7-18-2018

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

IN THE SUPREME COURT OF THE STATE OF IDAHO

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

# APPELLANT'S REPLY BRIEF

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

Honorable George A. Southworth, District Judge, Presiding

Mark C. Peterson, ISB No. 6477
William K. Smith, ISB No. 9769
HAWLEY TROXELL ENNIS & HAWLEY LLP
877 Main Street, Suite 1000
P.O. Box 1617
Boise, Idaho 83701-1617
Telephone: 208.344.6000
Facsimile: 208.385.5384
Email: mpeterson@hawleytroxell.com
wsmith@hawleytroxell.com

Attorneys for Petitioner/Appellant

Tahja Jensen
GEM COUNTY PROSECUTING ATTORNEY'S OFFICE
306 E. Main St.
P.O. Box 671
Emmett, Idaho 83617
Telephone: 208.365.2106
Facsimile: 208.365.9411

Attorneys for Defendant/Respondent

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## I. INTRODUCTION

The only issue before the Court is whether services must be *actually available* at a facility willing to accept and provide needed care to the Patient before those services can be considered in determining what services "**are** the most cost-effective." The Board of Commissioners of Gem County (the "County" or "Board") has interpreted the Medical Indigency Statutes as requiring it to deny the Patient assistance because Dr. Dammrose, a medical expert for the County, expressed a clinical opinion that the Patient *could have theoretically* (but not actually) been transferred to a lower cost facility at a certain point. The County argues that it is bound by Dr. Dammrose's opinion and that Idaho law does not require any consideration as to the availability of care when determining whether the services provided to the Patient were the most cost-effective under Idaho Code Section 31-3502(18)A(e).

It is the purview of this Court to interpret Idaho law. Common sense, the language of the statutes, as well as this Court's existing precedent, plainly require that the availability of alternative treatment must be considered in determining whether the services provided were the most cost-effective under Section 31-3502(18)A(e).

## II. STATEMENT OF FACTS

As noted in St. Luke's opening brief, the underlying facts of this case are undisputed. Appellant's Opening Brief ("App. Op. Br.") at 2; Tr., p. 25, LL. 24–25 ("As the parties have acknowledged, there's really no dispute of facts."). However, the County makes certain allusions, and in some cases certain direct statements, that are incompatible with the facts of the case. St. Luke's rebuts those assertions below.

### A. Response to Respondent's Statement of Facts.

The County argues that "[i]t is uncontroverted that the dates of care denied by the County were not the most cost-effective service." Resp't Br. at 5. This assertion, as well as others the County makes in its Respondent's Brief, has no factual basis in the record. The care denied by the County ***was*** the most cost-effective service because it is uncontroverted that such service was the ***only*** service actually available to the Patient.

On January 26, 2016, the Patient was admitted to St. Luke's in critical condition. She was found unconscious at her home and transported to St. Luke's where she was emergently treated for brain lesions and meningitis. AR at 318; Agency Tr., p. 4, LL. 6–17. By February 19, 2016, the Patient was medically stable enough that from a clinical standpoint she no longer required the services at the level of a short term acute care hospital like St. Luke's. Tr., p. 26, LL. 22–25. It is undisputed, however, that the Patient "could not have been simply discharged home given her medical condition." *Id.* It is further undisputed that from February 19, 2016, to March 9, 2016, St. Luke's was the ***only*** facility that was available and willing to treat the Patient. *See* App. Op. Br. at 2–3, 12 & n.4; AR at 313, 316–17; Tr., p. 27, LL. 2–5. Thus, despite the County's unsupported assertion otherwise, the care provided by St. Luke's from February 19, 2016, to March 9, 2016, ***was*** the most cost-effective service because it was the ***only*** care actually available to the Patient.

Next, the County asserts that at the appeal hearing before the Board, one of the Commissioners asked St. Luke's whether the care offered from February 19, 2016, to March 9, 2016, was billed by St. Luke's at the higher care rate. Resp't Br. at 2. The County then states that "[t]he hospital admitted that there was less care provided but did not offer a reduced rate."

*Id.* This statement of fact by the County is incorrect. Indeed, the exchange cited to by the County actually reveals the opposite:

> Comm. Elliott: Yeah. I just have a question of interest. So during the 20 days that [the Patient] did not need the higher rate of care, was that care still administered at that rate and was it billed at that rate?
>
> . . . .
>
> Mr. Peterson: So, to answer your question, certainly the charges were less than prior[.]

Agency Tr., p. 17, L. 6 – p. 18, L. 3.

The Commissioner then goes on to acknowledge that the care provided during the dates in question was provided at a lower charged amount than when the Patient was in the ICU, and queries whether the amount charged by St. Luke's was "close to matching" the amount that would have been charged by Life Care. *Id.*, p. 18, LL. 4–5. St. Luke's counsel responded that he was unfamiliar with Life Care's charges but acknowledged that Life Care was a lower cost facility than St. Luke's. *Id.*, p. 18, LL. 6–22. St. Luke's, as it did before the Board, acknowledges that the cost of care it provided the Patient cost more than the care the Patient would have received at a lower cost facility if such a facility would have been available to the Patient. However, an acknowledgment that an acute care hospital like St. Luke's is more costly than Life Care is markedly different from the County's assertion that St. Luke's did not lower the charges—St. Luke's clearly lowered the charges when the Patient's care became less intensive. *See* Agency Tr., p. 17, L. 6 – p. 18, L. 3.

The County also alludes throughout its brief that St. Luke's "decided" to "keep" the Patient at its facilities. In particular, the County asserts that placement at Life Care "could have

been, and in fact should have been, entered into in February. A lower level of care could have been achieved much sooner and much more cost effectively as reiterated by Dr. Dammrose." Resp't Br. at 7–8. The County further asserts that "St. Luke's seeks to be paid for their decision not to transfer the Patient to a lower level of care at the time that it was appropriate," *id.* at 11, and that "St. Luke's kept the Patient in its acute care facility for twenty (20) days beyond the point where the Patient no longer required that level of care." *Id.* at 12. The suggestion from these statements is that St. Luke's somehow made a deliberate decision to retain the Patient out of some sort of financial motivation. Such an assertion is patently false and is unsupported by the factual record. Notably, the County provides no citations to the record for these incorrect factual assertions.

It is important to note that there is no dispute that the Patient could not be discharged home. *See* Tr., p. 26, LL. 22–25 ("Both parties agree the [Patient] . . . could not have been simply discharged home."). Further, the record clearly shows that St. Luke's made extensive efforts to place the Patient in a lower cost facility as soon as possible. App. Op. Br. at 2–3; AR at 316. The reality is that the only facility willing to provide the ongoing care to the Patient was St. Luke's. *Id.* In fact, the only reason why such a placement was ultimately successful was because St. Luke's agreed to pay for the Patient's charges at a different facility. *See* Agency Tr., p. 10., LL. 16–25; AR at 320–25. Indeed, in the hearing before the Board, counsel for the County acknowledged that St. Luke's acted appropriately. Agency Tr., p. 20, LL. 5–6. Additionally, at no point did Dr. Dammrose opine that there was a facility willing to provide the lower level of care noted in his report. Dr. Dammrose gave a medical opinion about when the Patient was clinically stable enough to be transferred to a lower level of care. He did not opine

that there was such a facility willing to accept transfer of the Patient and provide the ongoing care that the Patient still needed. AR at 24–39.

Finally, and most importantly, the only evidence in the record is that while St. Luke's made multiple efforts to transfer the Patient, there were simply no lower cost facilities willing to accept the Patient, due primarily to the lack of any confirmed health insurance or other funding source. *See* App. Op. Br. at 2–3, 12 & n.4; AR at 313, 316–17. This is a fact not disputed by the Board in its findings. AR at 11–13. This is also a fact acknowledged, and undisputed, by Dr. Dammrose: "Due to her lack of insurance she was said to have no viable option for care." AR at 37. Thus, despite the County's allusions to the contrary, St. Luke's did not "decide to keep" this uninsured Patient at its facilities in lieu of transferring her to a lower cost provider. Rather, the facts clearly demonstrate that St. Luke's attempted to transfer the Patient as soon as possible and even went as far as to pay for the Patient's care at a different provider in order to facilitate the transfer sooner. *Id.*

The facts are undisputed. Although the Patient no longer required the level of care available at a short term acute care facility like St. Luke's, she still needed inpatient care and could not be discharged home. *See* Tr., p. 34, LL. 19–22; Tr., p. 26, LL. 22–25. However, there were no lower level care facilities that would accept the transfer of the Patient. *See* App. Op. Br. at 2–3, 12 & n.4; *see also* AR at 313. Simply put, from February 19, 2016, to March 9, 2016, St. Luke's was the only facility willing to provide the care the Patient needed. *Id.* Any assertion or allusion that St. Luke's made a "decision to keep" the Patient beyond February 19, 2016, or that the Patient "could have been" transferred before March 9, 2016, is wholly unsupported by the facts in the record and is not a finding of fact that was made by the Board.

## III. ARGUMENT

The only question before the Court is whether services at a lower cost facility must be actually available to the Patient before they can be considered in determining whether the services provided to the Patient "**are** [sic] the most cost-effective" under Idaho Code Section 31-3502(18) A(e). The County argues that the actual availability of services at a facility willing to provide the care has no impact on whether the services provided to a patient "are the most cost-effective" services available. Further, the County argues that if actual availability is considered, there would be no limitation on what services hospitals could be compensated for. For the reasons discussed below, both of these arguments fail.

### A. The County Did Not Correctly Apply Idaho Code Section 31-3502(18) and Therefore Acted in Violation of Statutory Provisions and Exceeded Its Statutory Authority.

In arguing that the County correctly applied Idaho Code Section 31-3502(18), the County asserts three basic points: (1) the language of the statute does not require the County to consider actual availability of care at a facility and it is not the County's responsibility to provide alternative care; (2) the County is bound by what Dr. Dammrose opines; and (3) the Court should not consider a case that interpreted a subsection of the same statute at issue here.

#### 1. The language of Section 31-3502(18)A(e) clearly requires that only those services at a facility that are actually available to the Patient be considered when determining medical necessity.

As an initial note, the County does not provide any authority for this sub-argument. *See* Resp't Br. Part A.1 at 7–8 (providing no citation to any cases, statutes or other relevant authority). As such, the Court may disregard the County's arguments made under this section. *See Idaho Power Co. v. Idaho Dep't of Water Res.*, 151 Idaho 266, 278, 255 P.3d 1152, 1164

(2011) (declining to address issues raised by a respondent when respondent failed to support its argument with legal authority or argument as required by I.A.R. 35(b)(6)); *State v. Nickel*, 134 Idaho 610, 613 n.3, 7 P.3d 219, 222 n.3 (2000) (same).

Moreover, the entirety of the County's argument in this regard is: "If the legislature wanted to require the County to consider whether alternative service **are** actually available to the hospital . . . they could have put that in the statute." Resp't Br. at 7 (emphasis in original). However, the legislature did just that. Idaho Code Section 31-3502(18)A(e) requires that the services rendered "**are** the most cost-effective service or sequence of services[.]" I.C. § 31-3502(18)(e) (emphasis added). As detailed in St. Luke's Opening Brief, the use of the affirmative verb "are" clearly indicates a requirement that the services considered must be those actually available to the Patient. *See* App. Op. Br. at 8–13. The County offers no rebuttal to this argument. Further, even if the use of the affirmative verb "are" was ambiguous, the statute should be interpreted to require that the services considered are actually available to the Patient in order to serve the clearly stated policy of the Medical Indigency Statutes. *See id.* at 13–19. The County offers no rebuttal to this argument either.

Instead, the County attempts to divert the Court's attention by making the unfounded assertion that the Patient could have been transferred "much sooner and much more cost effectively." Resp't Br. at 8. As detailed above, there is absolutely no factual support in the record for this assertion. *Supra*, Part II.A. The uncontroverted facts show that while Dr. Dammrose noted that a lower level of care was clinically appropriate, no lower level care facilities were actually available to the Patient during the dates in question and only became available when St. Luke's transferred the Patient to a facility willing to accept the transfer based

upon St. Luke's voluntarily agreeing to pay for the Patient's treatment. *See* App. Op. Br. at 2–3, 12 & n.4. St. Luke's was under no statutory obligation to agree to pay for the Patient's treatment at another facility. Nowhere in the Medical Indigency Statutes is a provider required to pay for the necessary medical services of indigent patients. *See* I.C. § 31-3501 *et seq.* Conversely, the purpose of the Medical Indigency Statutes is 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)). By statute, the cost of providing medical services to indigent patients falls on the counties. I.C. § 31-3501 (noting that one of the purposes of the Medical Indigency Statutes is to "provide for the payment" of medical services provided to the indigent); I.C. § 31-3503(1) ("The county commissioners . . . shall . . . pay for necessary medical services for the medically indigent[.]").

The County cannot escape this statutory responsibility by claiming that because certain services at a more cost-effective facility were theoretically (but not actually) available to the Patient, the services rendered by St. Luke's were not medically necessary. To do so not only defies logic (by default, the only services available **are** the most cost-effective), but also places the statutory burden clearly intended for the County onto the providers. The County's argument that St. Luke's was somehow responsible for ensuring that the Patient's medical services were paid for is unsupported by authority and is contrary to the clear language and policy of the Medical Indigency Statutes.[1]

[1] The County's argument that hospitals would have no financial motivation for lowering a patient's level of care because "they would receive compensation for the higher levels of care whether that care was necessary or not," Resp't Br. at 8, is also unfounded. Clearly, the care

### 2. The County is not required to follow Dr. Dammrose's legal opinion and, in any event, Dr. Dammrose did not opine on the availability of lower cost services.

