RENDERED: October 2, 1998; 2:00 p.m.
NOT TO BE PUBLISHED

Commonwealth Of Kentucky

Court Of Appeals

No. 1997-CA-001875-MR

MARYMOUNT MEDICAL CENTER, INC. — APPELLANT

v.

APPEAL FROM FRANKLIN CIRCUIT COURT
HONORABLE WILLIAM L. GRAHAM, JUDGE
ACTION NO. 96-CI-01516

COMMONWEALTH OF KENTUCKY,
CABINET FOR HEALTH SERVICES — APPELLEE

OPINION
REVERSING AND REMANDING

* * * * *

BEFORE: GUIDUGLI, JOHNSON and SCHRODER, Judges.

JOHNSON, JUDGE: Marymount Medical Center, Inc. (Marymount) appeals from an order entered in Franklin Circuit Court on June 26, 1997, affirming the Administrative Law Judge's (ALJ) July 11, 1996 opinion which denied Marymount's request for an increase in its reimbursement rate set by the Cabinet for Health Services (the Cabinet) to compensate Marymount for the costs of inpatient, acute care services rendered to Medicaid beneficiaries.

Marymount argues that it has been denied fundamental due process and that the Franklin Circuit Court failed to use the appropriate standard in reviewing the ALJ's opinion. We agree with the second argument, and reverse and remand.

Marymount is a one-hundred bed, full service, general acute care hospital located in London, Kentucky, which participates in the Kentucky Medical Assistance Program (KMAP). Approximately seventy-five percent of its patients are Medicare or Medicaid patients and the hospital is heavily dependent on reimbursement of Medicare and Medicaid expenses.

Medicaid is a largely state-administered program for the federal and state financing of medical costs among specific disadvantaged groups, notably, the impoverished. The Medicaid program is designed, implemented and administered by states using federal funds and following federal guidelines.[1] At its inception, the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., was not specific in its regulation of allowable cost. However, in 1972, Congress adopted a Medicare program which required payment on a "reasonable cost" basis. As a practical matter, the "reasonable cost" reimbursement method meant that the state paid for virtually all care provided Medicaid recipients. Mary Washington Hospital, Inc. v. Fisher, 635 F.Supp. 891, 893 (E.D. Va. 1985). Congress ultimately found the Medicare reasonable cost reimbursement principles to be

[1] Medicaid differs from Medicare which is administered exclusively by the federal government.

inherently inflationary and to contain no incentives for efficient performance. 46 Fed.Reg. at 47966.

State participation in Medicaid is voluntary, but to obtain federal financial assistance the state must comply with federal Medicaid laws and regulations. See Wilder v. Virginia Hospital Association, 496 U.S. 498, 501, 110 S.Ct. 2510, 2513-2514, 110 L.Ed.2d 455, 462 (1990). The state must devise a scheme for reimbursing health care providers and have that plan approved by the Secretary of Health and Human Services. The Cabinet is the state agency charged with administering the Kentucky Medicaid program. At the time of the action sub judice,[2] it was also required that the state plan comply with the Boren Amendment which was enacted in 1980.[3] 42 U.S.C. § 1396a (a)(13)(A). The Boren Amendment strongly encouraged states to

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[2] The Balanced Budget Act of 1997 repealed several provisions of the Boren Amendment. This appeal is unaffected by the repeal. See Balanced Budget Act of 1997, Title IV, Subtitle H, Chapter 2, Sec. 4711.

[3] The Boren Amendment, in pertinent part, requires the State to provide

> for payment . . . of the hospital services . . . provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . .

contain costs within fixed limits or suffer substantial financial penalties in the form of reduced federal contribution.

Kentucky's program, approved by the federal government, based reimbursement rates upon the operating costs, capital costs, and professional costs of treating eligible Medicaid patients during the previous year. Operating costs are comprised of both routine costs and ancillary costs. Routine costs are the total administrative costs divided by the total number of patient days at the hospital, regardless of payor. Ancillary costs, on the other hand, are expenses which are directly attributable to a specific patient and are based upon that patient's actual use of a particular service (such as lab tests, x-rays, pharmaceuticals and surgery). Operating costs are calculated annually with payment rates applied prospectively.

Kentucky uses two basic methods of limiting Medicare expense reimbursement: a median-based limit and a rate-of-increase control (RIC).[4] To determine the median-based limit, hospitals are divided into "peer groups" based upon the number of hospital beds available and a median per diem cost is computed. Marymount is in the peer group for acute care hospitals with fifty-one to one hundred beds, which has a hospital reimbursement rate of 110% of the median per diem cost. However, as a hospital which services a disproportionately high number of Medicaid patients, Marymount can receive up to 120% of the median cost.

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[4] The RIC was implemented in July 1993.

