

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET NO. 11-1187

APPALACHIAN REGIONAL HEALTHCARE, INC.,
D/B/A BECKLEY ARH HOSPITAL,

NOV 21 2011

Plaintiff Below, Petitioner,

v.

(Civil Action No. 10-C-2311)

WEST VIRGINIA DEPARTMENT OF HEALTH AND
HUMAN RESOURCES; MICHAEL L. LEWIS, M.D., PH.D.,
Secretary, in his official capacity and not individually;
WEST VIRGINIA BUREAU FOR MEDICAL SERVICES;
NANCY ATKINS, Commissioner, in her official capacity and
not individually,

Defendants Below, Respondents.

PETITIONER APPALACHIAN REGIONAL
HEALTHCARE, INC., D/B/A BECKLEY ARH HOSPITAL'S BRIEF

Michael S. Garrison (WV Bar No. 7161) (Counsel of Record)
Spilman Thomas & Battle, PLLC
48 Donley Street, Suite 800 (26501)
Post Office Box 615
Morgantown, West Virginia 26507-0615
tel: (304) 291-7926
mgarrison@spilmanlaw.com

Stephen R. Price, Sr. (Admitted *Pro Hac Vice*)
Wyatt, Tarrant & Combs, LLP
500 West Jefferson Street, Suite 2800
Louisville, Kentucky 40202-2898
tel: (502) 589-5235
sprice@wyattfirm.com

Counsel for Petitioner

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I. ASSIGNMENTS OF ERROR

1. The Circuit Court erred in signing, without modification, the order drafted entirely by Respondents, stripping W. Va. Code §§ 16-29B-20 and 9-5-16(A) of all meaning and function, and leaving Respondents with unfettered authority to set Medicaid rates in the arbitrary and capricious manner they have employed.
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3. The Circuit Court erred in holding that federal law preempted a state court action; if allowed to stand, the Circuit Court's interpretation of West Virginia law would raise federal supremacy clause issues and claims.
4. The Circuit Court erred in finding that Respondents could not have breached the Provider Agreement by failing to establish Medicaid rates that did not meet the requirements of state and federal Law.
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6. The Circuit Court erred in holding that Federal Upper Payment Limit rules in federal regulations that classify government operated hospitals separately from privately operated hospitals serve as a reasonable classification to pay West Virginia government hospitals higher Medicaid reimbursements than similarly situated privately owned hospitals.
7. The Circuit Court erred in finding that none of the ten Counts in the Complaint could provide relief for Respondents' failure to follow statutory requirements in setting the hospital Medicaid rates.
8. The Circuit Court applied the wrong standards in dismissing the Complaint under West Virginia Rule of Civil Procedure 12(b)(6).
9. The Circuit Court misapplied West Virginia Rule of Civil Procedure 12(b)(6) and, considering matters outside the pleadings, effectively converting Respondents' motion to one for summary judgment under West Virginia Rule of Civil Procedure 56, while improperly deciding genuine issues of material fact.

I. STATEMENT OF THE CASE

This appeal involves the lower court's July 19, 2011 Order ("the Order") granting the Respondents/Defendants' motion dismissing Petitioner/Plaintiff's ten count Complaint in its entirety at the outset of the case. While the Circuit Court of Kanawha County, West Virginia ("Circuit Court") considered Respondents' affidavits and resolved genuine issues of material fact in their favor, it treated the motion as one to dismiss and not one for summary judgment, refusing to consider affidavits and other evidence filed by Petitioner. (A.R. 3).¹

A. The parties

Petitioner, Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital ("**Beckley ARH**") operates a 173-bed acute care and psychiatric hospital in Beckley, West Virginia. Beckley ARH provides much needed access to medical services to both Medicaid beneficiaries and the general population in a primary service area that includes Raleigh County (where the hospital is located), as well as the surrounding counties of Summers, Mercer, Fayette, and Greenbrier. Its secondary service area includes Nicholas, Boone, and Wyoming counties. (A.R. 27-29).

Beckley ARH filed this action for declaratory, injunctive, and other legal or equitable relief because the Respondents' failure to administer the West Virginia Medicaid Program in accordance with the provisions of both West Virginia and federal law is causing Beckley ARH to suffer great losses. These losses, in turn, threaten access to quality hospital services in the southern half of the state. For example, it costs \$14.7 million a year to treat West Virginia Medicaid patients, yet Respondents' rates cover only \$9.9 million or, on average, sixty-seven

¹ References to the Appendix Record – the contents of which were agreed to by the parties – are set forth as "A.R. #."

percent of the costs necessary to provide that care. (A.R. 5). This enormous disparity between rates and costs is not, however, the result of poor management by Beckley ARH. According to figures compiled by the West Virginia Health Care Authority (“WV HCA”), Beckley ARH is one of the lowest cost hospitals in West Virginia. (A.R. 8, 280-81). Both its sixty-bed psychiatric unit and its one-hundred acute care beds are operated at near capacity.² However, the Circuit Court summarily dismissed the entire ten count Complaint holding, for example, that Beckley ARH could not challenge the adequacy or reasonableness of even Respondents’ lowest Medicaid rates paying only forty-eight percent of costs. (A.R. 14-15).

The Respondent, West Virginia Department of Health and Human Resources (“DHHR”), is currently responsible for administering West Virginia’s Medical Assistance Program (“Medicaid Program”) which it does through the Respondent, Bureau for Medicaid Services (“BMS”). Respondents, Michael J. Lewis, M.D., Ph.D, the Secretary of DHHR (“Secretary”), and Nancy Atkins, the Commissioner of BMS (“Commissioner”),³ were joined specifically because injunctive and mandamus relief are among the remedies sought. (A.R. 28).

B. Procedural history

Beckley ARH gave Respondents and the Attorney General thirty days’ notice as required by W. Va. Code § 55-17-3 before filing the Complaint on December 27, 2010 with the Circuit Court, the Honorable James C. Stucky presiding. (A.R. 28, 253-55). Respondents moved to

² Beckley ARH is licensed for 173 beds but only has 160 beds in service. With its high Medicare utilization, the hospital is designated as a Medicare Dependent Hospital (“MDH”). As an MDH, its Medicare reimbursements would be reduced if the hospital had more than 100 acute care beds in operation. (A.R. 278-79).

³ Both the Secretary and the Commissioner were named in their official capacities and not individually. For purposes of simplicity, Respondents will be referred to collectively herein as “**Respondents**” unless it is necessary to identify the individual Respondent specifically for purposes of clarity.

dismiss or, in the alternative, for summary judgment, on February 28, 2011. (A.R. 49).⁴ A brief hearing was conducted on May 4, 2011, and the Circuit Court requested that the parties submit Proposed Findings of Fact and Conclusions of Law. (A.R. 629). Sometime in July, in apparently an *ex parte* communication, the Circuit Court asked Respondents to draft an order dismissing the case. Respondents' proposed Order granting their motion to dismiss in its entirety was summarily granted and entered without change on July 19, 2011. (A.R. 3).

In its Order, the Circuit Court held that “[o]nly matters contained in the *pleading* can be considered on a motion to dismiss.” (A.R. 5) (emphasis added). But then, the Court considered Respondents' affidavits and other exhibits – matters that were *outside* the pleadings – somehow finding that they were not “outside the allegations of the Complaint.” (A.R. 9, 19). The Court ignored, however, the detailed affidavits and other evidence submitted by Beckley ARH in response to Respondents' Motions. And, the Court treated *all* the facts pleaded in the fact-laden, twenty-page Complaint as conclusions of law.

The focus of this appeal is on glaring substantive and procedural errors committed by the Circuit Court below. In so doing, the Circuit Court brushed aside important issues of first impression and great significance to every citizen in the State of West Virginia.

C. Background

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396u, provides for the establishment of programs of medical assistance to make health care available to indigent or

⁴ On March 1, 2011, Respondents filed an amended memorandum of law in support of their motion to dismiss or, in the alternative, for summary judgment, to correct inadvertent omissions in a number of the Exhibits contained in their February 28, 2011 filing. Respondents did not file an amended motion. That said, citations to Respondents motion is to that filed on February 28, 2011 (A.R. 49-51), while citations to Respondents' supporting memorandum of law and attached Exhibits are to those submitted on March 1, 2011 (A.R. 52-111).

impoverished persons. These programs, commonly referred to as “Medicaid,” are cooperative federal-state programs. The federal government provides the bulk of the funds. Participating states match those funds with their own funds and administer the individual state’s Medicaid Program. Participation by a state in Medicaid is entirely voluntary. But, the state must agree to structure its Medicaid program in compliance with federal Medicaid statutes and regulations. West Virginia has elected to participate with the federal government in implementing and administering its Medicaid Program. (A.R. 28).

