

IN THE MISSOURI SUPREME COURT

DEPARTMENT OF SOCIAL SERVICES, )  
DIVISION OF MEDICAL SERVICES, )  
 )  
Plaintiff/Appellant, )  
 )  
v. ) Case No. SC88430  
 )  
LITTLE HILLS HEALTHCARE, L.L.C., )  
d/b/a CENTERPOINTE HOSPITAL, )  
 )  
Defendant/Respondent. )

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Appeal from the Administrative Hearing Commission

The Honorable June Striegel Doughty

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Brief of *Amicus Curiae*  
Missouri Health Care Association  
in Support of Defendant/Respondent

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## **JURISDICTIONAL STATEMENT**

After opinion by the Court of Appeals, Western District, the Missouri Supreme Court granted transfer of this case. See Mo. Const. art. V, § 10; Rule 83.04. This Court has jurisdiction to finally determine the case the same as on original appeal. Mo. Const. art. V, § 10; Rule 83.09.

In its first point relied on, the Department of Social Services (Department) argues that the Administrative Hearing Commission (AHC) lacked subject matter jurisdiction. This Court would not have jurisdiction over this appeal if the AHC lacked jurisdiction in the first instance. Casey v. Dep't of Soc. Servs., 727 S.W.2d 462, 463 (Mo. App. E.D. 1987). The Missouri Health Care Association (MHCA) addresses the Department's jurisdictional argument in its response to the Department's first point relied on.

## INTEREST OF AMICUS CURIAE

Missouri Health Care Association (MHCA) is an association of long-term care facilities, headquartered in Jefferson City. Approximately 300 nursing facilities in the State of Missouri are MHCA members. MHCA represents its members' interests with respect to various matters, including those relating to rulemakings to establish Medicaid reimbursement policies. MHCA's Board of Directors has authorized it to participate in this action as *amicus curiae*. Appellant Department of Social Services, Division of Medical Services and Respondent Little Hills Healthcare, L.L.C. d/b/a CenterPointe Hospital (Hospital) consented to MHCA filing this amicus brief. See Rule 84.05(f)(2).

Resolution of this case greatly interests MHCA. MHCA members are long-term care providers, with an important perspective on Medicaid reimbursement and administrative law issues affecting the health care industry. Of the approximately 550 nursing facilities in Missouri, more than 90 percent accept Medicaid, and all of MHCA's member facilities accept Medicaid. The Department's Medicaid reimbursement policies directly impact MHCA's members. See, e.g., Dep't of Soc. Servs. v. Senior Citizens Nursing Home Dist. of Ray County, 224 S.W.3d 1, 4, 20 (Mo. App. W.D. 2007) (nursing home operator was entitled to \$3.63 per patient day increase in its Medicaid per diem rate). MHCA monitors notices of proposed rulemaking and orders of final rulemaking for its members to help them plan for their anticipated Medicaid revenue or lack thereof.

The Court's resolution of this case will determine whether MHCA's members will continue to be prospectively notified of changes in the Department's Medicaid reimbursement policies pursuant to Chapter 536, RSMo. The Department has also raised

points of error concerning the AHC's jurisdiction and its proper role in Missouri's administrative system. Thus, this decision has the potential to impact the rights of regulated parties in administrative appeals, which would also affect MHCA's members.

## STATEMENT OF FACTS

The facts relevant to this *amicus curiae* brief are set forth below.

### **A. The Parties and the Missouri Hospital Association**

The Department administers the Missouri Medicaid program through its Division of Medical Services. § 208.201, RSMo 2000. The Department determines reimbursement rates for Medicaid providers by promulgating rules and regulations. § 208.153.1, RSMo 2000.

The Hospital is a Medicaid provider, and most of its patients are Medicaid beneficiaries. L.F. 791. Ardent Healthcare (Ardent) sold the Hospital to Little Hills Healthcare, L.L.C. on April 1, 2003. Id. at 792. In preparing to sell the Hospital, Ardent significantly curtailed its operations by utilizing only one of six available units. Id. As a result, during SFY 2003,<sup>1</sup> the Hospital experienced the lowest provision of Medicaid services in its history. Id. In statistical terms, SFY 2003 was clearly an outlier year for the Hospital. After the sale, the Hospital's provision of Medicaid services in SFY 2004 increased more than 100 percent from SFY 2003. Id.

The Missouri Hospital Association (MHA) is an advocacy organization for Missouri hospitals. Id. at 793. The Hospital is a member of MHA. Id.

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<sup>1</sup> A state fiscal year (SFY) runs from July 1 of the preceding calendar year through June 30 of the calendar year for which the fiscal year is named. Thus, SFY 2004 was the 12-month period from July 1, 2003, through June 30, 2004. L.F. 792.

## **B. Medicaid Reimbursement**

Medicaid reimbursement to hospitals consists of several different types of payments. Each hospital receives Medicaid “per diem” reimbursement at a rate established by 13 CSR 70-15.010(3). L.F. 499, 792. The per diem rate is a per patient per day rate based on the hospital’s 1995 cost report<sup>2</sup> with trend factors added to adjust that data for inflation. Id. 499, 792.

In addition to their per diem rate, hospitals also receive “direct payments” pursuant to 13 CSR 70-15.010(15) for certain allowable costs not included in the per diem rate. Id. at 793. Direct Medicaid payments are the difference between a hospital’s trended cost and its per diem rate multiplied by “estimated Medicaid patient days.” Id.; 13 CSR 70-15.010(15)(B)2.<sup>3</sup> Direct Medicaid payments are designed to mitigate the impact of the federal reimbursement allowance (FRA) on Medicaid providers. See L.F. 793.

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<sup>2</sup>Hospitals participating in Medicaid must submit an annual cost report to the Department. L.F. 500, 793; 13 CSR 70-15.010(5)(A)1. For Medicaid purposes, a cost report details the cost of rendering covered services for the fiscal reporting period. L.F. 498; 13 CSR 70-15.010(2)(G).

<sup>3</sup> The Department’s hospital reimbursement plan for Medicaid, or 13 CSR 70-15.010, uses the terms “estimated Medicaid days” and “estimated Medicaid patient days” interchangeably. See L.F. 793; 13 CSR 70-15.010(15)(B).

The FRA is a provider tax that Missouri hospitals pay for the privilege of engaging in the business of providing inpatient healthcare. Id. at 792. It is calculated as a percentage of a hospital’s operating revenue less tax revenue and other government appropriations. Id. Provider taxes such as the FRA are used to generate state revenue that is then matched with additional federal payments. Id. at n.1. Because the federal government provides funds to match the FRA, the FRA and its federal matching funds increase the total amount of money that the Department can use to pay hospitals. Id. The percentages of the FRA assessment are set by 13 CSR 70-15.010. Id. at 792. The Department frequently incorporates MHA’s comments into the process of determining the FRA assessment. Id. at 802.

