IN THE COURT OF APPEALS OF IOWA

No. 2-297 / 11-1145
Filed June 27, 2012

SUNRISE RETIREMENT COMMUNITY, FRIENDSHIP HAVEN, PRESBYTERIAN VILLAGE, ROSE VISTA HOME, LONGVIEW HOME, UNITED PRESBYTERIAN HOME, RICEVILLE COMMUNITY REST HOME, HUBBARD CARE CENTER and HAPPY SIESTA CARE CENTER,
Petitioners-Appellants,

vs.

IOWA DEPARTMENT OF HUMAN SERVICES,
Respondent-Appellee.

Appeal from the Iowa District Court for Polk County, Arthur E. Gamble, Judge.

Petitioners, nursing facilities, appeal from the district court's ruling on judicial review affirming the Iowa Department of Human Services' decision that changed a previous practice in ruling that required cost reports could not include their payments to outside vendors for medical services provided to their Medicare Part A patients. **REVERSED AND REMANDED WITH DIRECTIONS.**

Patrick B. White of White Law Office, P.C., Des Moines, for appellants.

Thomas J. Miller, Attorney General, and Timothy L. Vavricek, Assistant Attorney General, for appellee.

Heard by Eisenhauer, C.J., and Potterfield and Doyle, JJ.

POTTERFIELD, J.

This is an administrative law appeal from a decision by the director of the Iowa Department of Human Services (DHS), which was affirmed on judicial review by the district court. The director's decision upheld the disallowance by its auditors of costs for laboratory services, x-rays, and prescription drugs traditionally included on the annual reports required to be filed by nursing homes. All parties agree that the costs listed on the reports had been incurred on behalf of Medicare patients for lab services, x-rays, and prescription drugs received by the patients, and had been paid by the nursing homes. The issue is whether the director's decision to disallow the costs is in compliance with the administrative rules governing the cost reports and whether the change in practice is within the scope of Iowa Code section 17A.19(10)(h) (2011) (providing that the court "shall reverse, modify, or grant other appropriate relief from agency action . . . if it determines that substantial rights of the person seeking judicial relief have been prejudiced because the agency action is . . . action other than a rule that is inconsistent with the agency's prior practice or precedents, unless the agency has justified that inconsistency by stating credible reasons sufficient to indicate a fair and rational basis for the inconsistency"). The district court acknowledged the change, but concluded that the director had appropriately justified the inconsistency per section 17A.19(10)(h).

Because administrative rules governing the payment rate for nursing facilities do not exclude the costs expended for Medicare Part A patient lab, x-ray, and prescription drug services, which the facilities must annually report as

costs—and in the past had been considered by DHS to be “allowable costs”—we reverse and remand with directions to return this matter to the agency.

I. General Background.

Petitioners are Iowa nursing facilities that are residences for both Medicare Part A and Medicaid patients. The federal government prospectively pays the facilities for Medicare patients based on consolidated billing from which standardized federal per diem rates are calculated. The State pays the facilities for Medicaid patients on the basis of a per diem rate calculated by DHS from the information in an annual financial report required to be filed by the facilities. The annual report is a single report covering both Medicare and Medicaid patients.

A. Medicaid versus Medicare. Medicaid is a medical assistance program jointly financed by state and federal governments for low-income individuals. Medicare is a federally funded system of health and hospital insurance for U.S. citizens age sixty-five or older, for younger people receiving Social Security benefits, and for persons needing dialysis or kidney transplants for the treatment of end-stage renal disease.

B. Primary payment source. All residents of nursing facilities are admitted with an identified primary payment source. Some residents are private-pay residents, some are Medicare Part A residents, some residents have private insurance, and the rest rely upon Medicaid. Regardless of primary payor source, federal and state laws require that every nursing facility participating in Medicare and Medicaid provide certain services to every resident. *See* 42 U.S.C. § 1396d(a)(1)–(5), (17); 42 C.F.R. §§ 483.1, .25, .60; Iowa Code § 249A.2(7); Iowa Admin. Code rs. 481-58.19, 481-58.23 (hereinafter all citations to the Iowa

Administrative Code will be to Rule(s)). The required services include the services at issue in this case─lab, x-ray, and prescriptions.

