

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET No. 15-0595

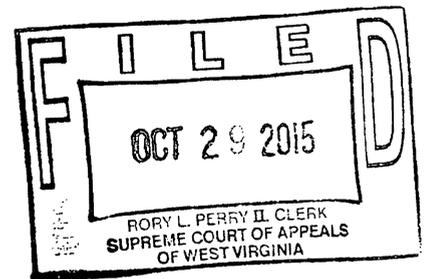
**HEARTLAND OF BECKLEY WV, LLC
HEARTLAND OF CLARKSBURG WV, LLC
HEARTLAND OF MARTINSBURG WV, LLC
HEARTLAND OF RAINELLE WV, LLC
HEARTLAND-PRESTONCOUNTY OF KINGWOOD, LLC
HEALTH CARE and RETIREMENTCORPORATION OF AMERICA, LLC
d/b/a HEARTLAND OF CHARLESTON,**

Petitioners,

v.

BUREAU FOR MEDICAL SERVICES,

Respondent.



RESPONSE BRIEF

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INTRODUCTION

In their *Brief*, the Petitioners, Heartland of Beckley WV, LLC, Heartland of Clarksburg WV, LLC, Heartland of Martinsburg WV, LLC, Heartland of Rainelle WV, LLC, Heartland-Preston County of Kingwood, LLC and Health Care and Retirement, d/b/a Heartland of Charleston (hereinafter referred to as “HCR”), continue to ignore the relevant issue in this case: the reasonableness of the rates HCR asks this Court to set for the West Virginia Medicaid program. HCR seeks to include millions of dollars of negligence claims in the rates to be paid by West Virginia. The Bureau for Medical Services (hereinafter referred to as “BMS”), as the single state agency administering the West Virginia Medicaid program, has the duty pursuant to federal law to ensure the rates are reasonable. 42 C.F.R. §447.253(b)(1)(i). The unrefuted evidence at the hearing demonstrates these paid settlement claims did not result in reasonable rates.¹ Likewise, nowhere in its brief does HCR address the reasonableness of the rates it urges this court to adopt. Instead, HCR ignores federal law and continues to mischaracterize the facts of the case while maintaining it is the victim of new policies and should be able to pass all its costs, regardless of amount or effect on the rates, onto the taxpayers of West Virginia.²

STATEMENT OF THE CASE

HCR ManorCare owns and operates nursing home facilities in several states, including West Virginia. BMS is the single state agency administering the Medicaid program in West Virginia. W. Va. Code § 9-1-2(n). “Medicaid is a cooperative federal-state program in which

¹ At the hearing, HCR did not argue the reasonableness of the rates, but did present testimony that it was reasonable to pass the costs of their negligence claims made against HCR onto the West Virginia Medicaid program as the cost of doing business given the current state of the tort system in West Virginia. AR 204-205.

² At the hearing, HCR also claimed to be a victim of the West Virginia tort system (AR 192-197), predatory law firms (AR 191-193) and plaintiffs’ attorneys’ characterization of HCR as a “large company that prizes profits over people.” AR 192-193. In particular, HCR was concerned about a \$94 million verdict, including \$80 million worth of punitive damages, against the HCR of Charleston facility.

the federal government provides financial assistance to the states. Participating states match federal funds with state funds and use this money to administer each state's Medicaid program." *Appalachian Regional Healthcare, Inc. v. WVDHHR, et. al.*, 232 W. Va. 388, 391, 752 S.E.2d 419, 422 (2013). The funds are paid directly to Medicaid providers for providing Medicaid services to the indigent and disabled in the state, including nursing home services.

The rates paid to the nursing home facilities are calculated every six months by the Office of Accountability and Management Reporting (OAMR). 42 C.F.R. § 447.253(b)(1) requires:

[t]he Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

In setting rates, there are two 6 month cost reports submitted a year; the first is January-June and the second is July-December. (AR 64-65.) The January- June cost report produces the rate used for the October-March rate period and the July-December cost report produces rates used for the April-September rate period. (AR 64-65.) These rates are often referred to as the June and December cost reports. (AR 65.) Since West Virginia nursing homes bill a month in arrears, the October- March rates are not used until November 1, so the rates are set by the third week in October while the July-December rates are not used until May 1 and thus are set by the third week in April. (AR 69-70.)

In determining the rates, the nursing homes are divided into large bed facilities, those with more than 91 beds, and small facilities, those with 90 or less beds. (AR 61.) The per diem is calculated for each facility by dividing the total allowable costs by the total patient days. (AR 61.) The per diems are arrayed from high to low and the 90th percentile is calculated. (AR 61.) The 90th percentile becomes the CAP. (AR 61.)

As Lane Ellis, HCR's accountant and expert witness, acknowledged, the CAP is designed to monitor costs when he testified, "The purpose of the CAP is to put... ceilings and monitor

costs... from the State's perspective to determine what's a reasonable and allowable cost. That's a part of the system. That's the way the system works." (AR 304.)

