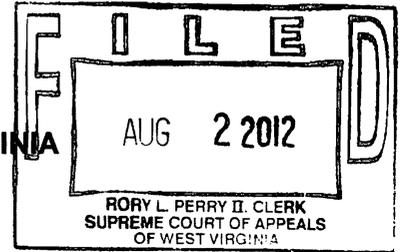


DOCKET NO. 11-1187

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

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



Plaintiff Below, Petitioner,

v.

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.

RESPONDENTS' AMENDED BRIEF

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I. SUMMARY OF ARGUMENT

Respondents' Motion to Dismiss for failure to state a claim upon which relief can be granted was properly granted. Mandamus is a remedy for administrative inaction and is not available where action has already been taken, and does not provide a vehicle for judicial review of the rates set by Respondents. A contractual claim does not arise under a statute unless the Legislature explicitly expresses to waive sovereign immunity and create a contractual remedy. Verbatim adoption of proposed findings and conclusions of law prepared by one party does not constitute reversible error, and may be reversed only if findings adopted by the court inaccurately reflect the existing law and the trial record.

II. STATEMENTS REGARDING ORAL ARGUMENT AND DECISION

Respondent submits that the dispositive issue in this matter is whether or not the trial court committed reversible error by granting Respondents' 12(b)(6) Motion to Dismiss. The standard for granting a Motion to Dismiss has been authoritatively decided. Respondent further offers that the facts and legal arguments are adequately presented in the briefs and record on appeal. Based on the foregoing, oral argument pursuant to Rule 18 (a) (3) and (4) appears to be unnecessary.

Respondent submits that this matter may be suitable for a Rule 19 argument as it involves assignments of error in the application of settled law, that is, the trial court committed reversible error by using the wrong standards in granting Respondents' 12(b)(6) Motion to Dismiss.

Respondent offers that this matter may not be suitable for a Rule 20 argument because the issue of the standard in granting or deny a 12(b)(6) motion is not one of first impression.

III. ARGUMENT

- 1. The Trial court did not commit reversible error by signing, without modification, the order drafted entirely by Respondents, did not strip W.Va. Code §§ 16-29B-20 or 9-5-16(A) of all meaning and function, and did not leave Respondents with unfettered authority to set Medicaid rates in an arbitrary and capricious manner.**

Petitioner complains that the trial court adopted verbatim the proposed findings and conclusions of law prepared by the Respondents.¹ Verbatim adoption of proposed findings and conclusions of law prepared by one party is not the preferred practice, but it does not constitute reversible error. See, *State of West Virginia ex rel. Thornton Cooper v. Caperton*, 196 W.Va. 208, 470 S.E.2d 162 (1996).

Counts I - IV of the Complaint alleged violations of state statutes that result in Respondents' reimbursement rates set for hospital services provided to Medicaid recipients not being adequate, reasonable or in accordance with state statutory standards found at W.Va. Code §§ 16-29B-20 and 9-5-16 or federal regulatory standards found at 42 U.S.C. § 1396a (a)(30)(A). **(A.R. 29, 38-40).**

Count I of the Complaint alleged that Respondents violated W.Va. Code §16-29B-20. In response to the Complaint allegations, Respondents answered they had not. In their Motion to Dismiss, Respondent argued through the affidavit of Ms. Tina Bailes that she was the former Chief Financial Officer for Respondent's Bureau for Medical Services, was responsible for WV Medicaid reimbursement methodologies, was aware of the Bureau for Medical Services being the Medicaid single state agency, and was aware of the execution of Petitioners' Medicaid provider agreement. **(A.R. 132-134).**

¹ Pursuant to W.Va. Rev. R. App. P. 41(c), Respondent's request substitution of ex-Department of Health and Human Resources Secretary Michael Lewis' name with the name of the newly appointed Department of Health and Human Resources Acting Secretary, Rocco F. Fucillo.

Count I of the Complaint further alleged that Respondents violated W.Va. Code § 16-29B-20 by failing to apply proper standards in setting the rates for reimbursing Petitioner for providing care to Medicaid beneficiaries, and caused it substantial harm. **(A.R. 38)**. Respondents Motion to Dismiss argued that Respondents had not failed to apply proper standards in setting the rates for reimbursing Petitioner for providing care to Medicaid beneficiaries due to the Legislature having not revoked the provisions of W.Va. Code § 16-29B-20(a)(1) and (3) when it transferred Medicaid rate setting authority to the Bureau for Medical Services. Respondents argued the West Virginia Health Care Authority, (WVHCA), never had Medicaid hospital rate setting authority and supported its argument with the affidavits of Sally Richardson, former Director of the WVHCA and James Pitrolo, Jr., current Director of the WVHCA. **(A.R. 109-111)**. Petitioner admitted in footnote 9 of its Response in Opposition to Respondent's Motion to Dismiss or for Summary Judgment that "it is undisputed that during all times relevant to this litigation, DHHR and its division, Bureau for Medical Services, have been solely responsible for setting adequate Medicaid rates..." **(A.R. 210-211)**. At the hearing on the Motion to Dismiss, counsel for Petitioner admitted that W.Va. Code § 16-29B-20 did not apply to Medicaid hospital reimbursement rates. The trial court Order concluded that W.Va. Code § 16-29B-20 does not apply to Medicaid reimbursement rate setting. **(A.R. 19)**. No matters outside the allegations of the Complaint were considered.

The Petitioner argued that the trial court committed error in holding Petitioner does not have a clear legal right to challenge Respondents' not setting Medicaid rates in compliance with W.Va. Code § 16-29B-20. Petitioner alleged because the authority to set Medicaid rates was first held by the WVHCA and later transferred to Respondents, Respondents must continue to follow the HCA standards for setting hospital rates. But Petitioner cites only part of HCA statutes to support its claim, and ignores federal statutory and case law regarding rate setting for Medicaid services provided by health care providers.

The Complaint fails to note the provision of W.Va. Code § 16-29D-3(b) which states

(b) It is expressly recognized that no other entity may interfere with the discretion and judgment given to the single state agency which administers the state's Medicaid program. Thus, it is the intention of the Legislature that nothing contained in this article shall be interpreted, construed, or applied to interfere with the powers and actions of the single state agency which, in keeping with applicable federal law, shall administer the state's Medicaid program as it perceives to be in the best interest of that program and its beneficiaries.

The Complaint cites Chapter 16-29B-10(a) for the proposition that Respondents must follow the HCA methods of rate setting, but W.Va. Code § 16-29D-3(b) **expressly** states that is not the case regarding the Medicaid program. **(A.R. 9, 125)**. See, also, *United Hosp. Center, Inc. v. Richardson*, C.A.4 (W.Va.) 1985; 757 F.2d 1445. The issue in *United Hosp. Center v. Richardson*, a section 1983 action, was the jurisdiction of the WVHCA Board to govern health service charges by state acute care hospitals in the interim between the effective date of the Boards' creation, and the date after the assumption of jurisdiction over such rates by the Board and the issuance of initial rates for the hospitals. Regulations adopted by the Board created under West Virginia Health Care Review Act were not intended to apply to adjustments made in connection with Medicare or Medicaid charges. Thus, the regulations of the Board did not contravene the Social Security Act and were not constitutionally invalid under supremacy and due process clauses of the Federal Constitution. 757 F.2d 1445, *Id.*, at 1449 The trial court did not commit error by holding that under WV Code §§16-29B-10 or 20, Petitioner failed to state a claim upon which relief may be granted. **(A.R. 9-15, 19 and 49)**.

Count I of the Complaint further alleged that Respondents violated W.Va. Code §9-5-16 by failing to apply proper standards in setting the rates for reimbursing Petitioner for providing care to Medicaid beneficiaries, and this violation caused substantial harm to Petitioner. **(A.R. 30, 38)**. However, that Code provision only requires Respondents to study its rates. It does not give Petitioner a right to challenge Respondents method for setting its rates. Further, W.Va. Code §9-5-16(e) specifically states:

(e) Nothing in this section shall be construed to give the Legislature any jurisdiction over the Medicaid program or its operations. Acts 1988, c.86.

The conclusion of law of the trial court on this issue accurately reflects existing law and the trial record. The dismissal of Count I of the Complaint should be affirmed.

2. The Trial Court did not commit plain error in holding Petitioner does not have a clear legal right to challenge respondents' Medicaid rates.

Petitioner complains the trial court order is based on matters outside of the Complaint, the wrong standard was used for granting relief to the Motion to Dismiss, and therefore the Motion to Dismiss should be converted into a Motion for Summary Judgment. Respondents disagree.

