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Opinion

Missouri Court of Appeals

Western District

Case Style: Department of Social Services, Division of Medical Services, Appellant, v. Little Hills Healthcare, L.L.C., d/b/a Centerpointe Hospital, Respondent.

Case Number: WD66879

Handdown Date: 02/20/2007

Appeal From: Circuit Court of Cole County, Hon. Richard G. Callahan

Counsel for Appellant: David P. Hart

Counsel for Respondent: Joanna W. Owen and Daniel R. Schramm

Opinion Summary:

The department of social services, division of medical services, appeals the administrative hearing commission's decision granting more than \$3.56 million in direct Medicaid payments to Little Hills Healthcare, d/b/a Centerpointe Hospital. The commission's decision changed the division's decision granting approximately \$1.76 million in direct Medicaid payments to Centerpointe, increasing the amount awarded to include approximately \$1.8 million more, plus interest. In its four points on appeal, the division challenges: (1) the commission's jurisdiction; (2) the commission's determination that the division was required to promulgate its guidelines for estimating Medicaid patient days as a rule; (3) the commission's failure to defer to the division's estimate of Centerpointe's Medicaid patient days; and (4) the commission's order that the division pay additional sums in direct Medicaid payments to Centerpointe.

REVERSED AND REMANDED.

Division Two holds: The commission had jurisdiction over Centerpointe's complaint, but the estimate of Medicaid patient days is not a rule. The case is remanded to the commission for a determination of whether the division's method of estimating Medicaid patient days for state fiscal 2004 was an abuse of discretion. The division's third and fourth points of appeal are not addressed because the case was reversed and remanded on its second point of appeal.

Citation:

Opinion Author: Robert G. Ulrich, Judge

Opinion Vote: The judgment is reversed and the case is remanded. Lowenstein and Smith, JJ., concur.

Opinion:

The Department of Social Services, Division of Medical Services (DMS), appeals the decision of the Administrative Hearing Commission (the Commission) granting \$3,564,909 in direct Medicaid payments to Little Hills Healthcare, d/b/a Centerpointe Hospital (Centerpointe). The Commission's decision changed DMS's decision granting \$1,760,925 in direct Medicaid payments to Centerpointe, increasing the amount awarded to include an additional \$1,803,984 plus interest. In its four points on appeal DMS challenges: (1) the Commission's jurisdiction; (2) the Commission's determination that DMS was required to promulgate its guidelines for estimating Medicaid patient days as a rule; (3) the Commission's failure to defer to DMS's estimate of Centerpointe's Medicaid patient days; and (4) the Commission's order that DMS pay additional sums in direct Medicaid payments to Centerpointe. The judgment is reversed, and the case is remanded.

Facts(FN1)

Centerpointe is a psychiatric hospital in St. Charles, Missouri, providing Medicaid services under Title XIX of the Social Security Act to Medicaid dependent children and adolescents. The Missouri Department of Social Services is the state agency charged with administering the Missouri Medicaid Program. DMS is the subpart of the Department of Social Services that administers Medicaid reimbursement payments to Medicaid service providers, including Centerpointe.

Little Hills Healthcare, L.L.C., (Little Hills) acquired Centerpointe from Ardent Healthcare (Ardent) on April 1, 2003. In anticipation of selling Centerpointe, Ardent significantly curtailed the hospital's operations to provide only core services at the hospital and utilize only one out of six available units that had been previously utilized. Accordingly, Centerpointe's Medicaid services during State Fiscal Year (SFY) 2003(FN2) were the lowest in its history, due to the presale curtailment of services. During SFY 2004, after Little Hills acquired Centerpointe and resumed full operation, Centerpointe's utilization of Medicaid services increased over 100% from SFY 2003.

In addition to a per diem reimbursement, hospitals providing Medicaid services receive direct Medicaid payments pursuant to Regulation 13 CSR 70.15.010(15)(FN3) for certain allowable Medicaid costs not included in the per diem rate. Direct Medicaid payments are the difference between a facility's trended cost and its per diem rate, multiplied by estimated Medicaid days. Direct Medicaid payments are designed to mitigate the impact of the Federal Reimbursement Allowance (FRA) on Medicaid providers. The FRA is a tax on Missouri hospitals for the privilege of engaging in the business of providing inpatient healthcare. Each hospital must submit a cost report to DMS each year. DMS uses the cost reports for several purposes, including estimating certain components of the estimated Medicaid days calculation.

The Missouri Hospital Association (MHA) is an advocacy organization that represents Missouri's hospitals. Centerpointe is a member of MHA. MHA is permitted to comment on and is involved in the process of determining the FRA assessment each year.

DMS issues two notices to each hospital during the SFY computing the hospital's FRA assessment, per diem rate, direct Medicaid payments, and uninsured add-on payments. Each notice as to direct Medicaid payments is based on estimated Medicaid days, as the actual number of days is not determinable until the end of the SFY. DMS uses three components to calculate estimated Medicaid days. These include

(1) fee for service (FFS) days, (2) MC+ days, and (3) out-of-state days. FFS days are days paid directly by DMS; MC+ days are days paid by managed care health plans; and out-of-state days are days paid by another state for patients who came to Missouri. Until SFY 2003, the second notice had never differed from the first notice in determining the estimated number of Medicaid days for the SFY. Making a second estimate of Medicaid days would involve considerable expense and effort for DMS in redistributing FRA dollars and could result in overpayments to the hospitals.

Toward the end of SFY 2003, the State of Missouri conducted a reconciliation and realized that insufficient funds existed to continue making Medicaid payments. Due to the budget shortfall, DMS approached MHA regarding the possibility of adjusting the FRA for SFY 2003. During this time period, several thousand children were added to the State Children's Health Insurance Program (SCHIP), resulting in more costs and more Medicaid days for providers. Therefore, MHA agreed to update the FRA to meet the budget shortfall but also proposed updating the estimates of the number of Medicaid days. DMS determined the Medicaid days by using actual SFY 2003 Medicaid days for the first two thirds of the SFY and estimated the days for the remainder of the SFY based upon the actual days thus far in the year. To this DMS added MC+ days and 1999 out-of-state days. DMS thus began its determination of FFS days with the actual Medicaid patient days for FFS patients, based on data from July 19, 2002, through March 7, 2003 – the current SFY. DMS then annualized this number of days. In prior years, and in its first notice for SFY 2003, DMS had not used actual FFS days for the current SFY. It examined available data from the past SFY and made a prospective estimate. The projected direct Medicaid payments for SFY 2003 pursuant to the second notice were a dramatic reduction from the first notice due to the reduction in Medicaid days.

