

**IN THE MISSOURI SUPREME COURT**

**No. SC89737**

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**BEVERLY ENTERPRISES-MISSOURI, INC., ET AL.**

**Appellants,**

**v.**

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

**Respondent**

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**APPEAL FROM THE CIRCUIT COURT OF COLE COUNTY, MISSOURI  
THE HONORABLE BYRON L. KINDER, CIRCUIT JUDGE**

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**SUBSTITUTE BRIEF OF THE RESPONDENT**

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## **JURISDICTIONAL STATEMENT**

This case was previously heard and decided by the Missouri Court of Appeals, Western District. This Court, by order dated February 24, 2009, granted transfer of this case. Jurisdiction is pursuant to Article V, § 10 of the Missouri Constitution.

## STATEMENT OF FACTS

This case involves the Medicaid reimbursement paid to Missouri nursing homes.

Appellants, collectively referred to as “Beverly,” operate 17 long-term care facilities in Missouri. Appendix, A-3 to A5, ¶ 1-20; LF 277-279; 503-506. The Beverly facilities are certified to participate in the Missouri Medicaid Program, and the Department of Social Services administers Medicaid payments, including reimbursement rates. Appx. A-5, ¶ 21; LF 507. Respondent MO HealthNet Division, formerly known as the Missouri Division of Medical Services, is a division of the Department of Social Services. § 208.201, RSMo<sup>1</sup>. LF 507.

Under the Medicaid program, a nursing facility receives a set daily rate for each Medicaid resident, its per diem reimbursement rate. Appx. A-5, ¶ 22; LF 507. Medicaid rates are set by regulation, not by statute, and the rule governing Medicaid per diem reimbursement to nursing facilities is 13 CSR 70-10.015, the “Prospective Reimbursement Plan for Nursing Facility Services.” Tr. 254, l. 19-26; Ex. Z, J. Ex. 1.

The “Reimbursement Plan” set out in 13 CSR 70-10.015 went into effect on January 1, 1995. Appx. A-5, ¶ 22, Jt. Ex. 86. It is a “prospective reimbursement plan.” Tr. 264, l. 4-9. The Reimbursement Plan was the result of the work of a task force commissioned by the Governor to recommend a new, better reimbursement plan. Tr. 332. The task force started meeting in 1993 and consisted of representatives from the Departments of Health and of Social Services, and from the Divisions of Aging and of Medical Services, along with

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<sup>1</sup> Unless otherwise noted, all statute references are to the Cum. Suppl. 2008.

industry representatives and other interested parties. Appx. A-5, A-6, ¶¶ 23-24; Tr. 332. The task force analyzed other states' reimbursement systems, considered actual industry experience, and ran various cost scenarios. The task force recommended and the Division adopted an 85% minimum utilization adjustment for the administration and capital cost components in the 1995 version of the Reimbursement Plan because that was the average occupancy rate of Missouri facilities at the time. Appx. A-6, ¶ 24; Tr. 334-335.

Each nursing facility submits an annual cost report to the Division, which records the facility's expenses in caring for all of its patients. Tr. 476, 480, 496. The cost report does not break down the costs associated with care provided to just the facility's Medicaid patients. Tr. 261. Instead, the cost reports contain the facility's costs of caring for Medicaid, Medicare, private-pay, and all other patients. Tr. 237, 480.

Prior to calculating the per diem rates, the Division removes costs that are not allowed under the regulation. Tr. 258. "Allowable Cost Areas" are detailed in paragraph (7) of the regulation. Ex. Z. The allowable costs are identified in the Division's Audit Adjustment Report, generated during the review of the cost report. Tr. 472, 496-497, 500; Ex. FF, GG2-UU2, WW2. The per diem rate is calculated based on the "allowable costs" in previous years, and the application of trend factors, along with certain incentives, and adjustments. Ex. Z, Tr. 250, l. 16 - 251, l. 20.

The allowable costs that are used to determine a nursing facility's per diem rate are grouped into four cost components: patient care, ancillary, administration, and capital. 13 CSR 70-10.015(4)(Q), (11)(A)-(D). Appx. A-8, ¶¶ 33-35; J. Stip. ¶33. The per diem rate is the sum of these individual cost components. From the allowable cost on the cost reports,

the Division calculates an average per patient per day cost of care for residents by dividing the total costs by total patient days. Tr. 262-263.

The administration and capital cost components are subject to a minimum utilization adjustment. The minimum utilization percentage is a reasonableness and efficiency standard to prevent the Division from paying for an excessive number of empty beds. J. Ex. 6; Tr. 1267-68. In adjusting the capital and administration cost components for minimum utilization, the cost component that is included in the per diem for a facility with an occupancy rate below 85% is calculated as if the facility experienced 85% occupancy. 13 CSR 70-10.015(7)(O); J. Stip. ¶39.

The effect of adjusting cost components for minimum utilization is to spread a nursing facility's costs over more patient days than the facility actually observed, thereby decreasing the facility's per diem rate. Appx. A-9, ¶ 40, 42; J. Stip. ¶41. Here, eight of Beverly's 17 facilities had occupancy rates below 75% for 2001, and four of the facilities' occupancy rates were below 55%. J. Stip. ¶43.

After the patient care, ancillary, and administration cost components of a facility are calculated, the respective calculations are compared to a ceiling figure for that component. 13 CSR 70-10.015(11)(C); Tr. 258; Ex. Z. The figure used for each component in the facility's per diem rate is the lower of its calculated per diem rate for that component or the ceiling for that component. Tr. 258.

### **The July 2004 change in per diem reimbursement and a budget shortfall.**

During the 2004 legislative session, the General Assembly passed and the Governor signed Senate Bill 1123, which was codified as § 208.225, RSMo Cum.Supp.2004, and

became effective on July 1, 2004. Appx. A-11, ¶ 50; J. Ex. 2; J. Stip. ¶48. Section 208.225 required the Division to recalculate Medicaid per diem reimbursement rates and to set the administration cost ceiling at 110% of the median cost center. J. Stip. ¶49-50; J. Ex. 2. Although not required by § 208.225, the Division also changed the regulation's minimum utilization adjustment for the capital cost component from 85% to 73% and eliminated the 85% minimum utilization adjustment for the administration cost component. Tr. 322, 327. The Division made these changes after consulting with the industry, and running various cost assessment scenarios. Tr. 325-327

The Division, by letters dated July 1 and July 13, 2004, notified the nursing facilities participating in the Missouri Medicaid program of their new per diem rates, effective July 1, 2004, for state fiscal year 2005 (FY2005), which ran from July 1, 2004 through June 30, 2005. J. Ex. 8 – 29; J. Stip. ¶53. The new rate calculations were based on Senate Bill 1123, which mandated paying only one-third of the increase in rates as calculated by the Division based upon the 2001 cost reports, and the additional changes to the Division's reimbursement Plan made through the Division's implementing regulation. J. Ex. 1; Tr. 346; J. Stip. ¶52.

The result in FY 2005 of the change in the per diem rates was that Beverly's facilities received an average increase in their Medicaid per diem rates of \$6.35 from their previous per diem rates of FY 2004. Ex. U. In addition, Beverly's per diem rates for the preceding year, FY 2004, were \$5.44 higher than their rates in FY 2003. Ex. C-S; Tr. 310.

The Division calculated that implementing the July 2004 rate increase would cost \$58.4 million for FY2005, but the General Assembly only appropriated \$42.5 million to fund

the July 2004 rate increase, a shortage of some \$16 million. Appx. A-13, ¶ 57, 60-61; J. Exs. 4, 47; J. Stip. ¶59. Therefore, the Division would run out of money before the end of the fiscal year. The Division notified the General Assembly in June 2004 of the appropriation shortfall, and the need for a supplemental appropriation. Ex. A; Tr. 153-154. In October 2004, the Division submitted its supplemental appropriation request to the Office of Budget and Planning and the Governor's budget staff. Tr. 154-156.