To determine the RIC, the routine and ancillary costs from the previous year are totaled and that figure is then increased by one and one-half times the hospital's specific inflation factor, which is known as the "DRI."[5]

In this case, the RIC rate is based on Marymount's 1994 inpatient rate, which, in turn, is based on Marymount's 1993 fiscal year's cost report. Using data from fiscal year 1993, the Cabinet set Marymount's reimbursement rate at $547 per diem for 1995 even though Marymount's actual Medicaid recognized operating cost was $656 per diem. The median cost limit for Marymount's peer group was $681 per diem. However, Marymount was not eligible for $656 per diem because when the RIC was applied to the previous year's cost, it was capped at $547 per diem. There can be no upward adjustment above the median-based limit and the RIC unless specific exceptions apply.

Marymount initiated administrative proceedings claiming the per diem reimbursement rate was "unreasonable and inadequate" and requesting an increase based upon Section 113(b), (c), and (f) of the Medicaid Reimbursement Manual for Hospital Inpatient Services authorized under 907 KAR 1:013E. Section 113 of the manual provides as follows:

> Participating hospitals are provided a mechanism for a review of Program decisions when any of the following circumstances occur:

[5] The DRI (Data Resources, Inc.) is a nationally recognized calculation frequently used for Medicaid rate-setting purposes.

(a) The addition of new and necessary services requiring Certificate of Need approval.

(b) Major changes in case mix.

(c) Major changes in types or intensity of services.

(d) Costs of improvements incurred because of certification were established if those costs were not considered in the rate calculation.

(e) Extraordinary circumstances which may include fires, floods, etc.

(f) Program decisions of a substantive nature relating to the application of this payment system.[6]

Marymount's major contention is that, based upon its audited financial data, it experienced major changes in case mix and/or major changes in types or intensities of service and therefore qualified for an upward adjustment under Section 113 (b) and (c). Marymount argues that implementation of the RIC in 1993 qualified it for an increase in its reimbursement rate under Section 113 (f). Marymount argues that because it has managed to shorten the average length of stay, the average cost per day has necessarily increased.[7] Marymount argues that even though it

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[6] The Cabinet has no regulation or internal memorandum defining the terms used in Section 113.

[7] It is undisputed in this case that a hospital stay costs more in the first few days. Thus, for example, if a patient can be released in five days rather than seven days, the cost per day on the five-day stay is higher than the cost per day on the seven-day stay.

operates efficiently, the $547 reimbursement rate penalized it by not adequately reimbursing it for its reasonable costs.

A program review meeting was held on January 9, 1996, between representatives of Marymount and the Cabinet. Marymount argued that fiscal year 1993 was not a proper base year in which to impose the RIC because changes made in the 1993 fiscal year[8] resulted in higher ancillary costs and a significant reduction in average length of stay. Marymount argued that these changes and a decline in obstetrical services increased the facility's per diem operating costs beyond the maximum recognized reimbursement amount. Marymount has historically contained operating costs well below the median for its peer group.[9]

In the final report, the hearing officer and acting director of reimbursement operations, Pam Aldridge (Aldridge), stated that the decrease in hospital occupancy should have

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[8] In 1992, Marymount experienced its first unprofitable year since 1982 due to the loss of $1 million in annual income caused by the state's discontinuance of the indigent care program. In an attempt to make up for that large revenue loss, Marymount made changes: increasing employee contribution to insurance premiums, raising deductibles on its malpractice insurance, implementing a wage structure, entering into a management contract, opening a twenty-four bed dual-licensed unit, implementing a new utilization review program as well as other changes in an attempt to reduce average length of stay.

[9] An analysis by an accounting firm revealed that when overall hospital operating costs were divided by adjusted patient volume, the hospital experienced only modest increases in operating expenses--less than four percent over a two-year period. Marymount argues that this analysis indicated that the large increase in Medicaid costs was attributable to something other than failure to control costs.

resulted in a commensurate decrease in ancillary and nursery costs. She stated that the hospital administrator failed to monitor changes in utilization of the facility and those costs did not decrease. Aldridge concluded that the hospital was not operated in an efficient and economical manner and recommended no increase in Marymount's reimbursement rate.

Pursuant to 907 KAR 1:671, Section 14, Marymount requested an administrative hearing arguing that it was an efficiently and economically operated facility and an increase in per diem reimbursement rate was warranted under sections (b), (c), and (f) of Section 113. At a hearing on April 19, 1996, Marymount presented evidence from its president/chief executive officer, chief financial officer and a certified public accountant, Mark Carter (Carter). The Cabinet presented only the testimony of Aldridge.

