5-30-2018

Re: Medical Indigency Application of C.H. Appellant's Brief Dckt. 45614

IN THE SUPREME COURT OF THE STATE OF IDAHO

In Re: Medical Indigency Application of C.H. (Gem Co. Case No. 16-026) ST. LUKE'S HEALTH SYSTEM, LTD., Petitioner/Appellant, vs. BOARD OF COMMISSIONERS OF GEM COUNTY, IDAHO, Defendant/Respondent.	Supreme Court Docket No. 45614 Gem County No. CV2017-145

APPELLANT'S OPENING BRIEF

Appeal from the District Court of the
Third Judicial District for Gem County

Honorable George A. Southworth, District Judge, Presiding

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I. STATEMENT OF THE CASE

A. Nature of the Case.

This is a medical indigency case. St. Luke's Health System, Ltd. ("St. Luke's") appeals the Gem County District Court's decision affirming the determination of the Board of Commissioners of Gem County (the "County" or "Board") that certain dates of service provided to C.H. (the "Patient") were not compensable as "necessary medical services" under the Medical Indigency Act, Idaho Code Section 31-3501, *et seq.* (the "Medical Indigency Act").

B. Course of Proceedings.

The Patient was treated at St. Luke's from January 26, 2016, to March 9, 2016. *See* Medical Indigency Hearing – Executive Session, Transcript of Medical Indigency Case No. 2016-026 ("Agency Tr."), p. 4. On September 19, 2016, based on an application for County aid submitted by St. Luke's, the County issued an Initial Determination of Approval for County Assistance as to certain dates of service. Agency Record ("AR") at 14.[1] The Initial Determination found the Patient medically indigent, but denied dates of service from February 3, 2016, to March 9, 2016. AR at 14. St. Luke's timely appealed the denial of the remaining dates. AR at 9.

On February 6, 2017, a hearing was held before the Board regarding its prior determination that services provided after February 2, 2016, were not medically necessary. *See generally*, Agency Tr., pp. 1–21. St. Luke's appeared, inquired regarding the County's medical review, and offered evidence, argument, and authority demonstrating that all dates of service from January 26, 2016, through March 9, 2016, were compensable under the Medical Indigency Act. *See* Agency Tr., pp. 7–21; AR at 313–25.

[1] The Agency Transcript and the Agency Record are included in the Clerk's Record on Appeal as exhibits. *See* R. at 85.

On February 6, 2017, the Board issued an Amended Determination of Approval for County Assistance. AR at 11–13. The Board maintained its denial of payment as to dates of service February 19, 2016, through March 9, 2016. AR at 11–13. Thereafter, St. Luke's timely filed a petition for judicial review with the Gem County District Court. R. at 3.

St. Luke's and Gem County submitted briefs and a hearing on the petition for judicial review was held on October 10, 2017, before the Honorable George A. Southworth, District Judge, Third Judicial District, County of Gem. Judicial Review Hearing Transcript ("Tr."), p. 1. On October 18, 2017, the District Court entered its Order on Judicial Review affirming the Board's decision to deny county assistance for dates of service February 19, 2016, through March 9, 2016. R. at 76–77. Thereafter, St. Luke's timely filed this appeal. R. at 79.

C. Statement of Facts.

The facts of this case are undisputed. Tr., p. 25, ll. 24–25 ("As the parties have acknowledged, there's really no dispute of facts."); Tr., p. 34, ll. 10–11 ("[A]gain the facts here are undisputed"). The Patient was treated at St. Luke's for meningitis and severe brain lesions between January 26, 2016, and March 9, 2016, and also received additional inpatient care thereafter at a different facility on the condition that St. Luke's pay for the care. Agency Tr., p. 4; AR at 278–86. There is no dispute that the Patient is an indigent resident of the State of Idaho and Gem County is obligated under Idaho Code Section 31-3506. AR at 11–13. Indeed, the County ultimately approved the Application with respect to certain treatment rendered to the Patient from January 26, 2016, through February 18, 2016. *Id.*

The Patient was admitted emergently on January 26, 2016, after being found unconscious. Tr., p. 4. She received emergency treatment. As early as February 5, 2016, St. Luke's began assessing the propriety of a lower level of care at a long-term acute care hospital, although acknowledging the reality that the Patient's lack of a payment source would

likely be a "barrier for placement." *See* AR at 317; *see also* Tr., p. 26, ll. 18–22. On February 16, 2016, St. Luke's contacted Meridian Care regarding placing the Patient in a lower level of care, but it would not take the Patient because of her lack of financial resources. *See* AR at 316. The following day, St. Luke's contacted two additional facilities, which likewise declined to admit the Patient because she was self-pay. *Id.* Another facility declined admission on the basis that the Patient did not have a primary care physician that would follow her to the facility. *Id.*

On February 22, 2016, St. Luke's contacted two additional inpatient facilities, and on February 25, 2016, each facility declined to take the Patient due to concerns about the Patient's clinical status. *See* AR at 315. Two additional facilities evaluated the Patient beginning on February 25, 2016, and finally, on March 9, 2016, the Patient discharged to Life Care Treasure Valley ("Life Care"). *See* AR at 314–15. Of significant note, before Life Care would agree to admit the Patient, however, a single patient agreement was negotiated that required St. Luke's to be financially responsible for the charges incurred at the lower level of care. *See* Agency Tr., p. 10, ll. 16–25; AR at 320–25.[2]

On May 16, 2016, Dr. Dammrose submitted a utilization management review. *See* AR at 24–27. The review determined that the care provided after February 3, 2016, was not medically necessary because the County had apparently not submitted medical records to Dr. Dammrose for that care. *See* AR at 25.[3]

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[2] St. Luke's is not seeking compensation for the amounts it paid to Life Care on the Patient's behalf. St. Luke's is only seeking compensation for the dates of denied service from February 19, 2016, through March 9, 2016, when the Patient was still at St. Luke's.

