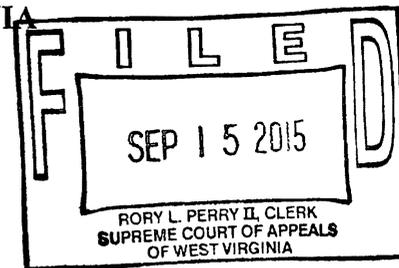


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET NO. 15-0595



HEARTLAND OF BECKLEY WV, LLC
HEARTLAND OF CLARKSBURG WV, LLC
HEARTLAND OF MARTINSBURG WV, LLC
HEARTLAND OF RAINELLE WV, LLC
HEARTLAND-PRESTON COUNTY OF KINGWOOD, LLC
HEALTH CARE and RETIREMENT CORPORATION OF AMERICA, LLC
d/b/a HEARTLAND OF CHARLESTON,

Petitioners,

v.

BUREAU FOR MEDICAL SERVICES,

Respondent.

BRIEF OF PETITIONERS

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Petitioners Heartland of Beckley WV, LLC, Heartland of Clarksburg, WV, LLC, Heartland of Keyser WV, LLC, Heartland of Martinsburg, WV, LLC, Heartland of Rainelle, WV, LLC, Heartland-Preston County of Kingwood WV, LLC, and Health Care and Retirement Corporation of America, LLC, d/b/a Heartland of Charleston (collectively, “HCR”) submit this brief in support of their appeal from the Circuit Court of Kanawha County’s final order denying HCR’s petition for certiorari from the decision of the Bureau for Medical Services (the “Bureau” or “BMS”). Contrary to the circuit court’s order, first dollar losses relating to HCR’s insurance deductibles are proper under 42 U.S.C. § 1396, *et seq.* (the “Medicaid Act”), corresponding regulatory provisions, and § 2162.5 of the federal Provider Reimbursement Manual (“PRM”).¹ The consistent prior practice of the Bureau allowed such costs as reimbursable. Without notice or comment, the Bureau in effect modified its rules on reimbursement to create a conflict with federal law. This Court, therefore, should reverse the circuit court’s order. Alternatively, the Court should vacate the order and remand this action for further proceedings.

I. ASSIGNMENTS OF ERROR

- A. The circuit court erred in denying HCR’s petition for certiorari.
1. HCR met the requirements of the Medicaid Act, its corresponding regulatory provisions, and the PRM § 2162.5.
 2. BMS’s interpretation of the State Plan, which has changed several times, is not entitled to deference and is preempted by federal law in any event.
 3. BMS violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR’s losses relating to deductibles and changing the method of setting Medicaid reimbursement rates and the cap without notice and comment.
 4. West Virginia public policy does not prohibit BMS from reimbursing HCR for losses relating to deductibles.

¹ See <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>

B. The circuit court erred in failing to grant HCR's motion for discovery and failing to review the entire administrative record and supplemental evidence.

1. HCR was entitled to requested discovery in its petition for certiorari.
2. The circuit court should have reviewed the entire administrative record, including evidence stricken and proffers made, and supplementations.

II. STATEMENT OF THE CASE

For providers of skilled nursing service, payment rates for Medicaid providers depends in part as allowable costs. For at least the past twenty years, as part of its cost-reporting to the Bureau, HCR has included first dollar losses within its liability insurance deductibles for paying and settling claims. A.R. at 215. For the period at issue from January 1, 2012 to June 30, 2012, HCR reported the following costs for losses relating to such deductibles:

Heartland of Beckley -- \$1,625,577 for 201 beds or \$8,087 per bed
Heartland of Charleston -- \$1,486,542 for 184 beds or \$8,079 per bed
Heartland of Keyser -- \$989,703 for 122 beds or \$8,112 per bed
Heartland of Clarksburg -- \$973,075 for 120 beds or \$8,108 per bed
Heartland of Martinsburg -- \$975,521 for 120 beds or \$8,129 per bed
Heartland of Preston County -- \$973,912 for 120 beds or \$8,115 per bed and
Heartland of Rainelle -- \$486,839 for 60 beds or \$8,113 per bed

A.R. at 437.

By letters dated October 30, 2012, the Office of Accountability & Management Reporting ("OAMR") informed HCR that an adjustment of costs was being made in determining the Medicaid rate. OAMR indicated that HCR's reported costs for taxes and insurance for the relevant period were reduced by the following losses relating to liability insurance deductibles:

Heartland of Beckley – (\$1,320,449) for removal of settlements
Heartland of Charleston – (\$1,207,512) for removal of settlements
Heartland of Keyser – (\$803,932) for removal of settlements
Heartland of Clarksburg – (\$790,425) for removal of settlements
Heartland of Martinsburg – (\$792,412) for removal of settlements
Heartland of Preston County – (\$791,105) for removal of settlements and
Heartland of Rainelle – (\$395,457) for removal of settlements

A.R. at 469-96.

OAMR further imposed a “cap” of \$1,433 per bed on losses relating to liability insurance deductibles, which resulted in the following allowed costs:

Heartland of Beckley -- \$287,937
Heartland of Charleston -- \$263,584
Heartland of Keyser -- \$174,767
Heartland of Clarksburg -- \$171,902
Heartland of Martinsburg -- \$171,902
Heartland of Preston County -- \$171,902 and
Heartland of Rainelle -- \$85,951

AR at 398.

In calculating the “cap” for such losses, OAMR relied on a 90th percentile cut off that is specified in the Bureau’s Provider Manual § 514.30.2.² OAMR, however, adjusted the costs to be included in the ranking of facilities for purposes of determining the 90th percentile “cut off” that constitutes the cap identified in Section 514.30.2. The adjustment to the “cap” was a charge for the procedure previously approved. OAMR removed all costs that were not direct insurance premium payments from those reported by the HCR facilities, and from the costs reported by another large nursing home provider, Golden Living. As noted, the removal of those costs had not been done in prior years. The effect of the removal was to lower the cap for allowable costs. For some HCR facilities, that constituted a further lowering of the allowable costs. The result of the desk review adjustment was disallowance of 81% of the losses relating to liability insurance deductibles reported from January 1, 2012 to June 30, 2012.

HCR appealed from the desk review adjustment. On June 17, 2013, the Bureau issued a document/desk review decision that acknowledged that the State Plan is silent on the requirements for nursing home providers to maintain self-insurance up to the amount of their deductible. The Bureau then looked to the PRM as guidance, but ignored § 2162.5 of the PRM,

²See <http://www.dhhr.wv.gov/bms3/Documents/Manuals%20Archive/Chap514NursingFacility2011.pdf>.

which was cited by HCR. Instead, the Bureau concluded that based on the language of § 2162.7 of the PRM and the reasoning of the California Court of Appeals with regard to that provision in *Oroville Hospital v. Department of Health Services*, 146 Cal. App. 4th 468, 52 Cal. Rptr. 3d 695 (2007), such payments are not allowable costs under the West Virginia Medicaid program.³ A.R. at 395-96.

HCR requested an evidentiary hearing, which was held on January 17, 2014. The evidence shows that the Bureau had never notified HCR that its method of reporting losses relating to liability insurance deductibles is inappropriate. A.R. at 226. The Bureau had never given any public notice that such losses are not allowable. The State Plan promulgated by the Bureau approved by the federal government, had not changed. A.R. at 124. The Provider Manual had not changed with regard to calculation of the liability cap. A.R. at 124-25.⁴ No other state's Medicaid program has ever asserted that the PRM requires HCR, which operates in 29 states in addition to West Virginia, to obtain an independent fiduciary and make payments to a separate trust in order to report as allowable HCR's losses relating to its deductibles. A.R. at 225. Moreover, neither the Centers for Medicare and Medicaid Services ("CMS"), which is the federal agency charged with administering the Medicaid Act, nor any other federal authority has ever notified HCR that § 2162.7 as opposed to § 2162.5 of the PRM applies to HCR's method of cost reporting. A.R. at 226.