DMS's methodology for estimating Medicaid days for purposes of the second notice for SFY 2003 was based on the most current data and for many hospitals resulted in a higher number of days than the first notice; thus, it was the most favorable for the industry as a whole. Because the direct Medicaid payments were greatly reduced per the second notice to Centerpointe for SFY 2003, DMS sought reimbursement of \$2,236,726 from Centerpointe for overpayments for SFY 2003. Centerpointe paid the portion for the period during which Little Hills operated the hospital, and Ardent paid the portion for the period during which it operated the hospital. If a hospital's actual days are lower than the estimate, DMS does not normally recoup payments made on the basis of the estimates. DMS did so only at the end of SFY 2003, when it revised the estimated Medicaid days for all hospitals.

In estimating the Medicaid days for SFY 2004, DMS initially performed a regression analysis based on paid days from February 1999 through December 2002, and then went through a calculation similar to that used in SFY 1999. In estimating Medicaid days for SFY 1999, DMS first performed a regression analysis based on Medicaid days paid from July 1992 to April 1998 in order to estimate the total days for SFY 1999. The regression analysis used historical data of paid Medicaid days to project Medicaid days for the SFY in question. The total estimated days for SFY 1999 were then compared to the total days paid for May 1997 through April 1998 to arrive at a percentage, which was used to inflate each facility's paid days from May 1997 through April 1998. DMS then added on MC+ days using an FFS percentage. In SFY 2004, however, DMS did not use this figure because the FRA schedule for SFY had already been started, using January through December 2002 days, and DMS used the revised days from SFY 2003 for SFY 2004 because those were more current than the days used for the regression analysis. The actual days from August 2002 through March 2003 were a higher number and more favorable to the industry as a whole, so DMS used those days. DMS consulted with MHA, which agreed to this methodology. Thus, DMS began its estimation of Medicaid days for SFY 2004 with the same number of annualized FFS days that it had used in calculating the second notice for SFY 2003: 1,644 for Centerpointe. SFY 2003 was the year in which Centerpointe experienced a significant reduction in services due to the pending sale, however, and 1,644 did not approximate Centerpointe's FFS days for SFY 2004. For SFY 2004, the FFS percentage was 82.83% based on 2000, the fourth prior reporting

year. This resulted in a calculation of 1,985 total in-state Medicaid days (FFS days plus MC+ days). DMS added 387 out-of-state days from the 2000 base reporting year, resulting in 2,372 estimated Medicaid days for SFY 2004.

DMS frequently incorporates MHA's comments into the process of determining the FRA assessment. DMS again had input from MHA before sending out its second notices for SFY 2004, even though DMS did not experience a funding crisis that year as it had in SFY 2003. MHA had no objection to DMS's proposed method of estimating Medicaid days for SFY 2004 because DMS was using more current information than it had in past years utilizing the regression analysis.

On June 4, 2004, DMS sent a notice to Centerpointe for SFY 2004 stating:

The Division of Medical Services (Division) notified your facility on September 3, 2003 of the proposed computation for State Fiscal Year (SFY) 2004 for the FRA assessment, per-diem rate, Direct Medicaid payments and Uninsured Add-On payments.

The Division will be filing emergency and proposed regulations on June 7, 2004 to change the FRA assessment percentage from 5.23% to 5.32%. This change affected your FRA assessment, Direct Medicaid payments, and Uninsured Add-On payments for SFY 2004. The attached worksheets provide the Division's final decision.

....

Your FRA assessment will be adjusted on the June 4, 2004 remittance device (June 21, 2004 check) to recoup the unassessed FRA assessment owed for SFY 2004. Also, your add-on payments will be adjusted on the same cycle to pay the balance due your facility for SFY 2004 and for the enhancement pool distributions.

An attached sheet calculated Centerpointe's direct Medicaid payments as follows:

SFY 2004 cost per day 2000 trended cost 787.16

Assessment per day 188.10

Utilization adjustment per day 138.36

Estimated cost per day 1,113.62

Less per diem SFY 2004 (371.24)

Difference between estimated cost per day and per diem 742.38

Projected SFY 2004 days + 2000 Medicaid out-of-state days 2,372

Total direct Medicaid payments 1,760,925

The number of estimated Medicaid days was the same as on the first notice for SFY 2004: 2,372. The notice stated that this was a final decision that could be appealed to this Commission.

If DMS had used the same methodology for calculating estimated Medicaid days on its second notice for SFY 2004 that it had used on its second notice for SFY 2003, but based on days through May 2004, the estimated Medicaid days for Centerpointe would have been 4,802. The estimate for SFY 2004 was made before the SFY began, however, and before this data was available. Based on 4,802 Medicaid days, Centerpointe's direct Medicaid payments for SFY 2004 would be \$3,564,909, which is \$1,803,984 more than DMS had determined. Centerpointe actually had 4,884 Medicaid days in SFY 2004.

Centerpointe filed a complaint with the Commission on June 25, 2004, challenging DMS's computation of Centerpointe's Medicaid reimbursement for SFY 2004. Centerpointe challenged DMS's determination

of Centerpointe's Medicaid days, a number used in calculating the amount of direct Medicaid payment. Centerpointe alleged DMS's decision was arbitrary, capricious, and unreasonable and resulted in Centerpointe being underpaid by \$1,803,984 for Medicaid services rendered during SFY 2004.

The Commission heard evidence in a two-day hearing. Its decision, in favor of Centerpointe, was issued on July 12, 2005. The Commission found DMS "failed to promulgate a rule for the estimation of Medicaid days for purposes of determining direct Medicaid payments." The Commission further found that, as a result, Centerpointe "is entitled to additional reimbursement of \$1,803,984 plus interest for Medicaid services rendered during ... SFY 2004."

DMS filed a petition for judicial review in the Cole County Circuit Court. The circuit court affirmed the Commission's decision. DMS's timely appeal followed.

Standard of Review

On appeal in an administrative review case, the Commission's decision, and not the judgment of the trial court, is reviewed. *Psychare Mgmt., Inc. v. Dep't of Soc. Servs. Div. of Med. Servs.*, 980 S.W.2d 311, 312 (Mo. banc 1998). Reviewing authority may not determine the weight of the evidence or substitute its discretion for that of the administrative body. *Id.* Its function is to determine whether competent and substantial evidence upon the whole record supports the decision, whether the decision is arbitrary, capricious, or unreasonable, and whether the Commission abused its discretion. *Id.* An administrative body's finding is arbitrary and unreasonable where it is not based on substantial evidence. *Stacy v. Dep't of Soc. Servs., Div. of Med. Servs.*, 147 S.W.3d 846, 852 (Mo. App. S.D. 2004).