[3] Dr. Dammrose's May 16, 2016, report states: "The 02/04/2016 to 03/09/2016 inpatient stay is considered not medically necessary based for purposes of payment since no medical records are provided for those dates of service other than a note about insertion of a feeding tube on

On October 24, 2016, after the County submitted additional medical records, Dr. Dammrose amended his review, finding that "the additional clinical notes indicate the patient was medically stable on 02/12 and it appears she no longer needed the services of an acute care inpatient hospital." *See* AR at 33.

On November 16, 2016, after the receipt of additional physician's notes, Dr. Dammrose again amended his review, finding that the Patient "was medically stable on 02/19 and it appears she no longer needed the services of an acute care inpatient hospital." *Id.*

On February 6, 2017, St. Luke's participated in an appeal hearing regarding the denied dates of service. St. Luke's did not, and does not, dispute Dr. Dammrose's opinion that the Patient was sufficiently stabilized by February 19, 2016, such that, to the extent available, treatment at a lower level facility, rather than a short-term acute care hospital such as St. Luke's, was appropriate from a clinical standpoint. St. Luke's presented evidence of its substantial efforts, beginning in early February, to locate a more cost-effective medical facility equipped to provide the level of care required for the Patient. *See* AR at 313–25; Tr., p. 9. Importantly, there is no dispute that the Patient could not have been simply discharged home. *See* Tr., p. 34, ll. 19–22 ("[The Patient] no longer needed St. Luke's but did require a facility to provide her with a lower level of care of rehabilitative care before she could be discharged home."); Tr., p. 26, ll. 22–25 ("Both parties agree that [the Patient] . . . could not have been simply discharged to home[.]"); AR at 313. Therefore, the ability to provide the Patient with care at a lower level

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02/10." AR at 25. However, the record shows that St. Luke's submitted its medical records to the County on April 6, 2016. AR at 43. Included in those records, among other things, were the medical notes for dates of service February 3, 2016, to February 13, 2016. AR at 76–81. In particular, the notes submitted by St. Luke's included the notes from a chest X-ray conducted on February 13, 2016. AR at 81. Yet, according to Dr. Dammrose's report on November 16, 2016, those notes, including the notes from the chest X-ray conducted on February 13, 2016, were not provided to him until October 19, 2016. AR at 37 ("On 10/19 the County provided additional information . . . [which] indicated an improved chest X-ray on 02/13[.]").

facility depended entirely upon the willingness of an equipped facility to accept and admit the Patient.

Dr. Dammrose is a physician who provided only a clinical opinion that a lower level of care was appropriate from a clinical standpoint and none of his reports suggest that care at such a lower level facility was actually available to this Patient. *See* AR at 24–40. During the hearing, St. Luke's addressed at length the efforts it undertook to try to find a facility willing to accept the Patient without a payer source, and that it was only able to ultimately find such a facility upon agreement that St. Luke's actually paid for such care. Agency Tr., pp. 8–11. The County did not present any evidence suggesting or otherwise even claim that there was more cost-effective care actually available to treat the Patient. *See* Agency Tr., p. 14, l. 12 – p. 15, l. 4; p. 20, ll. 1–17; *see also generally*, Agency Tr., pp. 3–21. The County did not contend St. Luke's efforts to place the Patient at a different facility were not sufficiently diligent or otherwise inappropriate. *Id.* At the close of the hearing, counsel for the County acknowledged that St. Luke's had done what it should have done. *Id.*, p. 20, ll. 5–6 ("I don't think anybody in this room is saying, hey, they didn't . . . do what they should have done."). There was also no contention by the County that the Patient had failed to avail herself of available treatment at a lower cost facility. *See* Agency Tr., p. 14, l. 12 – p. 15, l. 4; p. 20, ll. 1–17; *see also generally*, Agency Tr., pp. 3–21. Nonetheless, without noting or even discussing the actual availability of a facility willing to provide ongoing care, the Board upheld the denial of treatment from February 19, 2016, to March 9, 2016. *See* Agency Tr., pp. 20–21. As such, even though it is clear the Patient is indigent, she would be legally responsible to pay the full bill for those dates of service.

After the hearing, the Board issued its Amended Determination of Approval for County Assistance ("Final Order"). AR at 11–13. In its Final Order, the Board does not include any

findings of fact or conclusions of law and does not specify or indicate why it was not approving dates of service from February 19, 2016, through March 9, 2016. *Id.* In fact, there is no mention of that date range at all or any reasons why those dates were not included in the approval. *Id.*

On review to the District Court, St. Luke's again argued that cost-effective care must actually be available to a patient before it can be considered when deciding what treatment is medically necessary under the Medical Indigency Act. R. at 21–28. St. Luke's also argued that the Board's decision was not based on the evidence in the record and was an abuse of the Board's discretion. R. at 6, 9, 10, 11, 14. Again, the County did not present any evidence or argue that there was actually any lower level of care available to this Patient. R. at 1–11. The District Court affirmed the Board. R. at 76–78.

