IN THE SUPREME COURT OF MISSOURI

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

ON APPEAL FROM THE COLE COUNTY CIRCUIT COURT
HONORABLE RICHARD G. CALLAHAN, PRESIDING

SUBSTITUTE BRIEF OF RESPONDENT LITTLE HILLS HEALTHCARE, L.L.C., d/b/a CENTERPOINTE HOSPITAL

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASE LAW **PAGE**

STATUTES AND REGULATONS

CONSTITUTIONAL AUTHORITY

SECONDARY AUTHORITY

JURISDICTIONAL STATEMENT

This is an appeal from a judgment entered by the Cole County Circuit Court, Honorable Richard G. Callahan presiding (the "trial court"), affirming a Medicaid reimbursement decision issued by the Administrative Hearing Commission (the "Commission"). On July 12, 2005, the Commission ordered appellant Department of Social Services, Division of Medical Services ("DMS") to reimburse respondent Little Hills Healthcare, L.L.C., d/b/a CenterPointe Hospital ("CenterPointe) for an underpayment of $1,803.984 plus interest for Medicaid services rendered by CenterPointe during state fiscal year ("SFY") 2004. On August 11, 2005, DMS filed a petition for review in the trial court, and the trial court then issued its judgment affirming the Commission's decision. DMS filed a timely notice of appeal to the Missouri Court of Appeals Western District. On February 20, 2007, the Western District issued its opinion reversing the Commission's decision and remanding for a determination of whether DMS abused its discretion. CenterPointe filed a timely motion for rehearing or transfer, which was denied, and CenterPointe then applied to this Court for transfer. On May 29, 2007, this Court granted CenterPointe's application for transfer under its discretionary authority pursuant to Article 5, §10 of the Missouri Constitution.

STATEMENT OF FACTS

Nature of the Case

This is an appeal from a Commission decision to award a hospital relief on its claim for Medicaid reimbursement. The hospital here, CenterPointe, challenged the amount of reimbursement it received to cover an estimate of the reasonable cost of Medicaid services rendered during State Fiscal Year "SFY" 2004. [1]

Parties and Procedural History

CenterPointe is a psychiatric hospital in St. Charles, Missouri. *LF 55.* CenterPointe provides Medicaid services under Title XIX of the Social Security Act, primarily by serving Medicaid dependant children and adolescents. Id. The Missouri Department of Social Services is the state agency charged with administering the Missouri Medicaid Program. The appellant, DMS, is the Department's division that administers Medicaid reimbursement payments to

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[1] DMS attached a five page section to its Substitute Brief styled, "Introduction." (DMS Substitute Brief, pp. 14-18). CenterPointe is unsure whether this section is intended to be a summary of DMS's arguments or an abbreviated statement of the facts. Regardless of its purpose, CenterPointe objects to the "Introduction" because it is argumentative and it purports to lay out facts, in many instances, without reference to the record. Centerpointe disagrees with significant portions of the "Introduction," but will address its specific disagreements in the body of this Brief and not in a separate section.

Medicaid service providers like CenterPointe.

CenterPointe filed a Complaint with the Commission challenging a final decision made by DMS on June 4, 2004, computing CenterPointe's Medicaid reimbursement for SFY 2004. *LF 5.* Specifically, CenterPointe challenged DMS's methodology or formula, or more accurately, the lack of such methodology or formula, in determining the estimated Medicaid days used in calculating its direct Medicaid payment. *LF 6-7.* CenterPointe charged DMS with making an arbitrary, capricious and unreasonable decision, which resulted in an underpayment to CenterPointe of $1,803,984 for Medicaid services rendered by CenterPointe during SFY 2004. *LF 7.* The Commission heard evidence on CenterPointe's complaint in a two-day hearing. *LF 31, 266.*

Commissioner June Striegel Doughty (the "Commissioner") issued the Commission's decision (the "Decision") in favor of CenterPointe. The Commission found that DMS "failed to promulgate a rule for the estimation of Medicaid days for purposes of determining direct Medicaid payments." *LF 787.* The Commission also found that as a result CenterPointe "is entitled to additional reimbursement of $1,803,984, plus interest for Medicaid services rendered during . . . SFY 2004." *Id.*

DMS filed a Petition for Judicial Review and Counterclaim for Equitable Set-Off in the trial court. *LF 822-837.* CenterPointe moved to dismiss DMS's Counterclaim asserting that equitable claims could not be appended to a Petition for Judicial Review. The trial court granted CenterPointe's motion to dismiss the

Counterclaim and then affirmed the Commission's Decision. *LF 842-43.* DMS appealed to the Missouri Court of Appeals, Western District. *LF 844-48.*

The Western District reversed and remanded for additional findings on whether DMS abused its discretion. (Western District Opinion, p. 29). In reaching its decision, the Western District rejected the Commission's conclusion that DMS's method of estimating Medicaid days was a "rule." (Western District Opinion, pp. 23-24). The court held that the Commission was incorrect in finding that DMS's methodology applied across the entire hospital industry and was not "just one specific set of facts." (Western District Opinion, pp. 23-24). Instead, the Western District held that DMS had the discretion to change its method of making estimates from year to year, that the estimates have no future effect, and they do not act on unnamed or unspecified persons or facts. The court premised these conclusions on its assertion that "the time frame selected only applies to the specific hospitals that qualify for the current fiscal year." (Western District Opinion, p. 24).

CenterPointe challenged the Western District's conclusions in its motion for hearing or transfer, and then its application for transfer to this Court. (See, Respondent's Motion for Rehearing or Transfer; Application for Transfer to the Missouri Supreme Court). This Court has granted transfer of the appeal. (See, Order granting transfer, dated May 29, 2007).

Summary of the Evidence

CenterPointe

Little Hills Healthcare, L.L.C. acquired the hospital from Ardent Healthcare ("Ardent") on April 1, 2003. *LF 55*. Ardent significantly curtailed the hospital's operations in preparation for selling it and was operating only core services and using only one out of the six available units immediately prior to the sale. *LF 59, 71-72*. During SFY 2003, CenterPointe's provision of services was the lowest in its history because of Ardent's decision to curtail services. *LF 60*. During SFY 2004, CenterPointe's provision of Medicaid services increased over 100% from SFY 2003. *Id*.

State Fiscal Year

The Missouri Medicaid Program is administered based on the State Fiscal Year which runs from July 1st through June 30th. *LF 90*.

Statutory and Regulatory Framework

Medical assistance in the form of Medicaid is governed by the Social Security Act. *LF 473-81*. The Social Security Act delegates to the States administration of the state's Medicaid Program. *Id*. States are allowed extensive flexibility in implementing the state Medicaid program;[2] however, there is certain information that States must publish including: the proposed rates, the methodologies underlying the establishment of such rates and the justification for

[2]*LF 78, 152.*

the proposed rates. *LF 49, 480*. The policy behind requiring States to publish this information is to allow providers, beneficiaries and their representatives and other concerned state residents a reasonable opportunity for review and comment on the proposed rates, methodologies and justifications. *LF 458-65*.

Section 208.152 et seq., RSMo[3] sets out Missouri's statutory provision concerning Medicaid reimbursement to hospitals under the Missouri Medicaid Program. *LF 458-65*. In pertinent part, 208.152.1 provides, "[b]enefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of *reasonable cost of the care* . . . for the services." (emphasis added) *LF 458-65, 81*.

Section 208.153.1 provides, "[p]ursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, [DMS] *shall by rule and regulation* define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided. . . ." (emphasis added). DMS, in turn, has promulgated certain regulations under 13 CSR 70-15.010 et seq. *LF 510-38.* These regulations establish the basis for the administration of the reimbursement of hospital services provided by Medicaid providers and the state agency's "methodology employed for reimbursement" of Medicaid providers. *Id.*

[3] All statutory citations are to the 2000 Missouri Revised Statutes unless otherwise noted.

13 CSR 70-15.110 establishes the formula for determining the Federal Reimbursement Allowance assessment for each hospital which is a tax on hospitals for the privilege of doing business in the State. *LF 494-97, 181.*

Several principles underlie reimbursement to hospitals for providing Medicaid services. First, a hospital is reimbursed based on a "per diem rate." The formula for calculating the "per diem rate" is set forth in 13 CSR 70-15.010(3). *LF 512, 81-82*. Notably, the data used in calculating the per diem rate of reimbursement is based on the historical data of each hospital. *LF 85*.

A second principle behind reimbursement of hospitals providing Medicaid services is to reimburse for certain allowable Medicaid costs not included in the per diem rate. 13 CSR 70-15.010(15), *LF 512, 81-82*. These payments are called direct Medicaid payments, and essentially bring the rate of payment to a current state fiscal year rate since the "per diem rate" uses old data. *LF 85*. In determining a provider's direct Medicaid payment, the rate determined under the regulation is multiplied by the current state fiscal year days to get a total payment which would represent the hospital's reasonable costs for providing services under the Missouri Medicaid Program. *Id*. The direct Medicaid payment is made separate and apart from the per diem payment. *LF 88*. It is calculated separately with a different rate. *Id*. In order to derive the direct Medicaid payment, DMS subtracts the per diem payment that has already been paid from the direct Medicaid rate calculation and multiplies that result by the "estimated Medicaid patient days in the current year." *LF 89, 85*. Thus, the "estimated Medicaid days" calculated by DMS becomes a

significant component in determining what a hospital is reimbursed through direct Medicaid payments. *Id*. An example of how this works in practice is that if DMS derives a rate of $753.53 using the formula set forth in the regulations, it then multiplies that rate by the estimated Medicaid days calculated by DMS to arrive at the direct Medicaid payment payable to the hospital. *LF 91-92*.

In determining the "estimated Medicaid days", DMS looks at fee for service days or actual days in which services are provided by the hospitals for a time period.[4] *LF 95*. Fee for service days represent a key component of the direct Medicaid payment. *LF 96*.

The overriding principle to direct Medicaid payments is that the hospitals providing Medicaid services should be reimbursed their reasonable cost of care of Medicaid patients. *LF 81, LF 510-38*. If DMS uses a consistent method for determining the estimated Medicaid days, and specifically the fee for service days component, then over a period of time, hospitals would recover their reasonable

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[4] Each notice of a hospital's direct Medicaid payments is based on estimated Medicaid days, as the actual number of days cannot be determined until the end of the SFY. DMS uses three components to calculate Medicaid days. *LF 123*. These include: (1) fee for service days, (2) MC+ days, and (3) out-of-state days. *Id*. Fee for service days are days paid directly by DMS to the hospitals. Id. MC+ days are days paid by managed care health plans. Id. Out-of-state days are days paid for patients who come to Missouri for Medicaid services. *Id*.

costs. *LF 89-90*. It logically follows that if DMS's fee for service days component does not reasonably reflect the hospital's Medicaid days provided, a hospital cannot recover their reasonable costs. *LF 141-42*. In the instant case, when DMS was calculating the direct Medicaid payment for SFY 2004, it simply took the fee for service days it used in SFY 2003 and used those same fee for service days in SFY 2004. *LF 103.* Centerpointe contends this approach did not result in a reasonable estimate of the Medicaid services provided by Centerpointe. *LF 103*.