The federal Centers for Medicare and Medicaid Services (“CMS”) oversees the federal government’s participation in state Medicaid programs. While the states have been given significant latitude in setting reimbursement rates for providers of Medicaid services, federal law imposes certain requirements or guidelines for setting those rates. For example, the federal Equal Access Provision requires that a state Medicaid program pay rates to providers that

are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough 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 service area .

42 U.S.C. § 1396a(a)(30)(A). (A.R. 29).

In 1983, in initially authorizing West Virginia’s Medicaid Program, the West Virginia Legislature gave the West Virginia Health Care Authority (“WV HCA”) the authority to set and regulate hospital rates for Medicaid services. *See* W. Va. Code § 16-29B-10(a) (A.R. 29). In doing so, the State Legislature also set standards for establishing the Medicaid rates to be paid to hospitals for Medicaid services that were consistent with federal law. For example, in W. Va. Code § 16-29B-20(a)(1), the State Legislature instructed that hospital rates, in general, should be set to ensure that “the costs of the hospital’s services are reasonably related to the services provided and the rates are reasonably related to the costs.” In subsection (a)(3) of that same

statute, the Legislature was very specific concerning the Medicaid rates that were to be set for hospitals. Those rates were to be

reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provision of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for Medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

This language was taken almost verbatim from the federal Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A).⁵ The West Virginia Legislature also prohibited rate-setting that included discounts *below* hospital costs or which caused cost shifting to other payors. 42 U.S.C. § 1396(a)(2). (A.R. 29-30).

While Respondents dispute the fact that the WV HCA ever had authority to set Medicaid rates (A.R. 133, 195), that was not the finding of the federal court in *United Hospital Center, Inc. v. Richardson*, 757 F.2d 1445 (4th Cir. 1985). (A.R. 29). More importantly, though, Respondents could not explain why the West Virginia Legislature included the Boren Amendment language for setting Medicaid rates in W. Va. Code § 16-29B-20(a)(3), unless it intended for the State's rates to conform to that standard. Subsection (a)(3) of the statute, in particular, is a meaningless dead letter if it does not apply to Medicaid rates.⁶

CMS requires that a single state agency be responsible for a state's Medicaid Program. In addition to rate setting, this includes such matters as beneficiary benefits and eligibility

⁵ The Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), was repealed in 1997. The language of that statute has been retained in federal regulation, 42 C.F.R. § 447.253, as well as the West Virginia statute.

⁶ The Circuit Court simply labeled Beckley ARH's allegations "without merit," resolving factual issues in Respondents' favor based on the affidavits of Sally Richardson and James Pitrolo, Jr. (A.R. 9).

standards, matters the rate-setting WV HCA presumably was not suited to oversee. Thus, BMS, as a division of DHHR, was recognized as “the federally designated single state agency charged with the administration and supervision of the state Medicaid program.” W. Va. Code § 9-1-2(n). (A.R. 30).

But, the provisions of W. Va. Code § 16-29B-20(a)(1) and (a)(3) were not revoked. Significantly, in giving Medicaid rate setting authority to BMS, the West Virginia Legislature again stressed that in setting Medicaid rates, the agency was

to encourage the long-term well planned development of fair and equitable reimbursement methodologies and systems for all health care providers reimbursed under the Medicaid program in its entirety, and to ensure that reimbursement for services of all such health care providers is determined without undue discrimination or preference and with full consideration of adequate and reasonable compensation to such health care providers for the cost of providing such services.

W. Va. Code § 9-5-16(a) (emphasis added). Thus, the expressed intention of the Legislature has always been that adequate and reasonable rates should be set for the Medicaid Program.

The Circuit Court held, however, that neither W. Va. Code § 9-5-16 nor W. Va. Code § 16-29B-20 required Respondents to establish Medicaid rates that were “adequate, reasonable or in accordance with them.” (A.R. 11). Relying solely on federal law, the Circuit Court held that “[t]here is a legal duty on the part of Defendant to establish Medicaid rates in accordance with methods and standards developed by the state.” Those standards included the duty to (1) “take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;” (2) “to set rates that are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities;” and (3) “to assure that eligible Medicaid recipients will have reasonable access to inpatient hospital services of adequate quality.” (A.R. 15) The Circuit Court found, however, that all these requirements had been met

by Respondents, thereby resolving *all* factual issues in Respondents' favor in granting their motion to dismiss. *Id.*

By any measure, the Medicaid rates set by Respondents are woefully inadequate and unreasonable. The rates have not been set in accordance with any applicable statutory standards. They are causing Beckley ARH great financial harm. (A.R. 31). For example, during its Fiscal Year End June 30, 2009 (“FYE 6/30/09”),⁷ Beckley ARH incurred \$6.1 million in costs providing inpatient acute care services to West Virginia Medicaid beneficiaries. It was paid only \$2.9 million, however, by the Medicaid Program for those services, an amount representing **forty-eight percent** of its costs. During that same rate period, Beckley ARH incurred \$3.9 million providing outpatient acute care services to West Virginia Medicaid beneficiaries. It was paid only \$2.6 million for those services (or, **sixty-seven percent** of its costs incurred in treating those patients). A substantial portion of the psychiatric patients treated in Beckley ARH's psychiatric unit are also Medicaid patients. During its FYE 6/30/09 Beckley ARH provided 7,558 days of psychiatric care to Medicaid patients. It incurred \$4.5 million in costs in treating those patients, but received only \$4.3 million in Medicaid reimbursements (an amount equaling **ninety-four percent** of its costs for those patients from Respondents). (A.R. 31).

Thus, in that one year it cost Beckley ARH \$14.7 million in total, to treat Medicaid patients. It only received, however, \$9.9 million in payments from Respondents for that care. Therefore, Beckley ARH's overall or average cost coverage for treating West Virginia Medicaid

⁷ At the time Beckley ARH gave the required thirty-day notice to Respondents, the hospital's FYE 6/30/09 Cost Report was the most recent, available cost report. It is representative, though, of the chronic problems with the Medicaid rates.

patients was **sixty-seven percent** of costs. This left the hospital with a \$4.8 million annual loss.⁸ (A.R. 31).

Pursuant to federal regulation, Respondents are required to give “assurances” to CMS that their methodology produces adequate and reasonable Medicaid rates in compliance with federal standards. 42 C.F.R. § 447.253(a). CMS also requires that a state Medicaid agency make “findings” that its rates are “adequate and reasonable”⁹ to support the “assurances” made to the federal agency. 42 C.F.R. § 447.253(b). Respondents did not allege, nor did they produce, any “findings” regarding the adequacy of their Medicaid rates. Any “assurances” Respondents may have made to CMS are suspect given the fact that Beckley ARH, a very efficient, low-cost hospital, is being paid, on average, sixty-seven percent of its costs for treating Medicaid patients.

Respondents argued that CMS’ approval of Respondents’ State Plan based on “assurances” given proved the rates must be adequate and reasonable. That circular argument

⁸ In order to clearly illustrate the entire picture, Beckley ARH informed the Circuit Court in its Complaint that it received Disproportionate Share Hospital (“DSH”) payments of approximately \$300,000 for treating a disproportionately high number of Medicaid and indigent patients without insurance. Those DSH payments had to set off, however, against \$11.5 million in unreimbursed costs for care Beckley ARH provided primarily to indigent patients without insurance. It also received in its FYE 6/30/09, for example, approximately \$1.7 million in “enhanced” payments. However, Respondents fund the state portion of both these DSH and enhanced payments, in part, with intergovernmental transfers (“IGTs”) from the Public Employees Insurance Agency (“PEIA”). That agency provides health care benefits to West Virginia public employees in return for fronting PEIA money for the state Medicaid match. As a *quid quo pro*, PEIA reduces the rates it pays to providers through its prospective payment system to rates that approximate the Medicaid rates. Therefore, the adequacy of the Medicaid rates cannot be assessed in a vacuum. The funding for the Medicaid Program is complicated and all the pieces need to be examined. Neither Respondents nor the Circuit Court wanted to get into any details. They simply brushed all issues aside in a rush to dispose of the case. But even if the \$300,000 in DSH payments and \$1.7 million in enhanced payments are included in Beckley ARH’s total Medicaid payments for FYE 6/30/09 and corresponding costs are discounted, then the total payments of \$11.9 million still do not come anywhere *close* to covering Beckley ARH’s \$14.7 million in annual costs incurred in treating Medicaid patients. (A.R. 32-33).