II. ISSUES PRESENTED ON APPEAL

1. Whether the Board violated statutory provisions and exceeded its statutory authority in denying dates of service February 19, 2016, through March 9, 2016, where care at a lower cost facility was unavailable to the Patient.

2. Whether the Board's decision to deny dates of service February 19, 2016, through March 9, 2016, was based on substantial evidence and was arbitrary, capricious, or an abuse of discretion.

3. Whether St. Luke's rights have been prejudiced.

4. Whether St. Luke's is entitled to costs and attorney's fees.

III. STANDARD OF REVIEW

"A county's denial of an application for indigency benefits is reviewed under the Administrative Procedure Act, chapter 52, title 67, Idaho Code." *Sacred Heart Med. Ctr. v. Nez Perce Cnty. Comm'rs,* 138 Idaho 215, 216, 61 P.3d 572, 573 (2002). "Judicial review of an administrative order is limited to the record." *Shobe v. Ada Cnty. Bd. of Comm'rs,* 130 Idaho

580, 583, 944 P.2d 715, 718 (1997). Under the Administrative Procedure Act, an appellant is entitled to relief if the county's findings, inferences, conclusions or decisions were (1) in violation of statutory or constitutional provisions; (2) in excess of the statutory authority of the commissioners; (3) made upon unlawful procedure; (4) not supported by substantial evidence on the record as a whole; or (5) arbitrary, capricious, or an abuse of discretion. *Saint Alphonsus Reg'l Med. Ctr. v. Elmore Cnty.*, 158 Idaho 648, 650, 350 P.3d 1025, 1027 (2015) (quoting I.C. § 67-5279(3)).

On issues of law and statutory interpretation, an appellate court freely reviews the interpretation of a statute and its application to the facts. *See St. Luke's Reg'l Med. Ctr., Ltd. v. Bd. of Comm'rs of Ada Cnty.,* 146 Idaho 753, 755, 203 P.3d 683, 685 (2009). As to questions of fact, judicial review of an administrative order is limited to the record, and the reviewing court may not substitute its judgment for that of the administrative agency. *Application of Ackerman*, 127 Idaho 495, 903 P.2d 84 (1995).

A reviewing court may reverse the decision of the county only if the substantial rights of the appellant have been prejudiced. I.C. § 67-5279(4). Finally, "[i]f the agency action is not affirmed, it shall be set aside, in whole or in part, and remanded for further proceedings as necessary." I.C. § 67-5279(3).

IV. ARGUMENT

This case is largely a question of statutory interpretation. There is no question that the Patient was indigent and the underlying facts are undisputed. Tr., p. 25, ll. 24–25 ("As the parties have acknowledged, there's really no dispute of facts."); Tr., p. 34, ll. 11–13. The fundamental question for the Court to answer is as follows: Under the Medical Indigency Act, can the County appropriately deny the medical necessity of treatment to this Patient based upon the clinical appropriateness of care being delivered at a lower cost facility, when no lower cost

facility was willing to accept and treat the Patient. Given the plain language of the Act, the expressly stated policy behind the Act, and existing Idaho Supreme Court precedent, it should be readily apparent that only medical care that is actually available to the Patient should be considered by the Board in its medical necessity analysis. Accordingly, it is clear that the denied dates of service were compensable necessary medical services. It further follows that the Board exceeded its statutory authority by denying the Patient eligibility for those treatment dates and, by doing so, acted without a basis in substantial evidence and such action was arbitrary and capricious.

A. The Board Acted in Violation of Statutory Provisions and Exceeded Its Statutory Authority When It Denied the Dates of Service February 19, 2016, to March 9, 2016, as Being Not Medically Necessary.

Idaho Code Section 31-3502(18) is clear and unambiguous. It plainly requires medical services to be actually available when considering whether care is a necessary medical service. Further, even if it was ambiguous, the cannons of statutory interpretation dictate an interpretation that requires medical services to be actually available when determining whether services are necessary medical services.

1. The plain language of Idaho Code Section 31-3502(18) establishes that the denied dates of service were compensable necessary medical services and the Board acted in violation of statutory provisions and exceeded its statutory authority by denying compensation for those dates.

Statutory interpretation begins with "'the literal words of the statute, and this language should be given its plain, obvious, and rational meaning.'" *Seward v. Pac. Hide & Fur Depot*, 138 Idaho 509, 511, 65 P.3d 531, 533 (2003) (quoting *Jen-Rath Co. v. Kit Mfg. Co.*, 137 Idaho 330, 335, 48 P.3d 659, 664 (2002)). "If the statutory language is unambiguous, 'the clearly expressed intent of the legislative body must be given effect, and there is no occasion for a court to consider rules of statutory construction.'" *St. Luke's Reg'l Med. Ctr., Ltd.*, 146 Idaho at 755,

203 P.3d at 685 (quoting *Payette River Prop. Owners Ass'n v. Bd. of Comm'rs of Valley Cnty.*, 132 Idaho 551, 557, 976 P.2d 477, 483 (1999)).

A statute is ambiguous when:

> [T]he meaning is so doubtful or obscure that reasonable minds might be uncertain or disagree as to its meaning. However, ambiguity is not established merely because different possible interpretations are presented to a court. If this were the case then all statutes that are the subject of litigation could be considered ambiguous . . . . [A] statute is not ambiguous merely because an astute mind can devise more than one interpretation of it.

Jayo Dev., Inc. v. Ada Cnty. Bd. of Equalization, 158 Idaho 148, 152, 345 P.3d 207, 211 (2015) (quoting *Farmers Nat'l Bank v. Green River Dairy, LLC*, 155 Idaho 853, 856, 318 P.3d 622, 625 (2014)).

Here, the statutes at issue are unambiguously clear. Idaho Code Section 31-3503 provides: "**Powers and duties of county commissioners**. The county commissioners . . . shall . . . pay for *necessary medical services* of the medically indigent[.]" I.C. § 31-3503(1) (second emphasis added). "Necessary medical services" is defined in Idaho Code Section 31-3502(18). In its entirety, Section 31-3502(18) reads:

> (18) A. "Necessary medical services" means health care services and supplies that:
>
> (a) Health care providers, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms;
>
> (b) Are in accordance with generally accepted standards of medical practice;
>
> (c) Are clinically appropriate, in terms of type, frequency, extent, site and duration and are considered effective for the covered person's illness, injury or disease;

(d) Are not provided primarily for the convenience of the person, physician or other health care provider; and

(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury or disease.

B. Necessary medical services shall not include the following:

(a) Bone marrow transplants;

(b) Organ transplants;

(c) Elective, cosmetic and/or experimental procedures;

(d) Services related to, or provided by, residential, skilled nursing, assisted living and/or shelter care facilities;

(e) Normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care;

(f) Medicare copayments and deductibles;

(g) Services provided by, or available to, an applicant from state, federal and local health programs;

(h) Medicaid copayments and deductibles; and

(i) Drugs, devices or procedures primarily utilized for weight reduction and complications directly related to such drugs, devices or procedures.

The only issue addressed at the hearing before the Board and argument raised by the parties thereto, was whether care at a lower cost facility was clinically appropriate for this Patient and the availability of a facility willing to admit the Patient. *See generally* Agency Tr., pp. 3–21. Counsel and staff for the County appeared to be advocating the position that the availability of a facility willing and able to provide a lower level of care was immaterial under the Medical Indigency Act and that because Dr. Dammrose's clinical opinion was that a lower level of care was appropriate, the care provided by St. Luke's during the dates at issue was not medically

necessary regardless of whether lower level care was actually available. *Id.*; p. 20, ll. 1–14. The Board, however, failed to address the availability of care in its Final Order. AR at 11–13. Similarly, in the Order on Judicial Review, the District Court notes: "The Act defines 'necessary medical services' as services that are 'clinically appropriate' and 'the most cost-effective service' and shall not include 'services provided by, or available to, an applicant from state, federal and local health programs.' I.C. § 31-3502(18)." R. at 76–77. The District Court noted that the Patient was no longer in need of services at a short-term acute care hospital, but it did not address the impact of the unavailability of a lower cost facility willing to accept the Patient. *Id.* The failure to consider the actual availability of the care being considered for purposes of determining medical necessity under Section 31-3502(18) contradicts the plain language of the statute.

The plain language of Idaho Code Section 31-3502(18) clearly requires that only those services that are actually available to the Patient are to be considered when determining whether the services rendered "**[a]re** the most cost-effective." In pertinent part, subsection 18A(e) requires that necessary medical services: "**Are** the most cost-effective service or sequence of services . . . ." I.C. § 31-3502(18)A(e) (emphasis added). Thus, in order to be a "necessary medical service," the services being provided "are" to be the most cost-effective. The use of the affirmative verb "are" clearly indicates that the services rendered to the patient must be actual, rather than hypothetical or theoretical, services. There is no suggestion from this verb choice that the services to be considered are those that are merely potential, such as would be the case if the statute employed the words "would be." Rather, by using the affirmative "are," the statute plainly contemplates that the services to be considered are those actually available to be employed to produce the "therapeutic or diagnostic results for the person's illness, injury or

disease." *Id.* By its plain language, the statute requires that the necessary medical services "**[a]re** the most cost-effective service" available, not that the medical services "**[would be]** the most cost-effective service" if only such service was available. *Id.*

In the present case, it is undisputed that although the Patient no longer needed all the services of a short-term acute hospital, such as St. Luke's, the Patient could not be discharged to home and still required further treatment at an inpatient facility. *See* Tr., p. 34, ll. 19–22 ("[The Patient] no longer needed St. Luke's but did require a facility to provide her with a lower level of care of rehabilitative care before she could be discharged home."); Tr., p. 26, ll. 22–25 ("Both parties agree that [the Patient] . . . could not have been simply discharged to home[.]"); AR at 313; AR at 37 (noting that the Patient was still "considered unsafe for discharge"). It is also undisputed that there were no more cost-effective facilities that were able and willing to take the Patient until March 9, 2016.[4] Tr., p. 34, ll. 15–25.

Simply put, there is no question that the Patient still required necessary inpatient services from February 19, 2016, to March 9, 2016, and there is no question that St. Luke's was the **only** facility that could and would provide those services. *Id.*; Tr., p. 27, ll. 2–5; *see generally* Agency Tr., pp. 3–21 (County does not dispute that there were no other available facilities or suggest that there was a facility other than St. Luke's that was actually available to the Patient). Thus, while other facilities "**[would be]** more cost-effective," those facilities were not available to the Patient. In contrast, St. Luke's services were the **only** services available to the Patient, and therefore by definition they "**[a]re** the most cost-effective service." *See St. Joseph Reg'l Med.*

[4] This is true despite significant efforts by St. Luke's to transfer the Patient. *See supra* at pp. 2–3; AR at 316. Even on March 9, 2016, a facility was only willing to take the Patient because St. Luke's agreed to be financially responsible for the charges. *See* Agency Tr., p. 10, ll. 16–25; AR at 320–25.

