

**IN THE  
SUPREME COURT OF MISSOURI**

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**SC92015**

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**MERCY HOSPITALS EAST COMMUNITIES,  
Appellant,**

**vs.**

**MISSOURI HEALTH FACILITIES REVIEW COMMITTEE,  
Respondent,**

**JAMES K. TELLATIN,  
Respondent,**

**PATIENTS FIRST COMMUNITY HOSPITAL,  
Intervenor/Respondent.**

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**Appeal from the St. Louis County Circuit Court  
The Honorable Richard C. Bresnahan, Judge**

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**SUBSTITUTE BRIEF OF RESPONDENTS**

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## STATEMENT OF FACTS

### Introduction

Appellant Mercy Hospitals East Communities (f/k/a St. John's Mercy Health System) ("Mercy") is a not-for-profit Missouri corporation that operates Mercy Hospital St. Louis in Creve Coeur, Missouri, and Mercy Hospital Washington in Washington, Missouri. (L.F. 6). Respondent Missouri Health Facilities Review Committee ("MHFRC") is the state agency whose responsibilities include reviewing, approving, and disapproving all applications for certificate of need (L.F. 64) pursuant to §§ 197.300 to 197.366 of the Revised Statutes of Missouri, the Certificate of Need Law. *See* § 197.300, RSMo.<sup>1</sup> Respondent Edna Talboy is the Chair<sup>2</sup> of MHFRC and is a party in her official capacity. (L.F. 7). Respondent-Intervenor Patients First Community Hospital ("Patients First") is a Missouri non-profit corporation. (L.F. 15).

### Procedural History

On April 9, 2010, Patients First submitted a request to MHFRC for a non-applicability determination for a proposed three-bed hospital located in

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<sup>1</sup> All statutory references are to the Revised Statutes of Missouri 2000, unless otherwise noted.

<sup>2</sup> Formerly Gordon L. Kinne at the time Mercy filed its First Amended Petition for Declaratory Judgment, Injunctive Relief, and Writ of Prohibition, and James K. Tellatin at the time Mercy filed its Notice of Appeal. (L.F. 6).

Washington, Missouri. (L.F. 29-38). Patients First submitted its request after four of its cardiologists had their staff privileges revoked at Mercy Hospital Washington. (L.F. 61-62). Patients First estimated the cost to complete the hospital to be \$953,750.00. (L.F. 31). A non-applicability determination would mean that the three-bed hospital proposed by Patients First would not require a certificate of need from MHFRC. (L.F. 31-33).

On May 7, 2010, Mercy filed its Petition for Declaratory Judgment, Injunctive Relief, and Writ of Prohibition with the Circuit Court of St. Louis County, Missouri. (L.F. 1). On July 30, 2010, Mercy filed its First Amended Petition for Declaratory Judgment, Injunctive Relief, and Writ of Prohibition. (L.F. 6-63). In its amended petition, Mercy sought: 1) to have 19 CSR 60-50.400 (hereinafter, “New Hospital Rule”) and other regulations of MHFRC declared invalid and enjoined; 2) a declaration that all new hospitals, including the three-bed hospital proposed by Patients First, required a certificate of need and that MHFRC cannot determine that a proposed new hospital does not require a certificate of need; 3) an award of attorney’s fees; and 4) preliminary and permanent writ against MHFRC. (L.F. 20-23; 24-27). In August 2010, both Patients First and MHFRC and its Chair filed respective motions to dismiss. (L.F. 77-79, 104-109). Additionally, MHFRC and its Chair filed their Motion for Judgment on the Pleadings. (L.F. 110-112).

Based on the parties’ pleadings, on September 8, 2010, the St. Louis County Circuit Court issued its Order and Judgment. (L.F. 186-190). In its Order

and Judgment, the Court found that no justiciable controversy existed and that Mercy's case was not ripe for judicial determination. (L.F. 187). The Court further disagreed with Mercy's interpretation of § 197.305, RSMo, and how it applied to a new hospital. (L.F. 188).

On October 18, 2010, Mercy filed its Notice of Appeal and sought review of the trial court's Order and Judgment with the Court of Appeals, Eastern District. (L.F.191-193). On July 26, 2011, the Court of Appeals reversed the trial court on the issue of ripeness and justiciability, but held that the New Hospital Rule is valid because it is consistent with statutory authority. (App. A-13). As a result, the Court of Appeals dismissed with prejudice Mercy's First Amended Petition for Declaratory Judgment, Injunctive Relief, and Writ of Prohibition. (App. A-13).