DMS's Notices

Every year, DMS issues two notices to each hospital during the SFY, computing the hospital's Federal Reimbursement Allowance assessment, Medicaid per-diem rate, direct Medicaid payments, and other payments.[5] *LF 90, 135.*

It has been DMS's practice to issue two notices for each SFY since the current Medicaid program came into existence in 1991. *LF 90- 91, 119-20*. DMS

[5]DMS states in its Substitute Brief that "[w]ith the exception of SFY2003, since 1991, the Department's procedure has been to issue one estimate of Medicaid days at the beginning of each SFY." (DMS Substitute Brief, p. 23). DMS fails to state that it does not issue a separate estimate of Medicaid days. Instead, it issues a notice of "FRA Assessment, direct Medicaid payments and Uninsured Add-on Payments." *LF 90.* The payments in these schedules are determined using many factors, only one of which is the estimated Medicaid days. *LF 83-85.*

issues one notice near the beginning of the SFY, and issues the other notice near the end of the SFY. *LF 90*. Because there has always been a second notice, the first notice is not treated as a final notice. *LF 90-91*. The second notice gives DMS's final notice of what the hospital's Federal Reimbursement Allowance assessment and Medicaid reimbursement will be for that SFY. *Id*. The direct Medicaid payment set forth in the second notice is different from the first notice virtually every year. *LF 164-65.*

DMS's regulations provide no methodology for determining estimated Medicaid days. *LF 240*. The methodology for estimating Medicaid days is not consistent from one SFY to the next. *LF 110-11*. Donna Siebeneck, Assistant Deputy Director for the Institutional Reimbursement Unit of DMS, determines the time period of days to use for estimated Medicaid days on DMS's notices. *LF 273, 275-76*. Siebeneck makes this determination by consulting with the Missouri Hospital Association ("MHA"), an advocacy organization representing Missouri hospitals, and with her supervisor, Margie Mueller, who is the Chief Financial Officer of DMS. *LF 275-76*.

DMS's Estimation of Medicaid Days for SFY 2003[6]

In estimating Medicaid days for SFY 2003, DMS first performed a linear regression analysis[7] based on Medicaid days paid from February 1999 to December 2001. *LF 195*. That is, DMS used actual historical data from prior years to arrive at an estimate of the Medicaid days for SFY 2003.[8]

On July 2, 2002, DMS sent a notice to CenterPointe for SFY 2003, basing

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[6] The Commission details those facts surrounding DMS's methodology for estimating Medicaid days for SFY 1999-2002 and SFY 2005 in its Decision, *LF 795-96, 804-05* respectively but, in the interest of brevity, those facts are not included here. Nonetheless, this history supports the Commission's conclusion that DMS's methodology for estimating Medicaid days is inconsistent from year to year.

[7] The purpose of this analysis is to project historical data forward in time.

[8] The total estimated days for SFY 2003 were then compared to the total days paid for January 2001 through December 2001 to arrive at a percentage that was used to inflate each facility's paid days from January 2001 through December 2001 to a figure for SFY 2003. DMS then added on MC+ days using a fee for service percentage from the 1999 desk review, and added 1999 desk-reviewed out-of-state days. A desk review is completed from information DMS receives from the hospital facilities on their cost report. It gives DMS total charges for the facility. *LF 195*.

direct Medicaid payments on 6,102 estimated Medicaid days. *LF 92, LF 547-51*. The projected direct Medicaid payment for SFY 2003 for CenterPointe was $4,610,244. *Id*.

On May 7, 2003, DMS sent its second notice to CenterPointe for SFY 2003, basing the direct Medicaid payments on 1,994 estimated Medicaid days–a dramatic reduction from the initial estimate of days of 6,102. *LF 552-55, 94, 96*. In this second notice, instead of using historical data, DMS used current, actual SFY 2003 Medicaid days for the first two thirds of the SFY and estimated the days for the remainder of the SFY based upon the current, actual days thus far in the year.[9] *LF 195-96*.

In prior years, and in its first notice for SFY 2003, DMS had not used current, actual days for the current fiscal year. *LF 139*. Because of the dramatic reduction in the number of estimated Medicaid days by DMS from the first to second notice, the direct Medicaid payment for SFY 2003 pursuant to the second notice was $1,795,537–a huge reduction from the first notice, due to the reduction in actual Medicaid days provided in SFY 2003. *LF 552-55*. In sum, the first notice sent in SFY 2003 provided for a payment to CenterPointe of $4,610,244. *LF 92, 547-51*. The second provided for payment to CenterPointe of $1,795,537. *LF 552-55, 97*. Hence, according to DMS's revised notice, CenterPointe had been overpaid by more than two million dollars. *LF 98, 547-51*.

[9] To this DMS added MC+ days and 1999 out-of-state days. *LF 195*.

DMS's methodology for estimating Medicaid days for purposes of the second notice for SFY 2003 was based on the most current data available. Because of the reduction of Medicaid services by CenterPointe in SFY 2003, the number in Centerpointe's second notice was much lower.[10]

Because the direct Medicaid payment was greatly reduced per the second notice to Centerpointe for SFY 2003, DMS sought reimbursement of $2,236,726 from Centerpointe for overpayments in SFY 2003. *LF 98*. CenterPointe paid the portion for the period during which it operated the hospital, and Ardent paid the portion for the period during which it operated the hospital. *LF 121*.

DMS's Estimation of Medicaid Days for SFY 2004

In estimating the Medicaid days for SFY 2004, DMS initially performed a regression analysis based on historical paid days from February 1999 through December 2002, and then went through a calculation similar to that in SFY 1999. *LF 197*. However, DMS did not use this figure. *LF 198*. DMS used the fee for service days from SFY 2003 for SFY 2004 because those were more current than the days used in the regression analysis. *LF 198*. This approach resulted in a higher number for most hospitals and generally was more favorable to the hospital industry as a whole. *LF 282*. DMS consulted with MHA, which agreed to this methodology. *LF 283, 375*. Thus, DMS began its estimation of Medicaid days for

[10] The reduction in services was related to the sale of the hospital from Ardent to CenterPointe. *LF 59-60*.

SFY 2004 with the same numbers that it had used in calculating the second notice for SFY 2003: 1,644 fee for service days for CenterPointe. *LF 100, 140, 552-55, 482*. However, SFY 2003 was the year in which CenterPointe experienced a significant reduction in services due to the pending sale, and 1,644 did not approximate CenterPointe's actual Medicaid days provided for SFY 2004. *LF 101, 482*.

On September 3, 2003, DMS sent a notice to CenterPointe for SFY 2004 stating, "[t]he enclosed schedules reflect the FRA assessment, Direct Medicaid payments and Uninsured Add-on payments for State Fiscal Year ("SFY") 2004 as calculated by [DMS]." *LF 102, 656-59.*

The notice did not provide any calculation or explanation of how DMS determined estimated Medicaid days for SFY 2004. *LF 102*. The notice stated that this was a final decision that could be appealed to the Commission. *LF 656.*

DMS did not send the September 3, 2003, notice by certified mail. *LF 361*. According to standard procedure, a secretary stamped "Copy" on a copy of the September 3, 2003, notice to CenterPointe, and placed the copy in CenterPointe's file. *LF 361-62*. The secretary placed the original in the box for outgoing mail from DMS. *LF 363*. DMS drivers pick up the outgoing mail from DMS's outgoing mailbox. *LF 362*. The drivers are responsible for getting the mail to the United States Post Office. *Id*.

CenterPointe did not receive DMS's September 3, 2003, notice. *LF 73-74, 572-73*. No other hospital appealed the notice for SFY 2004. *LF 285*.

Tariq Malik, the Chief Executive Officer of CenterPointe, observed that the payments in SFY 2004 had not significantly changed from SFY 2003. *LF 402*. Malik contacted Kim Carlstrom at MHA to find out when the Medicaid days would be adjusted since the actual Medicaid days at CenterPointe had so greatly increased in SFY 2004. Ms. Carlstrom indicated that the days had not been changed thus far from SFY 2003. *LF 399-401*.

Carlstrom suggested that Malik write a letter to Margie Mueller, Chief Financial Officer of DMS, inquiring as to when the estimated Medicaid days would be adjusted. *LF 401*. On March 10, 2004, Malik sent a letter to Mueller, stating that the hospital's operations were greatly reduced in SFY 2003, and that consistent with the methodology for SFY 2003, an adjustment should be made for SFY 2004 Medicaid days. *LF 61-62*. Malik noted that DMS's projections for SFY 2004 days were reduced based on SFY 2003 annualized data, which subsequently reduced CenterPointe's Medicaid payment for SFY 2004. *Id*. On March 19, 2004, Malik sent another letter correcting his estimate of the SFY 2004 Medicaid days. *LF 62-63*.

On April 7, 2004, Siebeneck responded to Malik's letters to Mueller, stating, "At this time, [DMS] is still in the process of finalizing SFY 2004 projected days. The Division will take your concerns into consideration as we work through this process." *LF 663*.

DMS frequently incorporates MHA's comments into the process of determining the estimated Medicaid days to be used. *LF 276, 311, 316-17*. DMS

again had input from MHA before sending out its second notice for SFY 2004. *LF 378*. MHA had no objection to DMS's proposed new method of estimating Medicaid days for SFY 2004 because DMS was using more current information than it had in past years using its regression analysis. *LF 378, 384*. None of the hospitals were informed of the change in the method of estimating day for SFY 2004. *LF 318.*

When sending its second notice for SFY 2004, DMS used the same fee for service days that it used on its first notice for SFY 2004. *LF 100*. On June 4, 2004, DMS sent a notice to CenterPointe for SFY 2004 stating:

> [DMS] notified your facility on September 3, 2003 of the proposed computation for State Fiscal Year ("SFY") 2004 for the FRA assessment, per-diem rate, Direct Medicaid payments and Uninsured Add-On payments.
>
> [DMS] will be filing emergency and proposed regulations on June 7, 2004 to change the FRA assessment percentage from 5.23% to 5.32%. This change affected your FRA assessment, Direct Medicaid payments, and Uninsured Add-On payments for SFY 2004. *LF 664.*

The notice did not provide any calculation or explanation of how DMS determined estimated Medicaid days for SFY 2004. *LF 102*. The number of fee for service days was the same as on the first notice for SFY 2004: 1,644. *LF 101, 628-31, 632*. The notice stated that this was a final decision that could be appealed to AHC. *LF 664*.

DMS did not provide any notice to the hospitals that it was going to use the same fee for service days in SFY 2004 that it used in SFY 2003 for determining estimated Medicaid days for SFY 2004. *LF 318*.

