, has further articulated what rulemaking is: “Rulemaking ‘involves the formulation of a policy or interpretation which the agency will apply in the future to all persons engaged in the regulated activity.’” *Mo. Soybean Ass’n v. Mo. Clean Water Comm’n*, 102 S.W.3d 10, 23 (Mo. banc 2003) quoting Arthur Earl Bonfield, STATE ADMINISTRATIVE RULE MAKING, Section 3.3.1, at 76 (1986). In short, a rule must establish a “standard of conduct” that has the “force of law.” *Missouri Soybean Association*, 102 S.W.3d at 23. And, it must purport, “in and of itself to create certain rights ... or otherwise to have the direct and consistent effect of law.” *Id.* Pivotaly, to require rulemaking necessarily entails that the agency will apply a policy “in the future to all persons engaged in the regulated activity.” *Missouri Soybean Association*, 102 S.W.3d at 23 quoting Bonfield, STATE ADMINISTRATIVE RULE MAKING, Section 3.3.1, at 76

⁷ As the Western District notes in its decision, the definition of “rule” was contained in § 536.010(4), RSMo (2000), and was subsequently renumbered to subsection (6) without changing the definition. *Little Hills Healthcare*, 2007 WL 505658 at 15.

(1986). It must be an “agency statement of policy or interpretation of law of future effect which acts on unnamed and unspecified facts” *NME Hospitals, Inc. v. Dep’t of Soc. Serv’s, Div. of Med. Serv’s*, 850 S.W.2d 71, 74 (Mo. banc 1993) (“*NME I*”) quoting *Missourians for Separation of Church and State v. Robertson*, 592 S.W.2d 825, 841 (Mo. App. 1979).

The test of whether an action involves an agency rule or an agency decision is whether “the action seeks a declaration concerning a statement of policy or interpretation of law of future effect which acts on unnamed and unspecified persons or facts, or whether the action involves specific facts and named or specified persons or facts.” *Missouri Health Care Ass’n, et al. v. Missouri Dep’t of Soc. Serv’s*, 851 S.W.2d 567, 570 (Mo. App. 1993). The Western District concluded that “[i]n the former situation the action involves an agency rule, in the latter an agency decision.” *Id.*

Medical Services’ process for making estimates of patient days does not meet the definition of a rule because it applies by operation of law to only a limited subset of Medicaid providers, has no future effect, and does not tread upon a legally protected right or privilege. Also, Medical Services is required to promulgate as a rule its payment methods or standards under both RSMo § 208.153.1 and 42 U.S.C. 1396a(a)(13)(A). But because the federal government approved Missouri’s Medicaid State Plan without the estimation process codified in the Plan, the process is not considered a “‘method or standard’ for setting payment rates” as a matter of law. *Indiana Ass’n of Homes for Aging Inc. v. Ind. Office of Medicaid Policy & Planning*, 60 F.3d 262, 269 (7th Cir. 1995). Accordingly, it is not part of Medical Services’ payment “methodology” and need not be promulgated in a rule.

A. State law does not require Medical Services to promulgate steps taken by its auditors in estimating Medicaid patient days in SFY 2004 as a rule.

The parties agree that Medical Services has promulgated rules detailing how direct Medicaid payments, Medicaid per diem rates, and other payments, incentives and add-ons, are made to hospitals. LF 122, 128, 510, 538. The rules are encompassed in 13 CSR 70-15.

Specifically, regulation 13 CSR 70-15.010(15) governs how direct Medicaid payments are made to hospitals. There is no dispute that the regulation was validly promulgated. LF 122. The portion of the rule pertaining to the estimate of Medicaid patient days states, in pertinent part: “the unreimbursed Medicaid costs are determined by subtracting the hospital’s per diem rate from its trended per diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.”⁸ 13 CSR 70-15.010(15)(B)2. The regulation does not mandate that Medical Services consult any particular data or follow certain guidelines in its decision-making process in estimating the days for each of Missouri’s hospital Medicaid providers. Those decisions are left, by rule, to Medical Services’ discretion. LF 186, 275.

Medical Services is not required to promulgate rules defining every word in its regulation, or the decision-making process it uses to estimate variables and sub-variables in its payment method, especially where changing its process for estimating days from year to year does not change its federally-approved payment methodology and does not command

⁸ Paragraphs 13 CSR 70 15.010(15)(B)3-4 also reference the estimation of Medicaid days.

Missouri hospitals to “do anything or to refrain from doing anything.” *Missouri Soybean Association*, 102 S.W.3d at 23; see *Baugus v. Director of Revenue*, 878 S.W.2d 39, 42 (Mo. banc 1994) (not every “generally applicable statement or ‘announcement’ of intent by a state agency is a rule”). Moreover, following proper rulemaking, the Joint Committee on Administrative Rules (“JCAR”), approved the rule. Thus, JCAR did not believe the regulation to be invalid because of a lack of detail regarding how Medical Services would estimate days. Finally, again, under proper rulemaking, the hospital industry could have filed comments concerning the rule. The Missouri Hospital Association filed no complaints, and indeed, it “like[s] the flexibility” granted to Medical Services for the estimation of Medicaid patient days. LF 385, 386.

1. Medical Services’ process for estimating days for SFY 2004 cannot by law apply to unnamed persons or unspecified facts.

Centerpointe’s entire challenge to Medical Services’ estimate of Centerpointe’s patient days is simple: it does not like the time period selected (August 2002 through March 2003). But the selection of the time period was a decision, not a rule. Specifically, it is a decision and not a rule because it cannot “act[] on unnamed and unspecified persons or facts[.]” *Missouri Health Care Ass’n*, 851 S.W.2d at 570.

Medical Services’ use of the August 2002 through March 2003 time period (annualized) for its estimates of Medicaid patient days for hospitals with a base cost report enrolled in Medicaid at the start of SFY 2004 did not – and indeed cannot – anyone else. Centerpointe argues in its Application for Transfer that the Western District erred in concluding that there is a subset of “specific hospitals” for which each year’s estimate

applies. Application, p. 6. It argues that the Commission is correct when it held that Medical Services' method of calculating estimated Medicaid days was "a statement of general applicability, as it applied to all Medicaid provider hospitals in Missouri." Application, p. 6 quoting LF 813.

Medical Services' estimation process does not apply to all Medicaid providers, only to providers with a base cost report. Hospitals without a base year report – i.e., those joining Medicaid in the future – have another rule that governs their direct Medicaid payments:

(C) For new hospitals that do not have a base cost report, Direct Medicaid payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid payments shall be divided into quartiles based on total beds;
2. Direct Medicaid payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid payment per bed; and
3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid payment per bed.

13 CSR 70-15.010(15)(C). By the express terms of Medical Services' rules, its estimation process is not a policy of general applicability – it applies only to facilities with a base cost report enrolled in Medicaid at the start of a SFY, not to all Medicaid providers.

The Commission's conclusion that Medical Services' estimation process applies to all hospitals is contrary to the plain language of the rule. Accordingly, Medical Services' process for estimating Medicaid patient days for SFY 2004 was not a policy of general

applicability that “acts on unnamed and unspecified persons or facts[.]” *Missouri Health Care Ass’n*, 851 S.W.2d at 570. The Commission’s decision requiring rulemaking should be reversed.

