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Supreme Court of Texas.
El Paso Hospital District d/b/a R.E. Thomason General Hospital District, et al., Petitioner,
v.
Texas Health and Human Services Commission and Don Gilbert, Commissioner,
Respondents.
No. 05-0372.

November 15, 2006

Appearances:
Marie R. Yeates (argued), Vinson & Elkins, L.L.P., Houston, TX, for petitioner.
Rance L. Craft (argued), Assistant Attorney General, Office of Attorney General, Austin, TX, for respondent.

Before:

Don R. Willett, Wallace B. Jefferson, Nathan L. Hecht, Dale Wainwright, Scott A. Brister, David M. Medina, Paul W. Green, Phil Johnson, Harriet O'Neill

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JUSTICE: Please be seated. Court is ready to hear argument in 05-0372 El Paso Hospital District versus Texas Health And Human Services Commission.

ORAL ARGUMENT OF MARIE R. YEATES ON BEHALF OF THE PETITIONER

MS. YEATES: Thank you, your Honor. My name is Marie Yeates and I represent 14 hospitals in Texas that provide Medicaid services. The issue here, here this morning your Honor is whether the manner in which the state agencies -
JUSTICE: How many -
MS. YEATES: - is ...
JUSTICE: How many hospitals are there?
MS. YEATES: There are 350 hospitals in Texas that provide Medicaid services
JUSTICE: And how come only 14 applied?
MS. YEATES: We are 14, there are several others but we are 14 that recognize this problem and elected to appeal to the agency and complain

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about it and we didn't get a relay from the agency we filed to the clerk in the International branch, and that brings me here.

JUSTICE: What I mean, what is there about-- I look at here the list here of -

MS. YEATES: These particular hospitals ...

JUSTICE: - these particular hospitals trying to figure out what El Campo and the East Houston ...

MS. YEATES: They happened to be a group of hospitals, your Honor, that are all relatedly in exposing the issue that is recognized. These related hospitals all, you know, all filed appeals and all filed the DJ action; declaratory judgment. So the issue is whether the agency which is responsible for the reimbursement for Medicaid to the hospitals in interpreting and applying its base year rule. That's what we have on a board here. The base year rule whether being interpreting and implying that, now we say erroneously. The agencies is violating its statutory mandate and the statutory mandate, your Honors, we put on our-- at top of one of our poster booklet. The statutory mandate is that the agency is to adopt the rules to assure that the payment rates are reasonable and adequate to meet the cost incurred by the hospital. So the agency decides what rules to adopt and we say the agency then has to follow its own rules because if they're not following the rules they adopt then we have no assurance that they have reasonable and adequate rates to meet our cost. If this is the mechanism that the Legislators assumes and agency assumes will give us to reasonable and adequate reimbursement and they're not following their own rules that's what we're complaining about today, your Honor. And here's why they're not following their own rules. The base year definition on it tai-- the poster booklet calls for them in deciding what the prospect of reimbursement rate it's going to be. To use a twelve consecutive month period of claims debt, twelve consecutive month period. But they say, and this is at page 26 of their brief to this Court, they say okay, we could have used twelve consecutive months of paid claims but we elected instead to use twelve consecutive months of admissions to the hospitals. So claims related to twelve consecutive months of admissions to the hospitals is what the agency decided to use. That's supposed to be the twelve consecutive months of claims debt. But what's undisputed on this record, is that they're not used in twelve consecutive months of claims debt. It's undisputed on this record that three to five percent of the claims of the admissions and the claims that relate to those admissions don't get taken into account because in addition to this base year rule, they have overlaid on the rule, something that is not written in their rules. They have internally overlaid on the rule. Another requirement that in addition to this twelve consecutive months of admitted claims, those claims not only have to be admitted in those twelve months but they have to be paid by the February 28 cutoff after the base year and the result of that and again everything upsets a person disputed. The result to that is, we get what we like to call "swiss cheese." The base year ends up with holes in it because claims also the 3 to 5 percent of claims that did left out and importantly it's also undisputed because the big dollar claims take longer due process and paid. They tend to be the one's that did left out. So we have 3 to 5 percent of the claims did left out those are predominantly the large dollar claims and, and here is what, I think, is most important Mr. Risonover who was their principal witness at trial and his title is manager of hospital raid analysis, so he is the big cheese in terms of the raid analysis and he testifies twice in the record and cited in our brief that the over all effect of leaving out this big

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dollar claim, the overall effect of leaving out big dollar claims is to decrease the standard dollar amount that determines our reimbursement rate. It decreases the standard dollar amount. Makes sense when you leave that ...

JUSTICE: Well, next, next script, next script this is on their, on their part but is there ever a period when those claims are factored in to this formula?

MS. YEATES: No, sir, there's none, your-- Judge Medina and that's the problem they-- once those claims that represented by the holes, once they fall out, they'll never kick back up and expect-- could you get me the brief-- there's a three-year cycle ...

JUSTICE: There's not a probation in here like on a, a tale when you can come back and may claims for those type of large medical expenses.

