

IN THE MISSOURI SUPREME COURT

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

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APPEAL FROM THE CIRCUIT COURT OF COLE COUNTY

Honorable Byron L. Kinder

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SUBSTITUTE BRIEF OF APPELLANTS

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HUSCH BLACKWELL SANDERS LLP

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

ATTORNEYS FOR APPELLANTS

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## JURISDICTIONAL STATEMENT

This appeal arises from a decision of the Administrative Hearing 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 of Social Services. Appellants filed the only notice of appeal. Under Rule 84.05(e), the party aggrieved by the agency decision files the appellant's brief and reply brief. Since this Court reviews the AHC decision and both parties were aggrieved by the AHC decision, the parties are effectively briefing this case as a cross-appeal even though it is not technically a cross appeal. Order (Mar. 3, 2009).

In this opening brief, Appellants argue that the Department's rules are invalid – an issue on which the AHC made findings of fact but no conclusions of law. See, e.g., Monroe County Nursing Home Dist. v. Dep't of Soc. Servs., 884 S.W.2d 291, 292-93 (Mo. App. 1994). The Circuit Court made the only legal determination regarding the validity of the rules. Accordingly, Appellants' points relied on challenge that Court's decision. Appellants anticipate that the Department will challenge the AHC's determination that the administration cost component ceiling was incorrectly calculated in its opening brief – an issue on which Appellants prevailed at the AHC. See id. Appellants will, in turn, support that decision in their second brief.

This Court sustained Appellants' transfer application after opinion by the Court of Appeals. Accordingly, this Court has jurisdiction. Mo. Const. art. V, § 10.

## STATEMENT OF FACTS<sup>1</sup>

### **A. Parties**

Appellants Beverly Enterprises-Missouri, Inc. and Commercial Management, Inc. (collectively Beverly) operated 17 long term care facilities in Missouri. AHC Dec. ¶¶ 1-20 (LF 277-79). Respondent Missouri Department of Social Services, Division of Medical Services (Department) administers the Missouri Medicaid program and has authority to determine Medicaid reimbursement rates for nursing facilities. AHC Dec. ¶ 21 (LF 279).

### **B. Missouri Medicaid reimburses skilled nursing facilities using a prospective per diem rate based on historical cost information.**

Under the Missouri Medicaid program, skilled nursing facilities are generally paid on a per resident per day basis. AHC Dec. ¶ 22 (LF 279). That “per diem” rate is a fixed, prospective rate. J.S. ¶ 26 (LF 199). The Department establishes each facility’s per diem rate in advance and the rate does not vary even if that facility’s actual cost of caring for a resident exceeds the per diem reimbursement rate. AHC Dec. ¶ 28 (LF 281). The Department calculates the prospective per diem rates using historical cost data for the facilities. AHC Dec. ¶¶ 28-32 (LF 281). To establish the rate, the Department selects a base cost year. AHC Dec. ¶ 28 (LF 281). For that year, the Department then

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<sup>1</sup> This statement of facts relates to the points relied on being argued in this brief and does not set forth all of the facts necessary to address the points relied on likely to be raised by the Department.

determines each facility's per day costs of caring for residents from annual cost reports that the facilities file with the Department. AHC Dec. 28 (LF 281). The cost data is adjusted for various factors. AHC Dec. ¶¶ 32, 35 (LF 281-82). Costs are divided by patient days. See AHC Dec. ¶¶ 40-41 (LF 283). That per day cost then becomes the facility's prospective per diem rate. AHC Dec. ¶ 35 (LF 282).

This methodology has limits. Over time, a prospective per diem rate based on historical data becomes a less and less reliable reflection of actual costs. P. Ex. 107 (EF 462, 474-82). Costs of caring for patients increase over time because of inflation, increases in the minimum wage, rising heating and cooling costs, and the like. J. Ex. 1 (EF 011-015); P. Ex. 107 (EF 490-94). The Department has addressed these changes by proposing specific adjustments to the historical per diem rate. J. Ex. 1 (EF 011-015). In some years, those increases are funded. Tr. 143 l. 22-25, 144 l. 1-4. In other years, they are not. Tr. 143 l. 22-25, 144 l.1-4, 738 l. 19-25

To account for these changes, reimbursement rates are periodically “rebased.” J. Ex. 1 (EF 002); P. Ex. 107 (EF 493-94). A “rebase” occurs when the Department selects a new, more current base year, evaluates facilities' costs, and assigns them new prospective rates. Id. In this way, cost increases wrought by time are taken into account. Id.

By regulation, the Department has set forth the factors that it must consider when it chooses to re-evaluate rates: “The reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be

incurred by efficiently and economically operated providers.” J. Ex. 1, 13 CSR 70-10.015(3)(O) (EF 001; emphasis added). In their testimony before the AHC, the Department’s representatives acknowledged that nursing home reimbursement rates should be set to reimburse facilities for the costs that must be incurred by efficiently and economically operated facilities. 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.

Missouri’s current prospective reimbursement plan for skilled nursing facilities first went into effect on January 1, 1995. J. Ex. 86 (EF 443). Prospective rates were based on 1992 cost report data. J. Ex. 86 (EF 451). Over time, the prospective per diem rates decreased relative to the actual costs of caring for Medicaid residents. P. Ex. 107 (EF 474). In 2001, the State Auditor concluded that nursing facilities’ Medicaid reimbursement rates were on average \$9.80 less per resident per day than their allowable costs. P. Ex. 107 (EF 475). In 2004, the General Assembly mandated that facilities’ prospective per diem rates be rebased using 2001 cost report data. AHC Dec. ¶¶ 50-56 (LF 285-87); J. Ex. 1 (EF 015). The rebased rates were to be phased in over time and were initially effective July 1, 2004. AHC Dec. ¶ 53 (LF 286). In the spring of 2005, the Department made regulatory changes which reduced nursing facility reimbursement rates from the levels at which they were set in 2004. AHC Dec. ¶¶ 71-74 (LF 290-91). That reduction is the subject of this appeal.