Whether an action is arbitrary focuses on whether an agency had a rational basis for its decision. Capriciousness concerns whether the agency's action was whimsical, impulsive, or unpredictable. To meet basic standards of due process and to avoid being arbitrary, unreasonable, or capricious, an agency's decision must be made using some thing other than mere surmise, guesswork, or "gut feeling." An agency must not act in a totally subjective manner without any guidelines or criteria.

Id. (quote marks and citation omitted). "The temptation to substitute the [reviewing authority's] judgment on factual matters for the [C]ommission's fact-finding must be resisted." *Psychare Mgmt., Inc.*, 980 S.W.2d at 312. Questions of law are for reviewing authority's independent judgment. *Id.* If the pertinent facts are undisputed between the parties, reviewing authority reviews the matter as a question of law. *Mo. Dep't of Soc. Servs., Div. of Med. Servs. v. Great Plains Hosp., Inc.*, 930 S.W.2d 429, 433 (Mo. App. W.D. 1996). Similarly, reviewing authority draws its own conclusions from the Commission's findings. *Se. Mo. Hosp. Ass'n v. Mo. Dep't. of Soc. Servs., Div. of Med. Servs.*, 886 S.W.2d 94, 97 (Mo. App. W.D. 1994). Evidence is viewed in the light most favorable to the Commission's decision. *Id.*

The party aggrieved by an administrative agency decision has the burden of persuasion upon appeal. *Stacy*, 147 S.W.3d at 850. The Commission's decision is presumed valid and the attacking party bears the burden of overcoming this presumption. *Id.* This burden has been characterized as "heavy." *Id.*

Point I

In its first point on appeal, DMS argues the Commission erred in holding it had jurisdiction to hear Centerpointe's complaint. It claims the Commission's decision was in excess of its statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious, or unreasonable under section 536.140.2.(FN4) DMS asserts Centerpointe failed to timely appeal its decision setting Centerpointe's estimate of Medicaid patient days, and Centerpointe

may not collaterally attack a prior decision through a challenge of a subsequent decision. DMS further argues the evidence presented does not support the Commission's finding that Centerpointe did not receive DMS's September 3, 2003, decision setting Centerpointe's Medicaid patient days.

At issue on appeal is DMS's determination of Centerpointe's Medicaid patient days, which is used to calculate the amount of the direct Medicaid payments Centerpointe receives. Section 208.156.8 states:

8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission except that claims of less than five hundred dollars may be accumulated until they total that sum and at which time the provider shall have ninety days to file his petition.

On September 3, 2003, DMS sent a notice to Centerpointe for SFY 2004, stating, among other things, that Centerpointe's projected SFY 2004 days plus its 2000 Medicaid out-of state days were 2,372. The notice stated it was a final decision and could be appealed to the Commission. This notice was not sent via certified mail. On June 4, 2004, DMS sent a notice to Centerpointe for SFY 2004, stating, among other things, that Centerpointe's projected SFY 2004 days plus its 2000 Medicaid out-of state days were 2,372. The notice stated it was a final decision and could be appealed to the Commission. Centerpointe filed its complaint regarding the determination of its Medicaid patient days with the Commission on June 28, 2004.

Given that the number of SFY days plus 2000 Medicaid out-of-state days did not change from the first notice to the second notice, DMS argues Centerpointe's opportunity to appeal the determination of Medicaid patient days lapsed thirty days after the September 3, 2003, notice. It claims the June 4, 2004, notice did not re-open the issue of whether DMS's determination of Medicaid patient days was correct and said determination could not be appealed after November 2003. Accordingly, DMS asserts the Commission was without jurisdiction to hear Centerpointe's allegedly untimely complaint.

The Commission relied on two independent bases in concluding it had jurisdiction. First, it concluded DMS's determination of Centerpointe's Medicaid patient days could be appealed within thirty days of the June 4, 2004 notice. It concluded this because: (1) the June 4, 2004, notice stated it could be appealed; (2) the determination of Medicaid patient days was a figure used in the calculation at issue in the June 2004 notice; (3) the figures were not final until the June 2004 notice; and (4) DMS affirmatively determined in the June 2004 notice that the estimate of Medicaid patient days as set forth in the September 2003 notice need not be changed. The second basis relied upon by the Commission was its finding that Centerpointe never received the September 3, 2003, notice. The Commission noted that if there is inadequate notice of the right to appeal within thirty days the time for filing the appeal does not start to run. While it stated it preferred to rest its jurisdiction on the first basis, the Commission articulated and relied upon both of these independent bases.

On appeal, DMS asserts the first basis (appeal made within thirty days of June 4, 2004, notice) is a misinterpretation of the law and the second basis (Centerpointe did not receive September 3, 2003, notice) is not supported by the evidence. It does not dispute that either basis, standing alone, is sufficient to confer jurisdiction upon the Commission. Instead, it claims both bases are without merit.

Since either basis alone is sufficient to confer jurisdiction, only the second basis is discussed. DMS claims the Commission's finding that Centerpointe did not receive the September 3, 2003, notice is unsupported by the evidence. It notes the presumption that a letter duly mailed has been received by the addressee. *Clear v. Mo. Coordinating Bd. for Higher Educ.*, 23 S.W.3d 896, 900 (Mo. App. E.D.

2000). Once proof of proper mailing is adduced, the presumption may be rebutted by evidence demonstrating the mailing was not received. *Id.* "Evidence of non-receipt does not nullify the presumption but leaves the question for the determination of the finder of fact under all the facts and circumstances of the case." *Id.*

DMS claims Centerpointe failed to rebut this presumption, and, accordingly, the Commission's finding Centerpointe never received the September 2003 notice is in error. It first focuses upon the evidence presented demonstrating the letter was duly mailed on September 3, 2003, to Centerpointe's correct address. DMS's recitation of evidence supporting this conclusion need not be discussed as the Commission's finding was not that DMS failed to duly mail the notice to the correct address. Instead, it found the notice was never received by Centerpointe.

Centerpointe presented evidence rebutting the presumption it received the September 3, 2003, notice. Tariq Malik, CEO of Centerpointe, testified the first time he saw the September 3, 2003, notice was when DMS produced it after Centerpointe appealed the June 4, 2004, notice. He stated he had no communication with DMS regarding SFY 2004 or the estimated number of Medicaid days from April 2003 through March 10, 2004.