In late January 2005, the Division learned that its supplemental appropriation request for approximately \$16 million was not part of the Governor's supplemental appropriations request to the legislature. Appx. A-13, ¶ 59; LF 287. The General Assembly did not appropriate supplemental funds for Medicaid nursing home reimbursement for FY2005. J. Stip. ¶60. Without the supplemental appropriation, the Division projected that Medicaid payments to nursing homes for FY2005 would end in May 2005. Appx. A-13, ¶ 61; Tr. 158-159.

The Division examined different options for emergency rule promulgation to enable it to make payments within the appropriated amount for FY2005. Tr. 155, 177. The Division reviewed the cost reports submitted by all Missouri Medicaid nursing home and constructed databases with the homes' cost information. Tr. 480 and 496; Ex. X. As the cost reports recorded all costs associated with patient care, the Division could assess the impacts of potential changes on each cost component, including the patient care component. Ex. X; Tr. 235, 475-476.

The Division also reviewed the State Certificate of Need Program's quarterly surveys and summaries. Ex. X; Tr. 372-377. The surveys indicated that the number of Missouri

Medicaid nursing facilities had remained fairly steady since 2001, the number of available Medicaid beds had increased slightly since 1995, and that 51% of Medicaid-eligible beds were occupied as of 2005. Ex. X; Tr. 372, 375, 377. The Division was also aware of a State Auditor's Report which concluded that the nursing home industry in Missouri was overbuilt. Ex. 107. The Division even met with representatives of two nursing home associations in the state, the Missouri Health Care Association (MHCA) and the Missouri Association of Homes for the Aging (MOAHA), to obtain feedback on proposed changes to the Reimbursement Plan. Tr. 166; Ex. X.

The Division examined various changes to the regulation, and the impact that each scenario would have on the nursing facilities. Ex. X; Tr. 235, 351 and 356. Scenarios examined by the Division included the elimination of trend factors and a pro rata reduction of rates. While those options would have kept Medicaid payments within the appropriation, the Division rejected them because they would have affected the patient care and ancillary cost components. Tr. 151-153. The Division also examined amending the minimum utilization percentages, considering different combinations of 0, 73, and 85% for the capital and administration cost components and the possibility of pegging the minimum utilization percentages to the current occupancy levels in the state. Ex. X; Tr. 412. Based on its analysis of the different scenarios and the Division's experience with an 85% minimum utilization adjustment from 1995 until 2004, the Division ultimately concluded that increasing the minimum utilization percentages of the capital and administration cost components best met its goals. Tr. 483-484.

The Division's goal in amending the reimbursement method under the regulation was to avoid affecting the patient care and ancillary cost components – the ones most directly tied to the cost of patient care. Tr. 153. The Division did not want to pay for empty beds by not having a minimum utilization percentage. J. Ex. 6. The Division also had to stay within its appropriation. Tr. 151-153. The Division determined that it could not continue to make payments under the then current utilization percentages because it would not meet the goal of continuing to make payments to nursing homes, and was precluded from borrowing money. Tr. 149.

The Division examined the possibility of pegging the minimum utilization percentages to the current occupancy levels for all beds in nursing facilities in the state. Tr. 412; Ex. X. The Division rejected this, however, because the trend throughout the state had been a steady decrease in overall nursing facility occupancy rates from 85% in 1995 to 73% in 2005, and at some point the Division would have to make a public policy decision as to how many empty beds it wanted to pay for. Tr. 412; Ex. X; J. Ex. 6. The Division concluded that increasing the utilization percentages of the administration and capital cost components best met its goals of not wanting to pay for empty beds, and not wanting to reduce the patient care and ancillary cost component per diem rates, while enabling the Division to continue to make payments to nursing homes for the remainder of FY 2005. Tr. 483-484. The Division had 9.5 years of experience with the 85% minimum utilization percentage for the nursing home industry, and could observe its impact. Tr. 210. The Certificate of Need summary information supported the Division's conclusion that there would be no mass exodus of providers from the Medicaid program, which could negatively impact patient care. Tr. 413.

## **The amendments to the regulation**

Initially, the Division filed an emergency rule amendment to 13 CSR 70-10.015 on March 3, 2005, to take effect on March 16, 2005. J. Stip. ¶¶62; J. Ex. 48- 66. But on March 10, 2005, the Division withdrew that emergency amendment so it could obtain additional public comment, and that amendment never went into effect. J. Ex. 67; J. Stip. ¶¶63, 64. That amendment was more financially harsh to the nursing home industry than the amendment which the Division ultimately promulgated. Tr. 162, 166.

On or about March 21, 2005, the Division filed an emergency amendment to 13 CSR 70-10.015. Appx. A16, ¶ 71; J. Ex. 4; J. Stip. ¶¶65. The March 21 amendment provided that the Medicaid per diem reimbursement rate for nursing facilities would be rebased effective April 1, 2005, using each facility's 2001 cost report. J. Ex. 30-46. The emergency rule also amended the regulation's minimum utilization adjustment for the capital cost component from 73% to 85% and the administration cost component from 0% to 85%. J. Ex. 4; J. Stip. ¶¶47, 66; LF 509. The March 21 emergency rule was effective from April 1 to September 27, 2005. Appx. A-18, ¶ 79; J. Stip. ¶72.

The financial effect of the March 21 emergency rule change was that every facility received a higher amount than it had on June 30, 2004, but a lower increase in their per diem reimbursement than the July 1, 2004 rate. Ex. U. On average, the per diem rate for Beverly's facilities increased \$5.11 from the previous fiscal year, even after their rates were reduced from the July 1, 2004 rates. Ex. BB, U.

As the AHC found, the March 21 amendment reduced the average per diem to the Beverly facilities by \$1.25. But the AHC also noted that “[d]espite this decrease, each of [Beverly’s] facilities still received a higher per diem than each received before the July 1, 2004, rate change.” Appx. A-19 to A-20; ¶ 85.

On March 29, 2005, the Division filed a proposed amendment to make the changes in the March 21 emergency amendment permanent and to provide for the calculation of rates for FY2006. Appx. A-18, ¶ 80; J. Stip. ¶73. By order of rulemaking published in the Missouri Register on or about August 15, 2005, the Division promulgated the March 29 proposed amendment to 13 CSR 70-10.015 as a final rule with minor changes. Appx. A-18, ¶ 81; J. Stip. ¶74; J. Ex. 6.

On June 20, 2005, the Division issued another emergency amendment for calculation of per diem reimbursement rates effective from July 1 through December 25, 2005. It had the same rate structure as the March 21 amendment. Appx. A-19, ¶ 82; Jt. Ex. 7; LF 293.

The Division also requested and received approval of its rule changes, including the resetting of the minimum utilization percentage to 85%, from the Centers for Medicare and Medicaid Services (CMS), the federal agency that reviews such requests for compliance with federal laws governing the program. Ex. T and ZZ. The changes were incorporated into Missouri’s federally-approved Medicaid State Plan. Ex. ZZ.

### **The AHC proceedings**

Each of Beverly's facilities filed a complaint with the AHC regarding their new per diem reimbursement rates effective April 1, 2005. LF 507. Following a hearing on the consolidated cases, the AHC issued its decision. Appx. A1.