**C. Administration and capital cost components are adjusted for minimum utilization.**

The Department's current Medicaid reimbursement plan (Plan) for skilled nursing facilities is codified at 13 CSR 70-10.015. AHC Dec. ¶ 22 (LF 279). The allowable costs that are used to determine a skilled nursing facility's per diem rate are grouped into four cost components: administration, ancillary, capital, and patient care. AHC Dec. ¶ 33 (LF 282) The Department determines an allowable cost for each of those components, and then divides the component costs by the facility's total annual patient days to calculate a per resident per day cost. AHC Dec. ¶¶ 33-35 (LF 282). In making that calculation, the Department applies a "minimum utilization" adjustment to the administration and capital cost components. AHC Dec. ¶ 40 (LF 283).

To adjust for minimum utilization, the Department calculates a cost component per diem for a nursing facility with an occupancy rate of less than the minimum utilization percentage as if the facility experienced an occupancy rate at the minimum utilization percentage. AHC Dec. ¶ 40 (LF 283). When cost components are adjusted for minimum utilization, a nursing facility's costs are spread over more patient days than the facility actually observed thereby decreasing the facility's per diem rate. AHC Dec. ¶ 42 (LF 283). The minimum utilization adjustment is intended to provide lower reimbursement to lower occupancy facilities as a way to encourage "more efficient and economical use of Medicaid reimbursement." AHC Dec. ¶ 42 (LF 283-84). The Department believes it is more efficient and economical for facilities to spread their administration and capital costs over more patients. AHC Dec. ¶ 42 (LF 283).

For example, for a 100-bed skilled nursing facility with 60 percent occupancy and \$500,000 in total allowable administration costs for the year, the facility's administration costs per patient per day would normally be  $\$500,000 / (100 \text{ beds} \times 60 \text{ percent} \times 365 \text{ days}) = \$22.83$  per patient day. AHC Dec. ¶ 41 LF 283). To apply an 85 percent minimum utilization percentage adjustment, the Department would substitute 85 percent for the actual occupancy rate. Id. Thus, the allowable administration costs would be  $\$500,000 / (100 \text{ beds} \times 85 \text{ percent} \times 365 \text{ days}) = \$16.12$  per patient day. Id.

**D. In 1995 and 2004, the Department selected the average occupancy rate as the minimum utilization percentage.**

When the Department established new Medicaid per diem rates for facilities in 1995 and 2004, the Department selected the average occupancy rate for Missouri nursing homes as the proper minimum utilization percentage. AHC Dec. ¶¶ 24, 48 (LF 280, 285). In 1993, the Governor commissioned a nursing home task force to establish the 1995 rates. AHC Dec. ¶¶ 23-24 (LF 279-80). The task force began meeting some time in 1993 and consisted of representatives from several state agencies, including the Department of Health, the Department of Social Services, the Division of Aging, and the Division of Medical Services, plus industry representatives and other interested parties. AHC Dec. ¶¶ 23-24 (LF 279-80). The task force analyzed other states' reimbursement systems, considered actual industry experience, discussed the various types of existing reimbursement plans, ran scenarios, and conferred about the Plan that Missouri ultimately implemented. AHC Dec. ¶ 23 (LF 279-80). The task force recommended that the Department adopt an 85 percent minimum utilization percentage in the version of the

Plan effective January 1, 1995, because it was the average occupancy rate of facilities. AHC Dec. ¶ 24 (LF 280).

Likewise, in 2004, the Department adopted a 73 percent minimum utilization percentage for the capital cost component. AHC Dec. ¶ 48 (LF 285). It did not subject the administration cost component to any minimum utilization adjustment. *Id.* Seventy-three percent was selected because it was the average occupancy rate of nursing facilities at the time. AHC Dec. ¶ 48 (LF 285). In selecting that minimum utilization percentage, the Department relied upon the methodology established by the task force in 1995 for selecting the applicable minimum utilization percentage. *See* AHC Dec. ¶¶ 24, 48 (LF 280, 285). Thus, in 1995 and 2004, the Department determined that the average occupancy rate for Missouri nursing facilities was a reasonable benchmark for establishing the minimum utilization adjustment percentage. AHC Dec. ¶¶ 24, 48 (LF 280, 285).

**E. In 2005, the Department increased the minimum utilization percentage to make up a budget shortfall.**

In 2005, the Department decided that it could not fully fund Medicaid reimbursement as established in its 2004 rebasing. AHC Dec. ¶¶ 60-61 (LF 287). By June of 2004, the Department knew the cost of implementing the rebase would exceed its appropriation from the General Assembly. AHC Dec. ¶ 57 (LF 287). The Department learned in January of 2005 that it would not be receiving a supplemental appropriation. AHC Dec. ¶ 59 (LF 287). At that time, the Department projected that its appropriation would run out sometime in May 2005, leaving it without funds to reimburse facilities for

part of May and all of June 2005. AHC Dec. ¶ 61 (LF 287). The Department, however, did not propose any rule change until March 2005. AHC Dec. ¶¶ 67, 71 (LF 289-90).

Nine months after determining that its appropriation authority was insufficient and two months after learning that it would not receive a supplemental appropriation, the Department finally responded by proposing an emergency amendment on March 21, 2005 (“March 21 Emergency Amendment”). J. Ex. 4 (EF 084); AHC Dec. ¶ 71 (LF 290). The March 21 Emergency Amendment was effective April 1, 2005, and expired on September 27, 2005. AHC Dec. ¶ 79 (LF 292). On March 29, 2005, the Department filed a proposed amendment to make the changes in the March 21 Emergency Amendment permanent and to provide for the calculation of rates for state fiscal year 2006, or from July 1, 2005, through June 30, 2006 (“Proposed Amendment”). AHC Dec. ¶ 80 (LF 292). By order of rulemaking published in the Missouri Register on August 15, 2005, the Department promulgated the Proposed Amendment as a final rule with minor changes. AHC Dec. ¶ 81 (LF 292).