On March 10, 2004, Mr. Malik wrote a letter to the Chief Financial Officer of DMS. The purpose of this letter was to ensure the number of patient days reflected in Centerpointe's records was consistent with DMS's records with respect to SFY 2004. Mr. Malik testified he wrote the letter because he was expecting an adjustment in patient days, as had occurred in SFY 2003, so that Centerpointe would be compensated for the difference between its actual and estimated patient days.

Mr. Malik wrote a second letter to DMS's Chief Financial Officer on March 19, 2004. He wrote this letter after speaking with MHA, wherein he was informed of a discrepancy between the numbers Centerpointe provided to DMS and its calculations. This second letter was intended to correct the numbers in the first letter so DMS could reflect the changes in its reimbursement to Centerpointe for SFY 2004. Mr. Malik testified he wrote both letters because he assumed DMS was currently working on calculating the number of patient days for SFY 2004. Neither letter referenced any of the specific figures set forth in the September 3, 2003, notice.

Mr. Malik received a letter from DMS dated April 7, 2004. The letter stated:

Dear Mr. Malik:

This letter is to acknowledge receipt of your letters dated March 10, 2004 and March 19, 2004 regarding Medicaid reimbursement and projected days for SFY 2004. At this time, the Division is still in the process of finalizing SFY 2004 projected days. The Division will take your concerns into consideration as we work through this process. If you have any questions, please feel free to call....

Mr. Malik testified his understanding after reading this letter was that Medicaid days would be revised, and he would be notified of a final determination of the number of days forthcoming.

Steve Frantz, Centerpointe's CFO from June 2002 through December 2003, testified via deposition that he first saw the September 3, 2003, notice when handed to him during his deposition testimony. Mr. Frantz further testified that he and Mr. Malik had multiple conversations regarding what Centerpointe's payments would be, and at the time he left Centerpointe in December 2003, "that was still an open issue for us."

DMS argues the presumption that Centerpointe received the mailed September 2, 2003, notice was not rebutted, citing various evidence introduced at the hearing. First, it claims Centerpointe's CFO was aware DMS issued final decisions concerning direct Medicaid payments every fall accompanying the

issuance of the first payment for the SFY. Upon being asked if he would have received some sort of document indicating when Centerpointe began to receive direct Medicaid payments in the fall, Mr. Frantz stated, "Traditionally, yeah, we would receive some kind of letter or announcement when payments started, yeah."

Second, DMS claims Centerpointe had actual notice DMS issued its decision concerning direct Medicaid payments when it received \$441,558 in direct Medicaid payments from DMS on September 22, 2003. Thereafter, Centerpointe received a payment of \$73,593 from DMS. Mr. Malik testified he was aware that the amount of Medicaid payments made by DMS changed by a small amount in September 2003. He further stated he was not familiar with the Missouri Medicaid program prior to becoming Centerpointe's CEO on April 1, 2003. Moreover, Mr. Malik was unfamiliar with how Medicaid reimbursements worked in September 2003, when the payment amount changed, and he did not realize the payments would not be further adjusted to reflect the increase in Centerpointe's operations.

Third, DMS asserts Centerpointe's CFO admitted other important documents from DMS were stored in files that were not searched despite DMS's discovery request demanding the documents. Mr. Malik testified he never received the September 3, 2003, notice. On cross-examination Mr. Malik stated, pursuant to DMS's discovery request, that he produced every document he received from DMS's Institutional Reimbursement Unit from June 1, 2003, to July 10, 2004. In responding to the discovery request, Mr. Malik did not produce the September 3, 2003, notice. He also failed to produce an October 17, 2003, desk review letter summarizing Centerpointe's Medicaid costs. Given that the costs were in the millions of dollars, Mr. Malik agreed the desk review letter was a "fairly important document" and should have been retained in Centerpointe's files. He testified he did not produce the desk review letter because it is filed in a different filing area than the one used for FRA-related letters. He further conceded he could have failed to produce other documents received from DMS during the time period in question if the document related to "a different process."

Fourth, Centerpointe notes that if letters are undeliverable as addressed, they are returned to DMS and placed into DMS's file for the facility; there were no returned letters for Centerpointe. Moreover, none of the 140 other hospitals in the Medicaid program complained of not receiving the September 2003 decision letter. DMS strenuously asserts the evidence in the record supports the conclusion that Centerpointe received the September 3, 2003, letter and misplaced it in its filing system. It argues that Mr. Malik overlooked or misplaced the letter because he did not recognize the letter's importance, and Centerpointe was in a period of chaotic transition.

The presumption that Centerpointe received the September 3, 2003, notice arose upon DMS's introduction of evidence demonstrating the notice was duly mailed to the correct address. "[T]he so-called presumption of due receipt of mail matter is no more than a rebuttable presumption of fact." ***Hood v. M. F. A. Mut. Ins. Co.*, 379 S.W.2d 806, 812 (Mo. App. 1964)**. "It is both more appropriate and more accurate to say that evidence that mail matter has been properly addressed and mailed with postage prepaid permits, but does not require, the [fact finder] to draw an inference of fact that such mail matter was received by the addressee in due course." ***Id.*** Centerpointe introduced rebuttal evidence.

As argued by DMS, evidence was presented from which the Commission could have concluded Centerpointe received the September 3, 2003, notice. That was not its finding, however. Instead, the Commission explicitly found Centerpointe did not receive the notice. The question on appeal under the standard of review is whether this finding is contrary to the overwhelming weight of the evidence. ***Miller v. Dunn*, 184 S.W.3d 122, 124 (Mo. App. E.D. 2006)**. As discussed, this finding was supported by substantial evidence and was not against the weight of the evidence. DMS relies solely upon the presumption that Centerpointe received the September 2003 notice. Rebuttal evidence was presented

however, and, thus, the issue became a question of fact for the Commission. *Clear*, 23 S.W.3d at 900. Its conclusion withstands the standard of review, and, accordingly, the Commission's determination it had jurisdiction was not error.

Point denied.

Point II

In its second point on appeal, DMS argues the Commission erred in holding it was required to promulgate its internal guidelines(FN5) for estimating Medicaid patient days as a rule. It claims its estimate of Medicaid patient days does not meet the definition of a rule under section 536.010(4).(FN6) DMS asserts its method of estimating does not have to be promulgated according to state and federal case law because it does not have future effect, does not impact the property rights of providers, does not meet the definition of a rule, and/or by law is not a payment method or standard.

The Commission noted several pertinent statutory provisions in its decision. Section 208.152.1 states, in relevant part:

Benefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of *the reasonable cost of the care or reasonable charge* for the services as defined and determined by the division of medical services....

(emphasis added). Section 208.153.1 states, in relevant part:

Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the division of medical services *shall by rule and regulation* define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided....