On or before April 1, 2011, construction was completed on Patients First's three-bed hospital located in Washington, Missouri. (App. A-27).

## STANDARD OF REVIEW

“The question presented by a motion for judgment on the pleadings is whether the moving party is entitled to judgment as a matter of law on the face of the pleadings.” *RGB2, Inc. v. Chestnut Plaza, Inc.*, 103 S.W.3d 420, 424 (Mo. App. S. D. 2003). “The well-pleaded facts of the non-moving party’s pleading are treated as admitted for purposes of the motion.” *Eaton v. Mallinckrodt, Inc.*, 224 S.W.3d 596, 599 (Mo. banc 2007). Review is *de novo* because judgment on the pleadings addresses an issue of law. *Cures Without Cloning v. Pund*, 259 S.W.3d 76, 80 (Mo. App. W.D. 2008). The interpretation and construction of a statute by an agency charged with its administration is entitled to great weight. *Foremost-McKesson, Inc. v. Davis*, 488 S.W.2d 193, 197 (Mo. banc 1997), quoting *Federal Trade Comm’n v. Mandel Bros., Inc.*, 359 U.S. 385, 391 (1959).

## ARGUMENT

**I. Mercy’s “as applied” challenges to the New Hospital Rule were not ripe at the time and are not challenges for which Mercy has standing as a competitor. (Responds to Appellant’s Point I)**

“[A] challenge to the construction and application of an administrative regulation which requires a review of the facts relating thereto presents matters other than purely legal issues of constitutionality. Such a challenge requires exhaustion of administrative remedies to develop a factual record for review.” *Boot Heel Nursing Center, Inc. v. Missouri Dep’t of Social Services*, 826 S.W.2d 14, 16 (Mo. App. W.D. 1992). As applied, Mercy’s challenge to the New Hospital Rule required the trial court to determine whether the new hospital proposed by Patients First could be developed under one million dollars, including whether certain expenses in the development could be determined as capital expenditures. Mercy’s “as applied” challenge of the New Hospital Rule is an attempt to force judicial review of the factual basis for a decision by the MHFRC that had yet to be made at the time the Mercy filed its First Amended Petition. Because such a challenge requires an exhaustion of administrative remedies, it was premature and not ripe for consideration.

Additionally, Mercy lacks standing to challenge MHFRC’s decision to not subject Patients First’s project to certificate of need review. Competitors do not have standing to challenge a certificate of need decision by MHFRC. *Community Care Centers, Inc. v. Missouri Health Fac. Rev. Comm’n.*, 735 S.W.2d 13, 16

(Mo. App. W.D. 1987); *Mid-Am. Georgian Gardens, Inc. v. Missouri Health Fac. Rev. Comm'n.*, 908 S.W.2d 715, 717 (Mo. App. W.D. 1995); *PIA Psy. Hosps., Inc. v. Missouri Health Fac. Rev. Comm'n.*, 724 S.W.2d 524, 525 (Mo. App. W.D. 1986). “Generally speaking the ‘right’ to be free from legitimate competition is not a right at all and is certainly not one protected by law.” *St. Joseph’s Hill Infirmary, Inc. v. Mandl*, 682 S.W.2d 821 (Mo. App. E.D. 1984). Only the applicant has standing to challenge the MHFRC decision. § 197.335, RSMo.

Mercy’s “as applied” challenge required the trial court to delve into the facts underlying the dispute as to whether Patients First’s proposed project could be completed for under one million dollars. That is indistinguishable from an appeal from an MHFRC decision that certificate of need review is unnecessary. When Mercy complains that it should be protected “from unlawful competition” (L.F. 20), this alleged competition is “unlawful” only insofar as MHFRC determined facts incorrectly and concluded that Patients First’s project was not subject to certificate of need review, a challenge that is not available for a competitor like Mercy.

Mercy’s argument that the trial court erred in dismissing the action is based on the assumption that the trial court ruled only on Patients First’s motion to dismiss. Mercy ignores the fact that MHFRC filed a motion for judgment on the pleadings. (L.F. 110-112, 186). The trial court ruled on the motion for judgment on the pleadings when it denied Mercy request for a preliminary injunction and preliminary writ and dismissed the case at Mercy’s cost. (L.F. 186-190). If this

were not clear from the initial paragraph, the trial court spent three full pages upholding the various challenged rules, including the New Hospital Rule. (L.F. 187-190). By ruling on MHFRC's motion for judgment on the pleadings, the trial court was correct to reach the merits of the case.