Count II of the Complaint claimed Respondents failed to comply with W.Va. Code §§16-29B-20, 9-5-16(a) and other applicable provisions by establishing unreasonable and inadequate rates, and sought a writ of mandamus directing Respondents to reimburse it for Medicaid services at rates that are adequate, reasonable, in keeping with statutory standards, and meets all its costs in providing hospital services to Medicaid beneficiaries. **(A.R. 39).**

A Writ of Mandamus will not be issued 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 Petitioner seeks to compel, and (3) the absence of another adequate remedy. Petitioner has no clear legal right to any set amount of Medicaid reimbursement under WV Code §§ 16-29B-20 or 9-5-16(a). Petitioner has no clear legal right under WV Code §§ 16-29B-20 or 9-5-16(a) to being reimbursed for all its costs incurred in operating an acute care hospital. **(A.R. 33, 145-193).** Respondents have no legal duty under WV Code §§ 16-29B-20 or 9-5-16(a) to reimburse Petitioner for **all** its costs for providing hospital services to Medicaid beneficiaries. Petitioner has no claim under state law to recover all its costs for providing hospital services to Medicaid beneficiaries.

Respondents have developed reimbursement methodologies and systems for all health care providers reimbursed under the Medicaid program in its entirety within its budgetary constraints and in compliance with federal standards, which includes hospital services reimbursement. **(A.R. 132-134)**. The Complaint alleges that Respondents' rates are not reasonable and adequate to meet its costs. Respondent is not required to pay rates that meet Petitioners' costs as it is not a state government operated hospital. Petitioner alleges no statute, federal or state, that so requires. Respondents use the same rates methodology established for federal Medicare hospital reimbursement rates to set WV Medicaid hospital reimbursement rates. **(A.R. 150)**. Respondents submit that Petitioners' remedy to contest the rates set by Respondents for reimbursement of its provided Medicaid hospital services, other than withdrawing from the Medicaid program, may be had at Respondents' federally required public hearings prior to Medicaid reimbursement rate changes. **(A.R. 133)**. In, *In re NYAHS*, N.D.N.Y. 2004, 318 F.Supp.2d 30 (2004), affirmed 444 F.3d 147 (2006), it was held, "Medicaid Act provision requiring that state plans for medical assistance provide public process giving providers reasonable opportunity for review and comment on proposed Medicaid reimbursement rates for nursing facility services replaced opportunity to challenge rates by way of private action, authorized by the repealed Boren Amendment.

Petitioner argues that the *Cort/Hurley* test applied in *Cort v. Ash*, 422 U.S. 66 (1975), should have been applied by the trial court in determining whether or not it had a clear right to the relief requested. Petitioners Brief, p. 22 – 24. Petitioner bases its argument on the allegation that the Boren Amendment language has not been stricken from the West Virginia statutes, therefore, it remains state law. But the WV statutes and case law clearly state that Respondents must administer its federal assistance program consistent with federal law. W.Va. Code § 9-2-3. And, the intent of Congress in enacting the Balanced Budget Act of 1997, which repealed the Boren Amendment was that neither the Balanced Budget Act of 1997, nor

any other provision of 42 U.S.C. § 1396a was to be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive. (A.R. 17).

Petitioner has delivered an “*artful pleading*”, which is defined as “A Petitioner’s disguised phrasing of a federal claim as solely a state-law claim in order to prevent a Respondent from removing the case from state court to federal court. *Blacks Law Dictionary*, 9th Ed. (2004). Petitioner does have another adequate remedy if it is not satisfied with the reimbursement amount it agreed to accept as payment in full under its agreement voluntarily entered into with Respondents to be a provider of Medicaid hospital services. That remedy is to terminate its contract as a Medicaid provider. Petitioner argues termination is no adequate remedy, but it is. As the burden of proof as to all the elements necessary to obtain mandamus is upon the party seeking the relief, a failure to meet any one of them is fatal. *52 Am.Jur.2d Mandamus § 3 at 271 (2000) (footnote omitted)*. Mandamus relief is a proper remedy to require the performance of nondiscretionary legal duties by various governmental agencies or bodies. Syllabus Point 1, *State ex rel. Richey v. Hill*, 216 W.Va. 155, 603 S.E.2d 177 (2004). Mandamus does not lie “to obtain review of the decision of public officers who have acted and to command them to act in a new and different manner” *Boston Medical Corp., Harding v Comm. of Ins.*, 225 N.E.2d 903 (67), or to compel a public official “to exercise his or her judgment or discretion in a particular way.” *Urban Transport, Inc. v. Mayor or Boston*, 369 N.E.2d 1135 (1997).

Here, the Respondents’ statutory duty is to set rates of reimbursement for services provided under its State Plan by entering into contracts with providers who agree to accept the rates it has set. The Respondents have done exactly that. Mandamus does not provide a vehicle for judicial review of the rates set by the Respondents, even in the face of an argument that those rates fail to meet statutory standards. Section 1396a(a)(30)(A) cited by the Petitioner gives Bureau for Medical Services wide discretion to set Medicaid payments that are consistent

with efficiency, economy, and **access** to quality care (emphasis added). There has been no allegation that any Medicaid beneficiary does not have access to Medicaid services in Beckley, West Virginia or any other of Petitioners' service areas, only that "the current reimbursements continue to be similarly inadequate and *threaten* access to hospital service by Medicaid patients. (emphasis added) **(A.R. 31)**. Respondents' statutory duty is to set rates of reimbursement for providers of Medicaid hospital services who have entered into contracts agreeing to accept the rates set. 42 C.F.R. § 447.15; See, also, *Friedman v. Perales*, S.D.N.Y. 1987, 668 F.Supp. 216, affirmed 841 F.2d 47 holding, "under efficient cost standard for setting Medicaid reimbursement rates, states need not reimburse individual providers for costs they actually or even reasonably incur". Respondents have taken that discretionary administrative action of setting the reimbursement rates. Petitioner argues it has no other remedy and that not participating in the Medicaid is not a remedy. It may not be Petitioners remedy of choice, but not participating in the Medicaid program is a remedy. Going to the public hearings Respondent has held when it makes a change to its rates for hospital services reimbursement is the remedy authorized by the Department for Health and Human Services/CMS for Medicaid providers who wish to challenge reimbursement rates. This was averred to in Respondents' Motion to Dismiss, Bailes Affidavit, Exhibit 1, p. 2. **(A.R. 136)**.

Assuming Respondents have some contractual obligation to set Medicaid rates under an obligation of good faith and fair dealing, that contractual obligation is tempered by federal law requirements under 42 U.S.C. 1396a(a)(13)(A) to comply with the federal procedural requirements in setting its Medicaid rates.

The conclusions of law of the trial court on this issue accurately reflect existing law and the trial record. The dismissal of Count II of the Complaint should be affirmed.

Count III of the Complaint sought a declaratory judgment that Respondents must follow the West Virginia Health Care Authority (WVHCA) statutory standard in W.Va. Code § 16-29B-

20 for setting its hospital reimbursement rates. (A. R. 39-40). Respondents argued that this Court failed to state a claim against them because the WVHCA never had Medicaid hospital rate setting authority. Respondents supported their Motion to Dismiss this claim with the affidavits of Sally Richardson, former Director of the WVHCA and James Pitrolo, Jr., current Director of the WVHCA. (A.R. 120, 194-196). Petitioner admitted in footnote 9 of its Response in Opposition to Respondent's Motion to Dismiss or for Summary Judgment that "it is undisputed that during all times relevant to this litigation, DHHR and its division, Bureau for Medical Services, have been solely responsible for setting adequate Medicaid rates..." (A.R. 210-211). The trial court Order concluded that W.Va. Code § 16-29B-20 does not apply to Medicaid reimbursement rate setting. (A.R. 19). There was nothing within the Motion to Dismiss or its supporting affidavits that was not within the allegations of the Complaint. The conclusion of law of the trial court on this issue accurately reflects existing law and the trial record. The dismissal of Count III of the Complaint should be affirmed. See, also, **Assignment of Error # 7 Argument.**

3. The trial court did not err in holding that federal law preempts a state court action involving Medicaid reimbursement rates.

There is a legal duty on the part of Respondents to establish Medicaid rates determined in accordance with methods and standards developed by the state which have been approved by the federal government, and there is a legal duty on the part of Respondents to set rates that are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities. (A.R. 17). Petitioner argues that the trial court erred in holding that federal law preempts a state court action regarding Medicaid hospital reimbursement rates. Petitioner's Brief, pp. 26 – 27. The WV Legislature has recognized that Respondents' must administer federal assistance programs consistent with federal law. The Respondent Bureau for Medical Services is, and always has been, the single state agency responsible for the

administration of West Virginia's version of Medicaid. W. Va. Code §§ 9-1-2(n), 9-2-6 (2), (4), (5), (10), and (12), 9-2-9 (b) (3) through (6), 9-4A-1 *et seq*, 9-4C-11, 9-5-16. **(A.R. 194-196).**

W. Va. Code § 9-2-3 states:

The State assents to the purposes of federal-state assistance and federal 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 conditions imposed by applicable federal laws, rules and regulations.* Acts 1936, 1st Ex. Sess., c. 1; Acts 1947, c. 146; Acts 1970, c 78.

