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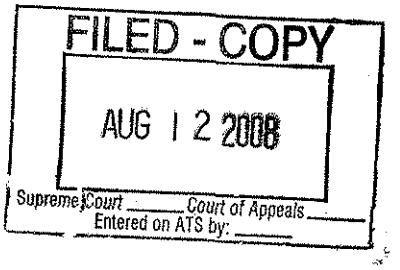
KMC v. Idaho Dept. of Health and Welfare Appellant's Reply Brief Dckt. 34879

IN THE SUPREME COURT OF THE STATE OF IDAHO

KOOTENAI MEDICAL CENTER (RE: TERESA K.) Petitioner-Respondent, v. IDAHO DEPARTMENT OF HEALTH AND WELFARE, Respondent-Appellant.	**NOS: 34879/34880/34881**
KOOTENAI MEDICAL CENTER (RE: JENNIFER G.) Petitioner-Respondent, v. IDAHO DEPARTMENT OF HEALTH AND WELFARE, Respondent-Appellant.	
KOOTENAI MEDICAL CENTER (RE: JOSHUA M.) Petitioner-Respondent, v. IDAHO DEPARTMENT OF HEALTH AND WELFARE, Respondent-Appellant.	



APPELLANT'S REPLY BRIEF

APPEAL FROM THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF KOOTENAI

Honorable John T. Mitchell
District Court Judge Presiding

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COMES NOW, Appellant State of Idaho Department of Health and Welfare, by and through its counsel of record, Whitaker F. Riggs, Deputy Attorney General, and submits the following Reply Brief in the present case.

I. ARGUMENT

A. Medicaid Providers Are Not Entitled To The Same Due Process Protections As Medicaid Beneficiaries.

The bulk of KMC's argument in its Respondent's Brief on Appeal rests on the supposition that KMC is entitled to the same due process protections enjoyed by Medicaid applicants and recipients. (Respondent's Brief, pp. 15, 17-31.) As authority for its proposition, KMC cites Title 42, Chapter IV, Subchapter C, Part 431, Subpart E (42 C.F.R. §§ 431.200 *et seq.*) and *Goldberg v. Kelly*, 397 US 254, 25 L.Ed.2d 287 (1970). As discussed more fully in Appellant's Brief on Appeal, 42 C.F.R. §§ 431.200 *et seq.* and *Goldberg* apply only to recipients and applicants of the Medicaid program; not to service providers such as hospitals.

The Seventh Circuit provided a thoughtful analysis of the question of whether the due process protections enunciated in *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.* apply to parties other than Medicaid recipients and applicants in *Banks v. Secretary of Indiana Family and Social Services Administration*, 997 F.2d 231 (7th Cir. 1993). In the words of the Seventh Circuit:

> While subpart E defines the process that is due individuals seeking or receiving Medicaid benefits, its provisions in no way provide for notice and a hearing to a recipient either before or after a *provider's* claim for reimbursement is denied. Rather, the regulations cover an individual's initial and continued eligibility for Medicaid services - hence use of the terms "applicants" and "recipients"- not provider reimbursement determinations.

Id. at 243 (*citing* 42 C.F.R. § 431.220 and *O'Bannon v. Town Court Nursing Ctr.*, 447 US 773, 786-87 (1980) (*emphasis original*)).

In *Banks*, the Indiana Department of Public Welfare had refused reimbursement to a Medicaid provider for services rendered to Mr. Banks, a Medicaid recipient, shortly before his death. The Medicaid provider subsequently obtained a judgment in small claims court against the widow of Mr. Banks, for the amount in question. Mrs. Banks and another recipient then brought a class action suit against the Secretary of Health and Human Services and the state Medicaid agency because the latter failed to provide them notice and a hearing when their providers' claims for reimbursement were denied. While the petitioners were not providers themselves, the sources of authority upon which they relied, *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.*, were the same as those relied upon by KMC in the cases at hand. In both cases, the analysis is the same.

Banks makes clear that the due process requirements described in *Goldberg*, at least for present purposes, extend only to determination of a *recipient's* Medicaid *eligibility or covered services*. 997 F.2d at 243 (citing 42 C.F.R. § 431.201). Thus, although the recipients in *Banks* had standing generally to claim the protections afforded by *Goldberg* and the applicable federal regulations, due process did not provide them relief since the state action in question was against a provider with respect to provider reimbursement, rather than against a recipient or applicant with respect to eligibility or a covered service. By analogy, KMC, as a provider, cannot step into the recipients' shoes given the facts that only the recipients have the relevant due process rights and

that the recipients admittedly have no claim against the Department. 42 C.F.R. § 431.201; *see Banks*, 997 F.2d at 243; *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981); *Cervoni v. Sec'y, of Health, Ed. and Welfare,* 581 F.2d 1010, 1018-1019 (1st 1978).)

Furthermore, the Ninth Circuit has said that Medicaid providers have no property interest in Medicaid provider status. *Erickson v. United States ex rel. Dep't of Health and Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995). If providers have no property interest in status as a Medicaid provider, it is difficult to see how they could have a property interest in Medicaid reimbursement. Nor is a liberty interest at stake in these cases. A liberty interest is implicated if a charge impairs a person's reputation for honesty or morality. *Id.* There is no "charge" against KMC here, so neither the accuracy of the "charge" nor KMC's reputation is in question. Neither, in terms of the *Vanelli* test enunciated in *Erickson*, have the Department's reimbursement decisions resulted in an alteration of some right or status of KMC's that is recognized by law. *Id.*

While KMC evidently acknowledges that it does not meet the test for a liberty interest as stated by the Ninth Circuit in *Erickson*, it urges that a distinction should be made between providers who seek to retain status as a Medicaid provider and those who merely seek Medicaid reimbursement. (*See* Respondent's Brief, p. 25.) Although it points to no specific page numbers within the decisions, KMC concludes that the Ninth and Tenth Circuits both "recognize a distinction between due process rights relative to status and due process rights relative to

claims for payment for services rendered." *Id.* No such distinction was made in either case.

As to provider *reimbursement*, the *Geriatrics* Court said:

> Eventide argues also that termination of benefits would force the Home to close and that it therefore has a significant financial interest to retain its certification. The Home's financial need for government assisted patients is incidental to the purpose and design of the program. . . . The unfortunate reality that it will probably encounter difficulty operating at capacity is not of constitutional significance. See Town Court Nursing Center, Inc. v. Beal, 586 F.2d 266 (3d Cir.); *Case v. Weinberger*, 523 F.2d 602, 607 (2d Cir.).