Ms. Snow, the Bureau's Director of Reimbursement, testified that she is not aware of any regulation stating that settlement payments or claim payments are not allowable costs. A.R. at 131-32. In addition, prior to 2012, the Bureau had never advised nursing homes that expense payments below their insurance deductible were not allowed. A.R. at 134. Nor had the Bureau

³ As discussed below, Section 2162.7 deals with self insurance funds and allowability of payments into the funds. HCR, however, has no such fund but instead has high deductible insurance.

⁴ There was a change in the Provider Manual subsequent to the periods at issue, discussed further *infra* at n. 8.

disallowed, prior to 2012, portions of expenses for any facility under review for any reason other than late data or re-balancing accrual information. A.R. at 124. The scope of the change in the Bureau's position is substantial. Under the rule the Bureau now seeks, insurance premiums, no matter how expensive or irrational, will be the only allowable costs. A.R. at 157-58. Ms. Snow expressly stated that the substantial scrutiny applied to HCR's reported costs that triggered the change arose because the Bureau "noticed some large increases" in the reported costs. A.R. at 60.

The only evidence in the record is that PRM § 2162.5 applies and that its requirements were met. In the proceedings before the hearing examiner, HCR's vice president and chief compliance officer Barry Lazarus testified. Mr. Lazarus reviewed the PRM § 2162.5, and then confirmed that it applies to HCR's deductibles as follows:

Q. Is it your understanding that if the Provider Reimbursement Manual were to be applied, then it's the sections of the PRM that relate to deductibles and co-insurance that would govern, not the sections related to providers that choose to create independent fiduciary trust funds?

A. **That's correct.**

A.R. at 268.

HCR's expert witness Lane Ellis also testified that the PRM § 2162.5 applies to allow HCR's deductibles. A.R. at 288. Mr. Ellis, who provides services to the "majority" of the nursing facilities in West Virginia, and his firm compile annual cost data on all West Virginia nursing facilities. A.R. at 283-85. Mr. Ellis testified that the Bureau accepts settlement costs and other costs submitted by other nursing facilities throughout West Virginia. A.R. at 287-88. His testimony was that direct liability payments (below any deductible) had been routinely included as liability costs by other facilities in the state prior to the period at issue:

Q. So far as you know do most West Virginia nursing home facilities report any direct liability payments they make as part of their cost report in that – any malpractice costs the incur in that taxes and insurance cost center?

A. **Right. In particular, I think the deductible part of claims get reported in that cost center.**

Q. All right. Is that routine?

A. **Prior to 1/1/13, yes, it was.**

A.R. at 289-90.

The Bureau's counsel asked Mr. Ellis to disclose the names of those nursing facilities that had been including such costs. Mr. Ellis said he did not believe he could reveal the names of other facilities submitting such costs, without violating his ethical duties. HCR's counsel proposed sealing the transcript, at which point counsel for BMS expressly threatened action against any facilities that Mr. Ellis disclosed. Faced with that explicit threat, Mr. Ellis did not believe he could ethically reveal the names of clients, and the hearing examiner granted the BMS motion to strike. A.R. at 326-27.

Mr. Ellis further testified that BMS undertakes audits every three years. A.R. at 322. Mr. Ellis opined that there was no barrier to BMS knowing of the practice of submitting losses relating to deductibles as follows:

Q. All right. Would there have been any difficulty over the past – Well let me back up. How long, to your knowledge, have facilities been reporting as a cost in that taxes and insurance cost center payments they make within their deductible to settle claims, to pay claims, or to pay judgments for malpractice insurance and malpractice claims?

A. **For a very long time.**

Q. All right. Is there anything secret about what the facilities are doing when they report those costs?

A. **No, they incur costs within their deductible and include them in those components of costs.**

Q. Would there have been any barrier to the Bureau to discovering in the last ten years that facilities routinely include those costs in the costs they report to Medicaid as part of their cost report?

A. **Any barrier? I know that in their audit process they select samples of checks when they do their Medicaid audits. I would believe that that would provide opportunity to look and investigate those costs as those audits are conducted.**

Q. So in providing sample checks for any given cost from time to time samples should have included payments of settlements, payments of judgments. Is that correct?

A. **I would say they should. Could I say that they did? I can't recall one at the moment. But in the typical process of sampling it should have come up.**

A.R. at 297-98.

There was, in addition, no barrier to obtaining information from HCR. The Bureau's witness expressly confirmed that she "had never had any problem getting information that [she] thought was trustworthy" from HCR's designated representative, Linda White. A.R. at 136-38.

Subsequent to the hearing, HCR submitted an affidavit of Karla Martin in rebuttal to the testimony of Jeanne Snow, the witness for BMS, that she had never been aware that other providers submitted such costs. A.R. at 913-23. The proffered affidavit had attached to it pertinent email exchanges between Golden Living employees and Jeanne Snow. The exchanges in 2010 and 2012 made it absolutely clear that Golden Living is self-insured, and that its submissions were for paid claims, not insurance premium costs. Ms. Snow further inquired about an increase in costs from on April 9, 2010. Thereafter, the relevant portions of the exchange (put in chronological order from earliest to latest) were all on April 12, 2010, as follows:

Karla Martin to Jeanne Snow

Jeanne,

The increase in general liability expense between 12/31/09 and 06/30/09 is due primarily to an increase in paid claims between the two periods.

If you have any questions or need additional information, please let me know.

Karla Martin
Manager, Reimbursement

Jeanne Snow to Karla Martin

Karla,

Do you base the general liability expense on premiums or paid claims? Are you self-insured?

Thanks,
Jeanne

Karla Martin to Jeanne Snow

Jeanne,

Effective with the merger in March 2006, general liability insurance for Golden Gate National Senior Care (GGNSC) is covered under a Self-Insured program. As a result, these facilities have reported paid claims plus fees as allowable costs on their facility cost reports.

Thanks, Karla

Jeanne Snow to Karla Martin

Thanks, that's what I needed to know!

A.R. at 920-21.

Then, in October of 2012, Ms. Snow inquired about another increase in liability expenses, and *confirmed that she knew that Golden Living was self-insured* and then asked whether settlement costs were included. The exchange below (all separate emails on October 23, 2012) shows that Ms. Snow did know that the liability costs were included.

Jeanne Snow to Freddia Sullivent

Freddia,

I'm reviewing GLC – Glasgow's cost report for the period ending June 30, 2012. There is a huge increase in the liability expense (from \$61,154 for 12/31/2011 to \$600,928 for 6/30/2012). Could you please explain this increase? I know that your facilities are self-insured. Are settlement awards included in this liability expense? Can you provide a spreadsheet showing this information?

Thanks,
Jeanne

Karla Martin to Jeanne Snow

Jeanne,

You are correct, general liability insurance for Golden Gate Nation Senior Care (GGNSC) is covered under a Self-Insured program and has been since the merger in 2006. The facilities have reported paid claims plus fees as allowable costs on their facility cost reports. The increase in general liability expense between 12/31/11 and 06/30/12 for Fac. #3534 – Glasgow is due to an increase in paid claims between the two periods. The amount of general liability paid claims will commonly fluctuate from one period to the next causing fluctuations in general liability expense. Attached please find the paid claims report by claimant for Fac. #3534 for the period 01/01/12 – 06/30/12.