Hospitals must submit cost reports to the Department each year. Id. at 793; 13 CSR 70-15.010(5)(A). The Department conducts desk reviews of the cost reports in which it examines the charges each hospital billed to Medicaid, and it uses the cost reports to determine certain components of its “estimated Medicaid days” calculation. L.F. 793. The dispute in this case concerns the Department’s methodology for estimating Medicaid days in the calculation of direct Medicaid payments.

**C. The Department’s Notices and Estimated Medicaid Days**

The Department issues two notices to each hospital during the SFY. L.F. 793. The notices compute, among other things, the hospitals’ FRA assessments, per-diem rates, and direct Medicaid payments. Id. Since the FRA program began in 1991, the Department has customarily issued one notice near the beginning of the SFY and a second notice near the end of the SFY. Id.

In determining the direct Medicaid payments, the Department uses three components to calculate estimated Medicaid days: (1) fee for service (“FFS”) days, (2) MC+ days, and (3) out-of-state days. Id. at 794. FFS days are days paid directly by the Department. Id.; 13 CSR 70-15.020(1)(H). MC+ days are days paid by managed care health plans. L.F. 794; 13 CSR 70-15.020(1)(J). Out-of-state days are days paid by another state for patients who came to Missouri. L.F. 794.

In estimating Medicaid days for any given SFY, the Department uses the same methodology for each of the approximately 140 hospitals in the industry in Missouri. Id. The Department does not publish its methodology for estimating Medicaid days as a rule. Id. at 805.

From SFY 1999 through SFY 2002, the estimate was determined based on a regression analysis, with various adjustments each year. Id. at 794, 795, 796, 799, 804-05, 821. The same methodology applied to all hospitals. Id. at 794.

**D. In SFY 2003, the Department changed its methodology for estimating Medicaid patient days mid-year.**

Initially, for SFY 2003, the Department estimated Medicaid patient days as it had in years past. Id. at 796, 821. Under the initial estimate, the Hospital was to receive \$4,610,244 in direct Medicaid payments based on an estimate of 6,102 Medicaid days. Id. at 796. But, near the end of SFY 2003, the Department reconciled its budget and realized that it did not have enough money to continue making Medicaid payments. Id. Because of the budget shortfall, the Department approached MHA to discuss the possibility of increasing the FRA for SFY 2003. Id. at 797. During this time period,

several thousand children had been added to the State Children's Health Insurance Program (SCHIP) which had resulted in higher costs and more Medicaid days for providers. Id. An increase in the FRA provider tax would allow the Department to obtain additional federal matching funds to bridge its budget shortfall. Id. MHA proposed that the Department also update its estimate of the number of Medicaid days to offset the additional FRA paid by hospitals. Id. A revised estimate of days would include the additional SCHIP beneficiaries, and would thus increase most hospitals' direct add-on payments. Id. at 374-76. The Department agreed to MHA's proposal. Id. at 797. The Department promulgated its change to the FRA as a rule, but did not promulgate the change to its methodology for estimating patient days. Id. at 536, 552, 794.

With approximately two months left in SFY 2003, the Department sent its second notice to the hospitals on May 7, 2003. Id. at 797. For this notice, the Department determined the hospitals' Medicaid days by using actual SFY 2003 Medicaid days for the first two-thirds of the SFY and estimating the days for the remainder of the SFY based upon the actual days that had occurred to date that year. Id.

For the Hospital, the Department's revised estimate was 1,994 Medicaid patient days. Id. at 798. The projected direct Medicaid payments for SFY 2003 pursuant to the second notice were \$1,795,537. Id. In the first notice for SFY 2003, the payments totaled \$4,610,244. Id. at 796. The dramatic difference was due to the reduction in Medicaid days from the first to the second notice. Id. at 798.

Because the direct Medicaid payments were greatly reduced in the second notice

to the Hospital, the Department requested that the Hospital reimburse it \$2,236,726 for overpayments received for SFY 2003. Id. In years past, the Hospital would have been entitled to retain this windfall payment. L.F. 142-43. In future years the Department would have benefited when the low number of days experienced in SFY 2003 was used to estimate future days, resulting in a lower estimate for those years. See id. at 142-43, 805. Under the revised methodology, the Hospital was required to pay that money back. Id. at 798. Ardent paid a portion of reimbursement for the period during which it operated the hospital and the Hospital paid the remainder as its share. Id. They did not appeal the Department's decision to conform its estimate of days to eight months of actual usage data based on the budget shortfall being experienced by the Department. Id. at 582-84.

**E. In SFY 2004, the Department changed its methodology yet again, and grossly underestimated the Hospital's Medicaid days for SFY 2004.**

Rather than adhere to the SFY 2003 methodology, the Department changed its methodology for estimating days in SFY 2004. The Department used the revised days from SFY 2003 as the starting point for SFY 2004 because that data was more current than the days used for the regression analysis. L.F. 198-99, 582-84. In calculating the revised days, the Department annualized the hospitals' actual days from August 2002 through March 2003. Id. at 799-800. The Department then derived an FFS percentage based on the year 2000 and added each hospital's 2000 desk-reviewed MC+ days and out-of-state days. Id. at 800. The Department again consulted with MHA but did not promulgate the new methodology as a proposed rule and thus did not provide notice or an

opportunity for comment to the public. Id. The Department accordingly began estimating Medicaid days for SFY 2004 with the same number of annualized FFS days that it had used in calculating the second notice for SFY 2003, and ultimately calculated an estimate of 2,372 days for the Hospital. Id.

But, because SFY 2003 was an outlier year for the Hospital, the initial estimate did not approximate its FFS days for SFY 2004. Id. at 802. The Department's methodology did not include an individualized assessment to identify providers like the Hospital which experienced an outlier year in SFY 2003 and which might be adversely affected by the methodology as a result. See id. at 289.

On or about September 3, 2003, the Department sent a notice (September 3 Notice) to each hospital concerning its Medicaid reimbursement, including its estimated days. Id. at 800-01. The notices stated that the decision could be appealed to the AHC. Id. at 801. They were not sent by certified mail. Id. The Hospital never received its notice. Id.

The Hospital was receiving payments that closely approximated its SFY 2003 payments and was concerned. Id. at 802. In a March 10, 2004, letter to the Department, the CEO stated that the Hospital's operations were greatly reduced in SFY 2003, and that consistent with the methodology the Department had used for SFY 2003, an adjustment should be made for SFY 2004 Medicaid days. Id. The CEO noted that the Department's projections for SFY 2004 days were depressed based on the Hospital's SFY 2003 annualized data, which subsequently reduced the Hospital's prospective Medicaid payment for SFY 2004. Id. The Department responded that it would consider the

Hospital's concerns: "At this time, the Division is still in the process of finalizing SFY 2004 projected days. The Division will take your concerns into consideration as we work through this process." Id. (emphasis added); see id. at 663 (April 7, 2004, letter from the Department to the Hospital's CEO).