2. Medical Services’ estimation process has no future effect, and therefore is not a rule.

Medical Services is not required to promulgate a rule under the provisions of RSMo § 536.010(6)(b) because its use of a time period upon which to base estimates for the industry is premised upon specific facts and intended to apply only to those specific facts. And, to require rulemaking necessarily entails that the agency will apply a policy “in the future to all persons engaged in the regulated activity.” *Mo. Soybean Ass’n*, 102 S.W.3d at 23 quoting ARTHUR EARL BONFIELD, STATE ADMINISTRATIVE RULE MAKING, Section 3.3.1, at 76 (1986). The provisions of RSMo § 536.010(6)(b) (Cum. Supp. 2006) exempt from the formal rulemaking requirements a “declaratory ruling issued pursuant to section 536.050 *or* an interpretation issued by an agency with respect to a specific set of facts and intended to apply only to that specific set of facts[.]” *Emphasis added*

Medical Services’ selection of a time period upon which to base its estimate of Medicaid patient days for the hospital industry changes based upon a specific set of facts. The selection of the time period is made after reviewing the data from the hospital industry and comparing different calculations for estimating days. LF 675-676. Based upon a specific data set, Medical Services selects the time period that has the highest number of days for the industry. LF 278. The time period selected only applies to the hospitals who are

enrolled in the Medicaid program that have a base cost report for a specific SFY as a separate decision is issued every year. LF 191-200; 13 CSR 70-15.010(15)(C).

Accordingly, Medical Services is not required to specify in its regulations the specific time period and variables applied to the time period, especially where the Commission notes in its very decision that Medical Services' estimation process does not have future effect, but only addresses the estimate for the industry *for that particular year*. LF 821. Medical Services' estimation process is "an interpretation issued by an agency with respect to a specific set of facts and intended to apply only to that specific set of facts[.]" and need not be promulgated as a rule. RSMo § 536.010(6)(b) (Cum. Supp. 2006).

3. Medical Services' estimates of Medicaid patient days do not "tread upon a legally protected right or privilege."

Every year, each hospital in the Medicaid program knows what it will be paid in direct Medicaid payments at or near the beginning of the year. It can choose to withdraw from the program, or appeal and hope for more. And, it is unclear that requiring formal rulemaking would result in any more options for hospitals. To require rulemaking also necessitates that a policy of general applicability "treads upon a legally protected right or privilege." *McIntosh v. LaBundy*, 161 S.W.3d 413, 417 (Mo. App. 2005). It must potentially impact "the substantive or procedural rights of some member of the public." *Baugus v. Director of Revenue*, 878 S.W.2d 39, 42 (Mo. banc 1994). But providers have no property right or interest in prospective Medicaid reimbursement or reimbursement rates. *Blecker v. State of New Jersey*, 723 A.2d 540, 545 (N.J. App. 1999); *AGI Bluff Manor Inc. v. Reagan*, 713 F. Supp. 1535, 1545 (W.D. Mo. 1989); *Holliswood Care Center v. Whalen*, 448

N.Y.S.2d 265, 267 (N.Y. App. 1982); *Kaye v. Whalen*, 391 N.Y.S.2d 712, 720 (N.Y. App. 1977). Providers only have a property interest in reimbursement for services already performed in reliance on “a duly promulgated reimbursement rate.” *United Cerebral Palsy Assoc. of New York State v. Cuomo*, 783 F. Supp. 43, 51 (N.D.N.Y. 1992); *Oberlander v. Perales*, 740 F.2d 116, 120 (2nd Cir. 1984).

Direct Medicaid payments are not payments reimbursing a hospital’s costs for services provided. They are prospective payments based upon projected costs and are designed, in part, to defray the impact of hospital taxes and voluntary contributions. Because providers have no vested property interest in any set amount of prospective Medicaid reimbursement, they have no vested right in the process Medical Services uses in estimating a variable in the direct Medicaid payment equation. Accordingly, the Commission erred as a matter of law in requiring Medical Services to promulgate its estimation process as a rule, and its decision must be reversed.

B. Analogous cases demonstrate that Medical Services’ estimation process is not a rule, and need not be promulgated.

In *Couch v. Division of Family Services*, the Western District upheld a Division of Family Services’ (DFS) decision based on its manual, which was not promulgated as a rule. 795 S.W.2d 91, 93 (Mo. App. 1990). The court ruled that insofar as a manual of DFS “does not attempt to set forth rules and regulations, but merely states policies and provides guidelines for DFS in making its decisions, it is not to be considered void in total[.]” *Couch*, 795 S.W.2d at 93. Accordingly, it could be used by DFS as a guideline to assist it with its decision-making.

The *Couch* case is directly on point. As in *Couch*, Medical Services' process used in estimating days simply guides its decision-making for selecting the time period upon which to base estimates, and annualizing and trending the estimates. Medical Services is not seeking to impose any standard of conduct upon the hospital industry. Indeed, the only reason why the Medical Services' process in estimating days is relevant is to demonstrate that Medical Services' decision estimating days for each of Missouri's hospital providers is not arbitrary, capricious, or unreasonable. Accordingly, the Commission erred as a matter of law, and its decision should be reversed.

In *McIntosh v. LaBundy*, the Western District concluded that, although a decision of the Department of Corrections prevented a clinical social worker from being listed on an approved list of therapists – effectively precluding him from certain work – and although the court could not conclude that the Department of Corrections' requirements for being listed fit within an enumerated exception to rulemaking, it nonetheless held that no rulemaking was required because the requirements did not “instruct McIntosh how to practice his trade nor do they regulate his professional behavior.” *McIntosh*, 161 S.W.3d at 418.

McIntosh is also applicable. Here, as in *McIntosh*, Medical Services' process for making estimates of Medicaid patient days do not instruct hospitals to do any type of conduct. Indeed, they do not even apply to hospitals, but to Medical Services in guiding how its auditors estimate – guess – the number of Medicaid patient days a hospital will experience in the coming year and thus tell the hospital, in advance, what it will be paid if it participates in Medicaid.

C. *NME I* cited by the Commission in support of its decision, is not analogous.

1. *NME I*'s pivotal holding, that RSMo § 208.153 requires Medical Services' to promulgate rules setting forth its payment methods, is inapplicable to this case.

The lynchpin holding of *NME I* was that Medical Services was required, by statute, to promulgate rules setting forth the “reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance,” but had failed to do so. *NME I*, 850 S.W.2d at 75 quoting RSMo § 208.153.1. Specifically, Medical Services in *NME I* decided not to pay for certain types of costs incurred by hospitals for which it had previously paid. Here, by changing the data upon which Medical Services bases an estimate, Medical Services has not changed the standards imposed upon providers governing their reimbursement. Centerpointe continues to be paid direct Medicaid payments based upon “subtracting the hospital’s per diem rate from its trended per diem costs” and then multiplying the difference by the “estimated Medicaid patient days for the current SFY.” 13 CSR 70-15.010(15)(B)(2). Accordingly, it is not changing a payment method or standard, and *NME I* is inapplicable.