Marymount contended that changes it had made in 1993 resulted in a reduced average length of stay and a commensurate increase in ancillary costs. Marymount presented audited financial data supporting this argument. Those changes included the opening of a dual-licensed unit, the increased use of observation beds, and the implementation of a case management approach to cost control. Marymount also noted that it had a change in obstetrical services[10] during the 1993-1994 year when one primary care physician discontinued deliveries due to the

[10] Approximately 78% of deliveries in the area served by Marymount are Medicaid cases.

cost of insurance premiums. Marymount emphasized that although total deliveries decreased in 1994, the number of Caesarean deliveries increased when two other primary care physicians began obstetrical care.[11]

Marymount attempted to prove that it was an economical and efficient hospital by presenting the following statistics: it is below both state and national averages for its costs per discharge; it uses only 3.8 full-time equivalent employees for each patient per 100 adjusted discharges versus the Kentucky average of 5 full-time equivalent employees; it pays its employees an average salary of $29,000 which is below the Kentucky average of $31,000, its Medicare average length of stay was the shortest in the region; its costs per discharge were the lowest of the twenty hospitals in the Sisters of Charity of Nazareth system; its costs per adjusted discharge were only one half of the costs for comparable Kentucky facilities; and it was the only hospital in the state with a variable staffing program. Marymount noted that the decrease in average length of stay which it achieved brought a substantial savings to the Kentucky Medicaid Programs; and that even if it received the full upward rate adjustment, it would nevertheless save Medicare over nine percent.

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[11] Caesarean deliveries produce increased ancillary costs, whereas routine deliveries are a lower intensity, i.e., lower cost, service.

Before accountant Carter testified, Marymount sought a stipulation concerning the reliability of its basic data. The Cabinet indicated that it had no objection to the data.[12] Through Carter, Marymount entered Exhibit 1, fourteen tables based upon audited financial data, which Carter explained in great detail. Carter testified that a shortened average length of stay combined with an increasing case mix index will cause a hospital's ancillary cost to rise[13] and that Marymount had such a

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[12] Prior to accountant Carter's testimony, the following colloquy took place:

> Marymount's counsel: And maybe I could just --Mr. Ramsey, we are not, as I understand it, in disagreement as to their basic source numbers that we are using here today.
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> The Cabinet's counsel: Fine. This is information that came from us.
>
> Marymount's counsel: So we won't put on proof as [to] the source and accuracy of that base information then.
>
> ALJ: That's fine.

[13] The Cabinet argues that we must defer to statements of agency policy. A major change in case mix index is a critical issue in this case. Marymount argues that agency policy fluctuates depending on the circumstances. Aldridge generally defined case mix as noted above; however, Marymount contends that in a recent Medicare rate appeal involving another hospital, a Cabinet staff member testified that case mix actually referred to "payor type" and that the agency had always interpreted the phrase in that manner. Marymount included in its reply brief before this Court as an exhibit the transcript of the testimony given by the Cabinet employee at a recent rate appeal hearing. Marymount argues the Cabinet's interpretation of "case mix" changes to fit the circumstance. The Cabinet has requested that this Court strike Marymount's exhibit because CR 76.12(4)(c)(vi) prohibits using as an exhibit a document which was not part of
(continued...)

situation. Carter also presented a single page unaudited document, Exhibit 2, Attachment E, containing only numbers rather than tables. Carter testified that Attachment E "was included just to show that some of the measures that the hospital reports monthly to its corporate office and it is held accountable to by the leadership in their corporate office." Carter explained that the parent corporation used this data to compare its hospitals to one another and to the state and national averages. He was not cross-examined about Attachment E.

On direct examination, Aldridge was asked about each of the tables Carter presented. When asked about Table #4, she noted that the total hospital discharges in Attachment E did not match those in Table #4. However, she did state that she was not sure about her testimony because she "didn't work through this one." When asked if there was anything else she wished to add regarding Table #4, she reiterated her belief that "exhibit E . . . kind of contradicted this [Table #4] a little bit . . . ." Regarding Table #9, the case mix table, Aldridge stated that the case mix index may be roughly described to mean "the ratio of the number of patients requiring minor services to those requiring more serious services." Aldridge noted again that Attachment E "really didn't reflect--what was on that particular page didn't reflect such an extreme increase in acuity levels." On cross-examination when asked about Table #9, Aldridge stated:

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[13](...continued)
the record below.

> I did look at this but there again like we mentioned earlier, I mean I don't have anything to base this on. I'm just looking at this chart and the chart would indicate that the case mix has changed but there again, that is not--I had already looked at-- prior to looking at that, I had looked at E of exhibit #2 also which really reflected something a little bit different in the trends in that case mix. So there I had two different documents that I was looking at and they seemed to indicate different things.

When asked about Table #10, the Medicaid admissions chart, Aldridge noted that Attachment E indicated a reduction in admissions rather than an increase as presented in Table #10.

In conclusion, when Aldridge was asked her opinion on whether Marymount had shown an increase in case mix or case types, she replied that having reviewed all the materials, "it does not indicate a change in services or intensity as we have applied it in the past and based on our interpretation of what the intent of the manual is." She stated that the reason for that decision is that "it looks like the majority of what we are seeing here or pretty much all of what we are seeing is something that is representative of what's going on in the industry from provider to provider." She explained that routine fluctuations are going to occur when operating a business. She testified that "we were trying to find something that was unique to Marymount that we wouldn't be seeing across the board or that we wouldn't be seeing at all the rural hospitals or everywhere in the state. And, no, I did not see anything that was truly unique to Marymount."