(emphasis added). Regulations 13 CSR 70-15.010(1)(A) and 13 CSR 70-15.020(3) provide for reimbursement based on the per diem rate. Regulation 13 CSR 70-15.010(15), entitled Direct Medicaid Payments, states, in relevant part:

(A) Direct Medicaid payments will be made to hospitals for the following allowable Medicaid costs not included in the per diem rate as calculated in section (3):

1. The increased Medicaid costs resulting from the FRA assessment not included in the cost report ending prior to January 1, 2001;
2. The unreimbursed Medicaid costs applicable to the trend factor which is not included in the per diem rate;
3. The unreimbursed Medicaid costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in paragraph (3)(A)4.;
4. The increased cost per day resulting from the utilization adjustment. The increase [sic] cost per day results from lower utilization of inpatient hospital services by Medicaid recipients now covered by an MC+ health plan;
5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region; and
6. The increased cost resulting from including out-of-state Medicaid days in total projected Medicaid days.

(B) Direct Medicaid payment will be computed as follows:

1. The Medicaid share of the FRA assessment will be calculated by dividing the hospital's Medicaid patient days by total hospital's patient days to arrive at the Medicaid utilization percentage. This

percentage is then multiplied by the FRA assessment for the current SFY to arrive at the increased allowable Medicaid costs;

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the *estimated Medicaid patient days for the current SFY*.

....

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ Health Plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the *estimated Medicaid days for the current SFY* to arrive at the Medicaid utilization adjustment;

....

6. [T]he costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report.

(emphasis added). In its decision the Commission noted Regulation 13 CSR 70-15.010(15)(B)(2)A explains the trending methodology, which is not in dispute in this case, and Regulation 13 CSR 70-15.010(15)(B)(2)B provides base year operating costs for hospitals like Centerpointe to be based on the "fourth prior year cost report." As recognized by the Commission, Centerpointe only challenged DMS's determination of the number of estimated Medicaid patient days and did not otherwise dispute DMS's calculations of these various formulae.

13 CSR 70-15.010(15)(B) is the regulation setting forth how direct Medicaid payments are calculated. As noted by the Commission in its decision, the regulation refers to estimated Medicaid patient days but fails to set forth how the number of Medicaid days is estimated. The Missouri Administrative Procedure Act (MAPA) defines a "rule" as "each statement of general applicability that implements, interprets, or prescribes law or policy." **Section 536.010(4)**. There are numerous exceptions to this definition. **Section 536.010(4)(a)-(m)**. The Commission determined DMS's method of calculating estimated Medicaid days was a statement of general applicability given that it applied to all Medicaid provider hospitals in Missouri. Moreover, the Commission stated the calculation was an implementation and interpretation of the regulation. Thus, it concluded DMS's method of ascertaining estimated Medicaid patient days was a rule as defined by section 536.010(4) and did not fall within any of the exceptions.

In its second point, DMS presents several arguments in support of its assertion that promulgation as a rule is not required. Only the persuasive argument is discussed. Section 536.010(4)(b), excepts from the definition of "rule" the following:

A declaratory ruling issued pursuant to section 536.050, or an interpretation issued by an agency with respect to a specific set of facts and intended to apply only to that specific set of facts[.]

Further, rulemaking "'involves the formulation of a policy or interpretation which the agency will apply in the future to all persons engaged in the regulated activity.'" *Mo. Soybean Ass'n v. Mo. Clean Water Com'n*, 102 S.W.3d 10, 23 (Mo. banc 2003)(citation omitted). Accordingly, DMS argues that the guidelines it uses to determine the estimated Medicaid patient days do not fall within the definition of "rule" because they apply to a specific set of facts and have no future effect. *See V.M.B. v. Mo. Dental Board*, 74 S.W.3d 836, 841 (Mo. App. W.D. 2002)(stating, "A rule is an agency statement of policy or interpretation of law of future effect which acts on unnamed and unspecified persons or facts." (quote marks and citation omitted)).

As noted by the Missouri Supreme Court:

Seeking to clarify this concept of a "rule" as set out in the administrative procedure acts, commentators have proposed various explanations and definitions of "rules" and "rulemaking." ... Rulemaking "involves the formulation of a policy or interpretation which the agency will apply in the future to all persons engaged in the regulated activity." Arthur Earl Bonfield, *State Administrative Rule Making*, sec. 3.3.1 at 76 (1986) *quoting* E. Gellhorn, *Administrative Law and Process in a Nutshell* 121-122 (1972); *see also* 73 C.J.S. *Public Administrative Law and Procedure* sec. 87 (1983). Stated differently, rulemaking "affects the rights of individuals in the abstract and must be applied in a further proceeding before the legal position of any particular individual will be definitively touched by it." Kenneth Culp Davis & Richard J. Pierce, Jr., *Administrative Law Treatise* sec. 6.1 at 228 (3d. ed.1994); Bonfield, *supra* sec. 3.1, at 60, *quoting* J. Dickinson, *Administrative Justice and the Supremacy of Law* 2 (1927). In distinguishing between rules and general statements of policy, it has been said that an agency statement is a rule "... if it purports in and of itself to create certain rights and adversely affects or serves by its own effect to create rights or to require compliance, or otherwise to have the direct and consistent effect of law." 73 C.J.S. *supra* sec. 87, p. 578. Stated more simply, as explained by one federal court, "a properly adopted substantive rule establishes a standard of conduct which has the force of law." *Pacific Gas & Electric Company v. Federal Power Commission*, 506 F.2d 33, 38 (D.C.Cir.1974).

***Mo. Soybean Ass'n*, 102 S.W.3d at 22-23(footnote omitted).** "It has been noted that MAPA's definition of a rule is of little assistance because it is broad enough to encompass virtually any statement an agency might make in any context." ***United Pharmacal Co. of Mo. Inc. v. Mo. Bd. of Pharmacy*, 159 S.W.3d 361, 365 n.3 (Mo. banc 2005)(quote marks and citation omitted).** Moreover, "[a]n administrative agency need not promulgate rules ... simply because it has the power to do so." ***Mo. Nat. Educ. Ass'n v. Mo. State Bd. of Educ.*, 34 S.W.3d 266, 287 (Mo. App. W.D. 2000).** Finally, the Missouri Supreme Court has noted "[n]ot everything that is written or published by an agency constitutes an administrative rule." ***United Pharmacal Co. of Mo. Inc.*, 159 S.W.3d at 365.**

While selling Centerpointe, its prior owners reduced the level of activity in the hospital, keeping only core services open in an attempt to reduce overhead and direct costs. Upon Centerpointe being sold and fully opened by the new owners, the utilization of Medicaid services increased by over one hundred percent. Mr. Malik acknowledged that for a hospital to experience a massive decrease followed by a massive increase in Medicaid services is unusual.