Geriatrics, 640 F.2d at 265. Although the issue presented in *Geriatrics* was the timing of the hearing regarding Medicaid provider certification, the Tenth Circuit made clear that provider reimbursement claims are of no greater significance than provider status claims. Neither type of claim amounted to a protectable property interest. *Id.* at 264-65.

The *Erickson* Court did not address reimbursement to Dr. Erickson in its opinion. However, in holding that physicians have no property interest in continued participation in Medicare, Medicaid or the federally-funded state health care programs, the Ninth Circuit stated that it chose to follow the reasoning of the First and Tenth Circuits. *Erickson*, 67 F.3d at 862. The cases from those circuits that the *Erickson* Court analyzed were *Koerpel v. Heckler*, 797 F.2d 858 (10th Cir. 1986), and *Cervoni v. Sec'y of Health, Ed. and Welfare*, 581 F.2d 1010 (1st Cir. 1978).

In reviewing *Koerpel*, the *Erickson* Court stated:

> The Secretary argues that plaintiffs have no property interest in continued participation in Medicare, Medicaid or other related programs. . . .
>
> Presented with this precise issue in *Koerpel v. Heckler*, 797 F.2d 858, 863-65 (10th Cir. 1985), the Tenth Circuit held that a physician had no property interest in his eligibility for Medicare reimbursement. *Heckler* notes that the physician was not the intended beneficiary of the Medicare program and that, although he stood to suffer financial losses because of his exclusion from Medicare, such losses were "not of constitutional significance for the establishment of a protectable property interest." *Id.* at 864.

Erickson, 67 F.3d at 862. In its consideration of *Cervoni*, the *Erickson* Court stated:

> Similarly in *Cervoni v. Sec'y of Health, Ed. and Welfare*, 581 F.2d 1010 (1st Cir. 1978), the First Circuit concluded that Medicare is nothing more than a governmental insurance program for the elderly. "As such the real parties in interest are the beneficiaries; physicians are parties in interest only as assignees of the beneficiaries." *Id.* at 1018. Accordingly, the plaintiff physician had no protectable property interest in his participation in Medicare. *Id.* at 1019.

Erickson, 67 F.3d at 862-63. Both *Koerpel* and *Cervoni*, the two cases upon which the *Erickson* Court relied in making its ruling that providers have no property interest in Medicaid provider status, involved provider reimbursement. Thus, if any distinction is recognized by the Ninth Circuit between due process rights relative to provider status and due process rights relative to claims for payment for services rendered, the distinction is that only a claim with respect to

provider status is of constitutional significance. KMC is not entitled to due process protection beyond that already provided for under Idaho law for its reimbursement claims.

B. IDAPA 16.05.03.131 Provides A Mechanism For Petitioners To Present Evidence Not Previously Made Available To The Department.

KMC asserts that it was deprived of due process protections to which it is entitled under *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.* when the hearing officer in each of the cases at bar ruled that she could not consider evidence beyond that which was made available to the Department or its agent, Qualis Health, before the reimbursement decisions were made. (Respondent's Brief, pp. 18-19.) This contention fails for several reasons.

First, KMC is not entitled to the full gamut of protections to which beneficiaries are entitled, as discussed above. Second, IDAPA 16.05.03.131 mandates that if an appellant "shows there is additional relevant information that was not presented to the Department with good cause, the hearing officer shall remand the case to the Department for consideration." KMC gave no indication before any of these hearings that it had or wished to present additional relevant information for consideration. Had it done so and given an adequate explanation as to why such information had not previously been provided, the hearing officer would have been obligated to remand the matter for further consideration in light of the new information. The Department would then have considered the new information itself, or referred it to Qualis Health for consideration, after which consideration a new decision would have been issued. At that point, if KMC wished to pursue its petition, the additional information would have been made

available to the Department, and the hearing officer would have been able to consider it at hearing. KMC, however, made no effort in any of these cases to obtain a remand so that any new information could be considered.

Third, contrary to KMC's suggestion at page 18 of its brief, the hearing officer did take into consideration all the testimony offered by KMC's witnesses other than that which sought to introduce information not made available to the Department or Qualis at the time the reimbursement decisions were made. The hearing officer only ruled inadmissible, testimony "explaining and expanding on the details within the medical chart." (R., Ex. 5, p.21 (J.M.); R., Ex. 5, p. 23 (J.G.); R., Ex. 5, p. 19 (T.K.).) It is apparent from the wording of her rulings that the hearing officer did take into account KMC witnesses' testimony about facts *already* in the medical records. It is also reasonable to conclude that she considered the KMC witnesses' opinions and arguments, since the reference to "details within the medical chart" suggests factual information; the kind of information the medical records needed to contain in order to demonstrate medical necessity for the dates of service in question. This understanding of the hearing officer's rulings is consistent with her decisions which, in each case, summarized KMC witnesses' testimony in her Findings of Fact. (R., Ex. 5, pp. 5-7 (J.G.); R., Ex. 5, pp. 5-7 (J.M.); R., Ex. 5, pp. 5-6 (T.K.).)

KMC further asserts that, pursuant to *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.*, it "must be given the opportunity to appear personally before the official whose findings determine eligibility." (Respondent's Brief, p. 18.) As discussed above and in the Appellant's Brief, Medicaid providers have no such right,

without the peer reviewer's written consent. In fact, also as discussed in the Appellant's Brief, even Medicaid *recipients* have no such right. 42 U.S.C. § 1320c-9; 42 C.F.R. §§ 480.101(b)(1), 139; *see also Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 444 F.3d 991, 995-96. Medicaid providers certainly do not enjoy due process protections greater than those afforded to Medicaid beneficiaries.

C. KMC Was Not Entitled To Confront Or Cross-Examine the Peer Reviewer At Hearing.

KMC argues that the district court correctly ruled that evidence of the findings and conclusions of the physician peers who reviewed the medical records in these cases for Qualis Health should be stricken from the record because it had no opportunity to cross-examine them. (Respondent's Brief, p. 19.) KMC bases this argument on the premise that under *Goldberg* and 42 C.F.R. §§ 431.200 *et seq*. due process encompasses the right to confront adverse witnesses. KMC is not entitled to those due process protections for the reasons discussed above and in the Appellant's Brief. Furthermore, also as discussed previously, the identities of Medicaid peer reviewers may not be disclosed without the reviewer's written consent. 42 C.F.R. 480 §§ 139, 480.101(b)(1). The district court should not have stricken the evidence of the Qualis Health physician peer-reviewers' findings and conclusions.