MS. YEATES: Your Honor, this is for purposes of setting the prospective reimbursement rate so do why they, they fall out of the system in the big claims that are-- the holes never get put back in for purposes of adjusting the prospective reimbursement rate. So we never get the benefit of those big claims for the prospective reimbursement rate. So here's how they do it, they have a three-year cycle. This is laid down in their brief honestly, your Honor, there brief is better than mine on this description okay. There's a three-year cycle for how they do it. The first is the base year, the second is the evaluation year and there's an inactive year and what they do is they take the base year and they apply the third-- the 28th cutoff and they say, "If your claims are paid in the red period, it will count." But if their claims that are represented by the holes in the base year are paid in the red period we're just not going to count. And-- of course, they make their administrative necessity argument. I need to cover that. They said well, of course, the claims have to be paid because if they are not paid then we don't know what their Medicaid eligible claims. And I don't disagree with that, your Honor. My problem is when they say they have to be paid and the fact that they've elected not to use the base year for the base year twelve consecutive months of paid claims they could have done that and then they would have had all paid claims but they elect to use twelve consecutive months of admissions instead of paid claims and then they overlay on top of that but you've got to get on paid by the February 28 deadline and here's the checker, we have no control over when they process and pay the claim. You see it's they're-- and I'm not trying to say that they're doing this on purpose but it's their necessary if you want to say delay ...

JUSTICE: What other reason what would be doing?

MS. YEATES: I'm sorry?

JUSTICE: What other reason would they be doing

MS. YEATES: Well, the testimony is that the big dollar claims are more complex and therefore they have to go to more reviews. I mean, I'm not saying that the evidence reflects if they are doing this on purpose. I'm just saying that's the effect, that's the effect and as far as administrative necessity, of course, one thing they could do is they could say, "We're going to use twelve consecutive months of paid claims." That would give all the-- if we wouldn't have any holes, there'd be no Swiss cheese or they could say, instead of having the new rates effective on September 01, 2001 we'll move that to the end of the inactive year, to the end of the blue year and then they have 18 more months to get the holes taken care of by getting the paid claims paid. They could do that or they could do what they do for appeals. For appeals from claims, they allowed-- this goes your question Judge

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Medina-- when, when claims are appealed they pick them up later and they added them into the reimbursement rate but they don't do that for my client claims. In fact, they say the claims should just don't make the February 28 cutoff year claims don't, don't satisfy the appeals rules and so we're not going to treat them like appeals. But here's how they do appeals, if appeals are completed at the yellow period of the reimbursement year then that data from the appeals was added then for purposes of the September 01, 2001 rate. Okay? So it comes after the red period but they give this new data during the yellow period, they added in the orange period and is counted for the new rates. All right, now, the next on the ...

JUSTICE: Let me just ask this quick that the September 1, the September 1 '99 day. I just want to make sure I understand.

MS. YEATES: Right.

JUSTICE: Does people admitted to the hospital on that day and those who come after?

MS. YEATES: Right. During that green period ...

JUSTICE: And so that's why there's not a rolling ...

MS. YEATES: That's right, that's right it's every three-years and that's why our prospective rate skewed because of what they're doing and it never gets altered, this Judge Medina asked it never gives ...

JUSTICE: Such that it won't be somebody who was admitted on August 31st it's only those admitted on September 01 on.

MS. YEATES: September 1, '99 to August 30, '99 would be that base year. Okay. Now if appeals are not completed during the yellow period okay then their rules should expressly provide. Say, they get completed in the blue year the inactive year. Then they picked it up, they picked up that new debt and they added it for the next prospective year. So see the agency knows how to keep adding a new data but they wont do that for our debt and so-- the reason I say this to the Court is not that I'm suggesting that, your Honor, you should tell the agency this is how you have to do it. I'm only giving this example to demonstrate the bigger administrative necessity argument brings hallow because in other ways they know how to add a new data and they just are not doing it for my new data so that-- that's why I bring this so, so you see that their administration necessity argument we believe, shouldn't apply. Now the ...

JUSTICE: How, how, how would you remedy that? You say you do it on claims pay ...

MS. YEATES: Right.

JUSTICE: But then that wouldn't give your perspective

MS. YEATES: Yeah, yes your Honor

JUSTICE: To support your helping mechanic.

MS. YEATES: It would, your Honor, you could take the base year and take twelve consecutive months of paid claims. It's whatever claims get paid during the base year and because large dollar claims are getting paid just like small dollar claims we're going to get whatever large dollar claims get paid during the base year.

JUSTICE: Where you could gain, you could gain that too -

MS. YEATES: I'm sorry, your Honor

JUSTICE: - You could gain that too by delaying filing your claims -

MS. YEATES: But you ...

JUSTICE: -to stock them up with ...

MS. MARIE R. YEATES: No, no there's a filing deadline and we have to follow. That's what is so ...

