

IN THE SUPREME COURT OF MISSOURI

SC 89737

BEVERLY ENTERPRISES OF MISSOURI, INC., et al.,

Appellants,

v.

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

Respondent.

**Appeal from the Circuit Court of Cole County
State of Missouri
The Honorable Byron L. Kinder**

AMICI CURIAE BRIEF

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INTEREST OF AMICI CURIAE

The *amici curiae*, collectively referred to as the "Missouri Associations" or the "*amici curiae*," are the Missouri Association of Osteopathic Physicians and Surgeons; the Missouri Pharmacy Association; and the Missouri State Medical Association.

The **Missouri Association of Osteopathic Physicians and Surgeons** ("MAOPS") is a Missouri non-profit corporation in good standing with the state of Missouri. MAOPS is a professional membership association of licensed Missouri osteopathic physicians and surgeons, and is headquartered in Jefferson City, Missouri. MAOPS has more than 1,800 member physicians, surgeons, and osteopathic medical students. MAOPS represents its members' interests before the state legislature, state agencies, and state courts.

The **Missouri Pharmacy Association** ("MPA") is a professional society representing Missouri pharmacists, united to improve public health and patient care, enhance professional development, and advocate the interests of the profession. MPA has approximately 1,200 members and is located in Jefferson City.

The **Missouri State Medical Association** ("MSMA") is a Missouri non-profit organization of physicians and medical students. MSMA serves its members through the promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri. MSMA has approximately 6,000 members and is located in Jefferson City, Missouri. MSMA represents its members' interests before the state legislature, state agencies, and state courts.

The Missouri Associations represent individuals and entities that participate in the Missouri Medicaid program, and are therefore directly affected by the Medicaid

reimbursement rates set by the Missouri Department of Social Services, Division of Medical Services (hereinafter “the Department”). Because the Missouri Associations represent primary care providers who treat Medicaid patients and act as consultants for nursing facilities, they are familiar with the issues at hand. This appeal challenges actions taken by the Department which improperly decreased Medicaid reimbursement rates for all nursing facilities in Missouri. The Missouri Associations have an interest in the Department’s ability to cut Medicaid reimbursement rates arbitrarily, and are concerned that, if the Circuit Court’s decision is affirmed, the Department will have a precedent to follow for further rate cuts for other Medicaid programs and facilities, including those in which their members participate. The Missouri Associations assert that insufficient reimbursement rates, such as the ones imposed by the Department in this case, adversely impact providers’ ability to deliver quality health care to Missouri Medicaid patients. Medicaid rate cuts reduce health care provider participation in Medicaid, and increases costs to the health care system, thereby negatively impacting patients’ access to care. The Missouri Associations urge this Court to reverse the decision of the Circuit Court, and find that the Department’s process in promulgating the rules challenged herein was arbitrary and capricious and violated §§ 208.152.1 and 208.152.8 RSMo 2000 & Supp. 2008 and 13 CSR 70-10.015(3)(O), and threaten providers’ ability to provide quality care. Both parties consented to the Missouri Associations’ request to file this *amici curiae* brief.

JURISDICTIONAL STATEMENT

This appeal arises from a decision of the Administrative Hearing Commission (the “Commission”) that aggrieved both parties. Both parties petitioned the Circuit Court for judicial review, and that Court then decided the issues in favor of the Department. Appellants Beverly Enterprises-Missouri, Inc. et al. (hereinafter collectively referred to as “Beverly”) filed the only notice of appeal. This Court sustained Beverly’s transfer application after opinion by the Court of Appeals. Accordingly, this Court has jurisdiction. Mo. Const. art. V, § 10.

Statement of Facts

The *Amici Curiae* set forth a brief summary of the procedural facts below, and otherwise hereby adopt and incorporate by reference the Statement of Facts contained in Beverly's Brief.

In July 2004, the Department promulgated an emergency amendment to implement SB 1123, which called for the recalculation of Medicaid rates for nursing facilities that had a prospective rate as of June 30, 2004. This emergency amendment increased the reimbursement rates for all Medicaid-participating nursing facilities, using a 73% minimum utilization adjustment¹ for the capital cost component and no minimum utilization adjustment rate for the administration cost component. P. Ex. 148 at (20)(A)(6), (7).² The Department lacked appropriation authority to fully fund the new

¹ Pursuant to 13 CSR 70-10.010(7)(O), if a facility's occupancy rate is below a certain percentage set by the Department (the minimum utilization percentage, which is referenced in this brief as 73% or 85%), the per patient day rate for that facility will be adjusted as if the facility was occupied at the minimum utilization rate.

² Citations to Petitioner Beverly's exhibits in the proceedings below will be listed as "P. Ex. [exhibit number]"; citations to the parties' joint stipulation of facts will be listed as "J. Stip. Para [paragraph]"; citations to the transcript of the proceedings before the Commission shall be listed as "Tr. [page], [line]"; citations to the parties' joint legal file will be listed as "J. LF [page]"; and citations to the Department's brief to the Circuit Court shall be listed as "Cross-Petitioner's Legal Brief [page]."

rates, so, in March 2005, it filed emergency and proposed amendments, which again rebased the Medicaid reimbursement rates. 13 CSR 70-10.015; J. Ex. 4; Tr. 704, l. 3-21. This second rebase increased the minimum utilization adjustment for the administration and capital cost components to 85%, thus decreasing reimbursement rates. J. Stip. Para. 66. The Department published the amendment as a final rule on August 15, 2005. J. Ex. 6; J. Stip. Para 74. Beverly filed a complaint with the Commission challenging the Department's decision to promulgate the emergency and final rules which increased the minimum utilization adjustment to 85%. J. LF 160. The Commission ordered the Department to recalculate the administration cost component of Beverly's rates without using a minimum utilization adjustment. J. LF 275. The Department appealed to the Cole County Circuit Court, which reversed and entered judgment in favor of the Department. J. LF 114.