On June 4, 2004, the Department sent a notice to the Hospital for SFY 2004 (June 4 Notice). Id. at 664-65; see id. at 803. The June 4 Notice stated that it was "a final decision regarding administration" of Medicaid that could be appealed to the AHC. Id. at 664; see id. at 804. The Department used the same estimate of Medicaid days in its second notice for SFY 2004 as it had used in the first notice. Id. at 803. The Department applied the same general methodology to the Hospital that it applied to the other 140 hospitals. Id.

The Department did not promulgate a rule to notify the public that it was changing its methodology for estimating days between SFY 2003 and SFY 2004. Id. at 805. If the Department had used the same methodology to calculate estimated Medicaid days in its second notice for SFY 2004 as it had used in its second notice for SFY 2003 using days through May 2004, the estimated Medicaid days for the Hospital would have been 4,802. Id. The Hospital would have received \$3,564,909 in direct Medicaid payments, or \$1,803,984 more than the Department determined for the same time frame. Id.

#### **F. Appeal to the AHC**

The Department's changes to its general methodology for estimating days between SFY 2003 and SFY 2004 disparately impacted the Hospital. In SFY 2003, the Hospital returned over \$2 million in reimbursement that it had received. L.F. 798. The Hospital

chose not to appeal, accepted the revised estimate which resulted in an estimate of days that more closely approximated its actual days, and returned the money. Id. In SFY 2004, the Department changed its policy yet again, used the Hospital's data from its outlier SFY 2003 to determine its initial estimate of days, and grossly underpaid the Hospital in relation to its actual usage. See id. at 799-802, 804. This time, the Hospital appealed. Id. at 787.

The AHC agreed that the Department's SFY 2004 methodology for estimating days was a rule that could not be enforced against the Hospital because it was not promulgated pursuant to notice and comment procedures. Id. at 815. The AHC estimated the Hospital's days applying the pre-existing methodology from SFY 2003. Id. at 804, 818-20. That estimate resulted in a Medicaid estimate of days of 4,802 – only 82 days less than the Hospital's actual usage. Id. at 804. This appeal followed.

**POINTS RELIED ON**

- I. The AHC correctly determined that it had subject matter jurisdiction because the Hospital did not receive the September 3 Notice, which included tentative information, and it timely appealed the June 4 Notice pursuant to § 208.156, RSMo 2000.**

Psychiatric Healthcare Corp. v. Dep't of Soc. Servs., 996 S.W.2d 733 (Mo. App. W.D. 1999)

§ 208.156, RSMo 2000

- II. The Administrative Hearing Commission correctly concluded that the Department's methodology for calculating millions of dollars in direct Medicaid add-on payments to hospitals is a rule.**

NME Hosps., Inc. v. Dep't of Soc. Servs., 850 S.W.2d 71 (Mo. banc 1993)

Psychcare Mgmt., Inc. v Dep't of Soc. Servs., 980 S.W.2d 311 (Mo. banc 1998)

- III. The Administrative Hearing Commission was not required to defer to the Department because the Department did not promulgate its methodology as a rule.**

J.C. Nichols v. Dir. of Revenue, 796 S.W.2d 16 (Mo. banc 1990)

- IV. The Administrative Hearing Commission properly calculated the Hospital's reimbursement without giving effect to the SFY 2004 methodology change.**

## LEGAL ARGUMENT

**I. The AHC correctly determined that it had subject matter jurisdiction because the Hospital did not receive the September 3 Notice, which included tentative information, and it timely appealed the June 4 Notice pursuant to § 208.156, RSMo 2000.**

**A. Standard of Review**

In an appeal following judicial review of a decision of the AHC, the Court reviews the decision of the AHC and not that of the circuit court. Psychcare Mgmt., Inc. v Dep't of Soc. Servs., 980 S.W.2d 311, 312 (Mo. banc 1998). The Court does not determine the weight of the evidence or substitute its discretion for that of the AHC. Id. Rather, the Court determines whether the decision involves an abuse of discretion and whether it is supported by competent and substantial evidence upon the whole record; unauthorized by law; made upon unlawful procedure; or arbitrary, capricious, or unreasonable. § 536.140, RSMo Supp. 2006; see Mo. Const. art. V, § 18 (judicial review involves determining whether agency decisions are authorized by law and supported by competent and substantial evidence upon the whole record).

In reviewing an AHC decision, the Court defers to the AHC's factual findings. See EBG Health Care III, Inc. v. Dep't of Soc. Servs., 882 S.W.2d 143, 145 (Mo. App. W.D. 1994) (citing Barnes Hosp. v. Mo. Comm'n on Human Rights, 661 S.W.2d 534, 535 (Mo. banc 1983)). The AHC, and not the Court, judges the credibility of the witnesses. Id. (citing St. Louis County v. State Tax Comm'n, 406 S.W.2d 644, 649 (Mo.

banc 1966)). If the evidence would establish either of two opposing findings, the Court must uphold the factual determination of the AHC. Id.

When an agency's decision is based upon an interpretation, application, or conclusion of law, the Court's review is de novo. Psychcare Mgmt., 980 S.W.2d at 312. Whether an agency possesses subject matter jurisdiction is a question of law that is controlled by statute. Mo. Coalition for the Env't v. Herrmann, 142 S.W.3d 700, 701 (Mo. banc 2004).

**B. The AHC correctly determined it had subject matter jurisdiction over the Hospital's appeal.**

The AHC is a "creature of statute" and its jurisdiction is limited to that conferred by the legislature. Dep't of Soc. Servs. v. NME Hosp., Inc., 11 S.W. 3d 776, 779. (Mo. App. W.D. 1999) (hereinafter NME II). In the absence of statutory authority to consider an appeal, the AHC lacks subject matter jurisdiction over that appeal. Id. at 779-80.

The AHC has jurisdiction over Medicaid reimbursement disputes between the Department and Medicaid providers such as the Hospital. §§ 208.156, 621.055, RSMo 2000 & Supp. 2006. The provider must request review within 30 days "from the date of mailing or delivery of a decision" of the Department. § 208.156.8, RSMo 2000. Here, the Hospital timely appealed the June 4 Notice of its SFY 2004 Medicaid reimbursement. L.F. 5, 787, 809. That appeal conferred jurisdiction on the AHC. The Department complains that the Hospital should have appealed the earlier September 3 Notice. Dept. Br. 34-40. The AHC rejected that argument for two reasons. Id. at 805-09. First, after hearing testimony from witnesses for both the Department and the Hospital, the AHC

concluded that the Hospital did not receive the September 3 Notice. Id. 801. When the evidence plausibly supports either of two opposing findings, the standard of review requires the Court to uphold the AHC’s factual determination. EBG Health Care III, Inc. v. Dep’t of Soc. Servs., 882 S.W.2d 143, 145 (Mo. App. W.D. 1994). The Hospital could not appeal from a notice it did not receive.