The AHC found that it did not have jurisdiction to declare the validity of the challenged amendments to the rule and only made findings of fact on the issue. Appx. A-30 to A-31. The AHC did not hold that resetting the minimum utilization to 85% was improper. Appx. A-31. But the AHC did find that the Division's calculation of the administration cost ceiling under paragraph 11(C) of the regulation was incorrect by adjusting the cost figures for minimum utilization, and ordered a recalculation of the administration cost component ceiling for all of Beverly's facilities. Appx. A-21 to A-29; LF 768-776.

The AHC also denied an offer of proof by the Division concerning the financial condition of the Beverly homes. Tr. 960-977, 1276; LF 391-394.

## **The Circuit Court proceeding and appeal**

Both Beverly and the Division sought judicial review of the AHC's decision in the Circuit Court of Cole County under §§ 536.100-536.140, RSMo (Cum. Supp. 2006). LF 2, 12-26, 64-76.

The circuit court entered judgment on October 1, 2007. Appx. A-33. The circuit court denied Beverly's challenges to the Division's rule amendments and to the minimum utilization percentage. Appx. A-36 to A-46. The circuit court also reversed the AHC's decision ordering a recalculation of the ceiling, finding that the Division's calculation of the administration cost component ceiling complied with the plain language of the regulation. Appx. A-46 to A-50. The decision did not address the AHC's denial of the offer of proof, as the court concluded that the challenge was moot in light of its other rulings. Appx. A-50 to A-51; LF 5, 154-155.

From that decision, Beverly appealed to the Missouri Court of Appeals, Western District. The Court of Appeals issued a decision on September 9, 2008, finding in favor of the Division on all issues, and affirming the circuit court decision. This Court accepted transfer of the case on February 24, 2009.

## STANDARD OF REVIEW

Appellants – collectively referred to as “Beverly” – filed suit at the Administrative Hearing Commission (AHC) challenging the validity of emergency and proposed amendments to the Department’s regulation governing Medicaid per diem payments, 13 CSR 70-10.015.

The AHC held that the Department was incorrectly calculating the administration cost component ceiling under the rule. But it also held that the Department could base minimum utilization at an 85% level. The AHC did not invalidate the Department’s rules, finding that the rules did not directly and expressly conflict with any statute, and the AHC applied the rules in making its Decision.

Both parties filed for judicial review with the circuit court of Cole County. The circuit court ruled in favor of the Department on all issues, and Beverly filed a notice of appeal to the Court of Appeals.

For the issues decided by the AHC, the appellate court reviews the decision of the AHC, not the circuit court. *Cocktail Fortune, Inc. v. Supervisor of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999). The AHC’s decision will be upheld unless it is not supported by competent and substantial evidence upon the whole record; it is arbitrary, capricious, or unreasonable; it is an abuse of discretion; or it is otherwise unauthorized by law or is in violation of constitutional provisions. *Dep’t of Soc. Servs., Div. of Med. Servs. v. Little Hills Healthcare, L.L.C.*, 236 S.W.3d 637, 641 (Mo. banc 2007).

Since the AHC does not have the authority to amend or rewrite a rule, nor does it have the power to declare an administrative rule invalid, as that is a purely judicial function, so the

circuit court ruled on the constitutional validity of the regulation. *Cocktail Fortune, Inc.*, 994 S.W.2d at 957 (citing *State Tax Commission v. Administrative Hearing Commission*, 641 S.W.2d 69, 76 (Mo. banc 1982)). So here, the circuit court ruled on those issues *de novo*, finding in favor of the Department. This Court will affirm the trial court's decision unless it is unsupported by substantial evidence, it is against the weight of the evidence, or it erroneously declares or applies the law. *Murphy v. Carron*, 536 S.W.2d 30, 32 (Mo. banc 1976). Questions of law are reviewed *de novo*. *Little Hills Healthcare*, 236 S.W.3d at 641.

As this case involves decisions by the AHC on some issues, and decisions on other issues by the circuit court, the parties have agreed to modify the standard briefing under Rule 84.05(e). Normally, under that rule, the party aggrieved by an agency decision files the appellant's brief and the reply brief. Here, as both parties were aggrieved, this Court's order of March 3, 2009 permits each party to file an initial brief, and then a reply brief. As such, the Department's opening brief raises its issues with the AHC decision, and also responds to Beverly's opening brief.

**POINTS RELIED ON**

**I. The AHC erred in holding that regulation 13 CSR 70-10.015 required the Department to recalculate the administration cost component “ceiling” to exclude the application of the 85% minimum utilization from the calculation, because its decision was in excess of the statutory authority or jurisdiction of the AHC, is unsupported by competent and substantial evidence upon the whole record, is unauthorized by law, is arbitrary, capricious, or unreasonable and involves an abuse of discretion under RSMo § 536.140.2 in that the AHC applied the wrong standard of review and interpreted the rule contrary to its plain language and contrary to the canons of statutory construction, including *in pari materia*. [Point I of this brief.]**

*Lane v. Lensmeyer*, 158 S.W.3d 218 (Mo. banc 2005)

*Foremost-McKesson, Inc. v. Davis*, 488 S.W.2d 193, 197-198 (Mo. banc 1972)

13 CSR 70-10.015

**II. The AHC erred in holding that the Department’s offer of proof was not relevant because its decision is in excess of the statutory authority or jurisdiction of the AHC, is unsupported by competent and substantial evidence upon the whole record, is unauthorized by law, is arbitrary, capricious or unreasonable and involves an abuse of discretion under RSMo § 536.140.2 in that the offer of proof establishes that Beverly cannot meet its burden of establishing a Boren Amendment violation. [Point IV of this brief.]**

*Forest Health Systems v. Dept. of Social Services*, 879 S.W.2d 566 (Mo. App. W.D.

1994)

## **ARGUMENT**

The decisions of the AHC and the circuit court addressed five issues: (1) the calculation of the per diem's administration cost ceiling; (2) the setting of minimum utilization at an 85% level; (3) whether an emergency existed, justifying an emergency rule; (4) whether the emergency rule was properly promulgated; and, (5) the Department's proffer of proof concerning financial information about the Beverly facilities.

In this Brief, the Department will address the decisions of the AHC that were against the Department (Point I, calculation of the administration cost ceiling, and Point IV, the rejection of a proffer of proof), and respond to the arguments raised in Beverly's brief (Points II and III, herein).

### **Introduction**

Nursing homes are reimbursed for Medicaid at a per diem rate. The calculation of the individual homes' per diem is based on the allowable costs, which are grouped into four cost components: patient care, ancillary, administration, and capital. 13 CSR 70-10.015(4)(Q), (11)(A)-(D). J. Stip. ¶33; Tr. 258. Patient care costs include such items as staff salaries, food, nursing costs, and non-prescription drugs. Ancillary costs include physician service; physical, speech, and occupational therapy; and pharmacy, housekeeping and medical supplies. Administration costs include the administrator salary, utilities, maintenance, owners' compensation, and legal costs. The capital component covers such items as real estate rental, amortization, insurance, and taxes for real and personal property.

A nursing home's per diem calculation for each of the four cost components is compared to a specific ceiling figure – a limit on costs – and the home is paid the lower of the two amounts under the regulation. Tr. 258. Therefore, a higher ceiling potentially nets certain homes a higher per diem rate, and, hence, more money.

The dispute concerned the ceiling calculation for the administration cost component, and whether the 85% minimum utilization figure should be applied. After the per diem rate was reset by the emergency rule amendment starting April 1, 2005, Beverly's facilities, on average, made \$5.11 more than they did before the July 1, 2004 rate change. Ex. U.