See also, *Harrison v. Ginsberg*, 286 S.E.2d 276, 280 (1982), wherein this Court held, "it is by now axiomatic that the manner in which a state administers a federal assistance program must be consistent with federal law, (reaffirmed in *In re: E.B., A Minor*, --- S.E.2d ----, 2012 WL 2368978 (W.Va.), Med & Med GD (CCH) P 304,061.

4. The trial court did not err in finding that Respondents could not have breached the provider agreement.

This is a contract case. Counts VII through X of the Complaint alleged violations of state and federal statutes under different theories that result in Respondents' reimbursement rates set for hospital services provided to Medicaid recipients not being adequate or reasonable. Congress enacts many of the federal-state programs through which benefits are provided, such as Medicaid, the Child Welfare Act, the Food Stamp program, pursuant to the Spending Clause powers set forth in Article 1, section 8, clause 1 of the U.S. Constitution. Such programs are in the nature of a contract: the federal government provides money to states in exchange for states' agreements to comply with federal requirements for how the program shall be run. To ensure that states live up to their side of the bargain, a federal agency, such as the U.S. Department of Health and Human Services, typically is charged with

oversight responsibility, and the power to withhold federal funds if it finds that a state does not comply with federal requirements.

Count VII sought a declaration that pursuant to W.Va. Code § 29A-4-2, Respondents reimbursement rates “interfere with, impair, or threaten to interfere with or impair the legal rights or privileges of Petitioner”. **(A.R. 43)**. Count VIII identified the contract alleged to have been breached as having its basis in state statutory law alleging in ¶ 66 as “Petitioner’s provision of medical services to Medicaid beneficiaries was based upon full compliance with the reimbursement requirements provided for by state statute which, therefore, constituted a contractual agreement between Petitioner and the Bureau for Medical Services. **(A.R. 21-22, 43)**. Counts II and III identified the state statutes alleged to have been violated as W.Va. Code §§ 16-9B-20 and 9-5-16. Neither W.Va. Code 16-29B-20 nor W.Va. Code 9-5-16 establishes a contract nor gives rise to a direct right of action by Petitioner for their violation.

“A contractual claim does not arise under a statute unless the Legislature has explicitly expressed the intent to waive sovereign immunity and create a contractual remedy.” *Lopes v. Commonwealth*, 442 Mass. 170, 175-6, 811 N.E.2d 501, *id.* at 506-507. None of the statutes on which Petitioner relies expresses any intent either to waive sovereign immunity or to create a cause of action, in contract or otherwise. Case law has unequivocally established that the Medicaid Act does not abrogate the immunity of the states under the eleventh amendment to the United States constitution, and does not provide a private right of action. *Florida Dept. of Health & Rehab. Svcs. v. Florida Nursing Home Ass’n.*, 450 U.S. 147, 150, 101 S.Ct. 1032, 67 L.Ed.2d 132 (1981) (Medicaid Act does not abrogate eleventh amendment);

Long Term Care Pharmacy Alliance v. Ferguson, 362 F.3d 50, 58-59 (1st Cir.2004) (no private right of action to enforce 42 U.S.C. § 1396(a)(30)(A)), applying holding of *Gonzaga University v. Doe*, 536 U.S. 273, 283, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002) (no private cause of action exists unless statute “displays an intent to create not just a private right but also a private remedy”).

A Petitioner may not “fumble around searching for a meritorious claim where the claim is not authorized by the laws of West Virginia”. *State ex rel. McGraw v. Scott Runyan Pontiac-Buick*, 194 W.Va. 770, 766, 461 S.E.2d 516, 522 (1995). Petitioner participates in WV Medicaid program pursuant to an express written contract under which it agreed to accept the rates set by Respondents as full payment for services. Statutes relied upon by Petitioner do not imply private right of action to enforce, but for upon the express terms of its contract. If possible, a statute should be construed in a way that conforms to the plain meaning of the text. *Scott Runyan Pontiac-Buick, Inc., Id.* at 194 W.Va. 777, 461 S.E.2d at 523, *citing State ex rel. Frazier v. Meadows*, 193 W.Va. 20, 23-24, 454 S.E.2d 65, 68-69 (1994), which stated “We begin, as we must, by examining the statutory language, bearing in mind that we should give effect to the legislative will as expressed in the language of the statute... Generally, words are given their common usage... Courts are not free to read into the language what is not there, but rather should apply the statute as written. If the statute ‘is clear’ ...; if ‘the statutory scheme is coherent and consistent’ ...; and if the law is within the constitutional authority of the lawmaking body that passed it, then the duty of interpretation does not arise, and the rules for ascertaining uncertain language need no discussion.” (Citations omitted). Petitioner admits in its brief filed below that there is nothing whatsoever in the Provider Agreement expressly stipulating that the rates would be set paying sixty-seven percent, (67%), of its costs. **(A.R. 211)**. The express

terms of the Provider agreement are that the Petitioner would accept established rates, fee schedules, and payment methodologies as payment in full. **(A.R. 143).**

Petitioner does not say in this Count that Respondent breached the contract, but rather that contract law requires Respondent to exercise their discretion in setting Medicaid rates in compliance with their duty of good faith and fair dealing. Petitioner alleges that Respondents have unilaterally established Medicaid rates that are inadequate and unreasonable under applicable law, therefore have breached the covenant of good faith and fair dealing. **(A.R. 44-45).** A contractual claim does not arise under a statute unless the Legislature explicitly expresses to waive sovereign immunity and create a contractual remedy. *Boston Medical Center Corp. v. Secretary of the Executive Office of Health and Human Services*, 2010 WL 5348622 (Mass.Super.) (Healthcare providers brought action challenging decisions of Secretary of the Executive Office of Health and Human Services setting reimbursement rates under state Medicaid program for services provided by healthcare providers). None of the statutes Petitioner relies on express any intent to waive sovereign immunity or create a private cause of action. Respondent did not waive its sovereign immunity. Petitioner participates in WV Medicaid program pursuant to an express written contract under which it agreed to accept the rates set by Respondents as full payment for services. This court recognized in *Highmark West Virginia, Inc. v. Jamie*, 221 W.Va. 487,492, 655 S.E.2d 509, 514, that an implied covenant of good faith and fair dealing does not provide a cause of action apart from a breach of contract claim, *Stand Energy Corp. v. Columbia Gas Transmission*, 373 F.Supp.2d 631, 644 (S.D.W.Va. 2005), and that “[a]n implied contract and an express one covering the identical subject matter cannot exist at the same time,” syl. pt. 3, in part, *Rosenbaum v. Price Construction Company*, 117 W.Va. 160, 184 S.E. 261 (1936).

Count VIII of the Complaint alleges a breach of contract based on Respondents’ alleged failure to pay adequate and reasonable reimbursements. Petitioner alleges that its provision of

medical services to Medicaid patients is based on reimbursement requirements provided for by a state statute which it does not name, and that it has performed all of its obligations under the contract. **(A.R. 43)**. No statute in the WV Code creates a contract between Petitioner and the WV Medicaid program. Petitioners' provision of medical services to Medicaid patients is based on its *voluntary* execution of a Medicaid provider agreement with Bureau for Medical Services stating it would accept the Bureau for Medical Services Medicaid rate for its provision of hospital services. Respondents provided for public notice and comment participation in their ratemaking process prior to submission of their State Plan to CMS. Petitioner had an opportunity to participate in that public hearing. **(A.R. 135)**.

That Petitioner may not be able to contain its costs for providing Medicaid reimbursable services among the other services it provides does not equate to Respondents inadequately reimbursing Petitioner for Medicaid claims its submits for reimbursement. Petitioner failed to state a claim upon which relief may be granted. The conclusions of law of the trial court on this issue accurately reflect existing law and the trial record. **(A.R. 21-22)**. The dismissal of Count VIII of the Complaint should be affirmed.

In Count IX of the Complaint, Petitioner alleged under the theory of quantum meruit an unjust enrichment by the Respondents due to their not making adequate and reasonable payment for its hospital services provided. **(A.R. 29-44)**. Recovery on a theory of quantum meruit does not exist when there is an express contract covering the matter, and there is an express contract between the parties. *Boston Medical Center Corp., Id.* at p. 9; See also, *York v. Zurich Scudder Investments, Inc.*, 66 Mass.App.Ct. 610, 620, 849 N.E.2d 892 (2006), and cases cited; see *Machado v. Committee for Pub. Counsel Servs.*, 39 Mass.App.Ct. 178, 183, 654 N.E.2d 328 (1995). Pursuant to federal law found at 42 C.F.R. § 447.15; 48 FR 5730

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services

to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 431.55(g) or § 447.53...