Second, the June 4 Notice updated the Department’s rate decision for SFY 2004. Changes to Medicaid reimbursement aggregating more than \$500 trigger a provider’s statutory right to appeal. § 208.156, RSMo 2000. Thus, irrespective of the Hospital’s non-receipt of the first notice, the second notice constituted a new decision, which the Hospital could appeal. The Department characterizes the appeal of the second decision as a “collateral attack” on the first decision, implicitly invoking the principles of issue and claim preclusion (collateral estoppel and res judicata). Dept. Br. 34. But, of course, those doctrines only preclude relitigation of issues decided after a hearing on the merits, at which both sides have had a full and fair opportunity to litigate the issues. See, e.g., King Gen. Contractors, Inc. v. Reorganized Church of Jesus Christ of Latter Day Saints, 821 S.W.2d 495, 501 (Mo. banc 1991). By its argument, the Department would apply preclusive effect to issues that were not appealed, never litigated, and never decided on the merits.

Medicaid providers and the Department have an ongoing relationship. Medicaid providers’ rates are regularly adjusted according to the terms of the Department’s reimbursement regulations and any amendments to those regulations. Providers must weigh the costs and benefits of litigating a reimbursement decision. Litigation is always

expensive (in terms of cost, time, and strained relationships), and providers may choose not to appeal, even when their reimbursement has been incorrectly determined. If they make that election, they must, of course, accept that reimbursement determination, as long as it remains in effect. The provider cannot retrospectively challenge the monetary effect of the Department's reimbursement decisions. NME II, 11 S.W.3d at 779-80 (refusing to allow the hospital to seek retroactive reimbursement for a five-year period based on this Court's prior decision.)

By way of contrast, choosing not to appeal one administrative decision does not limit or otherwise preclude a provider from challenging a later decision that incorporates the same methodology. Thus, in Psychiatric Healthcare Corp. v. Department of Social Services, the Court of Appeals, Western District, correctly held that a provider may appeal from the Department's second notice confirming the calculations in a previous notice, because the correct rate was still a "live issue" until that time. 996 S.W.2d 733, 736-37 (Mo. App. W.D. 1999). In the instant case, the AHC relied on its experience and that of the Cole County Circuit Court with administrative appeals in applying the same principle and correctly reasoning that: "If the Department elects to exercise its authority and reopen or reconsider a prior decision, that is its right, but then the provider has an equal right to seek review of the new decision in its entirety without limitation to the second proceeding." L.F. 806-07 (quoting BHCA of Kansas City v. Dept. of Soc. Servs., Cole County Circuit Court, No. CV197-1719 (May 22, 1998)). Quite simply, a new decision triggers a new right to appeal. The provider cannot appeal reimbursement prior

to the effective date of the decision, but is allowed to appeal the prospective effect of the new decision in its entirety.

In this case, the June 4 Notice recalculated Hospital's reimbursement for SFY 2004. In appealing the June 4 Notice, the Hospital was entitled to challenge any aspect of the Department's methodology, including practices that had been followed in the past but not appealed and earlier tentative calculations of the Department. The AHC properly determined that it had jurisdiction.

**II. The Administrative Hearing Commission correctly concluded that the Department's methodology for calculating millions of dollars in direct Medicaid add-on payments to hospitals is a rule.**

**A. Standard of Review**

This point presents only questions of law. The Department did not appeal the AHC's factual findings concerning its methodology for calculating Medicaid reimbursement. Dept. Br. 41. This Court reviews questions of law de novo. Psychcare Mgmt., 980 S.W.2d at 312.

**B. Under the Missouri Administrative Procedure Act, agency rules are void and have no effect unless the public is notified of their proposed terms and allowed to comment on them before they go into effect.**

Administrative agencies implement and execute government policy within traditionally broad delegations of authority from the General Assembly. Their decisions determine the standards by which regulated communities must order their affairs, and are of the utmost importance to the public. Agencies combine many of the separate functions

of government in one body. See, e.g., Dabin v. Dir. of Revenue, 9 S.W.3d 610, 614 (Mo. banc 2000) (agencies may perform judicial and quasi-judicial functions); Mo. Coalition for the Env't v. Joint Comm. on Admin. Rules, 948 S.W.2d 125, 134 (Mo. banc 1997) (agency rules have the “force and effect of law”). As with any human endeavor, the concentration of power presents opportunities for abuse of that power. Agency officials are appointed (not elected), insulating them from direct political accountability at the ballot box. See, e.g., Mo. Const. art. IV, § 37 (providing for appointment of the director of the Department). Moreover, agencies – given the sheer breadth of their authority – face considerable logistical hurdles in developing sound public policy. Agencies usually have less information than the regulated community. Their policy choices may have unintended consequences or may be based on incorrect or incomplete information. Likewise, agency culture may be such that the agency represents a limited range of viewpoints (by circumstance or design) and fails to account for all viewpoints.

Given these unique challenges, the General Assembly has enacted the Missouri Administrative Procedures Act (MAPA) to ensure that effective checks exist on the authority of administrative agencies. Chapter 536, RSMo 2000 & Supp. 2006. MAPA does not define permissible and impermissible policies. Rather, like the constitutional requirement that due process must be provided before citizens may be deprived of their life, liberty, or property, MAPA chiefly safeguards the rights of the public by requiring that agencies follow certain processes. See, e.g., § 536.016, RSMo 2000 (agency rules must be based on substantial evidence); § 536.017, RSMo 2000 (agencies must engage in a takings analysis); §§ 536.200-.215, RSMo 2000 (agencies must engage in fiscal impact

analyses). By requiring consideration of important factors, advance notice of proposed agency action, and opportunities for public involvement, MAPA intends to foster better agency policies, greater public accountability, and ultimately greater legitimacy for the actions of agencies.

“Notice and comment” procedures are the centerpiece of MAPA’s rulemaking procedures. Before an agency adopts a legally binding statement of policy (i.e., a “rule”), the agency must first provide notice and an opportunity to comment to the public. § 536.021.2, RSMo Supp. 2006. The notice must include the proposed regulation, an explanation of the proposal, and the reasons therefor. Id. When a rule is finally adopted, the agency must publish that rule at least 30 days before it becomes effective. § 536.021.8, RSMo Supp. 2006. Public comments must be summarized and published with the rule, and any changes from the original proposal must be explained. § 536.021.6(2), (4), RSMo Supp. 2006. These notice and comment procedures are intended to protect members of the public from irrational, arbitrary or ill-advised agency rules by exposing proposed policies to public scrutiny and criticism before they go into effect. NME Hosps., Inc. v. Dep’t of Soc. Servs., 850 S.W.2d 71, 74 (Mo. banc 1993) (hereinafter NME I) (quoting St. Louis Christian Home v. Mo. Comm’n on Human Rights, 634 S.W.2d 508, 515 (Mo. App. 1982)). Opponents may alert the agency to unintended consequences of its proposed policies or the harm that may occur. Id. Proponents may emphasize the benefits of the policy. Id. Through this give and take, proposed policies are publicly tested before they go into effect.