KMC further urges that documentary and testimonial evidence with respect to the physician peer-reviewers' findings and conclusions should not have been allowed by the hearing officer, because such evidence was hearsay. (Respondent's Brief, p. 20.) In support of that suggestion, KMC contends that

insofar as I.C. § 67-5251(1) and IDAPA 16.05.03.134 allow hearsay to be admitted at hearing, that statute and that rule conflict with *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.* Again, KMC is not entitled to rely on these federal sources of authority to support its claim, and KMC has expressed no other reason why this Court should presume that the state statute and rule in question are unconstitutional as applied or on their faces. The hearing officer in each of these cases determined that the evidence in question was the kind of hearsay that was properly admissible under state law, and absent a showing of a violation of I.C. § 67-5279, the district court should have left her hearsay rulings in place.

KMC offers that if the identity of a peer reviewer is to remain undisclosed, then the Department may not present evidence at hearing as to that reviewer's findings and conclusions. (Respondent's Brief, p. 20.) KMC cites no authority for this proposition other than its prior references to *Goldberg* and 42 C.F.R. §§ 431.200, et seq. The result of KMC's suggestion is that no state agency could ever present evidence of its peer reviewers' findings and conclusions at hearing, without presenting the peer for cross-examination. Thus, state agencies would likely be unable to defend any Medicaid reimbursement denial, since they would be unable to present any peer evidence to respond to the provider's expert. Such a result would make peer review useless and frustrate Congress' intent that Medicaid agencies conduct utilization review to ensure that tax dollars are not spent without limit. 42 U.S.C. §§ 1320c-3(a). 1320c-7(a); 42 C.F.R. §§ 476.71, 431.630.

KMC suggests that the Department may elect to require its QIO to retain only peers who agree to allow their identities to be released and to present themselves for cross-examination at hearing. This notion ignores the practical reality of peer review. The near universal reluctance of physicians nationwide to agree to perform peer reviews without a guarantee of confidentiality caused Congress to enact legislation guaranteeing confidentiality of peer reviewers' identities, unless the reviewer consents in writing to release of his or her identity. 42 U.S.C. § 1320c-9; 42 C.F.R. §§ 480.139, 480.101(b)(1); *see also Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 444 F.3d 991, 995-96.

Like KMC, the Department would prefer to have the peer-reviewers present at hearing for testimony. Their presence would only enhance the Department's cases. However, because peer-reviewers are rarely willing to release their identities and to be available to present testimony, the Department must rely on hearsay in order to present those reviewers' findings and conclusions. Absent that, the Department would be unable to respond to evidence presented by providers' experts and would rarely be successful in defending its decisions not to fully reimburse providers. Such a result would be contrary to the federal mandate of Medicaid utilization review.

At page 20 of its Respondent's Brief on Appeal, KMC states that at hearing, it is not interested in knowing the identity of the peer, *per se*; but, merely seeks the opportunity to "'cross-examine adverse witnesses.'" One is left to wonder how KMC could conduct effective cross-examination of the peer psychiatrist without delving into the peer's background to the extent that his or her

identity would be revealed. In any event, the Department's QIO peer-reviewers exist to conduct independent, impartial reviews of requests for Medicaid and Medicare services or reimbursement and as such, do not truly qualify as "adverse witnesses". Therefore, even a Medicaid beneficiary would not have a right under *Goldberg* and 42 C.F.R. §§ 431.200 *et seq*. to confront and cross-examine a peer-reviewer.

Featherston v. Stanton, 626 F.2d 591 (7th Cir. 1980), is illustrative. In *Featherston*, the plaintiffs brought a class action suit against the Indiana Department of Public Welfare and the Marion County Department of Public Welfare, challenging the procedures for appealing the denial of dental and disability benefits, respectively. In both procedures, a hearing was conducted at which the plaintiff's evidence was submitted to the hearing officer, who then transmitted a summary of the evidence and tentative findings of fact to an initial review panel for review and evaluation. *Id.* at 592-93.

The plaintiffs in *Featherston* argued that the initial dental and medical review panels were used by the state agencies as expert witnesses or technical advisors, and as such, the plaintiffs had a right to confront and cross-examine the members of those panels, pursuant to 42 C.F.R. § 431.242(e). 626 F.2d at 593. The Seventh Circuit disagreed, holding that the initial review teams were not "adverse witnesses" as envisioned by the regulation. *Id.* The *Featherston* Court stated:

> Rather than functioning as adversaries to plaintiffs' claims, the initial review panels act as impartial assessors of plaintiffs' medical and social histories and as adjudicators of their entitlement to benefits.

> This is the procedure established by those entrusted at the federal level with administering the Social Security Act, and it is correctly followed by the Indiana DPW. As the Supreme Court said in *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971):
>
> The vast workings of the social security administrative system make for reliability and impartiality in the consultant reports. We bear in mind that the agency operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary. This is the congressional plan. We do not presume on this record to say that it works unfairly.

Id. at 594. Like the plaintiffs in *Featherston*, KMC seeks to cross-examine peer-reviewers who are not adverse witnesses. Even if *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.* did provide a mechanism for providers seeking reimbursement to claim the right to confront and cross-examine adverse witnesses, no such right exists here, where the reviewers are not adverse.

D. KMC Lacks Standing To Assert Due Process Protections Under *Goldberg* And 42 C.F.R. §§ 431.200 *et seq.*

KMC suggests that the Department argues that KMC lacks standing in these cases. (Respondent's Brief, p. 21.) The Department has never put forth that notion. To the contrary, the Department has consistently recognized that KMC has direct standing to be a petitioner in cases where the Department has refused payment for Medicaid services rendered. The Department does however, contest KMC's assertion and the district court's ruling that KMC has *third party* standing to represent its Medicaid patients in these cases.

Since KMC already has direct standing to bring these cases, the only reason it would seek third party standing is to obtain the due process protections

that *Goldberg* and 42 C.F.R. §§ 431.200 *et seq.* afford *only* to Medicaid recipients and applicants. KMC apparently recognizes that it cannot claim those protections as a provider seeking reimbursement.