Ctr. v. Nez Perce Cnty. Comm'rs, 134 Idaho 486, 490, 5 P.3d 466, 470 (2000) (holding that Idaho Code Section 18-3502(18)B(g) requires resources to be "actually available" to a patient before they can be considered as resources under the Medical Indigency Act).

Because there is no dispute that inpatient services were still medically appropriate, *see* Tr., p. 34, ll. 19–22; Tr., p. 26, ll. 22–25; AR at 313; AR at 37, and because there is no dispute that from February 19, 2016, to March 9, 2016, the only facility that would provide the needed treatment was St. Luke's, Tr., p. 34, ll. 15–25; Tr., p. 27, ll. 2–5; *see generally* Agency Tr., pp. 3–21, the services provided by St. Luke's "**[a]re** the most cost-effective service or sequence of services." As such, the services provided by St. Luke's were "necessary medical services" as defined under Idaho Code Section 31-3502(18).

Accordingly, because the dates of service from February 19, 2016, to March 9, 2016, were, by the plain language of Idaho Code Section 31-3502(18), necessary medical services, the Board was required to approve them for payment. I.C. § 31-3503(1) ("The county commissioners . . . *shall* . . . pay for necessary medical services of the medically indigent[.]" (emphasis added)); *Twin Falls Cnty. v. Idaho Comm'n on Redistricting*, 152 Idaho 346, 349, 271 P.3d 1202, 1205 (2012) ("The words 'must' and 'shall' are mandatory[.]"). By denying payment for the dates of service at issue, the Board violated the provisions of the Medical Indigency Act and thereby exceeded its statutory authority.

2. Even if Idaho Code Section 31-3502(18) is ambiguous, the cannons of statutory construction dictate an interpretation that would require medical services to be actually available when determining whether care is a necessary medical service.

Only when a statute is ambiguous will the court engage in statutory construction. *State v. Yzaguirre*, 144 Idaho 471, 476, 163 P.3d 1183, 1188 (2007) ("If the language of the statute is reasonably susceptible of only one interpretation, the statute is unambiguous and there is no

occasion to look beyond the text of the statute."). While St. Luke's, for the reasons stated above, believes the statute at issue is unambiguous, even if it was ambiguous, the result would be the same.

"If it is necessary for this Court to interpret a statute, the Court will attempt to ascertain legislative intent, and in construing a statute, may examine the language used, the reasonableness of the proposed interpretations, and the policy behind the statute." *St. Luke's Reg'l Med. Ctr., Ltd. v. Bd. of Comm'rs of Ada Cnty.*, 146 Idaho 753, 755, 203 P.3d 683, 685 (2009). Further, in interpreting a statute the court will look to "the whole act and every word therein" *Carrier v. Lake Pend Oreille Sch. Dist.*, 142 Idaho 804, 807, 134 P.3d 655, 658 (2006). "[A] statute is viewed as a whole and not in parts or sections, and is animated by its general purpose and intent. Consequently, each part or section should be construed in connection with every other part or section so as to produce a harmonious whole." *City of Idaho Falls v. H-K Contractors, Inc.*, ___ Idaho ___, 416 P. 3d 951, 956 (2018) (internal quote marks and citation omitted).

Applying these principles to Idaho Code Section 31-3502(18) leads to the conclusion that in order for a service to be considered the "most cost-effective service," that service must be actually available to the Patient.

a. Considering the statute as a whole.

When considered as a whole, it is apparent that the statute contemplates that when determining which services "**[a]re** the most cost-effective" only those that are actually available to the patient are to be considered. In reading Section 31-3502(18)A, it is notable that subparagraph (a) uses the words "would provide" to evaluate whether the choice of care accords with what other hypothetical health care providers would choose in that particular situation, i.e., the care must be in accordance with the standard of care. In contrast, the remaining subparagraphs in Section 31-3502(18)A all use the verb "are." This clearly indicates an intent by

the legislature to differentiate between the requirement that the care must be what a hypothetical care provider "would provide" to a patient given the circumstances, and the requirement that the services actually available and provided to the patient: "(b) **[a]re** in accordance with generally accepted standards of medical practice"; "(c) **[a]re** clinically appropriate . . . ; "(d) **[a]re** not provided primarily for [ ] convenience . . . ; and "(e) **[a]re** the most cost-effective." I.C. § 31-3502A(a)–(e).

Additionally, when one considers other parts of the Medical Indigency Act, it becomes even more clear that actual availability of the services is required. Idaho Code Sections 31-3503(2), 31-3503A(2), and 31-3507 recognize the interest a county and the board of the catastrophic health care cost program ("Cat Board") have in the availability and willingness of facilities to treat indigent county residents. Sections 31-3503(2) and 31-3503A(2) authorize counties and the CAT Board to contract with medical facilities to provide indigent care. Section 31-3507 actually empowers a county or the CAT Board to transfer a patient to a different facility within certain parameters that include the availability of care at the transferee facility. That is, Section 31-3507 explicitly requires that before the county or Cat Board can require the transfer of a medically indigent patient, the requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTLA") must be met and the "necessary medical service *must be available*" at the receiving facility. I.C. § 31-3507 (emphasis added). The EMTLA provisions provide: "[a]n appropriate transfer to a medical facility is a transfer . . . in which the receiving facility (i) has available space and qualified personnel for the treatment of the individual, and (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment." 42 U.S.C. § 1395dd(c)(2). Thus, before a medically indigent patient, such as the Patient here, can be transferred to another facility there must be a facility that is *actually*

available and willing to receive the patient and can *actually* provide the necessary treatment. It necessarily follows that when considering whether services "**[a]re** the most cost-effective," the services must be actually available to the patient.