The rates being appealed in this litigation are related to the January 1, 2012- June 30, 2012 cost report. (AR 74.) But OAMR had concerns about HCR's cost reports prior to the June 2012, cost report. (AR 59.) In the periods prior to the June 2012, cost report, OAMR noticed that HCR was driving the CAPS and as rates started to become unreasonable, OAMR began investigating what was impacting the rates. (AR 80.)

I. January 1, 2010- June 30, 2010 cost reports

Based on the cost reports submitted by HCR for the January 1, 2010- June 30, 2010, period, HCR was driving the CAP; in other words, HCR's expenses were higher than the other facilities. (AR 60-62.) After the cost reports were submitted, the costs were subject to a desk audit. (AR 61.)

HCR had one facility in the small bed group and six facilities in the large bed group. HCR's large bed facilities were in the top nine per diems, specifically, in the third, fourth, fifth, sixth, eighth and ninth positions. The CAP was set with positions six and seven. Therefore, HCR helped set the CAP for the large bed group for the January 1, 2010- June 30, 2010, cost report period. (AR 61-62, 429.)

II. July 1, 2010- December 31, 2010 cost reports

When the July 1, 2010- December 31, 2010, cost reports were submitted, OAMR noticed an increase in the liability expense and realized HCR made an adjustment that affected the whole year not just the relevant 6 month period. This adjustment was an attempt to true up the actual expenses, but it was for the entire year not just the 6 month period. (AR 73.) Therefore, HCR reported total expenses of \$37,652,429 for that period and total claims for \$36,977,000. (AR 430.) This was a significant increase over previous cost reports. (AR 73, 430.) OAMR

requested additional information, but it wasn't received in time to be included; therefore, HCR was excluded from the CAPS for that period. (AR 68-69, 429-430.)

Significantly, the CAPS decreased for that time period when HCR was excluded. (AR 70-71, 429.)

III. January 1, 2011- June 30, 2011 cost reports

The caps increased when HCR was included in the cap calculations for the January 1, 2011- June 30, 2011, cost reports. (AR 71, 429.)

IV. July 1, 2011- December 31, 2011 cost reports

When the July 1, 2011- December 31, 2011, cost reports were submitted, OAMR discovered HCR had again included expenses for the entire year not just the relevant 6 month period. (AR 72, 429-430.) HCR had accrued approximately \$6,000,000 a month until December, when there was an increase to \$18,000,000. (AR 72, 429-430.) An adjustment was made to the total expenses, but HCR was still included in the CAPS. (AR 72, 429.)

The CAPS for the large bed facilities increased 38%, even with an adjustment to HCR's expenses, and the small bed facilities increased 3.9%. (AR 429.)

V. January 1, 2012- June 30, 2012 cost reports- Basis for Appeal

These are the rates being appealed. When the cost reports were submitted, OAMR again noticed HCR was driving the CAPS in setting the rates. (AR 74.) By the time the rates were being set based on the January 1, 2012- June 30, 2012 cost reports, the expenses submitted by HCR drove the rates up so high they were no longer reasonable and adequate to meet the costs of an efficiently and economically operated provider. (AR 80.) After investigating HCR's expenses further, OAMR discovered HCR was including paid settlement claims in their expenses and passing the cost of their negligence on to the West Virginia Medicaid program. (AR 78.) OAMR disallowed these expenses and set rates which were reasonable and adequate to meet the costs of an efficiently and economically operated provider. (AR 37-41, 435-439.)

Specifically, when the cost reports were submitted for the January 1, 2012- June 30, 2012 period, HCR's liability expenses had increased. (AR 74, 429-430.)

Unlike the previous periods, HCR made a 6 month adjustment to their accruals rather than waiting until the end of the year. (AR 76, 430.) But the expenses increased from about \$6.5 million a month to \$33 million for the month of June 2012. (AR 76, 430.)

OAMR asked HCR to explain the increase. (AR 74-75.) HCR submitted additional documentation. (AR 74-77, 431.)

Based on the documentation, OAMR realized HCR was including paid liability claims in the liability insurance expenses included in the cost reports when documentation regarding settlements was submitted. (AR 78, 432.) Medicaid can only pay for patient related care expense and medically necessary expense. (AR 78-79.) Therefore, the cost of settlements, including those for the negligence of HCR in patient care, is not reimbursable by the West Virginia Medicaid program. (AR 79.)

The deadline for setting the rates using these cost reports was looming and OAMR had to find a way to remove the settlement costs. (AR 81-82.) Ms. Jeanne Snow, Director of Rate Setting for OMAR developed a calculation to estimate and remove the settlement costs from the cost reports. (AR 81-84, 434-437.)

Ms. Snow's methodology for removing the costs was very accurate. While preparing for this litigation, Ms. Snow received information from HCR regarding the actual paid claims. (AR 94-99.) When the rates were calculated using the actual numbers, the rates were very close to Ms. Snow's calculation. However, the initial rates Ms. Snow calculated using her estimation were actually more favorable to HCR. (AR 94-99, 443-468.) The more favorable rates were the rates which were paid to HCR for the October 2012- April 2013 rate period. (AR 97.)