⁹ These “findings” are to be made by the state Medicaid agency any time it makes changes to its rate setting methodology but, in any event, no less often than annually. 42 C.F.R. § 447.253.

was adopted in whole by the Circuit Court. (A.R. 16-17). But CMS does not look behind a state's "assurances." The federal agency made that clear in *Association of Residential Resources in Minnesota (ARRM) v. Minnesota Commissioner of Human Services*, 2004 WL 2066822 (D. Minn. Aug. 18, 2004). In that case, a provider association and the parents of a Medicaid beneficiary brought suit joining the CMS Regional Administrator ("RA"), seeking to compel him by mandamus or other means to conduct a targeted and focused review of the Minnesota Medicaid program's new rebasing plan for home and community based care. The CMS RA defended, however, on the basis that the law was "designed to limit the Secretary's review to the State's assurances, not its findings" and only "very limited, and even minimal review by the federal government" was required. *ARRM*, 2004 WL 2066822 at *3. The court agreed, finding that CMS had discretion to do next to nothing in reviewing a State Plan Amendment:

That discretion is limited only by the requirement that the State provide assurances to the Secretary [of CMS], and those assurances need be adequate only to the Secretary. The statute contemplates only minimal review by the Secretary, 42 U.S.C. § 1396n(f)(2). For example, the Secretary is not required to make findings, or investigate a State's assurances; but only to receive assurances that are satisfactory *to the Secretary*.

Id. at *4 (citing 42 U.S.C. § 1396n(c)(2)) (emphasis added).

In other words, the CMS review is complete once a state submits a boiler-plate, check-list of "assurances." Therefore, CMS' acceptance of a state's assurances does nothing to establish the adequacy of the rates. It just demonstrates that the state agency knew how to parrot the right words to CMS. The Circuit Court leaned heavily, however, on this straw man.

The federal government provides most of the funds used in West Virginia's Medicaid Program. This federal contribution (known as the "Federal Medical Assistance Percentage" ("FMAP")) varies from state to state and is based on each state's per capita income relative to national averages. At the time the Complaint was filed, the federal government's FMAP for

West Virginia was 83.05%. This is the second highest FMAP in the nation (Mississippi was then receiving 85%). For each dollar West Virginia put into Medicaid the federal government contributed \$4.90. (A.R. 33).

In SFY 2009, West Virginia Medicaid Program expenditures totaled \$2.4 billion. Of this amount, \$1.9 billion came from federal funds. The State contribution totaled \$680,123,202. Twenty-four percent of those State funds (\$165,400,000) actually came from provider taxes paid by hospitals, including Beckley ARH. See Joint Committee on Government and Finance, DHHR, August 2010, Medicaid Report (May 2010 Data) (A.R. 33). In Beckley ARH's FYE 6/30/09, the hospital paid \$1.4 million in provider taxes to West Virginia. With the FMAP at 83.05%, the federal government, in effect, paid \$8.2 million of the \$9.9 million in Medicaid payments made to Beckley ARH that year. Since Beckley ARH effectively paid \$1.4 million of the state match with its provider taxes, Respondents needed only about \$800,000 from other sources to complete the state match and cover all of Beckley ARH's costs for Medicaid services. Beckley ARH was left, however, as already noted, with a \$4.8 million Medicaid loss for treating Medicaid patients (along with a \$1.4 million provider tax bill). (A.R. 33). Respondents never contended, however, that they lacked adequate state funds to get the additional federal monies needed to pay adequate Medicaid rates. The West Virginia Legislature has been appropriating more than sufficient funds for the job. For example, in SFY 2010 the Medicaid Program finished the fiscal year with a \$255 million surplus.¹⁰ (A.R. 34).

¹⁰ Each \$1 million of state money that West Virginia put into its Medicaid Program generates \$5 million in new economic activity, creates forty-seven new jobs, and \$1.8 million in new wages. See Families USA Medicaid calculator at www.familiesusa.org (using 2008 data before the FMAP increased to eighty-three percent). That means the \$255 million Medicaid surplus could have been used to produce almost \$1.3 billion in new economic activity, almost 12,000 new jobs and \$454 million in new wages for West Virginians. (A.R. 34). Any efforts by the State Legislature to stimulate West Virginia's economy with
(continued...)

Respondents know the rates they are setting are inadequate and unreasonable. Respondents set Medicaid rates for state-owned or operated hospitals in the same manner and employing the same methodology used to set Beckley ARH's Medicaid rates. But Respondents make special, additional payments to state-owned or operated hospitals to make up for those grossly inadequate rates. State-owned or operated hospitals receive supplemental, quarterly payments based upon the difference between what Medicare would pay for the same services and the much smaller amount Medicaid pays. *See* State Plan Attachment 4.19-A, p. 24d. (A.R. 41). This disparity and special treatment of state hospitals, by itself, creates a genuine issue of material fact as to the reasonableness of Respondents' Medicaid rates paid Beckley ARH.

This is not a case where a poorly performing, inefficiently run hospital wants more money to make up for bad management. Beckley ARH is a very efficiently run hospital. In its 2010 Annual Report, the WV HCA calculated that Beckley ARH had an "All Payor Adjusted Cost Per Discharge"¹¹ ("cost per discharge") of \$4,532, which was \$1,062 below the median cost of its peers. In other words, it would cost \$1,062 less, on average, to treat the same patient with the same medical problems at Beckley ARH than at one of its hospital peers. In fact, as calculated by the WV HCA, Beckley ARH is not only the lowest cost hospital in its peer grouping, it is also the second lowest cost acute care hospital in the state. (A.R. 279-81; *see also* A.R. 34). The Medicaid rates established by Respondents for hospital services simply are not

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federal Medicaid dollars are being stymied by Respondents' failure to follow statutory directives for using the funds appropriated for the Medicaid Program.

¹¹ An "All Payor Adjusted Cost Per Discharge" means hospital costs were adjusted by their relative case mix indexes ("CMI") to account for differences in the severity of illnesses. This enables an apples-to-apples comparison of costs between hospitals and is one of the standard means used to compare hospital costs and efficiency in the industry. (*See* A.R. 280).

adequate for low cost, efficient providers, or Beckley ARH¹² would receive more than sixty-seven percent of its costs of providing care. (A.R. 34). Respondents have not set rates giving consideration to what is adequate and reasonable compensation for providing Medicaid services.

D. The effects of inadequate Medicaid reimbursements

The effect of inadequate Medicaid rates on Beckley ARH's continuing ability to operate or to make necessary and critical capital expenditures is significant. A disproportionately large percentage of the Beckley ARH's patients are Medicaid patients making up approximately twenty-two percent of the hospital's patient mix. For a hospital to suffer a thirty-three percent loss on twenty-two percent of its business is not a sustainable proposition. To make matters worse, this shortfall in Medicaid reimbursements cannot be covered by cost shifting to other payors, both as a practical matter and according to statute. *See* W. Va. Code § 16-29B-20(a)(2).

Approximately forty-seven percent of Beckley ARH's payor mix is comprised of Medicare patients. Medicare pays Beckley ARH approximately ninety percent of its costs, so the hospital loses money on those patients, too. Another fourteen percent of Beckley ARH's payor mix is comprised of other government programs, bad debt or charity cases, all of which pay less than cost, if anything at all. Add twenty-two percent Medicaid, and for seventy-three percent of its patients Beckley ARH is paid less than its costs or nothing at all. These shortfalls simply cannot all be passed on to the remaining payors.¹³ (A.R. 35-36).

¹² At the same time, the WV HCA 2010 Annual Report contains different quality measures showing that Beckley ARH provides services at or above national quality standards. Since Beckley ARH operates at an eighty percent occupancy level, it is also clear that hospital resources are not being underutilized due to excess capacity. (A.R. 281).

¹³ Significantly, one recent study found that underreimbursements by Medicare and Medicaid annually caused an estimated cost shift from public to private payers of \$88.8 billion nationwide (or, fifteen percent of the current amount spent by commercial payers on hospital and physician services). This means that a typical family of four has to pay an additional \$1,788 annually in health insurance premiums
(continued...)

In its rush to judgment, the Circuit Court missed the importance of these crucial facts, stating that:

The allegations that PEIA is not paying enough to Plaintiff for services to its insured's, [sic] and Medicare is not paying enough to Plaintiff for services to its insured's [sic], therefore BMS rates are inadequate and must offset Plaintiffs' [sic] losses from those two programs is without merit and does not support the required declaration of rights.

(A.R. 19) (emphasis added). Beckley ARH has not asked Respondents to “offset” its losses from other government programs. It only asks that the Medicaid Program pay its fair share of the costs incurred in treating Medicaid patients. No hospital can survive indefinitely subsidizing the Medicaid Program in this manner.

E. The coming federal health care reform will make matters worse

Under the Patient Protection and Affordable Care Act (“PPACA”) (signed into law March 23, 2010) and the Health Care Education Reconciliation Act of 2010 (signed into law on March 30, 2010), states are now permitted to expand Medicaid eligibility to all non-Medicare eligible individuals under age 65, including adults without dependent children with incomes up to 133% of the federal poverty limits. For a while the federal government will increase its FMAP to cover these new enrollees. When the West Virginia Medicaid rolls are expanded and the federal government bases its payments on the grossly inadequate Medicaid rates presently being paid by Respondents, Beckley ARH's Medicaid losses will skyrocket. (A.R. 36-37).