Even if this Court were to agree with Mercy and conclude that the trial court ruled exclusively on Patients First's motion to dismiss and improperly ruled on the merits of this case, it appears a remand would be futile because the trial court ruled against Mercy. In cases where the trial courts err procedurally by deciding merits where they should not, courts of appeal have chosen to review the merits when a remand would be futile. *Clifford Hindman Real Estate, Inc. v. City of Jennings*, 283 S.W.3d 804, 808 (Mo. App. E.D. 2009). "[C]ourts of appeal may review the issue of law directly where the trial court's premature legal ruling effectively precludes the plaintiff from refiling the same cause of action; or in this case, effectively precludes any fresh look on remand." *State ex rel. Am. Eagle Waste Indus. v. St. Louis County*, 272 S.W.3d 336, 341 (Mo. App. E.D. 2008). Regardless of how the procedural posture of the trial court's judgment is viewed, the Court of Appeals correctly reviewed the issue of whether the New Hospital Rule is valid and properly ruled that the New Hospital Rule is consistent with its statutory authority. Slip. Op. at 13.

**II. The New Hospital Rule does not conflict with the certificate of need law. (Responds to Appellant's Point II)**

**A. Principles of Statutory Interpretation**

In interpreting statutes, courts must ascertain the intent of the legislature from the language used, give effect to that intent if possible, and to consider the words used in their plain and ordinary meaning. *Riordan v. Dierker*, 959 S.W.2d 258, 260 (Mo. banc 1997). “The cardinal rule of statutory construction is that the intention of the legislature in enacting the statute must be determined and the statute as a whole should be looked to in construing any part of it.” *J.S. v. Beaird*, 28 S.W.3d 875, 876 (Mo. banc 2000). In determining the intent and meaning of statutory language, the words must be considered in context and sections of the statutes *in pari materia*, as well as cognate sections, must be considered in order to arrive at the true meaning and scope of the words. *State v. McLaughlin*, 265 S.W.3d 257, 267 (Mo. banc 2008).

When the legislative intent cannot be ascertained from the language of the statute, by giving it its plain and ordinary meaning, the statute is considered ambiguous and the rules of statutory construction can be applied. *Habjan v. Earnest*, 2 S.W.3d 875, 881 (Mo. App. W.D. 1999). ““If the plain language of a statute creates ambiguity, the statute will be construed to avoid unreasonable or absurd results.”” *McKnight Place Extended Care v. Missouri Health Facilities Rev. Comm'tee*, 142 S.W.3d 228, 232 (Mo. App. W.D. 2004), quoting *J.S. v. Beaird*, 28 S.W.3d at 876. The doctrine of *in pari materia* is a cardinal tenet of

statutory construction. *Romans v. Dir. of Revenue*, 783 S.W.2d 894, 895 (Mo. banc 1990). The doctrine requires statutes relating to the same subject matter to be construed together even though the statutes may be found in different chapters and were enacted at different times. *Id.* at 896.

Where two statutory provisions covering the same subject matter are unambiguous standing separately but are in conflict when examined together, a reviewing court must attempt to harmonize them and give them both effect. *South Metro. Fire Protection Dist. v. City of Lee's Summit*, 278 S.W.3d 659, 666 (Mo. banc 2009). When two provisions are not irreconcilably inconsistent, both must stand even if some tension exists between them. *Turner v. School Dist. of Clayton*, 318 S.W.3d 660, 667 (Mo. banc 2010). If harmonization is impossible, a chronologically later statute, which functions in a particular way, will prevail over an earlier statute of a more general nature, and the latter statute will be regarded as an exception to or qualification of the earlier general statute. *South Metro.*, 278 S.W.3d at 666.

#### **B. The Two Statutes at Issue**

Mercy raises concerns over two statutes, § 197.305 and § 197.366, RSMo. In pertinent part, § 197.305 provides:

As used in sections 197.300 to 197.366, the following terms mean:

\* \* \*

(9) "New institutional health service":<sup>3</sup>

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;<sup>4</sup>

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (12) hereof costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

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<sup>3</sup> Section 197.315.1, RSMo, states: "Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered."

<sup>4</sup> For new institutional health services, the expenditure minimum means one million dollars in the case of capital expenditures, excluding major medical equipment. *See* § 197.305 (6)(c), RSMo.