He further testified that in May 2003, Centerpointe received a letter from DMS stating its number of actual Medicaid patient days was lower than its estimated number of Medicaid patient days. Centerpointe reimbursed DMS for the difference between its actual number of Medicaid patient days and estimated Medicaid patient days for SFY 2003. The actual number of Medicaid patient days was based on data from April or May 2003. Mr. Malik stated that in March or April 2004, Centerpointe was expecting the same type of revision letter informing it that the actual number of Medicaid patient days based on 2004 data was higher than the estimated number of Medicaid patient days. This never occurred. Unlike SFY 2003, the prospective estimates for SFY 2004 were not changed to reflect current data. The sole issue in the point is focused upon DMS's determination of estimated Medicaid patient days for SFY 2004.

The evidence presented by both parties at the Commission was that, with the exception of SFY 2003, estimated Medicaid patient days are determined prospectively, and the prospective nature of the estimate has value. Edward Knell, an expert in the area of Medicaid reimbursement presented by Centerpointe, testified that states are given a great deal of flexibility in structuring their state Medicaid plans under federal law. Mr. Knell agreed that the estimate of the number of Medicaid patient days by DMS at or near the beginning of every state fiscal year is critical. DMS has done this every year since the FRA system was implemented in 1991. Since 1991, DMS has done a second estimate of Medicaid patient

days only once – in SFY 2003. SFY 2003 is also the only year DMS recouped extra money paid to hospitals. Every other year, hospitals that are overpaid because their estimated Medicaid patient days exceed actual patient days are allowed to keep the extra money.

In estimating SFY 2003 and SFY 2004 Medicaid patient days, DMS considered the time period between July 2002 and March 2003. Thus, the time frame examined was current for SFY 2003 and prospective for SFY 2004. Centerpointe argued that current data should have been used for SFY 2004, as was done in SFY 2003. SFY 2003 was the only year current data was examined because of the Missouri Medicaid system's impending insolvency if the previously determined prospective estimates were utilized. Mr. Knell conceded that using a nine-month period and annualizing the data in determining an estimate of patient days for a year was reasonable.

Sue Nilges, an employee of DMS and expert in Medicaid calculations, testified that current data for a SFY is not used in estimating Medicaid patient days because the estimate is done at the beginning of an SFY before current data for that SFY is available. The regulations do not require DMS to use a certain time period to estimate Medicaid patient days or to do an estimate more than once; DMS is given discretion. Medicaid payments are prospective. She stated DMS always uses the most current data it has at the time it begins calculating. Further, the same time period is used for all hospitals to promote consistency and fairness. DMS does not use the same month to month time period each year. The time period used to make an estimate depends on when the FRA is scheduled to be calculated each year. DMS tries to do the calculations early, so it can make budget projections. Ms. Nilges testified that Centerpointe's desire that data from SFY 2004 be used to estimate SFY 2004 Medicaid patient days was unrealistic because that data was not available when the September 3 notice was issued.

Donna Siebeneck, Assistant Deputy Director of the Institutional Reimbursement Unit and an expert in hospital Medicaid reimbursement, testified that the regulations do not specify the time period to be used in estimating Medicaid patient days, and the decision is within DMS's discretion. In determining what time period to use, Ms. Siebeneck consults DMS's Chief Financial Officer and MHA. She testified that a second estimate for SFY 2004 was unnecessary because the actual days were demonstrating fewer than the estimated days. She also stated that doing two estimates per year every year would involve substantial additional administrative work and could result in overpayments to hospitals. The range of dates examined in estimating Medicaid patient days has changed from year to year. MHA is involved in the process of determining FRA assessment. She testified that before DMS changes how estimated days are calculated, it informs MHA. DMS focuses on what is best for the hospital industry as a whole.

Dwight L. Fine, Senior Vice President for Governmental Relations of the Missouri Hospital Association, testified that MHA represents the hospital industry in discussing the Medicaid program with DMS. His understanding of the regulations is that DMS has discretion in how to prepare estimated Medicaid patient days. He also stated that over time MHA has not had much involvement with the process of estimating days. In more recent years, MHA has had more involvement and detailed conversations with DMS regarding the issue. Generally, MHA was satisfied that DMS's "methodology" was a reasonable way of determining estimated days. Every year MHA reviews the schedules and shares information with its members so that they can utilize the information in their budget process. He stated that "a lot" of interaction occurs between DMS, MHA staff, and MHA's membership. Mr. Fine also stated DMS making its estimate and beginning payments at the beginning of the fiscal year is important to the hospital industry. Mr. Fine testified that in SFY 2003 DMS realized that the Medicaid program was going to exhaust its funds and would not be able to complete the payment cycles. DMS approached MHA about adjusting the FRA assessment – about increasing the tax hospitals pay so as to generate additional funds. MHA responded that it would be willing to work with DMS on increasing the tax and suggested, in conjunction with this, that the estimated Medicaid patient days be updated. Thus, doing a second estimate of patient days was MHA's suggestion. MHA has not requested a second estimate of

patient days in subsequent years because a similar set of circumstances has not reoccurred. Mr. Fine stated MHA may desire a second estimate if there again arose the need for an additional tax. He also declared that flexibility in the process is desirable and necessary.

Moreover, the evidence presented demonstrated that DMS does not have a "methodology" for estimating Medicaid patient days. The time frame examined changes yearly based on the current data available and what is most beneficial to the hospital industry as a whole. Mr. Knell, Centerpointe's expert witness, testified:

My conclusion is that they [DMS] don't have a methodology [to determine estimated Medicaid patient days]. They have certain steps that they go through each year; for example, they will go through a process of doing a calculation of days but then they may use that calculation, they may not use that calculation, and the process year to year is different.

And I think you could go back in time, and as I see it, what they did in 2001 is different than what they did in 2000, what they did in 2002 is different than what they did in 2001. It's not consistent...

In addition, the Commission found the following in its decision:

21. DMS's regulations provide no methodology for determining estimated Medicaid days. In particular, they do not identify the three separate components (FFS days, MC+ days, and out-of-state days), and do not provide a methodology for determining FFS days.

22. In estimating Medicaid days for any given SFY, DMS uses the same method for each of the approximately 140 hospitals in the industry in Missouri. The methodology is not consistent from one SFY to the next.

