IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

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

v.

Civil Action No. 14–AA–100
Judge Louis H. Bloom

Bureau for Medical Services,
Respondent.

FINAL ORDER

On April 9, 2015, the parties appeared by counsel to present evidence and argue their positions on a *Petition for Appeal* filed by the Petitioners (HCR, collectively) on October 15, 2014. The *Petition* alleges that the Respondent, Bureau for Medical Services (BMS), erred when it disallowed reimbursement of HCR's liability expenses claimed under the Medicaid program. Upon review of the parties' legal memoranda, the record, and the applicable law, the Court finds and concludes as follows.

FINDINGS OF FACT

1. HCR is a provider of long-term-care services with locations throughout West Virginia, as well as numerous other states.[1]

2. HCR had a $10,000,000.00 deductible for each liability claim and third party insurance up to $125,000,000.00.[2]

[1] Hr'g Tr. 167–168, 179, Jan. 17, 2014.

3. HCR facilities receive payments under the West Virginia Medicaid Program.

4. BMS administers the Medicaid program in West Virginia. BMS is a State agency organized under the West Virginia Department of Health and Human Resources ("DHHR").[3]

5. BMS is responsible for setting reimbursement rates for long-term-care facilities under the Medicaid program. BMS sets payment rates based on costs reported to DHHR's Office of Accountability and Management Reporting (OMAR) by long-term-care facilities. Every six months, long-term-care facilities submit cost reports to OMAR. The first report covers January through June (June period), and the second report covers July through December (December period).[4]

6. Because West Virginia nursing homes bill a month in arrears, the October–March rates are not used until November 1, with the rates being set by the third week in October. Likewise, the July–December rates are not used until May 1, and thus are set by the third week in April.[5]

7. To determine rates, OMAR divides nursing homes into large bed facilities (those with more than 91 beds) and small bed facilities. OMAR then calculates how much Medicaid reimbursement each facility is seeking per bed—the amount of money per bed is called the "per diem." OMAR then lists the per diems from high to low and calculates the 90th percentile, which becomes the "cap" or ceiling utilized by OMAR to determine which costs are reimbursable.[6]

8. The purpose of the cap is to exclude excessive costs.[7]

9. HCR has one small bed facility and six large bed facilities.[8]

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[2] *Id.* at 142.

[3] W. Va. Code § 9-1-2(n).

[4] Hr'g Tr. 14, 20–21, 247, Jan. 17, 2014.

[5] *Id.* at 25–26.

[6] *Id.* at 17–18.

[7] *Id.* at 249.

10. In the instant appeal, the rates in contest are HCR's cost reports for the June 2012 period.[9]

11. Prior to 2012, HCR has never been advised that liability or settlement costs are not reimbursable by Medicaid.[10]

12. The Centers for Medicare and Medicaid Services (CMS) has never taken any position with regard to HCR's method of reporting claims.[11]

13. Prior to the June 2012 period, OMAR was concerned with HCR's cost reports. As the rates and, in turn, caps started to increase, OMAR began investigating to determine the cause.[12]

June 2010 Period

14. For the June 2010 period, HCR's large-bed facilities were among the top nine highest per diems in West Virginia. Specifically, HCR's large-bed facilities were the third, fourth, fifth, sixth, eighth, and ninth highest per diems.[13]

15. For the June 2010 period, BMS set the cap with positions six and seven. [14]

December 2010 Period

16. For the December 2010 period, HCR reported total expenses of $37,652,429.00 and total claims of $36,977,000.00.[15] This was a significant increase over previous cost reports.[16]

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[8] *Id.*

[9] *Id.* at 30.

[10] *Id.* at 80, 90.

[11] *Id.* at 182.

[12] *Id.* at 15–16, 34, 152.

[13] *Id.* at 17–18.

[14] *Id.*

[15] *Id.* at 28–29; DHHR Ex. 7.

[16] *See id.*

17. As a result of the increases, OMAR requested additional information from HCR. HCR did not provide the requested information in time for its costs to be included in the cap calculation.[17]

18. After HCR's costs were excluded from the cap calculation, the cap decreased for the December 2010 period by 6.3% for small-bed facilities and 9% for large bed facilities.[18]

June 2011 Period

19. For the June 2011 period, HCR's costs were reintroduced into the cap calculations. The cap increased by 7.5% for small-bed facilities and 11.8% for large-bed facilities.[19]

December 2011 Period

20. For the December 2011 period, HCR's cost reports included expenses for the entire year, rather than the appropriate six-month period. As such, HCR's total expenses jumped from approximately $6,000,000.00 per month to $18,000,000.00 for December. OMAR adjusted HCR's total expenses to reflect a six-month period's worth of expenses rather than a year's worth.[20]

21. Nonetheless, the caps increased by 38% for large-bed facilities and 3.9% for small-bed facilities.[21]

June 2012 Period

22. The rates set for the June 2012 period are the subject of this appeal.

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[17] Hr'g Tr. 24–25; DHHR Exs. 6 & 7.