Finally, as will be addressed in more depth below, it is notable that in interpreting a subsection of the same statute at issue here, this Court stated, "only those resources *actually available* to an applicant can be considered for purposes of eligibility for medical indigency benefits." *St. Joseph Reg'l Med. Ctr. v. Nez Perce Cnty. Comm'rs*, 134 Idaho 486, 490, 5 P.3d 466, 470 (2000) (emphasis added) (interpreting Idaho Code Section 31-3502(18)B(g)).

Thus, when viewed as a whole, the statute clearly contemplates that only those services that are *actually available* to the Patient should be considered when determining whether services "**[a]re** the most cost-effective service or sequence of services[.]"

b. Considering legislative intent.

Such an interpretation is also consistent with the intent and purpose of the Medical Indigency Act. "[T]he legislature's intent in enacting the medical indigency assistance statutes was two-fold: to provide indigents with access to medical care and to allow hospitals to obtain compensation for services rendered to indigents." *Univ. of Utah Hosp. v. Ada Cnty.*, 143 Idaho 808, 810, 153 P.3d 1154, 1156 (2007) (quoting *Carpenter v. Twin Falls Cnty.*, 107 Idaho 575, 582, 691 P.2d 1190, 1197 (1984)). The County's interpretation of the requirements of Section 31-3502(18) directly conflicts with that purpose.

Utilizing hypothetical services, rather than actually available services, to determine that care is not compensable undermines the intent of the Medical Indigency Act. That is, doing so would result in a provider being faced with the choice of either: (1) discharging a patient home before they are clinically approved for discharge, or (2) continuing to treat the indigent patient without any compensation. In either scenario, one of the purposes of the Medical Indigency Act

is frustrated. Either the indigent patient is denied access to medical care by being discharged to home before they are clinically approved; or, the provider is deprived of its right to compensation for medical services rendered to an indigent patient (and in fact incurs additional expenses). The legislature did not intend such results.

Furthermore, the first choice outlined above is not a choice St. Luke's could ethically or legally make as it could jeopardize the life of the patient. This leaves the second, and only real choice, as the only viable option, which results in the provider being denied compensation and incurring additional expense, a scenario expressly against the fundamental policy behind the statute. *See* I.C. § 31-3501 (stating that part of the intent of the Medical Indigency Act is to "provide for the payment" of medical services rendered to the medically indigent). Indeed, in this case, not only was St. Luke's denied compensation for nearly three weeks of medical services to an indigent patient, but St. Luke's ended up contracting to pay for the Patient's care at Life Care as a condition to transfer the Patient. Agency Tr., p. 10, ll. 16–25; AR at 320–25.

That this was not the legislature's intent is further borne out by the fact that the legislature recognized the issue of ensuring cost efficiency and saw fit to grant counties and the Cat Board the right to "contract with providers, transfer patients, [and] negotiate provider agreements." I.C. §§ 31-3503(2); 31-3503A(2). In other words, the County and the Cat Board have the statutory right to contract with providers to ensure that circumstances such as those that have occurred in this case are minimized or eliminated.

The purpose of the Medical Indigency Act is to ensure that indigent patients receive the necessary medical care they need and to ensure that providers receive payment for medical care provided to indigent residents. The legislature has provided counties with ample authority to ensure that treatment is provided in a cost-effective manner. Interpreting Idaho Code Section

31-3502(18) to allow the County to deny payment based on hypothetical, rather than actually available services, is inconsistent with the Medical Indigency Act's purpose.

c. Reasonableness of proposed constructions.

Although absurdity has no bearing on a statute's plain language, *Verska v. Saint Alphonsus Reg'l Med. Ctr.*, 151 Idaho 889, 896, 265 P.3d 502, 509 (2011), when engaging in statutory interpretation this Court has held that absurd results are disfavored. *Stonebrook Const. LLC v. Chase Home Fin., LLC*, 152 Idaho 927, 932, 277 P.3d 374, 379 (2012) ("Statutory constructions that would lead to absurd . . . results are disfavored.").

Here, if Idaho Code Section 31-3502(18) were interpreted to allow hypothetical or theoretical services, rather than services actually available to a patient, to be considered in determining whether services rendered "**[a]**re the most cost-effective" it would lead to absurd and unreasonable results. The facts of this case present the scenario where a lower cost facility was unavailable because the facility was not willing to accept the Patient based upon the lack of funding. However, there could be other reasons a lower cost facility would not be available to a patient that would yield equally absurd results. For example, if the statute were interpreted as the County suggests, even facilities that are not in operation in Idaho would have to be considered in the medical necessity analysis. As an illustration, in the continuum of medical care, long-term acute care hospitals were not in operation in Idaho until fairly recently.[5] Moreover, there are numerous other specialty type treatment facilities available nationally or internationally that are still not available in Idaho. Yet, under the County's interpretation of the statute, these out-of-

[5] Southwest Idaho Advanced Care Hospital and Complex Care Hospital of Idaho were not formed as entities until November 2006 and November 2007, respectively. *See* Idaho Secretary of State website, Viewing Business Entity, Southwest Idaho Advanced Care Hospital, Inc., *available at* https://www.accessidaho.org/public/sos/corp/C169997.html; *id.* Complex Care Hospital of Idaho, *available at* https://www.accessidaho.org/public/sos/corp/D117065.html.

state specialty hospitals, although clearly unavailable to the patient, would have to be considered in determining whether the care was the "most cost-effective service" that *could* possibly be rendered to the patient.