23. Donna Siebeneck, Assistant Deputy Director for the Institutional Reimbursement Unit of DMS, determines the time period of days to use as the bases for estimated Medicaid days on DMS's notices. Siebeneck makes this determination by consulting with MHA and with her supervisor, Margie Mueller, who is the Chief Financial Officer of DMS.

61. Although MHA was involved in the process, DMS did not directly provide the hospitals with any notice that it was changing its methodology of computing the Medicaid days from year to year, nor did it publish its methodology anywhere.

The Commission further found that "DMS was completely inconsistent in its methodology of estimating Medicaid days from year to year, but was consistent as to all providers each year."

This evidence demonstrates that DMS's estimation of Medicaid patient days is not a rule. While the regulations mandate an estimate be used, DMS is given discretion with respect to how to make the estimate. The Commission found that the exception from the definition of a rule contained in section 536.010(4)(b) was not applicable because DMS's methodology applied across an entire industry of approximately 140 hospitals. The Commission asserted this situation was not "just one specific set of facts." This is incorrect. DMS selects the time period to use to estimate Medicaid patient days after reviewing data from the hospital industry and comparing different calculations for estimating days. This is done every year, utilizing different data, and resulting in different time frames being selected each year. Moreover, while the time frame selected applies to all eligible hospitals for that SFY, the time frame effects Medicaid payments for the SFY at issue only. The estimates do not have future effect. Further, they do not act on unnamed or unspecified persons or facts. Instead, DMS examines all the data, determines which time frame is most beneficial to the hospital industry as a whole, and makes the estimates. The time frame selected applies only to the specific hospitals that qualify for the current SFY. The list of hospitals that qualify is subject to change with each SFY. The estimation of Medicaid patient days does not fall within the definition of a rule.(FN7)

This conclusion finds support in caselaw. A situation similar to the one in the current case arose in ***Branson R-IV School District v. Labor & Industrial Relations Commission*, 888 S.W.2d 717 (Mo. App. S.D. 1994)**, wherein the Branson School District (Branson) received permission to build two school facilities. Pursuant to statutory mandate, workers employed by private contractors in the construction of certain public facilities "must be paid not less than the prevailing hourly rate of wages for work of a similar character in the locality in which the work is performed." ***Id.* at 719**. Accordingly, Branson asked the Department of Labor and Industrial Relations (Department) to determine the prevailing rate of wages for workers to be employed on a specific project. ***Id.*** The Division of Labor Standards (Division) made preliminary wage rate determinations for relevant trades in the specified county. ***Id.*** Dissatisfied with the determinations, Branson argued the method used by the Division to determine prevailing wages constituted a rule under section 536.010. ***Id.* at 719-20**. The method utilized by the Division was the mode method of statistical analysis wherein the prevailing wage rate for a given trade is the actual wage most frequently paid in the locality. ***Id.* at 720**. The Southern District found that the Division's determination was not based on a rule and, accordingly, no rulemaking procedures were required. ***Id.*** The Southern District enumerated several bases for its holding, many inapplicable in the case *sub judice*. Among these, was a determination that the prevailing wage rates were calculated "with respect to a specific set of facts and [were] intended to apply only to that specific set of facts." ***Id.* at 721 (quoting section 536.010(4)(b))**. The court noted a statutory requirement that a separate request for a wage determination must be filed for each separate project by a public body and a statutory prohibition that one public body may not use the wage determination made for another public body. ***Id.*** While ***Branson*** is not identical to the present case, similarities exist. In both cases, the determination at issue was based on a specific set of data. Further, the data was different each time the determination was made. Finally, the determination only applied to a specific issue; it was not used as a guideline for future determinations.

Cases relied upon by the Commission and Centerpointe are distinguishable and illustrate why the estimation of Medicaid patient days is not a rule. In ***Missouri State Division of Family Services v. Barclay*, 705 S.W.2d 518, 520 (Mo. App. W.D. 1985)**, the legal guardian of a nursing home patient sought to withhold \$82 from the patient's monthly social security benefits to pay certain expenditures. The Division of Family Services (DFS) determined that the only allowable deductions were \$25 for the patient's personal needs and \$14.60 for the Medicare insurance premium. ***Id.*** This determination was made pursuant to a method set forth in the Missouri Division of Family Services Income Maintenance Manual (IMM). ***Id.*** As stated by this court, the issue was whether the IMM provided "a permissible means to carry out agency policy affecting the legal rights of a person like the [patient]." ***Id.*** The court concluded the portion of the IMM at issue fell within the statutory definition of a rule and had no controlling force as it was not promulgated as a rule. ***Id.* at 521**. In ***Barclay*** there was a methodology set forth in writing that was consistently applied for all cases. The written method was a reference for DFS to refer to whenever the issue arose. In the current case, DMS never set forth its method of estimating Medicaid patient days in writing so that the method could consistently be applied year to year. Instead, the method changed every year after DMS examined all available data, conferred with MHA, and determined which time frame was most beneficial. One year's method of estimating Medicaid patient days could not be referred to a guideline the following year as the data changed yearly.

The Commission relied upon ***St. Anthony's Medical Center v. Department of Social Services*, No. 03-0661 (Mo. Admin. Hearing Comm'n Apr. 6, 2004)**, in concluding the determination of estimated Medicaid patient days falls within the definition of rule. ***St. Anthony's*** involved the methodology utilized by DMS to calculate case mix increase and resulting rate amount increase, a methodology not at issue in the case *sub judice*. Unlike the present case, DMS conceded in ***St. Anthony's*** that the methodology at issue does not change from year to year and has been consistent over the years. ***Id.* at 14**. In contrast, DMS's method of estimating Medicaid patient days changes based on the data available

for each SFY. (FN8)

The Commission also relied upon *NME Hospitals v. Department of Social Services*, 850 S.W.2d 71 (Mo. banc 1993), wherein the Missouri Supreme Court held invalid DMS's policy dictating psychiatric services, other than electric shock treatment, were not reimbursable under Medicaid because the policy was not announced as a rule. The Commission quoted the following language from *NME* in its decision:

A.