If DMS had used the same methodology for calculating estimated Medicaid days in its second notice for SFY 2004 that it had used in its second notice for SFY 2003, but based on days through May 2004, the estimated Medicaid days for CenterPointe would have been 4,802. *LF 108-09, 484, 818.*

Based on 4,802 Medicaid days, CenterPointe's direct Medicaid payment for SFY 2004 would have been $3,564,909, which is $1,803,984 more than DMS determined. *LF 110, 652*. CenterPointe actually had 4,884 Medicaid days in SFY 2004. *LF 111, 485.*

POINTS RELIED ON

I

THE COMMISSION DID NOT ERR IN FINDING THAT IT HAD SUBJECT MATTER JURISDICTION TO HEAR CENTERPOINTE'S COMPLAINT BECAUSE THIS DECISION WAS AUTHORIZED BY §208.156.8 RSMo (2000) AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT CENTERPOINTE PRESENTED EVIDENCE TO SUPPORT THE COMMISSION'S FINDING THAT CENTERPOINTE DID NOT RECEIVE THE PRIOR DMS NOTICE DATED SEPTEMBER 3, 2003, THE SECOND DMS NOTICE DATED JUNE 4, 2004, GAVE CENTERPOINTE THE

RIGHT TO APPEAL, AND ALTHOUGH THE ESTIMATED NUMBER OF MEDICAID DAYS DID NOT CHANGE FROM THE FIRST TO THE SECOND NOTICE, THAT FIGURE WAS PART OF THE CALCULATIONS AT ISSUE IN THE SECOND NOTICE, AND THOSE CALCULATIONS DID NOT BECOME A FINAL DECISION OF DMS UNTIL THE AGENCY DEPARTED FROM ITS PRIOR POLICY AND DETERMINED IN THE SECOND NOTICE THAT NO CHANGE WOULD BE MADE IN THE NUMBER OF ESTIMATED DAYS.

Psychiatric Healthcare Corporation v. Department of Social Services, 996 S.W.2d 733 (Mo.App. W.D. 1999)

BHCA of Kansas City v. Department of Social Services, No. 96-0020 SP (Mo.Admin.Hearing Comm'n Nov. 3, 1997), *rev'd,* Case No. CV197-1719 (Cole Co. Cir., May 22, 1998), *aff'med,* Appeal #WD55986 (June 15, 1999)

State ex rel. Die Casting Corporation v. Morris, 219 S.W.2d 359 (Mo. 1949)

Clear v. Missouri Coordinating Board for Higher Education, 23 S.W.3d 896 (Mo.App. E.D. 2000)

§208.156.8 RSMo (2000)

II

THE COMMISSION DID NOT ERR IN FINDING THAT DMS HAD FAILED TO MEET ITS DUTY TO PROMULGATE A RULE FOR

ESTIMATING HOW MEDICAID DAYS WERE BEING CALCULATED BECAUSE THIS DECISION WAS CONSISTENT WITH THE DEFINITION OF A "RULE" UNDER THE MISSOURI ADMINISTRATIVE PROCEDURE ACT AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT DMS ADMITTED THAT ITS METHODOLOGY FOR ESTIMATING MEDICAID DAYS APPLIED ACROSS THE BOARD TO ALL OF THE APPROXIMATELY 140 HOSPITALS IN THE STATE, THAT THIS METHODOLOGY DETERMINED HOW DMS CALCULATED MEDICAID REIMBURSEMENTS IN MISSOURI AND THAT THIS MADE IT A RULE, BUT DMS ALSO ADMITTED THAT IT HAD FAILED TO PROMULGATE THIS RULE AS A REGULATION, THE EVIDENCE SHOWED THAT THIS METHODOLOGY HISTORICALLY CHANGES FROM YEAR TO YEAR AND DMS ADMITTED THAT IT DOES NOT NOTIFY HOSPITALS OF PROPOSED CHANGES IN HOW ESTIMATED MEDICAID DAYS ARE CALCULATED.

NME Hospitals, Inc. v. Department of Social Services, 850 S.W.2d 71 (Mo. banc 1993)

Missouri State Division of Family Services v. Barclay, 705 S.W.2d 518 (Mo.App. W.D. 1985)

St. Louis Christian Home v. Missouri Commission on Human Rights, 634 S.W.2d 508 (Mo.App. W.D. 1982)

Sunset Retirement Homes, Inc. v. Department of Social Services, 830 S.W.2d 18 (Mo.App. W.D. 1992)

§536.010(6) RSMo (Cum.Supp.2005)

III

THE COMMISSION DID NOT ERR BY FAILING TO GIVE SUFFICIENT DEFERENCE TO DMS CALULATIONS IN ESTIMATING CENTERPOINTE'S MEDICAID PATIENT DAYS IN SFY 2004 BECAUSE THE COMMISSION ACTED WITHIN THE SCOPE OF ITS AUTHORITY IN DECIDING THIS ADMINISTRATIVE APPEAL UNDER STATE LAW IN THAT THE COMMISSION IS DESIGNATED BY CHAPTER 621 AS THE ADMINISTRATIVE AGENCY THAT HEARS APPEALS FROM VARIOUS STATE AGENCIES, INCLUDING DMS, AND IT MUST RENDER THE ULTIMATE ADMINISTRATIVE DECISION, NO DEFERENCE WAS REQUIRED WHERE DMS FAILED TO FOLLOW RULEMAKING PROCEDURES IN ESTABLISHING ITS METHODOLOGY FOR ESTIMATING MEDICAID DAYS AND THE COMMISSION APPILED THE CORRECT STANDARD OF REVIEW IN REQUIRING CONSISTENCY AND NOTICE WHEN DMS APPLIED A RULE OF GENERAL APPLICABILITY.

Department of Social Services v. Mellas, 220 S.W.3d 778 (Mo.App. W.D. 2007)

Department of Social Services v. Senior Citizens Nursing Home District of Ray County, 224 S.W.3d 1 (Mo.App. W.D. 2007)

Geriatric Nursing Facility v. Department of Social Services, 693 S.W.2d 206 (Mo.App. W.D. 1985)

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

§208.156.2 RSMo (2000)

IV

THE COMMISSION DID NOT ERR IN AWARDING CENTERPOINTE ADDITIONAL MEDICAID REIMBURSEMENT OF $1,803,984 PLUS INTEREST BECAUSE THIS DECISION WAS WITHIN THE SCOPE OF THE COMMISSION'S STATUTORY AUTHORITY AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT THE COMMISSION HAD AUTHORITY TO REMAKE THE ULTIMATE AGENCY DECISION WHERE DMS'S METHODOLOGY WAS NOT PROMULGATED AS A RULE, THE COMMISSION ADOPTED CENTERPOINTE'S METHOD, WHICH REVERTED BACK TO DMS'S LAST METHODOLOGY FOR SFY 2003 AND MET THE STATUTORY REQUIREMENT UNDER §208.152 RSMo (2000) OF PROVIDING A REASONABLE ESTIMATE OF THE COST OF CARE FOR MEDICAID SERVICES, AND DMS OFFERED

NO ALTERNATIVE METHOD FOR CALCULATING THE AMOUNT OF CENTERPOINTE'S MEDICAID REIMBURSEMENT.

Department of Social Services v. Mellas, 220 S.W.3d 778 (Mo.App. W.D. 2007)

Department of Social Services v. Senior Citizens Nursing Home District of Ray County, 224 S.W.3d 1 (Mo.App. W.D. 2007)

Geriatric Nursing Facility v. Department of Social Services, 693 S.W.2d 206 (Mo.App. W.D. 1985)

Miller v. Dunn, 184 S.W.3d 122 (Mo.App. E.D. 2006)

§208.156.2 RSMo (2000)

§621.055 RSMo (Cum.Supp. 2005)

ARGUMENT

Standard of Review

The same standard of review applies to all four points raised by DMS in its appeal. On appeal, this Court reviews the decision of the Commission and not the decision of the trial court. *EGB Health Care III, Inc. v. Missouri Department of Social Services*, 882 S.W.2d 143, 145 (Mo.App. W.D. 1994). Under §536.140.2 RSMo,[11] this Court's review is limited to determining whether the Commission's decision is supported by substantial and competent evidence upon the whole

[11] Subsection 3 of this statute was amended by H.B. 576 (93rd General Assembly 2005). The general scope of inquiry in Subsection 2 was not changed.

record, whether it is arbitrary, capricious or unreasonable, or whether the Commission abused its discretion. *Id.* at 145 (affirmed Commission's decision to deny increase in Medicaid reimbursement rate); *Clear v. Missouri Coordinating Board for Higher Education*, 23 S.W.3d 896, 899 (Mo.App. E.D. 2000) (affirmed Coordinating Board's decision to issue wage withholding order to collect student loan).

An agency's decision is not supported by competent and substantial evidence only in the rare case when the decision is contrary to the overwhelming weight of the evidence. *Miller v. Dunn*, 184 S.W.3d 122, 124 (Mo.App. E.D. 2006), citing *Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220, 223 (Mo. banc 2003). This Court cannot substitute its judgment of the facts unless the Commission's findings are unsupported. *Smarr v. Sports Enterprises, Inc.*, 849 S.W.2d 46, 47 (Mo.App. W.D. 1993) (reversed trial court's judgment and reinstated Commission's decision to impose 30-day suspension of liquor license). But this Court may draw from the Commission's factual findings its own conclusions of law. *Concerned Services, Inc. v. Department of Social Services*, 834 S.W.2d 908, 909 (Mo.App. W.D. 1992) (affirmed Commission's finding that Medicaid provider had not shown extraordinary circumstances to justify rate increase).

I

THE COMMISSION DID NOT ERR IN FINDING THAT IT HAD SUBJECT MATTER JURISDICTION TO HEAR CENTERPOINTE'S

COMPLAINT BECAUSE THIS DECISION WAS AUTHORIZED BY §208.156.8 RSMo (2000) AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT CENTERPOINTE PRESENTED EVIDENCE TO SUPPORT THE COMMISSION'S FINDING THAT CENTERPOINTE DID NOT RECEIVE THE PRIOR DMS NOTICE DATED SEPTEMBER 3, 2003, THE SECOND DMS NOTICE DATED JUNE 4, 2004, GAVE CENTERPOINTE THE RIGHT TO APPEAL, AND ALTHOUGH THE ESTIMATED NUMBER OF MEDICAID DAYS DID NOT CHANGE FROM THE FIRST TO THE SECOND NOTICE, THAT FIGURE WAS PART OF THE CALCULATIONS AT ISSUE IN THE SECOND NOTICE, AND THOSE CALCULATIONS DID NOT BECOME A FINAL DECISION OF DMS UNTIL THE AGENCY DEPARTED FROM ITS PRIOR POLICY AND DETERMINED IN THE SECOND NOTICE THAT NO CHANGE WOULD BE MADE IN THE NUMBER OF ESTIMATED DAYS.

Applying the applicable standard of review, this Court must accept the Commission's factual findings which support its legal conclusion that it had subject matter jurisdiction to hear CenterPointe's Complaint. The Commission's finding that CenterPointe did not receive the first DMS notice dated September 3, 2003 was supported by competent and substantial evidence. DMS ignores the evidence presented by CenterPointe to overcome the presumption that it received this first notice. But even if the evidence did not support this finding, the

Commission had jurisdiction to hear CenterPointe's Complaint because the second DMS notice dated June 4, 2004 gave CenterPointe the right of appeal. Although the estimated number of Medicaid days did not change from the first to the second notice, the Commission properly found from the evidence that DMS did not make a final agency decision on this point until it issued the second notice.