If you have any questions or need additional information, please let me know.

Karla Martin
Manager, Reimbursement

Jeanne Snow to Karla Martin

Thank you for this information!

A.R. at 922-23.

The proffered evidence was direct rebuttal to testimony of Ms. Snow, and the lack of availability of a Golden Living representative at the hearing was not the fault of HCR. Emails to and from the Bureau confirm this knowledge. A.R. at 920-23.

The hearing examiner entered a recommended decision on September 3, 2014. A.R. at 16-39. In a footnote, the hearing examiner excluded HCR's proffered affidavit of Karla Martin. A.R. at 16. On the merits, the hearing examiner's decision upheld the document/desk review decision in all respects, but the hearing examiner changed the justification for the Bureau's

action for a second time. The hearing examiner found that the PRM is not binding in this matter, and he apparently did not rely on the PRM for guidance. Contrary to the document/desk review decision, the hearing examiner reached the conclusion that the State Plan was a barrier to allowance of losses relating to deductibles, although making no claim that this position had even been suggested by the Bureau in the past. The hearing examiner did not discuss the inconsistency of the position with the prior approach of the Bureau, or the absence of any regulatory change. The hearing examiner simply held that “past behavior does not preclude the Bureau from properly enforcing its regulation during subsequent audit periods.” A.R. at 31.

The Bureau adopted the hearing examiner’s recommended decision without modification in a letter dated September 8, 2014. A.R. at 15.

HCR petitioned for certiorari to the circuit court. A.R. at 6.⁵ HCR designated the entire administrative record, but BMS only provided the transcript from the administrative hearing and exhibits. A.R. at 40-43. The circuit court held a hearing on April 9, 2015. Following the hearing, HCR filed a motion for discovery on the issues of whether BMS has been approving inclusion of settlement and other liability costs beyond liability insurance premiums in setting rates for other providers and whether BMS was on notice that other providers included settlement and other costs in their submissions to BMS. A.R. at 760-68. In addition, HCR filed a supplemental statement of evidence in the record, which included among other things the affidavit of Karla Martin, which was excluded by the hearing examiner. A.R. at 833-34. The circuit court never ruled on those motions, but entered a final order in favor of the Bureau on May 14, 2015. A. R. at 865-78. The circuit court concluded that the Bureau “pinpointed the reason for the incline of HCR’s expenses and then ensured reasonable rates . . . by removing

⁵ HCR’s petition followed the precautionary custom of citing to both West Virginia Code § 29A-5-4 and West Virginia Code § 53-3-1, which governs petitions for certiorari.

liability and settlement costs from the cap calculation.” A.R. at 872. According to the circuit court, this shift is not a new policy or rule, and, therefore, no notice was necessary. A.R. at 872. The circuit court further held that the Bureau’s interpretation of the State Plan is entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). A.R. at 874. The circuit court further held that reimbursement of liability expenses incurred under a high deductible insurance policy is against West Virginia public policy. A.R. at 877. The circuit court concluded that assuming that the PRM applies, HCR has adduced no evidence that it has satisfied the terms of this provision and has not explained how it is entitled to the presumption created by the provision. A.R. at 878.

HCR filed its notice of appeal to this court on June 12, 2015.

III. SUMMARY OF THE ARGUMENT

The circuit court erred in denying HCR’s petition for certiorari because the Bureau’s denial of Medicaid reimbursement for losses relating to HCR’s liability insurance deductibles is improper under the Medicaid Act, corresponding regulatory provisions, and § 2162.5 of the PRM. HCR met the requirements of § 2162.5, which expressly allows first dollar losses relating to qualifying insurance deductibles and coinsurance. Contrary to the circuit court’s order, the Bureau’s interpretation of the State Plan, which has changed several times, is not entitled to deference and is preempted by federal law in any event. The Bureau violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR’s losses relating to deductibles and changing the method of setting Medicaid reimbursement rates and the cap without notice and an opportunity to be heard. West Virginia public policy does not prohibit the Bureau from reimbursing HCR for losses related to its deductibles.

The dramatic, unannounced, and retroactive attempt to change the governing rules independently requires reversal. In addition, the circuit court erred in failing to grant HCR's motion for discovery and failing to consider the entire administrative record, including evidence stricken and proffers made, as well as supplemental evidence provided to the circuit court. HCR's substantial rights were violated because it was entitled to the requested discovery in its petition for certiorari. Moreover, the circuit court should have reviewed the entire administrative record designated by HCR, which included among other things, the stricken testimony of Mr. Ellis and the proffered affidavit of Ms. Martin, as well as the supplemental statement of evidence in the record, which was submitted to the circuit court post-hearing.

Therefore, this Court should reverse the circuit court's order and remand this action for allowance of the losses at issue. Alternatively, the Court should vacate the order and remand for further proceedings to allow full exploration of the Bureau's change in policy and its prior knowledge of longstanding practice of providers at this point.

IV. STATEMENT REGARDING ORAL ARGUMENT AND DECISION

This appeal is suitable for oral argument under West Virginia Rule of Appellate Procedure 20(a) because it involves issues of first impression on matters of fundamental importance including the due process rights of parties to agency proceedings. Because the Court should reverse or in the alternative vacate the circuit court's judgment and remand the action for further proceedings, a memorandum decision may not be appropriate.

V. STANDARD OF REVIEW

The Administrative Procedures Act, W. Va. Code § 29A-5-4, *et seq.* (the "APA") "does not apply to contested cases involving the receipt of public assistance." *J.S. ex rel. S.N. v. Hardy*, 229 W. Va. 251, 728 S.E.2d 135, Syl. Pt. 1 (2012). "A writ of certiorari in the circuit

court of Kanawha County is the proper means for obtaining judicial review of a decision made by a state agency not covered by the [APA].” *State ex rel. Ginsberg v. Watt*, 168 W. Va. 503, 285 S.E.2d 367, Syl. Pt. 2 (1981). This Court recently explained that the circuit court should not give deference to the agency’s factual and legal determinations on certiorari as follows:

The obligation of a circuit court that accepts a case for review under certiorari is clear: “On certiorari the circuit court is required to make an independent review of both law and fact in order to render judgment as law and justice may require.” Syl. Pt. 3, *Harrison v. Ginsberg*, 169 W. Va. 162, 286 S.E.2d 276 (1982); *see also* Syl. Pt. 2, *State ex rel. Prosecuting Attorney v. Bayer Corp.*, 223 W. Va. 146, 672 S.E.2d 282 (2008) (holding that “[u]nless otherwise provided by law, the standard of review by a circuit court in a writ of certiorari proceeding under W. Va. Code § 53-3-3 (1923) (Repl. Vol. 2000) is de novo”). . . .

Of import . . . is the opportunity provided to a trial court to consider additional evidence when reviewing a matter on certiorari. As we acknowledged in *North v. West Virginia Bd. of Regents*, 160 W. Va. 248, 233 S.E.2d 411(1977), “[u]pon the hearing of [a] writ of certiorari, the circuit court is authorized to take evidence, independent of that contained in the record of the lower tribunal[.]” *Id.* at 248-49, 233 S.E.2d at 413, syl. Pt. 4, in part.

Bills v. Hardy, 228 W. Va. 341, 719 S.E.2d 811, 815-16 (2001).

In *Bills*, the Court further explained its standard of review as follows:

As we recently held in syllabus point two of *Jefferson Orchards v. Zoning Board of Appeals, Inc.*, 225 W. Va. 416, 693 S.E.2d 781 (2010), “[t]his Court applies an abuse of discretion standard in reviewing a circuit court’s certiorari judgment.” When questions of law are presented in the scope of such review, those matters will be reviewed by this Court in plenary fashion. *See* Syl. Pt. 1, *Chrystal R.M. v. Charlie A.L.*, 194 W. Va. 138, 459 S.E.2d 415 (1995).