The AHC found that the Department's setting minimum utilization at an 85% figure was acceptable, but held that minimum utilization should not be used to calculate the ceiling figure. Not applying minimum utilization meant that the administration ceiling figure increased, netting more money for the Beverly homes, as eight of Beverly's facilities had occupancy rates below 75%, and four were below 55%. J. Stip. ¶43. The result in FY 2005 of the change in the per diem rates was that Beverly's facilities received an average increase in their Medicaid per diem rates of \$6.35 from their previous per diem rates of SFY 2004. Ex. U. Beverly's FY 2004 rates were \$5.44 higher than their rates in FY 2003. Ex. C-S; Tr. 310.

I. The AHC erred in holding that regulation 13 CSR 70-10.015 required the Department to recalculate the administration cost component “ceiling” to exclude the application of the 85% minimum utilization from the calculation, because its decision was in excess of the statutory authority or jurisdiction of the AHC, is unsupported by competent and substantial evidence upon the whole record, is unauthorized by law, is arbitrary, capricious, or unreasonable and involves an abuse of discretion under RSMo § 536.140.2 in that the AHC applied the wrong standard of review and interpreted the rule contrary to its plain language and contrary to the canons of statutory construction, including *in pari materia*.

**A. In calculating the administration cost component for a facility’s per diem, the regulation required that minimum utilization – one of the allowable costs adjustments – be used to determine the ceiling figure.**

Beverly challenged its per diem’s calculation under 13 CSR 70-10.015, as amended. At the AHC hearing, Beverly conceded that: (1) the Department has calculated the administration per diem rate in the same manner since the inception of regulation on January 1, 1995 through the 2005 rate calculations at issue herein; and, (2) that this calculation method has never been challenged. Tr. 270, l. 12 - 271, l. 11; 317, l. 15-22; 318 l. 16-19.

The AHC erred in finding that the calculation of the cost ceiling under the regulation should exclude using minimum utilization in arriving at the median. This decision is contrary to the provisions of the regulation, and the canons of construction.

The same principles of construction are used in interpreting regulations as in interpreting statutes. *Teague v. Missouri Gaming Com'n*, 127 S.W.3d 679, 687 (Mo.App. W.D. 2003). This includes using the plain and ordinary meaning of words in the regulation,

reading the regulation as a whole and in *pari materia* with related statutes and rules, and giving effect to all of the language used in the regulation. *Lane v. Lensmeyer*, 158 S.W.3d 218 (Mo. banc 2005); *Forest Health Systems, Inc. of Missouri v. Missouri Dept. of Social Services*, 879 S.W.2d 566, 569 (Mo. App. W.D. 1994). In addition to the general rules of statutory construction, “[w]hen interpretation of an agency’s own rule is at issue, [the Court should] give deference to the agency’s determination.” *Willard v. Red Lobster*, 926 S.W.2d 550, 553 (Mo. App. E.D. 1996). As the AHC recognized, the Department’s interpretation of its own regulation is entitled to “great weight.” LF 770, 774 (citing *Foremost-McKesson, Inc.*, 488 S.W.2d at 197-198).

### **B. The AHC Decision**

The AHC found that the Division, in calculating the administration ceiling, improperly based the median on the individual home’s administration per diems adjusted for minimum utilization. The AHC found that the median should, instead, be based on the raw cost data in the data bank. The AHC based its decision on the fact that only section 11(C)1 of the regulation explicitly mandated a minimum utilization adjustment and that such adjustment was not required in calculating the ceiling under section 11(C)2 or under the definitions of “median” in section 4(KK) or “data bank” in section 4(S) of the regulation. Appx. A-23 to A-27.

The AHC is right that there are no references to minimum utilization in the definitions of median and data bank. But in demanding such references, the AHC’s decision looks at the regulation’s sections in isolation. The regulation requires the application of minimum utilization in calculating both the per diem and the ceiling figures.

The effect of adjusting cost components for minimum utilization is to spread a nursing facility's costs over more patient days than the facility actually observed, thereby decreasing the facility's per diem rate. J. Stip. ¶41. And Beverly wanted to avoid such a decrease, as its facilities had occupancy problems: eight of Beverly's facilities had occupancy rates below 75% for 2001, and four were below 55%. J. Stip. ¶43.

### **C. Calculation of the administration per diem and the ceiling**

Under the regulation, 13 CSR 70-10.015, the amount each nursing home receives for its administration costs is based on determining two figures under subsection 11(C), and the home is then paid the lower of the two figures. The first figure, determined under 11(C)1, is each nursing home's per diem for administration costs. The second figure, determined under 11(C)2, is the ceiling for that cost component. J. Ex. 1; Ex. Z.

The Division calculated the per diem for each nursing home, then adjusted that per diem for minimum utilization. Tr. 459, 461, 463-464. This is based on its allowable costs, and applying a minimum utilization figure, if applicable. 11(7) and 11(8) of the regulation.

The second figure, determined under 11(C)2, is a "per diem ceiling," which is 110% of the "administration median as determined from the data bank." The Division selected the middle value of all the per diems it calculated under 11(C)1, yielding a median of \$19.45. Tr. 459, l. 1-14; 461, l. 8-14. Then the Division multiplied that median by 110%, yielding a ceiling figure of \$21.40. Tr. 464, l. 20 – 465, l. 24; Ex. Z, DD, and EE. It is uncontested that the Department has calculated the administration cost per diem ceiling in this manner since the inception of the Plan on January 1, 1995. Tr. 64, 68, 70.

Beverly does not dispute the application of the minimum utilization percentage to calculate the per diem figure under 11(C)1 of the regulation. Instead, Beverly contests minimum utilization's applicability to the ceiling calculation under 11(C)2 of the regulation. Tr. 461, l. 3-12; 463, l. 6-16; 1077, l. 8-20. In contrast to the Division's \$21.40 ceiling calculation, Beverly and the AHC calculated the ceiling at \$23.96 by eliminating the application of minimum utilization. LF 292, ¶ 78.

But an examination of the definitions in the regulation demonstrate that the AHC erred in finding that minimum utilization should not apply in determining the ceiling figure under 11(C)2 of the regulation. "Ceiling" is defined as:

Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is . . . one hundred ten percent (110%) for administration.

13 CSR 70-10.015(4)(L). The Division, after calculating a per diem for every home, selected the median from those individual per diems, as the median is defined as:

Median. The middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the data bank.

13 CSR 70-10.015(4)(KK); J. Ex. 1, Ex. Z; Tr. 459, l. 8-14; 1015, l. 3-12. This is in keeping with the definition of "ceiling" in 4(L), which requires apply a percentage to the "median per diem" for the cost component.

Section 4(L) of the regulation defines the ceiling as 110% of the administration cost component “median per diem.” The administration per diem is the figure calculated under section 11(C)1 of the regulation, and it is specifically adjusted for minimum utilization. As the median is defined in 4(KK) as the middle value of a distribution, the “median per diem” must be the middle value of the per diems.

“Per diem” is defined at (4)(PP) of the regulation as: “the daily rate calculated using this regulation’s cost components and used in the determination of a facility’s prospective and/or interim rate.” J. Stip. ¶34. A facility’s per diem rate is the sum of the individual cost component per diems for that facility, plus certain allowances, incentives, and adjustments. 13 CSR 70-10.015(11) and (13); J. Stip. ¶35. One of those adjusts is for allowable costs, and Paragraph 7(O) of the allowable cost section of the regulation requires adjusting the administrative cost component to reflect 85% minimum utilization. Ex. Z.

The AHC, in holding that the lack of reference to minimum utilization in the definition of “median” in 4(KK), incorrectly examined just that section in making its determination. The definitions of “ceiling” and “per diem” reflect that minimum utilization does apply, as it is part of the allowable costs used to calculate the per diem, and, hence, the “median per diem” referenced in 11(C)2 of the regulation.

The AHC’s error also stems from incorrectly finding that the definition of “data bank” in 4(S) of the regulation does not reference minimum utilization, so it should be applied. The AHC’s decision interpreted the use of the data bank to just the application of the raw data. LF 772.