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period[.]

Section 197.366 states:

The term "health care facilities" in sections 197.300 to 197.366 shall mean:

- (1) Facilities licensed under chapter 198;<sup>5</sup>
- (2) Long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012;<sup>6</sup>

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<sup>5</sup> Facilities licensed under Chapter 198 are residential care facilities I, residential care facilities II, immediate care facilities, and skilled nursing facilities. *See* § 198.066, RSMo.

<sup>6</sup> Hospitals described in § 198.012 are those hospitals licensed under Chapter 197, RSMo, and which are defined as a hospital in the traditional sense of care and

(3) Long-term care hospitals or beds in a long-term care hospital meeting the requirements described in 42 CFR, section 412.23(e);<sup>7</sup> and

(4) Construction of a new hospital as defined in chapter 197.

**C. Mercy’s Interpretation of §§ 197.305 and 197.366 Needlessly Creates Ambiguity between the Statutes**

Section 197.305(9) defines “new institutional health services” as being at least one of seven things, four of which cost a certain amount (subdivisions (a), (b), (c), and (d)) and three of which are a change in the amount of beds or services at a given facility (subdivisions (e), (f), and (g)). Section 197.366 defines “health care facilities” as constituting residential care, immediate care, skilled nursing, long-term care beds, long-term care hospitals, or the construction of a new hospital. When reading the language of § 197.305(9) and § 197.366, individually, it is evident that the plain and ordinary meaning of their words is unambiguous.

It is equally unambiguous to apply subdivision (a), which explicitly refers to new health care facilities, to a new hospital. In doing so, subdivision (a) could mean the “development of a...new hospital costing in excess of the applicable expenditure minimum.” Except for the redundancy of the term “new,” the provision reads logically, there is no ambiguity, and the two statutes can be

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length of stay. *See* § 197.020.2, RSMo.

<sup>7</sup> The requirements of 42 CFR § 412.23(e) primarily relate to patient length of stay.

harmonized. This is not the case with subdivisions (e), (f), and (g) as the language contained in these provisions creates illogical effects if they refer to a new hospital.<sup>8</sup> Slip Op. at 11. Mercy's insistence that these provisions apply to new hospitals creates ambiguity between the statutes, at the peril of subdivision (a).

Except for subdivision (d), all of the subdivisions in § 197.305(9) use the term "health care facility." As that term is used in these subdivisions, there is no conflict or ambiguity so long as "health care facility" refers to any of the facilities in § 197.366, except a new hospital (e.g. subdivision (e) could mean any "change in licensed bed capacity of a skilled nursing facility which increases the total number of beds by more than ten..." or subdivision (f) could mean health "services...which are offered in a long-term care hospital and which were not offered on a regular basis in such long-term care hospital within the twelve-month period prior..."). Conflict and ambiguity arise in these provisions when the term "health care facility" refers to a new hospital.

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<sup>8</sup> Mercy devotes a portion of its brief to analyzing how the express terms of § 197.305(9) also indicate that subdivisions (b), (c), and (d) apply to new hospitals and thus render the New Hospital Rule invalid because the rule does not address these subdivisions. *Appellant's Br. 20-22*. Mercy's analysis fails to acknowledge that the costs referenced in these subdivisions would be included in the expenditure minimum cost indicated for new hospitals in subdivision (a). Consequently, subdivisions (b), (c), and (d) do not apply to new hospitals.

Subdivision (g), on its face, is illogical if it refers to a new hospital: “A reallocation by an existing new hospital of licensed beds....” By definition, a hospital that already exists is not “new.” Subdivisions (e) and (f) become illogical by their own terms, as well as their effect on subdivision (a), if they refer to a new hospital.

Subdivision (e) would read: “Any change in licensed bed capacity of a new hospital which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period.” The terms “change” and “increases” imply an existing status, which by definition a new hospital cannot have. Also, a new hospital, by definition, does not exist for a two-year period prior to becoming “new.” And further, because a new hospital would have no beds prior to existing, any reference to a ten percent change<sup>9</sup> in beds defies the logic of mathematics.

Subdivision (f) would read: “Health services...which are offered in a new hospital and which were not offered on a regular basis in such new hospital within the twelve-month period prior to the time such services would be offered.” Again, the phrases “which were not offered” and “within the twelve-month period prior” imply an existing status, which as mentioned a new hospital does not have.