JUSTICE: Well, but I'm sure it runs from when the person discharge

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MS. YEATES: Discharge. That's right.
JUSTICE: Now you could just delay the discharge to stock up a few expansible ...
MS. YEATES: Well, I suppose so. We could ...
JUSTICE: Any, any rule could be gained.
MS. YEATES: I, I, I take your point. I take your point. Now, the Court of Appeals rise at page 9 of the opinion, that even if the explosion of these claims leaves to a decrease in the reimbursement rate, it doesn't follow that the hospitals' right to reasonable and adequate reimbursement has been affected. Your Honor, that can't be true, that can't be true because the state law is under this statute as part of the agency that they adopt the rules to assure, what to assure that we give to a reasonable reimbursement and if they adopted this rule and it-- and they're not complying with their own rule, and the result is the rate goes down, it couldn't possibly be that, that is now affecting our reasonable and adequate reimbursement that because the insurance for that is that the agencies rule gets us their.
JUSTICE: Is there, is there have been a situation where you recovered more [inaudible] .
MS. YEATES: Your Honor, I'm so glad you asked that because this is what-- I think this is where the Trial Court went off the track. The Trial Court has a series of findings where it says, let me go through these hospitals and we're going to compare your reimbursement rate to the reimbursement that you actually got in the history of four years to your cost reports because they're continually looking at the cost reports where it requires the hospitals to perform services okay, and by the way, they're continually updating that, that the record is undisputed on that, that can unplug date of my information that they're continually updating the cost reports of the agencies. All right, so they look at the cost reports and they compare it to what we got paid in reimbursement. Okay, and what the Judge conclude to what his findings are is that for so many of the hospitals in three-years, they got more than a hundred percent in their cost. Now, for serving of the hospitals, in those three-years like grand draw can real grand they didn't give a hundred percent of their cost. So as when the-- in the court of appeals, I was arguing to the panel, I said, well so does that mean it's okay if we don't have Medicaid and real grand and grand draw because obviously a hospital can't keep providing Medicaid if it's not getting paid its cost. But here is the real answer, the real answer is provided by the record Mr. Risonovo and Mr. Lorenzo were the two top officials from the agency who testified. They both testified that the purpose of the prospected system is to set a rate going forward. The hospital knows what the rate is and then the hospital has an incentive to reduce its cost so that it makes a profit, so that it makes a profit. In fact, Mr. Lorenzo said, and this is at page 9 to 10 of volume two of the record, you get more than your cost if you're efficient. So yes, the Trial Judge made findings that if look at these three-year periods some of the hospitals in effect got more than a hundred percent of their cost. But that could have been because of efficiency because that's the whole purpose of the system. Is that they set the cost and then the hospital can make the profit by cutting its-- I'm sorry-- they set the reimbursement rate and the hospital can make a profit going forward by being efficient by cutting its cost. And the agency wants us to do that because if we do not, the next time they re-base, the rates go down. So it's to our benefit to try to make the profit is to their benefit to get our cost down because our claims numbers will ultimately go down and it causes the reimbursement rate go

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down. That's why the Federal Government adopted the gravamen for Medicaid and told all the states to go to prospective system instead of the retroactive system. This so the hospitals would have an incentive to cut their cost. So here we come in this case, and the Trial Judge says "Oh, well you got more than a hundred percent your cause so you're out of here." Well, that's what we're suppose to do. That's what we we're trying to do and so for all you know, on this record, the reason we got a hundred percent-- more than a hundred percent is 'cause we were doing what we're supposed to do and being efficient.

JUSTICE: Is it clear that the basic in mathematical formula that filling in those holes would intact the rate?

MS. YEATES: Mr. Risonovor admitted, testified twice, that if you fill in those holes, in other words you add back in the big dollar claims, the standard dollar amount goes down and so and yes, we know the impact of this to race. That's the answer to that. And I think that I'm almost out of time but, your Honors, the appeals' process, I showed you what-- how they handle it, and they say that my claims don't-- my new claims and I say that didn't process on time. They don't come in because they are not mechanical, mathematical, or data entry error and I say, wait a minute, if I'm right about the right way to interpret the base year rule and you should have counted my claim but you didn't exclude the claim. Then it is a data entry error. So one of the things we're asking the Court to do here on appeal is to say that we do have the right to go back and pursue those claims that we've already asserted for this prior years so that we can get our reimbursement rate for those prior years corrected and get the money that we weren't paid. So one of the issues here on appeal is whether we are right that the appeals process as written in their own rules, if our interpretation of base rule is correct, then we should be entitled to use that appeals process to get our claims corrected and they denied us that right. That's one of the issues on appeal.

JUSTICE: Now let me just state that question here. When you talked about the profit incentive?

MS. YEATES: Yes, your Honor.

JUSTICE: That, that sort of go against the language of the statute reasonable and adequate to meet the cost that doesn't seem to be a profit. [inaudible]

MS. YEATES: It, it interesting in that because raise, the federal statute of the language, the federal statute of the language started is started instead of redequate-- reasonable and adequate to live the cost of the hospital meaning. What particular hospital talks about the reasonable and adequate to meet the cost of an efficient hospital. That it, it is supposed to be enough to meet your cost and but it is at the point, the point of the prospected system is you know what that rates going to be.

JUSTICE: But if you come in under isn't there a re-adjustment process where you can go back in and get some re-adjustment to make up for the loss?

MS. YEATES: You mean if my, my rate is under what it should be? If my reimbursement rate is under where it should be?

JUSTICE: Right.

MS. YEATES: Well, that-- that's my problem here, Justice O'Neill.

JUSTICE: No, no, not just your reimbursement right because I understand your saying one of the reasons that you loss was there's a profit that denied.