The amount removed from the rate calculation was \$53,285,372 at the corporate level. This resulted in a disallowance percentage of 81.23%, which was applied to the individual facilities. (AR 84-85, 436-437.)

Also, while preparing for litigation, Ms. Snow discovered HCR did have liability insurance for claims over \$10 million. (AR 99.)

Once the settlement costs were excluded from the taxes and insurance, HCR was still included in calculating the CAP. (AR 90.) When the CAP was calculated for the large bed group before HCR's settlement costs were excluded from the taxes and insurance, the CAP was \$60.60, and HCR's six large bed facilities occupied the top six spots. (AR 86, 438.) After they were removed, the CAP for the large bed group decreased to \$25.27 and HCR's six facilities were 49th, 48th, 43rd, 42nd, 38th, and 36th. (AR 87, 438.)

This CAP is comparable to CAPS for prior periods: The June 2010 CAP was \$27.82; the December 2010 CAP was \$25.32; the June 2011 CAP was \$28.31. Even the December 2011 CAP of \$39.07 was more than \$20 less than the \$60.60 CAP if the settlement costs hadn't been excluded. (AR 429, 438.)

Before the settlement expenses were excluded, the cost per bed for Heartland of Beckley, one of the large bed facilities, was \$8,087. (AR 90.) The cost per bed for the highest non HCR facility in the large bed group was \$2,367. (AR 90.) After the settlements were removed, the cost per bed for the Heartland of Beckley facility was reduced to \$1,518. (AR 90.)

The small bed group CAP was unaffected by removing the settlement costs as HCR only had one facility in this category. (AR 88-89.) However, before the settlements were excluded, HCR's per diem was the highest for this category and was nearly \$40.00 higher than per diem cost for the number two facility. (AR 439.)

When comparing the liability insurance reported by the large bed group, HCR again had the top six positions. (AR 91, 440.) The Heartland of Beckley facility reported the highest

liability insurance with approximately \$1.6 million. (AR 92, 440.) The Heartland of Clarksburg facility reported the sixth highest liability insurance at just below \$1 million. (AR 440.) The amounts reported for the other HCR large bed facilities were between these amounts. (AR 91, 440.)

The highest non-HCR facility reported liability insurance of \$284,064. (AR 92-93, 440.)

For the small bed group, the Heartland of Rainelle facility had the highest reported liability insurance at nearly half a million dollars. (AR 441.) The second highest facility was a non-HCR facility with reported liability insurance of just under \$100,000. (AR 441.)

The total amount claimed for liability insurance for the 51 facilities in the “large bed group” was \$11, 203,875. Of that amount, the **6 HCR facilities** reported \$7,024,330 or **62.5%** of the total amount. The remaining **45 facilities** totaled \$4,215,545 or **37.5%**. This clearly demonstrates the amounts reported by the HCR facilities are unreasonable. (AR 440.)

HCR presented evidence that West Virginia has the second highest loss rate among the profiled states. (AR 196-197, 441.) HCR does not accept any responsibility for the contributions its own negligence has made to this trend of higher liability expenses. First, HCR’s reported liability costs were as high as \$1.3 million dollars greater than those reported by other large bed homes. (AR 440.) Second, a jury returned a verdict for \$94 million against HCR for negligence at a facility in Charleston. This verdict included \$80 million in punitive damages. (AR 199.) Clearly, HCR is contributing to the loss rate in West Virginia.

According to HCR’s General Counsel, HCR’s liability costs are attributable to the fact HCR is an attractive defendant and plaintiff’s attorneys have gotten less reasonable than they ever were. (AR 192-193.) At no point has HCR acknowledged any fault in contributing to these unreasonable liability costs. HCR simply believes these liability costs are a cost of doing business to be passed onto the West Virginia Medicaid program. (AR 204-205.)

HCR's General Counsel testified it is reasonable for HCR to pass the costs of its negligence onto the West Virginia Medicaid program. (AR 204-205.) However, BMS, as the single state agency administering the West Virginia Medicaid program, has an obligation to ensure the rates are reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated provider. The cost reports submitted by HCR did not result in rates that were reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated provider. (AR 86.)

HCR argues they have always included settlement expenses in their cost reports and therefore, should be allowed to continue to do so. (AR 215-216, 316-317.) However, once OAMR recognized HCR was including paid settlement claims in the cost report, those expenses were removed.

HCR argues the regulations have changed. (AR 215-216.) That is incorrect. (AR 78-79.) Federal regulations have always required BMS to pay rates that are reasonable and adequate.