Id., 719 S.E.2d at 815.

VI. ARGUMENT

A. The Circuit Court Erred in Denying HCR’s Petition for Certiorari.

The circuit court erred in denying HCR’s petition for certiorari because the Bureau’s denial of Medicaid reimbursement for losses relating to HCR’s liability insurance deductibles is improper. The Medicaid Act authorizes the federal government to provide funds to states that

provide medical assistance to individuals “whose income and resources are insufficient to meet the costs of necessary medical services.” 42 U.S.C. § 1396. To participate in Medicaid, a state must submit a State Plan to CMS for approval. The State Plan describes the nature and scope of the state’s Medicaid program, including the policies and methods the state will use to set reimbursement rates for services provided by Medicaid participating health care providers. 42 C.F.R. §§ 430.10 & 447.201(b). The Medicaid Act, requires, among other things, that a State Plan provide the following process with regard to the establishment of rates:

(A) for a *public process* for determination of rate of payment under the plan for . . . nursing facility services . . . under which (i) *proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published*, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a *reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications*, [and] (iii) *final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published*].

42 U.S.C. § 1396a(a)(13)(A) (Emphasis added.)⁶

The Medicaid Act further requires that a State Plan

provide such *methods and procedures* relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist such providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*

42 U.S.C. § 1396a(a)(30)(A) (Emphasis added.)⁷

⁶ States must also comply with 42 C.F.R. § 447.205, a companion regulation to § 1396a(a)(13)(A), which requires public notice of any significant proposed change in the methods and standards for setting payment rates for Medicaid services.

⁷ See also 42 C.F.R. § 447.253(b)(1) (“Medicaid agency pays for . . . long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal Laws, regulations, and quality and safety standards”).

Included in West Virginia's State Plan is Section 4.19, which governs methods and standards for determining payment rates for non-state owned nursing facilities. The relevant portion of Section 4.19 provides as follows:

Allowable Costs for Cost Centers

Cost Center areas are standard services, mandated services, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

...

Mandated Services

Mandated services are defined as Maintenance, Utilities, *Taxes and Insurance* and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs by facility classification as determined by the current cost report.

A.R. at 410-11 (Emphasis added.) This Plan provision has not changed since 1995.

The Bureau's Provider Manual summarizes the description and administration of the Medicaid program. Section 130 of the Provider Manual states that while the Bureau attempts to ensure that the information contained in the Provider Manual is concise and reliable as of the date of issuance, compliance with all applicable state laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations is required. The Provider Manual contains the following disclaimer on every page: "*This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.*" (Emphasis added.) The Provider Manual, which refers to regulations, is not itself a regulation, and is not adopted with notice and comment procedures.

Chapter 514 of the Provider Manual effective during the relevant period⁸ summarized covered services, limitations, and exclusions, for nursing facilities. Section 514.23 established the following priorities regarding reimbursement requirements:

Federal and State law and State Plan and Medicaid regulations cover reimbursement principles in the following order. *When Medicaid regulations are silent and Medicare cost principles and regulations are silent, then generally accepted accounting principles (GAAP) will be applied.* None of these secondary applications will serve to reduce the Department's ability to apply reasonable cost limits under Medicaid.

(Emphasis added.)

Section 514.30.2 set forth as follows with regard to mandated services:

The mandated services component is comprised of four departmental cost centers: Activities, Maintenance, Utilities and *Taxes & Insurance*. A separate cost standard is calculated for each of these cost centers by bed group. Within each cost center the PPD allowable costs are arrayed from highest to lowest. The 90th percentile value of each cost center is then selected as the CAP. The Mandated Services cost standard is the sum of the cost center CAP for Activities, Maintenance, Utilities, and *Taxes & Insurance*. The cost standard then establishes the maximum allowable cost by bed group for Mandated Services.

(Emphasis added.)

The PRM is maintained by the CMS and used by CMS program components, partners, contractors, and state agencies. Although by its terms the PRM applies only to Medicare, the PRM's interpretive guidelines can and have been used for implementing federal Medicare and Medicaid regulations. Moreover, § 514.23 of the Provider Manual states that Medicare cost principles, which include the PRM, govern reimbursement where Medicaid regulations are silent.

Section 2162.5 of the PRM specifically discusses the allowability of actual losses related to deductibles as follows:

⁸ Chapter 514 was replaced effective January 1, 2013. At that time, § 514.13.32 was adopted to preclude liability damages "which should reasonably have been covered by liability insurance" as well as settlement costs. W. VA. MEDICAID PROVIDER MANUAL § 514.13.32. The fact that the Bureau subsequently made explicit its new approach to liability expenses only solidifies the reality that it had never before done so, in violation of notice and comment requirements.

Where you, at your option, are willing to commit your resources toward meeting first dollar losses through a deductible (as defined below), losses relating to the deductible are allowable costs in the year paid without funding if the aggregate deductible is no more than the greater of 10 percent of your (or, if appropriate, a chain organization's) net worth – fund balances as defined for Medicare cost reporting purposes – at the beginning of the insurance period or \$100,000 per provider. The same rule applies where you coinsure with an insurance carrier. This requirement is deemed a reasonable test as to whether you are acting prudently in this regard. So long as you stay within the above limitations, you can be assumed to be exercising sound judgment in deciding to meet first dollar losses or coinsurance payments out of available resources. This requirement also permits you to pay reasonable losses without incurring costs to fund such payments. If your deductible or coinsurance exceeds the above requirements and the provider does not make payments into a fiduciary fund as required by § 2162.7, any losses paid by the provider in excess of the greater of 10 percent of the provider's or, if applicable, a chain organization's net worth, or \$100,000 per provider, are not allowable.

A.R. at 785 (Emphasis added.)

1. HCR met the requirements of the Medicaid Act, its corresponding regulations, and the PRM § 2162.5.

HCR met the requirements of the Medicaid Act, corresponding regulations, and the PRM § 2162.5 set forth above. The circuit court ignored the import of 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.253(b)(1), which together require that payments be reasonable and consistent with efficiency, economy, and quality of care. The circuit court's order directly conflicts with the PRM § 2162.5, which expressly allows "actual losses related to deductibles or coinsurance" up to specified limits and further provides that "[t]his requirement is *deemed a reasonable test as to whether you are acting prudently in this regard.*" (Emphasis added.) The settlements and other costs that are within HCR's insurance deductible are expressly included by the plain language of § 2162.5, which states that "losses relating to the deductible are allowable costs" provided a cap set at 10% of the company's net worth is not exceeded.

As discussed above, the Provider Manual specifies that Medicare cost principles such as the PRM cover reimbursement principles when Medicaid regulations are silent. The Medicaid

regulations do not directly address this issue in this action. Therefore, in accordance with the Provider Manual the PRM, and specifically the PRM § 2162.5, applies.

The Bureau acknowledged the pertinence of the PRM in the Desk Review Decision. The Bureau relied on *Oroville Hospital v. Department of Health Services*, 146 Cal. App. 4th 468, 52 Cal. Rptr. 3d 695 (2007), but that case actually supports HCR's position. In *Oroville*, the California Department of Health Services declined to reimburse a healthcare provider for payments made to a reserve fund that did not meet the criteria set forth in PRM § 2162.7. The court in *Oroville* went on to discuss § 2162.5 of the PRM and ultimately approved the costs as payments of deductibles, explaining:

[Because] Oroville's policy required it to pay the first \$100,000 of health care costs for an individual employee or the first \$3,800,000 of costs for all employees, the payments in question were first-dollar losses not covered by a purchased insurance policy or a self-insurance program. Hence, it appears DHS did not err in determining that the payments were deductibles under the definition provided in section 2162.5.