[18] Hr'g Tr. 26–27; DHHR Ex. 6 & 7.

[19] Hr'g Tr. 27; DHHR Ex. 7.

[20] Hr'g Tr. 28; DHHR Ex. 6 & 7.

[21] *Id.*

23. For the June 2012 period, HCR's liability expenses increased yet again. Specifically, the expenses increased from approximately $6,500,000.00 per month to $33,000,000.00 for June alone.[22]

24. OMAR asked HCR to explain the increase, so HCR submitted additional documentation.[23]

25. Upon review of the additional documentation, OMAR discovered HCR was including paid liability claims in their cost reports.[24]

26. In an effort to set a reasonable rate, Ms. Jeane Snow, Director of Rate Setting for OMAR, developed a calculation to remove the settlement costs from the cost reports.[25]

27. OMAR disallowed $53,285,372 or 81.23% of HCR's expenses.[26]

28. Once the settlement costs were excluded, HCR's remaining expenses were included in calculating the cap.[27]

29. When BMS calculated the cap for the large-bed facilities prior to HCR's settlement costs being excluded, the cap per diem was $60.60, and HCR's six large-bed facilities were the top six highest per diems in West Virginia.[28]

30. After the settlement costs were excluded, the cap for the large-bed facilities decreased to $25.27, and HCR's six facilities dropped to 36th, 38th, 42nd, 43rd, 48th, and 49th.[29] The cap for

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[22] Hr'g Tr. 32; DHHR Ex. 7.

[23] Hr'g Tr. 30–33; DHHR Ex. 8.

[24] Hr'g Tr. 34–35; DHHR Ex. 9.

[25] *Id.* at 37–40; DHHR Exs. 10–13. Said calculation is illustrated in DHHR Exhibit 12.

[26] Hr'g Tr. 40–41; DHHR Exs. 12–13.

[27] Hr'g Tr. 45–46.

[28] *Id.* at 42; DHHR Ex. 14.

[29] *Id.*

the June 2012 is comparable to prior periods. The June 2010 cap was $27.82; the December 2010 cap was $25.32; and the June 2011 cap was $28.31.[30]

31. HCR maintains that it is entitled to be reimbursed for settlement and liability costs as part of doing business in West Virginia's "legal climate."[31]

32. BMS maintains that the cost of legal settlements and liabilities—including liabilities arising out of the negligence of HCR—is not reimbursable by the West Virginia Medicaid program. BMS further maintains that only patient-related and medically necessary expenses are reimbursable.[32]

33. On September 3, 2014, BMS entered its *Recommended Decision*, finding that BMS appropriately omitted HCR"s liability costs in its cap calculations because "[t]he expenses reported in [HCR's] 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."

DISCUSSION & CONCLUSIONS OF LAW

34. Under West Virginia law, "the Administrative Procedures Act does not apply to contested cases involving the receipt of public assistance. . . . Rather . . . 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 Administrative Procedures Act."[33] Further, "unless

[30] DHHR Exs. 6 & 14.

[31] Hr'g Tr. 11–13, 230–231.

[32] *Id.* at 35.

[33] *J.S. ex rel. S.N. v. Hardy*, 229 W. Va. 251, 254, 728 S.E.2d 135, 138 (2012) (internal citations omitted); W. Va. Code § 29A-1-3(c).

otherwise provided by law, the standard of review by a circuit court in a writ of certiorari proceeding . . . is *de novo*."[34]

35. Thus, the Court must determine whether HCR's liability costs should be included in BMS cap calculations.

36. HCR makes the following arguments: (1) BMS did not provide HCR with notice of BMS's change in rate-setting methods; (2) Neither the State Plan nor other advisory manuals or regulations discuss or define "allowable costs"; and (3) Federal regulations allow reimbursement of liability costs.

Notice

37. The Petitioner asserts that, because BMS changed its methods of setting reimbursement rates, BMS should have provided notice to HCR. For the following reasons, the Court finds that BMS did not change its methods, but rather, followed an extant method of ensuring reasonable rates.

38. The Medicaid Act requires that a State Medicaid Plan include procedural and substantive elements for setting rates.[35] The Act states:

> A State plan for medical assistance must . . . provide . . . for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published . . . .[36]

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[34] Syl. pt. 3, *Wysong ex rel. Ramsey v. Walker*, 224 W. Va. 437, 686 S.E.2d 219 (2009).

[35] The Medicaid Act preempts state law. *See* W. Va. Code § 9-2-3.

[36] 42 U.S.C. § 1396a(a)(13)(A).