But the regulation's references to data bank demonstrate that the AHC's interpretation is incorrect. The ceiling figure calculated under 11(C)2 of the regulation is to be "determined by the division from the data bank." Likewise, the definition of "median" states that "[t]his distribution is based on the data bank." The definition of data bank even refers to the "desk audited and/or field audited" cost reports. (4)(S). None of these sections require using just the raw data in the data bank, without considering allowable costs.

The cost reports that make up the data bank include the costs associated with providing care to every patient, including Medicaid, Medicare, private-pay, and any other patients. Tr. 237, 480. Nursing homes do not submit data to the Division that breaks down the costs associated with care provided to just Medicaid patients. Tr. 261.

The Division, based on these cost reports, calculates an average per patient per day cost of care for Medicaid patients at a particular home by dividing the total allowable costs by total patient days. Tr. 262-263. The Division removes costs which are not allowable under the Plan prior to calculating the per diem rate for the home. Tr. 258. The determination of the home's allowable costs is listed in the Audit Adjustment Report, the report generated during the Division's review of a cost report. Tr. 472, 496-497, 500; Ex. FF, GG2-UU2, WW2.

The data bank also includes the ancillary, patient care, administration, and capital cost component per diem rates as calculated under paragraph (11)(A-D) of the regulation. Tr. 462, 466. The administration per diem is found in the data bank at Column 3, p. 37, of Exhibit 145. Tr. 463, l. 6 - 464, l. 2; Tr. 1035, l. 11-22. The Division includes columns in the data bank that calculate the various per diem rates as a necessary corollary to the selection of

a “median per diem” as required by 13 CSR 70-10.015(4)(L). Tr. 466, l. 23 - 467, l. 10. The data bank must include the per diems because the regulation requires that the median be selected from the data bank and the value selected is a median per diem. Tr. 553, l. 7 - 554, l. 14.

Thus, a calculation from the data bank must be based on allowable costs, and a calculation based on the data bank has the allowable costs at hand. Minimum utilization is simply one of the allowable cost factors found in the allowable cost section of the regulation. Not applying it means that a calculation is not based on just the allowable costs, i.e., that it actually includes costs that are not allowable. The AHC excluded minimum utilization from calculating the ceiling, but did not exclude every other allowable cost adjustment.

The AHC erred in ruling that the Division incorrectly calculated the ceiling. Its decision essentially reads out of 13 CSR 70-10.015(4)(L) the requirement that the ceiling be determined by applying a percentage to the median per diem for the administration cost component. This would necessarily involve a re-writing of the Department’s regulation to arrive at “an entirely different rate” than the one outlined in the Department’s regulation, a legislative function reserved to the Department. *Monroe County Nursing Home Dist. v. Department of Social Services*, 884 S.W.2d 291, 293 (Mo. App. 1994).

The Department’s calculation of the ceiling complies with the plain language of the rule, and therefore should be followed. *Foremost-McKesson, Inc. v. Davis*, 488 S.W.2d 193, 197-198 (Mo. banc 1972). This Court should reverse the AHC’s decision on this issue.

**II. The regulation’s setting of minimum utilization at 85% complies with federal and state law, and the repealed federal Boren Amendment does not apply. (Responding to Beverly’s Points Relied On I and II)**

As found by the AHC and the circuit court, the Division’s regulation complies with both federal and state law, and were properly promulgated under Missouri law. The rules reimbursing nursing homes were not arbitrary, capricious, nor contrary to the applicable law. This Court should affirm the AHC and circuit court decisions.

**A. The per diem rate regulation complies with federal law**

Since 1981, Missouri’s Medicaid system uses a prospective reimbursement plan to create incentives for “cost containment measures which might either free funds for improved services for needy recipients or reduce the combined federal and state tax burden underwriting the program.” *AGI-Bloomfield Convalescent Center v. Toan*, 679 S.W.2d 294, 298 (Mo. App. 1984). Making prospective payments, rather than paying actual costs, “provide[s] reasonable reimbursement to participating providers while incorporating cost containment measures.” *Rolla Manor*, 865 S.W.2d at 815.

Beverly’s own expert witness, Derek Hunter, admitted that under the Department’s rule governing nursing facility Medicaid reimbursement, not all costs are reimbursable. He further admitted that the nursing homes’ cost reports, submitted to the Department, list the cost of caring for all of the patients of a nursing facility, including costs for both covered and non-covered services. Tr. 1071, l. 7-9; T. 1097, l. 7-9. Beverly cannot seek payment from the Department for nonallowable costs. 13 CSR 70-10.015(8); Ex. Z.

Medicaid is a joint state and federal program. As such, the Department's rules must comply with both state and federal law. Federal law requires the states to have a "State Plan," which includes the method for paying providers such as nursing homes. 42 U.S.C. §1396a. Amendments to the State Plan are submitted by Missouri to the federal government for review and approval. Ex. T, ZZ.

Prior to the March 21, 2005 emergency rule, Missouri had a valid State Plan that had been reviewed and approved by the federal government. Ex. T, ZZ. The Department submitted the new rules to CMS, the federal agency that reviews state plans for compliance with federal law. Ex. T, ZZ; Tr. 439, l. 24 – 444, l. 3. CMS approved the state's amendment to the State Plan, which incorporated the emergency rule and the current rule. Ex. ZZ. By law, CMS's approval is retroactive to the first day of the quarter in which the plan amendment was submitted for approval. 42 CFR 447.256, see also *Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158, 1166 (10th Cir. 1988) (approval by CMS of a State Plan amendment is not required before the State may implement the change in the State Plan).

At the time the emergency rule was promulgated, the Department was facing a budgetary shortfall. There simply was not enough money appropriated for the fiscal year to meet the payment obligations going forward. The federal courts have recognized that states may consider budgetary constraints in amending Medicaid rates, provided the amendments do not otherwise violate federal law. *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1235-1236 (7th Cir. 1984); *Mississippi Hosp. Ass'n Inc. v. Heckler*, 701 F.2d 511, 518 (5th Cir. 1983); *Colorado Health Care*, 848 F.2d at 1166. The budget may be the pivotal reason for

changing payment rates, so long as federal law is not violated. *Wisconsin Hosp. Ass'n*, 733 F.2d at 1235-1236.

Here, CMS approved the Department's amendments to its nursing home reimbursement rule, finding no violation of federal law. Ex. ZZ. Although CMS is not a party to this suit, Beverly's attempt to overturn the rule is a collateral attack on CMS's approval of the State Plan amendment. A direct challenge to CMS's determination on a rule (brought, ironically, by this Department) has already been rejected. *Missouri Dept. of Social Services v. Sullivan*, 957 F.2d 542 (8th Cir. 1992). The federal courts recognize that CMS's approval of a State Plan amendment is entitled to deference. *Pharm. Research and Mfrs. of Am. v. Thompson*, 362 F.3d 817, 821-22 (D.C. Cir. 2004).

Missouri properly submitted its amendments to the federal government for approval. The federal agency, CMS, approved the amendments and the change to the State Plan. As such, the amendments were found to be in compliance with federal law.

#### **B. The repealed "Boren Amendment" does not apply.**

One of Beverly claims before the AHC was that the rule violated § 208.152.9, RSMo. That statute requires the Department to comply with certain federal laws. Beverly's argument is that the rule is contrary to federal law, and that CMS failed to review the rule for compliance with 42 CFR 447.250.

But Beverly has no basis for its arguments. CMS approved the state's amendment to the State Plan, which incorporated the emergency rule and the current rule. Ex. ZZ. As such, it found that Missouri's plan complied with federal law. Beverly submitted no evidence that

CMS, in reviewing the proposed amendments, failed to review any federal law. As noted above, this type of collateral attack on the CMS determination is not allowed.