Marymount's president/chief executive officer and chief financial officer testified that the hospital would lose $400,000[14] per year at the $547 per diem rate and that the low rate of reimbursement set by the Cabinet will mean major changes in the services provided to Medicare patients. The officers opined that one of the major changes would be a discontinuation of obstetrical practice even though the nearest obstetric hospital is over twenty miles away.

At the close of the hearing, the ALJ gave the parties ten days to file simultaneous post-hearing briefs, which each party did. The Cabinet argued that Marymount's data was unreliable and it detailed perceived discrepancies between the tables used by the Cabinet and Attachment E. Unaware that the Cabinet was going to allege these discrepancies, Marymount simply summarized the evidence and detailed its audited financial data which it claimed supported its argument that it was an economically and efficiently operated hospital and that it should receive rates which are reasonable and adequate to meet its costs.

The ALJ, in her July 11, 1996 opinion, noted that "KMAP is required to pay for inpatient hospital services provided to eligible Medicaid recipients through the use of rates that are reasonable and adequate to meet the costs that are required to be

[14] The hospital forecasted a loss of $600,000 the first year at that rate.

incurred by efficiently and economically operated hospitals." The ALJ stated that "[t]he figures presented in this document . . . are largely inconsistent with those presented by Marymount in this appeal." The ALJ specifically noted several perceived discrepancies between the audited statistics and the unaudited report. In fact, four of fourteen "findings" made by the ALJ addressed these discrepancies. In her conclusions of law, the ALJ stated in pertinent part as follows:

> Section 113 provides the Cabinet and hospitals with necessary flexibility in applying the payment rate standards. However, that section is not to be interpreted liberally but rather is to be applied only in limited circumstances to resolve individual inequities unique to the facility seeking relief. This is especially true in light of the recent Memorial[15] decision in which KMAP's reimbursement system was held to be fair and reasonable. The Court in Memorial court [sic] concluded that KMAP reimburses Kentucky hospitals on average between 93 percent and 96 percent of Medicare eligible costs. "By any measure of Kentucky hospitals, this reimbursement is within a reasonable zone calculated to allow those efficient hospitals the ability to recoup their reasonable Medicaid related costs." Memorial, 896 F.Supp. at 1439. That is certainly not to say that the application of the same reimbursement methodology is mandated regardless of the circumstances. Certainly, Section 113 allows crucial flexibility in dealing with special situations faced by providers. However, it must be applied as an exception rather than a rule. Applied too liberally, Section 113 has the potential of inflicting a great deal of damage to an established reimbursement methodology system.

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[15] Memorial Hospital, Inc. v. Childers, 896 F.Supp. 1427 (W. D. Ky. 1995).

* * *

Marymount has failed to prove with any certainty that it experienced a major change in case mix or a major change in the types or intensities of services it offers. First, the impact of Marymount's efforts to cut costs and increase the efficiency of hospital operations during the time in question is unclear from the data presented at the administrative hearing in this matter. The evidence of a substantially decreased ALOS [average length of stay] and a corresponding increase in ancillary costs is riddled with uncertainties and is tenuous at best. There is conflicting evidence in Marymount's own documentation concerning whether a reduced ALOS for Medicaid patients was actually achieved. Contradictory evidence also exists as to Marymount's assertions that its CMI [case mix index] increased. . . .

* * *

Even if the financial data prepared and presented by Marymount was consistent and fully supportive of its arguments, a reduced ALOS and a routine fluctuation in obstetrical services do not qualify as major changes in case mix or types or intensities of services for purposes of Section 113. Marymount is not experiencing any type of individual inequity here; there is no evidence to suggest that Marymount's situation differs from that of other rural hospitals. The hospital's efforts to reduce the ALOS is an industry-wide trend. . . . Marymount's approach is a practical cost-cutting measure, but it is not a unique one and it is certainly not the type of individual inequity contemplated by Memorial and by Section 113.

The changes in the hospital's obstetrical practice are indicative of the normal ebb and flow of any rural hospital operation and do not represent a major change in case mix or type or intensity of service. . . . The discrepancies in Marymount's data aside, any changes experienced by Marymount appear to be temporary and not unusual. . . . Like the increase in the number of births or number of

> caesarean sections, these changes are normal and temporary fluctuations which are to be expected.
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> Marymount has not alleged that the program decision to apply the RIC effective July 1, 1993[,] was erroneous or faulty in any way, the hospital is just asking that the program decision not apply to it. There is no evidence to suggest that Marymount's circumstances differ from those of any other provider . . . or that the application of Section 113(f) is warranted in this particular case.
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> * * *
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> KMAP applied the proper rate limitation methodology to Marymount in establishing its inpatient operating costs and reimbursement amounts. KMAP's methodology is reasonable and has been applied in conformity with federal and state law. The exceptions to the established KMAP reimbursement procedures set forth in Section 113 of the Manual are necessary to resolve individual inequities in the reimbursement system. In this case, Marymount has failed to prove that it was the subject of any individual inequities or that its circumstances entitled it to the application of any of the exceptions enumerated in Section 113.