The federal government agrees. Medical Services must also promulgate rules governing how it makes payments to hospital Medicaid providers under 42 U.S.C. § 1396a(a)(13)(A). To comply with federal requirements, Medical Services submitted and received approval of its state plan amendment from the Centers for Medicare and Medicaid Services (“CMS”), the federal agency charged with reviewing and approving state plan amendments detailing states’ reimbursement methodologies. The amendment,

approved on February 28, 2003, and effective since June 4, 2002 mirrors the language of the regulation with regard to the estimation of Medicaid days:

B. Direct Medicaid Payment will be computed as follows:

* * *

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.

LF 736. Interestingly, the Commission believes that more detail is required by state rules than federal. And in so holding, the Commission erred as a matter of law.

Federal case law is clear that the federal government's approval of a state plan with a formula missing "indicates as a matter of law that the challenged formula is not a 'method or standard' for setting payment rates that must be included in the plan." *Indiana Ass'n of Homes for Aging Inc. v. Ind. Office of Medicaid Policy & Planning*, 60 F.3d 262, 269 (7th Cir. 1995) citing *Massachusetts Federation of Nursing Homes, Inc. v. Mass.*, 772 F.Supp. 31, 39 (D.Mass. 1991). The Health Care Financing Administration's (now CMS') interpretation of its own "regulation is of controlling weight unless plainly erroneous or inconsistent with the regulation." *Id.* at 266.

The U.S. Court of Appeals for the Eighth Circuit has also recognized this law, and its discussion on the subject is informative. In *Missouri Department of Social Services v. Sullivan*, Missouri challenged a decision of HCFA that Missouri's changing of "trend factors" equated to a change of Missouri's methods and standards of reimbursement,

requiring Missouri to amend its state plan, and hence, promulgate a regulation implementing the change. The court agreed with HCFA's conclusion, noting that "HCFA's interpretation of its own regulations deserves considerable deference, and we will not set it aside unless it is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Missouri Department of Social Services v. Sullivan*, 957 F.2d 542, 544 (8th Cir. 1992).

CMS has concluded here that the process followed by Medical Services in estimating Medicaid patient days is not a payment method or standard because CMS did not require it to be included in Missouri's federally approved Medicaid State Plan. Accordingly, *NME I* is inapplicable, and the Commission erred as a matter of law. The Commission's holding is also contrary to public policy which gives state Medicaid agencies flexibility in making payments. *See Friedman v. Perales*, 668 F.Supp 216, 221 (S.D.N.Y. 1987) (the court is not to rethink or reweigh the political and financial considerations that might have animated the decision to adopt a particular reimbursement scheme); *Dandridge v. Williams*, 397 U.S. 471, 478 (1970) (the Medicaid portion of the Social Security Act, gives each state great latitude in dispensing its available Medicaid funds).

Because Medical Services' estimation process is not even a payment method or standard under federal law, it cannot affect the procedural or substantive rights of Centerpointe, who does not even have a property right to prospective Medicaid payments. Medical Services was not required to promulgate its estimation process as a rule.⁹ Indeed,

⁹ *Senn Park Nursing Center et al. v. Miller*, 104 Ill.2d 169 (Ill. 1984) relied upon by the *NME I* court in its decision, specifically notes the fact that the payment method of

this Court would be setting new law in requiring Medical Services to promulgate its estimation process as a rule where CMS did not find it to be a payment method or standard.

2. Other cases articulate the inapposite nature of *NME I*, and the application of *NME I* to this case is contrary to public policy.

Unlike *NME I*, Medical Services has specified how direct Medicaid payments will be made in regulation. Further, unlike *NME I*, Medical Services has not changed its payment method as noted above, and the Medical Services' process for estimating Medicaid patient days applies to Medical Services, not to hospitals.

How the court in *Couch* distinguished that case from *Division of Family Services v. Barclay*, 705 S.W.2d 518 (Mo. App. 1985), illustrates the flaw in the Commission's reasoning in applying *NME I* to the instant case. In *Barclay*, the Division of Family Services ("DFS") applied a \$25 cap to the personal needs allowance of a Medicaid recipient stated in its manual, and failed to take into account federal rules requiring Medical Services to consider other factors. The court held: "although a state may design a plan to meet needs and conditions of the state, it still must operate within the framework laid out by the federal government." *Barclay*, 705 S.W.2d at 521. Thus, in *Barclay*, DFS attempted to apply a

the Illinois Department of Public Aid required the changing of the federally-approved state plan, whereas here, no change to the state plan was required. Accordingly, following the logic of *Senn Park*, Medical Services is not required to promulgate its decision-making process for estimating Medicaid patient days as a rule where the state plan did not have to change.

standard of general applicability to Medicaid recipients. But in *Couch*, DFS used its manual merely as guidance in determining that a trust was an “available resource” to a recipient under Medicaid rules.

Here, like in *Couch*, Medical Services used its estimation process to determine which prior time period of data to use for its estimate of Medicaid patient days for Centerpointe and other Missouri hospitals so that its decisions were based upon the same process for all Missouri hospitals with a base cost report enrolled in Medicaid at the start of SFY 2004. Medical Services’ process for coming up with the estimates for hospitals is not a rule because, borrowing from the court in *McIntosh*, it is “not being ‘applied’ to anyone because the requirements do not instruct” hospitals on how to practice their trade nor do they regulate hospitals. *McIntosh*, 161 S.W.3d at 418. If it is a rule, it only applies to Medical Services.

Finally, the Commission’s decision fundamentally misunderstands the *NME I* decision. *NME I* was intended to shield providers from cuts to their reimbursement implemented by Medical Services without proper rulemaking. The Commission converts *NME I* into a sword to be used by providers to extract money from Medical Services where Medical Services fails to promulgate every process, policy, procedure, and reference material it consults in making a decision as a rule if it uses the same process for similarly situated providers. This flawed interpretation creates an endless supply of litigation against Medical Services because even if Medical Services promulgates its process in determining every variable it uses in calculating payments to providers, providers will only then sue to change sub-variables or the definitions of terms used in the Medical Services’ rules that are not defined. *NME I* was not meant to tie Medical Services’ hands by requiring it to promulgate

every principle, guideline, process, etc. used or referred to in, not only making payments to providers under a rule, but also in making decisions required by a rule. Accordingly, the Commission erred as a matter of law, and its decision must be reversed.

III. The Commission erred in failing to defer to Medical Services' estimate of Medicaid patient days for Centerpointe of 2,372 for SFY 2004 and in requiring Medical Services to issue a second estimate of Medicaid patient days because it applied the wrong standard of review in violation of RSMo § 536.140.2 and contrary to state and federal case law in that Medical Services' estimate was based upon Centerpointe's own objective data, Centerpointe's expert conceded there was nothing "unreasonable" about Medical Services' SFY 2004 estimation process, and SFY 2004 was not an extraordinary year like SFY 2003 in which thousands of Medicaid recipients were suddenly added to Missouri Medicaid's rolls requiring a second update of Medicaid patient days to be done to keep the Medicaid program solvent.