Petitioner voluntarily executed an agreement with the Bureau for Medical Services to be a Medicaid provider knowing that a term of the agreement was to abide by federal and state laws regarding the Medicaid program. **(A.R. 24, 135)**. Petitioner did not seek to void the contract nor was it alleged to have done so in its Complaint. Petitioner failed to state a claim upon which relief may be granted. The conclusions of law of the trial court on this issue accurately reflect existing law and the trial record. **(A.R. 24)**. The dismissal of Count IX of the Complaint should be affirmed.

In Count X of the Complaint, Petitioner alleged a breach by Respondents of the Covenant of Good Faith and Fair Dealing. **(A.R. 44-45)**. Assuming Respondents have some contractual obligation to set Medicaid rates under an obligation of good faith and fair dealing, that contractual obligation is tempered by federal law requirements under 42 U.S.C. 1396a(a)(13)(A) to comply with the federal procedural requirements to set Medicaid rates. Respondents' Bureau for Medical Services is the single state agency authorized to "unilaterally" set Medicaid reimbursement rates. Respondent did not set its reimbursement rates with the "objective of preventing [Petitioner] from receiving its reasonable expected fruits under the contract". Petitioners' Brief, p. 28. Petitioner voluntarily entered into the provider agreement knowing the terms of Medicaid reimbursement rates. Petitioner attached to its Complaint a letter from the University of Virginia Health System to Respondents withdrawing from the WV Medicaid program and argued it supported its allegations that reimbursement rates were inadequate. **(A.R. 44-45)**. In the Motion to Dismiss and attached Affidavits, Respondents responded to this allegation by stating the University of Virginia Health System withdrew from the WV Medicaid program because Respondents refused to negotiate Medicaid

reimbursements rates with it. (A.R. 75). There was nothing in Respondents Motion to Dismiss Memorandum in Support Affidavits that was not within the allegations of the Complaint.

5. The trial court did not commit clear error in its construction of the federal prohibition against balance billing found in 42 C.F.R. § 447.15.

Petitioner argued that 42 C.F.R. § 447.15 addresses a balanced billing prohibition. Petitioner argues that the trial court erred in its interpretation of 42 C.F.R. § 447.15. It is Petitioner that misconstrues the regulation. 42 C.F.R. § 447 addresses payments for services by the single state agency to the Medicaid provider.

42 CFR § 447.15 states in part:

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. ...

Balance billing is the (usually) illegal practice of hospitals, clinics, doctors' offices and other medical facilities billing patients for the balance between what they want to charge their patients for services and what the insurance company (Medicaid) has already reimbursed them.

Petitioner failed to state a claim in Count X upon which relief may be granted. The conclusions of law of the trial court on this issue accurately reflect existing law and the trial record. (A.R. 23). The dismissal of Count X of the Complaint should be affirmed.

6. The trial court did not err in holding that Federal Upper Payment Limit (UPL) in federal regulations that classify government operated hospitals separately from privately operated hospitals serve as a reasonable classification to pay WV government hospitals higher Medicaid reimbursements than similarly situated privately owned hospitals.

Count VI of the Complaint alleged Respondents set their reimbursement rates for state-owned or operated hospitals using the same method used to set rates for it, but the rates are so inadequate that Respondents make special payments to state-owned or operated hospitals. Petitioner claims Respondents are intentionally treating it in a discriminatory manner in violation

of Section 10 of Article III of the State Constitution and the Respondents' State Plan. **(A.R. 41-42).**

Petitioner complains that Respondents rates deprive it of its property without due process of law or just compensation. **(A.R. 20, 40-41).** The First Circuit rejected a virtually identical claim in *Franklin Memorial Hospital v. Harvey*, 575 F.3d 121, 129-130 (1st Cir.2009) on the ground that "where a property owner voluntarily participates in a regulated program, there can be no unconstitutional taking." 575 F.3d 121, *Id.* at 129. *See also, Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Depart. of Pub. Welfare*, 742 F.2d 442, 445-447 (8th Cir.1984), cert. denied, 469 U.S. 1215, 105 S.Ct. 1191, 84 L.Ed.2d 337 (1985); *Massachusetts State Pharmaceutical Ass'n v. Rate Setting Comm'n*, 387 Mass. 122, 136 n. 13, 438 N.E.2d 1072 (1982) ("substantial question" whether Medicaid provider "has any constitutional claim that a rate of reimbursement is confiscatory," where "participation in the Medicaid program is voluntary").

Article 3, § 10 of the WV Constitution reads:

No person shall be deprived of life liberty or property without due process of law, and the judgment of his peers.

Petitioner did not state a claim in this Court of its Complaint upon which relief may be granted because it entered into a provider agreement stating it would accept what Respondents' paid it for its delivery of Medicaid services. Petitioner alleged in its Complaint that "A state that chooses to participate in this joint federal/state program agrees to structure its Medicaid program in compliance with federal Medicaid statues and regulations" and that "the State of West Virginia has elected to participate with the federal government in implementing and administering a Medicaid program." **(A.R. 28-29).** The trial court agreed. **(A.R. 10).** Respondents' reimbursement methodology complies with its State Plan and Federal law as evidenced by the Centers for Medicare and Medicaid Services acceptance of its State Plan. **(A.R. 10, 147-193).** Petitioner states it is bringing this matter under state law, but then says

federal law does not control how Respondent sets its Medicaid rates under state law. Yet the Complaint and Petitioners' briefs refer to 42 U.S.C. 1396a(a)(30)(A) as a basis for its claims for relief. **(A.R. 29)**. Federal law does control how Respondent sets its Medicaid rates for privately operated versus state operated hospitals. 42 C.F.R. § 447.272 describes calculation of upper payment limits (UPL) for three (3) classes of providers: 1) State government operated as defined in 433.50(a); 2) Non-State government operated; and 3) Privately operated. The general rule is that privately operated facilities are subject to in aggregate what Medicare would have paid; whereas state government and non state government owned facilities are limited to their cost. Petitioners are privately operated facilities subject to in aggregate what Medicare would have paid. There are exceptions including disproportionate share hospitals, (DSH), which have additional prescribed limitations. See, *University of Washington Medical Center v. Sebelius*, *W.D.Wash.2009, 674 F.Supp.2d 1206*, affirmed 2011 WL 477072. 42 C.F.R. 447.206 specifically addresses cost limit for providers operated by units of government and use of certified public expenditure (CPE) for financing the State share of cost. Federal law permits the different handling of reimbursement to state operated and privately operated hospitals. The WV Legislature has noted such and declared the federally assisted WV Medicaid program will comply with federal law. *W.Va. Code § 9-2-3; Harrison, Id. at 280*.

The Medicaid program is a cooperative federal-state program that provides medical care to needy individuals. To qualify for federal funds, States must submit to the federal agency Centers for Medicare and Medicaid Services, (CMS), a division of the Department of Health and Human Services, a state Medicaid plan that details the nature and scope of the State's Medicaid program. It must also submit any amendments to the plan that it may make from time to time. And it must receive the agency's approval of the plan and any amendments. Before granting approval, the agency reviews the State's plan and amendments to determine whether they comply with the statutory and regulatory requirements governing the Medicaid program.

See 42 U. S. C. §§ 1316(a)(1), (b), 1396a(a), (b); 42 CFR §430.10 *et seq.* (2010); *Wilder v. Virginia Hospital Assn.*, 496 U. S. 498, 502 (1990). And the agency's director has specified that the agency will not provide federal funds for any state plan amendment until the agency approves the amendment. See Letter from Timothy M. Westmoreland, Director, Center for Medicaid & State Operations, Health Care Financing Admin., U. S. Dept. of Health and Human Servs., to State Medicaid Director (Jan. 2, 2001), online at <http://www.cms.gov/SMDL/downloads/SMD010201.pdf> (as visited Feb. 17, 2012, and available in Clerk of Court's case file). *Douglas v. Independent Living*, 132 S.Ct. 1204, U.S. 2012.

The states, in accordance with federal law, decide eligible beneficiary groups, types, and ranges of service, payment levels for services, and administrative and operating procedures. Payment for services is made directly by the states to the individual or entities that furnish the services. 42 C.F.R. § 430.0 (1978). To receive matching federal financial participation for such services, states must agree to comply with the applicable federal Medicaid law. 42 U.S.C. § 1396 *et seq.* **(A.R. 132-144).**

Each state's Medicaid program, if it elects to have one, must be administered by a single state agency. 42 U.S.C. § 1396(a) (5); 42 C.F.R. § 430.10. Respondent's Bureau for Medical Services is, and always has been, the single state agency responsible for the administration of West Virginia's version of Medicaid. W. Va. Code §§ 9-1-2(n), 9-2-6 (2), (4), (5), (10), and (12), 9-2-9 (b) (3) through (6), 9-4A-1 *et seq.*, 9-4C-11, 9-5-16. **(A.R. 194-196).**

W. Va. Code § 9-2-3 states:

The State assents to the purposes of federal-state assistance and federal 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 conditions imposed by applicable federal laws, rules and regulations.* Acts 1936, 1st Ex. Sess., c. 1; Acts 1947, c. 146; Acts 1970, c 78. (emphasis added).