On July 26, 1996, Marymount filed exceptions to the ALJ opinion and maintained that the only issue of the proceeding was whether Marymount's reimbursement rate was adequate and reasonable. Marymount stated that the Cabinet waited until after the hearing to raise the issue of the inaccuracy of its basic financial data and that the ALJ "jump[ed] to extreme and completely insupportable conclusions based upon an incomplete and

uninformed review of Attachment E." Marymount attached an affidavit from accountant Carter stating in part as follows:

> Thus, while Attachment E is an important management tool, it would have to be audited or subject to independent review to determine its accuracy before being used for anything other than internal management purposes. I have not audited Attachment E but it appears to be largely consistent with the Tables in Exhibit 1 with minor discrepancies such as can be expected when different source documents or accounting assumptions are used.

Marymount argued that the ALJ's use of Attachment E as substantive financial data was a procedural due process violation because Marymount had not been afforded any opportunity to refute the Cabinet's allegations of financial discrepancies made in the post-hearing brief. The ALJ denied Marymount's exceptions and recommended that the requested rate increase be denied.

Pursuant to statute, Marymount filed exceptions with the Secretary of the Cabinet. Marymount attached materials which it claimed the Cabinet had in its files at the time of the hearing which demonstrated that Marymount's data was indeed correct. The Secretary adopted in toto the ALJ's recommendation stating that "[u]pon review of this matter I find that Marymount has failed to produce consistent and adequate evidence that it experienced major changes in its case mix or types or intensity of services as contemplated by Section 113 . . . ."

Marymount appealed the matter to the Franklin Circuit Court and argued that the Cabinet's decision to deny the rate increase was "arbitrary, capricious, or characterized by abuse of

discretion"; "without support of substantial evidence on the whole record"; "in violation of constitutional or statutory provisions including the federal Medicaid Act, . . . KRS 205.560, and Kentucky Constitution Section 2"; and "deficient as otherwise provided by law including Marymount's right to due process as protected by Kentucky Constitution Section 2 and KRS Chapter 13B". In its June 26, 1997 opinion, the circuit court stated in pertinent part as follows:

> The validity of the KMAP reimbursement procedure was recently challenged in federal court. In Memorial Hospital v. Childers, 896 F.Supp 1427 (W.D. Ky. 1995), the court considered a suit by a group of providers who claimed that the program violated the Boren Amendment's mandate of efficient and economically-run facilities. The Court concluded that every facet of the KMAP, including the RIC limit, was consistent with the Boren Amendment. The court found the RIC, at 1.5 times the nationally-established inflation rate, was not unlawful per se or unreasonable as applied. Evidence presented to the federal court, and considered by the hearing officer in this case, showed that in some circumstances the inflation rate actually overcompensated some facilities for Medicaid costs, even when considering increased technology and acuity rates. This is not to say, however, that the RIC can never be applied in an unreasonable manner. A case-by-case analysis of specific application should be taken to ensure the circumstances have not changed.
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> In Petitioner's case, the hearing officer addressed the RIC's impact specifically on its facility, and concluded that it was reasonable. Petitioner urged the Cabinet to find an exception within subsections (b), (c) and (f) of Reimbursement Manual Section 113. The hearing officer concluded that Petitioner had not proven "with any certainty that it experienced a major change in case mix or a

major change in the types or intensities of services it offers." He found that the data presented in support of its decreased length of stay was "riddled with uncertainties and is tenuous at best," including some inconsistencies with Petitioner's own data as to the overall results. In any event, the hearing officer concluded, the changes made within Petitioner's structure were not the types considered to be "major changes" for purposes of Section 113.

As for Section 113(f), Petitioner argued that the RIC's base date of July 1, 1993[,] adversely affects its operating cost base, because during the 1993 year Petitioner experienced a major change in its obstetrical services, making it an "aberrant" year for operating costs. The hearing officer rejected this argument, noting that the changes in types of services were the "normal ebb and flow" of providing health care services, which is to be experienced by every provider at some point. This normal occurrence, plus the fact that providers were beginning to convert to dual-licensed facilities, was not unique enough, according to the hearing officer, to fall within the exceptions in Section 113. The exceptions, the hearing officer opined, are to be a rare occurrence, and not the general rule.

Based on the evidence presented at hearing [sic], we conclude that there is substantial evidence to support the hearing officer's conclusion that the KMAP, and the RIC specifically, was not unreasonably applied. Section 113 provides an adequate remedy for facilities alleging extraordinary circumstances seeking an exception to the reimbursement plan. The circumstances alleged by the Petitioner in this case were not considered to be unique or extraordinary enough to warrant the requested relief. An agency's interpretation of its own regulations should not be disturbed unless it is found to be totally against the evidence or contrary to existing law. See J.B. Blanton Co. v. Lowe, Ky., 415 S.W.2d 376, 378 (1967). We agree that Section 113 was designed to be a rarely-applied exception,

> and not a process commonly-used to "end run" the established reimbursement procedure. Accordingly, the agency's decision shall not be disturbed.