Curiously, the federal law cited by Beverly is 42 CFR 447.250. That was the federal regulation that implemented the Boren Amendment, 42 U.S.C. 1396(a)(13)(A) (1992).

But the Boren Amendment was repealed in 1997, over ten years ago. *Illinois Council on Long Term Care v. Bradley*, 957 F.2d 305, 309 (7th Cir. 1992). Prior to its repeal, providers brought payment challenges against state agencies under the Boren Amendment. See, *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 547 fn. 11 (3rd Cir. 2002) (opining that a reason for Boren's repeal was to take away a Medicaid provider's right to sue the state agencies for changes in their rates.)

Beverly bases part of its claim on the language of § 208.152.8, RSMo: “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.” The Boren Amendment was, before its repeal, 42 U.S.C. § 1396a(a)(13)(A), or § 1902(a)(13)(A) of the Social Security Act. While the Boren Amendment was repealed, its implementing regulation, 42 C.F.R. § 447.250, remains. That regulation 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.”

But the regulation no longer tracks the actual federal law. The state statute does not require following a regulation that no longer complies with the underlying federal requirements. Moreover, the regulation follows the current federal law, stating that the Division “may” consider costs of efficiently and economically operated homes. 13 CSR 70-015(3)(O). The statute does not require following a federal law repealed over 10 years ago.

Since the repeal of the Boren Amendment, no court has interpreted the provisions of 42 CFR 447.250 to permit a private cause of action to attack a Medicaid reimbursement rate. The rule has been vacated, and Beverly cites no case authorizing a cause of action under this regulation since Boren’s repeal. In fact, the cases cited by Beverly on page 27-28, of its brief, are ones prior to Boren’s repeal, or where the issue arose before Boren’s repeal.

The decision in *AGI-Bloomfield Convalescent Center v. Toan*, 679 S.W.2d 294, 298 (Mo. App. W.D. 1984) was made shortly after the Boren Amendment was adopted. The Court of Appeals noted the greater flexibility it afforded the states in implementing cost-effective measures. *Id.* at 298-299. Under federal law, following the repeal of the Boren Amendment, that states have even greater flexibility in fashioning and implementing cost-effective measures. See 42 U.S.C. § 1396a(a)(13)(A).

Federal law does not prohibit the states from reacting to budgetary issues. Cost-containment is also a component that states may consider, and even under the old Boren standard, budgetary constraints could be considered, but the state still had to comply with federal Medicaid law. *Wisconsin Hosp. Ass’n*, 733 F.2d at 1235-1236. Here, CMS certified Missouri’s compliance with federal law after the regulation changes. Ex. ZZ.

Approval of the rules by CMS, and the repeal of the Boren Amendment, precludes Beverly's arguments. The CMS decision cannot be reviewed in this venue, and a vacated federal regulation cannot be applied. Beverly put forth no evidence that there is a violation of federal law, nor any evidence as to CMS. The AHC and circuit court were correct to reject this argument.

**C. The new rate complied with the regulation.**

Beverly also argues that the regulation requires the Division to consider, when setting a rate, costs that must be incurred by an efficiently and economically operated facility. But that is not the language of the regulation.

The actual language of the regulation makes Beverly's type of analysis permissive, not an absolute requirement:

“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 adjustment needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

13 CSR 70-015(3)(O) (emphasis added); Jt. Ex. 1.

Here, the Division had the cost reports from the homes, showing all costs that they incurred. The Division examined the financial impact on each home of changes to the regulation. The Division's actions in setting the new rate complied with the regulation.

**D. The rules were promulgated in accordance with state law**

Under Missouri law a rule is invalid if one of three circumstances exist: (1) There is an absence of statutory authority for the rule or any portion thereof; (2) The rule is in conflict with state law; or (3) The rule is so arbitrary and capricious as to create such substantial inequity as to be unreasonably burdensome on persons affected. § 536.014, RSMo. Beverly failed to show that any of these three circumstances existed.

The Division has broad authority under the Missouri statutes to promulgate rules, including emergency rules. §§ 208.001 and 208.159, RSMo. Rules and regulations promulgated by an agency pursuant to its broad legislative authority are prima facie reasonable if not inconsistent with, nor beyond the scope of, the enabling statutory authority. *Foremost-McKesson, Inc.*, 488 S.W.2d at 197, 201. The Division is also given broad discretion in the administration of the Missouri Medicaid Program. See, §§208.152.9, 208.153.1 and 208.159, RSMo; *AGI-Bloomfield*, 679 S.W.2d at 299 (“It is difficult to imagine a broader, less restrictive grant of administrative authority than that authorized [under the Medicaid statutes]”).

Here, the Division had the statutory authority to promulgate rules, including emergency rules. The AHC and the circuit court correctly found no lack of statutory authority by the Division to promulgate rules.

The rules at issue here do not exceed the Division’s authority. The statutes do not mandate a minimum utilization rate, nor do they prescribe how such a rate is to be calculated. But they also do not preclude a minimum utilization rate. Instead, § 208.001.3, RSMo grants the Department authority to promulgate rules implementing the Medicaid

statutes. While § 208.152 provides for the payment of “reasonable costs,” the method for calculating any costs is left solely up to the rules.

As the Department had the statutory authority for the rules, Beverly was required to show that the rules were unreasonable, plainly inconsistent with statutory authority, or that they bore no rational relationship to the legislative objectives of Missouri’s Medicaid Program. § 536.014, RSMo; *Foremost-McKesson, Inc. v. Davis*, 488 S.W.2d 193, 197 (Mo. banc 1972). Beverly also had to show that the rules were “so at odds with fundamental principles as to be mere whim or caprice.” *Id.* at 200. See also, *Linton v. Missouri Veterinary Med. Bd.*, 988 S.W.2d 513, 517 (Mo. banc 1999).

Beverly never met its burden. Neither the AHC, nor the circuit court, found any whim or caprice in the Department’s actions. Section 536.016.1, RSMo requires that a rule be “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.” Both the need, and the substantial evidence, were present in this case.

The looming and certain budget shortfall assuredly meets the need requirement for a rule under § 536.016.1, RSMo. Missouri obligated itself to provide care for nursing home patients through the Medicaid nursing home program, and had an undeniable interest in seeing that Missourians would be cared for through the end of the fiscal year, not just part of the fiscal year. 42 U.S.C. §1396a(a); LF 766; Ex. T, ZZ.

Moreover, the Department could not spend \$16 million more than it had been appropriated by the General Assembly. To do that would violate the Missouri Constitution, Article III, §§ 36, 37 and 39, and Article IV, § 23, and Missouri statutes, §§ 21.260 and

33.065, RSMo. That there existed a need for an immediate change in funding nursing home care cannot be doubted.

The testimony and exhibits support a finding that the Department's chosen means to address that need, the rule at issue here was based on substantial evidence. An agency acts unreasonably and arbitrarily if its findings are not based on substantial evidence. *Barry Serv. Agency Co. v. Manning*, 891 S.W.2d 882, 892 (Mo. App. 1995). The decision must use some kind of objective data rather than mere surmise, guesswork, or "gut feeling." *Id.* at 893.

The objective data was not only readily available at the time of rulemaking, it was already in the Department's possession. Historically, from January 1, 1995 until July 2004, the Department had calculated nursing home per diem rates using an 85% minimum utilization figure. Tr. 144, l. 5-9. The Department's March 21, 2005 emergency rule simply reverted the minimum utilization figure back to that 85% figure, the same figure used for over 9 years prior to the July 2004 rule change.