VI. THE TWO PRIOR HEARINGS

On June 17, 2013, the Bureau for Medical Services (BMS), issued a decision in this case to disallow costs from Petitioners' (HCR) cost reports. A hearing was requested by HCR a month later. The administrative hearing was held on January 17, 2014, before Administrative Law Judge Jeffrey Blaydes. After an extensive briefing process, the ALJ issued a recommended decision on September 3, 2014. The decision, which upheld the agency action, was adopted by the Bureau for Medical Services (BMS) on September 8, 2014. Only then, on November 25, 2014, did HCR send a Freedom of Information Act (FOIA) request to BMS.³ The circuit court also set a briefing schedule and scheduled a hearing. Counsel for HCR even requested a

³ "Generally, there is no constitutional right to pre-hearing discovery in administrative proceedings." *State ex rel. Hoover v. Smith*, 198 W.Va. 507, 482 S.E.2d 124 (1997). However, information is obtainable pursuant to the Freedom of Information Act.

continuance of the hearing. At the circuit court hearing on April 9, 2015, counsel responded inaccurately to the Court's questions regarding whether other facilities were allowed to include these costs. Only after counsel could not cite record on this issue, did HCR make a request for discovery.

Specifically, the Court asked:

Do you know of anybody else that—

Mr. Copland: Yes.

The Court: —has been allowed those costs?

Mr. Copland: Yes, your honor. Golden Living, for example, which is also a facility—

The Court: Is that in the record?

Mr. Copland: I believe Golden Living's is, your Honor. And the witness—

The Court: Can you point to that in the record for me?

Mr. Copland: I will have to supplement, your honor. I don't have the exact page to cite.

The Court: So that might be of some concern to the Court if that's in the record, of your being treated differently; but if that's not the case, I don't really see a whole lot of merit in your position.

(AR 856:10-857:3.)

Contrary to the assertions of HCR's counsel, Golden Living also had the liability costs removed from their cost reports for the same period as HCR and requested a hearing on that issue. HCR's counsel could not point to any place in the record where there was evidence that HCR was treated differently, because there was none.

HCR is once again attempting to improperly introduce evidence after 2 separate hearings at which they did not attempt to introduce the evidence to prevent BMS from cross-examining the witness or rebutting the evidence.

SUMMARY OF ARGUMENT

When BMS realized HCR was attempting to pass liability expenses onto the state of West Virginia, and those liability expenses were causing the Medicaid reimbursement rates to become unreasonable in violation of federal law, BMS removed those expenses from the cost reports. HCR continues to try to make amends for the lack of preparation at the two hearings held regarding this issue. First, despite the fact HCR has had two opportunities to legally present evidence at the administrative hearing and oral arguments before the circuit court, it has refused to do so. Instead, HCR has attempted to introduce evidence in violation of the rules of evidence and to prevent BMS from cross-examining and rebutting the evidence. Finally, after oral arguments, HCR attempted to conduct discovery after the case had been submitted. The circuit court acted properly by upholding the administrative decision and denying the writ of certiorari.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

This case raises no substantial questions of law, and oral argument is not necessary. A memorandum decision affirming the circuit court's denial of a preliminary injunction is thus appropriate. *Rev. R.A.P.* 21.

STANDARD OF REVIEW

The Petitioner's appeal of the circuit court order is based on a *writ of certiorari*. "This court applies an abuse of discretion standard in reviewing a circuit court's certiorari judgment." Syl. Pt. 2, *Jefferson Orchards v. Zonning Bd. Of Appeals*, 225 W. Va. 416, 693 S.E.2nd 789 (2010). Questions of law are reviewed *de novo*. See Syl. Pt. 1, *Crystal R.M. v. Charlie A.L.*, 194 W. Va. 138, 459 S.E.2nd 415 (1995).

The Administrative Procedures Act "does not apply to contested cases involving the receipt of public assistance." *J.S. ex rel. S.N. v. Hardy*, 229 W.Va. 251, 728 S.E.2d. 135 (2012). "Rather, in cases such as the instant one, this Court has recognized that '[a] writ of certiorari in the Circuit Court of Kanawha County is the proper means for obtaining judicial review of a

decision made by state agency no covered by the Administrative Procedures Act.” *Id.* at 255, 138 (quoting Syl. pt. 2, *State ex rel. Ginsberg v. Watt*, 168 W.Va. 503, 285 S.E.2d 367 (1981). “On certiorari the circuit court is required to make an independent review of both law and fact in order to render judgment as law and justice may require.” Syl. pt. 3, *Harrison v. Ginsberg*, 169 W.Va. 162, 286 S.E.2d 276 (1982).

ARGUMENT

I. The Circuit Court Correctly Denied HCR’s Petition for Certiorari

A. The rates sought by HCR are not reasonable.

The relevant issue in this case is whether the cost reports submitted by HCR results in “rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers...” 42 C.F.R. §447.253(b)(1)(i).⁴ This issue has been ignored by HCR; however, the unrefuted evidence presented at the hearing demonstrates the cost reports submitted by HCR did not result in reasonable rates.