Marymount filed a motion to reconsider asking for reconsideration and/or clarification of two issues as follows:

> An administrative appeals process required by federal law cannot be divorced, however, from corresponding federal standards. While Section 113 of the Hospital Inpatient Reimbursement Manual may legitimately set some limits on the scope of permissible administrative appeals, that appeals process must be implemented and interpreted in accordance with its federally mandated purpose--to insure rates in individual cases are adequate and reasonable.[4] . . .
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> [4] Thus, for example, whether a rate increase should be granted pursuant to Section 113 due to "program decisions of a substantive nature relating to the applications of this payment system" cannot be properly decided without reference to whether the program decision in question (in this case the implementation of the RIC), as applied to the hospital's individual circumstances produced rates that are inadequate under federal standards.
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> * * *
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> CHS indicated clearly before the hearing that it agreed Marymount's data showing it had reduced its ALOS was accurate; during the hearing CHS did not contest those figures; and after the hearing when CHS finally raised questions about Marymount's data it had access to its own audited cost report demonstrating the veracity and reliability of Marymount's data. The government should not be permitted to contest the accuracy of data while it holds confirming data in its own files. Under these circumstances, CHS should

> be equitably estopped from contesting the accuracy of Marymount's data.[16]
>
> * * *
>
> At a minimum, Marymount was entitled to ask Ms. Aldridge to explain why CHS's own audited cost report should be disregarded and to have her credibility assessed.

Marymount requested the circuit court, at a minimum, to "clarify that it is [sic] holding that federal reimbursement standards including the adequacy and reasonableness of Medicaid rates or affects on the accessibility of Medicaid services to beneficiaries are inapplicable and irrelevant and will not be considered by this Court in reviewing Section 113 administrative appeals."

The Cabinet responded to Marymount's arguments by stating that the elements of equitable estoppel were not present and even if the elements were present, the general rule is that equitable estoppel does not apply to governmental agencies unless special or exceptional circumstances are present. The Cabinet argued that it was improper to use an administrative appeals process to analyze whether KMAP complies with the Boren Amendment on a facility-by-facility basis. The Cabinet stated that "the Kentucky Medicaid Program's overall reimbursement methodology is in compliance with federal standards (i.e. the Boren Amendment)

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[16] Marymount pointed out that the Cabinet had conceded that it had not timely raised the question about the deficiencies in the data until after the hearing. The Cabinet responded that its action in attacking the data after the hearing "is of little consequence provided Marymount had the opportunity to respond to any questions raised."

and therefore does reimburse all Kentucky hospitals for inpatient services with rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers [emphasis original]." The Cabinet emphasized that KMAP's appeals procedure was upheld in Memorial, supra, as "viable" and "not a sham."

By order entered July 23, 1997, the circuit court stated that it held in its previous order that KMAP's "limitation on per diem payment increases from one year to the next -- called the rate of increase control (RIC) -- was not arbitrary." The circuit court did not comment on the ALJ's lack of a finding that Marymount's resulting rate, in and of itself, was "reasonable and adequate". The circuit court concluded that it was without power to rule on the Cabinet's failure to comply with federal law since Marymount did not raise that issue before the ALJ. This appeal followed.

Our standard of review is expressed in American Beauty Homes, Corporation v. Louisville and Jefferson County Planning and Zoning Commission, Ky., 379 S.W.2d 450 (1964), as follows:

> Basically, judicial review of administrative action is concerned with the question of arbitrariness. On this ground the courts will assume jurisdiction even in the absence of statutory authorization of an appeal. There is an inherent right of appeal from orders of administrative agencies where constitutional rights are involved, and section (2) of the Constitution prohibits the exercise of arbitrary power.
>
> Obviously within the scope of a proper review the court may determine whether the

> agency acted in exercise of its statutory powers. Such action would be arbitrary within the prohibition of section (2)[17] of the Kentucky Constitution.
>
> In the interest of fairness, a party to be affected by an administrative order is entitled to procedural due process. Administrative proceedings affecting a party's rights which did not afford an opportunity to be heard could likewise be classified as arbitrary.
>
> Unless action taken by an administrative agency is supported by substantial evidence it is arbitrary.
>
> The above three grounds of judicial review, (1) action in excess of granted powers, (2) lack of procedural due process, and (3) lack of substantial evidentiary support, effectually delineate its necessary and permissible scope. . . . In the final analysis all of these issues may be reduced to the ultimate question of whether the action taken by the administrative agency was arbitrary. As a general rule the yardstick of fairness is sufficiently broad to measure the validity of administrative action.

Id. at 456 (emphasis original) (citations omitted) (footnotes omitted). See also Kaelin v. City of Louisville, Ky., 643 S.W.2d 590, 591 (1983), and Commonwealth, Transportation Cabinet Department of Vehicle Regulation v. Cornell, Ky. App., 796 S.W.2d 591, 594 (1990).