MS. YEATES: Right

MS. YEATES: If we set one way to read those over a hundred percent

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cost ...

JUSTICE: But if you, if you, if you came to the Court and said that I got a big gap here, is there not a readjustment mechanism in the statute that allows you to come back and show that on a hospital, a hospital basis?

MS. YEATES: A big gap in my cost?

JUSTICE: No.

MS. YEATES: I mean, in my, in my collection from my reimbursement

JUSTICE: A big gap in my, in-- I mean, if you're losing.

MS. YEATES: Yeah. I'm losing money.

JUSTICE: You're losing money. All right, and is there not a way to re-adjust causes, there's no mechanism in the statute?

MS. YEATES: Okay. I don't have a mecahanism under the statute to go to the agency and say, "I'm losing money I need you to give me some more money." 'Cause that's not their problem. Whether I'm losing money, it's my problem. Okay? But what I am entitled to from the agency is reasonable reimbursement ...

JUSTICE: I guess that's my question. Isn't there a way that If you can show

MS. YEATES: Well, let's see

JUSTICE: What you're paying me is not reasonable and adequate to meet my cost.

MS. YEATES: That is, that is the attempt to go back and compare it to our cost reports and that's what the Trial Judge looked at and he said "Oh, well, based from the cost report, most of the hospitals are-- not at all-- but most to your report in hospitals are getting their cost reimbursed and so I'm not worried." Okay? But I'm trying to explain that, that is a false way to look at it because they may be me-- they may be getting more than a hundred percent of their cost because they're doing what they are supposed to do, they are being efficient and therefore their cost are lower so that the reimbursement rate shows that they're getting more than their cost. The reimbursement rate is like our revenue and our cost are our expenses and so it can get me more than a hundred percent of my cost in making a profit. But I could be giving more than a hundred percent of my cost not because I'm getting the revenue what I already get from the agency but because I'm being really efficient and cutting my cost and that's what I'm supposed to do under the whole prospective system. I'm only trying to make a point, Justice O'Neill, that the fact that they can show that for particular years, a hospital might under its cost reports that got more than a hundred percent its cost does not mean that they're getting reasonable and adequate reimbursement under the agencies [inaudible] or to meet the ...

JUSTICE: Okay, no further questions. Thank you. The Court is ready to hear argument from the respondents

COURT MARSHALL: May it please the Court. Mr. Craft will present argument for the respondent.

ORAL ARGUMENT OF RANCE L. CRAFT ON BEHALF OF THE RESPONDENT

MR. CRAFT: May it please the Court. This case the hospitals never try to prove that the Medicaid reimbursement is not reasonable and adequate to meet their cost. Did the evidences otherwise. Instead, they've identified an internal agency practice that they think is

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costing them some of money. That is the selection of the base year data on February 28. To get rid of that practice, they advanced tortured readings of the untruthful rules and statutes that would render that data's selection invalid.

JUSTICE: Okay. Let me just ask you ...

JUSTICE: Hold on. I don't, I don't know where you know these cutoff dates what they mean because they can be arbitrarily any date. Quite frankly, problem seems to me that their claims had been paid for by the hospital not recognized by your agency. And how do you address that?

MR. CRAFT: The "Swiss cheese" model that she's using presumes that their interpretation of the rule is correct and their interpretation is that this base year definition that the base year is 12 consecutive months claims data as selected by the department, means this, we pick the base year, we pick one and only one criteria to associate each claim and that's it that's the base agreed and so anything else that we do to select this data that, that results and the admission not being included is a but the rule doesn't plainly require that. Your not going to find this one and only one criteria in that rule ...

JUSTICE: Is your choriograph for claims that are appear to be more significant and more conversant with the process?

MR. CRAFT: Not necessarily, your Honor, and ...

JUSTICE: How they come about their allegation and faults?

MR. CRAFT: Yes, there is no complement evidence that prove that the fact of February 28 cutoff day is to just proportionally exclude high dollar claims. Their only evidence is that is their expert Ms. Neilsen and her analysis is problematic in two respects. She didn't examine every claim that is affected by February 28 cutoff day and she didn't make through all the steps that the commission goes through in calculating rates. On this issue of disproportion makes clear in high dollar claims. She only looked at claims the hospitals appealed not at every claim affected by February 28 cutoff day, only the ones they appealed and there's evidence that shows that in some instances-- not in every instance-- but in some instances, the hospitals were cherry picking claims that were affected by February 28 cutoff day to appeal. The cutoff day has two effects here.

JUSTICE: So you think the agency's position is if you extended the cutoff day, you actually pay less

MR. CRAFT: It's possible. We don't know, we don't know what the effect would be. There's no proof in the record that

JUSTICE: So if the petitioners win, they could lose money and you could win.

MR. CRAFT: It happens that way because they do not prove what the effect would be. And there, there -

JUSTICE: What if-- what is the effect -

MR. CRAFT: - there ...

JUSTICE: - of February 28 does not cutoff the for reimbursement? That might for claims that are, that are processed after that date?

MR. CRAFT: There, there are two effects. That is one if, if, if a claim, if the claim is paid after February 28.

JUSTICE: But in reasoning your twelve month period -

MR. CRAFT: Yes.