See also, *Harrison v. Ginsberg*, 286 S.E.2d 276, 280. (1982).

The chosen agency may not delegate to others its administrative discretion or its authority to issue “policies, rules, and regulations or program matter.” 42 C.F.R. § 431.10(e) (1). The state Medicaid program adopted and administered by the agency must comply with the Medicaid Act and the implementing federal regulations, and the agency must submit the plan to the Secretary for approval. 42 U.S.C. §§ 1396(a) (5), 42 C.F.R. §§ 430.10 (1988), 431.11 (1979). The Bureau for Medical Services has done so. **(A.R. 15-16, 132-193).**

Section 1902(a)(30) of the Medicaid Act requires a State plan to meet certain requirements in setting payment amounts to obtain Medicaid care and services. One of these requirements is that payment for care and services under an approved State Medicaid plan be consistent with efficiency, economy, and quality of care. This provision provides authority for specific upper payment limits (UPL) set forth in Federal regulations in 42 C.F.R. § 447 relating to different types of Medicaid covered services. With respect to inpatient hospital services, nursing facility, (NF), services and intermediate care facility services for the mentally retarded, (ICF/MR), upper payment limits are set forth in regulations at 42 C.F.R. § 447.272, “Application of upper payment limits.” This provision limits overall aggregate State payments and aggregate payments to State-operated providers. With respect to outpatient hospital services and clinic services, upper payment limits are set forth in regulations at 42 C.F.R. § 447.321, “Outpatient hospital services and clinic services: Upper limits of payment.” These regulations stipulate that aggregate State payments for services provided by each group of health care facilities, that is, inpatient hospital and outpatient hospital services, NF services, ICF/MR services, and clinic services may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. Federal Financial Participation, (FFP), is not available for state expenditures that exceed the applicable upper payment limit.

The state Medicaid plan must describe the policies and methods to be used to set payment rates for each type of service included in the plan. 42 C.F.R. §§ 430.20, 447.201(b), 447.253, 447.256. Respondent's State Plan does describe its methodology used in setting its rates for each type of service included in its plan. **(A.R. 145-193)**. Section 1396d (a) (1)-(5) requires participating states to provide for inpatient hospital services, outpatient hospital services, other laboratory and x-ray services, skilled nursing facilities, and physicians' services. W.Va. Code § 9-4C-1(c) defines an "inpatient hospital services provider", which Petitioner is, as a provider of inpatient hospital services for purposes of Section 1903(w) of the Social Security Act. The extent of medical assistance provided by the state for each of the services must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). See also 42 U.S.C. § 1396a (a) (10) (1974). A state has broad discretion, however, in developing standards for determining the extent of coverage it will provide in each of the mandatory categories. See *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 2370, 53 L.Ed.2d 464 (1977). Section 1396a(a)(17) requires only that a state plan for medical assistance "include reasonable standards ... for determining ... the extent of medical assistance under the plan which ... are consistent with the objectives of [the Act]." Hospital outpatient services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients by an institution that is licensed as a hospital. See 42 C.F.R. § 440.20(a) (1978).

Once a state establishes the extent of coverage it will provide in each of the mandatory categories, it must determine the rate at which it will reimburse medical providers for the covered services. Section 1396a(a)(13)(A) of the Act requires that state plans provide for payment ... of the hospital, skilled nursing facility, and intermediate care facility services approved under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the

situation of hospitals which serve a disproportionate number of low income patients with special needs...) which the State finds and makes assurance satisfactory to the Secretary, are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality....

Thus, a state plan must provide for reimbursement to hospitals at a rate that:

(1) is determined in accordance with methods and standards developed by the state;

(2) takes into account the situation of hospitals which serve a disproportionate number of low income patients with special needs; (3) is reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities; and (4) assures that eligible Medicaid recipients will have reasonable access to inpatient hospital services of adequate quality. **(A.R. 132-134, 148-193).**

If a state plan comports with the foregoing requirements, along with the other requirements under the Act, the Secretary must approve it. 42 U.S.C. § 1396a (b) (1974); *Arizona State Dep't of Public Welfare v. Dep't of Health Education and Welfare*, 449 F.2d 456, 461 (9th Cir.1971), *cert. denied*, 405 U.S. 919, 92 S.Ct. 945, 30 L.Ed.2d 789 (1972). The Respondents' State Plan meets the above requirements. The U.S. Department of Health and Human Services Secretary has approved the Respondents state plan provision for reimbursement to hospitals, including the methodologies it uses to determine the rates. **(A.R. 148-193)**. Once approved, a state plan is subject to continual scrutiny by the Secretary to ensure continued compliance with federal requirements. *Id.* Amendments to a state plan also must be submitted to the Secretary for review. 42 C.F.R. § 201.3.

Petitioner did not state a claim for relief on this issue in Count VI of its Complaint. Neither the Motion to Dismiss nor its affidavits raised any issue that was outside of the allegations of the Complaint or could not be judicially noticed by the Court. The Conclusions of Law of the trial court on this issue accurately reflect existing law and the trial record. (A.R. 20). The dismissal of Count VI of the Complaint should be affirmed.

7. The trial court did not err in finding that none of the ten Counts of the Complaint could provide relief for Respondents' failure to follow statutory requirements in setting the hospital Medicaid rates.

Respondents incorporate their arguments within Sections 1-6 of this Amended brief.

The Uniform Declaratory Judgments Act found at W. Va. Code § 55-13-1 *et seq.* is a remedial statute with its purpose being to settle and afford relief from uncertainty and insecurity with respect to rights, status and other legal relations. *Shobe v Latimer*, 162 W.Va. 779, 253 S.E.2d 54 (1979); *Farley v. Graney*, 146 W.Va. 22, 119 S.E.2d 833 (1960). However the person seeking the declaratory judgment must have standing to bring the action. *Shobe, Id.* 162 W.Va. at 784, 253 S.E.2d at 58; W.Va. Code § 55-13-2. A justifiable controversy must exist. *Shobe, Id.* 162 W.Va. at 784, 253 S.E.2d at 58; W.Va. Code § 55-13-12. In deciding whether a justifiable controversy exists, a trial court should consider the following factors: (1) whether the claim involves uncertain and contingent events that may not occur at all; (2) whether the claim is dependent upon the facts; (3) whether there is adverseness among the parties; and (4) whether the sought after declaration would be of practical assistance in setting the underlying controversy to rest. F.D. Cleckley, R.J.Davis, L.J. Palmer, Jr., *Litigation Handbook on West Virginia Rules of Civil Procedure*: § 57 (Juris Pub. 2011 Cumm Supp.) It is uncertain that Petitioner is or may lose money based on alleged inadequate reimbursement rates. It is uncertain that eligible Medicaid beneficiaries in Petitioners' service area will not have access to Medicaid services if Petitioner does not receive increased rates for its services.

Petitioners' claim has some dependence upon the facts, but the law controls and neither federal nor state law entitles Petitioner to contest the Medicaid rates it receives via this action. There is adverseness among the parties within this action, but the parties voluntarily entered into an agreement for Petitioner to provide Medicaid hospital services. Respondents do not believe there is any controversy because Petitioner's underlying claim is to increased Medicaid rates, and it has no legal right to challenge those rates.

Count IV of the Complaint sought a declaratory judgment pursuant to W.Va. Code § 29A-4-2, the State Administrative Procedures Act, (APA), that Respondents must follow the standards set forth in W. Va. Code § 16-29B-20. **(A.R. 28)**. The State APA does not apply to the receipt of public assistance, which Respondents' Medicaid Program is. W.Va. Code § 29A-1-3(c) clearly states:

The provisions of this **chapter** do not apply to rules relating to or contested cases involving ... the receipt of public assistances... (emphasis added)

The Complaint alleges that pursuant to 42 U.S.C. § 1396a(a)(30)(A), Respondent's Bureau for Medical Services must pay rates to hospitals that assure equal access to services. **(A.R. 29)**. Petitioner's request in Count IV of its Complaint for a declaration that that the Bureau for Medical Services failed to take into account the unreimbursed cost incurred in treating PEIA patients misreads Section 1396a(a)(30)(A), and frustrates Congress's purpose of giving States wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care. **(A. R. 40)**. There is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs. Section 1396a(a)(30)(A) does not set forth any requirement that a State consider cost incurred in treating Public Employee Insurance Agency, (PEIA), patients. Medicaid is not required to make up any alleged shortfall of PEIA. Nor does state law set forth any such requirement.