Id. at 701.

In another similar case, the court applied § 2162.5 to allow almost \$1,000,000 in provider liability costs to the appellant, which owned a chain of seventeen nursing homes. *Am. Healthcare, LLC v. Dep't of Med. Assistance Servs.*, No. CL11000548-00, 2012 WL 7964273 (Va. Cir. Ct. Jan. 9, 2012).⁹ The court framed the issue as what monetary sum a chain organization may claim in the aggregate for uninsured losses under Medicaid. The agency in that case recognized that the uninsured losses were appropriate costs, but argued that the losses should be limited to \$100,000 per provider within the chain that reported losses (in that case three) – not \$100,000 per provider in the chain. The court disagreed and held that the allowable

⁹ It should be noted that in that case the agency claimed that it had made the federal guidance document a regulation in Virginia. *See id.* at n.1.

costs could aggregate to \$100,000 per provider in the chain. Because the provider substantially prevailed, it was awarded costs and attorneys' fees by statute.

In this action, HCR's expenses, like those in *Oroville* and *American Healthcare, LLC*, are payments within a deductible and are reimbursable as such under the PRM § 2162.5. HCR's expert witness Mr. Ellis testified that the PRM § 2162.5 applies to allow HCR's deductibles. A.R. at 315. In addition, after reviewing the PRM § 2162.5 HCR's vice president and chief compliance officer Barry Lazarus testified that it applies to HCR's deductibles as follows:

Q. Is it your understanding that if the Provider Reimbursement Manual were to be applied, then it's the sections of the PRM that relate to deductibles and co-insurance that would govern, not the sections related to providers that choose to create independent fiduciary trust funds?

A. **That's correct.**

A.R. at 268.

HCR's evidence that it properly submitted its deductibles under the PRM § 2162.5 is unrefuted. The Bureau did not cross-examine HCR's witnesses on this issue. In addition, the Bureau has not presented independent argument or evidence that HCR's deductible is more than the greater of 10 percent of its net worth – fund balances as defined for Medicare cost reporting purposes – at the beginning of the insurance period. The Bureau's lack of challenge on this issue is not surprising since in *Manor Care, Inc. v. Douglas*, 234 W. Va. 57, 763 S.E.2d 73, 101 (2014), this Court recognized as a matter of public record that HCR holds a \$4 billion share of the annual nursing home market and has nearly \$8 billion in assets.¹⁰ Thus, HCR's deductible of \$10,000,000 clearly and irrefutably as a matter of public record is less than 10 percent of its net worth. Because there is unrefuted and irrefutable evidence that the PRM § 2162.5 applies to allow HCR's deductibles, the circuit court erred in denying the petition for certiorari.

¹⁰ BMS submitted a brief from the *Manor Care*, which characterizes HCR as a billion dollar conglomerate, to the administrative record; however the brief and several other documents were omitted from the circuit court's record.

2. BMS's interpretation of the State Plan, which has changed several times, is not entitled to deference and is preempted by federal law in any event.

In addition, BMS's interpretation of "allowable costs" as contained in the State Plan is not entitled to deference under *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984), because its interpretation of that term has changed several times and is preempted by federal law in any event. As a threshold matter, this Court has recognized that federal preemption requires the Bureau to comply with federal law regarding Medicaid reimbursement rates. *Appalachian Reg'l Healthcare, Inc. v. W. Va. Dep't of Health & Human Res.*, 232 W. Va. 388, 752 S.E.2d 419, 428 (2013). Consistent with that recognition of federal preemption, West Virginia Code § 9-2-3 states:

The State assents to the purposes of federal-state assistance, accepts federal appropriations and other forms of assistance made under or pursuant thereto, and authorizes the receipt of such appropriations into the state treasury and the receipt of other forms of assistance by the department for expenditure, disbursement, and distribution by the department in accordance with the provisions of this chapter and the conditions imposed by applicable federal laws, rules and regulations.

Similar to the circuit court, the Bureau ignores the import of the Medicaid Act, its corresponding regulatory provisions, and the PRM § 2162.5. As discussed above, 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.253(b)(1), together require that payments be reasonable and consistent with efficiency, economy, and quality of care, and the PRM § 2162.5 expressly allows "actual losses related to deductibles or coinsurance" up to specified limits and further provides that "[t]his requirement is *deemed a reasonable test as to whether you are acting prudently in this regard.*" (Emphasis added.) Nonetheless, the Bureau improperly interpreted the term "allowable costs" in the State Plan to exclude HCR's deductibles.

The portion of this State Plan relevant to this appeal provides:

Allowable Costs for Cost Centers

Cost Center areas are standard services, *mandated services*, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

...

Mandated Services

Mandated services are defined as Maintenance, Utilities, *Taxes and Insurance* and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs by facility classification as determined by the current cost reports.

A.R. at 410-11 (Emphasis added.).

On its face, Section 4.19 of the State Plan, which governs methods and standards for determining payment rates for non-state owned nursing facilities, does not conflict with federal law. Insurance is not just a cost – it is a mandated service under the State Plan. Under *Appalachian Regional Healthcare* and § 9-2-3, the Bureau’s interpretation of the State Plan must also be consistent with federal law. Manifestly, it is not.

Nonetheless, the circuit court erroneously concluded as follows:

BMS interpreted the above-quoted portion of the State Plan to mean that liability and legal settlement expenses are not allowed reimbursements. Upon *de novo* review of the relevant portions of the State Plan and granting BMS the appropriate deference, it does not appear that such claims are allowed. In interpreting the State Plan, BMS assessed the reasonableness of the rates pursuant to 42 C.F.R. § 447.253 and found that the inclusion of liability costs in the cap calculation rendered the rates unreasonable. BMS then removed said costs from the calculus so that it could find the costs reasonable before sending the report to CMS, again, pursuant to 42 C.F.R. 447.253. Thus, under a *Chevron* analysis, BMS’s interpretation is reasonable and entitled to deference.

A.R. at 876.

Contrary to the conclusion of the circuit court, in its interpretation of the term “allowable costs” the Bureau ignores the question of reasonableness from the proper perspective of an

efficiently and economically operated provider under § 447.253(b)(1)(i). Of course, Section 447.253(b)(1)(i) is a federal regulation, not a Bureau regulation, and as such the Bureau's interpretation of Section 447.253(b)(1)(i) is not entitled to deference.

As discussed above, the rates sought by HCR for insurance deductibles and/or coinsurance payments are deemed to be reasonable and proper under the Medicaid Act, and corresponding regulatory provisions, including Section 447.253(b)(1)(i), and § 2162.5 of the PRM. Moreover, HCR has presented unrefuted and irrefutable evidence of their reasonableness.

The Bureau's interpretation of the term "allowable costs" is merely an argument that is not worthy of deference for that reason alone. "[D]eference is not abdication, and it requires us to accept only those agency interpretations that are reasonable in light of the principles of construction courts normally employ." *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 260 (1991) (Scalia, J., concurring). Regarding deference to be accorded to agency interpretations, courts have been astute in observing that deference cannot be provided unless there is a tangible agency construction to which a court may defer. "Interpretations such as those in opinion letters—like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference." *Christensen v. Harris Cty.*, 529 U.S. 576, 587 (2000) (citing *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984)). Moreover, when the agency's position has been articulated as a litigation position this Court has declined to accord deference to the agency's interpretation. *See W. Va. Health Care Cost Review Auth. v. Boone Mem. Hosp.*, 196 W. Va. 326, 472 S.E.2d 411, 419 (1996) (observing that "courts customarily withhold *Chevron* deference from agencies litigating positions").