In addition, the Department had the cost reports from the individual nursing homes in Missouri, including those of the Beverly homes. In those reports, each nursing home details the cost of caring for all of its patients, including those costs that are covered and not covered by the State. Tr. 1071, l. 7-9; Tr. 1097, l. 7-9. The information in these cost reports – straight from the nursing homes themselves – are the type of "reasonably available empirical data," contemplated by the statute. It was logical and proper for the Department to use this data to estimate the cost of potential rate amendments to the state and to calculate the reimbursement rates to be paid to each individual nursing home. Ex. B.

As the Department used the data supplied directly from the nursing homes, it had no need to rely on surmise or guesswork. All of the costs and financial data had already been submitted. Based on this information, the Department ran a number of financial scenarios calculating the effect of a per diem change on nearly every nursing home in Missouri. Ex. X, Tr. 165, l. 15 – Tr. 170, l. 24.

The Department also had data from the State’s Certificate of Need program as to occupancy rates, and even consulted with nursing home organizations – the Missouri Health Care Association, and the Missouri Association of Homes for the Aged – about possible rate changes. Ex. X; Tr.166, l. 1 – Tr. 173, l. 18. The Department consulted state law, federal law, and the State Medicaid Plan. The Department relied upon its own experience and prior regulations. Tr. 252, l. 4 – Tr. 253, l. 12; J. Ex. 1, 4-6.

The evidence establishes a rational basis for the Department’s rules. There was empirical data reflecting each nursing homes’ reported costs. Based on these reported costs, numerous scenario calculations were run to assess the impact of changes to the rule on each individual home. Ex. X, CC, GG1, 2 through UU1, 2, and WW1, 2. There was information from the State as to occupancy rates, and even input from nursing home organizations. The Department used the readily available evidence.

Despite the Division’s actions, Beverly argues that the rules are invalid because the Division did not undertake a “study.” But, § 536.014, RSMo details the method to invalidate a rule, and it does not suggest that rulemaking requires a formal study. Likewise, § 536.016 does not require a study. Nor has any case interpreted the requirements of §§ 536.014 and 536.016 to require a study.

The only source of a “study” requirement is actually the now-repealed Boren Amendment. 42 U.S.C. 1396a(a)(13)(A)(1992). This requirement for a “study” or “findings” requirement was eliminated with Boren Amendment’s repeal, and is no longer in 42 U.S.C. 1396a(a)(13)(A). *Children’s Hosp. and Health Ctr. v. Belshe*, 188 F.3d 1090, 1094 (9th Cir. 1999). The remaining requirements of the Boren Amendment involved the public process of rate setting and equal access. 42 U.S.C. § 1396a(a)(13)(A) and (30) (A). But Beverly specifically denied at the hearing that it was bringing an equal access challenge. Tr. 20, l. 15 – 21, l. 1. See *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 364 F.3d 925, 929-31 (8th Cir. 2004). Therefore, there is no basis to procedurally challenge the amendments under federal law.

Even if Boren applied, Beverly still failed to meet its burden of proof. The Court of Appeals in *Forest Health Systems v. Dept. of Social Services*, 879 S.W.2d 566 (Mo. App. W.D. 1994), noted that the burden of showing a violation of a federal requirement is on the plaintiff. There, a hospital argued that the State had conducted no hearings or surveys, nor made any findings, to satisfy the procedural requirements of the Boren Amendment, and that the rule was arbitrary and unfair. *Id.* at 570. This argument was rejected, as the burden was on the plaintiff to show a violation of the law, not the State to show compliance. *Id.*

Yet Beverly produced no expert testimony, nor any exhibits, to bear its burden. Tr. 1010, l. 2 – 1012, l. 4; 1062, l. 5 – 1063, l. 5. Beverly submitted no evidence to demonstrate what a proper study would entail or involve. Just as in *Forest Health*, the burden was on Beverly to demonstrate a violation of law, and its lack of proof requires denial of its claims.

Here, the evidence was that the Department considered numerous financial scenarios before the rule was promulgated. Although the effect of the March 2005 emergency rule was to lower the per diem payment, the amount paid to every Missouri nursing home was equal to or higher than the Department paid prior to the July 2004 rule. In short, every nursing home still received a higher rate than the rate paid just nine months earlier.

Ironically, at the AHC Beverly proposed a competing payment method, using a different minimum utilization percentage. The irony is that this method was one of the scenarios actually considered by the Department, but rejected. Tr. 73, 76; Ex. X. Beverly put forth no evidence (by empirical data, study, or testimony) that Beverly's figure is more valid or correct than the one chosen by the Department. Equally important, it should be noted that even if Beverly's method, had it been adopted by rule, would have been invalid if held to the rulemaking standard Beverly urges here. Further, Beverly's method required more money, but the Division did not have the appropriation authority to spend that amount.

The Division's actions were based on both need and evidence. The Division was neither arbitrary nor capricious in its actions, and its rules comply with §§ 536.014 and 536.016, RSMo. This Court should affirm the decisions of the AHC and the circuit court on this point.

**III. The Division’s emergency amendment to its regulation, 13 CSR 70-10.015, met the requirements of state law, and was properly promulgated. (Responding to Beverly’s Point Relied on III).**

Neither the circuit court, nor the AHC, found a problem with the Division’s promulgation of an emergency amendment to 13 CSR 70-10. The emergency amendment was proper, as the Division had the authority to promulgate an emergency rule, the statutory requirements for an emergency rule existed, and the Division promulgated the emergency rule in compliance with the Missouri statutes.

**A. The Division had authority to promulgate the emergency rule.**

Missouri law permits a state agency to promulgate an emergency regulation, or to amend an existing regulation, if the agency: (1) finds that an immediate danger to the public health, safety, or welfare requires emergency action, or (2) if the agency finds that the regulation is necessary to preserve a compelling governmental interest that requires an early effective date. § 536.025.1(1), RSMo.

Here, the emergency rule was based upon two compelling governmental interests: not violating Missouri law by spending more money than the Legislature appropriated (LF 760; Ex. B), and carrying out the State’s obligation to Missouri’s Medicaid recipients. *Couch v. Division of Family Services*, 795 S.W.2d 91, 93 (Mo. App. W.D. 1990). As such, the intent of the emergency rule was to avoid an immediate danger to the health, safety, and welfare of Medicaid eligible nursing home recipients: no reimbursement for Missouri nursing homes when the funds ran out. Tr. 613, l. 9 – 21; LF 760, 766.

Accordingly, the Division had the authority to promulgate the emergency regulation and met the first requirement of § 536.025.1, RSMo.

**B. The Division complied with §536.025, RSMo’s requirements.**

To promulgate an emergency regulation, an agency must comply with four requirements: (1) identify an immediate danger to the health, safety and welfare or a compelling governmental interest; (2) follow procedures best calculated to assure fairness to all interested person or parties; (3) follow procedures in compliance with the Missouri and United States Constitutions; and (4) limit the scope of the rule to the circumstances creating the emergency and requiring emergency action. §536.025.1(1), (2), (3), and (4), RSMo.

Beverly’s sole statutory challenge is whether an emergency existed when the Department promulgated the emergency amendment. LF 778. According to § 536.025, RSMo, an emergency exists when the agency finds that an immediate danger to the public health, safety, or welfare requires emergency action.

As the evidence demonstrated, and as Beverly concedes, if the Department had not promulgated the emergency amendment, the expenses of the nursing home program would have exceeded – by \$16 million – the funds appropriated by the Legislature to pay for the program. J. Ex. 4, 47; LF 513. Catastrophically, the program would have run out of money before the end of the fiscal year, and the Department would have been unable to pay any of the nursing facilities in the state. If the Department could not pay the nursing facilities, patient care would have been compromised as nursing facilities rely on Medicaid payments to meet certain expenses, such as payroll, putting the health, safety, and welfare of thousands of nursing home patients in jeopardy. J. Ex. 4, 47; LF 513, 766; Tr. 613, l. 9-21.