Just analyzing the liability insurance reported for the HCR facilities demonstrates the unreasonableness of HCR’s costs. The lowest liability insurance reported for HCR’s large bed facilities was nearly \$1 million. The highest reported liability insurance was in excess of \$1.6 million. All four of HCR’s remaining large bed facilities were in between those two numbers. No other facility even came close to these numbers. The highest reported liability insurance for a non-HCR facility was only \$284,064. Similarly, the highest reported liability insurance for a small bed facility was an HCR facility at nearly half a million dollars, while the second highest

⁴ After the administrative hearing, HCR raised a 42 U.S.C. §1396a(a)(30)(A) argument before the circuit court. “Section 30(A) does not provide a private right of action or a right enforceable under §1983 for Medicaid providers.” *Burlington United Methodist Family Services v. Atkins*, 227 F.Supp.2d 593, 597 (S.D.W.Va., 2002). Therefore, this new argument fails. However, as discussed in this section, the rates must be reasonable and they were not reasonable when HCR’s negligence claims were included.

facility was a non HCR facility with reported liability insurance of just under \$100,000. (AR 441.)

Six HCR facilities had 62.5% of the total amount claimed for liability insurance for the 51 facilities in the “large bed group”. The remaining forty five facilities had 37.5% of the total expenses. Clearly, the amounts reported by HCR are unreasonable. (AR 440.)⁵ Also, clearly, contrary to HCR’s assertions, HCR’s expenses are not required to operate economically and efficiently.⁵

Another way to look at these expenses, prior to the removal of settlement expenses, the cost per bed at the Heartland of Beckley facility was \$8,087. (AR 90.) The cost per bed for the highest non HR large bed facility was \$2,367. (AR 90.)

Finally, before the settlement claims were removed, the CAP for the large bed group was \$60.60, and the top six spots were occupied by the 6 HCR large bed facilities. (AR 86, 438.) After the claims were removed, the CAP decreased to \$25.27 (AR 87, 438.) This can be compared to prior period CAPS to demonstrate the unreasonableness. The CAP for June 2010 was \$27.82, the December 2010 CAP was \$25.32, the June 2011 CAP was \$28.31. Even the December 2011 CAP of \$39.07 was more than \$20 less than the CAP of \$60.60, including paid claims. Clearly these rates would have been unreasonable.

Based on the effect these paid settlement claims had on the rates and the fact the final rates would have been unreasonable, BMS had a legal duty, pursuant to 42 CFR

⁵ General Counsel for HCR testified the exorbitant liability costs were simply because HCR is an attractive defendant because of its deep pockets. (AR 192-193.)

⁵ Not only did HCR not present evidence regarding reasonable rates, HCR did not present any evidence at the hearing regarding rates that are adequate to meet the costs to be incurred by an efficiently and economically operated provider. The ALJ specifically found that HCR’s submitted paid settlement claims did not represent an efficiently and economically operated provider. (AR 29.)

§447.253(b)(1)(i), to remove them.⁶ These paid claims had to be removed as nothing in the West Virginia State Plan permits reimbursement for paid negligence claims.⁷ (AR 35.)

HCR maintains BMS seeks a rule that “insurance premiums, no matter how expensive or irrational, will be the only allowable costs.” This is not the case. If HCR cannot obtain insurance at a reasonable rate based on its claim history, BMS would be obliged to disallow those costs to the extent they forced the rates to become unreasonable. HCR points to Ms. Snow’s testimony to support this result, but Ms. Snow’s full testimony was that “there’s no way of knowing the effect until you have the numbers to be able to put them in the process.” (AR 158.) As ALJ Blaydes found, “if all costs were to be reimbursed without scrutiny from BMS, such methodology could threaten the integrity of the Medicaid system.” (AR 30), citing *In the Matter of Westmount Health Facility v. Bane, as Commissioner of the New York State Department of Social Services, et al*, 195 A.D.2d 129 (N.Y. 1994).

ALJ Blaydes found “BMS has established by a preponderance of the evidence that the cost reports at issue were neither reasonable, nor evidence of an efficiently and economically operated provider.” (AR 27.) HCR did not present any evidence to establish the rates would have been reasonable if the paid settlement claims had been included. Rather HCR has continually refused to address this issue, choosing to claim instead that BMS changed the policy.

B. BMS did not change policy.

HCR refuses to produce any evidence that the rates they wish this Court to set are reasonable. Rather, HCR argues they always impermissibly submitted these costs and therefore, excluding them now amounts to a change in policy. HCR makes much out of Ms. Snow’s

⁶ Therefore, clearly, West Virginia public policy does prohibit BMS from reimbursing HCR for losses relating to deductibles.

⁷ HCR claims Ms. Snow “testified she is not aware of any regulation stating that settlement payments or claim payments are not allowable costs.” (AR. 704.) But Ms. Snow testified she relied on counsel for legal advice as she is not a lawyer. (AR 128-131.)

testimony that there was not a change in any of the regulations or manuals, but ignores her testimony and the federal regulation that required that as the rates became unreasonable, she had a fiduciary duty to the taxpayers to ensure the rates were reasonable.

