STATE OF WEST VIRGINIA
SUPREME COURT OF APPEALS

Heartland of Beckley WV, LLC;
Heartland of Clarksburg WV, LLC;
Heartland of Keyser WV, LLC;
Heartland of Martinsburg WV, LLC;
Heartland of Rainelle WV, LLC;
Heartland of Preston County of Kingwood WV, LLC;
Health Care and Retirement Corporation of America, LLC d/b/a/ Heartland of Charleston,
Petitioners

FILED
October 26, 2016
RORY L. PERRY II, CLERK
SUPREME COURT OF APPEALS
OF WEST VIRGINIA

vs) No. 15-0595 (Kanawha County 14-AA-100)

Bureau for Medical Services,
Respondent

MEMORANDUM DECISION

Petitioners (collectively, "HCR") by counsel, Gordon H. Copland, Amy M. Smith, and Cara N. Parcell, appeal an order entered in the Circuit Court of Kanawha County. In its order, the circuit court found respondent, Bureau for Medical Services ("the Bureau") did not err when it eliminated certain expenses from HCR's June 2012 cost report seeking Medicaid reimbursement.[1] The Bureau, by counsel, Patrick Morrisey and Kimberly S. Jones, filed a response, to which HCR filed a reply.

This Court has considered the parties' briefs, oral arguments, and the record on appeal. Upon consideration of the standard of review, the briefs, oral arguments, and the record presented, we find error in the circuit court's decision that HCR would not be reimbursed certain expenses under West Virginia's Medicaid program. For this reason, we reverse and remand the circuit court's order for further proceedings consistent with this decision. This case satisfies the "limited circumstances" requirement under Rule 21(d) of the Rules of Appellate Procedure and is appropriate for a memorandum decision rather than an opinion.

HCR is a private, for-profit corporation. It operates nursing homes and assisted living facilities throughout the United States, including seven locations in West Virginia. HCR is a voluntary provider of medical services through West Virginia's Medicaid program. Thus, it receives reimbursement from the Medicaid program for certain expenses related to the medical care it renders to qualified indigent individuals and families.

The Bureau is the state agency charged with administering West Virginia's Medicaid

[1] West Virginia's State Medicaid Plan and the parties interchangeably refer to these expenses as costs.

program. Pursuant to this authority, the Bureau drafted the State Medicaid Plan ("State Plan"), a comprehensive document which outlines the scope of expenses that may be reimbursable to nursing facilities. Under the State Plan, nursing facilities are reimbursed for their "allowable" costs, which include "liability insurance" expenses. In 2012, the State Plan did not define or otherwise elaborate what is properly included in a nursing facility's "liability insurance" expenses. The State Plan also did not mention whether insurance deductibles or liability claims paid by nursing facilities were reimbursable as allowable costs.

The Bureau uses the following procedure to determine a nursing facility's reimbursement under the Medicaid program. First, it requires West Virginia nursing facilities to submit a report twice a year (once in June and again in December) in which the nursing facilities outline their allowable costs. Then, the nursing facilities are grouped into two categories: one category for small bed facilities (0-90 beds) and another for large bed facilities (91 plus beds). Within each category, nursing facilities are ranked from highest to lowest, according to their allowable costs per bed. Finally, a "CAP," or a ceiling, is set at the ninetieth percentile of each category's ranking. The Bureau does not reimburse nursing facilities for any amount exceeding the CAP in that nursing facility's category. In addition to the CAP, the Bureau may audit a nursing facility's cost report.

HCR engaged in two practices which led to this appeal: (1) when sued for negligence, it would sometimes pay claims within its $10,000,000 liability insurance deductible; and (2) it would include the claims it paid as a "liability insurance" expense in its cost reports to the Bureau. The Bureau contends it did not know HCR was engaging in this practice.

The Bureau claims it started to pay closer attention to HCR's cost reports in 2010, after noticing a dramatic increase in HCR's liability insurance expenses.[2] Between 2010 and June 2012, HCR was among West Virginia's highest reporters of allowable costs. Because HCR operates six of the fifty-one large bed nursing facilities in West Virginia,[3] its reported expenses have the potential to drive up the CAP for large bed nursing facilities. The effect of HCR's reported expenses on the June 2011 CAP caused the CAP to rise 11.8% from December 2010, when HCR was not included in the CAP. The following period, December 2011, HCR contributed to the CAP rising an additional 38%.