The statute governing the Commission's review in this case is § 621.055.1, RSMo, which states that "[a]ny person authorized pursuant to section 208.153, RSMo to provide services for which benefit payments are authorized pursuant to section 208.152, RSMo, may seek review by the administrative hearing commission of any of the actions of the department of social services[.]" The statute, however, only states the following regarding the Commission's standard of review in such reviews: "The procedures applicable to the processing of such review shall be those established by chapter 536, RSMo," and "[i]n any proceeding before the administrative hearing commission pursuant to this section the burden

of proof shall be on the provider of services seeking review.” RSMo § 621.055.1. The only standards of review found in Chapter 536, RSMo are found in RSMo §§ 536.140 and 536.150. Both statutes prohibit the reviewer from substituting its discretion for that of the agency, and RSMo § 536.140 notes that courts shall give “due weight” to the “expertness and experience of the particular agency.” RSMo § 536.140.3.

The extent to which the Commission may exercise Medical Services’ statutorily vested discretion where Medical Services’ decision is supported by facts and law has never previously been addressed by this Court. And it presents a critical question to the Court: should the Commission be allowed to administer the Medical Services’ discretion *de novo*, thus enabling it to effectively change policies of Medical Services it does not like through selecting different sanctions and payments?

The Western District has issued two conflicting opinions addressing this question: The Western District’s *Mellas* decision is in direct conflict with its February 20, 2007 decision in this case. *Mellas v. Dep’t of Soc. Serv’s, Div. of Med. Serv’s*, 220 S.W.3d 778 (Mo. App. 2007). Medical Services agrees with this Court, that the Commission’s power “extends only to the ascertainment of facts and the application of existing law thereto in order to resolve” matters falling within the expertise of an agency. *J.C. Nichols Co. v. Director of Revenue*, 796 S.W.2d 16, 20 (Mo. banc 1990). But conspicuously absent from the standard as articulated by this Court in *J.C. Nichols* is a grant of authority to the Commission to exercise other state agencies’ discretion however it chooses. Indeed, such a grant is in contrast to case law and the statutes.

A. Missouri case law requires deference to Medical Services' discretionary authority to set estimates of Medicaid patient days.

Under Missouri law, courts are to defer to an agency or board on the subject of discipline imposed against persons the agency or board regulates. *KV Pharmaceutical Company v. Missouri State Board of Pharmacy*, 43 S.W.3d 306, 311-312 (Mo. banc 2001). In *KV Pharmaceutical*, this Court stated: "This Court defers to the Board's specialized knowledge of drug distributorships, as the Board is better equipped to determine the gravity of the infractions and the appropriate sanction." *KV Pharmaceutical*, 43 S.W.3d at 311-312, citing *Tadrus v. Missouri Bd. of Pharmacy*, 849 S.W.2d 222, 228 (Mo. App. 1993). That *KV Pharmaceutical* arose under a different statute is immaterial in light of the analogous nature of the cases: both involve an agency's attempt to regulate health care professionals – either payments to them or their conduct – where the agency has expertise in doing so.

Tribunals also defer to an administrative agency in the area of the agency's expertise when dealing with decisions based upon scientific or technological data. *Citizens for Rural Preservation, Inc. v. Robinett*, 648 S.W.2d 117, 128 (Mo. App. 1983). Further, and more importantly, deference to the agency is warranted where (1) administrative knowledge and expertise are demanded, (2) technical or intricate fact questions are to be determined, and (3) uniformity is important to the regulatory scheme. *Oberreiter v. Fullbright Trucking Co.*, 117 S.W.3d 710, 716 (Mo. App. 2003). The rationale behind such deference is to utilize agency expertise when an agency is acting within its area of specialized knowledge, experience, and expertise. 2 Am. Jur. 2d Administrative Law, § 504 Technical Issues (2004).

Such deference is required here. First, Centerpointe concedes that the estimating of Medicaid patient days is an intricate procedure: “The Western District misunderstood the facts, perhaps because the ‘estimation of Medicaid days’ is, in itself, not a simple procedure.” Centerpointe’s Application for Transfer, p. 4. And other states have specifically addressed the technical nature of Medicaid payments. The North Dakota Supreme Court held:

An agency has a reasonable range of discretion to interpret and apply its own regulations, and the agency’s expertise is entitled to deference when the subject matter is complex or technical.... On several occasions, we have said the scheme for determining Medicaid reimbursement rates ... involves complex and technical matters calling for agency expertise, and the Department’s expertise in this area is entitled to deference.

St. Benedict’s Health Center v. North Dakota Department of Human Services, 677 N.W.2d 202 (N.D. 2004)(citations omitted). Because the payment methodology under 13 CSR 70-15.010 is no less complex, the Commission erred in failing to apply *Citizens for Rural Preservation*, and *Oberreiter*, both of which necessitated deference to Medical Services’ estimate in this case.

B. Medical Services, not the Commission, has expertise in administering Medicaid making deference to Medical Services’ decision sound public policy.

The Missouri Legislature has placed the Medical Services, not the Commission, in charge of administering payments and determining appropriate reimbursement under the

Medicaid program – and, significantly, of reviewing the amounts paid to providers to assure that both amounts and services are appropriate under the Medicaid program. RSMo § 208.201. Medical Services must also administer the Medicaid program in accordance with the rules for administration as set by the United States government for the efficient operation of state medical assistance plans. RSMo § 208.201. Such requirements are found under the Social Security Act, and 42 U.S.C. § 1396a, and the regulations promulgated thereunder. Medical Services has developed extensive expertise in administering Medicaid after drafting or complying with the thousands of pages of rules that govern Medicaid’s administration; years of working with the hospital, nursing facility, physician, home healthcare, and counseling industries; and working with the Legislature to assure that the services Missouri wants to provide to Medicaid clients can be secured within Medical Services’ appropriation. Perhaps most importantly, the Medical Services must safeguard Medicaid funds to keep the state in compliance with federal requirements so that federal funding is not jeopardized. *See Psychiatric Healthcare Corp. of Missouri v. Department of Social Services*, 100 S.W.3d 891, 906 (Mo. App. 2003) (in the context of enforcing mere documentation requirements, the Western District noted that without stern penalties Missouri may risk being found “so lax in requiring the necessary documentation as to be considered in non-compliance with federal regulations”).

The Commission, conversely, has no expertise in administering the Medicaid program, and does not have to weigh and balance all of the requirements placed upon Medical Services regarding the program’s administration in arriving at its decisions. In fact, the courts have declared that the Commission has no expertise “except the commissioners’

expertise as lawyers[.]” *Geriatric Nursing Facility, Inc. v. Department of Social Services*, 693 S.W.2d 206, 209 (Mo. App. 1985). The Commission was also formed to “strike a balance between the need for the separation of powers and the practical necessity of utilizing agency expertise.” *State Tax Commission v. Administrative Hearing Commission*, 641 S.W.2d 69, 74 (Mo. banc 1982). In applying the wrong standard of review, one affording no deference to the decisions of Medical Services in the area of its expertise and over an industry it regulates, there is no “balance” struck at all – clearly not the intent of the legislature.

Second, uniformity is important to the regulatory scheme of the Missouri Medicaid program. Medical Services made direct Medicaid payments for SFY 2004 for roughly 140 hospitals in Missouri using an estimate for each based upon its Medicaid utilization from August 2002 through March 2003, annualized. Medical Services must treat similarly situated providers in the same fashion. *Wolfner v. Board of Adjustment*, 672 S.W.2d 147 (Mo. App. 1984) (in the context of a board of adjustment action, picking between similarly situated property owners for building permits is not allowed). The Commission, by contrast, decides only the individual matter placed before it; the Commission has neither the assignment nor the expertise nor the information necessary to ensure uniformity.