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and other costs due to this government caused cost-shifting. *See, Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid And Commercial Payers*, Milliman, <http://publications/milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift>. RR12-01-08.pdf. Will Fox and John Pickering (December 2008). (A.R. 36). This is a significant hidden tax on families and individuals and illustrates the importance of this case not just to this one hospital, but to the public at large because of the widespread concern regarding the increasing costs of health care.

F. Access to care is a growing problem

Inadequate Medicaid reimbursements are causing access problems that are increasing with time. The critical role Beckley ARH fills as a safety net hospital in the southern half of the State is only expanding. The University of Virginia Health System (“UVAHS”), where Medicaid patients has been transferred for more complex surgeries, gave notice a year ago that due to the inadequate Medicaid reimbursements it would no longer accept West Virginia Medicaid patients. (A.R. 36, 47-48). This is just the tip of the iceberg. Respondents’ Medicaid rates are simply insufficient to assure that medical services are accessible to Medicaid patients. (A.R. 36, 284).

Beckley ARH is operating at virtually full capacity as there is a great need for access to quality medical services in this region. The WV HCA calculated in its 2010 Report that Beckley ARH has the third highest inpatient occupancy rate of any general acute care hospital in the state. (A.R. 281-82). The Circuit Court unquestioningly agreed with Respondents, however, that if the Medicaid rates were inadequate, Beckley ARH could simply drop out of the Medicaid Program. (A.R. 16, 18). This cavalier attitude towards the health care needs of citizens of Beckley and surrounding areas ignores both the legal and practical realities of the situation.

Beckley ARH does not turn away or refuse to treat Medicaid patients. It does not and by law cannot discriminate against Medicaid patients or provide them with a lower quality of services than other patients. Nonprofit hospitals such as Beckley ARH have come under increasing scrutiny by government regulators to ensure that they provide community benefits adequate to maintain their nonprofit status. By virtue of its nonprofit status, Beckley ARH must provide health care services to all in need of care regardless of status or ability to pay. The federal Emergency Medical Treatment & Active Labor Act (“EMTALA”) requires that Beckley ARH treat all patients that require care in its emergency department without regard to their

ability to pay or insurance status. Section 9007 of the PPACA requires that Beckley ARH, as a nonprofit institution, perform a community health needs assessment to help monitor and ensure that it is doing sufficient charitable work commensurate with its non-profit status.¹⁴ The financial losses caused by the grossly inadequate Medicaid rates jeopardizes, however, Beckley ARH's ability to provide community benefits in fulfilling its nonprofit status. Quitting the Medicaid Program would, both as a practical and legal matter, mean closing the hospital's doors. (A.R. 37).

The Circuit Court assumed that since there was another hospital in Raleigh County, all Beckley ARH's Medicaid patients could go to that other hospital without creating any access problems. (A.R. 16 & 18). That assumption is patently erroneous. Beckley ARH has always treated a disproportionately high percentage of Medicaid patients. For example, the WV HCA calculated in its 2010 Annual Report that Beckley ARH had 12,825 inpatient days for Medicaid patients (or, twenty-eight percent Medicaid days out of a total of 45,915 inpatient days,¹⁵ compared to a state-wide average of twenty-two percent Medicaid days for general and acute care hospitals). (A.R. 282).

The other acute care hospital in Raleigh County is operated by the LifePoint Health System, a for profit system, and is known as Raleigh General Hospital ("RGH"). While RGH is a much larger hospital with 250 to 300 licensed beds, it had only 10,069 Medicaid patient days in

¹⁴ The federal health reform law provides no new funding, however, for hospitals to perform this needs assessment.

¹⁵ The fact that Medicaid patients comprise twenty-two percent of Beckley ARH's patients, while Medicaid days are twenty-eight percent of total days, illustrates the well-known fact that because of their poverty, Medicaid patients are generally sicker and require more hospital resources for their treatment than the general population. *See, e.g., Rye Psychiatric Hosp. Ct., Inc. v. Shalala*, 52 F.3d 1163, 1172 (2d Cir. 1995) (finding that hospitals treating a disproportionate share of indigent and low income patients are "short-changed" or "penalized" unless some adjustment is made to account for the additional costs).

2009 (compared to Beckley ARH's 12,825 Medicaid days). But according to the WV HCA 2010 Report, RGH suffered losses of \$4.78 million from providing inpatient services to those Medicaid and PEIA patients.¹⁶ Transferring almost 14,000 Medicaid and PEIA patient days to RGH would more than double that hospital's Medicaid losses. (A.R. 283). Obviously, the Medicaid rates are not adequate for that hospital either. Doubling that hospital's losses will not improve access to care by Medicaid patients or, for that matter, access by the general public.

If Beckley ARH quit taking Medicaid patients as the Circuit Court suggested, it would have to shut its doors. The adverse effect on Beckley and surrounding communities would be enormous. Both RGH and Beckley ARH already have extremely busy Emergency Departments ("ED"). One hospital could not meet all the need for emergency services of the region. RGH, with twenty-five ED beds, had 53,822 ED visits in 2009. Beckley ARH had 21,576 ED visits during the same time period. RGH's ED is constantly at capacity and emergency cases are frequently diverted elsewhere. RGH simply could not handle 21,526 more ED visits. (A.R. 283).

Beckley ARH's sixty-bed psychiatric unit is unique and indispensable to meeting the behavioral health needs of both the Medicaid population and the general population in the region. Twelve bays in Beckley ARH's ED are also specially designed for psychiatric patients. It is constantly receiving patients from the two state facilities, Mildred Mitchell-Bateman Hospital and Sharpe Hospital which are, respectively, one hour and fifteen minutes and two hours drive times away. Both those state psychiatric hospitals are operating at full capacity. Beckley ARH's psychiatric unit generally has a ninety-five percent occupancy rate.

¹⁶ The WV HCA included PEIA patient days with Medicaid days apparently considering PEIA days to be relevant to Medicaid reimbursements, a consideration disparaged by Respondents and the Circuit Court. Beckley ARH had 1,011 PEIA inpatient days and RGH had 1,410 PEIA inpatient days. (A.R. 283).

Approximately forty-three percent of the psychiatric unit's patients are Medicaid patients. They cannot go to RGH or the state psychiatric hospitals that are already full. If that unit were to turn away Medicaid patients as the Circuit Court suggested, those patients would go without care. (A.R. 284).

The Circuit Court simply turned a blind eye to these and many other facts pleaded in the Complaint or otherwise entered on the record, finding instead, as a matter of law, that Respondents' Medicaid rates were adequate and reasonable and that there were no access to care issues. The Motion to Dismiss should not have been granted. Neither was summary judgment appropriate. If anything, the facts in the record predominated in Beckley ARH's favor. Discovery should have proceeded to flesh out and clarify any remaining factual issues. The Circuit Court should be reversed and the case remanded with instructions to proceed.

III. SUMMARY OF ARGUMENT

Beckley ARH is one of the most efficient, lowest cost hospitals in the state treating a disproportionately large percentage of Medicaid patients. Yet, the Medicaid Program pays only sixty-seven percent of the costs of providing that care. These extremely low levels of reimbursements violate all federal and state statutory or regulatory standards. Respondents simply are not adhering to either state or federal standards even though the West Virginia Legislature has provided ample funds for them to do so. Respondents apparently believe and the Circuit Court concluded that Respondents did not have to follow any applicable authority as long as they mouthed the right words to CMS in unsupported "assurances" and got a rubber stamp of approval from that federal agency. There are numerous avenues of relief, both legal and equitable, that are available to correct Respondents' actions in this action. The cost of health care and how to pay for it, both as individuals and as a society, are issues of great importance. Those issues raised in this case should not have been summarily brushed aside. The Circuit

Court committed palpable error in dismissing this action and the Order should be reversed and this case remanded for further proceedings.

IV. STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Pursuant to Rule 18(a) of the Revised Rules of Appellate Procedure, this case meets the criteria for oral argument under Revised Rule 20(a)(1) and (a)(2) and a published, non-memorandum decision because it involves issues of first impression for this Court and issues of key public policy concerns for hospitals, other providers of health care services, and the general public. None of the criteria articulated in Revised Rule 18(a) that would obviate the need for oral argument are present.

Whether declaratory, injunctive, mandamus or contractual relief is available under West Virginia law when the state agency charged with setting adequate and reasonable rates fails to follow both federal and state statutory mandates are questions of first impression for this Court. The Circuit Court granted Respondents' Motion to Dismiss, however, in essence holding that Respondents' actions are insulated from review and not subject to any oversight by either the West Virginia Legislature or the judiciary.