In June 2012, HCR's reported expenses continued to increase. HCR reported the following liability insurance costs for its seven nursing facilities: (1) Beckley: $8,087 per bed; (2) Clarksburg: $8,108 per bed; (3) Keyser: $8,112 per bed; (4) Martinsburg: $8,129 per bed; (5) Kingwood: $8,115 per bed; (6) Rainelle: $8,113 per bed; and (7) Charleston: $8,079 per bed. By comparison, the highest reporting non-HCR large bed facility incurred liability insurance costs of

[2] The Bureau had to adjust HCR's cost reports twice in 2010 and 2011. In the December reporting periods of 2010 and 2011, the Bureau determined HCR included expenses for the entire year in its cost reports, when HCR was supposed to report expenses only for the previous six months.

[3] HCR has six large bed facilities and one small bed facility in West Virginia.

$2,367 per bed for the same reporting period. HCR's six large bed facilities reported 62.5% of the liability expenses for the fifty-one large bed facilities in West Virginia.

Because of these abnormal expenses, the Bureau subjected HCR's June 2012 cost report to a desk review audit. The Bureau claims it was during this desk review that it first learned HCR included paid legal claims within its deductible as a liability insurance expense. Upon learning this information, the Bureau eliminated *all* paid legal claims from HCR's cost reports through a "desk review adjustment." As a result of the desk review adjustment, HCR's seven facilities had some of West Virginia's lowest allowable costs per bed for liability insurance for the June 2012 reporting period.

In its desk review adjustment of HCR's cost report, the Bureau did not provide a reason for eliminating *all* of HCR's paid legal claims, as opposed to reducing them to a level determined to be reasonable. The Bureau made no inquiry into the structure of HCR's insurance program or its deductible, the nature of the paid legal claims included in HCR's cost report, or the practice of other similar nursing facilities including paid legal claims in their cost reports.

HCR sought administrative review of the Bureau's desk review adjustment. The Bureau issued a document/desk review decision finding it did not err. HCR then requested an evidentiary hearing on the matter. At the hearing, HCR argued that federal Medicare regulations presume that liability insurance costs, including deductibles, can be reimbursed. Because West Virginia's State Medicaid Plan was silent on this issue, HCR contended the Bureau should have relied upon the federal Medicare regulations. The hearing examiner entered a recommended decision affirming the Bureau's decision to eliminate all of HCR's paid legal claims within its liability deductible from its June 2012 cost report. In his order, the hearing examiner found that federal Medicare regulations and cost principles regarding liability insurance expenses were not intended to apply to West Virginia's Medicaid program and were not controlling in this case. The Bureau adopted the hearing examiner's recommended decision without modification.

HCR petitioned the circuit court for a writ of certiorari. In denying HCR's writ, the circuit court acknowledged that when Medicaid regulations are silent, Medicare cost principles and regulations apply. However, and without explanation, the circuit court stated: "HCR has . . . not explained how it is entitled to the presumption created by [Medicare]." HCR now appeals the circuit court's order finding the Bureau did not err.

HCR seeks review of the circuit court's denial of its writ of certiorari.[4] "This Court applies an abuse of discretion standard in reviewing a circuit court's certiorari judgment." Syl. Pt. 2, *Jefferson Orchards v. Zoning Bd. of Appeals*, 225 W.Va. 416, 693 S.E.2d 789 (2010). However, "When questions of law are presented in the scope of such review, those matters will

[4] "A writ of certiorari in the Circuit Court of Kanawha County is the proper means for obtaining judicial review of a decision made by a state agency not covered by the [APA]." Syl. Pt. 2, *State ex rel. Ginsberg v. Watt*, 168 W.Va. 503, 285 S.E.2d 367 (1981). "[T]he Administrative Procedures Act does not apply to contested cases involving the receipt of public assistance." Syl. Pt. 1, in part, *J.S. ex rel. S.N. v. Hardy*, 229 W.Va. 251, 728 S.E.2d 135 (2012).

be reviewed by this Court in plenary fashion." *Bills v. Hardy*, 228 W.Va. 341, 345, 719 S.E.2d 811, 815 (2001) (citations omitted).

In this appeal, we are asked to determine whether the Bureau erred by eliminating all expenses submitted by HCR for claims it paid under its insurance deductible and other legal claims it paid. The Bureau eliminated these expenses from HCR's June 2012 cost report seeking Medicaid reimbursement.

At the outset, we note that after the events giving rise to this dispute occurred, the Bureau revised its West Virginia Provider Manual.[5] Effective January 2013, Section 514.13.32 provides:

> Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, *as well as the associated legal deductibles* or legal costs *is non-allowable*. (Emphasis added).

Thus, as of 2013, liability claims paid by a provider within an insurance deductible are not "allowable costs" under West Virginia's Medicaid program. However, because this case pertains to HCR's June 2012 cost report, which HCR submitted before the new regulation's effective date, the amended language is not applicable.

We now return to the dispute between HCR and the Bureau regarding HCR's Medicaid reimbursement during the June 2012 cost reporting period. West Virginia's State Medicaid Plan provides that nursing facilities are reimbursed for their "allowable costs" which include, *inter alia*, "insurance." WEST VIRGINIA BUREAU FOR MEDICAL SERVICES, WEST VIRGINIA STATE MEDICAID PLAN, Attachment 4.19-D-1(II)(2) [2004]. Forms generated by the Bureau indicate it reimburses nursing facilities for the following four types of insurance expenses: property, liability, malpractice, and "other."

The parties agree that HCR may include its liability insurance premiums as an allowable cost. This dispute concerns whether HCR's allowable costs included paid legal claims within its liability insurance deductible when HCR submitted its June 2012 cost report.

The West Virginia Provider Manual describes the applicable law on Medicaid reimbursement as follows:

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[5] The West Virginia Provider Manual is published by the Bureau to summarize the description and administration of West Virginia's Medicaid program. In Section 120, the Provider Manual states: "WV Medicaid provider manuals contain detailed information about the WV Medicaid Program. The manuals document and communicate current policy requirements applicable to Medicaid-covered services as provided by specific provider types."

> Federal and State law, the West Virginia State Plan and Medicaid regulations cover reimbursement principles in the following order. *When Medicaid regulations are silent and Medicare cost principles and regulations are silent, then generally accepted accounting principles (GAAP) will be applied.*

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES, PROVIDER MANUAL § 514.12.3 [2012] (emphasis added). Thus, it is clear that, under the Bureau's own guidelines, federal Medicare statutes, regulations, and guidelines will be applied when federal and West Virginia Medicaid statutes, regulations, and guidelines are silent on a given point.

HCR argues that, when it submitted its June 2012 cost report, federal and state Medicaid statutes, regulations, and guidelines were silent on whether its paid legal claims within its liability insurance deductible were an allowable cost. The Federal Medicaid Act, 42 U.S.C. § 1396, *et seq*., and its corresponding federal regulations, 42 C.F.R. § 447, *et seq.*, do not address this issue. Moreover, in 2012, neither the State Plan nor the West Virginia Provider Manual touched on paid claims within an insurance deductible.

By contrast, HCR argues that guidelines contained in Medicare's Provider Reimbursement Manual ("PRM")[6] specifically address this issue. In Section 2162.5, the PRM provides:

> Where you, at your option, are willing to commit your resources toward meeting first dollar losses through a deductible (as defined below), losses relating to the deductible are allowable costs in the year paid without funding if the aggregate deductible is no more than . . . 10 percent of your . . . net worth . . . . This requirement is deemed a reasonable test as to whether you are acting prudently in this regard. So long as you stay within the above limitations, you can be assumed to be exercising sound judgment in deciding to meet first dollar losses or coinsurance

[6] The PRM is a comprehensive set of Medicare guidelines published by The Centers for Medicare & Medicaid Services, which is the federal agency charged with administering Medicare. Ordinarily, "the [PRM] does not implement new substantive policy, but rather provides optional guidelines clarifying existing regulations[.]" *John Muir Memorial Hosp., Inc. v. Schweiker*, 664 F.2d 1337, 1339 (9th Cir. 1981). However, under the West Virginia Provider Manual, federal Medicare law, including the PRM, is binding when Medicaid is silent. *See Appalachian Power Co. v. State Tax Dep't. of W.Va.*, 195 W.Va. 573, 583 n.8, 466 S.E.2d 424, 434 n.8 (1995) ("[A]n agency must follow and apply its rules and regulations in existence at the time of agency action."). Likewise, other jurisdictions have applied the PRM to resolve Medicaid reimbursement disputes. *See, e.g.*, *In re McKerley Health Facilities*, 145 N.H. 164, 761 A.2d 413 (2000); *Dep't of Health & Mental Hygiene v. Riverview Nursing Cntr., Inc.*, 104 Md. App. 593, 657 A.2d 372 (1995); *Hampton Nursing Cntr. v. St. Health & Human Serv Finance Comm'n*, 303 S.C. 143, 399 S.E.2d 434 (1990).

> payments out of available resources. . . . [A]ny losses paid by the provider in excess of . . . 10 percent of the provider's . . . net worth . . . are not allowable.

Thus, a Medicare guideline specifically addresses whether a nursing facility's allowable costs include paid legal claims within an insurance deductible. Medicaid statutes and regulations, as well as the West Virginia State Plan and West Virginia Provider Manual, were silent on this issue when HCR submitted its June 2012 cost report.[7]

Accordingly, under the clear language of the West Virginia Provider Manual, Medicare regulations and cost principles, including PRM § 2162.5, apply to this case. Under PRM § 2162.5, a nursing facility may include first dollar losses within its liability insurance deductible as an allowable cost, provided its aggregate deductible is no greater than ten percent of its net worth. Within these parameters, PRM § 2162.5 presumes HCR to have been reasonable in including its paid legal claims within its liability insurance deductible as an allowable cost in its June 2012 cost report.