C. Payment for lab, x-ray, and prescriptions differ depending on payor. In some instances, residents require services from a provider outside of the facility because the nursing facility does not provide those services on its premises. For Medicaid patients, the outside provider bills the State directly for those services and receives direct payment from the Medicaid program.

When a resident is admitted with Medicare as the primary payor source, however, the out-of-facility provider bills the facility and the facility is required to make payment to the provider. The Medicare Part A payment made to the facility for that resident represents a comprehensive payment for all care, treatment, and services—including the lab, x-ray, and prescriptions drug costs incurred by the facility. In this case, the costs were incurred for Medicare patients and paid by the facility.

D. Nursing facilities receive Medicaid reimbursement based upon "allowable costs of operation." Pursuant to rule 441-79.1, "The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule." Rule 441-81.1 defines "allowable costs" as "the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in rules."

Nursing facilities receive prospective "cost-related" reimbursement "on the basis of a per diem rate calculated prospectively for each participating provider

based on reasonable and proper costs of operation." Rule 441-79.1(1)(a). Pursuant to rule 441-81.10(1), "[a] per diem rate *shall be established based on information submitted according to rule 441-81.6*." (Emphasis added.)

E. Financial and statistical report. Rule 441-81.6 states, "all facilities in Iowa wishing to participate in the [Medicaid] program shall submit a Financial and Statistical Report, Form 4700-0030, to [DHS's] accounting firm," in an electronic format approved by DHS. The rule continues, "Costs for patient care services shall be reported, divided into the subcategories of 'Direct Patient Care Costs' and 'Support Care Costs.'" Rule 441-81.6. The Financial and Statistical Report form lists "pharmacy services," "x-ray services," and "laboratory" under support care costs. There is no dispute the costs at issue must be included on the Financial and Statistical Report.

"Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues." Rule 441-81.6(10). The Financial and Statistical Report form asks for revenue from Medicaid and Medicare.

From the revenues and costs reported on the Financial and Statistical Report, DHS's contracted accounting firm establishes a "modified price-based reimbursement rate" per patient per day pursuant to the seven-step process articulated in rule 441-81.6(16).

"For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits." Rule 441-881.10(2).

F. Costs at issue. In the year 2008, certain residents of the petitioners' facilities required lab work (for example, blood analysis), x-ray services, and prescription drugs. Because the nursing facilities did not provide these services at their facilities, they sent the residents to outside healthcare providers to perform the lab and x-ray services and to provide the prescription drugs. The residents who required these services were residents who were admitted to the facilities with Medicare Part A as their primary payor source. The outside providers billed the facilities, who then paid the providers. The facilities included these costs in their December 31, 2008 Financial and Statistical Reports, as required.

Schedule C of the Financial and Statistical Report is the "schedule of expenses" and lists "pharmacy services" on line 76, "x-ray services" on line 77, and "laboratory" on line 78. In the past, these expenses were reported and not "disallowed."

When reviewing the 2008 reports, however, the auditors came to the new conclusion that these costs were not allowable for purposes of the Medicaid per diem rate and made adjustments to reduce petitioners' per diem rates. This was a change from past practice. After being notified of the adjustments, petitioners filed an administrative appeal and requested a hearing. Because the auditors made the same lab, x-ray, and drug adjustments for all the petitioners' facilities, the administrative law judge (ALJ) consolidated the appeals into one proceeding.

G. Administrative hearing. A hearing was conducted on December 11, 2009, before the ALJ. Three DHS representatives testified at the hearing: Amy Perry, Jennifer Steenblock, and Andrew Johnson. Perry and Johnson work for

the Myers & Stauffer accounting firm, which is an accounting firm that reviews and audits the Financial and Statistical Reports on behalf of Medicaid agencies. DHS contracts with Myers & Stauffer to review annual reports, decide if costs should be denied, and make adjustments. Steenblock is DHS's long-term care program manager and is responsible for DHS policy to be implemented when auditing the facilities' Financial and Statistical Reports and making adjustments to the Medicaid per diem rate.