Moreover, when the final agency decision is published as a rule, the public is put on notice and advised of the policies that the agency will follow. § 536.021.8, RSMo Supp. 2006. This advance notice allows members of the regulated community to conform their conduct to known standards. See NME I, 850 S.W.2d at 75 (public has a “legitimate expectation” that prior notice of changes in statewide policies will be provided). It prevents agencies from formulating standards, keeping them secret from or simply failing to publish them to the public, and then penalizing people who run afoul of those unpublished standards. People should be informed – at least constructively – of the laws that govern their affairs. See Mo. Const. art. III, § 34 (statutes are revised and promulgated at least every 10 years). Finally, if members of the public disagree with the policy or the process by which it was formulated, the policy may be challenged in court or through political action. See, e.g., Lankford v. Sherman, 451 F.3d 496, 512 (8th Cir. 2006) (holding that plaintiffs established a likelihood of success on the merits for their claim that the Department’s emergency regulation restricting access to durable medical equipment violated the Medicaid Act); McNeil-Terry v. Roling, 142 S.W.3d 828, 834 (Mo. App. E.D. 2004) (holding that the Department’s emergency rule eliminating dental service for Medicaid-eligible adults except for dentures and mouth trauma “eviscerated” the statutory mandate to provide adult dental services as part of the Medicaid program). Thus, MAPA exposes the agency decision-making process to the full light of day, where the regulated community, members of the public, and ultimately the courts may scrutinize and have input into that process.

The next question is which agency policies must be promulgated as rules. By statute, a rule is defined as “each agency statement of general applicability that implements, interprets, or prescribes law or policy.” § 536.010(6), RSMo Supp. 2006. Cases have applied and clarified this definition. A rule is a formulation of 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 Rulemaking, § 3.3.1 at 76 (1986)). Not every generally applicable statement is a rule. Baugus v. Dir. of Revenue, 878 S.W.2d 39, 42 (Mo. banc 1994). Statements with no potential to impact the substantive or procedural rights of the public are not rules. Id. Agencies may also publicize their interpretations of law to the public. United Pharmacal Co. of Mo. Inc. v. Mo. Bd. of Pharmacy, 159 S.W.3d 361, 365 (Mo. banc 2005). Such publications need not be promulgated pursuant to notice and comment procedures. Id. However, such unpromulgated policies are not binding on the public or the courts. In fact, they have no effect whatsoever. Id. Contested case decisions or interpretations that apply only to a set of specific facts are excepted from the definition of “rule,” and do not trigger the obligation to follow notice and comment procedures. §§ 536.010(6)(b), (d), RSMo Supp. 2006.

From these cases interpreting § 536.010(6), the four following elements for a rule may be discerned:

1. A generally applicable policy statement or legal interpretation;
2. To be applied in the future;

3. As a binding policy with the force of law;
4. That has the potential to impact substantive or procedural rights.

If a rule is validly promulgated pursuant to notice and comment procedures, it is binding and has the force of law. See, e.g., Mo. Coalition for the Env't. v. Joint Comm. on Admin. Rules, 948 S.W.2d 125, 134 (Mo. banc 1997). But, if a rule is not promulgated pursuant to notice and comment procedures, it is “null, void, and unenforceable.” § 536.021.7, RSMo Supp. 2006. It therefore has no “force or legal effect.” United Pharmacal Co., 159 S.W.3d 361, 365.

**C. Medicaid reimbursement policies are rules.**

In 1993, this Court specifically considered whether the Department’s methodology for calculating reimbursements to Medicaid providers was a rule. NME I, 850 S.W.2d at 74. The Department made higher Medicaid payments to disproportionate share hospitals (DSH) that provided a high number of unpaid days of care. Id. at 73. As a DSH hospital, the provider’s reimbursement was the product of days of service multiplied by a special DSH rate. Id. The Department calculated the hospital’s DSH rate by excluding payments for psychiatric services (other than electric shock treatment) Id. The Department’s decision to exclude psychiatric services from reimbursement was published in the Missouri Medicaid Bulletin only, and was not promulgated as a rule pursuant to notice and comment procedures. Id. The Department’s policy change decreased the hospital’s DSH rate by \$12.48 per patient per day. Id. The hospital appealed. Id.

This Court held that the Department’s policy of excluding psychiatric services in calculating the DSH rate was a rule that was invalid because the Department did not

promulgate it pursuant to notice and comment procedures. Id. at 74. The decision to disallow the costs of psychiatric services was “a reimbursement standard of general applicability.” Id. The Court rejected the Department’s contention that the reimbursement standard was not a statement of “general applicability” because it applied to Medicaid participants and not all hospitals. Id. A reimbursement standard for Medicaid providers is a generally applicable statement. Id. The Court noted that § 208.153 expressly requires the Department to promulgate its determinations of reasonable costs, manner, extent, quantity, quality, charges and fees for Medicaid assistance as rules and regulations. Id.

The Court also rejected the Department’s attempt to enforce the same standard by contract: “If the amendment cannot be given effect as a rule, it cannot be given effect as a valid term of a contract.” Id. at 75. Accordingly, the Court held that reimbursement for psychiatric services should be included in the provider’s rate.

Appellate courts have continuously followed the holding of NME I, and have reiterated that Medicaid reimbursement policies must be promulgated as rules. Thus, in Psychcare Management, the Department had adopted its Medicaid provider manual in an emergency rule in response to NME I. 980 S.W.3d at 313. The emergency rule expired, but the Department continued attempting to enforce the provider manual as a rule. Id. This Court held that the expired regulation was a nullity and had no effect, making the provider manual inapplicable to the case. Id. at 313-14. Accordingly, the Court held that the provider’s reimbursement should have included the costs disallowed by the provider manual. Id. at 314. Accord Dep’t of Soc. Servs. v. Senior Citizens Nursing Home Dist.

of Ray County, 224 S.W.3d 1, 17-18 (Mo. App. W.D. 2007) (the Department cannot “read the language [it doesn’t like] out of the regulation completely because that effectively amounts to an amendment of the regulation”); Southeast Mo. Hosp. Ass’n v. Mo. Dep’t of Soc. Servs., 886 S.W.2d 94, 96-99 (Mo. App. W.D. 1994) (hospital was entitled to rate increase when the Department performed rate calculations contrary to its reimbursement plan; hospital was not informed of methodology until hospital’s accountant recognized something was wrong; rate letter “intimated it was established in accordance with the regulations”); J.P. v. Dep’t. of Soc. Servs., 752 S.W.2d 847, 850-51 (Mo. App. W.D. 1988) (adoptive parent entitled to increased subsidy payment after the Department misapplied its own regulation).