For several periods prior to the rate period at issue, Ms. Snow discovered errors in the cost reports submitted by HCR which were causing the rates to become unreasonable. By the time cost reports for the June 2012, rate period were submitted, the previous issues were being addressed properly, so Ms. Snow had to dig deeper to determine what was causing the rates to be unreasonable. This time she discovered HCR was including paid settlement claims. This was the first time she learned HCR was submitting these expenses, thus, she removed them. “Moreover, having concluded that paid negligence claims were not reimbursable, it would be *ultra vires* for BMS to pay such costs,” ALJ Blaydes noted. AR 34. He also found BMS did not change any rule, regulation or policy. (AR 32.)

BMS agrees with HCR’s assertion that there was not a change in policy. (AR 124.) As discussed *supra*, BMS always had a legal duty to ensure rates were reasonable.

Essentially, HCR is arguing that since they had always impermissibly submitted paid settlement claims to the West Virginia Medicaid program, and BMS did not catch it, they should be allowed to continue to do so. Even if there was evidence that BMS had allowed paid negligence claims to be submitted in the past, which there was not, pursuant to *Wishing Well Health Center, et al. v. Bureau for Medical Services*, Civil Action No. 04-AA-85, “past behavior does not preclude the Bureau from properly enforcing its regulation during subsequent audit periods.”⁸ (AR 955.) However, as ALJ Blaydes found, there was no evidence that BMS knowingly allowed those costs to be reimbursed. (AR 34.) BMS is not prevented from removing the paid settlement claims just because HCR impermissibly included these costs

⁸ Counsel for HCR should be familiar with this decision as he represented Wishing Well.

before. This does not amount to a change in policy. ALJ Blaydes found there was not a change in policy. (AR 32.)

Significantly, the parties agree there must be cost containment. Lane Ellis, HCR's accountant and expert witness, testified the purpose of the CAP is to control costs. (AR 304.) The ALJ found BMS was utilizing the CAP mechanism to control costs. (AR 32.) However, if HCR's position is adopted, the West Virginia Medicaid program would be required to pay whatever costs and rates the providers choose. Clearly, 42 C.F.R. § 447.253(b)(1), as discussed *supra*, prohibits such a result, but HCR ignores the requirements of this regulation. HCR specifically acknowledges Medicaid rate-setting is a field preempted by federal law and State agencies must comply with federal law, but refuses to address the requirement of federal law that rates must be reasonable by citing *Appalachian Regional Healthcare, Inc. v. WVDHHR, et al.*, 232 W.Va. 388, 752 S.E.2d 419 (2013). HCR simply ignores the requirements of 42 C.F.R. §447.523(b)(1) and urges the Court to adopt rates including all the costs submitted by HCR, regardless of reasonableness, by arguing that is how it has always been done.

Clearly, HCR's arguments regarding a change in policy fail. The evidence shows there was not a change in policy and BMS did not knowingly accept these expenses from HCR in the past.

C. BMS' interpretation of its own regulation is entitled to substantial deference.

HCR is not the first Medicaid provider to request BMS pay the rates the provider chooses. In a case involving a hospital seeking to control its own rates, the West Virginia Supreme Court of Appeals found, "[b]y enacting a statutory scheme that allows the states to establish rates in accordance with federal laws and regulation, the federal government has clearly manifested its intention that Medicaid reimbursement rates are preempted by the federal legislation." *Appalachian Regional Healthcare, Inc., v. WVDHHR, et al.*, 232 W. Va. 388, 752 S.E.2d 419, 428 (2013).

In this case, 42 C.F.R. § 447.253(b)(1)(i) provides “[t]he Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.” BMS has a fiduciary duty to the taxpayers and the indigent and disabled Medicaid recipients to ensure the rates are reasonable. Here, BMS simply fulfilled its regulatory and fiduciary duty by excluding the paid settlement claims from the rates.

Additionally, BMS’s interpretation of its own regulations is entitled to substantial deference. *Chevron USA v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); *Owen Electric Steel Co. of South Carolina, Inc. v. Browner*, 37 F.3d 146, 148 (4th Cir. 1994); *Georgia Dept. of Medical Assistance v. Shalala*, 8 F.3d 1565 (8th Cir. 1993). In reviewing such regulations, the plain language of the regulation should be considered. See e.g. *Crockett v. Andrews*, 153 W. Va. 714, 172 S.E.2d 384 (1970).

An agency’s interpretation of its own regulations must be given controlling weight unless clearly erroneous. *State of New York v. Shalala*, 199 F.3d 175 (2nd Cir. 1997); *Virginia Dept. of Medical Assistance Services*, DAB No. 1207 (1990). *Accord*, Syl. pt. 2, *Cookman Realty Group, Inc. v. Taylor*, 211 W. Va. 407 (2002), citing Syl. pt. 3, *Crockett v. Andrews*, 153 W. Va. 714, 172 S.E.2d 384 (1970) (“While long standing interpretation of its own rules by an administrative body is ordinarily afforded much weight, such interpretation is impermissible where the language is clear and unambiguous.”); Syl. pt. 1, *English Moving & Storage Co. v. Public Serv. Comm’n of West Virginia*, 143 W. Va. 146, 100 S.E.2d 407 (1957) (stating in context of administrative rule that “[w]hen a valid written instrument is clear and ambiguous it will be given full force and effect according to its plain terms and provisions”).