However, even if HCR met all of the terms of PRM § 2162.5, our inquiry does not end there. According to the PRM: "All payments to providers of services must be based on the reasonable cost of services[.]" CENTERS FOR MEDICARE & MEDICAID SERVICES, PROVIDER REIMBURSEMENT MANUAL §2100. "Reasonable cost" is defined, in part, as follows:

> [P]roviders are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, *except* where a particular institution's costs are found to be *substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.*

Id., § 2102.1 (emphasis added). Likewise, 42 C.F.R. § 413.9(c) provides that nursing facility reimbursement under Medicare is: "subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." Indeed, "the Medicare Act requires that costs not be substantially out-of-line from costs of comparable institutions[.]" *Maximum Home Health Care, Inc. v. Shalala*, 272 F.3d 318, 319 (6th Cir. 2001).

Therefore, the Bureau erred by eliminating *all* of HCR's paid legal claims from its June

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[7] Similarly, in *Ex parte Wilbanks Health Care Serv., Inc.*, 986 So.2d 422 (Ala. 2007), the court applied the following regulation on Medicaid reimbursement: "If this regulation is silent on a given point, Medicaid will normally rely on Medicare (Title XVIII) Principles of Retrospective Reimbursement[.]" *See* ALA. ADMIN. CODE r. 560-X-22-.02(3). The court found this regulation required application of Medicare law to resolve the dispute, noting that Medicaid did not "prescribe the manner of reimbursement for [certain] maintenance costs, [but] that subject *is specifically treated* in Medicare[.]" *Wilbanks*, 986 So.2d at 426 (emphasis in original).

2012 cost report. Those costs, which are reasonable, are allowable under PRM § 2162.5 up to a certain amount (essentially, up to ten percent of HCR's net worth). However, PRM § 2162.5 is subject to 42 C.F.R. § 413.9(c), which prohibits a nursing facility's costs from being "substantially out of line" from comparable institutions.[8]

Accordingly, we reverse and remand the circuit court's May 16, 2015, order affirming the Bureau's decision to eliminate, in total, *all* of HCR's paid legal claims from its June 2012 cost report. On remand, the parties should be allowed to introduce evidence as to whether HCR complied with the provisions of PRM § 2162.5 and 42 C.F.R. § 413.9(c)'s substantially out of line provision.[9]

The circuit court erred by failing to apply pertinent Medicare regulations and cost principles in resolving this matter. Thus, we reverse the circuit court's order and remand this case for further proceedings consistent with this decision.

Reversed and Remanded.

ISSUED: October 26, 2016

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[8] PRM § 2162.5 is subject to the substantially out of line provision in 42 C.F.R. § 413.9(c). *See Maximum Home Health Care, Inc.*, 272 F.3d at 321 ("The Administrator's reliance on [a PRM guideline] is misplaced [to the extent] it is inconsistent with the substantially out-of-line standard, . . . a regulation trumps a manual provision."); *Eagle Healthcare, Inc. v. Shalala*, 52 F.Supp.2d 1, 8 n.4 (D.D.C. 1999) ("To the extent that HHS' position . . . relies upon statements in the Provider Reimbursement Manual, those statements, . . . must yield to any relevant conflicting provisions of the Code of Federal Regulations.")

[9] HCR also argued the circuit court erred in denying its motion for discovery and its motion to supplement the record in regard to whether the Bureau treated HCR differently from other nursing facilities in eliminating paid legal claims from its June 2012 cost report. HCR submitted these two motions several days after oral argument, *i.e.*, after the close of evidence. It is well-established that "[w]hether a plaintiff will be allowed to introduce further evidence after the evidence in behalf of a defendant is concluded is ordinarily within the discretion of the trial court, and the exercise of such discretion will rarely constitute ground for reversal." Syl. Pt. 10, *Edminston v. Wilson*, 146 W.Va. 511, 120 S.E.2d 491 (1961). The record reveals no basis for us to find the circuit court's refusal to grant HCR's motion for discovery and motion to supplement the record after the close of evidence was an abuse of discretion. Moreover, even if the Bureau had previously reimbursed expenses of other nursing facilities within their deductibles, the Bureau is not bound by the laws of estoppel or the legally unauthorized acts of its officers in the performance of a governmental function. *See Cunningham v. Cnty. Ct. of Wood Cnty.*, 148 W.Va. 303, 310, 134 S.E.2d 725, 729-30 (1964).

CONCURRED IN BY:
Chief Justice Menis E. Ketchum
Justice Brent D. Benjamin
Justice Allen H. Loughry II
Justice Robin Jean Davis
Justice Margaret L. Workman