Additionally, if subdivisions (e), (f), and (g) were interpreted to apply to

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<sup>9</sup> Subdivision (g) also refers to a “reallocation of licensed beds...more than ten percent.”

new hospitals despite the aforementioned illogical problems, the effect of such an interpretation would be an unreasonable or absurd result that would render subdivision (a) meaningless as every new hospital would have an increase in beds or services and there would be no need to consider whether a new hospital cost more than the expenditure minimum.

**D. Even if Mercy’s Interpretation of §§ 197.305 and 197.366 Is Correct, in Order to Give Effect to Both Statutes, § 197.305 Prevails over § 197.366**

Mercy argues that neither the trial court nor the court of appeals acknowledged the standard this Court adopted in *Turner* and found irreconcilable inconsistency between § 197.305 and § 197.366. *Appellant’s Br. 14*. Mercy argues that the trial court and the court of appeals cited “three alleged conflicts between the statutes” that are present in subdivisions (e), (f), and (g) of § 197.305(9). *Appellant’s Br. 17-18*. Mercy contends, however, that the conflicts in these subdivisions amount to nothing more than “some tension” and are “reconcilable to the extent they exist.” *Appellant’s Br. 19*. Mercy’s argument is flawed.

In contending that the aforementioned subdivisions are reconcilable, Mercy focuses on each one independently and concludes that there is little to no conflict in each subdivision. But Mercy fails to address the effect its analysis has on subdivision (a), which renders it meaningless. Under the interpretation proposed by Mercy, there is no need to determine, per subdivision (a), whether a new

hospital costs less than the expenditure minimum because all new hospitals would be subject to certificate of need review as they would have changes in their number of beds or changes in their services, per subdivisions (e), (f), and (g).

Each word or phrase in a statute must be given meaning, if possible. *State v. Blocker*, 133 S.W.3d 502, 504 (Mo. banc 2004). Courts do not presume the legislature to enact meaningless provisions. *E & B Granite, Inc. v. Dir. of Revenue*, 331 S.W.3d 314, 317 (Mo. banc 2011), quoting *Kilbane v. Dir. of Revenue*, 544 S.W.2d 9, 11 (Mo. banc 1976). Rendering subdivision (a) meaningless is hardly “some tension” between § 197.305 and § 197.366. It is an absurd result that constitutes irreconcilable inconsistency between the statutes. Courts must construe statutes beyond their simple text when the direct application of the plain language would create an absurd result. Slip Op. at 12, citing *United Pharmacal Co. of Missouri v. Missouri Bd. of Pharmacy*, 208 S.W.3d 907, 912 (Mo. banc 2006).

Citing the *McKnight* decision, Mercy argues that applying only subdivision (a) to new hospitals “effectively writes out the other six definitions of ‘new institutional health service’ from the statute. *Appellant’s Br.* 27. As explained above, except for new hospitals, the remaining definitions of “health care facility,” per § 197.366, can be read into § 197.305 without leading to absurd or unreasonable results. Doing so by no means writes out the other six subdivisions of the statute.

Mercy argues that even if there is conflict among these subdivisions, the

later-enacted statute must prevail. *Appellant's Br. 19*. Mercy, however, mistakenly believes that § 197.366 is the more recently enacted statute. *Id*; Slip Op. at 12. In 1996, § 197.366 was repealed and, in lieu thereof, a new § 197.366 was enacted, resulting in the present language of the statute that greatly reduced which entities constitute a health care facility. (App. A-28). In 1997, § 197.305 was repealed and, in lieu thereof, a new § 197.305 was enacted, resulting in the present language of the statute that reflects the development of new health care facilities costing in excess of the expenditure minimum requiring certificate of need review.<sup>10</sup> (App. A-30). Furthermore, the more specific statute must prevail

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<sup>10</sup> Mercy also raises the point that after the legislature amended § 197.305 in 1997, the law allowed facilities such as ambulatory surgical centers to be built without a certificate of need if they cost less than the expenditure minimum. *Appellant's Br. 25*. Mercy argues that this “was most plausibly an accommodation to the soon-to-be deregulated businesses” because until such facilities would be fully deregulated in 2002 (the effective date of § 197.366) “they would be allowed to build small facilities without obtaining a certificate of need.” *Id*. Mercy’s argument, unsupported by any evidence, defies logic and its own interpretation of these statutes. First, under its interpretation, such facilities would still require certificate of need review because they would have a change in beds or an increase in services. Second, it is more plausible that existing hospitals wanted the freedom to expand their services without triggering review and so persuaded the legislature

over the general statute. *South Metro.*, 278 S.W.3d at 666. As the statute that applies the term “health care facility” and declares the thresholds for determining certificate of need review, § 197.305 is the more specific statute that must prevail over § 197.366. And language such as “increases,” “not offered on a regular basis...prior,” and “by more than...ten percent,” indicates a legislative intent that these provisions do not apply to new hospitals. Contrary to Mercy’s argument, § 197.305(9) trumps § 197.366 in resolving the conflict between these statutes.