**D. The Department’s methodology for estimating patient days is a rule.**

The dispute in this case is straightforward. A component of the Medicaid reimbursement paid to Missouri hospitals is calculated by multiplying a defined cost factor by “estimated Medicaid patient days for the current [state fiscal year].” 13 CSR 70-15.010(15)(B)2. The AHC found that the Department has a specific methodology each year for estimating patient days. L.F. 794. At the hearing before the AHC, the Department admitted that such a methodology exists and even testified that its methodology was a statement of general applicability that met the definition of the rule. Id. at 337-38. The same methodology applies to each of the 140 hospitals in Missouri. Id. at 794. The Department contends that its methodology is binding and must be deferred to as a matter of law by Medicaid providers, the AHC, and this Court. Dept. Br. 56-71.

Under these undisputed facts, the days counting methodology satisfied all four elements of a rule and should have been promulgated pursuant to notice and comment procedures. First, the methodology is a statement of general applicability because it generally applies to all 140 hospitals participating in the Medicaid program. NME I, 850 S.W.2d at 74; Arthur Earl Bonfield, State Administrative Rulemaking, § 3.3.1 at 75 (“Every statement implementing, interpreting, or prescribing law or policy that is directed at a class by description, that is, directed at all persons similarly situated, rather than at named individuals, is thus within the ambit of the definition.” (emphasis in original)). The Department did not make an individualized estimation of the Hospital’s days in this case. See L.F. 794. It would be a different case, for example, if the Department had individually considered the data available for each hospital, the reliability of that data, and why certain years should or should not be considered outliers based on that data (e.g., SFY 2003 for the Hospital) and then rendered a particularized estimate of days. That kind of determination might qualify for the exception for individualized decisions on particular facts. See § 536.010(6)(b). Of course, making individualized assessments for 140 hospitals would have been much more laborious for the Department. So, instead, the Department chose to establish one uniform standard for all hospitals. See L.F. 794. By employing a standard of general applicability, the Department triggered its obligation to notify the public of those proposed standards.

Second, the methodology has future effect because the prospective estimate of patient days determines a component of hospitals’ reimbursement for the coming year. Payments are made to hospitals only after the methodology is established. See id. at 793-

94. In fact, because the payments are determined by the methodology, they cannot – as a matter of logic – be made until the methodology has been established. See id. Thus, the methodology directly affects the amount of future Medicaid payments to the affected hospitals.

Third, the methodology is a binding statement with the force of law. The Department is vigorously attempting to enforce the methodology against the Hospital. It contends that its calculation binds the Hospital. The Department claims this Court and the AHC are legally required to defer to it. Dept. Br. 56-71. Such deference-commanding interpretations are exactly the type of agency policy decisions that must be promulgated as rules to be effective.

Fourth, the methodology determines the amount of Medicaid reimbursement to which hospitals are entitled and thus affects their legal rights. In this case, the Department's changed policy had the potential to and in fact actually cost the Hospital over \$1.8 million dollars. See L.F. 804. The Department cites federal case law and argues that Medicaid providers do not have a property right in their reimbursement because they voluntarily participate in the program. Dept. Br. 49. Those cases do not hold that providers have no rights. Providers have a right to be paid, of course, consistent with the Medicaid Act and state law. See, e.g., Dep't of Soc. Servs. v. Senior Citizens Nursing Home Dist. of Ray County, 224 S.W.3d 1, 14-16 (Mo. App. W.D. Feb. 13, 2007) (holding that Medicaid reimbursement must be paid pursuant to the plain language of the Department's regulations); Mo. Dep't of Soc. Servs. v. Great Plains Hosp., Inc., 930 S.W.2d 429, 431 (Mo. App. W.D. 1996). The Department's methodology for calculating

reimbursement affects that right, and the Department must follow notice and comment procedures when it implements such methodologies. The General Assembly specifically requires reimbursement decisions to be promulgated as rules, and this Court has previously so held. § 208.153.1; NME I, 850 S.W.2d at 74; Psychcare Mgmt., 980 S.W.2d at 313-14.

The Department's practical objections are also misplaced. The administrative burdens of complying with notice and comment procedures are not too great. The Department already follows those procedures. Since 1981, it has promulgated 94 regular amendments to the regulation at issue in this case, or approximately one change every three and a half months. 13 CSR 70-15.010; see L.F. 507-09. The Department makes frequent use of the emergency rulemaking procedures in § 536.025 when swifter action is required. Since 1981, the Department has promulgated 105 emergency amendments to the very regulation at issue in this case, or approximately one emergency change every three months. 13 CSR 70-15.010; see L.F. 507-09. The Department could have incorporated its methodology into one of those many rulemakings. The Department is not required to define the application of its regulations in every possible situation that may arise. Such a standard would, of course, be impossible. But, MAPA does require that, when the Department adopts a binding, uniform methodology for calculating payments to Medicaid providers, it must notify the public of that proposed methodology, allow for public comment, and notify the public of the final methodology. § 536.021, RSMo 2006. When such basic procedural protections are not afforded, important agency

decisions are made in the shadows and later enforced against individuals and entities like the Hospital with devastating effects.

At heart, the Department's argument is an implicit request for this Court to overrule NME I, claiming the decision is being used against it as a "sword" rather than "shield." Dept. Br. 55. The facts are to the contrary. The Hospital did not invoke NME I in SFY 2003 when it could have used the decision as a sword to retain the Medicaid reimbursement based on the Department's initial, higher estimate. The Hospital only resorted to litigation in SFY 2004 when the Department sought to withhold \$1.8 million in reimbursement based on a grossly inaccurate estimate of Medicaid days. NME I and MAPA shield providers from just this type of government overreaching. See, e.g., Senior Citizens Nursing Home District of Ray County, 224 S.W.3d 1, 17-18 (invoking NME I to shield a Medicaid provider from the Department's attempt to amend words out of its regulation by interpretation); Dep't of Soc. Servs. v. Mellas, 220 S.W.3d 778, 781 (Mo. App. W.D. 2007) (invoking MAPA to prevent the Department from effectively "entrapping" a Medicaid provider ). NME I is good law, and this Court should reaffirm that the Department must follow notice and comment procedures to change generally applicable Medicaid reimbursement policies.

The Department has raised the appropriate remedy for the MAPA violation in its fourth point relied on, and MHCA will address the remedy issue in responding to that argument.

**III. The Administrative Hearing Commission was not required to defer to the Department because the Department did not promulgate its methodology as a rule.**

**A. The Department’s third point relied on does not raise a justiciable argument and preserves nothing for judicial review.**

In its third point relied on, the Department makes an abstract argument that the AHC applied the wrong standard of review and should have deferred to its estimate of patient days. Dept. Br. 56. The Department’s point relied on does not articulate whether it is challenging a legal interpretation or factual finding of the AHC and does not identify the specific ground for judicial review (as specified in § 536.140, RSMo) that it is invoking. Id. Its supporting argument does little to illuminate the specific AHC error of which it is complaining or how that error led the AHC to make an incorrect decision in this case. In support of its third point relied on, the Department suggests that its days counting methodology did not involve an interpretation of law or a factual determination, but a third component of decisionmaking – the exercise of discretion – that is completely separate from finding facts or interpreting law. Dept. Br. 57-59. Apparently, the Department is arguing that its days counting methodology is an act of agency discretion and that the discretionary act commands the deference of the AHC and this Court. See id. Its point relied on does not present this argument. It is not clearly developed in the Argument section of the Brief and is not sufficient to preserve a claim of error for review. Crabtree v. Bugby, 967 S.W.2d 66, 72 (Mo. banc 1998). To the extent this Court

undertakes a review of this point, MHCA has attempted to discern the gravamen of the Department's concerns and respond to them as completely as possible.