As discussed above, the Bureau's position in this case is a dramatic departure from the past, and its justification for the position changed repeatedly at every stage of these proceedings. Initially, OAMR removed all costs submitted by HCR that were not direct insurance premium payments although OAMR had not removed such costs in prior years. The Bureau's document/desk review decision acknowledged that the State Plan is silent on the requirements for nursing home requirements for nursing home providers to maintain self-insurance up to the amount of their deductible. The Bureau then looked to the PRM as guidance, but ignored § 2162.5 of the PRM, which was cited by HCR. Instead, the Bureau concluded that based on the language of 2162.7 of the PRM that such payments are not allowable costs.

The hearing examiner's decision changed the justification for the Bureau's action for a second time. The hearing examiner found that the PRM is not binding in this matter, but without explanation, ignored the PRM as guidance. Contrary to the document/desk review decision, the hearing examiner reached the conclusion for the first time – and without the position being advanced by the BMS – that the State Plan precluded allowance of HCR's deductibles. The hearing examiner did not discuss the inconsistency of its decision with the prior approach of the Bureau or the absence of regulatory change.

Following its review, the circuit court's order concluded that "the evidence shows that BMS pinpointed the reason for the incline of HCR's expenses and then ensured reasonable rates, as it is required to do every six months pursuant to the State Plan, by removing liability and settlement costs from the cap calculation." The circuit court's decision does not and cannot point to any evidence that the Bureau's reduced rates were "reasonable," but it does reveal the true nature of the Bureau's position. OAMR cut HCR's costs without any principled basis simply because OAMR believed HCR's deductibles were too high. Then, in three levels of review the

Bureau and the circuit court articulated at least three different erroneous justifications for OAMR's cost-cutting measures. This is post-hoc rationalization at its worst, and it is not entitled to deference.

3. **BMS violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR's losses relating to deductibles and changing its method of setting Medicaid reimbursement rates and the cap without notice and comment.**

BMS also violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR's losses relating to deductibles and changing its method of setting Medicaid reimbursement rates and the cap without notice and comment. As discussed above, the Medicaid Act requires, among other things, that a State Plan include both procedural and substantive elements for setting rates and provides: "(A) for a public process for determination of rate of payment under the plan for . . . nursing facility services . . . under which (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, [and] (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published[.]" 42 U.S.C. § 1396a(a)(13)(A). States must also comply with 42 C.F.R. § 447.205, a companion regulation to § 1396a(a)(13)(A). That regulation requires public notice of any significant proposed change in the methods and standards for setting payment rates for Medicaid services. *See N.C. Dep't of Human Res. v. U.S. Dep't of Health & Human Servs.*, 999 F.2d 767, 771 (4th Cir. 1993) ("The public notice requirements mandated by 42 C.F.R. §[] 447.205 . . . [are] not burdensome and provide important procedural protections to providers and beneficiaries under the Medicaid program").

In addition, administrative agencies are required generally to provide notice and comment of a new interpretation of existing regulations. *Alaska Prof'l Hunters Ass'n, Inc. v. F.A.A.*, 177 F.3d 1030, 1035 (D.C. Cir. 1999) (once agency gives regulation an interpretation, it can only change interpretation as it would formally modify regulation itself: through process of notice and comment rulemaking); *Syncor Int'l Corp. v. Shalala*, 127 F.3d 90, 94–95 (D.C. Cir. 1997) (noting that modification of interpretive rule construing agency's substantive regulation will “likely require a notice and comment procedure. Otherwise, the agency could evade its notice and comment obligation by ‘modifying’ a substantive rule that was promulgated by notice and comment rulemaking”). Indeed, it is well settled in West Virginia as well that an agency must give appropriate notice of a change in its position and reasons for the change. *C & P Tel. Co. of W. Va. v. Pub. Serv. Comm'n of W. Va.*, 171 W. Va. 708, 301 S.E.2d 798, 804 (1983) (when agency reverses course from precedents, it must give reasonable notice and supporting rationale before changing standards, or its actions appear arbitrary and capricious); *Coordinating Council for Indep. Living, Inc. v. Palmer*, 209 W. Va. 274, 546 S.E.2d 454 (2001) (noting that agency reversal of interpretation of statute is *prima facie* arbitrary and capricious); *Weirton Heights Volunteer Fire Dep't, Inc. v. State Fire Comm'n*, 218 W. Va. 668, 628 S.E.2d 98 (2005) (where agency seeks to take away privilege it must provide notice of criteria to guide agency's determination; withdrawal of privilege in absence of duly promulgated rules or regulations setting forth criteria used to guide agency's determination is arbitrary, capricious and abuse of discretion). This clearly applies to agency action under the Medicaid Act.

In this action, the circuit court erroneously concluded that there is no evidence showing that BMS changed its methods and standards in calculating the cap and setting reimbursement rates such that no notice was necessary. Instead, as discussed above the circuit court determined

that “the evidence shows that BMS pinpointed the reason for the incline of HCR’s expenses and then ensured reasonable rates, as it is required to do every six months pursuant to the State Plan, by removing liability and settlement costs from the cap calculation.” That contention means only that the Bureau knew what HCR was reporting, but does not address the validity of the Bureau’s change in position.

In fact, the Bureau adopted an entirely new interpretation of the law with no notice whatsoever in a post-hoc attempt to rationalize OAMR’s cutting of HCR’s deductibles, which were allowable costs. Here, the Bureau, provided no notice whatsoever as to its newly-discussed theory on the meaning of the law. The Bureau did not change the State Plan (dated 1995). It did not change the Provider Manual. It did not (and could not) change § 2162 of the PRM. In fact, the Bureau could point to no statutory or regulatory change preceding its new treatment of the costs at issue here. The Bureau’s post-hoc rationalization is nothing but arbitrary and capricious.

This is particularly true because the Bureau’s existing methodology has a built-in limit on excessive costs. All costs above the 90th percentile are excluded under the Bureau’s long-standing written cap methodology of the Provider Manual: “The 90th percentile value of each cost center is then selected as the CAP.” Provider Manual § 514.30.2. The circuit court did not address the existence of this express cost-limiting methodology, nor point to evidence that HCR could have more reasonably or more cheaply provided liability protection. The circuit court also ignored the Bureau’s failure to cite “excessiveness” as a justification. The Bureau’s position was instead a categorical one, excluding any costs other than insurance premiums regardless of reasonableness.

For years, HCR has submitted, and the Bureau has allowed, the liability insurance costs at issue here. The Bureau had never before notified HCR that such claims were improper.

Jeanne Snow, the Bureau's Director of Reimbursement, also testified at the evidentiary hearing that she is not aware of any regulation stating that settlement payments are not allowable costs. A.R. at 130-32. In addition, prior to 2012, the Bureau had never advised nursing homes that expense payments below their insurance deductible were not allowed. A.R. at 133-35. Finally, Ms. Snow could not identify a single regulatory change that led to the Bureau's new method of calculating the cap:

Q. Was there any change in the Bureau's Medicaid regulations that related to the calculation of the CAP that you relied on?

A. No.

Q. Was there any change by the Bureau in the Medicaid manual the Bureau publishes that related to the Bureau's method of calculating the CAP?

A. No.

Q. Was there any change in the Provider Reimbursement Manual that related to the calculation of the CAP?

A. No.

A.R. at 124-25.