Mercy also argues that the New Hospital Rule is in conflict with § 197.315, RSMo Supp. 2010. *Appellant’s Br.* 27. Specifically, Mercy contends that “(i)t makes little sense to allow a new hospital to be built without a certificate of need under the New Hospital Rule when it must obtain a certificate of need to be licensed pursuant to § 197.315.3. Mercy ignores the plain language of the statute in making its argument. Section 197.315.1 states: “Any person who proposes to develop or offer a *new institutional health service* within the state must obtain a certificate of need from the committee prior to the time such services are offered (emphasis added).” As already discussed, a new hospital costing less than the expenditure minimum does not constitute a new institutional health service. Therefore, it is implicit in § 197.315.3 that those health care facilities not required

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to amend § 197.305 to include the expenditure minimum threshold. This is evident in the fact that the Missouri Hospital Association testified in support of Senate Bill 373 when the bill was before legislative committee. (App. A-29).

to obtain a certificate of need will still be issued a license.

Finally, Mercy argues that interpreting § 197.305(9) in a way that excludes “new hospital” from subdivisions (e), (f), and (g) creates a loophole that would enable developers to add hospitals with no determination of need. *Appellant’s Br.* 24. Mercy contends that “such a result is inconsistent with the cost-control purpose of the [certificate of need] law.” *Id.* Again, Mercy’s argument is without merit.

Mercy correctly explains that the prior definition of “health care facility” under § 197.366 included a great number and variety of medical facilities, including health maintenance organizations, psychiatric hospitals, practical nursing facilities, and tuberculosis hospitals. *Appellant’s Br.* 25. When the legislature amended the statute in 1996, it limited the definition of “health care facility” to a handful of facilities, as discussed above. Those facilities that were removed from § 197.366 also were removed from the mandates of certificate of need review under § 197.305(9). Consequently, existing hospitals, like those owned by Mercy, can now expand beds or services and do so without being subject to certificate of need review.

The certificate of need program was intended to reduce unnecessary duplication in health care facilities and thereby reduce the cost of health care to consumers. *McKnight*, 142 S.W.3d at 233; *see also Missouri Health Facilities Review Comm. v. Admin. Hearing Comm’n of Missouri*, 700 S.W.2d 445, 445 (Mo. banc 1985). Historically, the certificate of need program stems from federal

legislation that mandated states adopt such programs in order to receive federal funding for Medicare and Medicaid. STAFF OF S. INTERIM COMM. ON CERTIFICATE OF NEED, REPORT OF THE SENATE INTERIM COMMITTEE ON CERTIFICATE OF NEED 5 (COMM. PRINT 2007). Since the federal legislation was repealed in 1986, many states have repealed their certificate of need programs or investigated the worthiness of keeping them. *Id*; see also Pamela C. Smith and Dana A. Forgione, *The Development of Certificate of Need Legislation*, J. HEALTH CARE FIN. 35 (Winter 2009).

The intent of the Missouri legislature is evident in the language it adopted, which greatly reduces the number of entities subject to review and defines the parameters of the certificate of need program by such thresholds as number of beds increased in an existing facility or the cost of a new facility. The General Assembly has concluded, consistent with the overall trend of states backing away from certificate of need regulation, that entities below these thresholds, including new hospitals built under the expenditure minimum, do not affect health care in a way that requires review. Mercy's talk of a "loophole" is a misnomer. The law results in what the legislature intended when it wrote and passed these statutes.

## CONCLUSION

For the foregoing reasons, this Court should affirm the trial court's judgment.

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**CERTIFICATION OF SERVICE  
AND OF COMPLIANCE WITH RULE 84.06(b) AND (c)**

I hereby certify that a true and correct copy of the foregoing was filed electronically pursuant to Rule 103 and Court Operating Rule 27 through Missouri Case Net, this 21<sup>st</sup> day of December 2011 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 4,868 words.

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