On June 20, 2005, the Department issued another emergency amendment, which was for calculation of per diem rates effective July 1, 2005, through December 27, 2005 (“June 20 Emergency Amendment”). AHC Dec. ¶ 82 (LF 293). The June 20 Emergency Amendment extended the rebase that was effective April 1, 2005, including the increased minimum utilization percentage, into the next fiscal year. J. Ex. 7 (EF 094-096).

Collectively, the March 21 Emergency Amendment, the Proposed Amendment (as adopted by the August 15 order of rulemaking), and the June 20 Emergency Amendment are referred to as the “challenged rules.”

The challenged rules provided that the Medicaid rates of all nursing homes participating in Medicaid would be rebased effective April 1, 2005, using each facility's fiscal year-end 2001 cost report. AHC Dec. ¶¶ 72-73 (LF 290-91). They also amended 13 CSR 70-10.015(20)(A)6 and 7 to subject the administration cost component to an 85 percent minimum utilization adjustment and to increase the minimum utilization adjustment for the capital cost component from 73 percent to 85 percent. AHC Dec. ¶ 72 (LF 290). Eighty-five percent was not the average occupancy rate for nursing homes in April 2005 or thereafter. AHC Dec. ¶ 44 (LF 284). Rather, from October 2003 through June 2005, the average occupancy rate for Missouri nursing homes was approximately 73 percent. AHC Dec. ¶ 44 (LF 284).

In the emergency statement that was published in the Missouri Register with the March 21 emergency amendment, the Department explained that Medicaid reimbursement rates were being reduced because of budgetary constraints:

This emergency amendment provides for the recalculation of nursing facility Medicaid per diem rates effective for dates of service beginning April 1, 2005 to revise the rebase provisions to update the databank and to provide for a minimum utilization adjustment of eight-five percent (85%) for the administration and capital cost components. These adjustments to calculation of nursing facility Medicaid per diem rates are necessary to ensure that payments for such nursing facility per diem rates are in line with the funds appropriated for that purpose. If the funds appropriated for the payment of medical assistance benefits at any time become insufficient

to pay the full amount of the payment, no payment will be made through the Medicaid claims processing system. The Division of Medical Services is attempting to find a solution to this funding issue within the means that taxpayers, through the General Assembly, have given the division.

J. Ex. 4 (EF 085; emphasis added).

Thus, by its own emergency statement, the Department admitted that the minimum utilization percentage was changed to solve the Department's "funding issue." Id. In promulgating the June 20 emergency amendment, the Department issued a substantially similar emergency statement explaining that the emergency changes were being perpetuated in the new fiscal year because "the General Assembly did not include any funds for any per diem rate increases." J. Ex. 7 (EF 094).

The Department chose 85 percent as the minimum utilization percentage for the administration and capital cost components "because it met the goal of being able to fund the rates through the end of the state fiscal year, had the least impact on patient related cost, and encouraged efficiency and economy in nursing facilities by reducing the rates of those facilities with less than 85% occupancy." AHC Dec. ¶ 84 (LF 293). The Department did not independently determine whether its rates were adequate to reimburse the costs that must be incurred by efficiently and economically operated facilities. In fact, the Department did not gather the information that it would need to make such a determination. Between January 1, 1995, and 2004, the Department did not review or study its reimbursement plan. AHC Dec. ¶ 65.a (LF 289). The Department has "never requested information regarding, and does not know, the average cost of taking

care of a Medicaid resident in Missouri.” AHC Dec. ¶ 65.b (LF 289; emphasis added). The Department did not further investigate the State Auditor’s 2001 conclusion that additional reimbursement was needed for Missouri nursing homes. AHC Dec. ¶ 65.c (LF 289); P. Ex. 107 (EF 459-504). The Department did not consult or consider any data about nursing home quality of care. AHC Dec. ¶ 65.e (LF 289). It did not consult or consider the Missouri Department of Health and Senior Services’ licensure inspections or certification surveys. AHC Dec. ¶ 65.e (LF 289).

Rather, the Department believed that its Plan necessarily defines the only costs that an efficiently and economically operated facility must incur and that any costs not reimbursed by its Plan are not costs that an efficiently and economically operated facility must incur. Tr. 201, l. 6-23; Tr. 566, l. 15-20; Tr. 590, l. 11 - 591, l. 9. The Department reasoned that its reimbursement rates were sufficient as long as “facilities [were not] going out of business or being de-certified because of patient care deficiencies” and that its prior experience and observations led it to conclude that an 85% minimum utilization percentage would not cause such problems. AHC Dec. ¶ 86 (LF 294).

#### **F. Procedural posture**

The AHC made findings of fact, but did not make conclusions of law concerning the validity of the challenged rules. AHC Dec. at 30-31 (LF 304-05). Based on the

AHC's findings of fact, the Circuit Court decided that the challenged rules were valid.<sup>2</sup>

LF 118-26. This appeal followed. LF 133-57.

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<sup>2</sup> The AHC made findings of fact and conclusions of law regarding the proper method of calculating the administration cost component ceiling. Though the Circuit Court reversed the AHC decision in Beverly's favor on that issue, the Department must raise and argue that point on appeal. Rule 84.05(e).

**POINTS RELIED ON**

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

**§ 208.152.8, RSMo Supp. 2008**

**13 CSR 70-10.015(3)(O)**

**Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29 (1983)**

**Barry Serv. Agency Co. v. Manning, 891 S.W.2d 882 (Mo. App. 1995)**

**II. The Cole County Circuit Court erred in holding that the challenged rules are lawful in that Department’s use of an 85% minimum utilization percentage violated § 536.016, RSMo, because (1) the Department’s selection of that percentage was not based on substantial evidence and did not consider whether its Medicaid reimbursement rates would cover the costs of efficiently and economically operated nursing home providers as required by the Department’s own regulation (13 CSR 70-10.015(3)(O)) and § 208.152.8,**

**RSMo and (2) the Department did not make a finding that the rules are necessary to carry out the purposes of the statute.**

**§ 208.152.8, RSMo Supp. 2008**

**§ 536.016, RSMo 2000**

**13 CSR 70-10.015(3)(O)**

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

**§ 536.021, RSMo Supp. 2008**

**§ 536.025, RSMo 2000**

## ARGUMENT

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

As a threshold matter, the issue presented is whether the Department can reduce Medicaid reimbursement rates solely to solve funding issues. Under existing statute and rule, the State has required the Department to consider whether its Medicaid rate changes will reimburse the costs of efficiently and economically operated providers. The efficiently and economically operated provider standard has been interpreted by state and federal courts to preclude rate reductions based solely on budgetary factors.

The second part of the inquiry is factual and addresses whether the Department, in fact, made a budget-based decision. The Department, however, has already answered that question in the March 21 emergency statement that it issued contemporaneously with the rate reduction, where it flatly stated the rate reduction was intended to solve its funding issue. The Department has offered additional rationalizations of its decision since that time. Those post hoc rationalizations, however, are not credible or persuasive. The Department only considered whether its rates were so low that they would drive

providers out of business or result in them being delicensed. That analysis does not comply with the Department's obligation to consider whether its rates reimburse the costs of efficiently and economically operated providers as set forth in statute and its own regulation.

**A. Standard of Review**

The lawfulness of a regulation is a question of law which this Court reviews de novo. Dep't of Soc. Servs. v. Little Hills Healthcare, LLC, 236 S.W.3d 637, 641 (Mo. banc 2007). The AHC's findings of fact will be reversed only if they are not supported by substantial and competent evidence. Psychcare Mgmt., Inc. v. Dep't of Soc. Servs., 980 S.W.2d 311, 312 (Mo. banc 1998).

**B. The Department cannot solely base Medicaid program cuts on funding issues, because state statute and regulation require it to consider other factors.**

Agencies may not act arbitrarily, capriciously, or unreasonably. §§ 536.140.2(3), (6), RSMo 2000. This prohibition has both a substantive and a procedural component. Substantively, an agency decision is arbitrary, capricious, and unreasonable if it "shock[s] the sense of justice." See, e.g., Curtis v. Bd. of Police Comm'rs of Kansas City, 841 S.W.2d 259, 262 (Mo. App. W.D. 1992). Procedurally, "an administrative agency acts unreasonably and arbitrarily if its findings are not based on substantial evidence. Moreover, an agency that completely fails to consider an important aspect or factor of the issue before it may also be found to have acted arbitrarily and capriciously." Barry Serv.

Agency Co. v. Manning, 891 S.W.2d 882, 892 (Mo. App. 1995) (quoting Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983)); Hundley v. Wenzel, 59 S.W.3d 1, 8 (Mo. App. 2001). This case does not concern the substantive reasonableness of the challenged rules. Rather, Beverly contends that the challenged rules are invalid, because the decision-making process followed to implement them was arbitrary, capricious, and unreasonable.

In the leading case, the United States Supreme Court declared that the National Highway Traffic Safety Administration (“NHTSA”) acted arbitrarily and capriciously when it failed to provide an adequate basis and explanation for changing its rules. Motor Vehicle Mfrs. Ass’n, 463 U.S. at 32. As in this case, the agency adopted an initial policy position and later changed its position. NHTSA “imposed, amended, rescinded, reimposed, and now rescinded again” its passive restraint requirement. Id. at 34. The Court held that an agency’s decision-making process must be rational. Id. at 43.

Generally, agencies must limit their decision-making process to the relevant factors that the legislature intended for them to consider. Id. An agency rulemaking is arbitrary and capricious when the agency:

[1] has relied on factors which [the legislature] has not intended it to consider,

[2] entirely failed to consider an important aspect of the problem,

[3] 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. (numerical divisions supplied).

When rendering decisions, an agency must consider the relevant data and enunciate a satisfactory explanation for its action including a “rational connection between the facts found and the choice made.” Id. On judicial review of an agency decision, a court should not attempt to justify an agency’s decision nor may it offer a reasoned basis for the agency’s action that the agency itself has not provided. Id. Similarly, “the courts may not accept appellate counsel’s post hoc rationalizations for agency action.” Id. at 50. Instead, the agency must establish a rational connection between the facts it found and its decision, which the Court found that the NHTSA had failed to do. Id. at 52.

Missouri courts follow the same test to determine whether an agency has acted in an arbitrary, capricious, or unreasonable manner. See Barry Service, 891 S.W.2d at 892; Hundley, 59 S.W.3d at 8. In Barry Service, the plaintiffs successfully challenged administrative decisions on the basis that they were arbitrary and capricious. 891 S.W.2d at 891, 893. The plaintiff lenders in Barry Service contended that the Director of Finance had acted arbitrarily or capriciously in rejecting their proposed rate schedules as being “unacceptable” and “far higher than those found in the market as prescribed” by statute. Id. at 883, 887. In explaining his decision, the Director testified that determining the appropriateness of a proposed rate involved consideration of its affordability and profitability. Id. at 892.

Although the Director retained discretion to determine the appropriateness of the rates, the appellate court added that an administrative official's discretion is limited, and a reviewing court must determine whether the official "acted in an unlawful, unconstitutional, arbitrary, capricious, unreasonable, or abusive manner." Id. The Director had presented no evidence supporting his conclusion as to the profitability factor. Id. In addition, the Director conceded that any evidence of the affordability factor would be a guess as he had no precise range of figures in mind as to an appropriate rate for these types of loans. Id. The appellate court held that the Director had acted arbitrarily and capriciously insofar as his decisions were not based on substantial evidence and he had failed to consider the relevant statutory factors. Id. at 893.

Motor Vehicle Manufacturers Association and Barry Service establish that when rendering decisions, the Department must consider the relevant factors as established by law, must consider relevant data, and must proffer a rational connection between that data and its choice. Under this precedent, the Department cannot fail to undertake the necessary procedural steps and later attempt to assert new justification for its decisions.

- 1. In setting Medicaid reimbursement rates, the Department must consider whether its rates will reimburse the costs that efficiently and economically operated facilities must incur.**

In analyzing whether an agency's decision-making process was arbitrary, capricious, or unreasonable, the first step is to identify the factors that the agency should have considered. In Missouri, Medicaid providers are entitled to reimbursement of their reasonable costs. §§ 208.152, .153, .159, RSMo 2000 & Supp. 2008; Little Hills

Healthcare, LLC, 236 S.W.3d at 643. By statute and the Department’s own regulation, the Department must specifically consider whether its rates reimburse the costs of efficiently and economically operated nursing homes. § 208.152.8, RSMo Supp. 2008; J. Ex. 1, 13 CSR 70-10.015(3)(O) (EF 001).

First, for nursing home reimbursement rates, section 208.152.8, RSMo Supp. 2008, establishes the standards that the Department must consider in measuring the adequacy of its reimbursement rates: “Providers 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.” (emphasis added). 42 U.S.C. § 1396a(a)(13)(A), or § 1902(a)(13)(A) of the Social Security Act, was formerly known as the “Boren Amendment.” It was replaced in 1997 with a notice and comment provision. See Pub. L. No. 105-33, 111 Stat. 251, 507 (1997); 42 U.S.C. § 1396a. The implementing regulations, however, have not been repealed or amended and continue to be codified at 42 C.F.R. § 447.250, et seq. In relevant part, 42 C.F.R. § 447.250 provides that state Medicaid agencies must make findings that their Medicaid reimbursement rates for hospitals and long-term care providers 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.” 42 C.F.R. § 447.250.

When a state law incorporates another source by reference, the effect is the same as if the incorporated material “had been written into the adopting statute.” Rees Oil Co.

v. Dir. of Revenue, 992 S.W.2d 354, 359 n.6 (Mo. App. 1999) (quoting Gen. Installation Co. v. Univ. City, 379 S.W.2d 601, 604-05 (Mo. banc 1964)). Section 208.152.8 incorporates the “regulations promulgated” under “Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a” into Missouri state law. 42 C.F.R. § 447.250 is a regulation promulgated under that statute. While Section 1902 (a)(13)(A) has since been amended, 42 C.F.R. § 447.250 has not been amended or repealed, and it continues to be incorporated into Missouri law. Thus, the efficiently and economically operated provider standard is a requirement of Missouri statute.

The General Assembly is presumed to know the substantive law. Citizens Electric Corp. v. Dir. of the Dep’t of Revenue, 766 S.W.2d 450, 452 (Mo. banc 1989) (“When the legislature enacts a statute referring to terms which have had other judicial or legislative meaning attached to them, the legislature is presumed to have acted with knowledge of that judicial or legislative action.”). The obligations imposed by Boren Amendment standard have been settled by judicial construction. See, e.g., Mo. Dep’t of Soc. Servs. v. Great Plains Hosp., Inc., 930 S.W.2d 429, 434-38 (Mo. App. W.D. 1996). Since the repeal of the Boren Amendment in 1997, the General Assembly specifically amended § 208.152 in 2004, 2005, and 2007. On all three occasions, the General Assembly re-enacted the exact same language in subsection 8. Thus, the legislature has expressly chosen to continue the same reimbursement standard in effect as a matter of state law, notwithstanding the change in federal law. Citizens Elec. Corp., 764 S.W.2d at 452.

Second, the Department has promulgated a regulation identifying the factors that it will consider when it reevaluates Medicaid reimbursement rates: “The reimbursement

rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of costs increases that must be incurred by efficiently and economically operated providers." J. Ex. 1, 13 CSR 70-10.015(3)(O) (EF 001; emphasis added). Thus, the Department voluntarily chose to adopt and retain the efficient and economically operated provider standard. The regulation's use of the permissive "may" indicates that the Department is not required to reevaluate rates. However, when the Department chooses to reevaluate them, it must consider whether the costs increases of efficiently and economically operated providers are being covered. Agency rules have the force and effect of law. Mo. Coalition for the Env't v. Jt. Comm. on Admin. Rules, 948 S.W.2d 125, 134 (Mo. banc 1997). Agencies are bound by their own rules. State ex rel. Martin-Erb v. Mo. Comm'n on Human Rights, 77 S.W.3d 600, 607-08 & n.6 (Mo. banc 2002); State ex rel. Stewart v. Civil Serv. Comm'n of the City of St. Louis, 120 S.W.3d 279, 287-88 (Mo. App. 2003). By promulgating subsection (3)(O), the Department bound itself to base rate reevaluation decisions on those factors.

By re-enacting § 208.152.8 and adopting 13 CSR 70-10.015(3)(O), the State is not contradicting the federal law change. To the contrary, by repealing the Boren Amendment, Congress intended to give states greater flexibility in setting their reimbursement rates. Children's Hosp. and Health Ctr. v. Belshe, 188 F.3d 1090, 1100-01 (9th Cir. 1999). States are now permitted, but not required, to use the efficiently and economically operated provider as a state standard. HCMF Corp. v. Gilmore, 26 F.Supp.2d 873, 878-880 (W.D. Va. 1998), aff'd HCMF Corp. v. Allen, 238 F.3d 273 (4th

Cir. 2001). When presented with that choice, Missouri chose to retain the efficiently and economically operated provider standard. Thus, in their AHC testimony, the Department's witnesses agreed that Medicaid rates must compensate providers for the costs that must be incurred by efficiently and economically operated providers, and repeatedly testified that they are required to establish Medicaid reimbursement rates that reimburse the costs of efficiently and economically operated providers. 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.

**2. In promulgating the challenged rules, the Department should have considered whether its proposed changes would reimburse the costs of efficiently and economically operated facilities.**

The efficiently and economically operated provider standard has been previously interpreted by the Missouri Court of Appeals and other state and federal courts because it was federally mandated until 1997 in the Boren Amendment. Congress repealed the Boren Amendment as a federal standard in 1997, but states remain free to apply the standard as a matter of state law, as Missouri has done through § 208.152.8 and 13 CSR 70-10.015(3)(O).

At a minimum, the Department is required to (1) identify characteristics of an efficiently and economically operated provider, (2) determine what costs such facilities must incur to provide services in conformity with state and federal law, and (3) verify

that the state's Medicaid rates are sufficient to reimburse those costs. Great Plains, 930 S.W.2d at 433-38. In the leading Missouri case, the Court of Appeals invalidated a rate reduction when the Department "assumed" providers were not being efficiently and economically operated, but did not analyze what kinds of facilities were efficiently and economically operated and whether the costs of such facilities were being reimbursed. Id. at 435. The Court of Appeals rejected the Department's attempt to rationalize the rate reduction by reference to other factors that it did consider. Id. at 436. The Court of Appeals held that the Department's consideration of other factors did not rectify its failure to consider whether the costs of efficiently and economically operated providers would be reimbursed. Id.

Other courts have reached the same conclusion. If the state proffers no data to show that its rates would reimburse reasonable costs for any Medicaid providers, its evidence is "flagrantly devoid of any effort to make the federally required findings." See AMISUB (PSL), Inc. v. Colo. Dep't of Soc. Servs., 879 F.2d 789, 796-97 (10th Cir. 1989). Although "[s]tates can consider budgetary constraints as a factor in amending Medicaid payment methods" and in setting reimbursement rates, "consideration of budgetary factors alone does not translate to automatic compliance with the [requirement] that efficiently and economically operated hospitals are reasonably and adequately compensated for the costs which must be incurred." Id. at 799-800. Moreover, a state must articulate a rational connection between the factual findings and its choice, and "budgetary constraints alone can never be sufficient." Id. at 800, 801. "If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient

funds to meet them, it could rewrite the [legislatively] imposed standards at will.” Id. at 801.

States cannot base their “determination of which facilities were economically and efficiently run on the amount of appropriated funds available” because “the standard for an efficiently and economically run institution should be an objective one” and should not be changed by the state “whenever it seeks to change its rates.” Americare Props., Inc. v. Whiteman, 891 P.2d 336, 345 (Kan. 1995).<sup>3</sup> In order to support rate reductions, the state “must, at the minimum, make findings that the new rates are adequate to meet the costs which must be incurred by a facility meeting some objective standard of economic and efficient operation.” Id. at 347. When a state fails to consider providers’ costs in reevaluating its reimbursement rates, that constitutes a failure to contemplate the relevant factors, and thus the state “cannot possibly conclude that there [was] a rational relationship of those factors to the rates set.” Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1500 (9th Cir. 1996).

“[T]he state cannot meet its obligations to identify efficiently and economically operated facilities by simply indulging in the assumption that any facility whose costs fall below the state’s own reimbursement rate is efficiently and economically operated.”

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<sup>3</sup> The abrogation of Americare Properties, Inc. on other grounds was recognized in Schall v. Wichita State University, 7 P.3d 1144 (Kan. 2000).

Okla. Nursing Home Ass'n v. Demps, 816 F. Supp. 688, 700 (W.D. Okla. 1992).<sup>4</sup>

Furthermore, “the state cannot define or identify the costs which such facilities must incur by indulging in the same assumption.” Id.

**3. The Department selected an 85% minimum utilization percentage to solve its funding issue and without determining whether the costs of efficiently and economically operated providers would be reimbursed.**

In 2005, the Department reduced rates to solve a funding issue. Its analysis of the impact to providers was limited to a determination that providers would not go out of business or be decertified as a result of the rate reduction. AHC Dec. ¶ 86 (LF 294). The Department did not: (1) identify the characteristics of an efficiently and economically operated facility; (2) determine what costs such a facility must incur to comply with state and federal laws and applicable quality and safety standards; or (3) analyze its rates to determine whether it was reasonably and adequately reimbursing such costs. Moreover, the Department did not even:

- conduct any reviews or studies of the Plan between the implementation of Missouri’s prospective rate system on January 1, 1995, and 2004;

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<sup>4</sup> This decision was vacated when the parties agreed to a settlement increasing the nursing facilities’ rates by \$3.00 per patient day. Okla. Nursing Home Ass'n v. Demps, 1994 WL 740024 (W.D. Okla. Mar. 3, 1994).

- consider any data about the quality of care provided in facilities, including state licensure inspections or certification surveys;
- request information about and does not know what is the average cost of taking care of a Medicaid resident in Missouri; or
- conduct any studies to further investigate the Missouri State Auditor's 2001 conclusions regarding what additional amount of reimbursement would be necessary to reimburse a Medicaid provider's allowable costs.

AHC Dec. ¶ 65 (LF 289). In the emergency statement that was published with the March 21 emergency amendment, the Department candidly admitted that its sole reason for changing the minimum utilization percentage was to solve its "funding issue." J. Ex. 4 (EF 084).

During the course of the litigation, the Department tried to support its decision with additional rationalizations. Those justifications are insufficient for two reasons. First, they are divisionary and do not address the question at issue: did the Department ever consider whether increasing the minimum utilization percentage would reimburse the costs of efficiently and economically operated facilities? The Department cannot justify its failure to consider that factor by pointing to other factors that it did consider. Great Plains, 930 S.W.2d at 436. When asked how it determined whether the costs of efficiently and economically operated providers would be reimbursed, the Department circularly reasoned that the Plan "defines the Medicaid allowable costs that were included in the determination of the rate." Tr. 201, l. 6-23. The Department further stated that its analysis is outlined in the Plan itself. Tr. 566, l. 15-20; Tr. 590, l. 11 - 591, l. 9. When

asked whether the Department can change its definition of what constitutes an “efficiently and economically operated facility” at any time since it can amend the Plan at any time, the Department answered, “It’s up to the Department to set its standards, and we did change it.” Tr. 579, l. 24 - 580, l. 14. The Department reasoned that its rates were sufficient if facilities were not “going out of business or being de-certified because of patient care deficiencies.” AHC Dec. ¶ 86 (LF 294). The Department’s only “fiscal analyses” consisted of scenarios that included calculations involving different combinations of minimum utilization percentages at 0, 73, and 85 percent. AHC Dec. ¶ 86 (LF 294); Tr. 326, l. 13-25; Tr. 876, l. 2-23; see P. Exs. 126-29 (EF 505-11) (the Department’s internal e-mail correspondence indicating the fiscal impact of various scenarios). These analyses were solely intended to evaluate means of amending the Plan to alleviate the Department’s budgetary constraints. See Tr. 326, l. 13-25; Tr. 876, l. 2-23; P. Exs. 126-29 (EF 505-11). The Department’s only alleged considerations of patient care were based on its observation and experience and were not reduced to writing. AHC Dec. ¶ 86 (LF 294); Tr. 205, l. 22 - 206, l. 17; Tr. 209, l. 5 - 210, l. 19; Tr. 214, l. 19 - 216, l. 9; Tr. 613, l. 2 - 615, l. 21; Tr. 616, l. 12 - 617, l. 10.

Second, the Department’s justifications for the rule change are after-the-act attempts to rationalize a budget-based decision. The rationality of the agency’s decision-making process must be evaluated based on the agency’s actual rationale and not on post hoc rationalizations. Motor Vehicle Mfrs. Ass’n, 463 U.S. at 43, 50. The Department is legally required to file a statement that explains the basis for an emergency amendment. § 536.025, RSMo 2000. The Department filed such a statement with the March 21

amendment. In that contemporaneous statement, the Department stated the reason for its action – to solve its funding issue. J. Ex. 4 (EF 085). The Department cannot remedy its failure to consider the required factors at the time of promulgating the rules by relying on after-the-fact suggestions of other factors that it could have considered.

The Department's decision-making process in 2005 is in stark contrast to the rational and reasoned process that it undertook in 1995 and 2004. When Medicaid reimbursement rates were established in those years, the Department determined that one of the characteristics of an efficiently and economically operated facility was that its occupancy rate met or exceeded the average occupancy rate for the industry. See AHC Dec. ¶¶ 24, 44, 48 (LF 280, 284, 285). By way of contrast, in 2005 the Department arbitrarily selected 85 percent because that percentage allowed the Department to achieve its budgetary goals. See J. Ex. 4 at (20) (EF 084); J. Ex. 5 at (20) (EF 086); Tr. 707, l. 9-19. Nothing in the record demonstrates any factual basis for determining that only facilities with 85% or greater occupancy rates are being efficiently and economically operated. In fact, because the average occupancy rate is 73%, the Department's new rule necessarily assumes that most nursing homes in Missouri are not being efficiently and economically operated. That assumption is not supported by any reasoned analysis.

Federal and state courts have regularly held that such budget-based decisions are anathema to and inconsistent with the general purposes and express terms of state Medicaid plans. See, e.g., AMISUB (PSL), Inc., 879 F.2d at 799-801; Americare Props., Inc., 891 P.2d at 345; Great Plains, 930 S.W.2d at 436. If the budget were a sufficient reason to decrease reimbursement rates, state legislatures would have free reign to restrict

or eliminate Medicaid entitlements without any consideration of the medical necessity or, in this case, the ability of providers to maintain compliance with health and safety standards. See 13 CSR 70-10.015(3)(O); 42 C.F.R. § 447.250. But, since Medicaid is the means by which many individuals receive vital and necessary health care services, Congress and state legislatures have limited Medicaid agencies' discretion to make program cuts in response to perceived funding shortfalls. Program cuts that do not comply with state or federal statute are invalid. 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). In this case, as the AHC specifically found, the Department only considered the worst case scenarios of whether facilities might be decertified or go out of business, and never attempted to analyze whether efficiently and economically operated facilities would be reimbursed for their costs. AHC Dec. ¶¶ 65, 86 (LF 289, 294).

In Barry Service, the Director agreed that he had not considered a relevant factor (profitability) in his rulemaking. His decision-making process was therefore arbitrary and capricious. 891 S.W.2d at 892-93. Likewise, the Department's failure to consider the relevant factors in its selection of the new minimum utilization percentage rendered its decision-making process arbitrary and capricious.

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

**A. Standard of review**

The lawfulness of a regulation is a question of law which this Court reviews de novo. Little Hills Healthcare, LLC, 236 S.W.3d at 641.

**B. The Department violated § 536.016, RSMo, by not basing its challenged rules on substantial evidence and by failing to find that the rules were necessary to carry out the purposes of the statute.**

The Department’s actions and omissions, as described in the Argument under the First Point Relied On, also demonstrate that the Department failed to comply with § 536.016, RSMo 2000, which requires that rules shall be proposed “based upon substantial evidence on the record and a finding by the agency that the rule is necessary to carry out the purposes of the statute that granted such rulemaking authority” and that

“[e]ach state agency shall adopt procedures by which it will determine whether a rule is necessary to carry out the purposes of the statute authorizing the rule.”

In general, § 536.016 codifies and adds to the rational decision-making requirements of the Motor Vehicle Manufacturers Association and Barry Service cases. For example, those cases held that the rational decision-making requirements follow from the obligation to base agency decisions on substantial evidence. Motor Vehicle Mfrs. Ass’n, 463 U.S. at 44; Barry Serv., 891 S.W.2d at 892, 893. Section 536.016 expressly confirms that an agency’s decision to propose a rule must be based upon substantial evidence. For the same reasons that the Department’s challenged rules were arbitrary, capricious, and unreasonable, the challenged rules also violated the requirement in § 536.016 that rules must be based on substantial evidence.

But, § 536.016 also goes further. It requires the agency to make a specific finding that the rule is necessary to carry out the purposes of the statute that granted the rulemaking authority. The Department’s witnesses testified that it relied on §§ 208.153, 208.159, and 208.201 as authority for the challenged rules. AHC Dec. ¶ 83 (LF 293). But, the Department never made a finding that these rules furthered any statutory purposes related to its rulemaking authority. See Tr. 207, 1. 16 - 208, 1. 20. The only consideration the Department made when promulgating the challenged rules was whether those rules would trim its budget sufficiently to meet its appropriation authority. As a result, the Department violated § 536.016, RSMo 2000, when promulgating the challenged rules.