**B. The Department must promulgate its Medicaid reimbursement policies as rules in order to receive deference.**

In discharging their duties, agencies of course have “discretion.” By assigning responsibility for a particular subject matter to one agency, the General Assembly intends for that agency to develop experience and expertise in that area which will result in more informed decisionmaking and greater administrative efficiency. See, e.g., Asbury v. Lombardi, 846 S.W.2d 196, 200 (Mo. banc 1993); State Tax Comm'n v. Admin. Hrg. Comm'n, 641 S.W.2d 69, 74 (Mo. banc 1982). Most agency decisions involve the exercise of some discretion. Few agency acts are ministerial. See, e.g., Green v. Lebanon R-III Sch. Dist., 13 S.W.3d 278, 284 (Mo. banc 2000).

Consistent with any limits in their organic statutes, agencies may generally discharge their responsibilities and exercise their discretion in two ways. First, they can prescribe general standards for the public. If the agency wants the standard to have binding legal effect, it must follow MAPA's rulemaking requirements. §§ 536.010-.050, RSMo 2000 & Supp. 2006. If MAPA is not followed, the “rule” has no effect. See, e.g., § 536.021.7, RSMo Supp. 2006. Second, the agency may discharge its responsibilities by making decisions in individual cases that involve the application of law to a specific set of facts. Advisory opinions, licensing decisions, and enforcement actions are examples of such individualized decisions. When such actions are reviewed by the AHC, the AHC announces the decision of the agency. See, e.g., J.C. Nichols v. Dir. of Revenue, 796

S.W.2d 16, 20 (Mo. banc 1990). On appeal, the AHC is deferred to as the finder of fact. See, e.g., Psychcare Mgmt., 980 S.W.2d at 312. If the agency adjudicates its own disputes, it acts as the finder of fact and receives the deference afforded to the fact finder during judicial review. See, e.g., KV Pharm. v. Mo. State Bd. of Pharmacy, 43 S.W.3d 306, 310 (Mo. banc 2001) (noting that the licensing board determines the appropriate sanction in licensure case and therefore receives the deference afforded the finder of fact).

**C. The Administrative Hearing Commission is not required to defer to unpromulgated agency policies.**

In this case, the Department made a generally applicable policy determination concerning the methodology for estimating days. Section 208.153 specifically gives the Department discretion to implement Medicaid reimbursement policy. However, that statute does not allow the Department to implement policy in any way it deems fit. Rather, the General Assembly has specified the manner in which the Department must exercise its discretion: it must promulgate Medicaid reimbursement policies as rules and regulations. §§ 208.153, 536.021, RSMo 2000 & Supp. 2006. Contrary to the Department's contention, the AHC did not fault the Department for exercising its discretion. L.F. 816. The AHC faulted the Department because its interpretation was not promulgated as a rule. Id.

This Court and the AHC review questions of law de novo. Psychcare Mgmt., 980 S.W.2d at 312. They do not defer to agencies on questions of law. Id. If an agency does not promulgate its interpretation as a rule, the interpretation is “merely an expression of

the [agency's] interpretation of law without any force or legal effect." United Pharmacal, 159 S.W.3d at 365. Accordingly, the AHC properly refused to defer to the agency's unpromulgated interpretation of its rule.

Federal courts follow a much different interpretative model than in Missouri. They apply the Chevron test to determine whether an agency rule is a reasonable interpretation of a statute. Chevron U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837, 843-45 (1984). Informal agency interpretations not promulgated as rules may also receive deference commensurate with the persuasiveness of the interpretations. United States v. Mead Corp., 533 U.S. 218, 234-35 (2001) (citing Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944)). In Missouri, agencies do not receive deference unless they follow notice and comment procedures. See, e.g., United Pharmacal, 159 S.W.3d at 365. To the extent the Department relies on federal principles of deference to unpromulgated agency policies, those cases have no application in Missouri.

Over the years, the courts have frequently rebuffed the Department for attempting to enforce unpromulgated legal interpretations against the public. See, e.g., NME I, 850 S.W.2d at 74; Psychcare Mgmt., 980 S.W.2d at 313-14; McNeil-Terry, 142 S.W.3d at 834. Far from warranting deference, this history shows the public benefit that accrues when the AHC and courts independently review the actions of the Department. In a case decided only a few months ago, the Department interpreted its nursing home reimbursement regulation as if the words "prior to July 1, 1994" had "been completely removed" from that regulation. Dep't of Soc. Servs. v. Senior Citizens Nursing Home Dist. of Ray County, 224 S.W.3d 1, 17-18 (Mo. App. W.D. 2007) . The Department then

argued that this interpretation of its own regulation was entitled to deference, attempting to amend words out of its regulation by interpretation. *Id.* at 14-16. Judge Ellis rejected that argument noting that the Department’s “vague or even inept drafting” did not entitle it to “simply read the language out of the regulation.” *Id.* at 18. Accordingly, contrary to the Department’s plea for deference to its attempt to amend its regulation by interpretation, the Court gave effect to the plain language of the rule. *Id.* at 18-19. Likewise, in this case, the AHC was not required to defer to the Department’s unpromulgated reimbursement standard. The AHC’s attempt to enforce that standard to the detriment of the Hospital violated MAPA and was rightly rejected by the AHC.

**D. The Administrative Hearing Commission stands in the shoes of the agency and remakes its decision.**

As noted above, the days counting methodology is a generally applicable statement of policy and therefore should be reviewed under the standards for rules. However, the Department contends it is a “decision” that happens to apply to a group of 140 hospitals. Its Brief contains extensive discussion of the AHC’s role in reviewing the Department’s factual determinations, and seems to argue that the AHC must defer to the agency’s factual decisions. The Department is very concerned with the recent case of Department of Social Services v. Mellas, where both the AHC and Court of Appeals refused to allow the Department to invoke its “discretion” to justify the entrapment of a Medicaid provider representing himself pro se.

In Mellas, the Department instructed a provider to bill using the wrong code and had rejected his claims when he billed using the correct code, which resulted in the

provider being overpaid. Dep't of Soc. Servs. v. Mellas, 220 S.W.3d at 780. The AHC ordered the provider to return the 60 percent of the overpayments attributable to the federal government. Id. But, it held that the provider should not be required to repay the 40 percent state share of the payments. Id. On appeal, the Department argued that the AHC was legally required to defer to its decision to recoup the entire amount. Id. Judge Spinden noted it is settled law that the AHC stands in the shoes of the agency and remakes its decision. Id. at 782-83. He approved of the AHC's independent decision in the case. Id. In fact, the Department's attempt to shift the costs of its wrongful actions to the individual provider was "untenable": "If this were a criminal case, we would consider the department's action to be entrapment." Id. at 781 (emphasis added).