A. The Commission Has Subject Matter Jurisdiction if CenterPointe Filed a Timely Petition for Review.

The Commission has subject matter jurisdiction to hear a hospital's claim for Medicaid reimbursement if a timely petition for review is filed under §208.156.8 RSMo. This subsection provides that "[a]ny person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections *shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission*…." §208.156.8 RSMo. (emphasis supplied) DMS must give Medicaid providers notice of this thirty-day appeal period under §621.055.3 RSMo (Cum. Supp. 2005).

CenterPointe filed its petition for review here within thirty days after DMS issued its final decision dated June 4, 2004. *LF 5-23, 664-65.* Nevertheless, DMS argues that because CenterPointe did not appeal from the earlier DMS notice dated September 3, 2003, the Commission had no jurisdiction to hear CenterPointe's

Complaint.[12] (DMS Substitute Brief, pp. 36-37) Because this Court cannot substitute its judgment for the facts found by the Commission here, this Court must reject DMS's jurisdictional argument.

B. <u>CenterPointe Presented Sufficient Evidence to Support the Commission's Finding that CenterPointe Did Not Receive the First DMS Notice.</u>

Although the Commission did not consider it the "key" jurisdictional issue, the Commission found that CenterPointe did not receive the first notice dated September 3, 2003. *LF 801.* The Commission then reasoned that '[i]f there is inadequate notice of the right of appeal within thirty days, the time for filing the appeal did not start to run." *LF 809,* citing *State ex rel. St. Louis Die Casting Corporation v. Morris*, 219 S.W.2d 359, 363 (Mo. 1949) (tax assessment void because Department of Revenue failed to give jurisdictional notice). Applying this authority, the Commission concluded that it could rest its jurisdiction on CenterPointe's lack of receipt of the first notice. *LF 809.*

DMS argues that it is entitled to a presumption that its first notice served by mail upon CenterPointe was received. (DMS Substitute Brief at p. 38, citing *Clear v. Coordinating Board for Higher Education*, 23 S.W.3d 896, 900 (Mo.App. E.D. 2000). But DMS admits that this presumption is rebuttable. *Id.* The question of

[12] The record showed that DMS issues two notices to each Medicaid provider every fiscal year. *LF 90, 135*

whether sufficient evidence has been adduced to nullify the presumption is for the finder of fact. *Id.* This Court is bound by the Commission's finding that CenterPointe never received the first notice unless this finding is contrary to the overwhelming weight of the evidence. See, *Miller v. Dunn,* 184 S.W.3d at 124.

CenterPointe presented sufficient evidence here to support the Commission's finding that CenterPointe did not receive the first DMS notice. Tariq Malik, the Chief Executive Officer for CenterPointe, testified that the first time he saw the first notice was when DMS produced this document in the appeal. *LF 73-74.* Malik's testimony was confirmed by the deposition of Steve Frantz, who was the Chief Financial Officer of CenterPointe until he left in December, 2003. *LF 562.* Frantz also testified that he had never seen the first notice. *LF 572-73.* Frantz knew this because he and Malik had a number of conversations about projections up until Frantz left in December, and by that time, the payments for the coming year still were an "open issue." *LF 573.*

CenterPointe's assertion that it never received the first notice was consistent with Malik's letters to Margie Mueller at DMS dated March 10, 2004, and March 19, 2004. Malik wrote these letters to address some differences in patient days between CenterPointe's records and DMS records for SFY 2004. *LF 61-63.* Neither Malik letter mentioned the FRA Assessment, per-diem rate or any other specific figures in the first notice. *LF 660-62.*

DMS produced no overwhelming evidence to show that CenterPointe actually received the first notice. DMS did not send the first notice by certified

mail. *LF 361.* According to standard procedure, a secretary stamped "Copy" on a copy of the first notice and placed it in CenterPointe's file. *LF 361-62.* The secretary then placed the original in an outgoing box for a driver to pick up and take to the Post Office. *LF 362-63.* Under these facts and circumstances, the Commission had discretion to find that CenterPointe effectively rebutted any presumption that the first notice was received.

C. The Second DMS Notice Was a Final Decision that Gave Centerpointe the Right to Appeal.

Even if this Court should reverse the Commission's finding that CenterPointe did not receive the first notice, the Commission still had jurisdiction because CenterPointe filed a timely appeal from the second notice dated June 4, 2004. *LF 5-23, 664-65.* DMS stated in its second notice that this was a "final decision" and that CenterPointe had a right to appeal by filing a petition with the Commission within thirty days. *LF 664-665.*

Although the estimated number of Medicaid days did not change from the first to the second notice, the Commission found that this figure was part of the calculation in the second notice, and that the figures were not final until the second notice was issued each fiscal year and DMS affirmatively determined that no change was needed. *LF 806.* This factual finding was supported by competent and substantial evidence. *LF 90-91, 119-20.* Because this Court is bound by the Commission's finding of fact on this point, this Court should accept the

Commission's corresponding legal conclusion that it had jurisdiction over CenterPointe's appeal from the second notice under §208.156.2. *LF 806.*

The Commission cited two cases to support its decision to exercise jurisdiction: a Cole County Circuit Court decision reversing the Commission, which was affirmed by this Court without opinion in *BHCA of Kansas City v. Department of Social. Services*, No. 96-0020 SP (Mo. Admin. Hearing Comm'n Nov. 3, 1997),[13] and a decision issued by this Court in *Psychiatric Healthcare Corp. v. Department of Social Services*, 996 S.W.2d 733 (Mo.App. W.D. 1999).

The Circuit Court's decision in *BHCA of Kansas City* is directly on point. The Commission had denied a hospital's appeal from an add-on adjustment in a second notice because, as in this appeal, the Department only changed the dollar amounts and not the number of Medicaid days. But the Circuit Court reversed on the ground that Department effectively reopened or modified its prior decision by issuing the second notice. This election gave the hospital the right to seek review of the second decision in its entirety without limitation. Applying this same reasoning here, the Commission observed that this appeal presented an even stronger set of circumstances for the exercise of jurisdiction because of "the year-to-year inconsistency of DMS's estimations." *LF. 807.*

[13] The Circuit Court decision was in Case No. CV197-1719 (May 22, 1998). The Western District affirmed this decision in Appeal #WD55986 (June 15, 1999).

The Commission's decision to exercise jurisdiction also was supported by *Psychiatric Healthcare Corp. v. Department of Social Services,* 996 S.W.2d at 733. The Western District held in *Psychiatric Healthcare* that a hospital could appeal from a Department letter notifying a hospital that it would not increase an uninsured add-on payment from the amount reflected in a prior notice. The court reasoned that the Department left the impression from its correspondence that the rate determination "was still a live issue" and it was only the second letter that brought finality to the matter. *Id.* at 733.

The Commission found that DMS left a similar impression here that the estimated number of Medicaid days was still a live issue. *LF 808.* The evidence showed the DMS changed the number of estimated days from the first to the second notice in the prior fiscal year. *LF 96, 547-51.* When CenterPointe made inquiries about whether this same kind of adjustment would be made in SFY 2004, DMS responded with a letter from Donna Siebeneck dated April 7, 2004. *LF 663.* In this letter, DMS stated: "At this time, the Division is still in the process of finalizing SFY 2004 projected days." *Id.* As the Commission found, this letter hardly left the impression that the first notice for SFY 2004 gave a final determination of Medicaid days. *LF 808.*

DMS cannot avoid the effect of either *BHCA* or *Psychiatric Healthcare* with its assertion these decisions were legislatively overruled by the 2001 amendment to §621.055.3 RSMo (Cum.Supp. 2005). DMS cites no authority for this contention. The amendment to §621.055.3 does no more than impose a duty

upon DMS to give Medicaid providers written notice of the thirty-day appeal period under §208.156.8 RSMo. In this particular appeal, DMS included the same required notice language in both the first and second notices. *LF 656-657, 664-65.* DMS cannot now argue that it did not intend to give CenterPointe a right to appeal from the "final decision" contained in the second notice.

Nor can DMS rely upon the denial of jurisdiction under distinguishable circumstances in *Department of Social Services v. NME Hospitals, Inc.*, 11 S.W.3d 776 (Mo.App. W.D. 1999). The hospitals in *NME* were seeking rate adjustments from prior years because DMS withdrew an earlier regulation imposing a reimbursement rate cap. The Western District affirmed the Commission finding that the hospitals' demands were not timely filed because they did not have a legal right to demand additional payments outside the normal rate-setting period. *Id.* at 781. This has nothing to do with the issue presented here of whether CenterPointe had a right to appeal from the second notice setting the rate for the then current fiscal year. The Commission's conclusion that CenterPointe could appeal from this second notice was supported by the evidence and authorized by law.

II

THE COMMISSION DID NOT ERR IN FINDING THAT DMS HAD FAILED TO MEET ITS DUTY TO PROMULGATE A RULE FOR ESTIMATING HOW MEDICAID DAYS WERE BEING CALCULATED BECAUSE THIS DECISION WAS CONSISTENT WITH THE

DEFINITION OF A "RULE" UNDER THE MISSOURI ADMINISTRATIVE PROCEDURE ACT AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT DMS ADMITTED THAT ITS METHOD FOR ESTIMATING MEDICAID DAYS APPLIED ACROSS THE BOARD TO ALL OF THE APPROXIMATELY 140 HOSPITALS IN THE STATE, THAT THIS METHODOLOGY DETERMINED HOW DMS CALCULATED MEDICAID REIMBURSEMENTS IN MISSOURI AND THAT THIS MADE IT A RULE, BUT DMS ALSO ADMITTED THAT IT HAD FAILED TO PROMULGATE THIS RULE AS A REGULATION, THE EVIDENCE SHOWED THAT THIS METHODOLOGY HISTORICALLY CHANGES FROM YEAR TO YEAR AND DMS ADMITTED THAT IT DOES NOT NOTIFY HOSPITALS OF PROPOSED CHANGES IN HOW ESTIMATED MEDICAID DAYS ARE CALCULATED.

Calling it the "pivotal question" in this appeal, DMS charges in its second point that the Commission erred in finding that DMS had a duty to promulgate a rule for estimating how Medicaid days were calculated. (DMS Brief, p. 41). The Commission's decision on this point is consistent with the definition of a "rule" under the Missouri Administrative Procedure Act. DMS admitted that its method for estimating Medicaid days applies to all hospitals, that this methodology has a statewide impact on how DMS calculates Medicaid reimbursement rates and is a

rule, but that DMS never went through notice and comment ruling-making procedures. DMS also admitted that it does not notify hospitals of how Medicaid days are calculated. DMS cannot avoid the impact of its admissions with flawed legal arguments.