Another basis that treatment may not be available at a lower cost facility could be bed availability. That is, a county medical advisor could say a patient is clinically appropriate for a lower level of care, but no appropriate facility has capacity to accept the patient. Indeed, this Court directly addressed the issue of bed availability in *St. Joseph Regional Medical Center v. Nez Perce County Commissioners*, 134 Idaho 486, 5 P.3d 466 (2000). In that case, the county denied payment to a provider because care was, in theory, available at a state psychiatric facility. *Id.* at 489–90, 5 P.3d at 469–70. However, the facts of the case revealed that there were no beds actually available at the state psychiatric facility. *Id.* at 490, 5 P.3d at 470. This Court held that because there were no actual beds available for the patient, the state psychiatric facility could not be considered a resource under Idaho Code Section 31-3502(18). *Id.* Ignoring the reality that a lower cost facility is unavailable in the medical necessity analysis would lead to absurd results that would undermine the expressly stated purpose of the statute.

Accordingly, because when the statute is read as a whole, and because it would frustrate the intent of the Medical Indigency Act and lead to an absurd result otherwise, even if the Court determines that the statute is ambiguous, it should be interpreted to mean that only those services that are actually available to the patient should be considered when determining whether the services rendered "**[a]**re the most cost-effective" under Idaho Code Section 31-3502(18)A(e).

Such an interpretation would lead to the same result as discussed above, *see supra* Part IV.A.1, and by denying payment for the dates of service at issue, the Board violated the

statutory power and duty granted it under the Medical Indigency Act and thereby exceeded its statutory authority.

B. The Board's Decision Was Unsupported by Substantial Evidence on the Record and Was Arbitrary, Capricious, and an Abuse of Discretion.

"Evidence is substantial and competent only if a reasonable mind might accept such evidence as adequate to support a conclusion. To establish whether an agency's action is supported by substantial and competent evidence, this Court must determine whether the agency's findings of fact are reasonable." *Cooper v. Bd. of Prof'l Discipline of Idaho State Bd. of Med.*, 134 Idaho 449, 456, 4 P.3d 561, 568 (2000) (internal quotation marks and citations omitted). Accordingly, "[a] finding of fact without any basis in the record [is] clearly erroneous." *Dovel v. Dobson*, 122 Idaho 59, 62, 831 P.2d 527, 530 (1992) (citations omitted). "Also, a finding of fact lacking substantial and competent evidence to support it is clearly erroneous." *Id.* In order to uphold the County's decision under the clearly erroneous standard, the Court must conclude that the record contains "some reliable, probative, and substantial evidence in support of its position." *Idaho Cnty. Nursing Home v. Dep't of Health & Welfare*, 120 Idaho 933, 940, 821 P.2d 988, 995 (1991).

In *St. Joseph, supra*, the county denied an application because it found that the patient *could have* received care at lower cost facilities such as a state psychiatric facility or alcohol treatment through Port of Hope and Roger's Counseling Center rather than at an acute psychiatric hospital where the treatment took place. 134 Idaho 486, 5 P.3d 466 (2000). Relying upon the affidavit testimony of a state mental health program manager to that effect, the county applied the clinical assessment to the definition of "necessary medical services" and determined that because the services the patient had received at the acute psychiatric hospital were "available to" the patient "from state, federal and local health programs," the services rendered at the

hospital were not "necessary medical services" and therefore denied payment. *Id.* at 489–90, 5 P.3d at 469–70.

However, the factual record in *St. Joseph* revealed that a voluntary bed at the state psychiatric hospital was not available to the patient and that as soon as follow-up treatment could be arranged through Roger's Counseling Center, a lower cost facility, the patient was transferred. *Id.* at 490, 5 P.3d at 470. The Court outlined the efforts by the hospital therein to transfer the patient and the unavailability of a facility to take the patient until the transfer ultimately took place. *Id.* Based upon these facts, on appeal to the District Court, the District Court "dismantled the Board's finding that other resources were available to [the patient]" and determined that "none of the documentation upon which the Board based its decision provided any details as to ***whether specific services were actually available*** to [the patient]." *Id.* This Court noted that the District Court's reasoning was "in accord with authority prescribing that only those resources *actually available* to an applicant can be considered for purposes of eligibility for medical indigency benefits," and reversed the Board. *Id.* (emphasis added). The Court then went on to state that because the only evidence in the record was that the facilities identified by the county as "available" to take the patient were not *actually* available to take the patient, the evidence did not support the county's denial. *Id.*

The same is true here. The Board denied the dates of service from February 19, 2016, through March 9, 2016, because Dr. Dammrose, like the mental health program manager in *St. Joseph*, submitted a report that indicated that the Patient did not need the services of an acute care hospital and *could have* received care at a lower level facility. AR at 38. However, like in *St. Joseph*, it is clear that although St. Luke's pursued those alternative care options at other facilities, none of the other facilities were actually available to the Patient during the time period

at issue. Tr., p. 27, ll. 2–11. Then, again like in *St. Joseph*, as soon as a lower level of care became available (and only because St. Luke's agreed to pay the Patient's bill) the Patient was transferred. *Id.* Just like in *St. Joseph*, there is no evidence in the record that care at a lower level facility was available to the Patient at any time before March 9, 2016. Indeed, the County does not even allege the actual availability of a facility willing to provide a lower level of care and in fact admits that St. Luke's did what it should have. *See generally* Agency Tr., pp. 3–21 (County does not dispute that there were no other available facilities or suggest that there was a facility other than St. Luke's that was actually available to the Patient); Agency Tr., p. 20, ll. 4-6.