On April 6, 2010, the ALJ issued a proposed decision concluding that the costs for Medicare patient x-rays, labs, and prescriptions were properly included in the Financial and Statistical Reports but improperly excluded by the auditors. She wrote, in part:

> Contrary to the Department's position, [rule 441-81.6] may be read to require the inclusion of the Medicare Part A costs in the cost report since [rule 441-81.6] requires the facility to include all direct patient care costs and support care costs. There is no dispute in this record that the costs claimed by the facilities for their Part A residents were direct care cost. The rule requires that "costs for patient care shall be reported."
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> At the hearing the Department opined that Part A costs should be excluded because the costs are covered/paid for by the *Medicare* per diem and if the costs were included in the Medicaid per diem calculation, it would artificially inflate the Medicaid rate. This argument by the Department lacks merit however since the Medicare Part A revenue is also reported by the facility as a part of the cost report and already part of the equation. Moreover, the Department conceded that it could perform an offset to account for the costs/revenue associated with the costs for a Part A resident. As such the Department has methodology for dealing with this perceived "enrichment" without disallowing the costs on the Medicaid cost report.
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> . . . Nothing within [rule] 441-81.10 pertains to the preparation of the cost report and nothing authorizes disallowance of direct care costs. The prohibition on "supplementation" section of this rule does not apply to the cost report and merely provides that a facility may not supplement its billings for Medicaid residents.
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> . . . .

> [Rule] 441-81.10(2) requires the facility must exhaust all Medicare benefits before requesting payment under the Medicaid program. These facilities followed this rule for all of the costs associated with the Part A residents which were reported on the cost report. Disallowance of those costs creates conflict with this rule.
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> The rules relied upon by the Department do not support the action taken by the Department. Nothing within the plain language of these rules suggest that the rules can be applied in the manner argued by the Department.

The ALJ issued a proposed order reversing the cost report adjustments made by the auditors.

H. Intra-agency appeal. On April 13, 2010, DHS requested intra-agency review. On December 30, 2010, the DHS director issued a final decision. The director accepted the ALJ's findings of fact, but reversed her conclusions of law, writing in part:

> All allowable direct care and allowable support care costs should be reported on the Medicaid cost report for nursing facilities. There are inherent differences in how Medicare and Iowa Medicaid reimburse for nursing facility services. These differences include that Medicare Part A costs associated with x-ray, prescription drug and lab costs are part of the Medicare consolidated nursing facility reimbursement. However, for Medicaid reimbursement, these services are separately billed to Medicaid by the outside vendors that provide the service. Therefore, the Medicare Part [A] costs associated with x-ray, prescription drug, and lab costs should be excluded from the cost report as an unallowable Medicaid nursing facility expense, as Iowa Medicaid is responsible for establishing a rate based on Medicaid reimbursement principles.

In his decision, the director did not acknowledge or explain that the ruling was a departure from previous practice, nor why the departure rationally should go into effect.

I. Judicial review. The nursing facilities sought judicial review in the district court. The district court affirmed, writing:

> Upon review of the entire record the Court concludes the Director correctly interpreted [rule] 441-81.1 ([Iowa Code ch.] 249A). . . . This is the standard governing allowable costs under the applicable administrative regulation. The decision of the Director is a logical application of the plain language of [rule] 441-81.1 to the undisputed facts of this case. The Medicaid reimbursement rate is a cost-based rate and these particular costs are not part of the cost of providing nursing care services to Medicaid patients.

The district court acknowledged the interpretation was a change from past practice, but concluded the director had "justified that inconsistency by stating credible reasons sufficient to indicate a fair and rational basis for the change" per Iowa Code section 17A.19(10)(h).

The facilities now appeal.