JUSTICE: - and that's, and that admission might be paid after February 28 cutoff day.

MR. CRAFT: Yes.

JUSTICE: No question then that is not included in ...

MR. CRAFT: That is, that is not included. There is another effect.

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The other effect is that, if they claimed it's retroactively denied, if after February 28 it's determined that, that it's not in Medicaid eligible claim. We don't go back and, and pull it out of this database and there's evidence that the hospitals, when they were in fact most of this appeals dealt with not adding claims back in to the database. The majority in their appeals would have take claims out of the database and there's evidence that in some instances what they were doing is saying,"I'm going to appeal to take a thousand dollar claim out of the database. Because that's a low dollar claim."

JUSTICE: But I thought the Judge said that you don't allow appeals for these matters after February 28.

MR. CRAFT: We don't but that was the basis of their experts analysis. That was the basis of her analysis to show what the effect of the February 28 cutoff date was and that is the only evidence they presented. To show what the, what type of claims will be excluded by February 28.

JUSTICE: So you have add February 28 day requires the board all the hospitals.

MR. CRAFT: Yes

JUSTICE: Okay so that's-- that applies everybody not just these hospitals

MR. CRAFT: That's correct

JUSTICE: And the effect of that is to exclude claimants no question exclude some claimants admissions might be twelve moth period in time.

MR. CRAFT: It means that they are not concluded and ...

JUSTICE: And you have no process for them, them to appeal and actually had them included.

MR. CRAFT: That's right but that's not required by the rule. The rule says it's a twelve consecutive month period claims that was selected by the, by the department. The rule doesn't say anything about when we make that selection.

JUSTICE: Okay, claims data or admissions data?

MR. CRAFT: Claims data

JUSTICE: Okay then you have twelve months worth of claims data that you that you are applying

MR. CRAFT: We do, claims data means, the charge that the hospital made for the patient admission and what was the diagnosis related groups, that's what you get out of claims data. So that's why, we choose the emission date. What you get out of claims debt. So that's why we choose the admission day because that we're trying to get what are the hospitals experience during this base year that's why you can't use paid claims as Ms. Yeates suggested because if you say we're going to basing on paid claims your going to be picking up hospitals Medicaid experience from this prior year prior to the base year that we've selected. You could have somebody be admitted prior to September 1st, 1999 as an example. They go through their discharge and the claim was not paid so after that ...

JUSTICE: So what's wrong with that?

MR. CRAFT: What's wrong with that is that your getting claims data from prior to September 1st, 1999

JUSTICE O'NEILL: Why is it that effective in predicting what, what they will be in the future as well?

MR. CRAFT: Because we're charge beginning twelve consecutive months of claims data of hospitals past experience. When the claims data are release to what was the hospitals doing?

JUSTICE: Why isn't the paid cost the best analysis of the data?

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MR. CRAFT: It's not because you can end up with 18 months of experience by the hospital depending on when the claims was paid, when the claims we're paid. Paid doesn't say anything about when the hospital is actually treating this person.

JUSTICE: What is the matter? I mean the bottom line is what, what was cost the hospital was doing reimbursement provided by the agency?

MR. CRAFT: Because we're trying to, because the rule directs us to get twelve months of claims data. We need twelve months of the hospitals experience in treating people and if we, if we ...

JUSTICE: Sounds like you're mixing American cheese with cheddar cheesier just like you're so imaginal.

MR. CRAFT: Well, it we have a cheese we have doesn't have any holes

JUSTICE: Then why do you do the cutoff to have it February 28 cutoff? that that applies against that arguments.

MR. CRAFT: The reason for that is this the rule doesn't say when we select the data. So by making the final data selection on February 28 we're getting 100 percent of the claims data from the twelve consecutive month period that exist at that time. Now at that time there may be pending claims that have not been paid yet that were also believe being paid and so there not selected there maybe pending claims that are not going to be paid.

JUSTICE: But you could set the deadline on October 1st and then your argument would be presented.

MR. CRAFT: You could set the deadline on October 1st but that is not the decision of the agency has made

JUSTICE: But clearly it's not but it would have the same justification.

MR. CRAFT: It, it would have the same justification except that the goal for years to approximate this is the hospitals words not mine approximate the average cost for the hospital during this base year period and that's why, that why the rule doesn't say anything about when you take the step of finally selecting the database. There, there two goals of system. You've got one goal is to take some base period of that and from that extract an approximation of the hospitals average cost between an average Medicaid case, and over here that is goal of setting a prospective rate by particular deadline. This are going to be the final rates you're going to tell the hospital this is the rate which in we have going forward. What the, what the commission has decide is where in between those to time frames do we move from data collection to rate calculation. The, the rule doesn't say anything about when that happens so the commission has decided internally we're going to move from the step of data collection to rate calculation in the middle.

JUSTICE: But that's not fairly important to termination. You say they might have termination internally but it's in fact the bottom line.

MR. CRAFT: Well, first of all there's no complement evidence that does effect the bottom line and I want to address ...

JUSTICE: Whether it's higher or lower, I mean ...

JUSTICE: If what was left out will affect the bottom line ...