West Virginia has an approved State Plan for reimbursement of Nursing Home. Specifically, it is the **Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities-Excludes State-Owned Facilities.**

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

Allowable Costs for Cost Centers

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

Mandated Services

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

West Virginia State Plan, Attachment 4.19-D-1, Page 4 & 5.

The Bureau, therefore, recognizes insurance as a cost to nursing homes for providing services to its members. Assuming arguendo, these expenses are to be included, they still must be reasonable pursuant to the West Virginia State Plan and federal regulations.

Finally, a provider cannot argue BMS is precluded from enforcing its regulations during subsequent audit periods just because a particular type of documentation was previously accepted by BMS. *April 2005, order, Wishing Well Health Center and Wishing Well Manor v. Bureau for Medical Services*, Kanawha County Circuit Court, Civil Action No. 04-AA-85. A.R. pp. 953-956. Even if these expenses had incorrectly been used in the past, BMS is not precluded from excluding them now. *Id.*

Therefore, the action of BMS and the Recommended Decision of ALJ Jeffrey Blaydes must be upheld. The expenses reported in the cost reports at issue did not produce reasonable rates and BMS had to act to ensure the rates were reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers. BMS has a fiduciary duty to taxpayers and the indigent and disabled who rely on Medicaid to exclude claims from

reimbursement that are unreasonable and that tax or exhaust public funds that are earmarked to assist those in need of medical services who cannot afford them. (AR 36.)

D. HCR admitted it is not self- insured; therefore, the PRM does not apply.

Prior to when BMS issued the Document Desk Review (DDR) Decision, HCR did not clarify if it was self- insured. The DDR Decision had to cover all possible scenarios and at that time, it appeared HCR might argue it was self-insured. Therefore, the DDR Decision referred to the language in the PMR regarding self- insured providers for guidance.⁹ But at the hearing, HCR admitted it was not self-insured. (AR 186.) Therefore, it was no longer necessary to utilize the PMR for guidance regarding self-insured providers, as HCR was not self-insured.

II. The Circuit Court did Not Err By Denying HCR’s Untimely Request for Discovery or Refusing to Consider Evidence Properly Excluded at the Administrative Hearing.

Following the administrative hearing, HCR attempted to circumvent the rules of evidence by introducing emails and an affidavit as supplemental evidence AFTER the hearing. Counsel for BMS objected because BMS was not provided an opportunity to cross examine the witness or present testimony regarding the emails. The ALJ properly excluded the new evidence. Additionally, counsel for BMS moved to strike testimony from the record regarding other nursing facilities when the witness refused to provide the names of the other facilities. This was granted by the ALJ. However, HCR did not raise these issues in its writ of certiorari. In fact, HCR did not raise it until after oral argument before the circuit court. Similarly, HCR did not raise the issue of discovery until after oral argument. HCR refuses to follow the rules and rather than take responsibility for that, wants to blame everyone else. The circuit court properly refused to allow HCR to flaunt the rules and refused to address these issues.

⁹ The PRM applies to Medicare, but the DDR decision used it for guidance in determining if a provider was self-insured.

A. HCR Made a Request for Discovery After the Briefs Had Been Submitted and Oral Arguments.

HCR submitted briefs to the circuit court regarding its *writ of certiorari*, participated in oral argument and submitted the case before making a request for discovery. Therefore, the request was not timely and the circuit court properly refused to order discovery.

The statutes and cases upon which HCR relies provide the circuit court is authorized to take evidence, but this is not required. *Bills v. Hardy*, 228 W. Va. 341, 719 S.E.2nd 811, 815-816 (2001). In this case, the circuit court did not need additional evidence to reach a decision.

B. Counsel for HCR Refused to Let His Expert Answer Questions on Cross Examination.

When HCR requested an administrative hearing over 2 years ago on July 13, 2013, they claimed its facilities were being singled out and treated differently than other facilities. Specifically, HCR claimed BMS “previously allowed the same costs for HCR and for **other** providers, and has continued to do so in some cases even after the decision.” (AR 402.) Assignment of Error #6. (emphasis added).

At the hearing on January 17, 2014, HCR clearly did not support this allegation.¹⁰ Lane Ellis, HCR’s accountant, merely testified that prior to January 1, 2012, it was routine for nursing home facilities to include direct liability payments in their cost reports, particularly, the deductibles. (AR 289-291.) But that was the extent of his testimony. He did not give specific examples of nursing facilities that BMS allegedly allowed to include paid claims in their cost reports prior to January 1, 2012, and there was no testimony about a nursing facility submitting those costs for the period when HCR’s liability claims were disallowed.

However, when BMS properly cross examined Mr. Ellis on this general allegation, he refused to answer the questions.

¹⁰ HCR did not even attempt to discover information through the FOIA process until after the Recommended Decision was issued and adopted by BMS.