II. Scope and Standard of Review.

We review a final agency action for correction of errors at law. *Eyecare v. Dep't of Human Servs.*, 770 N.W.2d 832, 835 (Iowa 2009). We review the district court's decision by applying the Iowa Administrative Procedure Act to the agency's decision to determine if our conclusions are the same reached by the district court. *Id.* "As the legislature has not clearly vested DHS with the authority to interpret its rules and regulations, we will not defer to DHS's interpretation. Therefore, our review of DHS's interpretation of its rules and regulations is for correction of errors at law. Iowa Code § 17A.19(10)(c)." *Id.* at 836 (finding that because DHS is not clearly vested with authority to interpret Medicaid rules, court does not defer to DHS's interpretations of those rules).

III. Analysis.

The calculation of the facilities' Medicaid payment rate is determined by rule 441-81.6. The Medicaid rate "shall be the patient-day-weighted average of

the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount." Rule 441-81.6(4). This complicated—and even arcane—calculation begins with the reporting of costs for patient care services, *see* Rule 441-81.6 (first unnumbered paragraph), the disallowance of certain expenses, *see* Rule 441-81.6(11), and a seven-step process to achieve "the modified price-based reimbursement rate." *See* Rule 441-81.6(16).

All of the services involved in this case were provided by third parties to the facilities' Medicare Part A patients. The facilities paid for those services and included them in the Financial and Statistical Reports. DHS claims they are not "allowable costs" for the purpose of determining a per diem Medicaid rate for services at the nursing facilities. The appealing facilities rely upon the fact that they must pay the bill for these Medicare-related services and thus they are "costs" for purposes of rule 441-81.6.

There is an intuitive appeal to the claim that a Medic*aid* per diem should not take into account any Medic*are* expenses. But the administrative rules do not make any explicit statement to that effect and DHS's prior practices did not disallow the costs. DHS relies upon the definition of "allowable costs" and in the alternative upon the rule against supplementation; neither of which is very persuasive and both require rather distorted logic to apply to the facts of the case.

A. "Allowable costs." DHS's rule defining "allowable costs," rule 441-81.1, states the term "means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed

the limitations set out in rules."[1] By itself, this rule offers little to support DHS's argument. The definition goes more to the *value* of the services than to a limitation on the types of services for which a facility can be reimbursed.

And the interpretation is contrary to DHS's own manual on nursing facility "Coverage and Limitations," which contains a section on "Allowable Costs for Facility Payment." There, the manual explains that "[a] facility's per diem rate is intended to cover all normal costs of operating a nursing care facility," including fixed operating costs; building and medical equipment; salaries; disposable supplies; and "[a]ll services provided to residents." The manual continues, "In general, all services called for in the plan of care for a resident which are related to the residents' physical or psychosocial functioning must be included as costs of operation (audit costs)." There is no dispute the services here were provided to residents as a part of their care.

Rule 441-81.6(11) states, "[c]ertain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules."[2] Subparagraphs then "disallow" such things as federal and state income taxes; fees paid directors and nonworking officers' salaries; bad debts; charity allowances and courtesy allowances; and personal travel and entertainment. *See* Rule 441-81.6(11)(a)–(p). There is no mention of lab, x-ray, or prescription drug costs related to Medicare patients.

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[1] This definition reads very similarly to the "willing buyer/willing seller" test of fair market value. *See* Iowa Code § 441.21 (defining "market value" as "the fair and reasonable exchange in the year in which the property is listed and valued between a willing buyer and a willing seller . . . .").

[2] As noted on page four, the definition of "allowable costs" also references "limitations"—"'Allowable costs' means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed *the limitations set out in rules.*" Rule 441-81.1 (emphasis added).

B. Supplementation. The supplementation rule does not support the proposition DHS urges. Rule 441-81.10(5), states,

> Only the amount of client participation may be billed to the resident for the cost of care and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

How this limits the calculation of the per diem rate is not evident. Moreover, the Medicaid calculation takes into account "income" from Medicare without a corresponding and offsetting deduction for the related costs, which would tend to artificially lower the Medicaid per diem.