We will first review Marymount's claim that a procedural due process violation occurred when evidence was used against it without it being allowed to cross-examine the

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[17] Section 2 states in part as follows: "Absolute and arbitrary power over the lives, liberty and property of freemen exists nowhere in a republic, not even in the largest majority."

substance of the evidence. For there to be procedural due process rights, there must be a property interest. In The Board of Regents of State Colleges v. Roth, 408 U.S. 564, 576, 92 S.Ct. 2701, 33 L.Ed.2d 548, 560 (1972), the Court stated as follows:

> The Fourteenth Amendment's procedural protection of property is a safeguard of the security of interests that a person has already acquired in specific benefits. These interests--property interests--may take many forms.
>
> * * * * *
>
> Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law --rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.

One has a property interest in welfare benefits if she has previously been determined to meet the statutory criteria. Goldberg v. Kelly, 397 U.S. 254, 262-263, 90 S.Ct. 1011, 25 L.Ed.2d 287, 295-296 (1970). Procedural due process requires that a party has the right to notice, an unbiased decision-maker, fair procedures, and an opportunity to be heard which includes the right to call and fully cross-examine witnesses. Id. Also see Mathews v. Eldridge, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976).

In Kaelin, supra, a somewhat similar issue was presented. At an administrative hearing held for the purpose of granting or denying a zoning permit, the appellant was

specifically denied the right to cross-examine witnesses. The Supreme Court reversed this Court stating as follows:

> The purpose of a "trial-type hearing", as was stated in McDonald, [Ky., 470 S.W.2d 173 (1971)], is to permit the development of all relevant evidence that will assist the administrative body in reaching its decision. In such a hearing, as we view it, the parties must have the opportunity to subject all evidence to close scrutiny so as to determine its trustworthiness. A trial-type hearing implies the opportunity for full rebuttal, and the opportunity to impeach witnesses. Cross-examination is a time-tested and unique method of assisting in the quest for truth. Under the rules of the Commission, there is no opportunity to demonstrate the incompleteness, the untruth, the partiality or any other weakness or defect in the testimony of a witness. Without such opportunity, the search for truth may very well be impeded and restricted. In a hearing to terminate welfare benefits, the United States Supreme Court declared that the recipient must have an effective opportunity to defend by confronting any adverse witnesses which includes the right to "cross-examine the witnesses relied on by the defendant."(who sought to terminate benefits). Goldberg v. Kelly, [supra[18]].

Id. at 591-592 (emphasis original).

We cannot accept Marymount's argument that it was prohibited from cross-examining the Cabinet about the alleged discrepancies. Although counsel had agreed that the basic data

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[18] 907 KAR 1:671 Section 14 lists the procedural due process requirements of a hospital reimbursement rate adjustment hearing. It specifically states that "[t]he hearing officer shall consider the facts as presented at the hearing (including supplementary material if requested) and prepare a decision based on the record consistent with statutes and regulations."

was not an issue, testimony was presented which raised that issue. As noted, supra, on several occasions, Aldridge raised the issue that the data in Attachment E did not support Marymount's tables. At one point in his cross-examination of Aldridge, Marymount's counsel questioned her about the alleged discrepancy between Attachment #2 and Table #9. Aldridge stated that Attachment E "really reflected something a little bit different" and that "I had two different documents that I was looking at and they seemed to indicate different things". Marymount was not denied the right to cross-examine the Cabinet about the discrepancies; it could have cross-examined Aldridge when she pointed out what she perceived as discrepancies. The fact that Marymount failed to cross-examine Aldridge after she specifically stated on several occasions that the data did not match was certainly not a denial of Marymount's procedural due process.

We will now review whether the Cabinet acted in excess of its statutory power when it refused to apply the "reasonable and adequate" standard to the $547 per diem rate it set for Marymount. If a state agency has adopted a standard under which its entire program is operated, it must act within that standard or the agency has exceeded its granted powers. In Kentucky Power Co. v Energy Regulatory Commission of Kentucky, Ky., 623 S.W.2d 904, 907 (1981), the Supreme Court stated that even though a rate-setting agency must have broad latitude in conducting its proceedings, it is "the right and duty of the court to protect

parties who are subject to the authority of such an agency from arbitrary and capricious treatment. "Administrative authorities must strictly adhere to the standards, policies, and limitations provided in the statutes vesting power in them." Henry v. Parrish, 307 Ky. 559, 566, 211 S.W.2d 418 (1948).

907 KAR 1:013E, Section 1, states as follows:

> The Department for Medicaid Services shall pay for inpatient hospital services provided to eligible recipients of Medical Assistance through the use of rates that are reasonable and adequate to meet the costs that are required to be incurred by efficiently and economically operated hospitals to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Marymount contends that throughout the administrative proceedings it was clear that the federal standard of "reasonable and adequate to meet the costs that are required to be incurred by efficiently and economically operated hospitals" was applicable. Marymount claims that the Cabinet was fully aware of the federal efficiency and economy standards and specifically recognized their applicability throughout the administrative process as follows: in the initial program review report, Aldridge recommended denying Marymount's increase because the hospital was not operated in an efficient and economical manner; and in the ALJ's opinion, the ALJ stated that "KMAP is required to pay for inpatient hospital services provided to eligible Medicaid recipients through the use of rates that are reasonable and adequate to meet the costs that are required to be incurred

by efficiently and economically operated hospitals." Furthermore, the federal standard has been adopted as the state standard in its own regulation, 907 KAR 1:013E, Section 1, supra.