Effective January 1, 2013, which is after the relevant time in this action, Chapter 514 of the Provider Manual was replaced. At that time a new § 514.13.32 was adopted to preclude liability damages "which should reasonably have been covered by liability insurance" as well as settlement costs. Provider Manual § 514.13.32.¹¹ The Supreme Court has explained that the deliberate selection of language differing from that used in earlier provisions indicates that a change of law was intended. *Brewster v. Gage*, 280 U.S. 327 (1930). Under these circumstances, the fact that the Bureau subsequently made explicit its new approach to liability expenses only

¹¹ See http://www.dhhr.wv.gov/bms3/Documents/Chapter_514_NursingFacility.pdf.

solidifies the reality that it had not done so at the relevant time in this action, in violation of notice and comment requirements.

More importantly, that change to the Provider Manual does not support the Bureau's position in this proceeding, because the changed language is not a blanket preclusion of expenses other than liability premiums. Instead, the new language sets limits on when direct liability payments can be included. The Provider Manual now allows exclusion if the damages paid directly "should reasonably have been covered by liability insurance." Thus, for settlements or verdicts as that a prudent nursing facility would have covered with liability insurance, the costs are not allowable. Where however, a prudent operator would reasonably have purchased insurance with a deductible or retention amount, under the new provisions of Section 514.13.32, the expenses are allowable.

In this case, there was no evidence of any kind that HCR had been unreasonable or imprudent in structuring its insurance program. The Bureau submitted not a single word of testimony, and not a single exhibit of any kind, on the point. HCR, in contrast, explained in detail its insurance program, the layers of coverage, and its ongoing efforts to ensure that it had left undetected no superior alternative. A.R. at 186-89. In this case, HCR was insured for all losses over \$10,000,000 by various policies and reinsurance agreements. A.R. at 186, and the Bureau never suggested that HCR was unreasonable in its choices.

Moreover, the Bureau did not suggest at any time (much less provide evidence) that any other structure was even available. In fact, the sole testimony at the hearing was that HCR did not have the option, at the relevant time, for lower liability limits. A.R. at 187-88. The Circuit Court's conclusion that the Bureau acted properly to set a "reasonable" rate, by excluding the HCR costs, has no evidentiary basis and is in fact contradicted by the only evidence. This error

compounds the separate error of the Circuit Court that BMS had not changed its position, without notice, comment or explanation.

The circuit court's error in this regard is not cured by its further mischaracterization of HCR's argument and its conclusion that the State is not subject to the laws of estoppel or bound by ultra vires acts when acting in a governmental capacity. Neither estoppel nor ultra vires acts doctrine were argued below. The Bureau did argue below that it could not "waive" the correct interpretation. Moreover, the rule of law as to "estoppel" regarding the state does not overrule the fundamental requirement of administrative law, repeatedly recognized by this Court, that an agency may not be arbitrary and capricious, and that it may not implicitly change regulations without going through administrative procedures. *See C & P Tel. Co. of W. Va. v. Pub. Serv. Comm'n of W. Va.*, 171 W. Va. 708, 715, 301 S.E.2d 798, 804 (1983) (when agency reverses course from precedents, it must give reasonable notice and supporting rationale before changing standards, or its actions appear arbitrary and capricious); *Coordinating Council for Indep. Living, Inc. v. Palmer*, 209 W. Va. 274, 546 S.E.2d 454 (2001). Under the circuit court's view as to "non-estoppel" of the state, that entire branch of administrative law would be wiped out. The Bureau is not allowed to change, willy-nilly, the meaning of statutes and regulations, and to change course without notice and on a retroactive basis. In any event, as discussed above HCR's deductibles are deemed to be reasonable and proper under the Medicaid Act, and corresponding regulatory provisions, and § 2162.5 of the PRM based on undisputed and irrefutable evidence.

4. West Virginia public policy does not prohibit BMS from reimbursing HCR for losses relating to deductibles.

Moreover, the circuit court erroneously concluded: "Notwithstanding the deference afforded to BMS's interpretation of the State Plan, the Court finds that it is against the public policy of this State to reimburse healthcare facilities for expenses incurred by legal settlements

covered under a high deductible insurance policy such as the \$10,000,000.00 deductible in the instant case.” A.R. at 877. The circuit court’s conclusion has no basis in state law, especially as there is no evidence of any kind that HCR could have obtained coverage with a low deductible. “[P]ublic policy’ is that principle of law which holds the ‘no person can lawfully do that which has a tendency to be injurious to the public or against public good . . .’ even though ‘no actual injury’ may have resulted therefrom in a particular case ‘to the public.’” *Swears v. R.M. Roach & Sons, Inc.*, 225 W. Va. 699, 696 S.E.2d 1, 6 (2010) (citations omitted). In looking to the sources for public policy, this Court has looked to the constitution, statutes, and its prior decisions. *Id.* There is no constitutional or statutory provision precluding deductibles in insurance, and no prior decision of this Court so holding. The circuit court’s decision was without support. There was also no evidence that purchasing lower deductible insurance would result in a savings to HCR or the state. The only testimony was directly to the contrary. A.R. at 187-88. The theory that public policy precludes the course of action that is the most efficient and cost effective, as well as the only one available, defies fundamental logic.

Moreover, the circuit court’s decision is contrary to express federal policy for the Medicaid program, which preempts state law. As discussed above, 42 U.S.C. § 1396(a)(30)(A) requires, among other things, that a State Plan “assure that payments are *consistent with efficiency, economy, and quality of care and are sufficient to enlist such providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*” (Emphasis added.) See also 42 C.F.R. § 447.253(b)(1). In addition, the PRM § 2162.5 expressly allows reimbursement for a deductible or coinsurance where it is no more than the greater of 10 percent of net worth or

\$100,000 per provider, and further that such deductible or coinsurance is presumptively reasonable as follows:

This requirement is deemed a reasonable test as to whether you are acting prudently in this regard. So long as you stay within the above limitations, you can be assumed to be exercising sound judgment in deciding to meet first dollar losses or coinsurance payments out of available resources. This requirement also permits you to pay reasonable losses without incurring costs to fund such payments.

A.R. at 785.

High deductibles save money for providers and for West Virginia. Furthermore, for a provider the size of HCR, it is the only means to insurance coverage. The circuit court provided no basis for its conclusion that this costs-effective approach to coverage violates public policy.

B. The Circuit Court Erred in Failing to Grant HCR's Motion for Discovery and Failing to Review the Entire Administrative Record and Supplemental Evidence.

1. HCR was entitled to requested discovery in its petition for certiorari.

To the extent the Court had doubt whether HCR met the requirements of the Medicaid Act, its corresponding regulatory provisions, and the PRM § 2162.5, then HCR was entitled to the requested discovery in its petition for certiorari to the circuit court. In addition, if the circuit had any doubt as to whether the Bureau has been accepting settlement costs submitted by other providers as allowable costs or whether the Bureau had actual knowledge as the costs it had approved, then HCR was entitled to discovery before the circuit court.

Because this action was before the circuit court on petition for certiorari, the circuit court was empowered to conduct discovery and take additional evidence on appeal; it was not limited to the record below. West Virginia Code § 53-3-2 provides:

In every case, matter or proceeding, in which a certiorari might be issued as the law heretofore has been, and in every case, matter or proceeding before a county court, council of a city, town or village, justice or other inferior tribunal, the

record or proceeding may, after a judgment or final order therein, or after any judgment or order therein abridging the freedom of a person, be removed by a writ of certiorari to the circuit court of the county in which such judgment was rendered, or order made; . . .”

This Court has recognized that “the concept of an ‘inferior tribunal’ under the certiorari statute” may involve a tribunal which “also operates in administrative areas.” *North v. W. Va. Bd. of Regents*, 160 W. Va. 248, 233 S.E.2d 411, 419, n.11 (1977).

In addition, West Virginia Code § 53-3-3 provides:

Upon the hearing, such circuit court shall, in addition to determining such questions as might have been determined upon a certiorari as the law heretofore was, review such judgment, order or proceeding, of the county court, council, justice or other inferior tribunal upon the merits, determine all questions arising on the law and evidence, and render such judgment or make such order upon the whole matter as *law and justice may require*.

(Emphasis added.)

This Court has stated:

Of import . . . is the opportunity provided to a trial court to consider additional evidence when reviewing a matter on certiorari. As we acknowledged in *North v. West Virginia Bd. of Regents*, 160 W. Va. 248, 233 S.E.2d 411 (1977), “[u]pon the hearing of [a] writ of certiorari, the circuit court is authorized to take evidence, independent of that contained in the record of the lower tribunal[.]” *Id.* at 248-49, 233 S.E.2d at 413, syl. Pt. 4, in part.

Bills v. Hardy, 228 W. Va. 341, 719 S.E.2d 811, 815-16 (2001).

The decision in *Bills* implemented the long-standing rule that the certiorari statute “authorizes a liberality to cure such a defect as a *defective* or untruthful return.” *McClure-Mabie Lumber Co. v. Brooks*, 46 W. Va. 732, 734, 34 S.E. 921, 922 (1899) (emphasis added). To not allow a trial court to authorize new evidence on writ of certiorari would “frustrate the clear statutory mandate that the certiorari review satisfy the requirements of law and justice.” *North*, 160 W. Va. at 261, 233 S.E.2d at 419.

In this action, the administrative proceedings provided no mechanism for conducting discovery on the matter under appeal. At the hearing on April 9, 2015, the Court recognized that two central issues could affect the outcome of this matter. Yet during the proceedings before the Bureau and the hearing examiner, HCR had no method to obtain the evidence the circuit court sought. Accordingly, HCR filed a motion for discovery in the circuit court. The circuit court, however, erroneously denied HCR's petition for certiorari without ruling on its motion for discovery.

HCR's substantial rights were violated because it was unable to conduct discovery on two points the circuit court identified at the hearing as critical to its assessment of the case: (1) whether the Bureau has been approving inclusion of settlement and other liability costs beyond liability insurance premiums in setting rates for other providers; and (2) whether the Bureau was on notice that other providers included settlement and other costs in their cost report submissions to BMS. Because there was no opportunity for that discovery below, and because at the hearing the Bureau actively prevented exploration of one of the topics,¹² due process and fundamental

¹² As discussed above, Mr. Ellis testified that direct liability payments (below any deductible) had been routinely included as liability costs by other facilities in the state prior to the period at issue:

Q. So far as you know do most West Virginia nursing home facilities report any direct liability payments they make as part of their cost report in that – any malpractice costs the incur in that taxes and insurance cost center?

A. **Right. In particular, I think the deductible part of claims get reported in that cost center.**

Q. All right. Is that routine?

A. **Prior to 1/1/13, yes, it was.**

A.R. at 289-90. The Bureau's counsel asked Mr. Ellis to disclose the names of those nursing facilities that had been including such costs. Mr. Ellis said he did not believe he could reveal the names of other facilities submitting such costs, without violating his ethical duties. HCR's counsel proposed sealing the transcript, at which point counsel for BMS expressly threatened action against any facilities that Mr. Ellis disclosed. Faced with that explicit threat, Mr. Ellis did not believe he could ethically reveal the names of clients, and the hearing examiner granted the BMS motion to strike. A.R. at 326-27.

fairness required that the record be reopened by the circuit court and discovery allowed on those two points.

HCR specifically requested that it be allowed to send written discovery to BMS and subpoenas to third parties pursuant to the West Virginia Rules of Civil Procedure. This discovery would have enabled HCR to have a full and fair opportunity to present the relevant issues, along with evidence to support its arguments relating to those issues. The circuit court's failure to allow such discovery is error. To the extent that the issues identified by the circuit court may be dispositive, the error is unfairly prejudicial to HCR and requires a remand for further proceedings.

2. **The circuit court should have reviewed the entire administrative record, including evidence stricken and proffers made, and supplementations.**

Finally, the circuit court should have reviewed the entire administrative record, including evidence stricken and proffers made, and supplementations made in the circuit court. As discussed above, the hearing examiner granted BMS's motion to strike Mr. Ellis's testimony that direct liability payments (below any deductible) had been routinely included as liability costs by other facilities in the state prior to the period at issue. A.R. 326-27. In response to the circuit court's directive that HCR provide any specified references as to whether the Bureau has been approving inclusion of settlement and other liability costs beyond liability insurance premiums in setting rates for other providers at the hearing on April 9, 2015, HCR submitted a supplemental statement of evidence in the record, which cited to Mr. Ellis's testimony in that regard. Mr. Ellis's testimony should not have been stricken from the administrative record, and it proves that the Bureau has been approving such costs in setting rates for other providers. In its supplemental statement of evidence, HCR argued that the circuit court should have considered Mr. Ellis's

testimony, which is relevant to the issue the circuit court raised because it was wrongly stricken by the hearing examiner. Nonetheless, the circuit court did not consider Mr. Ellis's testimony.

In addition, when HCR petitioned for certiorari to the circuit court, HCR designated the entire administrative record. A.R. at 40. Nonetheless, BMS only provided the transcript from the administrative hearing and exhibits to the circuit court. A.R. at 43. Thus, several documents were improperly excluded from the record before the circuit court. Among these documents is the affidavit of Ms. Martin with attached email correspondence discussed above. A.R. at 913-23. HCR submitted the affidavit following the January 17, 2014, administrative hearing in rebuttal to the testimony of Ms. Snow that she had never been aware that other providers submitted such costs. In footnote 1 of its recommended decision, the hearing examiner erroneously excluded HCR's proffered affidavit of Ms. Martin. HCR included Ms. Martin's affidavit in its supplemental statement of evidence in response to the circuit court's directive that HCR provide any specific references as to whether the Bureau was on notice that other providers included settlement and other costs in their cost report submissions to BMS. A.R. at 802-38. Ms. Martin's affidavit should not have been excluded from evidence, and it proves that the Bureau was on notice that other providers included settlement and other costs in their cost report submissions. The circuit court should have considered Ms. Martin's affidavit, which is relevant to an issue the circuit court raised, because it was wrongly excluded from the administrative record. Nonetheless, the circuit court did not consider Ms. Martin's affidavit.

In conducting its *de novo* review of the administrative record, the circuit court should have considered the entire administrative record, including those parts that were improperly stricken or excluded by the hearing examiner, and those parts that were designated by HCR but omitted by the Bureau. The circuit court's failure to consider the whole record constitutes

prejudicial error. HCR submitted its supplemental statement of evidence in the record to provide the circuit court another opportunity to review relevant evidence that proves the issues identified by the circuit court during its hearing. Unfortunately, HCR's submission fell on deaf ears.

VII. CONCLUSION

For all of the foregoing reasons, this Court should reverse the circuit court's final order and remand this action for allowance of the losses relating to deductibles at issue. In the alternative, the Court should vacate the circuit court's judgment and remand this action for further proceedings.

Respectfully submitted this 15th day of September 2015.

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CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of September 2015, I caused the foregoing "Brief of Petitioners" to be served on counsel of record via U.S. Mail in a postage-paid envelope addressed as follows:

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