C. *Mellas* should not be followed.

Twenty-eight days *prior* to rendering its decision in this case, the Western District decided *Mellas v. Dep’t of Soc. Serv’s, Div. of Med. Serv’s*, 220 S.W.3d 778 (Mo. App. 2007), holding that the Commission’s standard of review in Medicaid cases is *de novo*, and the Commission owes no deference to Medical Services’ exercise of its discretion. The

Western District's decision in this case – holding that estimating days was a matter committed to Medical Services' discretionary decision-making, and the Commission is to determine whether the estimate Medical Services used for the hospital constituted “an abuse of discretion”¹⁰ – left Medical Services' discretion itself intact. In this case, the Western District correctly severed the exercise of Medical Services' discretion from the Commission's role of independently finding facts and issuing conclusions of law. *Id.*¹¹

But the Western District's decision in *Mellas* is contrary to Federal and other states' case law, making Missouri the only state granting judicial tribunals carte blanc to rewrite decisions of an agency with expertise simply because a quasi-judicial tribunal may not like them.

Federal case law articulates the standard reviewing tribunals are to apply when reviewing actions of state Medicaid agencies:

[T]he same standard of review afforded federal agency action applies to actions of a state agency administering federal Medicaid funding: a court is limited to deciding whether the action is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the [enabling law].... [A]

¹⁰ *Little Hills Healthcare*, 2007 WL 505658 at 17.

¹¹ In doing so, the Western District cites to *Mo. Nat'l. Educ. Ass'n v. Mo. State Bd. of Educ.*, 354 S.W.3d 266, 280 (Mo. App. W.D. 2000), a case arising under RSMo § 536.150, which highlights the distinct facets of decision making of fact finding, applying the law, and exercising discretion).

presumption of validity attaches state agency action, and the burden of proof rests with the party challenging such action. [Citations omitted.] Finally, the Court must recognize the fact that federal law and, more specifically, the Medicaid portion of the Social Security Act, gives each state great latitude in dispensing its available Medicaid funds. *Dandridge v. Williams*, 397 U.S. 471, 478 [] (1970).

SSM Healthcare System v. Reagan, 681 F.Supp. 625, 627-628 (W.D.Mo. 1988). The Legislature has given this latitude to Medical Services, not to the Commission. RSMo § 208.201.

The Supreme Court of South Dakota has addressed this issue, and concluded, just as the Federal courts have, that the standard of review must reflect deference to the agency:

We have never before reviewed a sanction for noncompliance with Medicaid regulations. For reasons set forth below, the standard of review for sanctions imposed for noncompliance with Medicaid regulations is whether the sanction imposed was “[a]rbitrary and capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.” SDCL -26-36(6). In *Butz v. Glover Livestock Comm’n Co.*, 411 U.S. 182, 185-186, 93 S.Ct. 1455, 36 L.Ed.2d 142 (1973), the United States Supreme Court held that when an agency is authorized to impose sanctions for noncompliance with administrative regulations, the agency is entitled to substantial deference, unless its choice of sanctions is “unwarranted in law” or “without justification in fact.”

Westmed Rehab Inc., v. Department of Social Services, 687 N.W.2d 516, 519 (S.D. 2004).

In *Steen v. North Dakota Department of Human Services*, 562 N.W.2d 83 (N.D. 1997), the North Dakota Supreme Court also reviewed the imposition of discipline by the North Dakota agency that administers the North Dakota Medicaid program under an abuse of discretion standard, concluding that the North Dakota Department of Human Services did not abuse its discretion by terminating a provider from the Medicaid program for five years for its failure to adhere to documentation requirements. *Id.* at 88-89.

The logic of the North and South Dakota Supreme Courts is compelling, and should be followed here. Indeed, the standard of review articulated by the courts is the same standard the Commission used in its decision which is the subject of *State Board of Registration for the Healing Arts v. Finch*:

The overwhelming evidence before this Commission supports a finding that Petitioner is rehabilitated, presently has good moral character, and if licensed, would be an asset to the medical profession. Petitioner has satisfied the requirement of good moral character in Section 334.031, RSMo 1969 and is qualified to take Respondent's written examination for licensure. Respondent's determination not to examine Petitioner is therefore under the law unreasonable, arbitrary, and constitutes an abuse of discretion.

State Board of Registration for the Healing Arts v. Finch, 514 S.W.2d 608, 620-621 (Mo. App. 1974) (Somerville, J. dissenting *quoting* the Commission's findings of fact and conclusions of law). Ironically, *Finch* is a case cited by the Commission in support of its conclusion that it owes no deference to Medical Services' exercise of its discretion.

Medical Services could not find a case suggesting that a Medicaid agency's decision was not entitled to deference, placing the Western District's decision in *Mellas* in contrast with how other tribunals have decided the issue.¹² Indeed, the only cases found by Medical Services stand for the proposition that the Medicaid agency's discretionary decisions should either be given deference, or are subject to review under an abuse of discretion standard.

¹² The Western District in *Mellas* cites to three cases in support of its position. But, two of the cases, *Geriatric Nursing Facility, Inc. v. Department of Social Services*, 693 S.W.2d 206, 210 (Mo. App. 1985) and *Department of Social Services v. Administrative Hearing Commission*, 826 S.W.2d 871, 874 (Mo. App. 1992), arise in the context of agencies misapplying the law, and stand for the position that the Commission may amend an agency decision to correct an error of law, which is not contested by Medical Services in this case. And the discussion in *Geriatric* focused on the limits of the Commission's authority, and should not be read to support additional Commission authority. The Western District also cites to *Finch*, but *Finch* is premised upon an appellate court's erroneous belief that the exercise of discretion cannot be separated from the other two facets of decision-making – making findings of fact and conclusions of law. Courts reviewing cases under § 536.140 (Cum. Supp. 2006) and § 536.150, RSMo – which clearly separates these functions – have had no trouble separating these roles. And the concurrence and dissent in the case both clearly articulate that the agency's decision should be reviewed under an abuse of discretion standard. *Finch*, 514 S.W.2d at 618, 620-621 (Pritchard, J., and Swofford, J., concurring and Somerville, J., dissenting).

Sikand v. Wilson-Coker, 888 A.2d 74, 78 (Conn. 2006) (agency’s discretionary determinations are to be accorded considerable weight by courts, and test is to determine if agency acted unreasonably, arbitrarily, illegally or abused its discretion); *St. Christopher’s Hospital for Children v. Pennsylvania Dep’t of Public Welfare*, 562 A.2d 1021, 1024 (Pa.Cmwlth. 1989) (test was if agency committed either an error of law or abused its discretion in its reimbursement method); *Gray et al. v. Department of Employment Security*, 681 P.2d 807, 815-816 (Utah 1984) (agency was not required to promulgate a rule, and deference is warranted to technical determinations of an agency with expertise).