There can be no doubt that Missouri had a compelling interest to ensure that Missourians in nursing homes would be cared for through the end of the fiscal year, not just part of the fiscal year. 42 U.S.C. §1396a(a); LF 766; Ex. T, ZZ.

Moreover, if the Division had not promulgated the emergency amendment, its only option other than to run out of money was to spend \$16 million more than it had been appropriated. To do that would have violated the Missouri Constitution. Mo. Const. Article III, §§ 36, 37 and 39; Article IV, § 23; §§ 21.260 and 33.065, RSMo. The Division, thus, had a second compelling governmental interest that made the emergency regulation necessary – not violating the Missouri Constitution by spending more money than it was authorized by legislative appropriation. See, *Rolla Manor v. Dep’t of Social Services, Div. of Med. Services*, 865 S.W.2d 812, 815 (Mo. App. S.D. 1993)(“purpose under Medicaid...is to provide reasonable reimbursement ...while incorporating cost containment measures”).

In addition to meeting the requirements for promulgating an emergency regulation under either prong, immediate danger or compelling interest, the Division also met the other requirements of §536.025.1, RSMo. When promulgating the amendment to 13 CSR 70-10.015, the Department followed the procedures best calculated to assure fairness to all interested persons and parties under the circumstances. § 536.025.1(2), RSMo. The Department followed the procedures complying with the protections of the Missouri and United States Constitutions. § 536.025.1(3), RSMo.

To ensure fairness, the Division met with leaders of the nursing home industry to seek input as to the best method to deal with the impending budget crisis. Tr. 343, 364, 675; Ex. X. The Department put into place a procedure to address the monumental shortfall that

would affect all Missouri nursing homes. LF 760-764. The Department considered data from all the nursing homes in creating the emergency rule. Ex. X. Thus, the Department followed procedures to assure fairness to all nursing homes in Missouri as required by §536.025.1(2), RSMo.

Finally, the Department limited the scope of the amendment to the circumstances creating the emergency and requiring the emergency action. § 536.025.1(4), RSMo. The Department limited the rate change to only two cost components rather than all rate components. LF 514. Moreover, the Department limited the time the emergency regulation would be valid to that period during which full notice and comment rulemaking could occur. J. Ex. 4-6. Thus, the Department made the most minimal change it could to allow it the funds to continue paying the nursing homes for the rest of the year, yet still giving nursing homes a higher reimbursement rate than the previous year. Ex. BB.

The Department complied with the requirements for emergency rulemaking. Accordingly, this Court should affirm the circuit court's judgment.

IV. The AHC erred in holding that the Department's offer of proof was not relevant because its decision is in excess of the statutory authority or jurisdiction of the AHC, is unsupported by competent and substantial evidence upon the whole record, is unauthorized by law, is arbitrary, capricious or unreasonable and involves an abuse of discretion under § 536.140.2, RSMo in that the offer of proof establishes that Beverly cannot meet its burden of establishing a Boren Amendment violation.

**A. The Division's offer of proof was relevant evidence in opposition to Beverly's claims as to the adequacy of its per diem reimbursement.**

During the AHC hearing, to refute some of Beverly's arguments, the Division offered into evidence deposition designations of two officers of Beverly Enterprises, Inc. (the corporate parent of Appellant Beverly Enterprises-Missouri, Inc.): Tina Chavis, senior director of financial services, and Kevin Roberts. LF 380-387; Tr. 960-977, 1276. The Division also offered Joint Exhibits 69-85, balance sheets for Beverly's facilities showing the profitability of the facilities. Tr. 976-977.

The AHC refused to admit the documents and deposition designations into evidence, and further denied the Division's request to accept the documents as an offer of proof, finding that the documents were "wholly irrelevant." LF 393-394. These documents have been filed with this Court, under seal, due to their financial information.

If this Court upholds the circuit court's decision, then these documents are irrelevant. But, if this Court disagrees with the AHC and circuit court and holds that the Boren Amendment or its implementing regulation apply, then the offer of proof is both relevant and probative, as the documents establish that Beverly cannot meet its burden under that law.

As noted in Point II above, Beverly has the burden of establishing a Boren Amendment violation. *Forest Health Systems v. Dept. of Social Services*, 879 S.W.2d 566 (Mo. App. W.D. 1994). It is not enough to simply allege that the Division conducted no hearings or surveys to satisfy the procedural requirements of the Boren Amendment. *Id.* at 570. To make a claim under Boren, Beverly must produce evidence of what should have been done or considered, presumably data establishing that the rule did not reimburse

efficiently and economically operated facilities for the requisite costs under Boren. *Id.*; 42 U.S.C. §1396a(a)13(A) (1992).

The offer of proof demonstrates that Beverly cannot establish a Boren Amendment violation. Beverly has not done any analysis or study to determine if the rates paid under the challenged emergency amendments to the Plan comply with Boren. The proffered deposition testimony of Kevin Roberts establishes that Beverly has not examined the rates paid under the emergency and proposed amendments and therefore, and has no idea whether the rates paid under the amendments do reimburse efficiently and economically facilities sufficiently under Boren. (Supp. Leg. File, p. 27-46).

The proffered evidence also demonstrates that the rates paid by under the emergency amendments comply with Boren, as the evidence shows the profitability of Beverly's facilities both under those per diem rates, and under the prior, lesser rates. The offer of proof includes balance sheets from Beverly's facilities for 2004 and 2005. (Supp. Leg. File, p. 47-63). The balance sheets, and the testimony of Tina Chavis establish the profitability of Beverly's facilities. (Supp. Leg. File, p. 1-26, 47-63).

Interestingly, for the first half of 2004 Beverly's facilities were paid at rates, on average, that were \$5.11 below the rates they received under the challenged rules. Thus, the proffered evidence is relevant to the payment issue. Beverly could concede that its facilities are efficiently and economically operated, in which case their profitability under the lower per diem rates demonstrates the challenged rules' compliance with Boren. Or, if Beverly did not concede that its facilities were efficiently and economically operated, it would no longer

be authorized to recover their necessary costs under Boren. 42 U.S.C. §1396a(a)(13)(A)(1992).

Beverly argued at the hearing, and the AHC agreed, that simply showing the impact of the rates under the challenged rules on a few facilities does not establish compliance with Boren. LF 388-390. While it is true that showing the impact of rates on just one or two facilities may not establish a Boren Amendment violation, the Division's offer of proof is not just the impact on one or two facilities. The evidence in the offer of proof shows the impact of the rates on all 17 of Beverly's facilities. These are facilities of varying size, occupancy rates, and facilities located throughout the State of Missouri. The Division's evidence encompasses a sufficient sampling of the impact to be probative.

Accordingly, the AHC erred in excluding the Division's offer of proof, and further erred in prohibiting the Division from even making an offer of proof. Should the Court find that Boren apply, the Court should remand the case to the AHC and order the AHC to consider the offer of proof.

### **CONCLUSION**

This Court should affirm the decision of the Circuit Court, and should reverse the decision of the Administrative Hearing Commission ordering the Department to recalculate the administration cost component ceiling for Beverly's facilities.

Respectfully submitted,

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

The undersigned hereby certifies that on this 15th day of April, 2009, one true and correct copy of the foregoing brief, and one disk containing the foregoing brief, were mailed, postage prepaid, to:

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The undersigned further certifies that the foregoing brief complies with the limitations contained in Rule No. 84.06(b), and that the brief contains 11,170 words.

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

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