A. The Definition of a "Rule" under the Missouri Administrative Procedure Act.

In concluding that DMS should have used rulemaking procedures to change its method for estimating Medicaid days, the Commission applied the definition of a "rule" under the Missouri Administrative Procedure Act. *LF 813-14.* Under the Act, the term "rule" generally means "each agency statement of general applicability that implements, interprets, or prescribes law or policy…." §536.010(6) (Cum.Supp. 2005).[14] An agency standard is a "rule" if it announces "[a]n agency statement of policy or interpretation of law of future effect which acts on unnamed and unspecified acts…." *NME Hospitals, Inc. v. Department of Social Services*, 850 S.W.2d 71, 74 (Mo. banc 1993), quoting *Missourians for Separation of Church and State v. Roberson*, 592 S.W.2d 825, 841 (Mo.App. W.D. 1979).

[14] The Commission refers to the definition of a "rule" under the former §536.010(4) RSMo (2000). The General Assembly did not change the substance of this definition when it was re-codified in 2004 at §536.010(6) RSMo (Cum.Supp. 2005).

Under this definition, changes in statewide policy are treated as rules. *NME Hospitals, Inc. v. Department of Social Services,* 850 S.W.2d at 74 (purported change in DMS Medicaid reimbursement policy to exclude psychiatric services other than electric shock treatment was "rule"); see also, *Missouri State Division of Family Services v. Barclay*, 705 S.W.2d 518, 521 (Mo.App. W.D. 1985) (methodology used by DFS in Income Maintenance Manual to determine individual's income allocation was "rule"). When a statewide policy substantially affects the legal rights of persons, the agency cannot find refuge within the statutory exceptions to the definition of a rule. *Id.*

If an agency makes a purported change in statewide policy that does not comply with rulemaking procedures, that policy is void and not enforceable by contract. *NME Hospitals, Inc. v. Department of Social Services*, 850 S.W.2d at 74. The notice and comment rulemaking procedures are contained in Section 536.021 RSMo. The purpose of these procedures is to provide information to the agency through statements of those in support of or in opposition to the proposed rule. *Id.* A rule adopted in violation of §536.021 RSMo is void. *Id.*, citing *St. Louis Christian Home v. Missouri Comm'n on Human Rights*, 634 S.W.2d 508, 514-15 (Mo.App. W.D. 1982), *Sunset Retirement Homes, Inc. v. Dep't of Social Services*, 830 S.W.2d 18, 21 (Mo.App. W.D. 1992) and *Missouri State Division of Family Services v. Barclay*, 705 S.W.2d at 521.

In this appeal, DMS admits that it never promulgated a regulation of its formula for estimating Medicaid days. *LF 240*. The sole question is whether the Commission was correct in concluding that this was a "rule."

B. DMS Admitted the Facts Necessary to Support the Commission's Conclusion that DMS Should Have Promulgated Its Method for Estimating Medicaid Days as a Rule.

At the hearing, DMS admitted those facts necessary to support the Commission's conclusion on the "rule" issue. The Commission was entitled to consider admissions of state officers charged with administering the Medicaid program as admissions against the interest of DMS at their employer. *Kansas City v. Keene,* 885 S.W.2d 360, 367 (Mo. banc 1993)

Donna Siebeneck, the Assistant Deputy Director for Institutional Reimbursement at DMS, admitted that the agency's method for estimating Medicaid days is a rule. *LF 337-38.* Siebenick admitted that the estimation of Medicaid days is a statement of policy issued by DMS that had general applicability to all hospitals, and that the DMS Medicaid reimbursement regulations apply to all of the approximately 140 hospitals in the State. *LF 284-85, 337-38.* Siebenick admitted that the estimation of Medicaid days determines, in part, how DMS interprets and implements the Medicaid law in Missouri. *LF. 337-38.* She also admitted that the regulations do not spell out how to estimate Medicaid days—that DMS just looks at a range of dates and those dates have changed from year to year. *LF 310.*

Sue Nilges, a Senior Auditor for DMS, made a similar set of admissions in her testimony. Nilges admitted that in contrast with calculations for things like unreimbursed and uninsured add-ons, there is nothing in the regulations that tells DMS how to formulate an estimate of Medicaid days. *LF 240, 242.* Nor is there anything in any internal memos that tells DMS how to make this calculation. *LF 241.* Because the regulations do not specify a time period for making this estimate, Nilges testified that this determination is left to the discretion of DMS. *LF 186.* Even though DMS changed the method for estimating Medicaid days for all facilities from SFY 2003 to SFY 2004, Nilges admitted that DMS does not notify the hospitals of this kind of change. *LF 258.*

CenterPointe presented the expert testimony of Ed Knell to explain the effect on hospitals of this DMS change in policy on estimated Medicaid days. Knell's objection was not with the "reasonableness" of DMS's approach in estimating Medicaid days, but with the anomalies in creating winners and losers by changing how DMS calculated the estimated Medicaid days--the method--from year to year, without notice. *LF 104.* That is, Knell showed that two hospitals which had the same number of Medicaid days in SFY 2003 and SFY 2004 would be paid substantially more and substantially less respectively for their Medicaid days simply because DMS changed how it calculated the estimated Medicaid days--its method--from SFY 2003 to SFY 2004. *LF 104.*

The Commission was entitled to rely on Knell's expert opinion to support its finding that the DMS methodology for estimating Medicaid days has not been

consistent from one year to the next. *LF 794, 816.* Because of these inconsistencies, the Commission concluded that DMS had a duty to follow emergency rulemaking procedures to change its methodology. The Commission did not find that the DMS methodology was unreasonable. The Commission held only that the law requires "consistency and notice when an agency makes a statement of general applicability." *LF 817.* Under the standard of review, this Court must accept those facts found by the Commission that support this legal conclusion. See, *Concerned Services, Inc. v. Department of Social Services*, 834 S.W.2d 908, 909 (Mo.App. W.D. 1992)

In CenterPointe's case, the change in DMS methodology dramatically reduced CenterPointe's Medicaid reimbursement for SFY 2004 by resorting back to depressed figures from SFY 2003. Because CenterPointe significantly reduced its Medicaid services in 2003 in anticipation of a pending sale, the 1,644 estimated Medicaid days used by DMS did not approach CenterPointe's reasonable cost of providing Medicaid services for SFY 2004. *LF 100-01, 482.* The CenterPointe example demonstrates how the change in DMS methodology had a substantial effect on the legal rights of this particular Medicaid provider.

Because DMS admitted that its method of estimating of Medicaid days is a statewide policy that affects Medicaid reimbursement rates for all of the approximately 140 hospitals in the State, the Commission had sufficient evidence to conclude that DMS should have promulgated a "rule" to change this method. *LF 813-14.* This decision was consistent with the definition of a "rule" under the

Missouri Administrative Procedure Act and was supported by competent and substantial evidence.

C. <u>DMS Cannot Avoid the Effect of Its Admissions with Flawed Legal Arguments.</u>

DMS ignores the admissions of its own officials when it argues that its method of estimating Medicaid days is exempt from rulemaking requirements under state law. DMS makes a series of flawed legal arguments to justify this change in position.

DMS argues that the method used for estimating Medicaid days is fact-specific because it "only addresses the estimate for the industry ***for that particular year."*** (DMS Substitute Brief, p. 48) (emphasis in original). But this is a circular argument. The DMS method for estimating Medicaid days is not fact-specific just because the Commission found that DMS has been inconsistent in applying its methodology to the hospital industry from one year to the next. *LF821*. And in making this argument, DMS is overlooking its own admissions and misapplying the definition of a "rule" under §536.010(6) RSMo (Cum.Supp. 2005).

DMS points to nothing in the record to support its factual allegation that there is some subset of "specific hospitals" that has changed with each fiscal year. Instead, DMS tries to justify this charge by citing a regulation suggesting that the estimation process only applies to existing hospitals with a cost basis report. (DMS Substitute Brief, pp. 45-46, citing 13 CSR 70-15.010(15) (C)). But the

speculative possibility that future Medicaid providers would not be subject to this estimation process is not evidence of an existing subset of "specific hospitals."

DMS ignores Donna Siebenick 's admission that "the estimation of Medicaid days under 13 CFR 70-15.101 is a statement of policy issued by DMS that had general applicability to all hospitals." *LF 337-38.* DMS also ignores Siebenick's admission that the DMS Medicaid reimbursement regulations apply to all of the approximately 140 hospitals in the State. *LF 284-85.* The DMS methodology for estimating Medicaid days applies across the board to each and every Missouri hospital. *LF 337-38.* The Commission found from this evidence that "DMS's method of calculating estimated Medicaid days was a statement of general applicability, as it applied to all Medicaid provider hospitals in Missouri." *LF 813.* DMS asks this Court to substitute its judgment of the facts by making up some subset of "specific hospitals" out of whole cloth.

This Court rejected DMS's approach to the "general applicability" issue in *NME Hospitals, Inc. v. Department of Social Services,* 850 S.W.2d 71, 74 (Mo. banc 1993). DMS argued in *NME,* just like it does here, that its policy change on Medicaid reimbursement for psychiatric services was not a rule because it applied only to Medicaid participants and not all hospitals in the state. But this Court rejected that contention because the policy change "applies generally to all participants in the Medicaid program." *Id.* Professor Alfred S. Neely, in his Missouri Practice treatise on the "rule" issue, stated: "[*NME*] illustrates that a rule may apply to less than the entire universe of theoretically potential targets and not

lose its status as a rule." 20 Mo.Prac., Administrative Practice & Procedure §5:10 (4th ed.) DMS loses sight of this concept in arguing that the DMS Medicaid reimbursement policy here was "fact-specific" because it only applied to a specific class of Medicaid participants.

DMS also tries to insulate itself from the rulemaking procedures by arguing that it has a regulation governing direct Medicaid payments to hospitals. (DMS Substitute Brief, pp. 44-45, citing 13 CSR 70-15.010(15)). But DMS officials admit that this regulation does not contain any formula for estimating Medicaid days. *LF 240, 242, 310.* DMS also admits that it changed the method for making this determination from SFY 2003 to SFY 2004 without notifying the hospitals. *LF 258.* This is precisely the kind of substantive change in policy that required a new rule under *NME.* DMS cannot avoid *NME* by arguing that DMS went through rulemaking procedures with the prior regulation or that this regulation was approved by the Joint Committee on Administrative Rules. If this were a valid defense, no substantive change in agency policy under an existing regulation ever could be challenged.

Nor can DMS rely on *Baugus v. Department of Revenue*, 878 S.W.2d 39, 42 (Mo. banc 1994) for its argument that DMS is not required to promulgate rules "defining every word in its regulation, or the decision-making process it uses to estimate variables or sub-variables in its payment method. " (DMS Substitute Brief, p. 44). Unlike here, the Department of Revenue's decision to place the word, "prior," before "salvage" in its title certificates invoked no change in

statewide policy that substantially affected anyone's rights. *Id.* The word merely communicated the difference between two types of titles. *Id.* This is a far cry from a change in DMS methodology that substantially affects a hospital's Medicaid reimbursement.