The Cabinet argues that as long as the methodology was determined to be "reasonable and adequate" within the standards of the Boren Amendment there is no need for further inquiry. However, Marymount is not arguing that the methodology used was not "reasonable and adequate"; rather, Marymount is arguing that the particular rate applied to it does not fit the "reasonable and adequate" standard. Marymount argues that by practically any measure, it is an efficient and economically operated hospital, and therefore, it is entitled to rates that are reasonable and adequate to meet its costs.

In Memorial Hospital Inc., 896 F.Supp. 1427, supra, the only published court opinion dealing with Kentucky's Medicare reimbursement program, twenty-six hospitals[19] sought to invalidate Kentucky's Medicaid reimbursement method for several reasons--one of which was the usage of the RIC.[20] The hospitals argued that the RIC was arbitrary in that it did not account for changes in the acuity level or increased cost of technology. The

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[19] Marymount's attorney in the action sub judice was one of the attorneys for the appellant, Memorial Hospital, Inc.

[20] Other reasons argued to invalidate the program included the calculation and payment of per diem rates, usage of a peer group methodology, usage of a median cost index, capital expenditure occupancy limits and failure to "take into account" hospitals which treat a disproportionate number of Medicaid patients. We limit our discussion to the RIC argument.

hospitals argued that the RIC unfairly limited all per diem reimbursements, even for hospitals with per diem costs below its peer group median. The federal court noted that "[t]hese persuasive arguments require careful consideration" but the Court then concluded that the evidence did not support Memorial's arguments. Id. at 1437. However, the Court cautioned:

> The RIC has existed for only two years. The formula may be revised in future years. Plaintiffs may have justifiable reason to fear the RIC's future impact: it is not inconceivable that at some future time the RIC could cause unlawful consequences; however, that time has not yet arrived. This Court need not predict the future and will not speculate when, if ever, a point of unlawfulness may arrive. This Court does conclude that the RIC is not unlawful per se or unreasonable, as currently applied.

Id. at 1438. The federal court concluded that the hospitals

> offered evidence of varying strength that parts of KMAP have some inherent unfairness. But they failed to show that plan as a whole is either unfair or contains incentives to create savings which are unlawful.
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> * * *
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> Plaintiffs' principal argument has a certain logic and appeal. Assuming for the moment that the Kentucky reimbursement formula defines an efficient and economical hospital, then how can it be that any of those hospitals so defined be denied their full cost recovery under the Boren Amendment? The answer is that neither the Boren Amendment nor any proof available to this Court define so precisely what are economical and efficient hospital costs. Neither the Boren Amendment's express language nor its intent require such a precise definition. The proof of reimbursements more than 93% of Medicaid costs is safely within any required zone of reasonableness. KMAP may not be

> equally fair to all hospitals, however, it does provide hospitals with substantial reimbursement of all reasonable Medicaid costs. To acknowledge that KMAP may produce some unfair results and that it may require belt tightening by some hospitals that claim to be efficient, does not, by any means, demonstrate that this Court must overturn it.

Id. at 1439-1440.

The Memorial Court used percentage of reimbursement of the actual costs as a yardstick for determining a zone of reasonableness of the rate-methodology. Memorial was being reimbursed for 93% of its actual costs and the Court concluded that the 93% reimbursement was within the zone of reasonableness for Kentucky hospitals. The Memorial Court stated that "[b]y any measure of Kentucky hospitals, this reimbursement is within a reasonable zone calculated to allow those efficient hospitals the ability to recoup their reasonable Medicaid related costs." Id. at 1439.

In the case sub judice, the Cabinet's reimbursement rate for Marymount only paid roughly 83% of its costs. The ALJ determined that none of the sections in Section 113 applied to Marymount even though she noted that the Memorial Court stated that "the Kentucky Medical Program reimburses Kentucky hospitals on average between 93 percent and 96 percent of its Medicare eligible costs." Id. The ALJ did not make a determination that the resulting rate for Marymount was reasonable. She stated that KMAP had applied the proper methodology and that the methodology was reasonable and applied in conformity with federal and state

law. However, we believe the proper question is whether an 83% reimbursement rate to an individual hospital is within the zone of reasonableness when that hospital's operating costs are less than the median operating costs of hospitals within its peer group. Neither the ALJ nor the circuit court applied the "reasonable and adequate" standard to Marymount's actual rate of reimbursement. The Cabinet did not act within the scope of its authority when it did not apply the proper standard to Marymount's rates and for this reason, we must remand this case to the ALJ for further proceedings in accordance with this Opinion.

ALL CONCUR.

BRIEFS AND ORAL ARGUMENT FOR APPELLANT:	BRIEF AND ORAL ARGUMENT FOR APPELLEE:
Hon. Stephen R. Price, Sr. Louisville, KY	Hon. Zachary S. Ramsey Frankfort, KY