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

**A. Standard of review**

The lawfulness of a regulation is a question of law which this Court reviews de novo. Little Hills Healthcare, LLC, 236 S.W.3d at 641.

**B. The March 21 and June 20 emergency amendments were invalid because no emergency existed to justify the Department's failure to follow notice and comment procedures.**

Before an agency changes a rule, the agency must first provide notice and an opportunity to comment to the public. § 536.021.2, RSMo Supp. 2008. The notice must include the proposed regulation, an explanation of the proposed change, and the reasons therefor. Id. When a rule change is finally adopted, the agency must publish that rule at least 30 days before it becomes effective. § 536.021.8, RSMo Supp. 2008. 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. 2008. 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) (quoting St. Louis Christian Home v. Mo. Comm'n on Human Rights, 634 S.W.2d 508, 515 (Mo. App. 1982)). Through this give and take, proposed policies are publicly tested.

In order to promulgate emergency rules without following notice and comment procedures, the Department must first find “an immediate danger to the public health, safety or welfare requires emergency action or the rule is necessary to preserve a compelling governmental interest that requires an early effective date as permitted pursuant to this section.” § 536.025.1(1), RSMo 2000. The specific facts, reasons, and findings for the emergency rule must be included in a written statement filed with the Secretary of State. § 536.025.2. Only if such an “emergency” exists may an agency change a rule without following the notice and comment process. § 536.025.1.

According to their respective accompanying written statements, the March 21 Emergency Amendment and June 20 Emergency Amendment were needed because the projected costs of Medicaid nursing homes services were going to exceed the amount appropriated. J. Ex. 4 (EF 084); see J. Ex. 7 (EF 094). The Emergency Statements to these amendments further provide: (1) the adjustments to the rate calculations were “necessary to ensure that payments for such nursing facility per diem rates [were] in line with the funds appropriated for that purpose”; (2) if the adjustments they contained were not enacted, the funds appropriated might become insufficient and result in no Medicaid

payments to the facilities; (3) the rate changes resulted from the Department's attempt to resolve the "funding issue within the means that the taxpayers, through the General Assembly, have given the division"; (4) "proactive action" was necessary by the division "to create an efficient and sustainable Medicaid program"; and (5) implementation of the rate changes had to occur "on a timely basis to ensure that quality nursing facility services continue to be provided to Medicaid patients in nursing facilities" through the end of the applicable state fiscal year. J. Exs. 4, 7 (EF 084, 094).

The Department's use of emergency rulemaking procedures was not justified. First, the danger was not immediate. The Department had known about the anticipated shortfall since June of 2004, which was nine to ten months before it issued the March 21 Emergency Amendment. AHC Dec. ¶ 57 (LF 287). As such, the Department had ample time to engage in normal notice and comment rulemaking. Further, if the Department could create an emergency by delaying implementation of a rule change until the last possible moment, the notice and comment rulemaking provisions would be effectively abrogated. The Department could always use its own inaction to justify dispensing with notice and comment procedures.

Second, an alleged budget shortfall is not an emergency that justifies cutting funds intended to pay for nursing home services for frail, elderly Missourians. The March 21 Emergency Amendment and June 20 Emergency Amendment effectively reduced the payments made for nursing home services to alleviate an alleged appropriation shortfall. The Department's rationale, if carried to its logical conclusion, would let the General Assembly and the Department curtail or eliminate any Medicaid program benefit or

service by failing to fund it, thereby creating instead of purportedly alleviating an immediate danger to the public.

Before promulgating its March 21 Emergency Amendment, the Department had six months to promulgate a proposed rule, receive comments, and adopt a final order of rulemaking before it lost its appropriation authority. The Department had nine months to undertake those procedures for its June 20 Emergency Amendment. Moreover, the Department promulgated the June 20 emergency amendment before the start of the next fiscal year when there was no imminent possibility of exhausting its appropriation authority. The budget shortfall for the previous year cannot justify dispensing with the notice and comment process for a rule change to be effective for the next fiscal year. On these facts, it is evident that the Department was not justified in its use of the procedures in § 536.025.1 to implement these emergency amendments, and the Department's failure to follow notice and comment procedures renders the March 21 Emergency Amendment and June 20 Emergency Amendment void and unenforceable. § 536.021.7, RSMo Supp. 2008 (“[A]ny rule, or amendment or rescission thereof, shall be null, void and unenforceable” unless promulgated in accordance with § 536.021).

## CONCLUSION

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

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

Respectfully submitted,

HUSCH BLACKWELL SANDERS LLP

By: \_\_\_\_\_  
HARVEY M. TETTLEBAUM, #20005  
ROBERT L. HESS II, #52548

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

ATTORNEYS FOR APPELLANTS

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

The undersigned counsel hereby certifies pursuant to Rule 84.06(c) that this brief (1) contains the information required by Rule 55.03; (2) complies with the limitations contained in Rule 84.06(b); and (3) contains 10,528 words, exclusive of the sections exempted by Rule 84.06(b)(2) of the Missouri Supreme Court Rules, based on the word count that is part of Microsoft Office Word 2003 SP-3. The undersigned counsel further certifies that the diskette has been scanned and is free of viruses.

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**CERTIFICATE OF SERVICE**

I certify that two copies of this brief and one copy on floppy disk, as required by Missouri Supreme Court Rule 84.06(g), were served on each of the counsel identified below by placement in the United States mail, postage paid, on this 26<sup>th</sup> day of March, 2009, to:

Mark E. Long  
Assistant Attorney General  
Office of the Attorney General  
Broadway State Office Building, 6th Floor  
221 West High Street  
Jefferson City, Missouri 65101

J. Scott Stacey, Assistant Attorney General  
Office of the Attorney General  
Broadway State Office Building, 7th Floor  
221 West High Street  
Jefferson City, MO 65101

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