Medical Services could not find any case suggesting that a judicial or quasi-judicial tribunal should give no deference to the discretionary decisions of a state’s Medicaid agency in administering Medicaid. If this Court upholds the *Mellas* decision on this point, it will place Missouri in isolation as the only state that gives judicial tribunals carte blanc to second-guess their Medicaid agency.

D. Applying the appropriate standard of review requires deference to Medical Services’ estimation.

The Commission erred in changing Medical Services’ estimate of Medicaid patient days for Centerpointe for SFY 2004. Applying the appropriate standard of review, the Commission is to defer to Medical Services’ estimate of Medicaid patient days unless arbitrary, capricious or unreasonable. An agency acts unreasonably and arbitrarily if its findings are not based on substantial evidence. *Barry Serv. Agency Co. v. Manning*, 891 S.W.2d 882, 892 (Mo. App. 1995). The decision must use some kind of objective data rather than mere surmise, guesswork, or “gut feeling.” *Id.* at 893.

In this case, Medical Services' estimate was based upon Centerpointe's own data – Centerpointe's Medicaid patient days from August 2002 through March 2003. As set forth below, the estimate did not involve “gut feeling” and the Commission should have deferred to Medical Services' SFY 2004 estimate. But the Commission changed Medical Services' estimate first by requiring Medical Services to use another number, and second by basing that number on data not in existence at the time Medical Services issued its September 3, 2003 decision estimating the days.

The Commission erred in failing to affirm Medical Services' estimation of Medicaid patient days for Centerpointe for SFY 2004 because Medical Services' estimate was reasonable, and consistent with regulations.

Medical Services estimated the days for Centerpointe by taking Centerpointe's paid days from August 2002 through March 2003, and annualizing these days. LF 675-676. Medical Services used the same time period upon which to base its estimation of days for all 140 hospitals, and August 2002 through March 2003 was the most recent time period for which Medical Services had accurate data at the time of the estimate. LF 200-202.

Centerpointe's expert, Mr. Knell, candidly admitted that there was nothing unreasonable about annualizing a nine month period of data for estimation of days purposes. LF 146. Mr. Knell also admitted that the use of this period would provide a “pretty reasonable” estimate. LF 146. And Mr. Knell also agreed that Medical Services' practice of not using a time period upon which to base an estimate older than 36 months is reasonable. LF 130. Mr. Knell testified that whatever time period that is used to estimate Medicaid patient days for the current state fiscal year should be the same time period for every single

hospital in the industry. LF 131. In short, Mr. Knell could not point to any specific act by Medical Services in estimating the days that was unreasonable.

Medical Services' particular use of August 2002 through March 2003 data was also not contrary to law. Medical Services' regulations do not specify what data is to be used in estimating fee for service days. LF 187. The regulation does not mandate using data from the "current" state fiscal year, only that an estimate of Medicaid patient days be made for every hospital for the current state fiscal year. LF 187, 498-509. Data from the "current" state fiscal year cannot be used as it does not exist at the time the estimates are made. LF 157. And Mr. Knell candidly admitted (1) that it is important for Medical Services to issue its estimates of Medicaid days for the hospital industry at the beginning of the year so that payments can begin to flow; and (2) that Medical Services could not have used the data he asked the Commission to use in estimating Medicaid patient days for Centerpointe because it did not exist at the time of Medical Services' September 3, 2003 decision. LF 135, 150. Mr. Knell also admitted that there is nothing in the text of the regulation requiring Medical Services to use data from the current state fiscal year in estimating Medicaid patient days for the current state fiscal year. LF 151.

There is nothing in Medical Services' regulations requiring it to "settle up" with hospitals at the end of the SFY and use the actual days. LF 187-188. This is because, with the one exception of 13 CSR 70-15.040, Medicaid is a prospective system under which payments are fixed and final. If Medical Services were to issue a second estimate of fee for service days for a SFY, payments made using the first estimate of days would have to be amended. This would cause a changing of the prospective payment not authorized under 13

CSR 70-15.010(E). LF 498, 503. Accordingly, Medical Services, with the exception of SFY 2003 where it had to take drastic action to keep the hospital program solvent, only issues one estimate of days per SFY to prevent the conversion of a prospective payment in to a retrospective payment.

Conversely, the Commission's findings of fact and conclusions of law changes the Medical Services' decision into an arbitrary one, as Centerpointe's calculation is now based upon a different set of data than the other roughly 140 hospitals in the state.

Second, the Commission also erred in following a two-estimate process as used in SFY 2003, one aberrational year in which the Missouri Hospital program experienced a funding crisis. LF 279. This is especially true where SFY 2004 was materially dissimilar from SFY 2003, and the conditions necessitating drastic action were not present.

Third, the Commission erred in failing to defer to Medical Services' decision of issuing one estimate of Medicaid days where the MHA, Centerpointe's representative, not only advocated one estimate for SFY 2004, but also encouraged Medical Services to use the precise time period used instead of taking an entire calendar year and applying regression analysis.

Fourth, the Commission erred in failing to defer to Medical Services' decision of issuing only one estimate of Medicaid patient days based upon the impact a second estimate would have for just one of 140 hospitals. Centerpointe's expert agrees:

Q And so you would agree that this estimate shouldn't be changed or the time period used for the estimate shouldn't be changed just because one hospital may get a benefit from using a different time period; is that correct?

A Nobody is advocating that anything should be changed for one hospital.

LF 131. Ironically, despite endorsing uniformity, Centerpointe's expert advocated, and the Commission later concluded a unique methodology for one hospital. LF 132-133. Centerpointe presented no evidence whatsoever on how changing Medical Services' procedure from one estimate to two would impact the hospital industry. The only evidence presented by Centerpointe was how the changing Medical Services' estimate to Mr. Knell's formula would impact Centerpointe. Mr. Knell admitted that he had no data on how his proposed changes to the estimation process would impact other hospitals, and Mr. Knell candidly admitted that the same time period should be used to base the Medicaid patient day estimates for the entire industry. LF 132-135.

Fifth, the Commission erred in failing to defer to Medical Services' decision where Centerpointe failed to adduce any evidence whatsoever that it was not being paid for its "reasonable costs" under the provisions of RSMo §§208.152.1. Again, Mr. Knell stated:

Q ... So am I to understand you correctly that you cannot say with certainty that according to your calculation, there were \$3,564,909 in Medicaid costs for this facility, actual costs for this facility, in state fiscal year 2004; is that correct?

A That's correct.

Q Thank you, sir. So you have no way of knowing ... whether or not the direct Medicaid payment made to this facility covered their actual costs, do you, sir?

A ... No, because the 2004 ... cost report ... hasn't been filed yet.

Sixth, the Commission erred in failing to defer to Medical Services' decision of issuing only one estimate absent an industry crisis where Medical Services utilized the same months for Centerpointe's SFY 2005 estimate that Centerpointe seeks to use for its SFY 2004 estimate. Accordingly, Centerpointe was not harmed by Medical Services' method of estimating days.

Finally, the Commission erred as a matter of law in failing to defer to Medical Services' decision because even it states that: "We agree that DMS historically used a reasonable methodology, and we recognize that it took action in SFY 2003 to keep the Medicaid system solvent." LF 817.