C. Direct costs and non-direct costs. The first of the seven steps in the rate calculation of rule 441-81.6(16) requires that "costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441-81.1." DHS argues in this appeal that the costs at issue fall under neither the definition of "direct care" or "non-direct care" under rule 441-81.1.[3] We disagree. The lab, x-ray, and pharmacy services expenses are listed on the report form under support care costs, which falls within the definition of "non-direct care." And, in the past, DHS has allowed the complained-of expenses either as "direct care" costs or as "non-direct" care costs. The change

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[3] These two terms are defined in rule 441-81.1 as follows:

> "*Direct care component*" means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
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> . . . .
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> "*Non-direct care component*" means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

in DHS's auditing adjustments here amounted to a retroactive, prejudicial change to the facilities, without a rational basis in the administrative rules.

We conclude DHS's interpretation of the administrative rules as evidenced by the director's ruling, and affirmed by the district court, is in error.

D. Change of policy supported by rational basis? We believe the question presented in this appeal comes down to whether the director's decision did, as the district court found, justify its departure from previous practice "by stating credible reasons sufficient to indicate a fair and rational basis for the inconsistency." Iowa Code § 17A.19(10)(h). While the facilities claim that DHS simply misunderstood the issue during the first appeal, and is now covering its tracks, the district court found that the director's decision states credible reasons for the inconsistency. Even if we assume the director's decision may provide justifiable reasons for the new interpretation of "allowable costs,"[4] the decision does not provide *any* reason for the change in interpretation.

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[4] The director may have enunciated a rational policy reason for not reimbursing nursing facilities for costs incurred by Medicaid patients where an outside provider can seek direct payment from Medicaid. But the application of that policy is not consistent across various types of services and is inconsistent with the inclusion of *Medicare* income in the calculation of a *Medicaid* per diem reimbursement rate.

Amy Perry testified that the method for adjusting x-rays and lab costs was prompted "when we did an evaluation, and we felt like, reading the rule [441-81.6(10)(b)], that we weren't being consistent with how we were applying the lab, x-ray part for therapy." She continued "[w]e used to only adjust the Part A therapy out of the costs, but we felt like by excluding that, we were being inconsistent with the way we were applying the prescription drug rule, and so we tried to make it (inaudible)—we tried to be consistent in how we are doing lab, x-ray, drugs and therapy . . . ."

In *Office of Consumer Advocate v. Iowa Utilities Board*, 770 N.W.2d 334, 342 (Iowa 2009), the court held that "[w]here, as here, 'an agency concludes that its application of a statute is in error, it is not required to go on indefinitely misapplying the statute; it may alter the application.'" However, that holding assumes that the agency's new application of the statute is proper. Here, we have concluded that the application of the rules is in error.

We must decide whether the director's decision meets the requirements of Iowa Code section 17A.19(10)(h), or whether it is a bureaucratic shift that properly should be considered in a rule-making context. The Iowa Supreme Court has held that section 17A.19(10)(h) is "intended to address inconsistencies in agency decisions for individual cases; it does not provide a vehicle to challenge changes in agency procedure that are applicable to all cases that come before the agency." *Office of Consumer Advocate v. Iowa Utilities Bd.*, 770 N.W.2d 334, 341–42 (Iowa 2009).

The change in accounting procedures here is a uniform change intended to conform DHS's procedures to the existing administrative rules—it is not a specific case inconsistency. Nor is this situation one in which the director has acknowledged that its previous application of the rules was in error. Nor has the director justified the inconsistency between its previous practice and its present practice. The district court erred in finding section 17A.19(10)(h) justified the director's decision here.

We reverse the district court's affirmance of the director's ruling upholding DHS's decisions implementing cost report adjustment for these nursing facilities. These proceedings should be remanded to the agency to reverse the cost reporting adjustments.

REVERSED AND REMANDED WITH DIRECTIONS.