A comprehensive public hearing and fully analyzed published decision is warranted in this case which significantly impacts not only all health care providers but also every person who needs health care services in the State of West Virginia.

V. ARGUMENT

1. **The Circuit Court erred in signing, without modification, the order drafted entirely by Respondents, stripping W. Va. Code §§ 16-29B-20 and 9-5-16(A) of all meaning and function, and leaving Respondents with unfettered authority to set Medicaid rates in the arbitrary and capricious manner they have employed.**

Beckley ARH filed a detailed Complaint seeking relief from Respondents' failure to follow the law. Instead of thoughtful consideration and careful guidance on what are, at their core, issues of great public importance, Beckley ARH received a rambling, discordant order drafted by Respondents' counsel and adopted without change by the Circuit Court. Without question, the Circuit Court's Order stripped W. Va. Code § 16-29B-20 and 9-5-16(a) of all meaning. The Circuit Court adopted Respondents' mantra that

[neither] W. Va. Code § 9-5-16 nor W. Va. Code §§ 16-29B-20 require Defendants to establish Medicaid rates that are adequate, reasonable or in accordance with them.

(A.R. 11, 13). The Circuit Court allowed Respondents to essentially write their own ticket, signing, without even the slightest modification, their proposed Order.

2. **The Circuit Court plainly erred in holding that Petitioner does not have a clear legal right to challenge Respondents' methodology of setting Medicaid reimbursements, an error that affected the Circuit Court's handling of the entire Complaint.**

The West Virginia Legislature adopted federal Boren Amendment standards into W. Va. Code § 16-29B-20(a)(3), and re-enforced those standards in W. Va. Code § 9-6-16(a). When the Legislature wrote those standards into state law, it evinced a clear and unambiguous intent to give Medicaid providers such as Beckley ARH an enforceable right to adequate and reasonable rates under state law. The Supreme Court of the United States examined that same language from the Boren Amendment in *Wilder v. Virginia Hospital Association*, 110 S. Ct. 2510, 2517 (1990). The Court found that Congress had clearly intended to give health care providers

enforceable rights under federal law. That right was not a mere procedural one to perfunctory findings and assurances that the rates were adequate, but a “substantive right to reasonable and adequate rates was well.” *Wilder*, 110 S. Ct. at 2517. By adopting Boren Amendment language, the West Virginia Legislature clearly evinced its intent to give health care providers in this State the same substantive rights to reasonable and adequate rates.

Every legislative pronouncement has been to the effect that Respondents should set Medicaid rates that are reasonable and adequate. Examining the same language in the federal statute used by the West Virginia Legislature here, the Supreme Court found that Congress had, by its usage, created more than just a congressional preference for a certain kind of conduct. By use of this language, Congress created a binding obligation on the governmental unit. *Id.* at 2517. The interest asserted by the provider in *Wilder* in adequate Medicaid rates was not “too vague and amorphous” such that it was “beyond the competency of the judiciary to enforce.” *Id.* (citations omitted). The Supreme Court could only conclude from the statutory language that health care providers had an enforceable right

to the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients. The right is not merely a procedural one that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy; **rather the Act provides a substantive right to reasonable and adequate rates as well.**

Id. (emphasis added). By adopting the Boren Amendment language into the West Virginia law, the Legislature has imposed a binding and enforceable obligation upon Respondents to adopt reasonable and adequate rates. *Id.* at 2518-19.

The Circuit Court noted that the Boren Amendment was repealed by the Balanced Budget Act of 1997 and that *some* Congressional committee notes expressed the intention nothing in 42 U.S.C. § 1396a was to be interpreted as giving hospitals a cause of action concerning the

adequacy of the Medicaid rates in the wake of the repeal of the Boren Amendment. (A.R. 17). Whether the repeal of the Boren Amendment strips providers of all 42 U.S.C. § 1983 claims has split the federal circuit courts. See e.g. *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, 443 F.3d 1005 (8th Cir. 2006) (sections (a)(13) and (a)(30)(A) of 42 U.S.C. § 1396a create enforceable federal rights); and contra, *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006) (concluding no Section 1983 cause of action under Section (a)(30)(A)). The claims brought by Beckley ARH here, however, are state-law claims and the West Virginia Legislature has not stricken the Boren language from the West Virginia statutes.

In *Wilder*, the Court rejected another argument Respondents made here which the Circuit Court adopted – that as long as certain procedural hoops were jumped through to obtain CMS acceptance of the State Plan, there was nothing else that was enforceable by the courts. *Wilder*, 110 S. Ct. at 2519. The Supreme Court saw right through that argument because it made the statutory requirement that rates be reasonable and adequate a dead letter. *Id.* at 2519-20. Nonetheless, Respondents would prefer to turn these state statutes into dead letters.

The Circuit Court should have also found Beckley ARH had a clear right to the relief requested by applying the slightly different test employed in *Cort v. Ash*, 95 S. Ct. 2080, 2089 (1975) (adopted in *Hurley v. Allied Chemical Corp.*, 164 W. Va. 268, 262 S.E.2d 757 (1980)), for determining whether a private right of action would be implied from a particular statute. That test is as follows:

- (1) the plaintiff must be a member of the class for whose benefit the statute was enacted;
- (2) consideration must be given to legislative intent, express or implied, to determine whether a private cause of action was intended;
- (3) an analysis must be made of whether a private cause of action is consistent with the underlying purposes of the legislative scheme; and
- (4) such private cause of action must not intrude into an area delegated exclusively to the federal government.

Id. at 763. All four prongs of this test are satisfied here.

First, the State Medicaid statutes regarding the adequacy of Medicaid payments are clearly intended to benefit providers of those services such as Beckley ARH. *Wilder*, 110 S. Ct. at 2517. As for the second factor – legislative intent – the absence of an administrative remedy in the statutes “would tend to suggest that the Legislature was willing to permit private enforcement where, as here, there is a clear statutory declaration” of the Legislature’s intent. *Hurley*, 164 W. Va. at 279, 262 S.E.2d at 764. In fact, in this case the remedy sought by Beckley ARH “is necessary or at least helpful to the accomplishment of the statutory purpose” and a court should be “decidedly receptive to its implication under the statute.” *Cannon v. University of Chicago*, 99 S. Ct. 1946, 1961 (1979) (*quoted with favor in Hurley*, 164 W. Va. at 282, 262 S.E.2d at 765); *see also United Steelworkers of America, AFL-CIO, CLC v. Tri-State Greyhound Park*, 178 W. Va. 729, 734, 364 S.E.2d 257, 262 (1987) (holding that a court will not withhold a private remedy where a statute explicitly confers a benefit on a class of persons but does not assure them a means of relief, and the legislature is aware of the doctrine of statutorily implied causes of action).

With regard to the third factor, a private cause of action forcing Respondents to pay rates that are consistent with legislatively mandated standards is consistent with the legislative scheme. Indeed, since Respondents insist that they are not subject to any review other than the “perfunctory” review CMS gives to state “assurances,” *Wilder*, 110 S. Ct. at 2517, then a private cause of action is needed to make the agency conform to the legislative scheme.

As to the fourth factor, a private cause of action by providers to enforce the statutory mandates does not intrude into an area delegated exclusively to the federal government. Medicaid is a joint venture and the responsibility to set rates has been expressly delegated to the

states. If anything, the federal government has largely withdrawn from the field leaving enforcement up to the states. That makes sense since the states set the rates. Respondents' failure to set adequate rates conflicts with federal and state law. Under the *Cort/Hurley*, test a private right of action is implicit here.

One means by which the right to rates in compliance with the law can be enforced is through a writ of mandamus. The Circuit Court held that Beckley ARH could not satisfy the three elements necessary for mandamus. (A.R. 13). A mandamus was awarded against DHHR, however, in *Hensley v. West Virginia Dept. of Health and Human Resources*, 203 W. Va. 456, 460, 508 S.E.2d 616 (1998), where this Court said:

[a] writ of mandamus will not issue unless three elements coexist – (1) a clear legal right in the petitioner to the relief sought; (2) a legal duty on the part of respondent to do the thing which the petitioner seeks to compel; and (3) the absence of another adequate remedy

Hensley, 203 W. Va. 460, 508 S.E.2d at 620 (citations omitted). In *Hensley*, two DHHR employees were awarded a mandamus to recover back pay as restitution for violations of the legislative mandate requiring “equal pay for equal work.” Beckley ARH similarly seeks to enforce a legislative mandate requiring that rates be adequate and set “without undue discrimination or preference.” W. Va. Code § 9-5-16(a). Under both *Wilder* and *Hurley*, there is a clear legal right to relief.