Accordingly, the Commission erred as a matter of law in failing to follow Medical Services' estimate of Medicaid patient days for Centerpointe hospital for SFY 2004 because Medical Services' estimate was not arbitrary, capricious or unreasonable. Accordingly, the Commission's decision must be reversed.

IV. The Commission erred in ordering Medical Services to pay more than \$1.8 million in additional direct Medicaid payments to Centerpointe and in refusing to consider proffered evidence by Medical Services because those decisions were in excess of the Commission's statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious or unreasonable under RSMo § 536.140.2 in that the Commission's Decision by its very terms applies an unpromulgated method of estimating Medicaid patient days, superintends Medical Services' procedures, incorrectly applies the Missouri case law to the facts, and is unreasonable in applying the Commission's new method of estimating Medicaid patient days to the only year which results in additional payments to Centerpointe and not to other years in which Medical Services would be owed additional money.

A. The Commission's Decision creating a new method for estimating Medicaid patient days was not promulgated as a rule, and therefore, under the terms of the Commission's very decision, it is void.

Even if the Court concludes that Medical Services was required to promulgate a rule specifying how it estimates Medicaid patient days, which it should not, the Commission's decision is still in error because: (1) the Commission's remedy of awarding more than \$1.8 million in additional direct Medicaid payments because Medical Services failed to promulgate a rule is unauthorized by law; and, (2) the Commission only has the authority to do what Medical Services can do, it expressly held that Medical Services was required to

promulgate a regulation detailing its estimation process, but then it created its own estimation process without promulgating a regulation in violation of its very decision.

- 1. The Commission's remedy of awarding more than \$1.8 million in additional direct Medicaid payments because Medical Services failed to promulgate a rule is unauthorized by law.**

Missouri cases establish that the remedy for an agency's failure to promulgate a rule is not to require the agency to write a check in whatever amount requested by the complaining party. It is to remand for additional findings or a hearing. *See Missouri Health Facilities Review Committee*, 700 S.W.2d at 450 (holding the Commission may not simply issue a certificate of need where procedural steps were not followed by MHFRC in its denial of the certificate).

Missouri State Division of Family Services v. Barclay should be followed here. In *Barclay*, the court held that the appropriate remedy for DFS' failure to promulgate a rule governing Medicaid minimum allowances to recipients was to "remand[] to DFS for determination of a reasonable allowance for the cost of the necessary medical and remedial care over and above the \$25 personal needs allowance provided by law" 705 S.W.2d at 523. The remedy was not for the court to arrive at a new allowance for the agency.

Even the *NME I* and *Senn Park Nursing Center* decisions preclude tribunals from making up new methods where an agency was required to set forth in regulation a particular change in its Medicaid payment methodology. In both cases, the courts reverted back to the prior, valid, method or policy, and did not make up a new one. In the instant case, this would require *reverting back to the prior state plan amendment governing the estimation*

of Medicaid patient days in effect before June 4, 2002. LF 113, see *Missouri Department of Social Services, Division of Medical Services v. Great Plains Hospital, Inc.*, 930 S.W.2d 429 (Mo. App. W.D. 1996) (reimbursement reverts back to method of the previous unamended plan). And, Medical Services' method prior to the state plan amendment since the inception of direct Medicaid payments in the early 1990s was to issue only one estimate of Medicaid patient days per year, which would preclude additional direct Medicaid payments to Centerpointe.

2. The Commission does not have the authority to fashion equitable remedies – it is not an Article V court.

Unlike an Article V court, the Commission's jurisdiction extends only to the finding of facts and the application of existing law thereto. *J.C. Nichols Co. v. Director of Revenue*, 796 S.W.2d 16, 20 (Mo. banc 1990). The Commission does not have equitable powers. *Soars v. Soars Lovelace, Inc.*, 142 S.W.2d 866, 871 (Mo. 1940). It may not superintend an agency's procedures. *Missouri Health Fac. Review Comm. v. Administrative Hearing Comm'n*, 641 S.W.2d 69, 75 (Mo. banc 1982), and cannot exercise the regulatory power of an agency, *Monroe County Nursing Home District v. Department of Social Services*, 884 S.W.2d 291 (Mo. App. 1994), *Citizens Memorial Health Care Fndn. v. Department of Social Services*, no. 91 000732SP (Mo. Admin. Hearing Comm'n, December 21, 1992). Further, it cannot strike down one of Medical Services' regulations. *State Tax Commission v. Administrative Hearing Commission*, 641 S.W.2d 69 (Mo. banc 1982).

The Commission's authority to fashion remedies is coextensive with Medical Services',¹³ and the Commission expressly held that "because [Medical Services] did not promulgate a rule for determining estimated Medicaid days, its determination is void." LF 815. Despite these limits on its authority, the Commission did not remand. Rather, it acted as a court in equity fashioning a remedy for Centerpointe by awarding it more than \$1.8 million in additional direct Medicaid payments. It did so based upon a never before used method for estimating Medicaid patient days with no legal grounds for the method. The Commission does not have the authority to act equitably and to grant additional direct Medicaid payments to Centerpointe absent statutory or regulatory authority.

The Commission seems to suggest that its equitable remedy could stand because of the language that the Commission "must remake Medical Services' decision." But the Commission can only *review* Medical Services' decision within the bounds of Medical Services' authority. RSMo § 621.055.1. As the Commission states, it may only "stand[s] in [Medical Services'] shoes" when reviewing an adjudication. *Monroe County Nursing Home Dist.*, 884 S.W.2d at 293. The Commission is not an Article V court. Accordingly, the Commission's decision is unauthorized by law, and must be reversed.

If Medical Services was required to promulgate as a rule its decision-making process and its decisions based upon an unpromulgated decision making process are void, then so too is the Commission's decision as it is not based upon any rule, but only a method suggested to

¹³ *Monroe County Nursing Home District v. Department of Social Services*, 884 S.W.2d 291, 293 (Mo. App. 1994).

it by Centerpointe, which coincidentally maximizes Centerpointe's payments. "[T]he Administrative Hearing Commission [can] not premise an adjudicative decision on a policy that an agency had never formally adopted as a regulation." *Branson R IV School District v. Labor and Industrial Relations Commission*, 888 S.W.2d 717, 722 (Mo. App. 1994) citing *Sunset Retirement Homes, Inc. v. Department of Social Services*, 830 S.W.2d 18 (Mo. App. 1992). The Commission's decision premised upon its own unpromulgated method of estimation is therefore void.

B. The Commission erred in superintending Medical Services' procedures by requiring a different data set to be used upon which to base an estimate of days, and in requiring a second estimate of Medicaid patient days for SFY 2004.

The Commission "has no authority to superintend the operation of [an agency], or to determine what procedures it should follow. It is limited to reviewing its decisions in accordance with governing statutes." *Missouri Health Facilities Review Committee v. Administrative Hearing Commission*, 700 S.W.2d 445, 450 (Mo. banc 1985) ("*MHFRC*"). The number of estimates Medical Services performs in arriving at the amount of direct Medicaid payments for Missouri hospitals is clearly a "procedure" under *MHFRC* which cannot be superintended. The Commission does not deny that it is superintending Medical Services' procedures; it simply suggests that it must under the circumstances. LF 816.