Beverly appealed the Circuit Court's decision to the Missouri Court of Appeals, challenging the Circuit Court's decision to uphold the emergency and final rules. The Department filed a cross-appeal, in which it argued that the Commission erred when it ordered the Department to recalculate the administration cost component of Beverly's rates; and when it held that an offer of proof made by the Department was not relevant. The Missouri Court of Appeals, Western District, treated the Circuit Court decision as a declaratory judgment, and affirmed the Circuit Court's decision. Slip. Op. 2, 8-9 and 27. Beverly filed an Application for Transfer with this Court, which was granted.

POINT RELIED ON

I. THE CIRCUIT COURT ERRED IN UPHOLDING THE 2005 EMERGENCY AND PROPOSED AMENDMENTS BECAUSE, BASED ON THE FACTUAL FINDINGS OF THE COMMISSION, THESE AMENDMENTS WERE NOT BASED ON REVIEWS, STUDIES, COST INFORMATION OR OTHER OBJECTIVE DATA, BUT RATHER ENTIRELY ON BUDGETARY CONCERNS, AND, THEREFORE, WERE ARBITRARY, CAPRICIOUS, AND UNREASONABLE; IN VIOLATION OF §§ 208.152.1 AND 208.152.8 RSMO 2000 & SUPP. 2008 AND THE DEPARTMENT'S OWN REGULATION, 13 CSR 70-10.015(3)(O); AND THREATEN THE PROVIDER'S ABILITY TO PROVIDE QUALITY CARE.

Section 208.152.1 RSMo 2000 & Supp. 2008

Section 208.152.8 RSMo 2000 & Supp. 2008

13 CSR 70-10.015(3)(O)

Motor Vehicle Mfrs. Ass'n of the United States, Inc. v. State Farm Mut.

Auto. Ins. Co., 463 U.S. 29 (1983)

ARGUMENT

I. THE CIRCUIT COURT ERRED IN UPHOLDING THE 2005 EMERGENCY AND PROPOSED AMENDMENTS BECAUSE, BASED ON THE FACTUAL FINDINGS OF THE COMMISSION, THESE AMENDMENTS WERE NOT BASED ON REVIEWS, STUDIES, COST INFORMATION OR OTHER OBJECTIVE DATA, BUT RATHER ENTIRELY ON BUDGETARY CONCERNS, AND, THEREFORE, WERE ARBITRARY, CAPRICIOUS, AND UNREASONABLE; IN VIOLATION OF §§ 208.152.1 AND 208.152.8 RSMO 2000 & SUPP. 2008 AND THE DEPARTMENT'S OWN REGULATION, 13 CSR 70-10.015(3)(O); AND THREATEN THE PROVIDER'S ABILITY TO PROVIDE QUALITY CARE.

Standard of Review

Questions of law are reviewed *de novo*. Psychiatric Healthcare Corp. of Mo. V. Dep't of Soc. Servs., 100 S.W.3d 891, 899 (Mo. App. W.D. 2003). Regulations are interpreted according to the same principles as statutes. Dep't of Soc. Servs., Div. of Med. Servs. v. Senior Citizens Nursing Home District of Ray County, 224 S.W.3d 1, 9 (Mo. App. W.D. 2007). When interpreting regulations, the words must be given their plain and ordinary meaning, and the Court assumes that absurd results were not intended. Id. at 9-10. However, the Commission's findings of fact will be reversed only if they are not supported by substantial and competent evidence. Psychare Mgmt., Inc. v. Dep't of

Soc. Servs., 980 S.W.2d 311, 312 (Mo. banc 1998). “The temptation to substitute the Court’s judgment on factual matters for the Commission’s fact-finding must be resisted.”

Id.

A. The Department’s Selection of an 85% Minimum Utilization Figure Was Arbitrary, Unreasonable, and Capricious.

In Motor Vehicle Mfrs. Ass’n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29 (1983), the United States Supreme Court established a standard to determine when an agency’s decision to promulgate or rescind a regulation is arbitrary and capricious.

Motor Vehicle Mfrs. Ass’n involved a passive restraint regulation for automobiles, known as Modified Standard 208 (the “Standard”), passed by the National Highway Traffic Safety Administration (NHTSA) in 1977. Motor Vehicle Mfrs. Ass’n, 463 U.S. at 37. The Standard required automobile manufacturers to install “passive restraints” in new vehicles: restraints that do not require passenger action to take effect. Id. at 35. The Standard allowed manufacturers to choose between installing airbags or automatic seatbelts. Id. In 1981, the NHTSA rescinded the passive restraint requirement, on the basis that it no longer appeared that the automatic restraint requirement would yield significant safety benefits. Id. at 38. According to the NHTSA, automobile manufacturers planned to install automatic seatbelts in 99% of new cars. Id. at 38-39. The NHTSA also learned that passengers could permanently disable these automatic belts, thus removing the safety benefit. Id. In addition, the NHTSA learned that the overwhelming majority of automobile manufacturers had elected not to install airbags. Id. Finally, the NHTSA

noted that the Standard would cost \$1 billion to implement. Id. at 39. The NHTSA decided to rescind the Standard, on the ground that it was not reasonable to impose this cost on manufacturers and consumers without additional assurance that the financial burden would increase safety. Id.