By Ms. Jones:

Q Can you tell us the names of the nursing facilities that are including the paid claims that they're submitting the cost reports to BMS?

A I'm not sure I can because of a (sic) ethics requirement.

Ms. Jones: Then I would ask for that part of the testimony be stricken from the record if he can't tell us who they are.

(AR 316-317.)

After ALJ Blaydes asked Mr. Copland if he could have it both ways, he told him he would either exclude the testimony or Mr. Ellis would have to testify about it. (AR 318.) Mr. Copland ultimately chose not to have his expert testify about the facilities which had submitted liability claims in their cost reports. (AR 326.) ALJ Blaydes stated, "I'm not sure I'm left with much choice. I don't think we can put the evidence out there, but then not permit cross examination." (AR 326.)

Despite the fact that HCR notified BMS years ago of its intent to prove that HCR was treated differently, HCR failed to do this at the hearing. In fact, HCR objected to counsel for BMS properly questioning their expert witness on the matter. After the hearing before the circuit court, HCR claimed it needed time to conduct discovery on a matter it included as an assignment of error over 2 years ago. HCR did not raise this issue prior to or at the hearing before the circuit court on April 9, 2015. HCR has wasted judicial and state resources by now requesting discovery on an issue which their own witness could have provided information about at the administrative hearing, but for HCR's counsel's decision to not have his expert respond.

Moreover, as the circuit court noted, BMS does not have that information. BMS began questioning the costs included in the Taxes and Insurance cost center as those costs became exorbitant. As HCR's counsel pointed out at the hearing before the circuit court, the liability costs were not clearly marked as such in the cost reports. (AR 3-6.) Therefore, even if HCR did

conduct discovery now, 2 years after identifying this issue as an error and having an opportunity to present it at a hearing, and after the matter has been submitted to this Court, BMS does not have any evidence regarding this issue. BMS is unaware of other nursing facilities passing these costs onto the West Virginia Medicaid program, because they are not identified as such. It would be an exercise in futility. Again, HCR's expert has the information, but he did not provide it at the administrative hearing.

Therefore, the *Motion for Discovery* was properly excluded as HCR chose not to present evidence on this matter at the administrative hearing. Also, conducting discovery on an issue HCR identified as an error 2 years ago, but refused to address at the administrative hearing is a waste of state and judicial resources. It is also futile as HCR's witness has the information HCR seeks, not BMS.

C. HCR Did Not Provide BMS the Opportunity to Cross-Examine or Offer Rebuttal Testimony Regarding the E-mails it is Attempting to Admit.

Following the close of the administrative record in this case, HCR attempted to submit the affidavit of Karla Martin¹¹ and emails between her and Jeanne Snow, a witness for BMS. The hearing officer did not allow that evidence to be submitted as BMS was denied the opportunity to cross-examine the affiant or the chance to respond. (AR 15 (footnote 1).)

Similarly, HCR tried to submit those same emails after the case has been submitted to the circuit court. If HCR believed the ALJ acted in error, that issue should have been raised in the writ before oral argument. Finally, even if the documents had been properly introduced at the administrative hearing, they are not responsive to the circuit court's question as they do not indicate what happened after the email exchange and do not prove HCR was treated differently. These emails are for different cost reporting periods. These are issues that would have been

¹¹ Karla Martin appears to have been employed by Golden Living, a nursing facility which has also had liability claims removed from its cost report. Golden Living has appealed that decision. Karla Martin did not testify at the HCR administrative hearing.

raised by BMS if HCR followed the rules of evidence. However, HCR continues to circumvent the rules of evidence in this matter. Therefore, the affidavit and emails were properly excluded.

CONCLUSION

The Bureau for Medical Services respectfully requests the Bureau's adoption of the Recommended Decision be upheld in all respects and the circuit court's denial of the *writ of certiorari* be upheld. When HCR attempted to pass their liability expenses onto the state of West Virginia, the Medicaid reimbursement rates became unreasonable. Then HCR was not prepared for the administrative hearing and continues to attempt to submit evidence without providing BMS the opportunity to cross-examine or respond. At the hearing before the circuit court on April 9, 2015, HCR made misrepresentations to the court regarding this case and is attempting to obfuscate the real issue in the case, whether the rates were reasonable, by circumventing the rules of evidence. Therefore, for the foregoing reasons, BMS respectfully requests the circuit court's order be upheld.

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET No. 15-0595

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

Petitioners,

v.

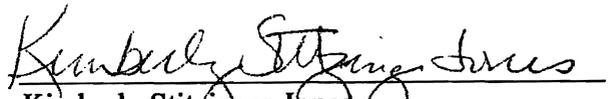
BUREAU FOR MEDICAL SERVICES,

Respondent.

CERTIFICATE OF SERVICE

I, Kimberly Stitzinger Jones, counsel for the West Virginia Department of Health and Human Resources, do hereby certify that on the 28th day of October, 2015, I caused a true copy of the foregoing Response Brief of the Bureau for Medical Services to be served on all parties by depositing the same in the U.S. Mail, postage-prepaid, first-class, to each.

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