Like in *St. Joseph*, the Board's decision to deny service for the dates at issue was not supported by the evidence in the record. As a result, the Board's decision was arbitrary, capricious, and an abuse of discretion. This case should accord with the holding in *St. Joseph*. The Court should reverse the County's denial of dates of service February 19, 2016, through March 9, 2016, because the only evidence in the record is that the more "cost-efficient" care identified by the County was not *actually* available to the Patient.

C. St. Luke's Substantial Rights Have Been Prejudiced.

The Medical Indigency Act grants hospital providers the right to compensation for providing necessary medical care to indigent patients. *Univ. of Utah Hosp. v. Ada Cnty.*, 143 Idaho 808, 810, 153 P.3d 1154, 1156 (2007) ("[T]he legislature's intent in enacting the medical indigency assistance statutes was two-fold: to provide indigents with access to medical care and to allow hospitals to obtain compensation for services rendered to indigents." (quoting *Carpenter v. Twin Falls Cnty.*, 107 Idaho 575, 582, 691 P.2d 1190, 1197 (1984))); *St. Luke's Magic Valley Reg'l Med. Ctr., Ltd. v. Bd. of Cnty. Comm'rs of Gooding Cnty.*, 150 Idaho 484, 488, 248 P.3d 735, 739 (2011) ("[T]he Medical Indigency Act was meant to ensure that hospitals obtain actual compensation for the care provided to indigent patients.").

Here, there is no question that the Patient was indigent. Tr., p. 34, ll. 10–13. By denying compensation for dates of service February 19, 2016, to March 9, 2016, when the only evidence in the record was that the Patient could not be discharged home and St. Luke's was the only provider that was actually available to provide the necessary services to the Patient, the Board violated St. Luke's right to compensation for providing necessary medical services to an indigent patient. By depriving St. Luke's of its statutory right to compensation, St. Luke's substantial rights have been prejudiced. *See generally, e.g., St. Luke's Magic Valley Reg'l Med. Ctr., Ltd.*, 150 Idaho 484, 248 P.3d 735 (noting in the standard of review that a substantial right must be prejudiced to overturn the Board's decision and then proceeding to overturn the Board's decision to deny the provider compensation because the Board's decision was contrary to the Medical Indigency Act).

D. St. Luke's Is Entitled to Reasonable Attorney's Fees.

St. Luke's requests attorney's fees on appeal pursuant to Idaho Code Section 12-117(1), which provides that "the court shall award the prevailing party reasonable attorney's fees, witness fees and reasonable expenses, if the court finds that the party against whom the judgment is rendered acted without a reasonable basis in fact or law." I.C. § 12-117(1). A party acts without a reasonable basis in fact or law when it "has no authority to take a particular action." *Univ. of Utah Hosp. v. Ada Cnty.*, 143 Idaho 808, 812, 153 P.3d 1154, 1158 (2007) (quoting *Fischer v. City of Ketchum*, 141 Idaho 349, 356, 109 P.3d 1091, 1098 (2005)).

As the foregoing clearly demonstrates, the County had no authority or evidence to support denial of the dates of service February 19, 2016, through March 9, 2016. Not only does the application of undisputed facts to the plain language of the statute demonstrate error, but a well-established medical indigency decision by the Idaho Supreme Court directly addresses the impropriety of denial based on more cost-effective service options without corresponding

evidence that such options were "actually available" to a patient. St. Luke's presented ample undisputed evidence that the services Dr. Dammrose references were not actually available until March 9, 2016. There was no evidence in the record, or even an allegation by the County, that services at a lower level facility were actually available to the Patient. The Board's decision had no basis in law or fact. Accordingly, St. Luke's respectfully requests an award of costs and attorney's fees.

V. CONCLUSION

Idaho Code Section 31-3502(18) requires that services be actually available before they can be considered in determining whether services provided to a patient "**[a]**re the most cost-efficient services[.]" The only argument presented by the County at the hearing before the Board was that the denial of the Patient's treatment for dates of service February 19, 2016, through March 9, 2016, was because the services provided were not the "most cost-effective services[.]" While St. Luke's does not dispute that care at a lower level facility would have been appropriate from a clinical standpoint, the undisputed evidence before the Board demonstrated that care at a lower level facility was not actually available to this Patient. Because St. Luke's services were the only services actually available to the Patient, they were, by definition, the most cost-effective. As such, those services met the statutory definition of necessary medical services and St. Luke's has a right to be compensated for those services. The County's denial of the dates of service at issue was a violation of statutory provisions and exceeded its statutory authority. Further, it is clear that the Board acted without a basis in substantial evidence and in an arbitrary and capricious manner.

St. Luke's, therefore, requests that the Court award its costs and attorney's fees and vacate the decision of the District Court and remand this matter to the District Court with

instructions to remand to the Board for approval of payment for dates of service February 19, 2016, through March 9, 2016.

DATED THIS 30th day of May, 2018.

HAWLEY TROXELL ENNIS & HAWLEY LLP

By _____
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 30th day of May, 2018, I caused to be served a true copy of the foregoing APPELLANT'S OPENING BRIEF by the method indicated below, and addressed to each of the following:

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