MR. CRAFT: Well, we dispute this left out. It's not included because it's, it wasn't claims that at a time ...

JUSTICE: It is, is but normal input rule making is poor. So they can make a record how it's going to affect the bottom line and argue it all on march 15 instead of February 28?

MR. CRAFT: The, the standard for whether ...

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JUSTICE: That is what's rule making is for so people can make a record and argue your agency back to that reasonably.

MR. CRAFT: That is the goal of rule making. It is not required in this case because this is not rule. That the mere fact that the hospitals ...

JUSTICE: It's not a suggestion.

MR. CRAFT: The fact that they are saying it may have cost them some money it doesn't mean that it fall buys the rule under the defamation of the APA

JUSTICE: I'm willing to grant you that we havn't had that fight use in-- maybe we haven't-- if. We don't know, let's assume we don't know whether if they, their going to be winners or losers. Why does that make it not a rule? It's a rule whether you win or lose isn't it.

MR. CRAFT: It's not a rule because the 80's definition of the rule requires that it is something that affects privates rights. They do not have a right to have a quantum of data included in their reimbursement rate. What they're saying in their brief is it's a rule because of the facts of the peculiarly interest. But the APA doesn't say affects private interest it says it affects private rights.

JUSTICE: Well, have now they have to treat these Medicaid patients in the lot of cases, do they not?

MR. CRAFT: It is a voluntary program. It have some-- now there are some public hospitals who's further mission say we're going to treat Medicaid patients. But it is a voluntary program. In fact ...

JUSTICE: They can turn them away if someone comes in in emergency room they can turn them away if they said their Medicaid.

MR. CRAFT: They are not, they are not required to visit any program

JUSTICE: My question was can the hospital turn the Medicaid patient way out emergency room and say to the homeless, "Take them 50 miles down the road."

MR. CRAFT: They can say we don't we don't treat Medicaid eligible patient. We don't mind, there's a, there's a-

JUSTICE: We don't, we don't want them to do that.

MR. CRAFT: But we-- We don't

JUSTICE: Now, we want to make sure they get their reasonable and adequate cost.

MR. CRAFT: That's correct.

JUSTICE: Do you agree that change in reimbursement cutoff will have us fully be effective in fact in the hospitals or rated care and services they provide outside of Medicaid.

MR. CRAFT: Out, out to-- do not Medicaid eligible patients.

JUSTICE: Okay the change in the Medicaid, change in the reimbursement cutoff date will have another impact on the hospitals care for even those outside the Medicaid ____ the hospital ___ ...

MR. CRAFT: There is no, there is no proof to that in the record there is no there is no evidence put on how does it affect the services of non-Medicaid patients.

JUSTICE: Mr. Craft think you suggested that using added missions basis for your twelve months advantage required by rule when you are asked what could use claims paid basis what's that rule.

MR. CRAFT: It's not, it's not the requirement. Well, its indirectly required because the rule directs us to use claims data depending the purpose of the rule is to examine what the hospitals experience is in treating patients over this twelve months. If you pick this twelve months and using the paid date then your not capturing what the hospitals are treating and what their charges were over that twelve

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month period.

JUSTICE: That identified the rule or the rate that you take direction to do that.

MR. CRAFT: The, well, the rule is-- it would be some subsection-- the well, the definition of the base year says the claims data and just it's not, there's not an expressed statement but it is the gist of the rule is to calculate what the hospitals cost experience in the experience period and what, what would happen if you use this paid data instead of using claims and diagnosis from some other period and they're having cross data from another period and is not matching up.

JUSTICE: So it is not an expressed requirement in a rule you think it that, that, that commissions approaches consistent with the purpose of this scheme that set up.

MR. CRAFT: It's is and because there is not a claim requirement to do it one way or the other. This is the commissions reasonable interpretation of that rule and so the court ...

JUSTICE: What will you say about the administrative code 355-1063(C) which directs the department to use the overall arithmetic mean base year payment per case.

MR. CRAFT: Yes

JUSTICE: Which is I get to be the commission to requirement to determine average cost again the language is arithmetic mean base year payment per case

MR. CRAFT: Yes

JUSTICE: Uses the word payment rather than admission. What's the effect of that to that rule?

MR. CRAFT: Because the base year payment per case is not what the hospital charged. The base year payment per case it is as defined in the rule. It is the hospitals average cost for treating its Medicaid patient divided by its case needs which depend-- which is an average of the relative weights. That for various diseases that it treats. So and you can't get those that base year payment for case without using cost data and claims data. So it's not just what the hospital charge. It's-- it would take a ratio of hospital's cost for the year over their charges for the year. And then we say, "That's the ratio that's going to be your cost ratio." So if your overall cost ratio is 50 percent then we're going to take each claim and we're going to take each charge then we included the database and say, "Your cost for that is 50 percent of that." Now, it might actually been 80 percent but, but because of the way the rule defines it, we're going to apply this cost discharge ratio and say, "No it's 50 percent." We average all those together and divided by the case submits. So you can't just get it from the payment.

JUSTICE: So, so if you take all of the claims made of the claims paid over the twelve month period. All of the process you talking about leave out none of the claims paid you have your average that you're talking about.

MR. CRAFT: You will, you will have the rule directs an average basing year payment per case but the commission selects the basing year. The basing year rule is not saying anything about when we select that base year. That's what is left to commission by the rule and that is the interpretation. It's not the courts role to say which of these various options should the commission be using. It's not to say what would we do differently we're running the commission. The role means to say this what the commission doing claiming inconsistent with the rule.

JUSTICE: Well, I-- our role is also to said, "Can you just do this or to duty or to have to have notice and opportunity for hearing to

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rule making.

MR. CRAFT: Yes and, and you don't in this case because this cutoff day is not, does not qualify as a rule under the APA.

JUSTICE: That's because they don't have public interest and that's because their not going to lose any money and your opinion.

MR. CRAFT: Well, there's no confident proof ...

JUSTICE: If there were confident proof. You said a while ago that there's no evidence that 2-28 cutoff this unfortunately impact side valid claims. But if there were evidence that which are this should be different.

MR. CRAFT: No it would be the same because the APA does not say that it needs thing that will affects pecuniary interest has to be in a rule.

JUSTICE: But you told me that what the rule was, so when is it not a rule?

MR. CRAFT: The rule, the definition of the rule is something that affects private right pecuniary interest is different from a private right. Because the hospitals do not have any right they have this particular set of data that they want to be included included they don't have a right to a specific ...

JUSTICE: Back to the assumption is that it has an effect of reasonable rates

MR. CRAFT: It has some effect but it's-- but they don't they do not have a right to have that reasonable rate calculated using a specific quantum of data and that is what their argument for.

JUSTICE: But if the quantum of data results in their not getting reasonable and adequate cost reimbursement why is that not a private right is affected.

MR. CRAFT: That-- because well they haven't shown the it was exactly ...

JUSTICE: But if they had?

MR. CRAFT: But if they had, if they have shown that the application of, of, of this rule affects their rights to a reasonable and adequate rates so it is producing unreasonable rate then they might say that affects their private right because they do have the right under the statute to that.

JUSTICE: So then they makes the questions supposed

MR. CRAFT: If ...

JUSTICE: You're looking at the merits of their client to determine whether it's a rule, it seems backwards.

MR. CRAFT: Well, but they have not, they have not argued that reasonable and adequate requires a precise quantum of data. They they have not admit it which is which is the federal authority is saying. But this is just a zone.

JUSTICE: Well, they just-- they say two things-- they say it's a rule and you haven't gone through a rule making but in the end they going to have some objections too. My question is, "who do we should have a district judge to decide this or your agency in an open forum of rule making and third court look it first?"

MR. CRAFT: Because it's, if the court will say that anything that affect that-- if you can show any change in your pecuniary interest then that necessarily qualifies as a rule if that's spend that has to be subjected to form a rule making that that agencies have to do and that and that would be the problem for APA.

JUSTICE: If this would, if, if this would determine to be a rule and had to go through the rule making procedures. Give me the parade of honorables. What would be wrong with that?

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MR. CRAFT: What would be wrong is that you'll be, you will be saying that they are really into one is that by merely showing some effect with pecuniary-- of pecuniary interest but that's enough that any, any agency practice the, that moves you by the line.

JUSTICE: So is the presidential barrier work.

MR. CRAFT: That is the that is one. The other is it would a wide distinction between rules and interpretations of rules. We have this entire body of jurisprudence and it says, "We interpret rules this is how you deal with interpretation of rules." If every rule that affects somebody in some way is interpreted then under their logic that interpretation has to be included in a rule and that's inconsistent with this distinction between rules and interpretations.

JUSTICE: Thank you, Mr. Craft ...

JUSTICE: With change-- Does sudden change in the cutoff affect the hospital's private rights?

REBUTTAL ARGUMENT OF MARIE R. YEATES ON BEHALF OF PETITIONER

MS. YEATES: Exactly what I need to address, your Honor, at tab 9 of our booklet we have a formula. For the-- And this is much conflict counsel woudn't dispute it. This is an active representation of formula what he, he sent and what counsel says that we didn't prove that reduces our right. He's talking about their complaint about our expert Julie Neilsen. Okay? I don't agree with this complaint but I don't need Julie Neilsen, why Julie Neilsen assigned, okay? I have undisputed testimony from Mr. Misner, M I S N E R, who is the guidance in charge at the independent agency at the independent contract or insurance company that the agency uses to create the file the claims down for the base year and he says that it takes longer to process and pay them of older-- bigger claims and therefore February 28 cutoff is going to mean that you'll lose bigger claims, just proportionately, bigger claims will going to be paid after the cutoff. So I have then undisputed evidence. Then I have Mr. Risonovor, whose skills had of-- the rate making at the agency, okay? Who testifies not one but twice. That the standard dollar amount taking all things into account. Including the case Mixandutch, that's what-- that's why of the arguments in their brief that Mr. Resonovor says including taking into account the case Mixandutch. Leaving out, big dollar will have the effect "overall" he says, that's the word he uses of reducing the standard dollar amount. If you come down here in the reimbursement rate is a, is a product of the standard dollar amount times the relative rate that's the of-- the type of procedure that the hospitals doing doing those, the heart transplant. This-- That's how you get to the reimbursement rate.