In contrast to the cases at hand, every case KMC has cited in support of its third party standing argument involved patients who *themselves* faced a loss of services. At pages 25 to 28 of its Brief, KMC cites *Singleton v. Wulff*, 428 U.S. 106, 49 L.Ed.2d 826, 96 S.Ct. 2868 (1977), which dealt with a challenge to a statute that excluded from Medicaid coverage, abortions which were not medically indicated. The physicians had third party standing to challenge the legislation that affected the recipients' services. No such legislation or action affecting recipients' services has occurred in the instant cases, and there is no suggestion in the administrative record that the same controversy will arise over any future treatment by KMC for T.K., J.M. or J.G.—given the dispute's highly fact-specific character--or even that any future treatment at all for those individuals is likely to be provided by KMC.

The same is true with respect to *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*, 293 F.3d 472 (8th Cir. 2002), cited at page 28 of Respondent's Brief, which involved funding cuts related to early intervention services to recipients and a concrete threat of reduced services to recipients. Under those circumstances, the plaintiff group, which included physicians, was ruled to have standing to assert the recipients' claim for relief. Of similar ilk is *Pennsylvania Psychiatric v. Green Spring HLT*, 280 F.3d 278 (3rd Cir. 2002), discussed at pages 28-31 of Respondent's Brief. There, the plaintiffs

alleged that the defendant managed health care organizations impaired the quality of health care provided by psychiatrists to their patients by, among other things, refusing to authorize necessary psychiatric treatment. *Id.* at 280. Once again, representational standing was premised on an injury to patients; *i.e.*, the plaintiffs were found entitled to stand in the shoes of the actually injured parties. KMC's patients here suffered no injury from the Department's actions; only KMC's grievance is before the Court.

The lack of such *patient* injury is undisputed. Medicaid eligibility had been determined after discharge in the J.M. and J.G. cases, and only five days before discharge in the T.K. case. KMC's request for reimbursement came months after all three patients had been discharged. All three patients received all the care KMC deemed medically appropriate, and all three were discharged entirely at KMC's discretion, without input or interference from the Department. Furthermore, none of these patients can ever be billed by KMC for the services in question. 42 C.F.R. § 447.15; IDAPA 16.03.09.079.08.c. There are, in sum, no shoes for KMC to step into for third party standing purposes, and, when relegated to its own shoes, KMC received all procedural process required by applicable law.

E. The Federal Requirement Of Certification Is Not In Conflict With The State Requirement Of Documentation.

On pages 31 to 32 of Respondent's Brief on Appeal, KMC argues that the documentation requirements of IDAPA 16.03.09.079.05 conflict with the certification requirements of 42 C.F.R. § 441.152. As discussed in Appellant's Brief on Appeal at page 30, there is no conflict between this regulation and rule. The documentation requirements of IDAPA 16.03.09.079.05 merely require the

provider to demonstrate in writing that inpatient care continues to be required, as defined in IDAPA 16.03.09.079.01 generally, and IDAPA 16.03.09.079.01.b.ii and b.iii, particularly.

42 C.F.R. § 441.151(a)(4) requires that inpatient psychiatric services to individuals under 21 be:

> Certified *in writing* to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with § 441.152.

42 C.F.R. § 441.151(a)(4). (*Emphasis added.*) That documentation must include evidence that:

> (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
>
> (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
>
> (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

42 C.F.R. § 441.152(a). Furthermore, the individual plan of care must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. 42 C.F.R. § 441.154(b).

The three criteria in 42 C.F.R. § 441.152(a) are essentially the same criteria that are in IDAPA 16.03.09.079.01.b, all of which must be met in order to demonstrate intensity of service criteria, which in turn must be satisfied in order to demonstrate medical necessity generally, under IDAPA 16.03.09.079.01. The requirements of IDAPA 16.03.09.079.05 are:

> a. Documentation sufficient to demonstrate the medical necessity criteria is still met; and
>
> b. A plan of care that includes documentation sufficient to demonstrate that the child's psychiatric condition continues to require services which can only be provided on an in-patient basis, including twenty-four (24) hour nursing observation under the direction of a psychiatrist or other physician qualified to treat mental disease; and
>
> c. Documentation sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the recipient's condition.

IDAPA 16.03.09.079.05. Since all of the criteria in IDAPA 16.03.09.079.01.b must be met in order to satisfy medical necessity, and since those criteria are essentially the same as the criteria in 42 C.F.R. § 441.152(a), there is no conflict with IDAPA 16.03.09.079.05.a and 42 C.F.R. § 441.152(a). Because the remaining two subsections of IDAPA 16.03.09.079.05 are virtually the same as subsections (2) and (3) of 42 C.F.R. § 441.152(a), there is no conflict between IDAPA 16.03.09.079.05. and 42 C.F.R. § 441.152(a).

Nothing in federal or state law prohibits state Medicaid agencies from making rules that parallel and expand on federal regulations, as long as Congress' intent is not frustrated. Here, Idaho has merely clarified the certification in writing that must be done under federal law. Far from conflicting with the federal regulation, IDAPA 16.03.09.079.05 supports Congress' intent to ensure wise spending of tax dollars.

KMC would have the Idaho rule declared invalid, so that it may follow its own definition of "certification in writing". Such a result would lead to lack of uniformity in certification among providers and would make utilization review

virtually impossible, thereby frustrating Congress' intent. Simply because KMC offers some writing and deems that sufficient to satisfy the federal requirements of certification does not mean that Idaho Medicaid must suspend its duty to conduct utilization review or must accept KMC's assertions on their face. The hospital has its obligations and the Department has its own. The obligations of one do not conflict with the other.

F. In Each Case, Appropriate Care Could Have Been Provided In A Less Acute Setting.

At page 34 of Respondent's Brief, KMC notes that the basis for non-certification of reimbursement for the dates of service in question for each case was that appropriate care could have been provided in a less acute setting. KMC asserts that there is no evidence in the record to support that determination and that the district court's ruling on that issue should be affirmed. Presumably, the ruling to which KMC refers is the ruling that the testimony of Dr. Lehman, the Department's only witness in these cases, should be stricken from each case in its entirety. (R., p. 270.)

The district court first struck the Qualis Health peer-reviewer's findings and conclusions in each case, because KMC had no opportunity to cross-examine the peer-reviewer. In support of the ruling, the district court stated:

> The Idaho regulations not only give no opportunity for the provider . . . to cross examine the reviewing physician, but those same regulations require the provider you [*sic*] cannot be known to whoever is challenging the reviewing physician's determination. Since there is a conflict on this issue between Idaho and federal regulations, the federal regulations are controlling.

Id. The premise upon which the district court made its ruling was faulty. The source of authority that impedes cross-examination of a peer is federal law; not the Idaho rules. 42 U.S.C. § 1320c-9; 42 C.F.R. §§ 480.139, 480.101(b)(1). As discussed above and in Appellant's Brief, this ruling should be reversed.

The district court then struck Dr. Lehman's testimony in each case, reasoning as follows:

> Dr. Lehman's opinions are not supportable, as he testified in each of the three cases that he had no idea what other less restrictive facilities there are in this area. Accordingly, his testimony is stricken as well. That leaves the testimony of the three treating psychiatrists in each of the three cases.

(R., p. 270.) As discussed in Appellant's Brief at page 27, knowledge of the whereabouts and availability of local options for less intensive services is not a QIO function. Knowledge of such resources is a discharge planning function, attributable to the hospital. Lack of such knowledge on the part of a reviewing physician does not make his testimony inadmissible, particularly where, as in these three cases, the testifying physician was the first reviewer for the case and thus has intimate personal knowledge of the case. The district court should not have stricken the testimony of Dr. Lehman.

T.K.

Contrary to KMC's assertion, each of the records does contain evidence that appropriate care could have been provided in a less acute setting than an inpatient psychiatric hospital. In the T.K. matter, by the hospital's own admission, discharge planning was not even begun until the patient was determined to be

Medicaid eligible on December 9, 2005. In the words of KMC's witness, Dr. Miller:

> They agreed she was gravely disabled . . . and therefore they committed her to the Department . . . and . .. there was no bed available for her . . . at the State Hospital so she . . . had to stay at our facility . . . and as she began to slowly improve with time here in our facility there was nothing available until she did get her Idaho Medicaid, as I said in December, and *then we were able to start to develop a discharge plan for her at that time because she had resources that made more options available to her.*

(R., Ex. 1, p. 23, LL. 12-21 (*emphasis added*).) It is evident from Dr. Miller's testimony that KMC could have initiated discharge planning sooner than December 9, 2005, had the patient had money to pay for care at a group home. Plainly, less restrictive appropriate care existed in the community for this patient throughout the dates of service in question.

A delay in discharge due to inability to fund placement in a less restrictive setting is not among the elements of 42 C.F.R. § 441.152, IDAPA 16.03.09.079.01 or 16.03.09.079.05; and thus does not constitute medical necessity for purposes of Medicaid reimbursement. Thus, KMC may not certify the need for continued inpatient care on the basis that it is unable to secure appropriate placement due to lack of funding. As noted above, Dr. Miller testified that discharge planning was initiated as soon as funding for placement became available on December 9, 2005. By KMC's own admission then, T.K. did not meet the certification requirements of 42 C.F.R. § 441.152(a) as of at least December 9, 2005, and thus, the last two days of the stay, December 13 and 14, are not reimbursable by Medicaid.

Nor does lack of funding for placement meet the "intensity of service" criterion found in IDAPA 16.03.09.079.01.b.iii. That rule states:

> b. Intensity of service criteria. The child must meet *all* of the following criteria related to the intensity of services needed to treat his mental illness: . . .
>
> iii. Treatment of the child's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist. . . .

IDAPA 16.03.09.079.01.b.iii (*emphasis added*). As testified to by Dr. Miller, by at least December 9, 2005, T.K. was ready for discharge to a group home. Therefore, as of at least that date, T.K. no longer required services on an inpatient basis, including twenty-four hour nursing observation under the direction of a psychiatrist. In order for a patient to meet the continued stay criteria in IDAPA 16.03.09.079.05, *all* of the criteria stated in IDAPA 16.03.09.079.01 must continue to be met, including subsection b.iii. IDAPA 16.03.09.079.05. Because inpatient care was no longer necessary by at least December 9, 2005, none of the continued stay requirements of IDAPA 16.03.09.079.05 were met after that date and Medicaid reimbursement for December 13 and 14, 2005 cannot be made.

The fact that 42 C.F.R. § 441.152(a), IDAPA 16.03.09.079.01.b.iii and IDAPA 16.03.09.079.05 all require that 24-hour inpatient psychiatric care under the direction of a physician or psychiatrist be necessary demonstrates that Medicaid was never intended to pay for any portion of an inpatient psychiatric stay that is attributable to placement difficulties, unnecessary delay of treatment or any other reason than a psychiatric condition that cannot be treated in a less acute facility anywhere.

J.M.

The discharge of J.M. was delayed due first to the attending psychiatrist's desire to see the results of a psychological report, and then to J.M.'s argumentative behavior and use of marijuana while released on August 27, 2005 temporarily to his mother's custody. (R., Ex. 1, p. 22, LL. 8-11; p. 24, LL. 10-17; p. 25, LL. 9-24; p. 26, LL. 1-12; R., Ex. 7, Ex. B, p. 15, 43-44 (J.M.).) The medical record shows that the discharge location for J.M. was always expected to be his home, and that he was discharged home, in the care of his mother. (R., Ex. 7, Ex. B, pp. 43, 108 (J.M.).) Thus, there was always a less restrictive setting available for J.M., and he should have been discharged on August 25, 2005, as concluded by the Qualis Health reviewers. 42 C.F.R. § 441.152(a); IDAPA 16.03.09.079.01.b, 16.03.09.079.05.

J.G.

The discharge of J.G. was also delayed due to the attending psychiatrist's desire to see the results of a psychological report, and to the attending psychiatrist's lack of communication with J.G.'s mother to get permission to start psychiatric medication. (R., Ex. 1, p. 26, L. 10 - p. 27, L. 16; R., Ex. 12,, Ex. C, pp. 43-44 (J.G.).) The psychological evaluation did not reach the attending psychiatrist until the day before discharge. (R., Ex. 12, Ex. C, p. 43-44 (J.G.).) KMC staff had contacts with J.G.'s mother while J.G. was at KMC, on or before December 24, 2005, on December 27, 2005, on December 30, 2005, and on January 2, 2006, but failed to coordinate a meeting between the mother and attending psychiatrist. (R., Ex. 12, Ex. C, pp. 43, 46, 53,89 (J.G.).) J.G. was

discharged back to the detention center from which she came, on January 4, 2006, having received no psychiatric medication while at KMC. (R., Ex. 12, Ex. C, pp. 10-11 (J.G.).)

KMC was aware that J.G. was required to be discharged back to detention at all times during her stay at KMC. Since a less restrictive setting was available to J.G. and medical necessity no longer existed, she should have been discharged by December 28, 2005. The Qualis Health reviewers properly determined that delays due to psychological testing and failure to coordinate communication between the mother and psychiatrist are not contemplated in the criteria for inpatient psychiatric care of persons under 21 years of age. 42 C.F.R. § 441.152(a); IDAPA 16.03.09.079.01.b, 16.03.09.079.05. (R., Ex.12, Ex. C, pp. 4-5.)

G. KMC's Assertion That IDAPA 16.03.09.079.05 Is Arbitrary And Capricious Is Contradicted By The Records.

J.M.

KMC takes issue with Dr. Lehman's comment that J.M.'s release to his parent on a pass suggested that J.M. no longer needed inpatient care. (Respondent's Brief, p. 36.) The Qualis Health reviewers concluded that J.M. no longer needed inpatient psychiatric treatment as of, and should have been discharged on August 25, 2005. (R., Ex. 7, Ex. B, pp. 5-6 (J.M.).) KMC issued the pass on August 27, 2005. (R., Ex. 7, Ex. B, pp. 5-6, 43-44 (J.M.).) Since the pass was issued two days after the date the peer-reviewers determined J.M. should have been discharged, the pass was not a factor in the reviewers' determination.

Even if the reimbursement decision had been based on the pass, the rules do not state that anytime a patient receives a supervised pass, they, by definition, still require inpatient psychiatric treatment. The rules only provide that in order to fit the criteria for medical necessity, no unsupervised pass may be issued. IDAPA 16.03.09.079.01.b.iii. A determination that medical necessity does not exist may still be made when a patient receives a supervised pass, if any medical necessity criteria are not present, as in this case. IDAPA 16.03.09.079.01.

In any event, the decision by Qualis Health was based on the lack of evidence in the medical record that after August 25, 2005, J.M. was a danger to himself or others, or was gravely disabled, so as to require acute inpatient care. (R., Ex. 7, Ex. B, pp. 5-6 (J.M.).) As Qualis Health noted, there was sufficient information available to KMC to begin medication without such extended delay, and withholding medication while awaiting psychological testing results was not medically necessary. (R., Ex. 7, Ex. B, pp. 5-6 (J.M.).) This example by KMC of Qualis Health's findings and conclusions does nothing to support KMC's argument that IDAPA 16.03.09.079.05 results in decisions that are arbitrary and capricious.

J.G.

KMC points out two instances in which J.G. told KMC staff that she had thoughts of self-harm. (Respondent's Brief, p. 37.) The instances occurred 3 and 4 days after the date the reviewers determined that medical necessity for inpatient care was no longer evident. KMC apparently argues that it should be able to keep patients indefinitely after medical necessity no longer exists, just to be safe.

Neither Congress nor the Idaho Legislature intended such extended care at taxpayer expense. 42 C.F.R. §§ 441.152(a), 476.71; IDAPA 16.03.09.003.040.b & 16.03.09.079.01. J.G. should have been discharged when the evidence of medical necessity no longer existed, on December 28, 2005, and readmitted, if necessary when medical necessity for admission was present. This is particularly so where J.G. was to be discharged to a secure detention facility that has a suicide watch program. (R., Ex. 1, p. 25, LL. 17-23 (J.G.).)

This patient needed psychiatric medication in order to improve her mental status. (R. Ex. 12, Ex. C, pp. 43-53 (J.G.).) However, no such medication was given. (R., Ex. 12, Ex. C, p. 10 (J.G.).) Such medication and the therapies provided by KMC during J.G.'s stay could have been provided in an outpatient setting. (R., Ex. 1, p. LL. 6-10; p. 22, LL. 10-15; p. 57, LL. 4-5, 12-17 (J.G.).) Further, JG. was discharged back to detention the day after her psychological evaluation was received by the attending psychiatrist, suggesting that the psychological evaluation had little or no impact on inpatient treatment or the decision to discharge. (R., Ex. 12, Ex. C, p. 43-44 (J.G.).)

Finally, J.G.'s condition did not change during her stay. (R., Ex. 12, Ex. C, pp. 43-53 (J.G.).) The fact that J.G. was discharged in the same condition in which she was admitted corroborates the reviewers' conclusion that after the initial certified period of evaluation, ending on December 28, 2005, medical necessity for continued inpatient psychiatric care no longer existed. KMC cited no reason this patient could not have been kept safe in the detention facility after December 28, 2005, or why she could not have been readmitted, if need be, after

that date. Like the J.M. example, this example of Qualis Health's findings and conclusions does nothing to support KMC's argument that IDAPA 16.03.09.079.05 results in decisions that are arbitrary and capricious.

T.K.

T.K. was admitted to KMC on November 6, 2005 and discharged on December 14, 2005. The dates of service for which KMC was reimbursed for services rendered to T.K. are November 6, 2005, to November 9, 2005, by Medicaid, and November 18, 2005 through December 12, 2005, by the Department, using state funds. Thus, the dates at issue in this appeal are November 9, 2005 through November 17, 2005 and December 13 and 14, 2005.

Qualis Health certified the first three days of the stay for evaluation, based on the evident need for an involuntary hold. (R., Ex. 1, p. 12, LL. 1-9; Ex. 11, Ex. C, pp. 5-6 (T.K.).) The certification ended when T.K. became a voluntary patient, on November 9, 2005. (Id.) The Department reimbursed KMC for services rendered from November 18, 2005 through December 12, 2005; the period during which T.K. was committed to the custody of the Department.

KMC notes that the first physician-reviewer for this case, and only witness for the Department at hearing, Dr. Lehman, was not familiar with the civil commitment statutes in Idaho. (Respondent's Brief, p. 38.) That is not surprising, inasmuch as Dr. Lehman lives and works in Seattle, Washington; and inasmuch as Idaho's civil commitment statutes have no bearing on medical necessity determinations for Medicaid reimbursement for inpatient psychiatric services. Idaho's civil commitment statutes are not referenced as criteria for Medicaid

reimbursement for inpatient psychiatric care in either federal or state law. The criteria for Medicaid reimbursement for inpatient psychiatric services are found at 42 U.S.C. §§ 1396d(h)(1) and 42 U.S.C. 1320c-3(a)(1), 42 C.F.R. §§ 441.150 *et seq.* and 476.71(a), and IDAPA 16.03.09.003.040 and 16.03.09.079.01. Further, the Designated Examiner notes from the commitment proceedings were not included in the medical record for review by Qualis Health, and thus the reviewers had no opportunity to see the clinical diagnostic process that the Designated Examiners went through to arrive at their determination to commit T.K. Dr. Lehman's lack of familiarity with Idaho's civil commitment statutes is of no relevance to the case.

KMC goes on to cite a number of instances when KMC staff members suspect that T.K. is hearing voices, then asserts that the refusal to reimburse KMC in the face of that evidence demonstrates that reimbursement determinations made by Qualis Health on behalf of the Department are arbitrary. (Respondent's Brief, pp. 38-40.) In addressing these instances of suspected auditory hallucinations at hearing, Dr. Lehman stated that documentation of such instances is a factor to consider, but that "chronic schizophrenics can hear voices and react to internal stimuli. And they are released to the street." (R., Ex. 1, p. 74, LL. 18-19 (T.K.).) Dr. Lehman stated further:

> In this case hearing voices is a concerning symptom, for sure, but it could be a symptom of chronic schizophrenia. People who are chronically schizophrenic can hear voices like for a very, very long time. But, they still, they live with it, they are treated for it. . . . But, in fact just hearing voices with no more delineation - are they telling her to do bad things, is this new hearing voices, are they -

> have they changed in some way? I have no indication from that statement that this is acute or that it is different or grave.

(R., Ex. 1, p. 48, LL. 8-15 (T.K.).)

T.K. was treated at KMC because she was considered to be gravely impaired. (R., Ex. 1, p. 27, LL. 1-23 (T.K.).) The medical necessity criteria for reimbursement for inpatient psychiatric services rendered to address grave impairment are contained in IDAPA 16.03.09.079.01.a.iii. That rule says:

> a. Severity of illness criteria. The child must meet one (1) of the following criteria related to the severity of his psychiatric illness: . . .
>
> iii. child is gravely impaired as indicated by at least one (1) of the following criteria:
>
> (1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or
>
> (2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or
>
> (3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication and/or behavior.

With respect to these criteria, Dr. Lehman testified:

> The - okay, the first . . . . I don't have evidence that that is fulfilled. The admit note describes . . . a person who doesn't want to answer questions and a person who can be hostile, although there are no quotes at all in terms of any element or anger or

> words from her mouth . . . . In the number two, the onset of psychosis, severe thought disorganization, the acute onset - the first time I could find the word schizophrenia or psychosis in her chart was on 12/8 on the 12/8 progress note . . . . Number three, need for treatment when it could not be done in a non-hospital based setting - again I have to read between the lines in the chart. I have somebody who I believe that were a different payment schedule had been arrived at earlier, in other words if she had gotten on Medicaid earlier than she did, that she possibly could have gone to an RTC earlier.

(R., Ex. 1, p. 44, L. 16 - p. 45, L. 10 (T.K.).) Simply put, although details are required by IDAPA 16.03.09.079.01.a.iii, very few details were provided by KMC in its medical record to support a determination of medical necessity for this five-week stay. Without those details, the medical record could not meet the detail requirements in rule and reimbursement could not be certified.

As discussed above, the intensity of service criteria found in IDAPA 16.03.09.079.01.b were not met in this case with respect to the last two days of the stay, since that portion of the stay was solely due to the fact that placement in another facility had not yet been secured. Intensity of service criteria were also not met with respect to the period November 9, 2005 to November 18, 2005. All of the intensity of service criteria must be met in order to establish medical necessity and justify Medicaid reimbursement. Consistent with his comments regarding severity of illness criteria, Dr. Lehman testified with respect to the intensity of service criteria in 42 C.F.R. § 441.152(a)(3) and IDAPA 16.03.09.079.b.ii:

> I do not believe I saw documentation to say that . . . there's a treatment plan saying that this patient was likely to improve from a 38-day stay.

(R., Ex. 1, p. 51, LL. 15-18 (T.K.).) Neither are 42 C.F.R. § 441.152(a)(2) and IDAPA 16.03.09.079.01.b.iii met here, since inpatient 24-hour nursing observation under the direction of a psychiatrist or physician is by definition not met when severity of illness criteria are not met.

In sum, the medical record did not contain the detail required by rule to demonstrate medical necessity and thereby substantiate reimbursement for the dates of service at issue. As with KMC's examples in the cases of J.M. and J.G., this example of Qualis Health's findings and conclusions does nothing to support KMC's argument that IDAPA 16.03.09.079.05 results in decisions that are arbitrary and capricious.

KMC suggests in Respondent's Brief at page 40 that the Department's reviewers might not have to rely on documentation as required by IDAPA 16.03.09.079.05, if it contracted with a QIO that operated near KMC's premises. KMC does not explain why such a move would make the documentation requirements in IDAPA 16.03.09.079.05 unnecessary. The reviewers could not sit in with the attending in every Medicaid case in order to see precisely what occurs each day of service, even if the reviewer consented to release of his or her identity. As Congress has recognized, utilization review cannot be conducted without documentation. 42 C.F.R. § 441.151(a)(4).

KMC simply wishes not to be burdened with the documentation requirements of IDAPA 16.03.09.079.05 and relies on 42 C.F.R. § 441.152(a) in support of that notion. As discussed above, the documentation requirements of IDAPA do not conflict with the certification requirements in the federal

regulations, and KMC must comply with both in order to be reimbursed by Medicaid. Furthermore, KMC's assertion on page 40 of Respondent's Brief that Dr. Lehman "simply cannot be satisfied" is belied by the record. For example, in the T.K. hearing, Dr. Lehman responded to questioning by counsel for KMC as follows:

> Well, let me answer the question a different way. The number of times that I or any of my colleagues would decertify the final day of a mental health hospitalization is astonishingly rare.

(R., Ex. 1, p. 80, LL. 19-21 (T.K.).) If KMC wishes to be reimbursed for its inpatient psychiatric services, it must include in its medical records the evidence of medical necessity described in IDAPA 16.03.09.079.01 and IDAPA 16.03.09.079.05.