DMS also argues that the change in its method of estimating Medicaid days within a fiscal year was not a rule because it had no future effect upon unnamed or unspecified persons or facts. (DMS Substitute Brief, pp. 47-48). In support of this argument, DMS refers to this Court's decision in *Missouri Soybeans Ass'n v. Missouri Clean Water Comm'n,* 102 S.W.3d 10, 23 (Mo. banc 2003). DMS's reliance on *Missouri Soybeans Association* is misplaced.

This Court held in *Missouri Soybeans Association* that the state's compilation of a list of impaired waters for further study was not a rule because it had no actual impact on the appellants. No study had occurred and no regulation had been proposed. *Id.* at 24. This Court also ruled that the controversy could not be resolved by declaratory judgment action and was not yet ripe for adjudication. *Id.* at 14. This is distinguishable from the DMS method of estimating Medicaid days. The time frame selected by DMS for estimating Medicaid days in SFY 2004 had a direct future impact on Medicaid reimbursement in that fiscal year for each Missouri hospital. Because the DMS applied this methodology against CenterPointe in a final agency action, this appeal was ripe for adjudication.

Nor was the DMS method for estimating Medicaid days exempt from rulemaking on the theory that the method did not apply to "unnamed or

unspecified persons." (DMS Substitute Brief, pp. 46-47). The *Missouri Soybeans Association* decision did not address DMS's contention that it is exempt from rulemaking duties just because the agency might have known the identity of the participating Medicaid hospitals within any given fiscal year. If that were an exemption, DMS would never have to promulgate any Medicaid hospital reimbursement regulations.

DMS next argues, inconsistently, that CenterPointe has no standing to challenge the change in DMS methodology because Medicaid providers have no vested right to prospective Medicaid reimbursements. (DMS Brief, pp. 48-49).[15] Proceeding from this faulty premise, DMS relies on *McIntosh v. Bundy*, 161

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[15]In raising this argument, DMS relies on cases holding that a hospital has no property interest in prospective Medicaid reimbursement payments for federal constitutional purposes. See, e.g., *AGI-Bluff Manor, Inc. v. Reagan*, 713 F. Supp. 1535, 1545 (W.D. Mo. 1989); *United Cerebral Palsy Assoc. of New York State v. Cuomo*, 783 F.Supp. 43, 51 (N.D.N.Y. 1992); *Oberlander v. Perales*, 740 F.2d 116, 120 (2d Cir. 1984); *Kaye v. Whalen,* 391 N.Y.S.2d 712, 720 (N.Y.App. 1977). Some courts disagree on this point. *AGI-Bluff Manor, Inc.,*713 F. Supp. at 1543, citing *Massachusetts General Hospital v. Weiner,* 569 F.2d 1156, 1160 (1st Cir. 1978). Regardless of the constitutional issue, these decisions do not control the question here of whether DMS must go through state rulemaking procedures to make a substantive change in its reimbursement calculations.

S.W.3d 413, 417 (Mo.App. W.D. 2005) for its holding that a rule must "tread upon a legally protected right or privilege." But in *NME,* this Court rejected any contention that a hospital could not challenge a change in DMS policy affecting Medicaid reimbursement rates. See, *NME Hospitals, Inc. v. Department of Social Services*, 850 S.W.2d at 75 (hospital had legitimate expectation that DMS would follow Administrative Procedure Act in implementing statewide changes in Medicaid program); Accord*, Tallahassee Memorial Regional Medical Center v. Cook,* 109 F.3d 693, 702 (11th Cir. 1997) (hospitals had standing to challenge change in Florida's Medicaid reimbursement rates in federal suit for declaratory and injunction relief).

In arguing that Medicaid providers have no vested right to prospective payments, DMS makes two misleading statements. First, DMS charges that "[d]irect Medicaid payments are not payments reimbursing a hospital's costs for services provided." (DMS Substitute Brief, p. 49). DMS goes on to charge that "[t]hey are prospective payments made based on projected costs, are designed in part to defray the impact of hospital taxes and voluntary contributions." (DMS Substitute Brief, p. 49). Neither statement is correct.

Under both a Missouri statute and a DMS regulation, direct Medicaid payments are designed to reimburse the hospital for the reasonable cost of providing Medicaid services during the fiscal year. Section 208.152.1 RSMo establishes that services provided to Medicaid beneficiaries are to be paid based on "the reasonable cost of care." "Reasonable cost" is defined in the DMS

regulations at 13 CSR 70-15.010(2)(O). DMS is wrong in asserting that direct Medicaid payments are not tied to the cost of providing Medicaid services. See, *Rate Setting Commission v. Baystate Medical Center*, 665 N.E.2d 647, 654 (Mass. 1996) (Massachusetts commission erred in failing to consider Medicaid patient-specific costs).

DMS also is wrong in arguing that because Medicaid payments are based on projected costs, they are not designed to reimburse costs, but only "to defray the impact of hospital taxes and voluntary contributions." (DMS Substitute Brief, p. 45). DMS cites no statute, regulation or evidence in the record to support this untrue statement. If the purpose of the Medicaid payments were "to defray the impact of hospital taxes and voluntary contributions," this would be contrary to federal law. Under 42 U.S.C §1396a(a)(12)(B)(ii), any state plan must make provisions, not for defraying hospital taxes or voluntary contributions, but "for reimbursing [a Medicaid provider] for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to such individual…." *LF 480.* Missouri implements this requirement with the "reasonable cost of care" standard under §208.152.1 RSMo.

Even if DMS had not misstated the premise for its prospective payment argument, DMS could not rely on *McIntosh*. The appellant in *McIntosh* was challenging a decision by the Department of Corrections to deny him placement on an approved list of sex offender therapists. Because the appellant had no right to be included on the list, the rulemaking procedures did not apply to that

individualized decision. *McIntosh v. Bundy,* 161 S.W.3d at 418. It is instructive that the *McIntosh* court distinguished *NME* because the rule there arose from "a statewide policy shift affecting benefit payments to thousands of Medicaid participants." *Id.* at 418. This appeal is distinguishable from *McIntosh* on the same ground.

DMS next tries to characterize its change in policy for estimating Medicaid days as no more than an internal "guideline" and not a "rule." (DMS Substitute Brief, pp. 49-50, citing *Couch v. Director, Missouri State Division of Family Services*, 795 S.W.2d 91 (Mo.App. W.D. 1990). DMS overstates the significance of *Couch* when it argues that this decision insulates agency guidelines from rule-making procedures. This Court held in *Couch* only that to the extent a DFS Income Maintenance Manual did not attempt to set forth rules and regulations, the manual was not void in total. *Id.* at 93. But in *Missouri State Division of Family Services v. Barclay*, 705 S.W.2d at 521, this Court held that part of this same IMM was void because the methodology in the manual, like the DMS methodology here, imposed a statewide policy that substantially affected the legal rights of people in the Medicaid program. The facts here are closer to *Barclay* than *Couch*.

Finally, DMS argues that CenterPointe is barred from challenging its method for estimating Medicaid days because the federal government approved the last DMS amendment of the State Plan. (DMS Substitute Brief, pp. 51-54). The Commission discounted the significance of this amendment because the Commission rested its decision on state and not federal law. *LF 791.* If federal

approval of the Missouri State Plan insulated DMS from the need for any further rulemaking, no Medicaid provider or participant ever could challenge a statewide change in Medicaid policy. *NME* and *Barclay* demonstrate that this is not the law.

DMS produced no evidence to show that the federal government reviewed or considered whether DMS used a consistent methodology in estimating Medicaid days. Because of this omission, DMS cannot rely on federal cases like *Missouri Department of Social Services v. Sullivan*, 957 F.2d 542, 544 (8th Cir. 1992) (federal agency rejected Missouri's proposed retroactive change in its State Plan without public notice) or *Indiana Association of Homes for the Aging Incorporated v. Indiana Office of Medicaid Policy and Planning*, 60 F.3d 262, 265 (7th Cir. 1995) (federal agency carefully reviewed and responded to appellants' objections in approving amendment to Indiana State Plan). See also, *Visiting Nurse Ass'n of North Shore v. Bullen*, 93 F.3d 997, 1011 (1st Cir. 1999) (deference given to the federal government not conclusive where factual record did not reveal federal agency's rationale for approving state plan amendment). These kinds of federal cases do not support DMS's illogical argument that the change in its method of estimating Medicaid days is not a "method" because the federal government never addressed it.

For these reasons, DMS has no genuine legal or factual basis for avoiding its rulemaking responsibilities. The Commission's conclusion on this point should be affirmed.

III

THE COMMISSION DID NOT ERR BY FAILING TO GIVE SUFFICIENT DEFERENCE TO DMS CALULATIONS IN ESTIMATING CENTERPOINTE'S MEDICAID PATIENT DAYS IN SFY 2004 BECAUSE THE COMMISSION ACTED WITHIN THE SCOPE OF ITS AUTHORITY IN DECIDING THIS ADMINISTRATIVE APPEAL UNDER STATE LAW IN THAT THE COMMISSION IS DESIGNATED BY CHAPTER 621 AS THE ADMINISTRATIVE AGENCY THAT HEARS APPEALS FROM VARIOUS STATE AGENCIES, INCLUDING DMS, AND IT MUST RENDER THE ULTIMATE ADMINISTRATIVE DECISION, NO DEFERENCE WAS REQUIRED WHERE DMS FAILED TO FOLLOW RULEMAKING PROCEDURES IN ESTABLISHING ITS METHODOLOGY FOR ESTIMATING MEDICAID DAYS AND THE COMMISSION APPLIED THE CORRECT STANDARD OF REVIEW IN REQUIRING CONSISTENCY AND NOTICE WHEN DMS APPLIED A RULE OF GENERAL APPLICABILITY.

DMS charges in its third point that the Commission failed to give sufficient deference to DMS in its estimate of CenterPointe's Medicaid days. In making this argument, DMS relies on federal cases and state cases from other jurisdictions which have no bearing on the standard of review in this appeal. DMS also relies on the Western District opinion in this case which this Court questioned when it granted transfer. DMS argues that *Department of Social Services v. Mellas*, 220

S.W.3d 778 (Mo. App. W.D. 2007), which merely confirms settled law, is in conflict with the Western District opinion. (DMS Substitute Brief, p. 57). Under Missouri law, the Commission is authorized by statute to render the ultimate agency decision. The Commission did not have to give deference to DMS because the agency failed to follow rulemaking procedures in changing its method of estimating Medicaid days. Finally, the record shows that the Commission correctly applied the standard of review in requiring consistency and notice when DMS applied a rule of general applicability.

A. Under Missouri law, the Commission is Authorized by Statute to Render the Ultimate Agency Decision.

Section 208.156.2, RSMo establishes that a Medicaid provider, like Centerpointe, "…shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of Chapter 621, RSMo." This chapter has been interpreted to mean that "[t]he legislature intended for the Commission to render the agency's decision. This is the import of the language of [Chapter 621]." *J.C. Nichols v. Director of Revenue*, 796 S.W.2d 16, 20 (Mo. banc 1990). This Court in *J.C. Nichols* held that "because the Commission announces the decision of the agency, the Commission's decision in this case . . .is within the authority of the Commission because it is within the authority of the agency." *Id*. It follows from the statutes and the case law that the Commission acted properly in adjusting DMS's determination as this kind of decision was within the authority of DMS.