There is no dispute that the disallowance of costs of psychiatric services other than electric shock therapy is a reimbursement standard of general applicability. As such, the standard is a policy change requiring promulgation of a rule. Section 536.010(4), RSMo 1986, provides, in pertinent part, that the term "rule" means "each agency statement of general applicability that implements, interprets, or prescribes law or policy...." An agency standard is a "rule" if it announces "[a]n agency statement of policy or interpretation of law of future effect which acts on unnamed and unspecified facts...." *Missourians for Separation of Church and State v. Robertson*, 592 S.W.2d 825, 841 (Mo.App.1979). The Department suggests that the policy change at issue is not one of general applicability because it governs only Medicaid participants, rather than all hospitals in Missouri; therefore, the Department contends, promulgation of a rule is not required. The Department is incorrect. The reimbursement policy applies generally to all participants in the Medicaid program. Definition of the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance under the program must be made by rule and regulation. Section 208.153.1. The Department's decision to exclude coverage for all psychiatric or psychological services other than electric shock therapy defines in part medical assistance within the meaning of section 208.153. As such, the Department's amendment required promulgation of a rule. Section 536.010(4).

B.

Promulgation of a rule requires compliance with the rulemaking procedures specified in section 536.021, RSMo Supp.1992. Section 536.021 provides in pertinent part:

1. No rule shall hereafter be made, amended or rescinded by any state agency unless such agency shall first file with the secretary of state a notice of proposed rulemaking and a subsequent order of rulemaking....

....

6. [A]ny rule, or amendment or rescission thereof, made after January 1, 1976, shall be void unless made in accordance with the provisions of this section.

Section 536.021 sets forth the notice and comment procedures for rulemaking, amending, and rescinding. The purpose of the notice and comment procedures is to provide information to the agency through statements of those in support of or in opposition to the proposed rule. In *St. Louis Christian Home v. Missouri Comm'n on Human Rights*, 634 S.W.2d 508, 515 (Mo.App.1982), the court observed: The very purpose of the notice procedure for a proposed rule is to allow opportunity for comment by supporters or opponents of the measure, and so to induce a modification.... To neglect the notice ... or to give effect to a *proposed* rule before the time for comment has run ... undermines the integrity of the procedure.
(emphasis in original).

A rule adopted in violation of section 536.021 is void. Section 536.021.6; *St. Louis Christian Home*, 634 S.W.2d at 514-15; *See also Sunset Retirement Homes, Inc. v. Dep't of Social Services*, 830 S.W.2d 18, 21 (Mo.App.1992); *Missouri State Div. of Family Services v. Barclay*, 705 S.W.2d 518, 521 (Mo.App.1985). There is no dispute that the Department failed to comply with rulemaking procedures in enacting the amendment that is the subject of the dispute in the present case. The amendment is void.

Id. at 74. As with the previous cases, the policy at issue in *NME* applied in all situations. It did not change upon a re-evaluation of the available data. It was a guideline referenced by the Department of Social Services whenever the issue of costs for psychiatric services arose. The same is not true in the current case.

Thus, DMS's determination of estimated Medicaid patient days is not a rule requiring formal rulemaking procedures. Instead, DMS has discretion to examine the data and determine the time period used to make the estimate. This discretion is not unfettered, however, and must be lawfully exercised. *See Mo. Nat'l. Educ. Ass'n v. Mo. State Bd. of Educ.*, 34 S.W.3d 266, 280 (Mo. App. W.D. 2000). The Commission found "that DMS historically used a reasonable methodology." It did not make a finding pertaining to whether DMS abused its discretion with its method of estimating Medicaid patient days for SFY 2004, though. Thus, the case is remanded to the Commission for consideration of this issue. It must determine whether DMS's use of a nine-month time frame from SFY 2003, which was annualized and prospectively applied to SFY 2004, was an abuse of discretion.

Point granted.

Points III and IV

In its third point on appeal, DMS argues the Commission erred in failing to defer to its estimate of Medicaid patient days for Centerpointe of 2,372 for SFY 2004 and in requiring DMS to issue a second estimate of Medicaid patient days. It claims the Commission applied the wrong standard of review in violation of section 536.140.2, state caselaw, and federal caselaw. In its fourth point on appeal, DMS argues the Commission erred in ordering it to pay more than \$1.8 million in additional direct Medicaid payments to Centerpointe and in refusing to consider evidence it proffered. It claims the Commission's decision was in excess of its statutory authority, unsupported by competent and substantial evidence upon the whole record, unauthorized by law, and/or arbitrary, capricious, or unreasonable under section 536.140.2. Given the disposition of Point II, these points need not be addressed. (FN9)

Conclusion

DMS's first point is denied as the Commission had jurisdiction over Centerpointe's complaint. Its second point is granted however, as the estimate of Medicaid patient days is not a rule. The case is remanded to the Commission for a determination of whether DMS's method of estimating Medicaid patient days for SFY 2004 was an abuse of discretion. DMS's third and fourth points are not addressed given the disposition of Point II.

The case is remanded for proceedings not inconsistent with this opinion.

All concur.

Footnotes:

FN1. Portions of the Commission's findings of facts are quoted without attribution. These portions are not contested on appeal.

FN2. The Missouri SFY is from July 1 of the preceding calendar year through June 30. For example, SFY 2004 was from July 1, 2003, through June 30, 2004.

FN3. All citations to the Code of State Regulations refer to the version in effect on June 4, 2004, the date of the notice Centerpointe is appealing.

FN4. All statutory citations are to **RSMo 2000** unless otherwise stated.

FN5. Use of the word "guidelines" is misleading. The time frame DMS selects to make its estimate of Medicaid patient days is at issue. DMS does not use written guidelines or formula in determining the appropriate time frame.

FN6. The definition of "rule" was contained in section 536.010(4), RSMo 2000. Section 536.010 was subsequently revised and subsection 4 was renumbered subsection 6. This was the only change made to the definition of "rule."

FN7. Centerpointe argues DMS admitted its determination of estimated Medicaid patient days was a rule. Thus, it concludes, without citation to authority, that the supposed admission prevents DMS from arguing the determination is not a rule. Closer examination of the testimony reveals DMS acknowledged that estimated Medicaid patient days were a component of a rule, namely 13 CSR 70-15.010(15). Nonetheless, DMS has consistently maintained it changed the timeframe used to determine estimated Medicaid patient days on a yearly basis after examining the data. It strongly asserted that the regulations conferred on DMS discretion with respect to the time period utilized to estimate Medicaid patient days. It never conceded its determination fell within the definition of a rule.

FN8. Moreover, the doctrine of stare decisis does not apply to administrative tribunals. *City of Columbia v. Mo. State Bd. of Mediation*, 605 S.W.2d 192, 195 (Mo. App. W.D. 1980).

FN9. As to Point III, this court directs DMS's attention to *Dep't of Soc. Servs. v. Mellas*, No. WD66602, 2007 WL150355 (Mo. App. W.D. 2007), which addresses the standard of review applicable to the Commission's review of DMS's decisions.

Separate Opinion:

None

This slip opinion is subject to revision and may not reflect the final opinion adopted by the Court.

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