H. Reimbursement Is Not Available At A Reduced Rate.

At page 41 of Respondent's Brief, KMC makes an argument for reimbursement at a lower rate than the rate for inpatient psychiatric care, in the event KMC does not prevail in these cases. Idaho does provide for reimbursement to providers at a lower rate than inpatient care rates when inpatient care is no longer required, and when placement outside the inpatient facility is still pending. This period of time is referred to as Administratively Necessary Days (AND). IDAPA 16.03.09.400.01. That rule states:

> An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for patients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or

> when catastrophic events prevent the scheduled discharge of an inpatient.

IDAPA 16.03.09.400.01. Although KMC refers in Respondent's Brief on Appeal to IDAPA 16.03.09.400.17 as the source of Idaho authority for a reduced rate of reimbursement, that rule applies to the Medicaid Utilization Rate (MUR), which is not a case-by-case reimbursement rate. The Idaho corollary to 42 C.F.R. § 447.253(b)(1)(ii)(B), referenced by KMC, is IDAPA 16.03.09.400.01, which is the applicable reimbursement mechanism for the period hospitals are seeking placement for inpatients who no longer need inpatient care.

Had T.K. been awaiting discharge to a Medicaid-covered facility such as a nursing facility, ANDs might have been available for the last two days of her stay, in order to allow for orderly discharge. ANDs are not, however, available for group homes. Nor are ANDs designed to reimburse hospitals for dates of service other than those necessary to complete an orderly transfer or discharge of a patient. Thus, the Department cannot reimburse KMC for any of the dates of service at issue in T.K.'s case and cannot reimburse KMC for any of the dates at issue in J.M.'s and J.G.'s cases.

Tallahassee Memorial Regional Medical Center v. Cook, 109 F.3d 693 (11th Cir. 1997), relied upon as authority for KMC's position, lends support to the limits of the Department's AND reimbursement. In analyzing 42 C.F.R. § 447.253(b)(1)(ii)(B), the *Tallahassee* court stated:

> The history of this rule, taken together with the mandatory language of the Boren Amendment and the holding in Beasley, requires that the plaintiff hospitals be reimbursed for the "grace" days spent by adolescent psychiatric care patient in their in-patient facilities, when the sole reason for retaining

> the patients in the upper level facility is the unavailability of alternative settings to which the patient may be discharged.

Tallahassee, 109 F.3d at 703. *Tallahassee* did not state that a state agency could not limit its AND reimbursement to cases in which the patient is waiting for transfer or discharge to a Medicaid-covered facility, and Idaho has so limited its AND reimbursement. Nor has the Ninth Circuit required Medicaid to provide for AND reimbursement when patients are awaiting transfer or discharge to a facility not covered by Medicaid. Under *Tallahassee*, had T.K. been awaiting discharge to a Medicaid covered facility during her last two days at KMC, AND would have been available to KMC. She was not awaiting placement is such a facility, however, and therefore no Medicaid reimbursement may be made.

Because placement was already secured in the J.G. and J.M. matters (detention and home, respectively), no AND reimbursement is possible in those cases, either.

I. These Matters Should Be Remanded Only If It Is Determined That The Hearing Officer Should Have Considered The Entire Testimony Of KMC's Physician-Witnesses.

KMC had the opportunity in each of the cases at bar to ask for a remand of the matter from the hearing officer to the Department, so that the psychiatrist-reviewers could consider any new or additional evidence that KMC wished to present. IDAPA 16.05.03.131. However, KMC made no effort to show good cause why such evidence was not presented to the Department or Qualis Health before the decision in question was issued, and in fact, has never articulated precisely what evidence it wanted considered.

KMC argues that as long as all the relevant evidence is available at hearing, a remand is inappropriate. (Respondent's Brief, p. 43.) Assuming that KMC believes it provided all the testimony at hearing in each case that it wanted to, then the Department does not disagree. The only reasonable basis for a remand to the Department is if the district court is affirmed in its ruling that the hearing officer should have considered *all* of KMC's witnesses' testimony. KMC argues that the hearing officer failed to consider some of KMC's witnesses' testimony in each case, so if the district court is affirmed as to this question, then the hearing officer should be given an opportunity to render her findings and conclusions with respect to that testimony. I.C. § 67-5279. Those findings and conclusions could alter the outcome of any of the cases.

To support its position that none of these cases should be remanded under any circumstances, KMC points to *Albert S. v. Department of Health*, 166 Md. App. 726 (2006). *Albert S.* is distinguishable from the instant cases. First, the ALJ in *Albert S.* did not resolve the matter on the merits before remanding. Unlike the case in *Albert S.*, the cases at hand were all resolved at the administrative level before proceeding through the court system. It is apparent that there is some testimony in each case that the hearing officer considered arguably irrelevant, because it consisted of information not made available to the Department or Qualis Health before the reimbursement decision was made.

Second, since *Albert S.* was a recipient's benefits case, the decision rested on 42 C.F.R. §§ 431.200 *et seq.*, which is inapplicable in the cases at bar. If the district court's ruling regarding the hearing officer's consideration of all of the

testimony from KMC's witnesses is affirmed, then the cases should be remanded to the hearing officer for further findings and conclusions.

KMC also cites *Bonner General Hospital v. Bonner County*, 133 Idaho 7, 981 P.2d 242 (1999), in support of its argument that these cases should not be remanded. The holding in *Bonner* was that no further findings of fact could be made from the "paucity of evidence" that would affect the outcome of the case. 133 Idaho at 11. Again, if the district court's ruling regarding consideration of the testimony of KMC's witnesses is upheld, then these cases should be remanded. Any testimony not previously considered by the hearing officer could conceivably affect the outcome of any of these cases upon remand. Therefore, the *Bonner* analysis is inapplicable in these cases.

II. CONCLUSION

The district court's judgments should be reversed in their entireties, and these matters should be remanded with instructions to dismiss the petitions for judicial review. Attorney fees and costs should be awarded to the Department, pursuant to I.A.R. 41, I.R.C.P. 54(e)(1), I.C. § 12-117.

Respectfully submitted,

Dated: August 12, 2008 OFFICE OF THE ATTORNEY GENERAL

By: _____
Whitaker F. Riggs
Deputy Attorney General

CERTIFICATE OF SERVICE

I hereby certify that on August 12, 2008, in accordance with I.A.R. 34(a), I caused to be served two (2) true and correct copies of the foregoing RESPONDENT'S REPLY BRIEF by the method indicated below, and addressed to the following:

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