JUSTICE: So private interest. The private interest probably 2001 out of 3600 is your losing money.

MS. YEATES: Yeah yes, well I'm you know I do have ...

JUSTICE: [inaudible] losing money is a rule.

MS. YEATES: Well, I do have a private interest in that my yes my reimbursement rate is being affected that's right.

JUSTICE: That's a private rights are the same as public interest

MS. YEATES: Well, I had an agreement that I mean I have a private interest in as a hospital providing Medicaid services in giving the reasonable reimbursement rate that I'm trying to exclude under the statute.

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JUSTICE: Ms. Yeates that seems take me back to Justice Johnson's -

MS. YEATES: Yes.

JUSTICE: - question but the requirement are lack thereof for a hospital to treat in an emergency room and Medicaid patient, seems to me that on their promises by the state that a hospital had chooses to do that does so in its own payroll in terms of a business risk because there's a possibility that it won't reimburse their service.

MS. YEATES: Judge Medina, I'm told that my hospital experts that we don't have that option that if somebody shows up in the emergency room, we got three of them.

JUSTICE: Correct.

MS. YEATES: Now, we can voluntarily decide to participate or not to participate in the Medicaid program in general that is voluntary, I will tell you, that if you don't participate in Medicaid you can't produce-- participate in Medicare either so the hospital that makes that decision to cut itself out of Medicaid also can't do Medicare. That's a big decisions so it's important to all the hospitals that they get paid correctly for their Medicaid services.

JUSTICE: And you keep this structure?

MS. YEATES: Yes

JUSTICE: The basic structure. But when did the cutoff paid a little bit or had procedure that adds some claim back in their-- in there still going to be some judgment on at some point you better say this is what we're going to do.

MS. YEATES: That's right, your Honor

JUSTICE: And if that's such to an agency from time to time every time they do that is that a require rule or a rule will make it-- hearing

MS. YEATES: No your Honor I'm talking about a decision of the agency the February 28 cutoff that undisputedly cause the effect of living out 3 to 5 percent of the claims and I don't understand why the counsel is telling me all that it don't have that effect, its only people testify that it has the effect of living out 3 to 5 percent of the claims.

JUSTICE: Like he said they get-- they had no order to go up in there.

MS. YEATES: Look, you see that's my point about the claim. His own guys says that they don't understand. So I don't think I got that issue but your right, your Honor, that unless you use a hundred percent of paid claims which they say in their brief they could have done I should decide not to. They could have used the hundred percent of paid claims that's page 26 of their brief but unless you do that if with if your going to have a cutoff at some point and, and as I said earlier I'm not trying to say the court has to tell me exactly what to do that they got 18 more months in there if they can get all the 3 to 5 percent of the 6 month red the red period for 6 months and you had 18 more months. You know, surely you get almost all and certainly our rights will be more protected than we are now.

JUSTICE: And I think if you get almost all that's not all so is there another set?

MS. YEATES: That's true that, that's true and that's one of the argument I am making all along that you know there's no place for us to get completely 100 percent but we do know that the cutoff has an effect of 3 to 5 percent and we do know that there are options to get more than that.

JUSTICE: What about the argument that used in claims paid may take you back 18 to 24 months that this might give you a 12 months snapshot

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of the hospitals cost.

MS. YEATES: Right

JUSTICE: Because you go back beyond twelve months.

MS. YEATES: Right and I suppose your Honor they opted to go for the 12 months of admitted debt and that's certainly their you know their decision and their-- but when we do that they got to get 12 months of data and their not getting 12 months of admitted data because because if they are not paid within that period they don't get counted. So I mean ...

JUSTICE: So you don't care which, which, which approach they take. So as long as they include this 3 to 5 percent or this money of the [inaudible] is basically practical and the calculation ...

MS. YEATES: Right, we are trying to get to the point where we don't have identified what portion of claims left out and if that are necessarily the big dollar claims. That's the problem we got with the February claim cutoff day.

JUSTICE: This judgment, [inaudible] your prayer is this is an invalid rule that they applied to 28th day and also that you want the appeals process that some kind of appeals process either or is this the question was regardless of the whether it a appeals process whether it's the 28th cutoff date is the question that asked is in the rule and this so

MS. YEATES: That's one, that's one , yes your Honor that's one of the question that Judge Chris that I've been and I think that it recovered but yes we think it's a rule and they deviate instead to adopt it but most importantly to me most importantly is that the very interpretation of the base year rule transfer in the plain language of the base year rule we say their interpretation is violating their statutory mandate to, to-- because they are not following their own rules that should supposed to be designed to get us to reasonable reimbursement

JUSTICE: So whether it's an appeal process you don't get orders to 28th cutoff day or your telling us that it's an invalid rule measured by the statute and that's what that's what you want us to take care of

MS. YEATES: That-- that's the most important thing but then we also would like to know may I ask the court to tell us why we are entitled to use the appeals' process and whether not why it should have been treated as a rule for APA administrational purposes are promulgating that to.

JUSTICE: Further question

MS. YEATES: Thank you, your Honor.

JUSTICE: Thank you, Counsel, the case just argued was been submitted

COURT MARSHALL: All rise ...

2006 WL 5918089 (Tex.)

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