The United States Supreme Court held that, when promulgating or rescinding a regulation, an agency must examine the relevant data and articulate a satisfactory explanation for its action, including a “rational connection between the facts found and the choice made.” Motor Vehicle Mfrs. Ass’n, 463 U.S. at 43, quoting Burlington Truck Lines v. United States, 371 U.S. 156 (1962). The Court considers whether the agency’s decision was based on “a consideration of the relevant factors and whether there has been a clear error of judgment.” Id. (internal citations omitted). An agency rule is arbitrary and capricious if:

...the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id.

The Supreme Court found that the NHTSA’s decision to rescind the Standard was arbitrary and capricious, because the NHTSA “gave no consideration whatsoever” to modifying the Standard to require use of airbag technology, and noted that, at the very least, the NHTSA should have addressed the airbag option and provided adequate reasons

for abandoning it. Motor Vehicle Mfrs. Ass'n, 463 U.S. at 46-48. The Supreme Court also noted that the safety benefits of seatbelts are well known, and no direct evidence supported the NHTSA's finding that automatic belts would not increase safety—in fact, the record showed that seatbelt usage doubles even with manual belts. Id. at 53. The Supreme Court additionally found that the NHTSA claimed to be concerned that automatic belts would not increase safety—but then failed to articulate a basis for why it did not require automatic belts that could not be disabled by passengers. Id. at 55. The Supreme Court held there was thus no “rational connection” between the available facts and the NHTSA's decision. Id. at 56.

Missouri courts have adopted similar guidelines for determining if state agency decisions are arbitrary and capricious. In Barry Service Agency Co. v. Manning, 891 S.W.2d 882 (Mo. App. W.D. 1995), the Director of Finance rejected lenders' proposed interest rate schedules for unsecured loans under \$500, as in violation of an emergency rule setting maximum rates. The Court held that the Director's decision was unreasonable, arbitrary, and capricious. Barry Service, 891 S.W.2d at 893. There was no evidence whatsoever that consumers could not afford or would not willingly borrow money at the lenders' proposed rates; in fact, there was contrary evidence. Id. at 892. Plus, the state of Missouri admitted it had “no real basis” to determine a fair profit margin; had “no precise figure or range of figures in mind,” yet “thought” the rates allowed lenders to make a fair profit; and conducted a “very very brief, abbreviated effort” to determine if lenders were making a fair profit. Id. at 892-93. No certified financial statements were requested; no audits were performed; no lenders were asked for

profitability data; and no formal investigations into operating costs or profit margin were conducted. Id. The Court found that the Director’s decision was not based on substantial evidence or objective data, and only amounted to “mere surmise, guesswork, or a ‘gut feeling.’” Id. at 893.

The Department’s decision to promulgate the challenged rules fails the test articulated in Motor Vehicle Mfrs. Ass’n and Barry Service. The Department’s selection of an 85% minimum utilization percentage was not based on substantial evidence or any objective data—in fact, the Department examined little to no data. The Commission found that the Department “did not conduct any reviews or studies of the reimbursement plan from January 1, 1995 through 2004”; “never requested information regarding, and does not know, the average cost of taking care of a Medicaid resident in Missouri”; “has not conducted any studies to further investigate the Missouri State Auditor’s 2001 conclusions regarding what additional amount of reimbursement would be necessary to reimburse Medicaid providers allowable costs”;³ and “did not consult or consider any

³ As stated in the Commission’s findings, the State Auditor concluded:

Missouri’s average occupancy rate for its nursing homes (80 percent) is one of the lowest in the nation and continues to decline. Nursing homes with low occupancy rates receive lower reimbursements and cannot fully recover administrative and capital costs under the current rate structure. In addition, the large number of unoccupied beds indicates more nursing homes are open than what is needed, which increase [sic] the costs for the Medicaid program.

licensure inspections or certification surveys from the Missouri Department of Health & Senior Services or any other data about the quality of care provided in the facilities.” J. L.F. 289. The Commission also found that the Department “considered the effect on patient care by engaging in fiscal analysis and by using the observation and experience gained from its past administration of the Medicaid program,” but “[n]o written document details the Department’s experience or observations with respect to its decision to promulgate” the amendments. J. L.F. 294.

The Department failed to obtain, let alone examine, the relevant data available, as required by Barry Service, *supra*. As such, the Department conducted “no formal investigation” and had “no real basis” for its decision, which was thus made upon “mere surmise, guesswork, or a ‘gut feeling,’” and was therefore arbitrary and capricious. Barry Service, *supra*, at 892-93.

The Department argued that its decision is justified by historical practice—however, this reasoning further indicates that its decision is arbitrary and capricious, and constitutes a factor “which [the legislature] has not intended [the agency] to consider,” and “runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency experience.” Motor Vehicle Mfrs. Ass’n, *supra*, at 43.

The Department asserted that its use of an 85% minimum utilization adjustment was rational because this percentage was used in the past: from January 1, 1995 through

P. Ex. 107; J. L.F. 288-89.

June 30, 2004. Tr. 708, l. 12-22; Tr. 726, l. 25 – 727, l. 14. This was not a valid reason to establish an 85% minimum utilization rate again in 2005. When 85% was selected as the minimum utilization percentage in 1994, the Department engaged in a thorough, reasoned process. The Governor commissioned a nursing home task force comprising representatives from multiple state agencies, including the Department of Health, Department of Social Services, Division of Aging, and Division of Medical Services, plus industry representatives and other interested parties. Tr. 332, l. 1-13. This amounted to “quite a large group of people that met to discuss the reimbursement plan that was in existence at that time and to discuss a new reimbursement plan that they felt would be better than the existing one.” Tr. 332, l. 13-17, See Tr. 812, l. 13-19. The task force considered a wealth of data, including other states’ reimbursement systems; industry experience; and different types of reimbursement plans; and, based on this data, recommended an 85% minimum utilization percentage—because it corresponded to the average occupancy rate of facilities at that time. Tr. 334, l. 13-25; Tr. 224, l. 22 – 225, l. 7; Tr. 703, l. 12-22.

The link the Department makes between its reasoned decision in 1995 and its baseless and arbitrary 2005 decision is faulty. Unlike the 1995 decision, the challenged rules were promulgated without a task force; without an examination of pertinent facts and statistics; and with complete disregard for the average occupancy rate of facilities, which in 2005 was no more than 73%. J. Stip. Para 42.

The Department is essentially arguing that, because these rates were adequate in 1995, they must be adequate now. A similar argument was rejected by the Tenth Circuit

in AMISUB (PSL), Inc. v. State of Colorado Dep't of Soc. Servs., 879 F.2d 789 (10th Cir. 1989), wherein the Colorado Medicaid program argued that, because its old plan was adequate, and the same sum was paid under its new plan, the new plan must be adequate. AMISUB, *supra*, at 799. The Court rejected this argument, and found that the Colorado Medicaid program failed to reasonably or adequately compensate any Colorado hospital's Medicaid costs and was therefore arbitrary and capricious. *Id.* at 799-800. Similarly, the Department's selection of an 85% reimbursement rate—simply because this rate had been used previously—“entirely failed to consider an important aspect of the problem”: quality nursing services and the actual costs of such services. Motor Vehicle Mfrs. Ass'n, *supra*, at 43. Plus, in 2004, the General Assembly determined that the old rates were not sufficient to properly reimburse facilities, and called for a recalculation of Medicaid rates for all nursing homes with a prospective rate as of June 30, 2004, using 2001 cost report data. LF 285-87; J. Ex. 1. As in Barry Service, the Department had no “real basis” to determine these costs, and its decision was arbitrary and capricious. See Barry Service, *supra*, at 892-93.

B. The Department's Selection of an 85% Minimum Utilization Figure Also Violated §§ 208.152.1 and 208.152.8 RSMo 2000 & Supp. 2008

The Department's rulemaking process in promulgating the challenged rules and selecting an 85% minimum utilization percentage for the capital and administration cost components also violated §§ 208.152.1 and 208.152.8 RSMo 2000 & Supp. 2008. By statute, the legislature imparted standards on the Department to use when determining if its Medicaid reimbursement rates are adequate. Sections 208.152.1 RSMo 2000 & Supp.

2008 provide that Medicaid benefit payments shall be made “on the basis of the reasonable cost of the care or reasonable charge for the services...” (emphasis added). Sections 208.152.8 RSMo 2000 & Supp. 2008 add to this “reasonable cost” standard in the long term care context: “[p]roviders of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902(a)(13)(A) of the Social Security Act, 42 U.S.C. § 1396a as amended, and regulations promulgated thereunder.” Sections 208.152.8 RSMo 2000 & Supp. 2008. Thus, Section §1902(a)(13)(A) of the Social Security Act and its regulations are intended to explain how the state must determine that its Medicaid rates reimburse facilities’ “reasonable costs” under Section 208.152.1.

Section 1902(a)(13)(A), also codified at § 1369a(a)(13)(A) and also known as the “Boren Amendment,” was implemented by 42 CFR § 447.250 (2004). The methodology of that federal regulation requires the Department to determine that its Medicaid reimbursement rates are “reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.” Accordingly, if a Medicaid rate reimburses the costs incurred by “efficiently and economically operated facilities...” then that rate would also reimburse “reasonable costs” as required by Section 208.152.1.

The Center for Medicare and Medicaid Services used the standard as stated in 42 CFR § 447.250 until the Boren Amendment was repealed in 1997. Despite the repeal of the Boren Amendment, 42 CFR § 447.250 (2004) remains codified, and the Department

conceded that 42 CFR § 447.250 (2004) is incorporated into Missouri law at § 208.152.8 RSMo 2000 & Supp. 2008 and is the standard that the Department must use to evaluate reimbursement rates.⁴ Plus, since the Boren Amendment's repeal in 1997, § 208.152.8 RSMo has been amended at least twice—and still incorporates the standards that the Boren Amendment created.⁵ When the Missouri legislature incorporated these standards into its own law, it became part of Missouri law, and remains part of Missouri law even though the federal statute has been repealed.

The Circuit Court incorrectly held that the repeal of the Boren Amendment erased the standard articulated therein from Missouri state law. After the repeal, use of the standard was not mandated, but it was not prohibited, either. *Quod lex nonn vatat permittit* (what the law does not forbid, it permits). The repeal permitted states to enact their own standards, but certainly does not preclude states from choosing to follow the standard articulated by Boren. In HCMF Corp. v. Gilmore, 26 F. Supp. 2d 873 (W.D. Va. 1998), aff'd HCMF Corp. v. Allen, 238 F.3d 273, 878-80 (4th Cir. 2001), the United States District Court for the Western District of Virginia held that states may enact standards for Medicaid reimbursement rates—and may choose to keep the efficiently and

⁴ See Tr. 210, l. 20-211, l. 14; Tr. 214, l. 19-215, l. 4; Tr. 234, l. 6-13; Tr. 264, l. 23-266, l. 6; Tr. 267, l. 25-268, l. 5; Tr. 408, l. 12-21; Tr. 468, l. 13-20; Tr. 566, l. 15-20; Tr. 575, l. 18-576, l.1; Tr. 579, l. 24-580, l.3; Tr. 584, l.22-586, l. 23; Tr. 590, l. 11-18; Tr. 592, l.21-593, l. 20; Tr. 704, l. 24-705, l. 5; Tr. 1213, l. 22-1214, l. 5.

⁵ Section 208.152 was amended by SB 1003 in 2004, and SB 539 in 2005.

economically operated standard: “[t]he Balanced Budget Act of 1997 left to the states entirely the formulation of new standards, prescribing only a public notice process for participating states to follow in setting those standards.” HCMF at 876. State standards were contemplated by Congress, as a supplement to the public notice process. In fact, HCMF stated: “There is no federal statutory rate language to parse. There is only a state standard.” Id. “Heritage correctly argues that because DMAS has not promulgated new reimbursement regulations, Virginia’s ‘current published regulations carry forward the ‘efficiency and economy reimbursement standard required by the repealed Boren Amendment.’” Id. at 879. While the Boren repeal removed the federal standard as a mandate, that standard, itself, remains part of Missouri law, and must be followed by the Department.

Westview Health Care Ass’n v. Missouri Dept. of Soc. Servs., Div. of Med. Servs., 851 S.W.2d 111 (Mo. App. W.D. 1993) is another example of how a standard’s elimination from one source does not prohibit other authorities from enacting it. Section 208.169.1(3) RSMo 1987 Supp. provided for use of the Dodge Construction Index to calculate capital expenses for nursing homes. Westview Health Care Ass’n at 112. Section 208.169.1(3) also expired on July 1, 1989. Id. Effective July 1, 1990, the Department of Social Services promulgated a regulation, which uses a standard for calculating such expenses, and which is equivalent to the Dodge Construction Index. Id. at 112-13. Appellant argued that, because Section 208.169.1(3) expired in 1989, the Department of Social Services was prohibited from adopting a rule that uses this index. Id. at 113. The Court of Appeals held that the Department had the power, under its

rulemaking authority in Sections 208.159 and 208.201 RSMo, to promulgate rules and regulations to establish reasonable costs, and therefore had the power to promulgate this regulation. Id. The sunset provision in the statute “simply means that the legislature did not mandate the use of the Dodge Construction Index after July 1, 1989. However, the insertion of the sunset clause did not withdraw any authority granted to the Department under Section 208.169 and Section 208.201 to promulgate rules and regulations to define reasonable costs incurred by nursing homes.” Id. Likewise, the repeal of the Boren Amendment simply means the federal government no longer mandated the efficiency and economy standard, but it did not withdraw the authority of the Missouri legislature to make it a Missouri statutory standard.

Moreover, even if the repeal of the Boren Amendment somehow precluded Missouri’s use of the language therein as a state standard codified at Section 208.152.8, Missouri would not be left without a standard. The “reasonable cost” requirement of Section 208.152.1 still applies. The rates set in the challenged rules by the Department, which did not know the average cost of caring for a Missouri Medicaid resident, fail to satisfy Section 208.152.1.

In addition, with regulation 13 CSR 70-10.015(3)(O), Missouri adopted a standard that is very similar to that articulated in 42 CFR § 447.250 (2004): “[t]he reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider’s cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated

providers.”⁶ J. Ex. 1 at (3)(O) (emphasis added). As such, when it sets reimbursement rates, the Department must ensure that its rates reimburse the costs of efficiently and economically operated providers. 13 CSR 70-10.015(3)(O); 42 CFR § 447.250 (2004).

The Department admitted that the minimum utilization adjustment is designed as a reasonableness standard, which sets the rate for economically and efficiently operated nursing facilities. See Tr. 468, l. 13-20; Tr. 525, l. 1-5; Tr. 575, l. 23 – 576, l. 1. However, the Department failed to offer any substantial evidence proving that the percent it selected satisfies this requirement. The Department’s selection of an 85% minimum utilization adjustment rate completely ignored this standard. It undertook no effort to objectively determine or evaluate whether an 85% minimum utilization requirement assured coverage of costs incurred by efficiently and economically operated providers. Without such a determination or evaluation, the 85% standard is arbitrary, unreasonable or capricious.

⁶ The Department may argue that this standard is not mandatory, given the use of the word “may” in the first sentence. However, while the Department’s regulation did not necessarily mandate a rebase, once the Department decided to rebase, then it was required to comply with the efficiency and economy standard. See McNeil-Terry v. Roling, 142 S.W.3d 828, 834 (Mo. App. E.D. 2004) (once Missouri chooses to offer a service, it is required, under federal law, to offer sufficient coverage to achieve the purpose of the service).

One Missouri case has interpreted the standard as it applies to the Missouri Medicaid program. Missouri Dept. of Soc. Servs., Div. of Med. Servs. v. Great Plains Hosp., Inc., 930 S.W.2d 429 (Mo. App. W.D. 1996). The Court of Appeals held that, when setting Medicaid reimbursement rates, the Department must show it conducted an objective analysis, evaluation, or some type of fact-finding process to determine the effect of the rates on the level of care Medicaid patients receive. Great Plains Hosp., 930 S.W.2d at 435. The Court of Appeals found that the Department failed to determine which facilities were “efficiently and economically operated”; failed to determine what costs must be incurred by these facilities in order to comply with the law; and, without this information, the Department could not have reasonably found that its rates reasonably and adequately compensated efficiently and economically operated facilities. Id. at 435-37.

Similarly, the Tenth Circuit has held that, in order to reimburse the costs of efficiently and economically operated facilities, the state Medicaid agency must make findings that identify and determine: 1) efficiently and economically operated facilities; 2) the costs these facilities must incur; and 3) payment rates that reasonably and adequately meet these costs. AMISUB, *supra*, at 896. In AMISUB, three Colorado hospitals challenged Colorado’s system for reimbursing the costs of efficiently and economically operated facilities. Id. at 790. The Tenth Circuit applied the above three criteria, and found that the Colorado Medicaid reimbursement rates failed to reasonably or adequately compensate Colorado hospitals, and the Medicaid plan was therefore arbitrary and capricious. Id. at 799-800.

The Tenth Circuit noted that the Colorado Medicaid Program had no data showing the new Medicaid rates actually reimburse providers for reasonable costs. AMISUB, *supra*, at 799. The Director asserted that, because the old system was adequate, and the same amount of money was paid out under the new plan, the new system must be adequate. Id. The Court rejected this reasoning, and found that the Division offered no credible evidence to support its conclusion that the new Medicaid rates sufficiently reimbursed the costs of efficiently and economically operated facilities. Id. at 799-800. Similarly, the Department's determination in this case that, because the 85% standard was acceptable in the past, it should be acceptable in the future, was not a sufficient basis for determining it "assures coverage of cost increases that must be incurred by efficiently and economically operated providers." This is especially true, given that the General Assembly had recently required a rate rebase, upon determining that rates were too low. "The findings requirement is not a mere formality that can be satisfied by having a state officer think a bit about hospital costs and then copy out the statutory language on a piece of paper, put the heading 'assurances' on that piece of paper, and send it to HCFA," Great Plains Hosp., *supra*, at 435, quoting Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 805 (5th Cir. 1993).

Similarly, Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997) held that, in order to establish Medicaid reimbursement rates that bear a reasonable relationship to efficient and economical facilities' costs of providing quality services, the state must rely on responsible cost studies that provide reliable data as a basis for its rate setting; and must consider the costs of providing such services. Orthopaedic Hosp. at 1496. See also

Oklahoma Nursing Home Ass'n v. Demps, 816 F. Supp. 688 (W.D. Okl. 1992) (holding that state cannot identify efficiently and economically operated facilities by indulging in the assumption that any facility with costs below the state's own reimbursement rate is efficiently and economically operated; nor can the state identify the costs of such facilities by indulging in this assumption).

The Department's selection of an 85% minimum utilization rate bears no relationship to the costs of efficiently and economically operated facilities. The Department never engaged in the process to determine what facilities in Missouri are efficiently and economically operated; nor engaged in the process to determine what costs efficiently and economically operated facilities incur; and could not, based on its lack of research, possibly determine what rates would reasonably and adequately meet these costs. See AMISUB, *supra*, at 896; and Great Plains Hosp., *supra*, at 435-37. In fact, Missouri Medicaid reimbursement rates already fell short. In 2005, the average shortfall in Missouri Medicaid reimbursement rates was -\$14.97 per patient day. BDO Siedman LLP, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, Sept. 2007.⁷ By selecting 85% merely because it satisfied its budgetary goals, the Department chose to assume that this rate adequately reimbursed efficiently and economically operated facilities. As the Court held in Oklahoma Nursing Home Ass'n, *supra*, this is a

⁷ Available at:

http://www.ahcancal.org/research_data/funding/Documents/2007_Report_on_Shortfalls_in_Medicaid_Funding.pdf (last visited March 24, 2009).

faulty assumption. Accordingly, the Department failed to comply with the standard found in 13 CSR 70-10.015(3)(O) and § 208.152.8 RSMo 2000 & Supp. 2008.

The Department also contends—incorrectly—that it is valid to base its decision-making process on budgetary considerations. The Department testified that it chose 85% as the minimum utilization percentage because of a budgetary shortfall: the legislature appropriated \$42.5 million for Medicaid reimbursement, and the actual cost of implementing the July 1, 2004 rebase was \$58.4 million. Tr. 701, l. 3- 21. The Department admitted that the emergency amendment was promulgated to “continue to make payments to nursing facilities through the end of the fiscal year” by allowing the Department to stay within its appropriation authority, and that the 85% minimum utilization figure would best meet the monetary goal related to the lack of appropriation. Tr. 177, l. 13-16; see Tr. 164, l. 15-20; Tr. 330, l. 19 – 331, l. 1; Tr. 640, l. 22- 641, l. 13; Tr. 353, l. 2-5; Tr. 809, l. 12- 810, l. 1. However, budgetary constraints and inadequate funding do not meet Missouri’s standard for measuring the adequacy of reimbursement rates. The standard is only concerned with whether the rates reimburse the reasonable costs of “efficiently and economically operated facilities.” J. Ex. 1. at (3)(O).

A similar argument was rejected in AMISUB, *supra*. The Tenth Circuit held that the state’s consideration of budgetary factors alone did not show that the Medicaid reimbursement rates complied with the requirement that efficiently and economically operated hospitals be reasonably and adequately compensated for their costs, and with no other basis, the Medicaid plan was arbitrary and capricious. AMISUB, 879 F.2d at 800.

In McNeil-Terry v. Roling, 142 S.W.3d 828 (Mo. App. E.D. 2004), the Court of Appeals rejected the Division’s position that Missouri’s budgetary constraints justified limitations on dental coverage. McNeil-Terry at 834. While states may restrict coverage out of fiscal necessity, such restrictions may not interfere with the purpose of offering that medical service. Id. Once Missouri chooses to offer a service, it is required, under federal law, to offer sufficient coverage to achieve the purpose of the service. Id. The Court of Appeals found that the Division’s restriction of dental services to dentures and mouth trauma was inconsistent with the federal purpose to treat disease, injury, or impairment affecting the oral or general health of Medicaid-eligible adults. Id. Similarly, once the Department decided to provide nursing home care in the Medicaid program, it was obligated to sufficiently fund the program, and cannot sacrifice this obligation in order to resolve its own budgetary error.

“[A]n agency’s action must be upheld, if at all, on the basis articulated by the agency itself.” Motor Vehicle Mfrs. Ass’n, supra, at 50. The basis articulated by the agency—a budget shortfall—requires reversal of the agency action. In fact, the Department’s own authority, cited in its brief to the Circuit Court, indicates that a Medicaid plan based entirely on budgetary concerns does not equate to a plan that reimburses the costs of efficiently and economically operated facilities. See Wisconsin Hosp. Ass’n v. Reivitz, 733 F.2d 1226 (7th Cir. 1984) (states must develop reimbursement rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities”); Mississippi Hosp. Ass’n, Inc. v. Heckler, 701 F.2d 511 (5th Cir. 1983) (when the legislature adopted the standard

of reimbursement of “efficiently and economically operated facilities,” it did not intend the states to develop rates solely on budgetary appropriations); and Colorado Health Care Ass’n v. Colorado Dep’t of Soc. Servs., 842 F.2d 1158 (10th Cir. 1988) (states can consider budgetary constraints only as a factor when determining if their Medicaid reimbursement rates meet the costs of “efficiently and economically operated facilities”).

Plus, the Department should not be allowed to bend the standards used to determine reimbursement rates for quality nursing services every time it has a funding shortage—a nursing home’s reasonable costs do not increase or decrease based on the status of the state budget. In Americare Properties, Inc. v. Whiteman, 257 Kan. 30 (Kan. 1995), the Kansas Supreme Court held: “[i]f [the state] were allowed to make its determination of which facilities were economically and efficiently operated based on the amount of money available, then...rates would never be subject to review because...an economical and efficient institution is one which receives all of its necessary costs.” Americare Properties, Inc., 257 Kan. at 43 (abrogated on other grounds). Likewise, if the Department’s arbitrary selection of an 85% minimum utilization rate—chosen only to meet the Department’s short-sighted budgetary “crisis”—is allowed to stand, the standard requiring the Department to examine quality nursing services disappears. The Department cannot be allowed to abandon the well-established standard of setting rates that reimburse reasonable costs, at the risk of driving costs down and jeopardizing the quality of Medicaid nursing services in Missouri.

Finally, the Department testified that it is required to “meet its obligations under the appropriation authority,” and is required “to live within the means that the legislature

has appropriated.” Tr. 580, l. 24-25; Tr. 583, l. 14-16. This is bad policy: what about the Department’s statutory obligation to provide rates which allow providers to give quality nursing services to Missouri Medicaid patients? The Department’s own Emergency Statement, issued along with the Emergency Amendment effective July 1, 2004, implementing the higher reimbursement rates without the 85% minimum utilization adjustment, emphasized the importance of providing quality nursing care to Medicaid patients:

This emergency amendment...must be implemented on a timely basis to ensure that quality nursing facility services continue to be provided to Medicaid patients in nursing facilities. As a result, the [Department] finds an immediate danger to public health, safety and/or welfare and a compelling governmental interest, which requires emergency action.

P. Ex. 14 (emphasis added). By the Department’s own reasoning behind implementing the 2004 Emergency Amendment—less than a year before it took the action challenged in this appeal—if rates remained at the 85% level, nursing facilities would not be able to provide “quality nursing facility services” to Medicaid patients. As a result, it eliminated the 85% minimum utilization requirement in 2004. Eight months later, without any new “substantial evidence” to support its decision, the Department reversed course 180 degrees and imposed the 85% minimum utilization standard. Clearly the Department’s decision was inappropriately budget-driven and was blind to reimbursing efficiently and economically operated facilities for the costs they incur to provide quality nursing services.

C. The Department's methodology of slashing Medicaid reimbursement rates to resolve its budgetary shortage, without regard to whether these rates reimburse nursing homes for reasonable costs, sets a dangerous policy of enabling the Department to underfund the entities responsible for caring for the poor.

The purpose of the Medicaid program is to provide medical assistance to needy persons whose income and resources do not meet their health care needs. In re Estate of Graham, 59 S.W.3d 15, 17. n. 2 (Mo. App. W.D. 2001); Section 208.152.1 RSMo. 2000 & Supp. 2008. The challenged rules, based on a budgetary shortage rather than nursing homes' reasonable costs, jeopardize facilities' ability to provide quality care for the poor. If the challenged rules are allowed to stand, the Department will have a precedent on which to base arbitrary rate cuts in other areas of the Medicaid program.

Lower Medicaid reimbursement rates leads to lower physician participation in the Medicaid program:

There is widespread agreement that Medicaid eligibles often have inadequate access to health care and that they have particular difficulties gaining access to the care of private, office-based physicians. The program's low reimbursement levels are the most often cited factor in physicians' reluctance to accept patients whose care is paid for by Medicaid.

J.D. Perloff, P.R. Kletke, & J.W. Fossett, *Which Physicians Limit Their Medicaid Participation, and Why*, 30 Health Services Research, No. 1, at 7-8 (1995).⁸ These low reimbursement levels drive primary and specialty care providers and pharmacists out of the Medicaid program, and also make physician recruitment difficult for facilities that treat Medicaid patients.

Missouri has a history of exceptionally low Medicaid reimbursement rates. In fact, according to the Medicaid Reform Commission Report, Missouri “is among one of the lowest payers in the nation, far worse (usually less than half) than what neighboring states pay, and only about 55% of what Medicare pays. These rates do not begin to cover the cost of providing the service, which is only about 35 cents on the dollar.”⁹ In 2005,

⁸ See also Joel W. Cohen, *Medicaid Policy and the Substitution of Hospital Outpatient Care for Physician Care*, 24 Health Serv. Research 33 (1989); and Jessie L. Tucker III, *Factors Influencing Participation in Medicaid in the USA*, 29 International Journal of Social Economics, No. 9, at 753-762 (2002) (citing in support, national studies, a 13-state pediatric study, and Mississippi and Missouri studies).

⁹ Medicaid Reform Commission Report, p. 25. The Missouri Medicaid Reform Commission was created in 2005, under Senate Bill 539, Section 208.014 RSMo 2000, and Senate Concurrent Resolution 15. The Commission was charged with writing a report by January 1, 2006, with recommendations for reforming, redesigning and restructuring a new Medicaid system. The report is available here:

the average shortfall in Medicaid reimbursement rates for nursing homes was -\$14.97 per patient day. BDO Siedman report, *supra*, at page 14. The projected shortfall for 2007 increased to -\$22.62 per patient day. *Id.* at page 15.

Missouri's low reimbursement rates have numerous detrimental effects:

Many physicians have no choice but to limit their participation in Medicaid. Consequently, patients often do not have access to appropriate care. Long waits, especially for specialty care, result in complications, expensive and unnecessary emergency room visits, hospitalization, and higher costs.

Id. The Center for Medicare and Medicaid Services' predecessor, the Health Care Financing Administration, issued a memorandum in 2001 addressing the need to increase children's access to Medicaid.¹⁰ In this memo, the HCFA commented that inadequate rates lead to an insufficient supply of primary care and specialty care providers, which in turn limits access to care for Medicaid eligible children, and creates long wait times for appointments for providers who limit the number of Medicaid patients they will see. *Id.* at page 3.

Medicaid patients who are unable to access a physician who will accept Medicaid are often forced to seek care at the emergency room, a rural health center, or a federally

<http://www.senate.mo.gov/medicaidreform/MedicaidReformCommFinal-122205.pdf>

(last visited March 24, 2009).

¹⁰ HCFA Memo, *Assuring Access to Care for Medicaid Children*, Jan. 19, 2001, available at: <http://www.healthlaw.org/library/attachment.60701> (last visited March 24, 2009).

qualified health center, which cannot refuse patients. Walter L. Stiehm, *Poverty Law: Access to Healthcare and Barriers to the Poor*, 4 Quinnipiac Health Law Journal 279, 291 (2001). These facilities have higher reimbursement rates, and their over-utilization by Medicaid patients thus raises costs for the health care system. Id. The financial strain on hospitals and physicians “may ultimately lead to reduced availability of healthcare services for the poor as some hospitals go out of business or relocate to more affluent areas where there is less likelihood of over-utilization by the poor.” Id.

The \$22 per patient day shortfall caused by the challenged rules has impacted Missouri nursing homes in three primary ways. First, facilities have less money to pay employees and provide wage raises. This reduces the number of staff hours per patient. Second, facilities have had to cut back on capital improvements, such as painting, carpeting, and safety system upgrades. Third, the shortfall translates into fewer resident activities, and reductions in meal quality. The rate cuts do not only affect “bad” facilities. The rate cuts hurt facilities that take on a greater share of indigent patients.

The Missouri Associations are concerned that, if the Department is permitted to slash Medicaid reimbursement rates solely on the basis of budgetary concerns without engaging in a reasoned rate setting process, more cuts will follow. If the Department is free to arbitrarily cut nursing home reimbursement solely for budgetary reasons, it is only a matter of time before it cuts reimbursement for physician and pharmacy services. When this occurs, more physicians, pharmacists and other providers will be forced to decline participation in the Medicaid program. The result is that Medicaid patients will have fewer choices, and a lower quality care than that available to private pay patients. If the

Department is allowed to circumvent the rate-setting process established by Missouri statute and regulation, the purpose of the Medicaid program—providing health care for the needy—will suffer.

Conclusion

For the reasons hereinabove stated, the *Amici Curiae* request this Court to affirm the decision of the Commission, and find that the Department's process in promulgating the rules challenged herein was arbitrary and capricious and in violation of §§ 208.152.1 and 208.152.8 RSMo. 2000 & Supp. 2008, and the Department's own regulation, 13 CSR 70-10.015(3)(O).

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APPENDIX

The *Amici Curiae* hereby adopt and incorporate by reference the Appendix contained in Beverly's Brief.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that two copies of this brief, and one copy on floppy disk, as required by Missouri Supreme Court Rule 84.06(g) were served, by placement in the United States Mail, postage paid, on this 25th day of March, 2009, to: Harvey M. Tettlebaum and Robert L. Hess II, Husch & Eppenberger, LLC, 235 East High Street, Jefferson City, Missouri 65102 and to Mark E. Long and J. Scott Stacey, Attorney General's Office, Broadway State Office Building, 7th Floor, 221 West High Street, Jefferson City, Missouri 65101.

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CERTIFICATE OF COMPLIANCE

The undersigned certified that:

- (1) this brief contains the information required by Rule 55.03;
- (2) this brief complies with the limitations contained in Rules 84.04 and 84.06.
- (3) there are 7,820 words in this brief;
- (4) the floppy disk containing a copy of this brief filed contemporaneously herewith has been scanned for viruses and is virus free.

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