39. The relevant portion of the West Virginia Medicaid Plan (State Plan), "Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities," has not changed since 2004.[37] Further, HCR does not contend that BMS failed to give proper notice when the relevant portion of the State Plan was approved in 2004.

40. Under 42 C.F.R. § 447.253(b)(1),

> Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings: . . . The 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.

HCR does not contend that the relevant portion of the State Plan failed to make the appropriate finding when it was approved in 2004.

41. The Court finds no evidence showing that BMS changed its methods and standards in calculating the cap and setting reimbursement rates. Rather, the evidence shows that BMS pinpointed the reason for the incline of HCR's expenses and then ensured reasonable rates, as it is required to do every six months pursuant to the State Plan, by removing liability and settlement costs from the cap calculation. Because no new policy or rule was enacted, no notice was necessary.

42. Insofar as the Petitioner contends that HCR should be reimbursed for its liability and settlement costs because it has been in the past, the Court notes the State of West Virginia is not subject to the laws of estoppel when acting in a governmental capacity.[38] Further, the State and

[37] J. Ex. 4 (Attachment 4.19-D-1 of the West Virginia Medicaid Plan).

[38] *City of Beckley v. Wolford*, 104 W. Va. 391, 140 S.E. 344 (1927).

its political subdivisions are not bound by past *ultra vires* or legally unauthorized acts of its officers in the performance of a governmental function.[39]

Allowable Costs

43. The Petitioner asserts that BMS's interpretation of "allowable costs" as contained in the State Plan should not be entitled to deference.

44. The abovementioned relevant portion of the State Plan, Attachment 4.19-D-1, titled "Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities" states:

> Allowable Costs
> Reimbursement for nursing facility services is limited to those costs required to deliver care to patients. These are facility operating costs, patient direct service costs, and costs for the physical setting.
>
> 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:
>
> 1. Standard Services
> Standard services are Dietary, Laundry/Housekeeping, Medical Records, and Administration. Cost standards for these services are computed from the current cost report; i.e., salaries, supplies and services as submitted by the facilities. Total allowable costs for all patients are arrayed assuming 100% occupancy, i.e., licensed beds times days, to establish a per patient day cost. The costs are then arrayed by bed range; i.e., 0-90 and 91 plus. Extremes are eliminated by including those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP), i.e., average cost per bed range. The CAP is then adjusted by a 90% occupancy level to establish the cost standard for each standard service department. These standard service departments' cost standards are then summed to obtain a cost ceiling that

[39] *Cunningham v. County Court of Wood County*, 148 W. Va. 303, 310, 134 S.E.2d 725, 729–30 (1964); *Samsell v. State Line Development Co.*, 154 W. Va. 48, 59, 174 S.E.2d 318, 325 (1970).

> establishes the maximum allowable cost by bed range for the standard services
>
> 2. 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 from the current cost report.

45. Under West Virginia law, "[a]n inquiring court—even a court empowered to conduct *de novo* review—must examine a regulatory interpretation of a statute by standards that include appropriate deference to agency expertise and discretion."[40] The United States Supreme Court opinion, *Chevron USA v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), lays out the analytical framework for determining how much deference should be given to an agency's interpretation of a statute. To determine appropriate deference, the WV Supreme Court has reiterated the *Chevron*'s framework as follows:

> [To] apply the standards set out by . . . *Chevron* . . . , we first ask whether the Legislature has directly spoken to the precise legal question at issue. If the intention of the Legislature is clear, that is the end of the matter. If it is not, we may not simply impose our own construction of the statute. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the [agency's interpretation] is based on a permissible construction of the statute.[41]

46. The parties agree that the State Plan does not directly address whether liability or settlement costs are reimbursable. The Court finds the intention of the Legislature on this issue unclear.

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[40] *Appalachian Power Co. v. State Tax Dept. of W. Va.*, 195 W. Va. 573, 582, 466 S.E.2d 424, 433 (1995).

[41] *Id.* (internal citations omitted).

47. The next step of the framework requires the Court to determine whether BMS's interpretation is "based on a permissible construction of the statute."[42] To do so requires the Court to allot the appropriate amount of deference to the agency's interpretation, which requires labeling the rule or law as "legislative" or "interpretive."[43]

48. The West Virginia State Administrative Procedures Act (APA) defines "interpretive rule" as "every rule adopted by an agency independently of any delegation of legislative power which is intended by the agency to provide information or guidance to the public . . . ." The APA defines "legislative rule" as "every rule . . . proposed or promulgated by an agency . . . which, when promulgated after or pursuant to authorization of the legislature, has (1) the force of law, or (2) supplies a bases for the imposition of civil or criminal penalty, or (3) grants or denies a specific benefit."[44]

49. Relying on the APA, the West Virginia Supreme Court has explained that legislative rules affect private rights, privileges, or interests, in what amounts to a legislative act, while interpretive rules do not create rights but merely clarify an existing statute or regulation. Because they clarify existing law, interpretive rules need not go through the legislative authorization process.[45]

50. The State Plan is drafted by BMS pursuant to 42 U.S.C § 1396a(a) and W. Va. Code § 9-2-6. The State Plan is then considered by CMS for approval. The Plan provides the framework for granting or denying Medicaid reimbursement, a specific benefit. Accordingly, the Court concludes that the State Plan is a legislative rule.