Declaratory judgment counts brought pursuant to West Virginia Code § 55-13-2 cannot provide relief because the contract speaks for itself and needs no adjudication. Petitioner

agreed to accept the payment it receives as payment in full. The trial court could not have interpreted the contract otherwise, so there was no relief that could be provided by it.

Many States are facing a new type of litigation from Medicaid providers seeking to use the courts to compel more favorable reimbursement rates. The majority of cases have been brought in federal court under 42 U.S.C. § 1983 alleging implied rights of action or violations of the Supremacy Clause to enforce sections of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, which governs the administration of State Medicaid programs.² This increase of cases comes at a time when most States are facing record deficits, exacerbated by their expanding Medicaid costs. The Complaint in the instant matter attempts to use state law as its vehicle for judicial review of Respondents Medicaid reimbursement rates. But that review cannot be complete without looking to the federal statutes, regulations, and guidance that Respondents and the W.Va. Legislature are mandated to consider in causing implementation of the this federal assistance program. To allow this private litigant to bring such an action because it believes the state has misread federal could devastate the Respondents' financial ability to provide public assistance to its ever-growing Medicaid population in the current economic climate. State Legislators as well as Respondent may lose the ability to respond quickly and innovatively to these changing conditions when their decisions can be second-guessed and enjoined by private Petitioners. Respondent is already capping the number of individuals accepted into its Aged and Disabled Waiver Program.³

Given the contractual nature of federal state programs, the Supreme Court has said that the states may only be bound by requirements that they "voluntarily" and "knowingly" accept. Thus, "if Congress intends to impose a condition on the grant of federal moneys, it must do so

² Eight circuits have considered whether § 1396a(a)(30)(A) may be enforced by Medicaid providers or beneficiaries under § 1983. The First, Second, Third, Fifth, Sixth, Ninth, and Tenth Circuits have concluded that it may not.

³ Ry Rivard, *Tomblin to put brakes on senior program*, Charleston Daily Mail, December 1, 2011; <http://www.dailymail.com/News/statenews/201111300212>.

unambiguously.” *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). That is, courts may not “imply” funding requirements into a federal statute that have not been plainly imposed by Congress. Otherwise, the states could be subject to massive liability based on contractual terms of which the states were unaware when they agreed to partner with the federal government.

The Supreme Court also has said that federal agency oversight, and the withholding of federal funding, rather than private lawsuits, is the typical means for enforcement of Spending Clause statutes. *Pennhurst*, 451 U.S. at 28. However, the court has permitted private parties to invoke the power of the courts to enforce federal statutes in limited circumstances. Among other things, to be able to sue, a private party must be able to demonstrate that Congress intended for such private enforcement and the provision at issue is not so “vague and amorphous,” or policy-driven, as to strain judicial competence, See generally *Gonzaga Univ. v. Doe*. 536 U.S. 273 (2003). (The Court found that a student could not enforce the provisions of the Family Educational Rights and Privacy Act, (FERPA), under section 1983).

Throughout the Complaint there are allegations that Respondents violate state law by not reimbursing Petitioner enough to meet its costs in providing hospital inpatient services, yet Petitioner admits that ...”federal law imposes certain requirements or guidelines with which the states must comply”, citing 42 U.S.C. § 1396a(a)(30)(A). **(A.R. 29, 134)**. Respondents agree. **(A.R. 134)**. This Equal Access Provision indeed requires state Medicaid programs to pay rates to hospitals that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are accessible to recipients of Medicaid. However, Petitioner is not the only acute care hospital in Beckley, WV that provides inpatient services. There are several others. **(A.R. 147, 161)**. Additionally, Petitioner, by its own admission is not a “safety net” hospital stating “...BARH meets all these qualifications except Qualification d”. **(A.R. 41-42)**.

Congress has explicitly addressed Medicaid rate-setting provisions. Before 1981, States were required to pay rates for hospital and long term care services that were directly related to cost reimbursement. To obtain approval from CMS,⁴ many States set rates using Medicare reasonable cost payment principles. In 1980 and 1981, the Congress enacted legislation, at section 962 of the Omnibus Reconciliation Act of 1980 (OBRA '80), Pub. L. 96-499 and section 2173 of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81), Pub. L. 97-35, collectively known as the "Boren Amendment" that amended section 1902(a)(13) of the Act to give States flexibility to deviate from Medicare's cost payment principles in setting payment rates for hospital and long term care services. Respondents set their rates using Medicare's cost payment principles and this action has been approved by its federal partner, CMS. **(A.R. 146, 150-193).**

Medicaid beneficiaries and health care providers began suing States under 42 U.S.C. § 1983 seeking to challenge what they thought were inadequate Medicaid reimbursement rates. The Supreme Court evaluated whether the Boren amendment could be privately enforced under section 1983 in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990). In *Wilder*, the State of Virginia cut its Medicaid reimbursement rates and an association of hospitals filed suit, claiming the rates were unreasonable and inadequate in violation of the Boren amendment. It used a three-part test formulated by the Court in *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989) to determine whether a statute creates enforceable rights. Under this test, a statute will not be found to have created an enforceable right unless (1) the provision in question is intended to benefit the Petitioner; (2) the provision imposes a binding obligation of the state; and (3) the right is not so vague that courts are unable to enforce it. Applying the test in *Wilder*, the Supreme Court concluded the hospital association could bring a private action under section 1983. However, when Congress

⁴ In the 80's, CMS was call the Healthcare Finance Administration, or "HCFA".

repealed the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), via the Balanced Budget Act of 1997, Pub. L. 105-33, § 4711(a)(1), 111 Stat. 251, 507-08 (1997), it expressly stated its intent not to create a cause of action:

Under the so-called Boren Amendment, States are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are “reasonable and adequate” to cover the costs which must be incurred by “efficiently and economically operated facilities.” A number of Federal courts have ruled that State systems failed to meet the test of “reasonableness” and some States have had to increase payments to these providers as a result of these judicial interpretations.

Section 3411 repeals the Boren Amendment and establishes a public notice process for setting payment rates for hospitals, nursing facilities, and ICFs/MR...

It is the Committee’s intention that, following enactment of this Act, *neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.* [H.R. REP. NO. 105-149, at 1230 (1997) (emphasis added).]

The repeal of the Boren amendment left the equal access provision as the primary federal guideline for challenging Medicaid reimbursement rates. See, *In re: NYAHSa Litigation*, N.D.N.Y. 2004, 318 F.Supp.2d 30, affirmed 444 F.3d 147. In its Brief for the United States as *Amicus Curiae* Supporting the California Department of Health Care Services, the Solicitor General argues “...the focus of [the equal access provision] is on the availability of services rather than meeting providers’ costs.” Brief for the United States as *Amicus Curiae*, *Maxwell-Jolly v. Independent Living Center of California*, 131 S. Ct. 992 (No. 09-958) at 9.⁵ In the later

⁵ The Supreme Court remanded the *Maxwell-Jolly* case to the Ninth Trial court of Appeals. “Together with No. 09–1158, *Douglas, Director, California Department of Health Care Services v. California Pharmacists Association et al.*, *Douglas, Director, California Department of Health Care Services v. California Hospital Association et al.* (see this Court’s Rule 12.4), *Douglas, Director, California Department of Health Care Services v. Independent Living Center of Southern California, Inc., et al.* (see this Court’s Rule 12.4)(previously the *Maxwell-Jolly v. Independent Living* case), *Douglas, Director, California Department of Health Care Services v. Dominguez, By and Through her Mother and Next Friend Brown, et al.* (see this Court’s Rule 12.4); and No. 10–283, *Douglas, Director, California Department of Health Care Services v. Santa Rosa Memorial Hospital et al.*, also on certiorari to the same court.

The Court stated, “After California enacted three statutes reducing the State’s payments to various Medicaid providers, the State submitted plan amendments to CMS. Before the agency finished its review, Medicaid providers and beneficiaries sought, in a series of cases, to enjoin the rate reductions on the ground that they were pre-empted by federal Medicaid law. In seven decisions, the Ninth Circuit ultimately affirmed or ordered preliminary injunctions preventing the State from implementing its statutes. The court

decision, *Gonzaga University, Id.*, the Court further restricted the ability to bring an action under 1983. Since the holding in *Gonzaga*, most appellate courts have held that the equal access provision is not privately enforceable under section 1983.⁶ Petitioners' argument that because the Legislature did not strike Boren Amendment language from the Medicaid reimbursement provisions of the State Code, it still is the state standard, is without merit.

WV Medicaid reimbursement methodology is addressed at W. Va. Code § 9-5-16(a) which states:

It is the purpose of the Legislature in enacting this section 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 will full consideration of adequate and reasonable compensation to such health care providers for the costs of providing such services.

Respondents have developed reimbursement methodologies and systems for all health care providers reimbursed under the Medicaid program in its entirety within its budgetary

(1) held that the providers and beneficiaries could bring a Supremacy Clause action; (2) essentially accepted their claim that the State did not show that its amended plan would provide sufficient services; (3) held that the amendments thus conflicted with §1396a(a)(30)(A); and (4) held that the federal statute pre-empted the new state laws. In the meantime, agency officials disapproved the amendments, and California sought further administrative review. The cases were in this posture when the Court granted certiorari to decide whether respondents could mount a Supremacy Clause challenge. After oral argument, CMS approved several of the State's amendments, and the State withdrew its requests for approval of the remainder.

Held: The judgments are vacated and the cases are remanded, thereby permitting the parties to argue before the Ninth Circuit in the first instance the question whether respondents may maintain Supremacy Clause actions now that CMS has approved the state statutes. Pp.5–8.”

⁶See, e.g., *Equal Access for El Paso Inc. v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007), cert. denied, 2008 U.S. LEXIS 7278 (Oct. 6, 2008) (“The Medicaid Act’s Equal Access provision ... does not confer individual private rights that are enforceable under § 1983.”); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (“We join the First, Sixth, and Ninth Circuits in concluding that [the equal access provision] does not create a federal right enforceable under § 1983.”); *Westside Mothers v. Olszewski (Westside Mothers II)*, 454 F.3d 532, 543 (6th Cir. 2006) (“[W]e are not persuaded that Congress has, with a clear voice, intended to create an individual right that either Medicaid recipients or providers would be able to enforce under § 1983... We therefore hold that § 1396a(a)(30) does not confer enforceable rights...”); *Sanchez ex rel. Hoebel v. Johnson*, 416 F.3d 1051, 1059-60 (9th Cir. 2005) (same). *But see Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (finding equal access provision created an enforceable private right for recipients and providers).

constraints and in compliance with federal standards, which includes hospital services reimbursement. **(A.R. 132-134).**

Article 3 § 9 of the WV Constitution reads in part that “Private property shall not be taken or damaged for public use, without just compensation...” Petitioner alleged that Respondents’ reimbursement rates are so low as to be confiscatory in nature. **(A.R. 40-41).** Petitioner further alleged that due to its status as a not-for-profit and other laws such as Emergency Medical Treatment and Active Labor Act, (“EMTALA”) and Section 9007 of the Patient Protection and Affordable Care Act, (PPACA) *PL 111-148 March 23, 2010, 124 Stat 119* requiring it to treat Medicaid, low-income and indigent patients, inadequate Medicaid rates disproportionately affect Petitioner due to the large percentage of Medicaid patients it treats. **(A.R. 40-41).** The Respondents have no authority or control over the Administration of the EMTALA or the PPACA. This case is about WV Medicaid reimbursement rates for inpatient hospital services for Medicaid eligible patients. The impact of other federal requirements on the operating costs of Petitioner cannot be held to be the basis of a claim against Respondents. There is another inpatient hospital service provider within the region that Petitioner serves which continues to treat Medicaid patients and accept Medicaid reimbursement. Medicaid patients in Petitioners’ service area will not be without access to Medicaid in-patient hospital services. **(A.R. 145-147).** No federal law allows private individuals to sue states to enforce the standard that Medicaid rates must be “sufficient to enlist enough providers” so that Medicaid recipients have access to care to the same extent as the general population in an area. No state law allows Petitioner to sue Respondents to enforce the standard that Medicaid rates must be “sufficient to enlist enough providers” so that Medicaid recipients have access to care to the same extent as the general population in an area. Federal and State health officials have “exclusive responsibility” for ensuring state compliance with equal access requirements, and Federal health officials can cut off Respondents’ Medicaid money if it believes Respondents

have not complied. The Medicaid law's promise of equal access to care is "broad and nonspecific," and federal and state health officials are better equipped than judges to balance that goal with other policy objectives, like holding down costs.

The fact that Petitioner may have made business decisions which have resulted in costs above what it is able to claim as a Medicaid reimbursable cost does not transform Respondents' method of calculating Medicaid reimbursement rates into a violation of Article 3 § 9 of the WV Constitution. As a matter of law, Petitioner is free to pursue its mission to "not turn away Medicaid patients or other low income or needy patients who lack the financial resources needed to pay for medical services" in whatever manner and by whatever means it chooses. Of course, economic realities may limit its options as a practical matter, but economic pressures are not the same as legal compulsion, which is necessary to support a claim of unconstitutional taking. See *Garelick v. Sullivan*, 987 F.2d 913, 917-918 (2d Cir.), cert. denied, 510 U.S. 821, 114 S.Ct. 78, 126 L.Ed.2d 47 (1993) ("A property owner must be legally compelled to engage in price-regulated activity for regulations to give rise to a taking"); *Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Dept of Pub. Welfare*, 742 F.2d at 446 (participation is voluntary despite "business realities" and "strong financial inducement"). Petitioner is a voluntary Medicaid provider. Petitioner must tighten its belt as the Respondents, and all providers of Medicaid services have. See, Syllabus Point 2 *Bowen v. Gilliard*, 483 U.S. 587, 107 S.Ct. 3008 (1987).

The "intricacies of Medicaid reimbursement" are well known by Respondent, and they have followed statutory and regulatory standards. The trial court was not "too hasty in dismissing this case". Congress has chosen to ensure state compliance with federal requirements in large federal-state programs such as Medicaid by federal agency oversight. Federal agency oversight, rather than private litigation, ensures the type of consistent and uniform interpretation of federal laws that states require when they administer complex

programs.

Respondent's Motion to Dismiss or its affidavits do not raise any issue that is outside of the allegations of the Complaint at Count IV or V, or could not be judicially noticed by the Court. The conclusions of law of the trial court on the issues of these counts of the Complaint accurately reflect existing law and the trial record. The dismissal of Counts IV and V of the Complaint should be affirmed. The trial court order correctly concluded that there were no claims for the relief requested under the due process or equal protection provisions of the State Constitution. **(A.R. 19, 20).**

8. The trial court did not apply the wrong standards in dismissing the Complaint under 12(b)(6) of the WV Rules of Civil Procedure.

This Court has defined the scope of appellate review of a trial court order as follows:

In reviewing challenges to the findings and conclusions of the trial court, we apply a two-prong deferential standard of review. We review the final order and the ultimate disposition under an abuse of discretion standard, and we review the trial court's underlying factual findings under a clearly erroneous standard. Questions of law are subject to a *de novo* review.

In re: E.B., A Minor, --- S.E.2d ----, 2012 WL 2368978 (W.Va.), Med & Med GD (CCH) P 304,061.

The standard of appellate review from an order dismissing a claim under rule 12(b)(6) is *de novo*. See, *Bowers v. Wurzburg*, 205 W.Va. 450, 519 S.E.2d 148 (1999). The controlling principal of law on appeal, as at the trial court level, is that a Complaint should not be dismissed unless it appears beyond doubt that the Petitioner can prove no set of facts in support of the claim which would entitle him/her to relief. See, *Conrad v ARA Szabo*, 198 W.Va. 362, 480 S.E.2d 801 (1996). The Court may consider judicially noticed documents without converting a Motion to Dismiss into a motion for summary judgment. *520 South Michigan Ave. Associates, Ltd. V. Shannon*, 549 F.3d 1119 (7th Cir. 2008). This Court stated in *Dimon v. Mansy* that "the singular purpose of a Rule 12(b)(6) motion is to seek a determination whether the Petitioner is

entitled to offer evidence to support the claims made in the Complaint.” *Dimon v Mansy*, 198 W.Va. 40, 479 S.E.2d 339 (1996).

For purposes of this Motion to Dismiss, the Complaint must be construed in the light most favorable to the party making the claim and essentially the court's inquiry is directed to whether the allegations constitute a statement of a claim under WV Rules Civ. Proc., Rule 8(a). Under WV Rule of Civil Procedure 8(a) (1), a pleading must contain a “short and plain statement of the claim showing that the pleader is entitled to relief.” Although entitlement to relief must be shown, a Petitioner is not required to set out facts upon which the claim is based.

Justice Cleckley, writing for the majority in *Scott Runyan Pontiac-Buick, Inc.*, stated: 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 intelligibly sufficient for a trial 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 Petitioner is not required to set out facts upon which the claim is based. *State ex rel. McGraw v. Scott Runyan Pontiac-Buick*, 194 W.Va. 770, 776, 461 S.E.2d 516, 522 (1995). Petitioner has not alleged a valid claim. Under West Virginia law, this Court has not adopted the more stringent federal pleading requirements as adopted in *Bell Atlantic Corporation v. Twombly*, 550 U.S. 544, 127 S.Ct. 1955 (2007) and *Ashcroft v. Iqbal*, 556 U.S. 662, 129 S.Ct. 1937, (2009), and all that is required by a Petitioner is “fair notice.” *Scott Runyan Pontiac-Buick, Id.* at 194 W.Va. at 776, 461 S.E.2d at 522; *see also Roth v. DeFelicecare, Inc.* 226 W.Va. 214, 220, 700 S.E.2d 183, 189 Nevertheless, this Court also held in *Scott Runyan Pontiac-Buick*, despite the allowance in Rule 8(a) that the Petitioner’s statement of the claim be “short and plain,” a Petitioner may not “fumble around searching for a meritorious claim within the elastic boundaries of a barebones Complaint [,]” or where the claim is not authorized by the laws of West Virginia. *See Chaveriat v. Williams Pipeline Co.*, 11 F.3d 1420, 1430 (7th Cir. 1993). Petitioner executed an agreement

stipulating that it would accept the reimbursement rate set by the Respondents. A Motion to Dismiss under Rule 12(b)(6) enables a trial court to weed out unfounded suits. *State ex rel. McGraw v. Scott Runyan Pontiac-Buick*, 194 W.Va. 770, 766, 461 S.E.2d 516, 522 (1995). It appears this Court somewhat agrees with portions of the *Twombly* holding that the Rule 8 standard demands more than an unadorned, the-Respondent-unlawfully-harmed-me accusation. *Bell Atlantic Corporation v. Twombly*, 550 U.S. 544, 555, 127 S.Ct. 1955 (2007).

This Court has recognized that a motion under Rule 12(b)(6) should be viewed with disfavor and rarely granted. *Cantley v. Lincoln County Commission*, 221 W.Va. 468, 655 S.E.2d 490 (2007)(per curium). On a Motion to Dismiss, the Complaint is construed in the light most favorable to the Petitioner. The purpose of a motion under Rule 12(b)(6) is to test the formal sufficiency of the statement of the claim for relief; it is not a procedure for resolving a contest about the facts or the merits of the case. 5A C. Wright & A. Miller, *Federal Practice and Procedure: Civil 2d* § 1356 (1990). Petitioner has not alleged any claims upon which relief may be granted.

Whether a Complaint states a claim upon which relief may be granted is to be determined solely from the provisions of such Complaint. Only matters contained in the pleading can be considered on a Motion to Dismiss under Rule 12(b)(6). *Chapman v. Kane Transf. Co.*, 160 W.Va. 530, 236 S.E.2d 207 (1977). *Blacks Law Dictionary, 9th Ed.*, (2004) defines “pleading” as a formal document in which a party to a legal proceeding (esp. a civil lawsuit) sets forth or responds to allegations, claims, denials, or defenses.

However, a court may consider, in addition to the pleadings, documents annexed to it, and other materials fairly incorporated within it. This sometimes includes documents referred to in the Complaint but not annexed to it. Further, Rule 12(b)(6) permits courts to consider matters that are susceptible to judicial notice. When a Complaint annexes and incorporates by reference a written instrument, any inconsistencies between the Complaint and the instrument

must be resolved in favor of the later. *Arruda v. Sears, Roebuck & Co.*, 310 F.3d 13 (1st Cir. 2002). That is, where an exhibit and the Complaint conflict, the exhibit typically controls. A court is not bound by the party's characterization of an exhibit and may independently examine and form its own opinions about the document. *Forrest v. Universal Savings Bank*, 507 F.3d 540 (7th Cir. 2007). Petitioner executed the Medicaid provider agreement accepting Respondent's rate of reimbursement for Medicaid services. **(A.R. 135-143)**. Respondents did not need to contest Petitioners' detailed numbers claimed allegedly demonstrating its Medicaid loses because Petitioner has no right to contest the Medicaid rates of reimbursements in this venue.

The Supreme Court has held that when a Petitioner opposes a Motion to Dismiss under Rule 12(b)(6) and claims that discovery would enable him/her to oppose such a motion, the Petitioner may request a continuance for further discovery pursuant to Rule 56(f). In order to obtain such a discovery continuance, a Petitioner must, at a minimum, (1) articulate some plausible basis for the Petitioner's belief that specified discoverable material facts likely exist which have not yet become accessible to the Petitioner; (2) demonstrate some realistic prospect that the material facts can be obtained within a reasonable additional time period; (3) demonstrate that the material facts will, if obtained, suffice to engender an issue both genuine and material; and (4) demonstrate good cause for failure to have conducted discovery earlier. *Harrison v. Davis*, 197 W.Va. 651, 478 S.E.2d 104 (1996). Petitioner did not request a continuance for further discovery pursuant to Rule 56(f). Although the discovery process may be available to enable a Petitioner to uncover evidence that may support the allegations set forth in a Complaint, where the allegations are merely conclusions, a court is not required to assume that a Petitioner can prove facts not alleged in deciding a Motion to Dismiss for failure to state claim. *Evancho v. Fisher*, 423 F.3d 347 (3d cir. 2005). A trial court's order may reference to material outside of the pleadings solely to provide background information, without

having to convert the motion to summary judgment, so long as the order does not demonstrate a legal reliance on the information. *Knighton v. Merscorp Inc.*, 2008 WL 5352004 (5th Cir.). See, *Hayden v County of Nassau*, 180 F.3d 42 (2d Cir. 1999) (“Where ... the court simply refers to supplementary materials, but does not rely on them or use them as a basis for its decision, the 12(b)(6) motion is not converted into a motion for summary judgment.”). See, also, F.D. Cleckley, R.J. Davis, L.J. Palmer, Jr., *Litigation Handbook on West Virginia Rules of Civil Procedure: § 12(b)(6)* (Juris Pub.2011 Cumm Supp.)

9. The trial court did not misapply WV Rules of Civil Procedure 12(b)(6), did not consider matters outside the pleadings, and did not convert Respondents Motion to Dismiss into one for Summary Judgment.

The trial court did not misapply WV RCP 12(b)(6) by considering matters outside of the pleadings, thereby converting the Motion to Dismiss into a Motion for Summary Judgment. The affidavits submitted with Respondents Motion to Dismiss did not contain matters outside the pleadings. Petitioner points to no specific statement or document filed by Respondent that contains matters outside the pleadings. Petitioner merely makes conclusory allegations that such is the case. Unlike the *Bd. Of Educ. Of Ohio County* and *Elliot* cases cited by Petitioner, the trial court did not award summary judgment prior to any discovery being had. Petitioner’s Brief, p. 37.

Because the affidavits did not contain matters outside the pleadings, the proceedings did not become one for summary judgment. Because the proceedings did not become one for summary judgment, but remained a proceeding for Motion to Dismiss for failure to state a claim upon which relief can be granted, the court did not have to determine whether there was a genuine issue for trial.

IV. CONCLUSION

Medicaid is a complex and regulated program which Respondents have implemented with the approval of their federal partner. Respondents' Motion to Dismiss for failure to state a claim upon which relief could be granted was properly granted due to (1) the allegations within the Complaint amounting to legal conclusions, rather than allegations of fact; (2) mandamus being a remedy for administrative inaction and not available where action has already been taken, and does not provide a vehicle for judicial review of the rates set by Respondents; (3) a contractual claim does not arise under a statute unless the Legislature explicitly expresses to waive sovereign immunity and create a contractual remedy; and (4) verbatim adoption of proposed findings and conclusions of law prepared by one party does not constitute reversible error, and may be reversed only if findings adopted by the court inaccurately reflect the existing law and the trial record.

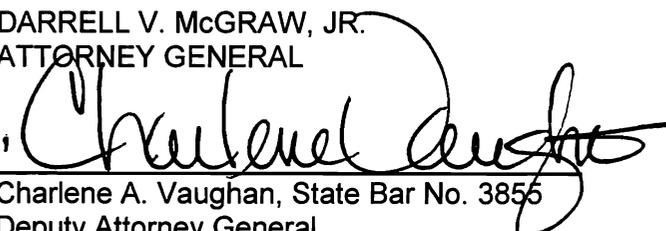
Respondents' pray this Court affirm the trial court Order granting their Motion to Dismiss this action for failure to state claims upon which relief may be granted.

Respectfully submitted,

West Virginia Department of
Health and Human Resources, et al

By Counsel

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DOCKET NO. 11-1187

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

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,

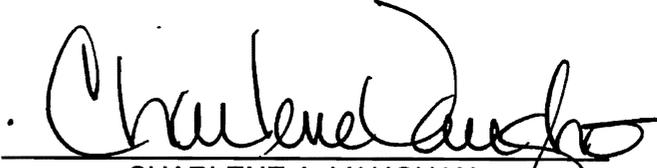
Defendants Below, Respondents.

CERTIFICATE OF SERVICE

I, Charlene A. Vaughan, Deputy Attorney General and counsel for the Defendants, West Virginia Department of Health and Human Resources, et al., do hereby certify that I filed the foregoing **RESPONDENT'S AMENDED BRIEF** with the Clerk of the Supreme Court of Appeals of West Virginia, by hand delivery and mailed a copy of all documents to the following on this the 2nd day of August, 2012.

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