DMS cites a North Dakota case to support its argument that because reimbursement is complex, this Court should defer to the expertise of the agency. *St. Benedict's Health Center v. North Dakota Department of Human Serivces*, 677 N.W.2d 202 (N.D. 2004). The difference between North Dakota and Missouri administrative procedure is striking. The court in *St. Benedict's* stated that under the North Dakota statute, the court will: "affirm an agency's decision if its findings of fact sufficiently address the evidence, its conclusions of law are supported by its findings of fact, its decision is supported by its conclusions of law, its decision is in accordance with the law and does not violate claimants constitutional rights, its rules or procedures have not deprived the claimant of a fair hearing, its order sufficiently explains its rationale." *Id*. at 205. Under Missouri's Administrative Procedure Act, the Commission takes on the agency's function in making findings of fact, conclusions of law and providing a fair hearing. Because of this fundamental distinction in administrative procedure, DMS's reliance on the North Dakota case is misplaced.

DMS correctly points out that the Western District, in *Department of Social Services v. Mellas*, 220 S.W.3d 778 (Mo. App. W.D. 2007), rejected DMS's argument that deference should be given to DMS because of its specialized knowledge. The *Mellas* court held that Section 621.055, RSMo, mandates "that the commission have the power to review the department's decision." *Id*. at 782. The Western District reasoned that "[a]s an independent, objective reviewer of the department's actions the commission plays a key role in helping Missouri

constituents contend with an administrative agency that can be blind to its own faults." *Id*. at 783.[16] The Western District reached this same conclusion on the deference issue in *Department of Social Services v. Senior Citizens Nursing Home District of Ray County*, 224 S.W.3d 1, 15-16 (Mo. App. W.D. 2007). See also *State Board of Registration for Healing Arts v. Finch*, 514 S.W.2d 608, 614 (Mo. App. 1974). (The Commission steps into the shoes of the department in remaking the decision or including the exercise of any discretion that the department would exercise).

B. <u>The Commission Did Not Have to Give DMS Deference Because DMS Failed to Follow Rulemaking Procedures</u>.

Since DMS failed to follow a consistent methodology in estimating Medicaid days in SFY 2004, the Commission corrected the DMS determination to establish consistency. The Commission cited an earlier Commission case in holding: "We are not bound to use DMS's methodology for estimating Medicaid days because it was not promulgated as a rule." *LF 818*, citing *St. Anthony's Medical Center v. Department of Social Services*, No. 03-0661 SP (Mo. Admin. Hearing Comm'n April 6, 2004).

The Commission also held: "Because DMS failed to follow rulemaking procedures in establishing a methodology for estimating Medicaid patient days,

[16] DMS applied for transfer of the *Mellas* appeal to this Court, but its application was denied. *Mellas*, 220 S.W.3d at 778.

we cannot defer to its determination." *LF 816*. The Commission held in *St. Anthony's* that "this Commission can do with the claim whatever [DMS] can do with it because we decide the claim *de novo* in a contested case proceeding." *St. Anthony's Medical Center,* at p. 9, citing *J.C. Nichols Co. v. Director of Revenue,* 796 S.W.2d 16, 20-21 (Mo. banc 1990); See, *LF 814*. Since the Commission's decision in this case, the Western District confirmed that the Commission was correct in applying this de novo review of the agency's decision. *Department of Social Services v. Mellas*, 220 S.W.3d 778, 782 (Mo. App. W.D. 2007).

C. **The Commission Applied the Appropriate Standard of Review**

DMS accuses the Commission of applying the "wrong" standard of review because it did not defer to DMS's estimate of Medicaid patient days. But the Commission applied the appropriate standard of review established by statute under Section 621.055, RSMo 2000, and confirmed most recently in the *Mellas* and *Ray County* decisions.[17]

[17] DMS addresses *Mellas* in Subpart III(C) of its Brief. (DMS Substitute Brief, pp. 61-66). Since *Mellas* is interwoven with CenterPointe's response to Subparts III(A) and (B), Centerpointe will not separately address this aspect of DMS's argument in Subpart III(C), except to remind this Court that (1) *Mellas* merely confirms settled law on the role of the Administrative Hearing Commission; and (2) DMS challenges *Mellas* by relying on cases from other jurisdictions with different administrative schemes and which have no bearing on Missouri law.

The crux of DMS's arguments appears to be that because DMS used CenterPointe's historical data in estimating Medicaid days, its estimate was reasonable and consistent with regulations. But DMS ignores its own inconsistent methodology. The evidence showed that DMS used nine months of actual, current data to estimate Medicaid days in SFY 2003. *LF 198*. The use of nine months of actual current data was a method. If DMS had consistently applied this method from 2003 in 2004, CenterPointe would have been reimbursed for a reasonable number of its Medicaid days in 2004. However, since DMS did not use current data in its 2004 estimation of days, but rather used the same estimate it used in 2003, DMS unreasonably changed its method and denied CenterPointe reasonable reimbursement for its cost of providing Medicaid services. *LF 100-01, 482*. DMS acted unreasonably in changing the method from one year to the next, without using its emergency rulemaking authority.

DMS argues that the Commission must give deference to its agency decision, and Commission cannot superintend its authority. (DMS Substitute Brief, p. 58-59) Insofar as DMS turns to state law to address these claims, DMS relies on *KV Pharmaceutical Company v. Missouri State Board of Pharmacy,* 43 S.W.3d 306 (Mo. banc 2001), *Citizens for Rural Preservation, Inc. v. Robinett*, 648 S.W.2d 117 (Mo. App. 1983) and *Oberreiter v. Fullbright Trucking Co.*, 117 S.W.3d 710 (Mo. App. 2003). None of the cases control this appeal.

KV Pharmaceutical does no more than recognize the expertise of the Pharmacy Board in applying its duly promulgated regulations to discipline a drug

distributor. *KV Pharmaceutical Company v. Missouri State Board of Pharmacy,* 43 S.W.3d at 310-11. Unlike here, the Commission heard the evidence and affirmed the discipline imposed by the Pharmacy Board. *Id.* at 311. There was no charge that the Commission improperly superintended the Board's authority. This has nothing to do with the issue here of whether the Commission is obligated to give DMS deference when it sets a Medicaid reimbursement rate in violation of its rulemaking duties. See, *LF 816.*

DMS's reliance on *Citizens for Rural Preservation, Inc. v. Robinette,* 648 S.W.2d 117,128 (Mo.App.W.D. 1983), is similarly misplaced. In *Citizens*, the Western District was confronted with conflicting expert testimony over uncertainties in the modeling of fugitive emissions. Because the Air Conservation Commission determined questions of credibility, the Western District deferred to the Commission's findings. The Western District could not say, as a matter of law, that the existing models were so accurate the Commission had no basis for finding otherwise. *Citizens,* 648 S.W.2d at 127-128. This holding does not compel the Commission to defer to DMS in the face of conflicting evidence.

Nor can DMS pin its deference argument on the holding in *Oberreiter v. Fullbright Trucking Company,* 117 S.W.3d 710, 717 (Mo.App. E.D. 2003). *Oberreiter* did not address DMS's argument that the Commission must defer to the purported expertise of an agency appearing before it. The question in *Oberreiter* was whether the Labor and Industrial Relations Commission had primary jurisdiction over a wrongful death claim involving a deceased employee.

The Eastern District concluded that the trial court had the power to determine that it lacked jurisdiction. The determination of whether the employer had five or more employees was not a technical question which first had to be addressed by the Commission. Primary jurisdiction has nothing to do with the issues here.

Apart from the distinct factual framework of these cases, DMS confuses the issue of the technicality of determining the estimated days with DMS's non-technical change of methodology in estimating days from one year to the next. CenterPointe would never quibble with DMS that the formula that DMS employs in estimating the Medicaid days is technical. But simply because the formula employed by DMS is technical, this does not mean that the courts must defer to DMS when DMS changes its method of calculating estimated days from one year to the next without notice--particularly when this change of method deprived CenterPointe of its reasonable cost for providing Medicaid services in violation of both State and Federal law.

In charging the Commission with applying the wrong standard of review, DMS ignores the Commission's findings. The Commission went out of its way to be flexible with the needs of DMS. The Commission stated: "By deciding that DMS was required to promulgate a rule, we by no means suggest that DMS is required to make two estimates of Medicaid days every year. All that the law requires is consistency and notice when an agency makes a statement of general applicability." *LF 817*.

The Commission made clear by its findings that DMS would continue to

have the flexibility to avoid future problems. The Commission stated: "We note that the regulation, according to the plain meaning of 'estimated' days, does not require the use of actual numbers for the current SFY, nor does it require DMS to recalculate the Medicaid days in its second notice every SFY. All that is required is for DMS to make a reasonable estimate for the current SFY." *LF 819-20.*

The Commission also explained why the promulgation of a rule as to estimated Medicaid days would not necessarily fetter DMS's discretion. The Commission observed that "Regulation 13 CSR 70-15.010 has a lengthy history of emergency amendments (every year, and sometimes more than once a year, ending in 2002)." *LF 816.* The Commission pointed out the comparable history of annual emergency amendments with Regulation 13 CSR 70-15.110, governing FRA assessments. *LF 816.* From this history, the Commission found: "If DMS had followed the rulemaking procedure for estimation of Medicaid days but needed to make adjustments, DMS would have had the emergency rulemaking procedure available to it." *LF 816*.

In short, the Commission's own findings demonstrate that DMS is wrong in arguing that the Commission applied the wrong standard of review. Instead, the Commission preserved DMS's authority and gave the agency the flexibility to avoid future cases like the one now before this Court. *LF 816-20.* The Commission did not superintend DMS's authority by requiring consistency and notice when the agency applied a rule of general applicability. *LF 817.*

IV

THE COMMISSION DID NOT ERR IN AWARDING CENTERPOINTE ADDITIONAL MEDICAID REIMBURSEMENT OF $1,803,984 PLUS INTEREST BECAUSE THIS DECISION WAS WITHIN THE SCOPE OF THE COMMISSION'S STATUTORY AUTHORITY AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE IN THAT THE COMMISSION HAD AUTHORITY TO REMAKE THE ULTIMATE AGENCY DECISION WHERE DMS'S METHODOLOGY WAS NOT PROMULGATED AS A RULE, THE COMMISSION ADOPTED CENTERPOINTE'S METHOD, WHICH REVERTED BACK TO DMS'S LAST METHODOLOGY FOR SFY 2003 AND MET THE STATUTORY REQUIREMENT UNDER §208.152 RSMo (2000) OF PROVIDING A REASONABLE ESTIMATE OF THE COST OF CARE FOR MEDICAID SERVICES, AND DMS OFFERED NO ALTERNATIVE METHOD FOR CALCULATING THE AMOUNT OF CENTERPOINTE'S MEDICAID REIMBURSEMENT.