The second element of mandamus is not just present, it is also undisputed. Respondents had the legal duty to set rates that are adequate and reasonable. The Circuit Court got one thing right when it said:

[t]here is a legal duty on the part of Defendant to set rates that are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities . . . [and] to assure that eligible Medicaid recipients will have reasonable access to inpatient hospital services of adequate quality

(A.R. 17). The Circuit Court then erred, however, concluding elsewhere that those duties had no basis in the state statutes. (A.R. 11). Respondents' legal duty to set adequate rates also arises under the state statutes. Without those state statutes, Respondents would have no authority to act at all.

The Circuit Court erroneously held that Beckley ARH had an adequate remedy and that, therefore, the third element for mandamus was not present. That "remedy," of course, was for Beckley ARH to quit the Medicaid Program, but that "remedy" is no remedy at all. In addition, the Circuit Court misread the law. As this Court recently said in *State ex rel. West Virginia Parkways Authority v. Barr*, 2011 WL 5064240, *5 (W. Va. 2011), it is the "absence of another adequate remedy at law" that is relevant. (emphasis added). Quitting the Medicaid Program because Respondents have failed in their duty is not a remedy at law any more than taking a physical beating is an adequate remedy at law (or otherwise) for an assault and battery. Furthermore, "while it is true that mandamus is not available where another specific and adequate remedy exists, if such other remedy is not equally as beneficial, convenient, and effective, mandamus will lie." Syl. pt. 3, *Barr* (quoting Syl. pt. 4, *Cooper v. Gwinn*, 171 W. Va. 245, 298 S.E.2d 781 (1981)). For a nonprofit hospital to simply quit treating Medicaid patients is not equally as beneficial, convenient, or effective.

Respondents want to insulate their actions from all review. Beckley ARH filed a ten count Complaint taking Respondents to task for their failure to follow applicable law. If Respondents cannot be made to comply with the law under one of the other Counts to the Complaint, then no adequate remedy at law exists and mandamus should lie. The Circuit Court erred in multiple respects in holding that Beckley ARH did not have a state law cause of action and the Complaint should not have been dismissed.

3. The Circuit Court erred in holding that federal law preempted a state court action; if allowed to stand, the Circuit Court’s interpretation of West Virginia law would raise federal supremacy clause issues and claims.

State standards concerning the adequacy of the Medicaid rates can and should be construed in harmony with federal standards. That is one thing Beckley ARH seeks to establish with this action. The Circuit Court erred in holding that “federal law . . . preempts any state law regarding reimbursement rate setting for WV hospitals participating in the Medicaid program.”

(A.R. 17).

State actions are preempted in three ways:

- (1) By express language in a congressional enactment;
- (2) By implication from the depth and breadth of a congressional scheme that occupies the legislative field; or
- (3) By implication because of a conflict with a congressional enactment.

Planned Parenthood of Houston and Southeast Texas v. Sanchez, 403 F.3d 324, 336 (5th Cir. 2005). None of those factors are applicable. There is no express language in the federal statutes preempting state action here. If Congress intended to preempt the field it would not have left rate setting in state hands.

Federal “obstruction” preemption occurs, however, when an aberrant state rule is preempted to the extent it actually interferes with the methods by which the federal statute is designed to reach its goals.¹⁷ One purpose behind 42 U.S.C. § 1396a(a)(30)(A) is to ensure that

¹⁷ See *Maxwell-Jolly v. Independent Living Center of Southern California*, 131 S. Ct. 992 (2011), in which oral argument was recently held. That petition involves three cases in which the Ninth Circuit found that state provisions freezing or cutting Medicaid rates were preempted by the provision of 42 U.S.C. § 1396a(a)(30)(A) and the Supremacy Clause to the federal Constitution. If Respondents acted in complete compliance with state law in setting the Medicaid rates at sixty-seven percent of costs and state law provides no remedy, then state law would be in conflict with and inimical to federal law. The Supremacy Clause could then come into play under those Ninth Circuit cases. However, that is not the case here since Respondents have ignored state law.

Medicaid payments to providers are “consistent with efficiency, economy, and quality of care” and are “sufficient to enlist enough 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.” While Respondents’ Medicaid rates do not meet that standard, it is only their failure to properly follow state and federal standards that is inimical to and obstructive of federal purposes.

4. The Circuit Court erred in finding that Respondents could not have breached the Provider Agreement by failing to establish Medicaid rates that did not meet the requirements of state and federal Law.

Beckley ARH entered into a Provider Agreement to provide hospital services to Medicaid beneficiaries with the reasonable expectation that Respondents would comply with federal and state laws in setting Medicaid rates. Without citation to any authority, the Circuit Court turned the law on its head, holding that Respondents’ duty of good faith and fair dealing was “tempered” or “preempted” by federal law. (A.R. 23-24). Federal and state statutes are in harmony, however, and reinforce that duty.

“Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.” *Restatement (Second) of Contracts* § 205 (1981). Courts generally apply this implied covenant of good faith to “effectuate the intentions of the parties, or to protect their reasonable expectations.” See, Steven J. Burton, *Breach of Contract and the Common Law Duty to Perform in Good Faith*, 94 Harv. L. Rev. 369, 371 (1980). The implied obligation of good faith and fair dealing embraces the mutual duty not to do “anything to injure or destroy the right of the other party to receive the benefits of the agreement.” 23 Williston on Contracts § 63:22 (4th ed.).

West Virginia has adopted the *Restatement (Second)* approach on the covenant of good faith and fair dealing. See *LaPosta Oldsmobile, Inc. v. General Motors Corp.*, 426 F. Supp. 2d

346, 354-55 (N.D. W. Va. 2006) (“[g]ood faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party”) (quoting *Restatement (Second) of Contracts* §205); see also *Barn-Chestnut, Inc. v. CFM Development Corp.*, 193 W. Va. 565, 571, 457 S.E.2d 502, 508 (1995).

“The implied covenant of good faith and fair dealing requires the parties to perform, in good faith, the obligations required by their agreement” which, in this case, would include rate setting functions. 17A Am. Jur. 2d Contracts § 370. “Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party.” *Restatement (Second)*, *supra*, § 205. The scope of the covenant is defined by the circumstances and express terms of the contract. 17A Am. Jur. 2d *Contracts* § 370. When a contract contains express provisions that allow one party discretion to deal with matters under the contract, the implied covenant of good faith and fair dealing may be used to limit the exercise of that discretion and preserve the reasonable expectations of the parties to the agreement. See 8 Bus. & Com. Lit. Fed. Cts. § 91:16 (2d ed). In other words, when certain decisions under the contract (e.g., price terms) are deferred to the discretion of one of the parties, that party must exercise its discretion in good faith. Burton, *supra*, at 381-82.

Thus, in *Wilson v. Amerada Hess Corp.*, 773 A.2d 1121 (N.J. 2001), the court stated the following test for determining whether the implied covenant of good faith and fair dealing had been breached:

[a] party exercising its right to use discretion in setting price under a contract breaches the duty of good faith and fair dealing if that party exercises its discretionary authority arbitrarily, unreasonably, or capriciously, with the objective of preventing the other party from receiving its reasonable expected fruits under the contract.

Wilson, 773 A.2d at 1130. In other words, pricing decisions deferred to the discretion of one of the parties must be made in good faith. *Id.* See also *Joc, Inc. v. ExxonMobil Oil Corp.*, 2010 WL 1380750 (D.N.J. April 1, 2010) (motion to dismiss denied where Exxon franchisees claimed Exxon violated the implied covenant of good faith and fair dealing in exercising unilateral discretion over price terms arbitrarily, capriciously, and in bad faith preventing plaintiffs from operating profitably); *Amoco Oil Company v. Ervin*, 908 P.2d 493, 498 (Colo. 1995) (“the duty of good faith and fair dealing applies when one party has discretionary authority to determine certain terms of the contract, such as quantity, price, or time”); *Beraha v. Baxter Health Care Corp.*, 956 F.2d 1436, 1443 (7th Cir. 1992) (controlling party must exercise its discretion reasonably with proper motive, not arbitrarily, capriciously, or in a manner inconsistent with the reasonable expectations of the parties). Respondents had to exercise their discretion in setting Medicaid rates in compliance with their duty of good faith and fair dealing. It was reasonable for Beckley ARH to expect that Respondents would set rates in compliance with statutory standards. It was arbitrary for Respondents to ignore those standards.

There is nothing whatsoever in the Provider Agreement expressly stipulating that the rates would be set paying sixty-seven percent of Beckley ARH’s costs. It was left up to Respondents to set rates in accordance with applicable law. In setting rates that are neither reasonable nor adequate, Respondents breached the implied covenant of good faith and fair dealing. Beckley ARH pleaded more than sufficient facts to establish a viable state law claim for breach of contract based on a violation of the implied duty of good faith and fair dealing. Respondents’ Motion to Dismiss was improvidently granted.

5. **The Circuit Court clearly erred in construing the federal prohibition against balance billing Medicaid patients in 42 C.F.R. § 447.15 to mean that Respondents could set Medicaid rates at any level they choose, no matter how low the rates were and even if they were in violation of statutory standards.**

42 C.F.R. § 447.15 prevents a health care provider from looking to the Medicaid beneficiary to pay anything more than co-payments approved by CMS. The provider can *only* look to the state Medicaid program for payment for Medicaid services. This prohibition against balance billing Medicaid beneficiaries *does not*, however, relieve Respondents of their duty to set adequate and reasonable rates. If anything, this regulation reinforces Respondents' duty of good faith and fair dealing since Beckley ARH can only turn to the Medicaid Program for payment.

The Circuit Court erroneously held, though, that because Beckley ARH had signed a Medicaid Provider Agreement, it had "agreed that payment for services made in conformance with established rates, fee schedules, and payment methodologies would be accepted by it as payment in full." (A.R. 4, 14). Quoting from 42 C.F.R. § 447.15, the Circuit Court held that Beckley ARH had "agreed to abide by the Medicaid 'free care' provision payment [sic] for services made in conformance with the established rates, fee schedules and payment methodologies and accepted the payment as payment in full." (A.R. 14). The regulation and the "free care" provision are, however, simply protections for Medicaid beneficiaries.

The balance billing prohibition in the regulation means that "[u]nder federal law, medical service providers must accept the state approved Medicaid payment as payment-in-full, **and may not require that the patients pay anything beyond that amount.**" *Barney v. Holzer Clinic, Ltd.*, 110 F.3d 1207, 1210 (6th Cir. 1997) (emphasis added). West Virginia actually has its own statute entitled "Prohibition on balance billing," which provides, in relevant part, as follows:

[t]he health care provider shall not bill the beneficiary or any other person on behalf of the beneficiary and, except for deductibles or other payments specified in the applicable plan or plans, the beneficiary shall not be personally liable for any of the charges, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the applicable department or divisions.

W. Va. Code § 16-29D-4 (1991). In *State ex rel. Aaron M. v. West Virginia Department of Health and Human Resources*, 212 W. Va. 323, 325, 571 S.E.2d 142, 144 (2001), this Court summed up the statute, stating “a Medicaid provider cannot bill another source for the difference between the allowable Medicaid rate and the provider’s customary rate.” *Id.* at 325.

All providers sign provider agreements with their respective Medicaid programs with this prohibition on balance billing. Since the federal courts are of limited jurisdiction, providers need a statutory basis to go into federal court. But, once there, neither the provider agreements nor the balance billing prohibition limits a claim that rates are inadequate or otherwise in violation of the law.¹⁸

The prohibition in 42 C.F.R. § 447.15 against balance billing Medicaid beneficiaries does not prohibit a provider from seeking a better rate from the Medicaid Program. If anything, it makes it even more imperative that Respondents comply with their duty to set adequate rates since providers cannot look to the Medicaid beneficiary to make up the shortfall. The Circuit Court’s error is readily apparent and cannot go uncorrected.

¹⁸ See *Concilio de Salud Integral de Loiza, Inc. v. Perez-Perdomo*, 551 F.3d 10 (1st Cir. 2008) (Federally Qualified Health Centers (“FQHC”) have 42 U.S.C. § 1983 cause of action under 42 U.S.C. § 1396a(bb)); *PeeDee Health Care, P.A. v. Sanford*, 509 F.3d 204, 209-12 (4th Cir. 2007); *Three Lower Counties Community Health Services, Inc. v. Maryland*, 498 F.3d 294 (4th Cir. 2007); *Chase Brexton Health Services, Inc. v. Maryland*, 411 F.3d 457, 461, 467 (4th Cir. 2005); *Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 136-140 (2d Cir. 2002); *California Assoc. of Rural Health Clinics v. Maxwell-Jolly*, 748 F. Supp. 2d 1184 (E.D. Cal. 2010).

6. The Circuit Court erred in holding that Federal Upper Payment Limit rules in federal regulations that classify government operated hospitals separately from privately operated hospitals serve as a reasonable classification to pay West Virginia government hospitals higher Medicaid reimbursements than similarly situated privately owned hospitals.

Respondents reimburse government owned or operated hospitals on the same basis as the Beckley ARH. But since that methodology provides such inadequate rates, Respondents make supplemental payments to government operated hospitals paying them the difference between what Medicare *would* pay and what Medicaid *did* pay. Beckley ARH is similarly situated to government operated hospitals that treat a large percentage of Medicaid patients. There is no rational basis for this preferential and discriminatory treatment. *See* W. Va. Code § 9-5-16(a).

The Federal Upper Payment Limits (“UPL”) rules were implemented because some states were gaming federal matching fund rules to obtain additional federal funds they used in many cases to over compensate government hospitals at the expense of privately owned hospitals. *See, e.g.,* 65 Fed. Reg. 60152 (Oct. 10, 2000). The federal government classified government operated hospitals separately from privately operated hospitals for UPL purposes so state Medicaid programs could not tap into the private hospitals’ UPL to pay more money to government hospitals. To hold, as the Circuit Court did, that that classification used by the federal government to prevent an abuse of the UPLs can now be used to justify compensating government hospitals fully while underpaying private hospitals is irrational. (A.R. 20-21).

This “special” treatment of state hospitals is a tacit admission that the Medicaid rates are inadequate. It is also a violation of the equal protection clause to treat Beckley ARH in such a disadvantageous manner compared to similarly situated state hospitals. Article III, §10 of the West Virginia Constitution guarantees equal protection of the law and is co-extensive with or broader in scope than the Fourteenth Amendment to the United States Constitution. *O’Dell v. Town of Gauley Bridge*, 188 W. Va. 596, 601, 425 S.E.2d 551, 556 (1992). Beckley ARH has a

fundamental right to be reimbursed for providing Medicaid services. Whether that fundamental right devolves into merely an economic right after a certain level of compensation is reached may determine what level of scrutiny is required. Is forty-eight percent of costs enough? That fact-based inquiry was not an issue to be decided at the pleading stage and without the benefit of discovery. Once again, the Circuit Court erred in dismissing the Complaint.

7. The Circuit Court erred in finding that none of the ten Counts in the Complaint could provide relief for Respondents' failure to follow statutory requirements in setting the hospital Medicaid rates.

The Circuit Court, in signing without modification, the Order drafted by Respondents' counsel, relinquished the well-established powers of the court. For example, the declaratory judgment counts were brought pursuant to the provisions of W. Va. Code § 55-13-2 which provides that “[a]ny person invested under a . . . written contract, or other writings constituting a warrant, or whose rights, status or other legal relations are affected by a statute . . . [or] contract . . . may have determined any question of construction or validity arising under the . . . statute . . . [or] contract . . . and obtain a declaration of rights, status or other legal relationship thereunder.” As this statutory language makes clear, “when a person’s significant interests are directly injured or adversely affected by government action, such person has standing under the Declaratory Judgments Act.” *Shobe v. Latimer*, 162 W. Va. 779, 791, 253 S.E.2d 54, 61 (1979). Where a lawsuit “seeks only to construe the statute and direct the parties, [it] is not a suit against the State within the provisions of Article VI, Section 35.” *Farley v. Graney*, 146 W. Va. 22, 27, 119 SE.2d 833, 837 (1960).

Similarly, as previously discussed, mandamus or injunctive relief is available here. This Court said a “mandamus will lie against a State official to adjust prospectively his or her conduct to bring it into compliance with any statutory or Constitutional standard,” in *Gribben v. Kirk*, 195 W. Va. 488, 497, 466 S.E.2d 147, 156 (1995), where mandamus was issued to allow two

state employees to recover back pay as restitution for violation of the legislative mandate requiring “equal pay for equal work.” *Hensley*, 203 W. Va. at 460, 508 S.E.2d at 620. This would not be the first time mandamus was appropriate where the Court was “asked only to order the executive branch to fulfill its obligation under clear and unambiguous statutory provisions.” *State ex rel. Matin v. Bloom*, 233 W. Va. 379, 381, 674 S.E.2d 240, 242 (2009) (citations omitted). The intricacies of Medicaid reimbursements can appear daunting. Respondents certainly do not welcome any scrutiny. But state law provides relief for Respondents’ egregious failure to follow statutory and regulatory standards. The Circuit Court was too hasty in dismissing this case.

8. The Circuit Court applied the wrong standards in dismissing the Complaint under West Virginia Rule of Civil Procedure 12(b)(6).

Pursuant to West Virginia Rule of Civil Procedure Rule 12(b)(6), a pleader is only required to set forth sufficient information to outline the elements of his claim. *John W. Lodge Distrib. Co., Inc. v. Texaco, Inc.*, 161 W. Va. 603, 605, 245 S.E.2d 157, 159 (1978). For purposes of a motion to dismiss, the complaint is to be construed in the light most favorable to the plaintiff and all allegations are to be taken as true. *John W. Lodge*, 161 W. Va. at 605, 245 S.E.2d at 159. While the Circuit Court paid lip service to those rules, it did not follow them. No road contractors would build state roads if they were paid sixty-seven percent of the costs. State employees would soon quit if they received only sixty-seven percent of their pay-checks. No one can say with a straight face that sixty-seven percent of the costs was a reasonable and adequate payment. But that is what the Circuit Court did in granting the Motion to Dismiss while holding that the rates were, in fact, adequate and reasonable. (A.R. 16, 17).

The Circuit Court expressly erred in applying *Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955 (2007). (A.R. 5-7). “[T]his Court has not adopted the more stringent [i.e., *Twombly*]

pleading requirements as has been the case in federal court and all that is required by a plaintiff [under the West Virginia Rules of Civil Procedure] is ‘fair’ notice.” *Roth v. DeFeliceCare, Inc.*, 226 W. Va. 214, 220, 700 S.E.2d 183, 189 n.4 (2010). This Court continued to describe the “fair notice” standard as follows:

The primary purpose of these provisions [referring to the provisions of West Virginia Rule of Civil Procedure 8] is rooted in fair notice. Under Rule 8, a complaint must be intelligently sufficient for a circuit court or an opposing party to understand whether a valid claim is alleged, and, if so, what it is. Although entitlement to relief must be shown, **a plaintiff is not required to set out facts upon which the claim is based.**

Roth, 226 W. Va. at 220, 700 S.E.2d at 189 (citing *State ex rel. McGraw v. Scott Runyan Pontiac-Buick, Inc.*, 191 W.Va. 770, 776, 461 S.E.2d 516, 522 (1995)) (emphasis in original). The fact that Respondents did not dispute Beckley ARH’s detailed numbers demonstrating its Medicaid losses should have caused the Court to dig deeper – not to cut off all factual inquiries altogether. The detailed fact-filled allegations in Beckley ARH’s twenty-page Complaint more than satisfied the “fair notice” standard. And as has been discussed herein at length, there are multiple bases upon which Beckley ARH could be entitled to relief given the pleaded facts. The Motion to Dismiss should have been denied.

9. **The Circuit Court misapplied West Virginia Rule of Civil Procedure 12(b)(6) and, considering matters outside the pleadings, effectively converting Respondents’ motion to one for summary judgment under West Virginia Rule of Civil Procedure 56, while improperly deciding genuine issues of material fact.**

Respondents’ Motion to Dismiss pursuant to Rule 12(b)(6) of the West Virginia Rules of Civil Procedure should have been treated as a motion for summary judgment. Respondents submitted with their motion extrinsic evidence in the form of affidavits which the Circuit Court considered in reaching its decision. (*See e.g.* A.R. 9). West Virginia Rule of Civil Procedure Rule 12(b)(6) states

[i]f, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

“When a motion to dismiss for failure to state a claim upon which relief can be granted under Rule 12(b)(6) of the West Virginia Rules of Civil Procedure is converted into a motion for summary judgment, the requirements of Rule 56 of the West Virginia Rules of Civil Procedure become operable. . . . Once the proceeding becomes one for summary judgment, the moving party’s burden changes and the moving party is obliged to demonstrate that there exists no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” *Riffle v. C.J. Hughes Const. Co.*, 226 W. Va. 581, 589-90, 703 S.E.2d 552, 560-61 (2010). Respondents did not carry their burden.

Furthermore, at the summary judgment stage, the trial court should not “weigh the evidence [or] determine the truth of the matter but . . . determine whether there is a genuine issue for trial.” *Riffle*, 226 W. Va. at 589-90, 703 S.E.2d at 560-61 (quoting *Anderson v. Liberty Lobby, Inc.*, 106 S. Ct. 2505, 2511 (1986)). All permissible inferences, including those respecting credibility, the weight to be given evidence and legitimate inferences to be drawn from the facts must be drawn in favor of the non-moving party. *Williams v. Precision Coil*, 194 W. Va. 52, 59, 459 S.E.2d 459 S.E.2d 329, 336 (1995) (internal citations omitted). Two inferences could be legitimately drawn from the undisputed fact that Beckley ARH receives only, on average, sixty-seven percent of its costs with Respondents’ rates. Either the rates are grossly inadequate and unreasonable, or the hospital is terribly inefficient. The undisputed fact

that Beckley ARH is one of the lowest cost hospitals in the state militates against the latter assumption. If anything, the undisputed facts showed that Beckley ARH is entitled to relief.

Significantly, “a decision for summary judgment before the discovery has been completed is viewed as precipitous.” *Bd. of Educ. of Ohio County v. Van Buren & Firestone, Architects, Inc.*, 165 W. Va. 140, 144, 267 S.E.2d 440, 443 (1980). *See generally Elliot v. Schoolcraft*, 213 W. Va. 69, 576 S.E.2d 796 (2002) (finding trial court abused its discretion by awarding summary judgment prior to allowing plaintiff an opportunity to conduct formal discovery because, “[a]s a general rule, summary judgment is appropriate only after adequate time for discovery”) (quoting *Celotex Corp. v. Catrett*, 106 S. Ct. 2548 (1986)). In this case, not only was discovery never completed, **discovery had not even begun before the Circuit Court dismissed the Complaint.** Beckley ARH should have been permitted to conduct discovery on this and other important factual issues. The Circuit Court’s Order dismissing this action should be reversed.

IV. CONCLUSION

Medicaid is often viewed as Byzantine in its complexity and as a morass for the uninitiated. The Circuit Court apparently took one look at what must have looked like a morass and bolted for the door. Ultimately, the issue is quite simple: are Medicaid rates that pay sixty-seven percent of the costs incurred by a low cost, efficiently and economically operated hospital adequate, reasonable, and in keeping with quality and access standards? How we pay for health care and the effect of government reimbursements on private insurance costs are important issues that affect all of society. The Complaint raises many questions that need to be addressed – not swept away. Respondents' Motion to Dismiss was inappropriate, legally unfounded, and should have been denied. This Court should reverse the Circuit Court and remand this case for further proceedings.

**APPALACHIAN REGIONAL HEALTHCARE, INC.,
d/b/a BECKLEY ARH HOSPITAL**

By counsel



Michael S. Garrison (WV Bar No. 7161) (Counsel of Record)
Spilman Thomas & Battle, PLLC
48 Donley Street, Suite 800 (26501)
Post Office Box 615
Morgantown, West Virginia 26507-0615
tel: (304) 291-7926
mgarrison@spilmanlaw.com

Stephen R. Price, Sr. (Admitted *Pro Hac Vice*)
Wyatt, Tarrant & Combs, LLP
500 West Jefferson Street, Suite 2800
Louisville, Kentucky 40202-2898
tel: (502) 589-5235
sprice@wyattfirm.com

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET NO. 11-1187

APPALACHIAN REGIONAL HEALTHCARE, INC.,
D/B/A BECKLEY ARH HOSPITAL,

Plaintiff Below, Petitioner,

v.

(Civil Action No. 10-C-2311)

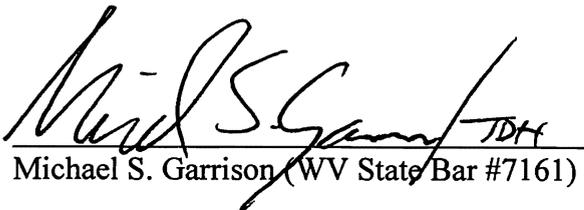
WEST VIRGINIA DEPARTMENT OF HEALTH AND
HUMAN RESOURCES; MICHAEL L. LEWIS, M.D., PH.D.,
Secretary, in his official capacity and not individually;
WEST VIRGINIA BUREAU FOR MEDICAL SERVICES;
NANCY ATKINS, Commissioner, in her official capacity and
not individually,

Defendants Below, Respondents.

CERTIFICATE OF SERVICE

I, Michael S. Garrison, hereby certify that service of the foregoing “Petitioner Appalachian Regional Healthcare, Inc., d/b/a Beckley ARH Hospital’s Brief” has been made via hand delivery on this 21st day of November, 2011, addressed as follows:

Charlene A. Vaughan, Esq.
The Honorable Darrell V. McGraw, Jr.
Office of the Attorney General
812 Quarrier Street, 2nd Floor
Charleston, West Virginia 25301
Counsel for the DHHR


Michael S. Garrison (WV State Bar #7161)