Analogous to *MHFRC*, the Commission here found that the agency's lack of compliance with the law was grounds for ruling for the opposition. This Court disagreed in *MHFRC*, as it should here. The Commission erred in superintending Medical Services'

procedures for estimating Medicaid patient days by ordering a second estimate of fee for service days for Centerpointe for SFY 2004. It further erred in changing the time period upon which Medical Services based its estimate to the time period suggested by Centerpointe. This time period, not surprisingly, maximizes revenue for Centerpointe. The decision was improper in three ways.

First, the Commission ordered a second estimate of Medicaid patient days for Centerpointe for SFY 2004 where Medical Services' procedure was to only issue one estimate for each of Missouri's 140 hospital Medicaid providers. Indeed, Centerpointe's expert conceded that Medical Services' procedure since 1991 was to only issue one estimate of Medicaid patient days per year except for SFY 2003, when Medical Services had to take extraordinary measures to keep the Medicaid program solvent.

Q Let's go back to 1991 so we can address this. From 1991 to state fiscal year 2002, isn't it true that my client only issued on estimate for Medicaid patient days for the current state fiscal year in all of those years?

A Well, you're testing my memory if you're going back to 1991. But to my recollection the answer would be yes, they only issued one.

Q So the only year that they did not issue one estimate was 2003; isn't that correct?

A To the best of my knowledge.

LF 137, l. 14-24. Yet the Commission ordered a second estimate of Medicaid patient days to be done for Centerpointe for SFY 2004 where there was no financial crisis and where Medical Services' issued only one estimate of Medicaid patient days for all Missouri

hospitals at or near the beginning of the State Fiscal Year in all but one of the previous 12 years.

Second, the Commission superintended Medical Services' procedures in selecting a different data set upon which to base its estimate. Medical Services estimated Centerpointe's SFY 2004 Medicaid days based upon the annualized actual days reported for August 2002 through March 2003. The Commission, adopting Centerpointe's proposed method, used annualized July 2003 through May 2004 actual days.

Finally, the Commission did not follow Medical Services' estimation process in SFY 2003 because Medical Services based its estimate on the actual days from August through March, not July through May. LF 352, 482, 485, 676, 818-820. The Commission superintended Medical Services' procedures.

The Commission's decision in superintending Medical Services' decision is outside the scope of its statutory jurisdiction, is contrary to law, and must be reversed.

C. The Commission's decision is arbitrary, capricious or unreasonable in only applying its newly constructed method to the one year which results in an windfall for Centerpointe, but not to others which would result in money due to the Medical Services.

Medical Services asks the Court to consider Medical Services' proffered exhibits in this case because the exhibits establish the unreasonableness of the Commission's decision. Exhibits U1-U4, V1-V4, and W establish that if the Commission's double-estimate method were adopted for 1999-2003, Medical Services would be owed at least \$5,545,244 in overpayments. It is unreasonable to award Centerpointe \$1.8 million for SFY 2004 based

upon a method of estimation in light of the fact that Medical Services would be owed more than \$5.5 million if a similar method was used for 1999-2003. Accordingly, the exhibits were relevant and should have been admitted into evidence by the Commission. If this Court is inclined to affirm the Commission's decision, it should remand the case to the Commission to consider the proffered exhibits for purposes of allowing Medical Services to offset the \$5.5 million from the amount the Commission found is owed to Centerpointe.

D. Regardless of the applicability of *NME I*, the Commission still erred in applying the law to the facts.

Even if the Court concludes that Medical Services failed to promulgate a rule in violation of *NME I*, which it should not, and temporarily assuming that the "prior method" used by Medical Services for estimating days was the second estimate of SFY 2003 (which is also incorrect as the prior method by law must predate 2002, the passage of the current State Plan Amendment), then the Commission still erred in its calculation of the amount of direct Medicaid payments owed to Centerpointe.

In *NME I*, when Medical Services failed to promulgate a change in a policy of general applicability as a rule, the Court reverted back to the policy in effect prior to the change. Even if the Court assumes that the prior time period was the prior year, as Centerpointe wants, the Commission should have used the second half of July 2003 through March 2004 time period to mirror the second half of July 2002 through March 2003 time period used in the prior estimate. LF 352, 482, 485, 676. If it did, this would have resulted in the following calculation of additional direct Medicaid payments:

Fee For Service (FFS) days in billing periods 7/25/03 through 3/19/04 ¹⁴	1,712
Annualized FFS days ¹⁵	2,417
FFS percentage (from 2000 fourth year prior base year) ¹⁶	82.83%
Total in state Medicaid days (FFS plus MC + days) ¹⁷	2,918
Plus out of state Medicaid days ¹⁸	387
Total estimated Medicaid days for SFY 2004 ¹⁹	3,305
Multiply days by \$742.38 per diem rate to get direct Medicaid payment	\$2,453,566
Subtract the amount of the direct Medicaid payment already received	\$1,760,925
Balance owed	\$692,641

¹⁴ LF 352, 485.

¹⁵ Multiply 2,417 by 24 (representing the number of billing cycles in 1 full year) then divide by 17 (the number of cycles used in the sample) = the annualized FFS days of 2,417.

¹⁶ LF 818 there is no dispute concerning this number.

¹⁷ Divide the FFS days (2,417) by .8283 (FFS percentage) = 2,918 total in state days. There is no dispute as to how these are calculated, only the number of FFS days is disputed (which impacts the number of total in state Medicaid days).

¹⁸ There is no dispute concerning this number.

¹⁹ In state days + out of state days. There is no dispute as to this calculation, only as to the number of total Medicaid patient days.

Instead, the Commission used the time period suggested by Centerpointe – July 2003 through May 2004 – which inflates the estimate due to an unusually large number of days reported in April 2004. Had the Commission reverted back to the prior decision, Centerpointe would only be owed an additional \$692,641 in direct Medicaid payments, not \$1,803,984.

The Commission stated that following the Medical Services' process from the prior year was arbitrary. LF 819. The Commission, however, does not get to choose another method of estimation it considers more reasonable. It must revert back to the prior policy, which it failed to do. Accordingly, the Commission incorrectly applied *NME I* to the facts, and its decision should be reversed.

Conclusion

In view of the foregoing, Appellant, the Department of Social Services, Division of Medical Services respectfully requests that this Court to reverse the decision of the Administrative Hearing Commission granting more than \$1.8 million in additional direct Medicaid payments to Centerpointe as the Commission was without jurisdiction to hear Centerpointe's complaint. Alternatively, Medical Services' requests that the Court affirm Medical Services' September 3, 2003 decision announcing Centerpointe's estimation of Medicaid patient days as it was not arbitrary, capricious or unreasonable.

Respectfully submitted,

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Certification of Service and Compliance with Rule 84.06(b) and (c)

The undersigned hereby certifies that on this 5th day of July, 2007, one true and correct copy of the foregoing brief, and one disk containing the foregoing brief, were mailed, postage prepaid, to:

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The undersigned further certifies that the foregoing brief complies with the limitations contained in Rule No. 84.06(b), and that the brief contains 19,237 words.

The undersigned further certifies that the labeled disk, simultaneously filed with the hard copies of the brief, has been scanned for viruses and is virus free.

Assistant Attorney General