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[42] *Id.*

[43] *Id.* at 583, 434.

[44] W. Va. Code § 29A-1-2.

[45] *Appalachian Power Co. v. State Tax Dept. of W. Va.*, 195 W. Va. 573, 583, 466 S.E.2d 424, 434 (1995).

51. The West Virginia Supreme Court has explained, "'Although they are entitled to some deference from the courts, the interpretive rules do not have the force of law nor are they irrevocably binding on the agency or the court. They are entitled on judicial review only to the weight that their inherent persuasiveness commands. . . . [A]n interpretive rule . . . is not to be given the full *Chevron* deference that applies to 'legislative' rules."[46]

52. Before the Court can assign *Chevron* deference to BMS's interpretation of the State Plan, the Court must first determine the rule's validity under *Chico Dairy Co., Store No. 22 v. W. Va. Human Rights Com'n*, 181 W. Va. 238, 382 S.E.2d 75 (1989), and *Kincaid v. Magnum*, 189 W. Va. 404, 432 S.E.2d 74 (1993). Under these cases, generally, a legislative rule can be ignored only if the agency has exceeded its constitutional authority or is arbitrary or capricious.[47] Here, the Petitioner does not contest the legitimacy of the State Plan, and neither party has indicated any reason to question the validity of the applicable provisions of the State Plan. Accordingly, the Court finds that the State Plan is a valid legislative rule.

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

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[46] *Id* at 583, 434, n.7.

[47] *Id.*at syl. 4.

54. The Petitioner further asserts that BMS's interpretation of the State Plan is a litigation position and therefore not entitled to deference.[48] The Court notes that nothing in the record indicates that BMS's interpretation was invented for litigation. Rather, the testimony in the record tracks BMS's reasoning before the appeals were filed.

55. Notwithstanding the deference afforded to BMS's interpretation of the State Plan, the Court finds that it is against the public policy of this State to reimburse healthcare facilities for expenses incurred by legal settlements covered under a high deductible insurance policy such as the $10,000,000.00 deductible in the instant case.

Medicare Provider Reimbursement Manual

56. The Petitioner contends that 42 C.F.R. § 447.253 does not address whether it is appropriate to reimburse HCR for settlement and liability costs. Under the Section 514.12.3 of the West Virginia Medicaid Provider Manual:

> 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 (GAPP) will be applied. None of these secondary applications will serve to reduce the Department's ability to apply "reasonable cost" limits under Medicaid.[49]

Thus, HCR argues, the Court should look to the federal Provider Reimbursement Manual for Medicare, which states in Section 2162.5:

> Allowability of Actual Losses Related to Deductibles or Coinsurance.--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

[48] *See Petition of Smuffer*, 193 W. Va. 412, 417, 456 S.E.2d 493, 498 (1995) (Cleckley, J., concurring) (deference does "not extend to *ad hoc* representations on behalf of an agency, such as litigation arguments.")

[49] The West Virginia Medicaid Provider Manual summarizes the description and administration of the Medicaid program.

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

57. HCR argues this provision allows reimbursement of liability and settlement costs. However, assuming *arguendo* that the Medicare Provider Reimbursement Manual applies, HCR has adduced no evidence that it has satisfied the terms of this provision and has not explained how it is entitled to the presumption created by this provision. The Court finds this argument unpersuasive as well.

58. Upon *de novo* review, the Court finds and concludes that HCR's liability costs should not be included in BMS cap calculations.

DECISION

Accordingly, the Court does **DENY** the *Petition*. There being nothing further, the Court does **ORDER** that the above-styled appeal be **DISMISSED** and **STRICKEN** from the docket of this Court. The Clerk is **DIRECTED** to send a copy of this *Final Order* to the parties and counsel of record.

ENTERED this 13 day of May 2015

Louis H. Bloom, Judge

Date 5/19/15
Certified copies sent to
counsel of record
parties
other
By: K. Jones
C. Copland
Deputy Circuit Clerk

STATE OF WEST VIRGINIA
COUNTY OF KANAWHA, SS
I, CATHY S. GATSON, CLERK OF CIRCUIT COURT OF SAID COUNTY AND IN SAID STATE, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE COPY FROM THE RECORDS OF SAID COURT.
GIVEN UNDER MY HAND AND SEAL OF SAID COURT THIS
DAY OF
CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA