IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

No. 23-ICA-207

West Virginia HCR Manorcare Facilities, Heartland of Beckley, Heartland of Charleston, Heartland of Clarksburg, Heartland of Keyser, Heartland of Martinsburg, Heartland of Preston County and Heartland of Rainelle,

Petitioners Below, Petitioners

vs.

West Virginia Department of Health and Human Resources, Bureau for Medical Services, Respondent Below, Respondent

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BRIEF OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iii

ASSIGNMENTS OF ERROR 1

STATEMENT OF THE CASE 2

SUMMARY OF THE ARGUMENT 7

STATEMENT REGARDING ORAL ARGUMENT AND DECISION 10

ARGUMENT 10

I. This Court has Jurisdiction of the Appeal 10

II. Standard of Review 12

III. The Hearing Decision is Based on Errors of Law, is Arbitrary and Capricious, and Without Substantial Evidence. 13

A. The Hearing Decision Erroneously Assessed Only Whether the Originally Reported Liability Costs of HCR Were Reasonable, and Improperly Accepted the Proposed BMS Figure Which Was Arbitrary and Without Substantial Evidence. 13

B. The Bureau Failed Once Again to Conduct an Analysis as to the Point at Which Costs become "Substantially Out of Line" or What Facilities are Similar in Light of "Relevant Factors." 15

i. The Bureau's $50,000 proposed figure is not a reasoned determination but merely a figure chosen by counsel. 16

ii The Bureau's reliance on the Genesis facilities comparison was never tied to the $50,000 calculation. 18

iii. The Genesis facilities were unusually low cost and not evidence of the limit beyond which costs become "substantially out of line." .. 18

C. The Bureau's Proposed $50,000 Addition Results in Costs Lower than Those Approved Elsewhere by the Bureau. 21

IV. The Methodologies Set Out by HCR'S experts—Which Converged to Within $1 of Each Other—Should Have Been Adopted. 23

A. Summary 23

B. The Bureau's Previously-Approved Rate in 2011 Sets a Minimum for Any Assessment of "Substantially Out Of Line." 24

C. Calculation of a New Rate Using a Limit of $5,600 Per Bed Per Year Confirms the Approach Set Out in Calculation Based on the Bureau's Previously-Approved Per Diem Rate of $39.07. 26

D. The Bureau did not Rebut the HCR Expert Testimony, and the Hearing Examiner's Stated Bases for Disregarding it ere Clearly Wrong. 31

CONCLUSION 32

CERTIFICATE OF SERVICE 344

TABLE OF AUTHORITIES

Cases **Page(s)**

Citizens Bank of Weirton v. West Virginia Board of Banking and Financial Institutions,
160 W. Va. 220, 233 S.E.2d 719 (1977) 8, 13, 14

Groves v. Cicchirillo,
225 W. Va. 474 17

Harris v. Saul,
2020 WL 221964 (E.D. Wis. Jan. 15, 2020) 16

Harrison v. Ginsberg,
169 W. Va. 162, 286 S.E.2d 276 (1982) 13

Heartland of Beckley WV, LLC v. Bureau for Medical Services,
No. 15-0595, 2016 WL 6248620 (W. Va. Oct. 26, 2016) 3, 4, 10

In re Queen,
196 W.Va. 442, 473 S.E.2d 483 (1996) 12

J.S. ex rel. S.N. v. Hardy,
229 W.Va. 251, 728 S.E.2d 135 (2012) 10, 13, 14

Morris Nursing Home v. W. Va Human Rights Commission,
189 W. Va. 314, 431 S.E.2d 353 (1993) 13

Princeton Community Hospital v. State Health Planning and Development Agency,
174 W. Va. 558, 328 S.E.2d 164 (1985) 13

Robert F. v. Kijakazi,
No. 121-CV-01025-MJDJRS, 2022 WL 2763233 (S.D. Ind. July 15, 2022) 17

Shepherdstown Volunteer Fire Dept. v. State ex rel. State of West Virginia Human Rights Com'n,
172 W. Va. 627, 309 S.E.2d 342 (1983) 17

St. Mary's Hospital v. State Health --Planning and Development Agency, 178 W. Va. 792, 364 S.E.2d 805, 809 (1987) 13

State ex rel. Ginsberg v. Watt,
168 W.Va. 503, 285 S.E.2d 367 (1981) 10

State ex rel. Heartland of Beckley WV LLC.,
No. 20-0961, 2021 WL 1944395 (W. Va. May 14, 2021) 4

W. Virginia Dep't of Health & Hum. Res. v. Downs-Jamal,
No. 22-ICA-129, 2023 WL 4027502 (W. Va. App. June 15, 2023)..... 11

Statutes

W. Va. Code § 16-1-22a (a)(1), (c) and (d) 11, 12
W. Va. Code § 29A-1-3 10
W. Va. Code § 29A-5-4 (g) (4), (5), and (6)..... 11, 12
W. Va. Code § 51-11-4, (b)(4)..... 11

ASSIGNMENTS OF ERROR

This case concerns appropriate Medicaid payment, for the cost reporting period from January 1, 2012 to June 30, 2012, due to the West Virginia HCR nursing facilities. ("HCR") The Bureau for Medical Services of the West Virginia Department of Health and Human Services ("BMS" or "The Bureau") reimburses nursing facilities, for services to West Virginia Medicaid recipients, based on "allowable costs." This appeal arises from the third evidentiary proceeding on the same cost report period, and concerns allowable costs related to liability insurance.

BMS initially held that any paid claim expenses incurred by nursing facilities with high insurance deductibles, such as legal fees and settlement costs, were not allowable costs. On appeal after the first evidentiary hearing, the Supreme Court of Appeals rejected that position as an error of law and remanded for further proceedings to determine the extent of costs that were reasonable and not "substantially out of line" under relevant federal regulations. A.R.1454. After the second evidentiary hearing, the BMS Hearing Examiner found that BMS had not complied with the mandate to assess those costs in accord with the Supreme Court's mandate. A.R. 1173.

At the third evidentiary hearing, BMS demonstrated that it has still failed to comply with the mandate of the Supreme Court of Appeals. The Bureau proposed including an additional $50,000 in allowable expenses for each HCR facility. A.R. 1511. The recommended decision of the Hearing Examiner, adopted by the Bureau (the "Hearing Decision" – A.R. 1606), approved the action of the Bureau and was in error, for the following reasons:

1. The $50,000 figure was not the product of an assessment made under the factors set forth in the decision of the Supreme Court or determined by any calculation or

assessment, but was adopted at the direction of BMS counsel. The Hearing Decision recognized that figure was "not satisfactorily explained." (A.R. at 1627). The Decision erred in accepting a facially arbitrary and capricious figure.

2. The Hearing Decision erroneously assessed only whether the originally reported liability costs of HCR were "substantially out of line," without assessing the point at which the costs became substantially out of line and what portion might be properly allowable.

3. The Hearing Decision made no assessment or analysis of the relevant factors to determine a correct level of allowable costs and thus exclude only those costs that were "substantially out of line."

4. The Hearing Decision was also in error in accepting the proposed $50,000 figure because there was no substantial support for it in the record, and it was contrary to the reliable and probative evidence in the record.

5. The Hearing Decision erred in rejecting the proposals of HCR, for $46.08 or $47.07 in costs per day (compared to the original limit of $60.60 per day) as a reasonable assessment of the point beyond which costs would be "substantially out of line." The Hearing Decision's stated bases were arbitrary or in clear legal error. For example, the Hearing Decision held that rates previously approved by BMS were not properly considered by HCR's experts because those rates included direct settlement and liability costs—a holding precluded by the Supreme Court's earlier decision.

STATEMENT OF THE CASE

The Hearing Decision arose from a hearing on October 19, 2022 regarding the appropriate reimbursement to the HCR nursing facilities for services provided to residents covered by West Virginia's Medicaid program. A.R. 1471. That hearing was the third hearing to

occur[1] in connection with an underlying agency decision issued more than 10 years ago, on June 17, 2013 (the "Desk Review Decision"). A.R. 1186.

West Virginia's Medicaid program reimburses nursing facilities based on allowable costs. The Desk Review Decision held that nursing facilities with high-deductible insurance policies could not include, as allowable liability insurance costs, settlement and litigation costs they incurred below their deductible. A.R. 1191 at ¶ 18 ("it is clear that such payments are not an allowable expense"). The Bureau disallowed over $53,000,000 in costs and substantially reduced the payments to the facilities. A.R. 1709-1710 (showing aggregate disallowance and effect on daily rates). The disallowance amounted to 81.23% of the total "Taxes and Insurance" cost center. A.R. 1255 at 40:8-41:4. The Bureau did not disallow legal expenses or fees such as direct insurance premium but attempted to remove all of the paid claim and settlement costs. A.R. 1360-1361 at 37:24-38:21; A.R. 1370 at 76:21-23. However, after getting more specific information on the HCR facility's paid claims costs, the Bureau realized some paid claims had not been disallowed, and Ms. Snow prepared DHHR Exhibit 19 to show the variance between the actual disallowance and what the disallowance would have been based on the later information. A.R. 1258–1259 at 50:13-54:11. The differential between the actual disallowance and the recalculated disallowance would have been about 2%. A.R. 1264 at 75:14-76:12.

The West Virginia Supreme Court of Appeals held that BMS committed an error of law in its conclusion that litigation and settlement costs were not allowable costs. *Heartland of Beckley WV, LLC v. Bureau for Medical Services*, No. 15-0595, 2016 WL 6248620 (W. Va. Oct. 26, 2016); A.R. 1454. The Court specifically held that that relevant federal regulations and

[1] The parties agreed that the full record from the prior two hearings would be deemed part of the record for the third hearing. A.R. 1474 at 9:7-10:4.

guidance applied in the absence of a state regulation on the issue, and authorized inclusion of the costs. A.R. 1459. The Supreme Court reversed the Bureau's holding and remanded for application of the correct legal standard, including the limitation set forth in § 2102.1 of the federal government's Provider Reimbursement Manual ("PRM"),[2] which excludes costs that are "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.*

Upon remand, a second evidentiary hearing was held on May 22, 2018. A.R. 1351. At the second evidentiary hearing the Hearing Examiner held that the Bureau had disregarded the mandate of the Supreme Court. A.R. 1173. The Bureau did not change its position and did not undertake an assessment of reasonableness as required under the relevant regulations. A.R. 1182-1883. The Hearing Examiner did not, however, render a decision on the existing evidence but instead recommended that the matter be remanded to allow the Bureau a second opportunity to present evidence on the issue as directed in the Supreme Court's prior ruling. A.R. 1184.

After delays in obtaining a hearing date, HCR filed a petition for writ of prohibition in the Supreme Court of Appeals, seeking to preclude a third hearing and require a ruling on the existing evidence. A.R. 1462. The Supreme Court denied the petition on May 14, 2021[3] and a third evidentiary hearing was held on October 19, 2022. A.R. 1462; 1468.

At the third hearing, BMS proposed that the payments to the HCR facilities be recalculated after inclusion of an additional $50,000 in allowable costs for each facility. A.R. 1475 at 16:7-18. The facilities vary in size from 60 beds to 201 beds and the scope of previously disallowed costs varied from approximately $400,000 to $1,300,000 A.R. 1709.

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[2] The Hearing Decision at one point incorrectly refers to the PRM as the "West Virginia PRM." A.R. 1610. The Hearing Decision elsewhere correctly notes that the PRM is a federal Medicare manual. *See e.g.,* A.R. 1622.

[3] *State ex rel. Heartland of Beckley WV LLC.*, No. 20-0961, 2021 WL 1944395 (W. Va. May 14, 2021)

The $50,000 figure was not the product of an assessment of the factors set forth in the Supreme Court's decision and not the product of any methodology. The Bureau's witness, Jeanne Snow (a former Director of Rate Setting at BMS), testified that counsel for BMS had selected the $50,000 figure. A.R. 1477 at 24:8-11. Ms. Snow provided no methodology or calculations regarding the figure that she said counsel selected. However, she provided an exhibit and testimony comparing the HCR liability costs to one other nursing home chain operating in West Virginia—Genesis HealthCare. A.R. 1475 at 14:1-15:6; A.R. 1511.

Ms. Snow acknowledged that, unlike HCR, Genesis was not self-insured. A.R. 1478 at 26:6-16. Ms. Snow relied on the Genesis facilities based on their "national chain" standing and without analysis of any relevant factors. *Id.* at 25:11-16. Ms. Snow also acknowledged that there were other national chains operating in West Virginia (A.R. 1371 at 79:9-12), none of which were considered. Ms. Snow did not know if Genesis reported all company-wide insurance costs under the "taxes and insurance" cost center as opposed to central office costs (A.R. 1478 at 26:18-22) and did not know whether the Genesis level of insurance coverage matched the $125,000,000 level of HCR. A.R 1371 at 80:7-10. Ms. Snow did not conduct any further analysis beyond reviewing the Genesis reported costs because she had "got[ten] the results I was looking for as far as the comparison." A.R. 1478 at 25:13-16.

The Genesis facilities were low cost, with the highest cost facility ranked at 13 out of 51 large bed facilities and the lowest at 42 of 51 (arrayed high to low). A.R. 1511. The Genesis faculties' costs were, therefore, substantially lower than that of the HCR facilities, which were the highest cost facilities in the large bed group. A.R. 1710. The Genesis costs were not only below many, many facilities in the cost period under review, but also much lower than the

$39.07 cost CAP approved by BMS in the rate period immediately prior. A.R. 1489–1490 at 72:19-73:10.

BMS provided no exhibits and no testimony connecting the costs submitted by Genesis to the $50,000 figure the Bureau proposed as the additional allowable costs.

HCR provided expert testimony from two experts from the same firm: Lane Ellis (at the 2014 and 2018 hearings) and, after the retirement of Mr. Ellis, Greg Gibb (at the 2022 hearing). A.R. 1381 at 120:6; A.R. 1485 at 53:17. Both were accepted by the different hearing examiners as experts A.R. 1306 at 242:21-243:5; A.R. 1486-1487 at 60:24-61:24.

The HCR experts proposed two different methodologies to assess the point at which costs for the HCR facilities would become "substantially out of line," both of which were proposed at the second evidentiary hearing. The first methodology started from the Taxes and Insurance CAP adopted by the Bureau for the cost report period ending December 31 2011, one day before the cost period at issue. A.R. 1489–1490 at 72:19-73:6. That methodology, which was set out in HCR Exh. 33 (A.R. 2173) applied the approved CAP from the prior period to the HCR reported expenses, by restating the HCR facility expenses at that rate and recalculating the statewide CAP including the adjusted (not full) HCR costs. A.R. 1389-1391 at 151:16-158:24. That methodology resulted in a recalculated state-wide CAP for Taxes and Insurance of $46.08 per diem. A.R. 2173. The second methodology was set out in HCR Exh. 35 (A.R. 2175) and started from a per-bed cost figure of $5,600. A.R. 1392 at 164:3-15. The $5,600 per bed figure for the Taxes and Insurance cost center came from the reported figure for another facility, which was $5,633 (A.R. 1387 at 142:10-143:4), and in consideration of average per bed costs in a national study by AON group, that included both West Virginia and Kentucky. A.R. 1393 at 166:8. The second methodology bases allowable costs on the $5,600 per bed for the HCR

facilities, and then re-calculates the state-wide CAP, using the modified HCR data with the pre-existing data for other facilities, to arrive at a CAP of $7.07. A.R. 1392–1393 at 164:3-169:5-13.

The Bureau did not call any experts to rebut the expert testimony offered by HCR, and did not ask Ms. Snow to assess the methodologies. The Hearing Examiner found that Mr. Gibbs was a credible expert. A.R. 1202. However, the Hearing Examiner did not accept either methodology proposed by HCR's experts, for two reasons. The first was that the HCR methodologies relied on cost data that would have included paid claims and the Bureau was not "knowingly paying for these costs before this dispute arose." A.R. 1655. The second stated basis was that the data from outside areas was not shown to have been available to the Bureau at the time it made the disallowance. *Id.*

The Hearing Examiner issued his decision on January 18, 2023 (A.R. 1633) but the Commissioner of the Bureau did not adopt the decision until April 24, 2023. A.R. 1634. HCR filed this appeal on May 23, 2023.

SUMMARY OF THE ARGUMENT

The Bureau's position at the third evidentiary hearing still fails to comply with the mandate of the Supreme Court. Instead of conducting the required analysis to determine the point at which costs would become "substantially out of line," the Bureau proposed a purely arbitrary addition to allowable costs to resolve the improper initial disallowance.

The Bureau initially held that inclusion of *any* paid claims costs was categorically improper. After the Supreme Court corrected that error, the Bureau did not change its position and did not undertake the assessment mandated by the Supreme Court. At the third evidentiary hearing, the Bureau proposed increasing the allowable costs by $50,000 per facility. The evidence showed, however, that the figure was not the product of the assessment directed by the

Supreme Court. The $50,000 figure was not the product of any analytical process. It was not derived from or calculated from the reported costs of the Genesis facilities about which the Bureau's witness testified and provided exhibits. There was no methodology at all provided for the calculation of the $50,000 figure, which was, in fact, simply selected by counsel.

The $50,000 allowance per facility provides widely different per-bed increases, because the facilities vary from 60 to 201 beds. In all cases, however, the proposal results in rates that are far below rates approved by the Bureau in other contexts, including the rate approved and applied by the Bureau for the period ending December 31, 2011, one day before the cost period at issue here.

The Hearing Examiner acknowledged the problems and charitably stated that the "rationale" for the $50,000 figure was not "satisfactorily explained." A.R. 1656. The Hearing Examiner nevertheless improperly accepted a figure that violated the long-established requirement for a "reasoned explanation" by an agency of its decision, and the duty to avoid arbitrary action. Syl. Pt. 2, *Citizens Bank of Weirton v. West Virginia Board of Banking and Financial Institutions,* 160 W.Va. 220, 233 S.E.2d 719 (1977). The Hearing Examiner then asserted that the "gratuitous gesture," even if "arbitrary," did not "invalidate the agency's *initial* determination" that the HCR reported costs were out of line." A.R. 1656.

That, however, does not answer the relevant question. The Bureau's Desk Review Decision disallowed all[4] settlement costs on an improper basis, and the question now is: what portion of the reported costs should have been disallowed as "substantially" out of line compared to facilities "similar in size, scope of services, utilization and relevant factors"? PRM § 2102.1. Showing that the total reported by the various HCR facilities was "substantially out of line" is

[4] As noted, the Statement of the Case, *supra* at 3, the Bureau later learned of additional information showing that the Bureau's methodology was imprecise and inadvertently left in about 2% of the costs.

not equivalent establishing the *portion* of the claimed total that would *not* be "substantially out of line."

HCR's experts provided two different, detailed methodologies that produced re-calculated "CAP" figures that diverged by only one dollar. One calculation relied on the rate approved by BMS immediately prior to the rate period in question and resulted in a CAP of $46.08 for "large bed" facilities. The second approach worked from a cost basis of $5,600 per bed, a figure based on the actual costs of a similar facility, and on the reported annual costs of West Virginia and Kentucky nursing facilities in the AON studies. That methodology yielded a per diem rate of $47.07 for the Taxes and Insurance cost center. The close correlation between the two numbers ($46.08 and $47.07) reinforces the reliability of both.

The Bureau did not provide expert testimony on the HCR methodologies or even solicit testimony from its witness, Jeanne Snow, even though it has had possession of the calculations since the second evidentiary hearing in May, 2018. Although the Hearing Examiner found that HCR's witness, Mr. Gibbs, was credible, he disregarded Mr. Gibb's testimony on two erroneous bases. The first was that both HCR methodologies incorporated cost data that included damage and settlement payments. Those costs however, were expressly allowed by the Supreme Court's decision. The second was simply that the Bureau did not track or have ready access to data from Kentucky (used in the second methodology). That point has nothing to do with whether the data is relevant or reliable.

Because the Bureau's proposed resolution is nothing more than a figure plucked by counsel from the air, and the HCR proposals are detailed methodologies fully explained and grounded in data, the Hearing Decision should be reversed and the Bureau directed to apply one of the HCR methodologies.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

HCR requests oral argument under Rule 20 of the Rules of Appellate Procedure. There are issues of first impression in this case, including jurisdiction of this Court over provider reimbursement cases, and the proper response to an agency that has had three evidentiary hearings on the same issue and has failed to correctly apply the law, even after a mandate of the Supreme Court of Appeals. In addition, there are over 1,600 pages in the administrative record, and the underlying payment methodologies are complex. For those reasons, a memorandum decision may not be appropriate.

ARGUMENT

I. THIS COURT HAS JURISDICTION OF THE APPEAL

The West Virginia Administrative Procedures Act does not apply, as to rule making and contested cases, to cases involving the "receipt of public assistance." W. Va. Code § 29A-1-3. For that reason, prior to the creation of this Court, review of provider payment decisions of the Bureau of Medical Services was by writ of certiorari to the Circuit Court of Kanawha Count. Syl. Pt. 2, *State ex rel. Ginsberg v. Watt*, 168 W.Va. 503, 285 S.E.2d 367 (1981) (holding that the West Virginia administrative Procedures Act did not apply to cases involving the receipt of "public assistance" and 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 a state agency not covered by the [APA]."); *Heartland of Beckley WV, LLC v. Bureau for Med. Servs.*, No. 15-0595, 2016 WL 6248620, at *3, FN 4 (W. Va. Oct. 26, 2016) (quoting *Ginsberg* and Syl. Pt. 2, *J.S. ex rel. S.N. v. Hardy*, 229 W. Va. 251, 728 S.E.2d 135 (2012) and holding that certiorari was the proper avenue for review).

Under the recently-enacted provisions of W. Va. Code § 51-11-4, however, this Court is given general jurisdiction over appeals of final decisions of administrative agencies. The specific language of the jurisdictional grant, however, may create a possible question as to proceedings of this kind, because it grants jurisdiction over:

> (4) Final judgments, orders, or decisions of an agency or an administrative law judge entered after June 30, 2022, heretofore appealable to the Circuit Court of Kanawha County pursuant to §29A-5-4 or any other provision of this code;

W. Va. Code § 51-11-4(b)(4). Under a very narrow reading of the foregoing language, there might be a claim that jurisdiction is lacking because provider appeals by Medicaid providers were "heretofore" by writs of certiorari, and were not made pursuant to W. Va. Code §29A-5-4.

Such a narrow reading is not warranted. First, the grant of jurisdiction also includes cases "heretofore appealable to the Circuit Court of Kanawha County . . . . *under any other provision of this code*." W. Va. Code § 51-11-4(b)(4) (emphasis added). Review by writ of certiorari was previously authorized under "other provisions" of the code, and the Legislature's use of "appealable" should not be given a hyper-technical reading in light of the absence of actual "appeals" authorized to the Circuit Court of Kanawha County, and the Legislature's evident intent to transfer review of administrative cases to this Court. This Court has regarded matters relating to public assistance as subject to review by this court under this provision of the code. *See, e.g., W. Virginia Dep't of Health & Hum. Res. v. Downs-Jamal,* No. 22-ICA-129, 2023 WL 4027502, at *1 (W. Va. App. June 15, 2023) (finding jurisdiction over appeal of decision to terminate provider's contract "pursuant to West Virginia Code § 51-11-4 (2022)").

Moreover, there is a new[5], specific grant of jurisdiction in Chapter 16 of the code, which deals with review of contested cases applicable to state public health matters and,

[5] The provisions of the cited sections became effective on May 23, 2023, the date on which this appeal was filed.

specifically, the Bureau for Medical Services. W. Va. Code § 16-1-22a. The new statute defines "agency" as including the Department of Health "Board of Review or the Bureau for Medical Services, as the case may be, that has been named as a party to any proceeding on appeal made pursuant to the provisions of this section." W. Va. Code § 16-1-22a(a)(1). The statute then provides:

> (c) Any party adversely affected or aggrieved by a final decision or order of the agency may seek judicial review of that decision by filing an appeal to the Intermediate Court of Appeals as provided in § 29A-5-4 et seq., of this code.
>
> (d) The process established by this section is the exclusive remedy for judicial review of final decisions of the Board of Review and the Bureau for Medical Services.

W. Va. Code 16-1-22a(c) and (d). The statute thus defines the right of review as being an appeal under § 29A-5-4 of the APA, without regard to whether the review would otherwise be authorized there, and states that such an appeal is the exclusive means of obtaining review.

II. STANDARD OF REVIEW

Under the West Virginia APA, an administrative agency decision must be reversed if (among other reasons) the decision is "affected by error of law," is "[c]learly wrong in view of the reliable, probative and substantial evidence on the whole record" or is "[a]rbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion." W. Va. Code § 29A-5-4 (g) (4), (5), and (6). "The 'clearly wrong' and the 'arbitrary and capricious' standards of review are deferential ones which presume an agency's actions are valid as long as the decision is supported by substantial evidence or by a rational basis." Syl. Pt. 3, *In re Queen,* 196 W. Va. 442, 473 S.E.2d 483 (1996). But there must be substantial evidence in the record, if the decision is to stand. Although a court should not substitute its judgment for that of the agency, substantial evidence requires "such relevant evidence, on the whole record, as

a reasonable mind might accept as adequate to support a finding." *Morris Nursing Home v. W. Va Human Rights Commission*, 189 W. Va. 314, 316, 431 S.E.2d 353, 355 (1993). And the deference to agency factual findings "does not mean a court should shirk its obligation to make a searching and careful inquiry into the facts." *Princeton Community Hospital v. State Health Planning and Development Agency*, 174 W. Va. 558, 328 S.E.2d 164, 171 (1985).

In addition, it has long been settled that "the law contemplates a reasoned, articulate decision which sets forth the underlying evidentiary facts which lead the agency to its conclusion, along with an explanation of the methodology." Syl. Pt. 2, *Citizens Bank of Weirton v. West Virginia Board of Banking and Financial Institutions,* 160 W. Va. 220, 233 S.E.2d 719 (1977). That requirement is so basic that it applies to any administrative decision, regardless of whether the APA applies. *Harrison v. Ginsberg*, 169 W. Va. 162, 171, 286 S.E.2d 276, 281 (1982) (the requirements of *Citizens Bank* "are clearly applicable to any administrative review.). Finally, the requirement that "an administrative agency rule on the parties' proposed findings is mandatory . . . [and] [a]lthough the agency does not need to extensively discuss each proposed finding, such rulings must be sufficiently clear to assure a reviewing court that all those findings have been considered and dealt with, not overlooked or concealed." *St. Mary's Hospital v. State Health --Planning and Development Agency,* 178 W. Va. 792, 364 S.E.2d 805, 809 (1987)

III. THE HEARING DECISION IS BASED ON ERRORS OF LAW, IS ARBITRARY AND CAPRICIOUS, AND WITHOUT SUBSTANTIAL EVIDENCE.

A. The Hearing Decision Erroneously Assessed Only Whether the Originally Reported Liability Costs of HCR Were Reasonable, and Improperly Accepted the Proposed BMS Figure, Which Was Arbitrary and Without Substantial Evidence.

As will be shown below, the BMS proposal of adding an additional $50,000 in allowable costs to each HCR nursing facility was not the result of any assessment of the point at

which costs become "substantially out of line with other institutions in the same area which are *similar in size, scope of services, utilization, and other relevant factors*." PRM § 2102.1 (emphasis added). Indeed, as discussed further below, the Bureau undertook no assessment of the demarcation point, as the Bureau's witness admitted (A.R. 1474 at 12:14-23), and the selection of figure was dictated by counsel. A.R. 1477 at 24:8-11.

The Hearing Decision acknowledged these problems in holding that the $50,000 figure was "not satisfactorily explained." A.R. 1656. As will be shown below (*see* III. B.) the Hearing Examiner's conclusion that the BMS proposed figure of $50,000 was "not satisfactorily explained" is an understatement. The Hearing Examiner's recommended decision did not correct the lack of a satisfactory explanation for the Bureau's position. This alone mandates reversal, because an agency has a duty to provide a "a reasoned, articulate decision which sets forth the underlying evidentiary facts which lead the agency to its conclusion." Syl. Pt. 2. *Citizens Bank of Weirton v. West Virginia Board of Banking and Financial Institutions*, 160 W. Va. 220, 233 S.E.2d 719 (1977). The Hearing Decision's acceptance of the BMS proposal was thus an error of law.

The acceptance of the figure was also improper because the Hearing Examiner's analysis was based on an entirely incorrect question: whether the *originally reported* costs of the HCR facilities for liability insurance costs were "substantially out of line." HCR, however, is not now seeking inclusion of its full reported costs, and has proposed methodologies resulting in $46.08 and $47.07 per day as the calculated CAP for the Taxes and Insurance cost center (A.R. 2173; 2175) figures well below the $60.60 per day resulting from the original data, but above the $25.27 resulting from the Bureau's unlawful exclusion of all paid claim costs. A.R. 1710. The decision nevertheless repeatedly stated that the "reported costs" were unreasonably high and

discussed those costs at length. *See, e.g.* A.R. 1624. The Hearing Decision then defended the $50,000 figure proposed by the Bureau as follows: "Even if this amount, which increases the amount of reimbursement to which HCR is now entitled, is an arbitrary number, this gratuitous gesture does not undermine the Bureau's rationale for concluding that *the original amounts claimed by HCR were substantially out of line* . . ." A.R. 1627 (emphasis supplied). But any excessiveness in those sums would do nothing to show that $50,000 is the proper figure nor would any excessiveness of those figures justify adopting an arbitrary figure.

B. The Bureau Failed Once Again to Conduct an Analysis as to the Point at Which Costs become "Substantially Out of Line" or What Facilities are Similar in Light of "Relevant Factors."

As shown above, Hearing Decision disregarded the relevant questions, and there is no evidence in the record remotely sufficient to uphold the Bureau's proposed $50,000 per facility adjustment. Acceptance of the $50,000 per facility adjustment would be improper, based on the actual record, because:

1. The Bureau's never tied the $50,000 figure to any of the data the Bureau submitted and never explained the calculation by which it was selected. When asked on cross examination where the figure came from, the Bureau's sole witness explained that counsel had selected the figure.
2. The Bureau's primary reliance was on a comparison between the originally submitted costs of HCR and facilities operated by Genesis HealthCare. HCR does not contend that the original cost submissions meet the test of PRM § 2102.1 but instead seek the lower limits calculated by its experts. In addition, the Genesis data was not part of any effort to ascertain the point at which costs become "substantially out of line."

3. The Genesis facilities are not even a proper comparison to the HCR facilities, because of the absence of demonstrated similarities.

i. The Bureau's $50,000 proposed figure is not a reasoned determination but merely a figure chosen by counsel.

The Supreme Court directed that the Bureau assess the "substantially out of line" issue in consideration of "size, scope of services, utilization and other relevant factors." A.R. 1240. The testimony of the Bureau's sole witness, Jeanne Snow, established that no such assessment occurred.

Ms. Snow testified at length about the original costs of the HCR facilities, and also about the costs reported by facilities owned by Genesis HealthCare, pointing how much lower the Genesis costs were. A.R. 1475 at 14:2-24 – 15:1-17. As will be discussed below, the Genesis facilities are not a proper comparison to the HCR facilities and were, in fact below costs at many other nursing facilities, thus, they do not represent the point where costs would become "substantially out of line." *See, infra*, III.B.iii. Ms. Snow acknowledged that the Supreme Court decision required finding the "demarcation point" at which a facility's costs would become "substantially out of line." A.R. 1477-1478 at 24:23-25:4. Ms. Snow admitted that she had not done anything "try to figure out where the demarcation point is," other than compare the HCR facilities to the Genesis facilities. A.R. 1478 at 25:7-12. When asked by the Bureau's counsel why she did not do anything else to determine the "demarcation point," Ms. Snow said: "[b]ecause I got my results that I was looking for, as far as the comparison." *Id*. at 25:13-15. In other words, the Bureau was looking for a result, not looking for data to that would allow an assessment of the proper "demarcation point" beyond which HCR's costs would become "substantially out of line." Working from a preconceived set of "the results [it] was looking for" is not compliance with the mandate of the Supreme Court and is not even a rational approach to

decision making. Although no West Virginia case appears to have considered this results-oriented approach, it has been rejected by federal courts. *See Harris v. Saul,* 2020 WL 221964 (E.D. Wis. Jan. 15, 2020) (rejecting ALJ conclusion because "the ALJ apparently chose the ten percent figure because that is where most vocational experts will draw the line between the acceptable and unacceptable, not because it was supported by substantial evidence.").

Most importantly, Ms. Snow made no claim that the additional $50,000 in allowable expenses was the product of an effort to comply with PRM § 2102.1 and the Supreme Court's mandate to ascertain the amount of costs "substantially out of line." In fact, Ms. Snow testified to a very different basis for selection of the number: *the direction of counsel.*

> Q. Let me start with the $50,000 number that appears as an addition on Exhibit No. 27. How did you come up with $50,000 as the number to be added?
>
> A. I was—that was requested from counsel.

A.R. 1477 at 24:8-11. An attorney opinion (much less an out-of-court opinion) appears never to have been offered, much less accepted, as the basis for an administrative agency's factual conclusion. There are, thus, no reported decisions on the remarkable position that BMS has taken here. Courts have, however, rejected reliance on a figure "seemingly pulled out of thin air with no basis in evidence" and held that a "completely arbitrary estimate" is not sufficient to support an administrative action. *Robert F. v. Kijakazi*, No. 121-CV-01025-MJDJRS, 2022 WL 2763233, at *3–4 (S.D. Ind. July 15, 2022) (rejecting ALJ conclusions that lacked apparent basis). Certainly, the reliance on counsel's choice does not amount to the "substantial evidence" needed to support an administrative decision. *Groves v. Cicchirillo*, 225 W. Va. 474, 478, 694, S.E.2d 639, 643 (2010) (citing Syl. Pt. 2, *Shepherdstown Volunteer Fire Dept. v. State ex rel. State of West Virginia Human Rights Com'n*, 172 W. Va. 627, 309 S.E.2d 342 (1983)).

ii. The Bureau's reliance on the Genesis facilities comparison was never tied to the $50,000 calculation.

The Bureau relied heavily at the hearing on the lower insurance costs reported by Genesis HealthCare. Ms. Snow's testimony discussed the facilities (A.R. 1475 at 14:1 – 15:3) and her Exhibit 25 highlighted the Genesis costs in comparison to HCR costs. A.R. 1511. Of course, showing that the *total* HCR costs reported were well above the Genesis figures does not show that *all* of the HCR costs should have been excluded, nor that the Genesis facilities are at the demarcation point for "substantially out of line." In addition, some of the numerous problems with the sole reliance on the Genesis costs are discussed below in subsections, iii and iv. But this Court need not even consider those detailed problems in light of one fact: the reported costs of the Genesis facilities were never connected in any way, by the Bureau's witness and evidence or by the Hearing Decision, to the Bureau's proposed $50,000 increase in allowable costs. There is not one word of testimony tying the Genesis costs to the $50,000 figure. And that is fully explained by the admission of the Bureau's witness, discussed above, that the figure was selected by counsel.

Nevertheless, HCR will discuss below some of the fundamental problems with use of the Genesis facility cost as any kind of yardstick for determining when costs become "substantially out of line."

iii. The Genesis facilities were unusually low cost and not evidence of the limit beyond which costs become "substantially out of line."

As discussed below, the Genesis nursing facilities were not a generally proper comparator for the HCR facilities. More importantly, however, to whatever extent they are at least relevant to the assessment, they could not be the "demarcation point" or the outer limit in

the range of costs beyond which the costs would be substantially out of line. The Bureau made no such claim and could not—the Genesis costs were too low. First, as the Bureau's Exhibit 25 shows, the Genesis facilities were scattered all through the ranking of the 51 large-bed facilities, with the highest cost facility at 13th position (from the top) and the lowest cost at the 42nd position. A.R. 1511. The Genesis reported costs would not show when costs were "out of line," much less "substantially" out of line. Second, BMS had approved a CAP of $39.07 per bed per patient day in for the last half of 2011—the cost report period ending one day prior to the one at issue in the hearing. A.R. 1389 at 152:6-15. The Genesis facilities reported costs per patient day that were well below that approved rate. A.R. 2174; 2029.[6] In addition, facilities such as the Arbors and Beverly Health Care Center reported aggregate (not just per patient day) costs for taxes and insurance well above the Genesis facilities. A.R. 2169; 1387.

In fact, the Genesis facilities' costs per bed were well below the amount set in the Desk Review Decision. The Desk Review Decision, based on the Bureau's erroneous legal standard as to allowable costs, set $1,433 as the maximum cost per bed per rate period for taxes and insurance. A.R. 1193. The Bureau's Exhibit 25 (A.R. 1511) showed the reported costs of all West Virginia facilities, as an aggregate, and not on a per-bed basis, but because the number of beds is given, the per bed calculation is easy. The reported figure for the Heritage Center, for example, was $132,948, but applying the $1,432.52 per bed sum to the 160 beds would have resulted in total costs for that facility of $229,203 ($1,432.52 x 160). The actual reported costs of $132,948 were more than $90,000 (40%) below the cost limit set in the Desk Review Decision.

[6] HCR Exhibit 34 (A.R. 2174) lists the as-reported cost per patient day for taxes and insurance for all non-HCR facilities, by name, and has an adjusted (not reported) HCR figure for those costs. DHHR Exhibit 13 (A.R. 2029) has the as-reported number for all facilities but omits the names of non-HCR facilities. The exhibits match as to the numbers for non-HCR facilities.

The Genesis facilities simply are not a proper basis for assessing when costs become "substantially out of line."

Neither the Bureau's witness, nor the Hearing Decision, discuss or address these problems. And there are further problems. Ms. Snow stated that Genesis was selected because it was a "national chain" like HCR. A.R. 1475 at 14:20 – 15:3. Genesis is not, however, the only other national chain with facilities in West Virginia, and Ms. Snow did not consider those facilities. A.R. 1371 at 79:9-12. In addition, Ms. Snow relied on the Genesis facilities alone without analysis of any relevant factors applicable to the facilities. Ms. Snow acknowledged: (1) that HCR was self-insured and Genesis was not (A.R. 1478 at 26:6-16); (2) that she did not know whether Genesis, like HCR, had become the target of a malpractice campaign by plaintiffs' attorneys (*id*. at 27:8-12); (3) that she had not determined whether all of the Genesis costs for settlements and legal expenses were reported in the "insurance" total or in central office expenses (*id*. at 26:18-22); and (4) that she had no information on any fact (such as utilization) other than the "national chain" standing of Genesis (*id.* at 25:11-16). That assessment failure was fully in accord with the Bureau's position at the second evidentiary hearing, in which Ms. Snow said that the Bureau had considered *nothing* but bed size (A.R. 1356 at 19: 1-4).

The Hearing Decision attempted to excuse the lack of any inquiry on the grounds that BMS did not have the information and that all nursing facilities strive to "meet the needs" of residents. A.R. 1613. In fact, the Bureau does have some relevant information, and it is fully capable of seeking more to carry out the Supreme Court's mandate. First, the Bureau has the exact bed size of each facility. A.R. 1511. Thus, the Bureau would *not* have to treat a 90-bed facility the same as a 200-bed facility, simply because both are lumped in the "large bed" category. Second, the Bureau has utilization data, one of the express factors mentioned. PRM

§ 2102.1. BMS tracks both total bed-days at each facility (all beds regardless of payer category), and Medicaid bed-days at each facility, as shown in the facility rate sheets (*see e.g.,* A.R. 1741, 1745) and as also shown in some DHHR exhibits. *Compare* A.R. 2029 (total rate days) *with* A.R. 1514 (Medicaid days). In addition, the Bureau could do ordinary research and obtain information that way. Most importantly, the Bureau could obtain information from West Virginia facilities by simple request—as the record showed was its practice in other contexts. The Bureau made specific inquiries in connection with issues at hand. The Bureau, for example, sought information from HCR and all West Virginia providers on whether they were self-insured. A.R. 1478 at 26:13-16. Ms. Snow conceded that she never had any problem getting information from HCR (A.R. at 138-1401 at 91:20 – 93:2), and the records shows request to other providers as well, A.R. 923-926 (prover request emails).

C. The Bureau's Proposed $50,000 Addition Results in Costs Lower than Those Approved Elsewhere by the Bureau.

The Bureau's proposed $50,000 figure could not be a reasoned demarcation point at which costs become "substantially out of line" in light of the Bureau's approval of higher liability costs. For example, the Bureau's approved $284,064 in taxes and insurance costs for the Arbors at Fairmont facility; that sum was substantially more than allowed several HCR facilities. A.R. 1364 at 50:6-23. In the third evidentiary hearing, Ms. Snow added $50,000 to the limited costs BMS had previously allowed the HCR facilities under the Bureau's erroneous legal position. The results can be found in DHHR Exhibit 27. A.R. 1516. As shown in the excerpt below, under that approach the supposed line at which five HCR facilities become "substantially out of line" is *below* the *allowed* costs for the Arbors, which is the non-highlighted facility in the exhibit between the Charleston and Keyser facilities of HCR:

WV Nursing Homes
Large Bed Group
Jan - June 2012 Cost Report
Allowed Liability Insurance

	Facility	Beds	Original Liability Ins Reported	Original Liability Ins Allowed + $50,000 (HCR)
1	Heartland of Beckley	201	1,625,577	355,128
2	Heartland of Charleston	184	1,486,542	329,030
3		120	284,064	284,064
4	Heartland of Keyser	122	989,703	235,771
5	Heartland of Martinsburg	120	975,521	233,109
6	Heartland of Preston County	120	973,912	232,807
7	Heartland of Clarksburg	120	973,075	232,650
8		164	204,240	204,240
9		120	171,931	171,931

In fact, however, if looked at as allowable costs per bed, the *increased* costs allowed to the HCR facilities as the theoretical maximum are *all* below the costs allowed the Arbors. Adding in a column for the "per bed" cost (which is just the allowed costs divided by beds) shows this:

	Facility	Beds	Original Liability Ins Reported	Original Liability Ins Allowed + $50,000 (HCR)	Per Bed
1	Heartland of Beckley	201	1,625,577	355,128	1,767
2	Heartland of Charleston	184	1,486,542	329,030	1,788
3	**[The Arbors]**	**120**	**264,064**	**284,064**	**2,367**
4	Heartland of Keyser	120	989,703	235,771	1,965
5	Heartland of Martinsburg	122	975,521	233,109	1,911
6	Heartland of Preston County	120	973,912	232,807	1,940
7	Heartland of Clarksburg	120	973,075	232,650	1,939

Thus, the supposed maximum possible costs for the HCR facilities—those that are "substantially" out of line—are *below* the costs actually allowed by the Bureau, per bed, in the very cost report period at issue. The Bureau's position is facially irrational.

IV. THE METHODOLOGIES SET OUT BY HCR'S EXPERTS—WHICH CONVERGED TO WITHIN $1 OF EACH OTHER—SHOULD HAVE BEEN ADOPTED.

A. Summary

HCR's experts submitted evidence on two approaches to determine the amount of allowable costs for the Taxes and Insurance cost center. In those alternative methodologies for determining what would be a reasonable cost standard, Mr. Ellis considered (and Mr. Gibbs concurred in assessment of) multiple factors. These included:

1. Costs previously approved by BMS as allowable;

2. Costs reported by other West Virginia Facilities to BMS;

3. Costs in West Virginia and Kentucky, as compiled by third party sources; and

4. The factors that would be "relevant" to whether facilities are "similar."

Assessing the issues from two different perspectives, HCR's experts' calculations produced results that were only $1.00 apart.

HCR's experts pointed out that the BMS Taxes & Insurance CAP of $25.27 was well below the $39.07 CAP approved by BMS for the last six months of 2011, one day before the rate period in question. A.R. 1490 at 73:1-18. As explained by Mr. Gibbs, because the Bureau had previously allowed the $39.07 CAP in the prior rate period, it was reasonable that would establish a floor for what could be considered substantially out of line. *Id.* at 73:19-23. Mr. Ellis and Mr. Gibbs recognized that the $1,433 set out as the maximum allowable Taxes & Insurance Cost per bed was well below other reported costs, and also nearly half the amount *approved* by BMS for other facilities. Adoption of either methodology proposed by HCR's experts would be far superior to the arbitrary position of BMS.

B. The Bureau's Previously-Approved Rate in 2011 Sets a Minimum for Any Assessment of "Substantially Out Of Line."

A simple starting point to assess whether costs are "substantially out of line"—even before considering what facilities are "similar" in relevant respects—is to consider costs actually approved by the Bureau. Mr. Ellis and Mr. Gibbs based one set of calculations on just such a number: the December 31, 2011 "CAP" or cost standard of $39.07, approved by the Bureau as to Taxes and Insurance. A.R. 1389 at 152:6-15; 1490 at 75:5-10. That amount was approved in the rate period *immediately* before the one at issue.

The prior period's CAP was more than 40% higher than the number the Bureau now contends is the maximum for a sum "substantially out of line." The Bureau's calculated CAP—based on an improper disallowance (for all facilities) of self-insured costs—was $25.27 for facilities over 90 beds. A.R. 1327; 1258 at 53:12-14. The increase caused by adding $50,000 in allowable costs—as proposed by the Bureau—results in payments well below the approved CAP of $39.07. According to the Bureau's Exhibit 26, an additional allowance of $50,000 for HCR facilities over 90 beds would, at most, increase the reimbursement per bed daily by $2.59. A.R. 1514. Adding that sum to the Bureau's initial taxes and insurance rate of $25.27 yields a maximum total revised CAP of $27.86 for taxes and insurance—well below the prior approved rate.[7] The Bureau's prior approved rate of $39.07 cannot be "substantially out of line" or it would not have been approved in the immediately prior rate period. The Bureau's current proposal is to set the "demarcation point" at which facility costs become "substantially out of line" by substantially reducing a rate approved for the period ending one day before the period at

[7] The Bureau's Exhibit 26 was based on a spreadsheet that BMS improperly refused to produce (A.R. 1480-1481 at 35:9 – 37:20. Thus, specifics of its calculations cannot be checked but the listed "original rates" range from $195.14 to $216.69. The $25.27 rate calculated on DHHR Ex. 14 (A.R. 1327) was not shown. The rates appearing are therefore clearly the rates for all mandated services cost centers—and not just for the Taxes and Insurance cost center.

issue. Even had BMS provided a more reasoned approach to adopting the $50,000 figure it proposes, its approach is clearly contrary to the Bureau's own history as to allowable costs.

Mr. Ellis's calculations, in HCR Exhibit 33 (A.R. 2173) show the rate impact if the HCR facilities had been allowed just those additional liability costs that would have resulted from being allowed $39.07 per day in Taxes & Insurance costs. A.R. 1389 at 153:13-16; A.R. 1491 at 77:6-10. To find the six-month total cost that each facility would be allowed under that CAP, Mr. Ellis multiplied $39.07 (the *per diem* amount) by the actual number of patient days for each facility, to get total allowable dollars per facility. A.R. 1491 at 77:24-78:5. When those sums are added to the actual data from other facilities, and then put through the rate methodology, the change results in hundreds of thousands of dollars in excluded costs being included within the June 2012 cost reporting calculations. The analysis appears in HCR Exhibit 33 (A.R. 2173):

HCR v. BMS No 15-0595 (Kanawha County 14-AA-100)			**Using 12/31/11 Cost Standard of $39.07 PPD**					**Exhibit 37**
ACT Number Name	46 Beckley	47 Charleston	48 Clarksburg	49 Keyser	50 Martinsburg	51 Preston	52 Rainelle	Source
Actual Days Reported	28,349	22,573	19,257	21,085	20,478	20,854	9,689	Exhibit 30
T&I Cost Standard 12/31/11	39.07	39.07	39.07	39.07	39.07	39.07	23.73	Rate Sheet
Liability Insurance Allowed	1,107,595	881,927	752,371	823,791	800,075	814,766	229,920	WV22
Other Insurance	1,628	1,310	2,368	2,542	2,210	2,423	1,388	WV22
Taxes Reported	424,991	365,167	342,623	320,406	359,195	315,327	158,324	WV22
T&I Allowable Costs	1,534,214	1,248,404	1,097,362	1,146,739	1,161,480	1,132,516	389,632	WV22
Correct Days Utilized	32,924	30,139	19,656	21,085	20,478	20,854	9,828	Exhibit 30
T&I Allowable Costs PPD	46.60	41.42	55.83	54.39	56.72	54.31	39.65	Calculated
Activities	5.81	6.23	7.63	5.88	6.16	5.84	6.40	Rate Sheet
Maintenance	3.16	5.52	3.90	3.28	4.76	5.09	8.25	Rate Sheet
Utilities	3.44	4.86	4.75	3.84	4.50	3.85	6.46	Rate Sheet
Mandated Services Total	59.01	58.03	72.11	67.39	72.14	69.09	60.76	Calculated
Recalculated Cost Standard - PPD								
Taxes & Insurance (T&I)	46.08	46.08	46.08	46.08	46.08	46.08	23.31	**ReCalculated**
Activities	8.68	8.68	8.68	8.68	8.68	8.68	9.98	Rate Sheet
Maintenance	9.29	9.29	9.29	9.29	9.29	9.29	11.58	Rate Sheet
Utilities	5.28	5.28	5.28	5.28	5.28	5.28	7.46	Rate Sheet
Mandated Services Cost Standard	69.33	69.33	69.33	69.33	69.33	69.33	52.33	Rate Sheet
Over (Under) Standard	(10.32)	(11.30)	2.78	(1.94)	2.81	(0.24)		
DHHR Mandated Services Standard	48.52	48.52	48.52	48.52	48.52	48.52	52.33	Rate Sheet

As shown in Exhibit 33 above,[8] the cost standard for Taxes & Insurance would be recalculated at $46.08, when recalculated with all facility data and the adjusted HCR data. A.R. 1491 at 79:12-13. That would *not* allow full recovery of all settlement costs even before the 90th percentile limit is applied. A.R. 1391-1392 at 161:10-24; 162:1-6.; 1495 at 96:4-7. In fact, that CAP calculation would remain well below the $60.60 CAP the Bureau calculated as resulting from including all reported settlement costs. A.R. 1327. Additionally, as explained by Mr. Gibbs, any additional payment due to HCR would not be solely the responsible of the State of West Virginia. Because the Medicaid program is a joint federal and state program, West Virginia would receive 75% federal matching dollars. A.R. 1492 at 83:13-19.

The BMS approval costs at the rate of $39.07 per bed per day sets a floor as to costs that could be considered "substantially out of line." That rate, the Bureau has contended, is not comparable because it occurred before the disallowance of settlement and other liability costs for self-insured facilities. But that, of course, was an unlawful basis to exclude costs from consideration, as the Supreme Court has held. It is more properly a starting point for determining the limit of costs that are not "substantially out of line."

C. Calculation of a New Rate Using a Limit of $5,600 Per Bed Per Year Confirms the Approach Set Out in Calculation Based on the Bureau's Previously-Approved Per Diem Rate of $39.07.

The calculation based on an assumed "allowable cost" limit of $39.07 per diem is not the only methodology HCR provided. Mr. Ellis and Mr. Gibbs further analyzed the problem from the point of view of costs per bed, not per day, to determine what costs would be considered "reasonable" and not *substantially* out of line. A.R. 1386 at 141:1-5; A.R.2169; A.R. 1492 at 84:13-17.

[8] The typed "Exhibit 37" the upper right portion of the excerpt was not the hearing exhibit designation. The hearing exhibit designation was HCR Exh. 33. *See* A.R. 2173

On a cost per bed basis, the HCR Facilities were the highest (around $8,000 per bed), but other non-HCR providers, such as Beverly Health Care Center and Arbors at Fairmont, had reported costs of $5,633 and $2,387, respectively. A.R. 2169. Those allowed costs handily exceed the cost per bed limit of $1,433 that BMS expressly set out as a limit in the Desk Review Decision. A.R. 1186. Both Beverly and Arbors are owned by national chains. A.R. 1387 at 143:13-16; 1496 at 100:8-13.

Most notably, BMS actually approved and included the costs of $2,387 for the Arbors in its own calculations. A.R. 2169; 1496 at 100:11-13. The reported costs of the Arbors was approved in an amount 40% *above* the maximum the Bureau now seeks to impose. The $50,000 increase in allowable costs proposed by BMS will, for HCR's largest facility of 201 beds (A.R. 1514) result in an increase of less that $250 per bed ($50,000 ÷ 201 = $248.76). The CAP would thus increase from $1,433 to only $1,683. Another 40% increase would be needed to reach the rate approved for the Arbors.

In addition, in the cost report period from July 1, 2012 to December 30, 2012 (beginning one day after the period at issue), two non-HCR facilities reported costs of $6,317 and $2,137 per bed. A.R. 1388 at 148:1-3; 2170; 1496 at 100:14-18. Further, Mr. Ellis and Mr. Gibbs considered cost reported in the cost period from July 1, 2013 to December 31, 2013. A.R. 2171. In that cost report period, non-HCR facilities in West Virginia reported costs of $7,765, $2,628, $2,535 and $2,347 per bed. *Id.* Mr. Ellis and Mr. Gibbs explained that other cost report periods were relevant to assess the reasonableness of the June 31, 2012 reporting period. A.R. 1388 at 148:3-5; 1496 at 100:22-101:8.

Finally, Mr. Ellis and Mr. Gibbs also examined the 2013 Long Term Care, General Liability and Professional Liability Actuarial Analysis, by AON, in the determination of

what was reasonable versus what was "substantially out of line." A.R. 1388 at 149:4-7; 2041; 1494 at 90:11-13. Mr. Ellis and Mr. Gibbs testified that the AON study reported average insurance cost for 2012 insurance, specific to West Virginia, in the amount $7,000 per bed per year or $3,500 for a six-month period per bed. A.R. 1388 at 149:10; 1494 at 91:11-12. The direct losses for malpractice payments are not the only consideration for the taxes and insurance cost center. Other considerations include insurance premiums, administrative fees, business taxes, and the provider tax that was substantial in 2012. A.R. 1494 at 92:16-18. With the addition of the other factors, Mr. Gibbs testified that the total per bed per six month period would be closer to $5,600 per bed. A.R. 1495 at 93:7-9. Notably, the West Virginia average was similar to that of Kentucky, which was $7,350 per bed in 2012 (A.R. 2066). Kentucky was a state identified by Mr. Parr as having a similar tort environment. A.R. 1379 at 112:4-7.

The average costs in the AON study—which included 5,100 West Virginia nursing beds (A.R. 2084) – do not set a maximum as to what is "substantially out of line." Mr. Ellis and Mr. Gibbs testified that an average is not the proper test for whether variation is substantially out of line, especially in light of BMS' own 90th percentile methodology and the provisions of the PRM authorizing reasonable costs "no matter how widely they vary." A.R. 1385 at 136:18-137:9; 1495 at 93:24-94:4. In fact, Mr. Ellis explained that "substantially" out of line should not be defined by a straight percentage of *average* costs, and that expected variation, as well as all other factors must be considered. A.R. 1395 at 175:8-9.

> MR. COPLAND: And you said before the average is not an appropriate limit. Correct?
>
> MR. ELLIS: That's correct.
>
> MR. COPLAND: And to be substantially out of line, it's your opinion that the costs must be above some bell curve level, not just a straight percentage of the average costs. Correct?

> MR. ELLIS: Well, that's only one factor. I mean, again, I think you have to consider the size and scope of services, the company that you're dealing with. It's been mentioned earlier that HCR was the largest healthcare company in the United States in the 2012 period.
>
> MR. COPLAND: Was that correct as far as you know?
>
> MR. ELLIS: That is correct. So you have to consider all the factors in play here, not just one factor such as where they fall relative to bed size.

A.R. 1395 at 174:18-175:9. Mr. Gibbs also confirmed Mr. Ellis' definition of substantially out of line.

> MR. COPLAND: Okay. What is your opinion that the assessment of what is substantially out of line should be substantially above the average?
>
> MR. GIBBS: Yes. Substantially out of line means substantially out of line. It doesn't mean, you know, close to the average or just slightly above the [average] or a little bit above the [average]. It means substantially out of line.

A.R. 1495 at 94:5-18.

After analysis all of the relevant data, Mr. Ellis prepared exhibits that would calculate the allowable costs and the appropriate CAPs if the Bureau had set $5,600 per bed (a figure actually reported by the Arbors in the June 30, 2012 cost report) as the maximum allowable cost per bed per day bed facilities. As noted below, Mr. Gibbs fully concurred in the analysis. The data is compiled in HCR Exh. 35 (as labeled at the hearing; the initial typed Exhibit designation is 33), which appears below (A.R. 2175):

HCR v. BMS No 15-0595 (Kanawha County 14-AA-100)			Liability Insurance at $5,600					Exhibit 33
ACT Number Name	46 Beckley	47 Charleston	48 Clarksburg	49 Keyser	50 Martinsburg	51 Preston	52 Rainelle	Source
Correct Days Utilized	32,924	30,139	19,656	21,085	20,478	20,854	9,828	Exhibit 30
Beds	201	184	120	122	120	120	60	WV6
Liability Insurance Allowed Per Bed	**5,600**	**5,600**	**5,600**	**5,600**	**5,600**	**5,600**	**5,600**	
Liability Insurance Allowed	1,125,600	1,030,400	672,000	683,200	672,000	672,000	336,000	WV22
Other Insurance	1,628	1,310	2,368	2,542	2,210	2,423	1,388	WV22
Taxes Reported	424,991	365,167	342,623	320,406	359,195	315,327	158,324	WV22
T&I Allowable Costs	1,552,219	1,396,877	1,016,991	1,006,148	1,033,405	989,750	495,712	WV22
T&I Allowable Costs PPD	47.15	46.35	51.74	47.72	50.46	47.46	50.44	Calculated
Activities	5.81	6.23	7.63	5.88	6.16	5.84	6.40	Rate Sheet
Maintenance	3.16	5.52	3.90	3.28	4.76	5.09	8.25	Rate Sheet
Utilities	3.44	4.86	4.75	3.84	4.50	3.85	6.46	Rate Sheet
Mandated Services Total	59.56	62.96	68.02	60.72	65.88	62.24	71.55	Calculated
Recalculated Cost Standard - PPD								
Taxes & Insurance (T&I)	47.07	47.07	47.07	47.07	47.07	47.07	23.31	**ReCalculated**
Activities	8.68	8.68	8.68	8.68	8.68	8.68	9.98	Rate Sheet
Maintenance	9.29	9.29	9.29	9.29	9.29	9.29	11.58	Rate Sheet
Utilities	5.28	5.28	5.28	5.28	5.28	5.28	7.46	Rate Sheet
Mandated Services Cost Standard	70.32	70.32	70.32	70.32	70.32	70.32	52.33	Rate Sheet
Over (Under) Standard	(10.76)	(7.36)	(2.30)	(9.60)	(4.43)	(8.08)		
DHHR Mandated Services Standard	48.52	48.52	48.52	48.52	48.52	48.52	52.33	Rate Sheet

Using $5,600 as a benchmark for Taxes & Insurance, Mr. Ellis calculated, and Mr. Gibbs confirmed, that a disallowance of actual costs above that limit would result in a CAP for the Taxes & Insurance cost center of $47.07. A.R. 1393 at 169:12; 2175; 1494 at 89:14-19. That figure corroborates the $46.08 *per diem* figure using the first methodology. A.R. 1494 at 89:19-23. Using this second methodology excludes significant liability settlement costs and is below the reported HCR costs for the June 30, 2012 period. A.R. 1393 at 168:8-11. This second methodology, in fact, is *substantially* lower than the $60.60 that is the re-calculated CAP prepared by Mr. Ellis (and introduced at the first hearing) based purely on the CAP methodology of Chapter 514. See A.R. 1740; 1744.

The two alternative approaches outlined above (starting from the approved $39.07 per diem rate and from an assumed $5,600 per bed limit) produces two numbers for Taxes &

Insurance—$47.07 and $46.08—that are within $1.00 of each other. That lends further support to Mr. Ellis' and Mr. Gibbs' reasonableness determination. If any alternative is used to remove costs (other than the methodology based on the $39.07 *per diem* rate), it should be calculation based on a per year maximum of $5,600 per bed which produces a large bed CAP for Taxes and Insurance of $47.07. A.R. 1445.

D. The Bureau did not Rebut the HCR Expert Testimony, and the Hearing Examiner's Stated Bases for Disregarding it ere Clearly Wrong.

The Bureau did not call any expert witness, nor have it sole witness, Jeanne Snow, testify with regard to the methodologies presented by HCR's experts. The Bureau had possession of the full methodologies and supporting exhibits since the 2018 hearing. A.R. 1388 at 149:20-24; A.R. 1392 at 163:16-22, (HCR Exh. 33 and Exh. 35 introduced into evidence). The Hearing Examiner did briefly address the methodologies in one paragraph. A.R. 1655. In that paragraph, the Hearing Examiner relied on two reasons for disregard of the methodologies. First, the examiner said that the methodologies were improper because based on "liability damages and negotiated settlements" or "jury verdicts or settlements" that BMS did not know about. *Id.* That, however, merely repeats the initial error of BMS in asserting that such costs are not allowable—a position expressly rejected by the Supreme Court. A.R. at 1240-41 (holding that "a Medicare guideline specifically address whether a nursing facility's allowable costs include paid legal claims within an insurance deductible" and that "the Bureau erred by eliminating *all* of HCR's paid legal claims") . The first basis is thus an error of law. The second stated basis was merely that it was not shown that the Bureau had access to data from any "broader area" such as Kentucky. A.R. 1655. That, of course, would not affect whether the information was reliable and probative, and whether it should be considered once it had been brought to the agency's attention. That stated basis was, therefore, not addressed to the actual

issue. Moreover, it would apply only to the second methodology, starting from $5,600 per bed per rate period, and only to one of many supports for the expert conclusion. The Hearing Decision is thus infected by error of law and is arbitrary and capricious, and should be reversed.

CONCLUSION

For the reasons stated herein, HCR and the HCR Facilities respectfully request that the Court reverse the Hearing Decision and order the Bureau for Medical Services to reimburse the HCR Facilities in the large bed group (Heartland of Beckley, Charleston, Clarksburg, Keyser, Martinsburg and Preston County), in accordance with a properly calculated rate, which would require inclusion of all improperly disallowed costs for Taxes & Insurance, as measured against and limited by a properly re-calculated CAP for Mandated Services.

The HCR specifically seeka recalculation of the payment due to each facility, based on a corrected *per diem* rate for each facility, multiplied by the relevant number of Medicaid bed days for each facility, and an order requiring payment of the net difference between the total due under the re-calculated payment, and the actual payments made to the relevant facility.

To recalculate the corrected rate, the HCR facilities request that all costs in the Taxes & Insurance cost center, within Mandated Services cost calculation, be included in the calculation of the reimbursement, except as those costs would be excluded by operation of a properly re-calculated CAP for Mandated Services. HCR specifically requests a recalculation occur:

1. by increasing the *per diem* CAP for the Taxes & Insurance cost Center, within Mandated Services, to a rate of either $46.06 or $47.07

for the "large bed" facilities (Heartland of Beckley, Charleston, Clarksburg, Keyser, Martinsburg and Preston County); and

2. by recalculating the *per diem* rate for the "large bed" facilities after giving them full credit for all reported costs in the Taxes & Insurance cost center, other than those excluded by the recalculated CAP for Mandated Services.

Respectfully submitted this 24th day of August 2023.

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CERTIFICATE OF SERVICE

I certify that on this 24th day of August 2023, I served the foregoing ***"Brief of Petitioners"*** by electronically filing a true copy thereof with the Court's designated electronic filing service, which will send notice thereof to the following counsel of record:

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