DMS charges in its fourth point that the Commission erred in awarding CenterPointe an additional Medicaid reimbursement of $1,803,984 plus interest. Under Missouri law, the Commission had statutory authority to set the amount of CenterPointe's Medicaid reimbursement where DMS violated rulemaking procedures. Contrary to the DMS arguments, the Commission did not make up a new method for calculating the reimbursement. The Commission simply used the same methodology applied by DMS in the prior fiscal year. This is not one of

those rare administrative cases where the decision is contrary to the overwhelming weight of the evidence.

A. <u>The Commission Had Statutory Authority to Remake the Ultimate Agency Decision</u>.

For reasons set forth above, the Commission is authorized to remake the ultimate agency decision under §621.055 RSMo (Cum.Supp. 2005). Section 208.156.2 also provides that a Medicaid provider, like CenterPointe, is "entitled to a hearing before the administrative hearing commission pursuant to the provisions of Chapter 621, RSMo."

The Commission's statutory role is reinforced by an established line of Missouri cases. Most recently, the Western District held in *Department of Social Services v. Mellas*, 220 S.W.3d 778 (Mo. App. W.D. 2007) that the "commission actually steps into the department's shoes and becomes the department in remaking the department's decision. This includes the exercise of any discretion that the department would exercise." *Id*. at 782, citing *State Board of Registration for the Healing Arts v. Finch*, 514 S.W.2d 608, 614 (Mo. App. 1974); Accord: *Department of Social Services v. Senior Citizens Nursing Home District of Ray County*, 224 S.W.3d 1, 15-16 (Mo. App. W.D. 2007); *J.C. Nichols Co. v. Director of Revenue*, 796 S.W.2d. 20 (Mo. banc 1990) (import of these statutes was for the "commission to render the agency's decision."); *Monroe County Nursing v. Department of Social Services*, 884 S.W.2d 291, 293 (Mo. App. E.D. 1994) ("[T]he AHC steps into the shoes of the DMS when reviewing appeals from

its decisions…."); *Geriatric Nursing Facility v. Department of Social Services*, 693 S.W.2d 206, 209 (Mo. App. W.D. 1985) ("The Administrative Hearing Commission decision becomes the administrative action of the Department."). These cases recognize the Commission's inherent authority to hear the evidence and make the ultimate DMS decision.

B. <u>The Commission Did Not Err in Adopting CenterPointe's Method of Calculating its Reimbursement Amount</u>.

The Commission's decision in setting the amount of Centerpointe's Medicaid reimbursement award was authorized by law and supported by competent and substantial evidence. Section 208.152 RSMo establishes that reimbursement for providing Medicaid services is to be "made on the basis of the reasonable cost of the care or reasonable charge for the service." *LF 458, 809*. Regulation 13 CSR 70-15.010(15)(B) requires DMS to determine "estimated Medicaid days for the current SFY." *LF 498, 819*. The Commission found from the evidence that DMS failed to use a reasonable estimate for Medicaid days. *LF 819*.

CenterPointe presented evidence of its proposed estimation of Medicaid days for SFY 2004 based on fee for service days provided from July 2003 through May 2004. *LF 101-11, 484, 487, 818*. CenterPointe's method used data that was available for the SFY at issue at the time DMS issued its second notice. *Id.* It provided a method of estimating the Medicaid days that was consistent with SFY 2003, and it provided a basis for making a reasonable estimate of Medicaid days

"for the current SFY," as opposed to using the prior year's data as done by DMS. *Id.*

The Commission adopted CenterPointe's method, which mimics DMS's SFY 2003 methodology because "CenterPointe's method uses data that was available for the SFY at issue at the time DMS issued its second notice, and it provides a basis for making a reasonable estimate 'for the current SFY' "[18] *LF 819-20*. If DMS had used the same methodology for calculating estimated Medicaid days on its second notice for SFY 2004 that it had used on its second notice for SFY 2003, but based on days through May 2004, the estimated Medicaid days would have been 4,802. *LF 484, 804*.

DMS criticizes CenterPointe's approach by charging that the regulations do not require DMS to "settle up" with hospitals at the end of the fiscal year using actual Medicaid days. (DMS Substitute Brief, p. 68). But CenterPointe's method makes no attempt to produce such a post-year adjustment to actual days. *LF 485*. Indeed, CenterPointe's methodology yields an estimate of 4,802 days, while the actual days provided in SFY 2004 were 4,884. *LF 484, 485, 804*. What is important, however, is that the 4,802 estimate reflects a reasonable estimate. *LF 111, 819-20*. DMS is only required to make a reasonable estimate for the current SFY. *LF 11, 820*.

In taking the estimate of 4,802 days and multiplying that number by

[18]CenterPointe's methodology is set forth in *LF 818, 484, 487*.

$742.38[19], CenterPointe should have had direct Medicaid payments of $3,564,909 for SFY 2004. *LF 110, 487, 820.* Because DMS allowed only $1,760,925 for CenterPointe's direct Medicaid payments for SFY 2004, the evidence showed that CenterPointe is entitled to an additional $1,803,984, plus interest. *See §*621.055 RSMo, *LF 820*. DMS has failed to show that the decision to award Centerpointe this amount of additional reimbursement is contrary to the overwhelming weight of the evidence. See, *Miller v. Dunn,* 184 S.W.3d 122, 124 (Mo.App. E.D. 2006).

DMS is in no position to challenge the sufficiency of the evidence to support the award because it offered no alternative method for calculating the reimbursement amount. As part of the Commission's explanation for why it adopted CenterPointe's method, the Commission observed: "It is the only data in the record that provides us with the basis for a reasonable estimate." *LF 820.*

Unable to challenge the sufficiency of the evidence to support the award, DMS tries to attack the Commission's authority to decide the case.[20] This charge

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[19]The estimated cost per day less per diem for SFY 2004.

[20] DMS also argues that the Commissioner erred in excluding certain exhibits which DMS claims would have shown that CenterPointe was overpaid for Medicaid services in prior years. (DMS Substitute Brief, p. 78). Even if the proffered exhibits did show what DMS claims (which CenterPointe denies), DMS cannot argue that past overpayments would justify a $1.8 Million underpayment to CenterPointe in SFY 2004. Equally important, the record reveals that DMS did

is misplaced. DMS relies on *Monroe County Nursing Home District v. Department of Social Services*, 884 S.W.2d 291 (Mo. App. E.D. 1994) as purporting to limit the Commission's authority to "fashion remedies." (DMS Substitute Brief, p. 75) *Monroe County* actually supports CenterPointe's position insofar as this decision establishes that the Commission must "step into the shoes of the DMS when reviewing appeals from its decision. . . ." *Id.* at 294. But unlike CenterPointe, Monroe County was seeking amendment of a DMS rule outside the regulatory scheme. *Id.* By contrast, CenterPointe here sought only to have DMS follow a consistent method of estimating Medicaid days so that CenterPointe could recover its reasonable cost of providing Medicaid services. *LF 5-7.* The

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not produce the proffered exhibits in discovery, that this "theory" of attempting to justify the underpayment by DMS in SFY 2004 was not disclosed to CenterPointe in DMS's pleadings; and the DMS exhibits were derived from a number of different documents, none of which were ever provided to CenterPointe prior to the hearing. Indeed, the exhibits themselves were manufactured in anticipation of litigation. *LF 217-221, 250, 260-261.* Finally, CenterPointe simply was not privy to any information related to DMS's payments prior to CenterPointe purchasing the hospital on April 1, 2003. *LF 217-21.* For these reasons, the Commissioner did not abuse her discretion in rejecting this evidence. See *Daly v. State Tax Comm'n*, 120 S.W.3d 262, 267 (Mo. App. W.D. 2003) (hearing agency retains broad discretion over discovery process and admissibility of evidence).

Commission did not exceed its authority by adjusting the amount of the hospital's Medicaid reimbursement. *LF 820.*

DMS makes an unsupported declaration that the Commission's decision to award CenterPointe additional Medicaid reimbursement is an "equitable remedy." (DMS Substitute Brief, p. 75) This declaration is a *non sequitur* that does not follow logically from any case or statute cited by DMS. Nor does it comport with the distinction between legal and equitable remedies. See, *State ex rel. Leonardi v. Sherry,* 137 S.W.3d 462, 471 (Mo. banc 2004) ("Damages and, in some instances, restitution constitute the legal remedies."). DMS cannot charge the Commission with providing equitable relief in setting a monetary award for CenterPointe's Medicaid reimbursement. *LF 820.*

DMS also argues that the *"NME I* and *Senn Park Nursing Center* decisions preclude tribunals from making up new methods where an agency was required to set forth in regulation a particular change in its Medicaid payment methodology." (DMS Substitute Brief, p. 73).[21] CenterPointe finds it ironic that DMS would rely on *NME* and *Senn Park* for this argument, since both decisions support the Commission's finding that DMS violated its rulemaking duties. DMS cannot use

[21] DMS is referring here to an Illinois Supreme Court case styled *Senn Park Nursing Center v. Miller*, 104 Ill.2d 169, 83 Ill. Dec. 609, 470 N.E.2d 1029 (1984) (Illinois had to following rulemaking procedures to change its method of calculating Medicaid reimbursement rates to account for inflation).

these same cases to challenge the award set by the Commission. The Commission did not "make up a new method" here. Instead, the Commission adopted the CenterPointe methodology which mimicked DMS's methodology for estimating Medicaid days in SFY 2003. *LF 819-20.* In essence, the Commission did exactly what DMS suggests by "revert[ing] back to the prior . . . method . . . and…not mak[ing] up a new [methodology]." (DMS Substitute Brief, p. 73). DMS cannot complain because the Commission applied the same methodology used by DMS in the prior fiscal year.

CONCLUSION

The Commission's decision to award Centerpointe additional Medicaid reimbursement was supported by competent and substantial evidence on the whole record, was not arbitrary, capricious or unreasonable, and the Commission committed no error of law. CenterPointe requests this Court to affirm both the Commission's decision and the judgment of the trial court.

Respectively submitted,

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CERTIFICATE UNDER RULE 84.06(c)

I, Daniel R. Schramm, hereby certify that I am one of the attorneys for Respondent Little Hills Healthcare, LLC, d/b/a CenterPointe Hospital, and that the foregoing Brief of Respondent:

(1) Includes the information required by Rule 55.03;

(2) Complies with the limitations contained in Rule 84.06(b); and

(3) Contains 16,060 words.

The undersigned further certifies that the disk submitted with this Brief has been scanned for viruses and is virus-free.

/s/ DANIEL R. SCHRAMM
DANIEL R. SCHRAMM

CERTIFICATE OF SERVICE

I, **DANIEL R. SCHRAMM,** hereby certify that I am one of the attorneys for Respondent Little Hills Healthcare, LLC, d/b/a Centerpointe Hospital, and that on the 6th day of August, 2007, I caused one copy of the aforesaid Substitute Brief of Respondent and a copy of the floppy disk for the brief to be served upon counsel for the Appellant and the *Amicus Curiae* by depositing the same in the United States mail, postage prepaid, addressed as follows:

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