Mellas followed settled principles of Missouri administrative law, as expressed by this Court. Independent review of Missouri agency decisions is not an accident of law, but a conscious policy decision. The importance that Missourians attach to independent review is reflected in the constitutional right to "direct review by the courts" of agency decisions. Mo. Const. art. V, § 18. More importantly here, the General Assembly has created the AHC as a separate administrative tribunal, where litigants and agencies may adjudicate their disputes. Chapter 621, RSMo 2000 & Supp. 2006. See generally State Tax Comm'n, 641 S.W.2d at 74-75. When the General Assembly has provided for AHC review, the AHC is permitted and, in fact, required to provide independent review. J.C. Nichols, 796 S.W.2d at 20; State Tax Comm'n, 641 S.W.2d at 74-75. In such cases, the agency and private litigants must persuade the AHC of the proper facts. Geriatric Nursing Facility, Inc. v. Dep't of Soc. Servs., 693 S.W.2d 206, 209 (Mo. App. W.D.

1985). The AHC then announces the decision of the agency. J.C. Nichols, 796 S.W.2d at 20; Geriatric Nursing Facility, 693 S.W.2d at 209. In doing so, it exercises any discretion that the agency may have. Mellas, 220 S.W.3d at 781; State Bd. of Registration for the Healing Arts v. Finch, 514 S.W.2d 608, 615 (Mo. App. 1974). These legal standards expressly apply when the AHC reviews Medicaid reimbursement decisions pursuant to §§ 208.156 and 621.055. Geriatric Nursing Facility, 693 S.W.2d at 209 (quoted with approval by J.C. Nichols, 796 S.W.2d at 20).

Thus, Missouri law stands in stark contrast to jurisdictions following the federal agency model, where private litigants may have to litigate through multiple layers of administrative bureaucracy before obtaining judicial review and where disputes between the public and an agency are first adjudicated by the agency – not a separate, independent administrative tribunal. State Tax Comm’n, 641 S.W.2d at 74-75. In that type of system, the agency may administratively establish a policy, enforce that policy against members of the public, represent itself in disputes with members of the public concerning that policy, and act as the arbiter of the dispute. Id. This commingling of functions raises substantial questions of fairness and effective administration from members of the public. Id. The citizens of Missouri have specifically rejected this system, in favor of direct judicial review and a separate administrative tribunal. Id.

Here, the AHC had specific jurisdiction over the Medicaid reimbursement dispute between the Hospital and the Department. §§ 208.156, 621.055, RSMo 2000 & Supp. 2006. The Hospital had the burden of proving disputed factual issues by a preponderance of the evidence. § 621.055, RSMo Supp. 2006. The Department, however, was not

entitled to the benefit of an additional thumb on the scales in its favor. The AHC stood in the shoes of the agency and rendered its decision. The Department was obligated to use its administrative expertise to persuade the AHC that the facts were as it had found them. Instead, the Department offered its unpromulgated methodology, and the AHC properly refused to enforce the methodology against the Hospital. L.F. 795, 815.

This case shows that the AHC exists with good reason. Unfortunately, agencies cannot be completely trusted. They may be blinded by their own misguided intentions and go so far as to entrap the public they are supposed to be protecting. See, e.g., Mellas, 220 S.W.3d at 781. Independent AHC review provides a check on agency overreaching. This Court should not disrupt settled Missouri law by analogizing to federal court cases that are inapposite and do not apply to Missouri's administrative system. The Department must support its factual findings by their persuasiveness and not by blind pleas for deference.

**IV. The Administrative Hearing Commission properly calculated the Hospital's reimbursement without giving effect to the SFY 2004 methodology change.**

**A. Standard of Review**

The standard of review for this point relied on is the same standard set forth for the first point relied on.

**B. The Hospital should be reimbursed according to the SFY 2003 methodology.**

The specific policy change being challenged in this lawsuit was the change in methodology between SFY 2003 and SFY 2004. That policy change was void and had

no effect because it was not promulgated pursuant to notice and comment procedures. In the past when the courts have found the Department at fault for following an unpromulgated rule to reimburse providers insufficiently, the remedy for the provider has been to revert to the preceding, validly promulgated rule. NME I, 850 S.W.2d at 74-76; Mo. Dep't of Soc. Servs. v. Great Plains Hosp., Inc., 930 S.W.2d 429, 437-39 (Mo. App. W.D. 1996). In the instant case, however, the Department's methodology has never been promulgated as a rule. L.F. 805. Based on these facts, the AHC properly concluded that the remedy was to determine the Hospital's reimbursement pursuant to the Department's SFY 2003 methodology.

Such a result is logical and fair. It results in estimated days for the Hospital within 82 days of its actual days of service. L.F. 804. The Department complains that the SFY 2003 policy was not promulgated as a rule either, and that it cannot be used as a valid benchmark for determining the Hospital's reimbursement. Dept. Br. 72-74. The Department – due to convenience, oversight, or incorrect legal judgment – decided not to promulgate its methodology for estimating days. In fact, its historical practice has quite likely been unlawful. The fact that the unlawful practice continued over a number of years does not legitimize it. See State ex rel. Ashcroft v. Blunt, 813 S.W.2d 849, 854 (Mo. banc 1991) (“[A]ny custom or practice contrary to law is ineffective and cannot be binding precedent.”). Many unlawful decisions go unchallenged because they are unnoticed, have little practical impact, or the costs of litigating them would be excessive. Few litigants can shoulder the cost and burden of litigation to vindicate a technical legal point. The Department cannot use a long history of noncompliance to defeat the

Hospital's claim for relief. Moreover, the Department cannot disavow its SFY 2003 methodology when it recouped \$2.23 million from the Hospital and its predecessor on the basis of that methodology. The proper remedy is to invalidate the SFY 2003/SFY 2004 policy change, reverting to the SFY 2003 policy.

**Conclusion**

This Court should AFFIRM the decision of the AHC.

Respectfully submitted,

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**CERTIFICATE OF COMPLIANCE WITH RULE 84.06(g)**

The undersigned certifies:

1. That this Brief complies with Rule 84.06(g) of this Court; and that this Brief contains 10,849 words according to the word count feature of Microsoft Word 2002 SP3 software with which it was prepared.
2. That the disks accompanying this Brief have been scanned for viruses, and to the best of his knowledge are virus-free.
3. That this Brief meets the standards set out in Mo. Civil Rule 55.03.

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**CERTIFICATE OF SERVICE**

The undersigned does hereby certify that a copy of the foregoing Brief and a diskette with the text of the Brief were served on this 8th day of August, 2007, by the following methods to the following individuals:

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