The County attempts to escape liability for payment of the Patient's medical services by arguing that the Board cannot authorize payment for "any service that utilization management has determined to be 'not medically necessary.'" Resp't Br. at 9. In essence, the County argues that, because Dr. Dammrose provided a clinical opinion that the Patient was suitable for a lower level of care as of February 19, 2016, the County was bound by Dr. Dammrose's opinion and could not authorize payment for the dates in question. *Id.* at 8–9. In support of this argument, the County cites Idaho Code Section 31-3505B. *Id.*

However, Idaho Code Section 31-3505B clearly states that the determination of necessary medical services rests with the County. Section 31-3505B states: "The county commissioners shall approve an application . . . *if it [i.e., the County]* ***determines*** *that necessary medical services have been or will be provided to medically indigent resident*[.]" (Emphasis added.) The statute clearly states that the County is responsible for making a determination of medical necessity. It does not say an application shall be approved or denied based on the medical advisor's legal conclusion regarding medical necessity. That the Board, not the medical advisor, is responsible for making legal findings and conclusions regarding medical necessity is further

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provided must be medically necessary. I.C. § 31-3503(1) (providing that the Board only has the power to "pay for necessary medical services of the medically indigent[.]"). Medical necessity requires that the services rendered "**are** the most cost-effective." I.C. § 31-3502(18)A(e). Accordingly, if a hospital retained a patient at a higher level of care when lower cost services were medically appropriate and available, the hospital would not be entitled to compensation. For example, here, had lower cost services actually been available to the Patient during the dates in question, St. Luke's would not be entitled to compensation. However, that is not the case—it is undisputed that services at a lower cost facility were not available to the Patient during the dates in question—and the County's hypothetical and hyperbolic assertions otherwise do not change the reality of these facts.

buttressed by the fact that it is the County that is responsible for ruling on applications, not the medical advisor. *See* I.C. § 31-3505C ("[T]he **county commissioners** shall make an initial determination to approve or deny an application . . . .") (emphasis added).

Moreover, Idaho Code Section 31-3505F explicitly provides: "In the event that a **county determines** that service is not a necessary medical service, a provider may submit the issue to a panel for arbitration [.]" (Emphasis added.) This is a clear statement that the Board, not the medical advisor, is to make the determination of whether a service is a necessary medical service. Section 31-3505F continues by outlining the arbitration processes, which includes review of the County's determination of medical necessity by three qualified medical professionals, and states: "No party shall be obligated to comply with or otherwise be affected or prejudiced by the proposals, conclusions or suggestions of the panel . . . however in the **interest of due consideration being given to such proceedings** . . . the applicable statute of limitations shall be tolled" while the claim being arbitrated and for thirty (30) days after. I.C. § 31-3505F(2) (emphasis added). This statement by the legislature makes it clear that a county can give "due consideration" to a decision by the panel despite any prior medical advisor opinion. Put another way, if the County was bound to follow the medical advisor's opinion, there would be no need for the legislature to provide for an arbitration panel or for the County to give "due consideration" to any decision by the panel because the County would already be strictly bound by the medical advisor's opinion.

The County's argument that the Board does not have the ability to make findings and draw conclusions regarding medical necessity independent of its medical advisor's clinical opinion is simply unsupported by the relevant authority. It should go without saying that

Dr. Dammrose is not a legal expert and his interpretation of the Medical Indigency Statutes is not binding on the Board.

Furthermore, Dr. Dammrose did not say that services at a lower level facility were actually available to the Patient. Indeed, he did not dispute that the Patient's lack of insurance created no viable alternative facility option. AR at 37. He noted that various facilities declined to accept transfer of the Patient. AR at 36–38. Dr. Dammrose only offered his clinical opinion that services at an acute care hospital like St. Luke's, from February 19, 2016, to March 9, 2016, were not necessary from a clinical standpoint and that care at a lower level facility would have been clinically appropriate. *Id.* Specifically, he determined that "the patient was medically stable on 02/19 and it appears she no longer needed the services of an acute care hospital," and "[h]er medical care was at maintenance level, and her needs were rehabilitative in nature." AR at 38. St. Luke's does not dispute those clinical opinions. Missing, however, is any suggestion that a lower cost facility was willing to accept transfer of the Patient. *See* AR at 36–38. The County has not pointed to any evidence that there was a lower level provider actually capable and willing to accept transfer of the Patient before March 9, 2016. This is because it is undisputed that care at a lower level facility was not available to the Patient. *See* App. Op. Br. at 2–3, 12 & n.4.

Ultimately, while St. Luke's does not dispute Dr. Dammrose's clinical opinion that the Patient was medically stable by February 19, 2016, St. Luke's does dispute the notion that the Board is bound by any legal conclusion reached by Dr. Dammrose regarding what services are "necessary medical services" as defined under the Medical Indigency Statutes. Here, Dr. Dammrose steps beyond his qualifications as a medical reviewer and interprets and applies Idaho law. He cites the statutory definition of "necessary medical services" and concludes that

the treatment at issue "is considered not medically necessary for purposes of payment." AR at 38. However, Dr. Dammrose is not authorized to draw legal conclusions regarding the Medically Indigency Statutes and the County cannot shirk its responsibility to determine medical necessity by arguing that it is absolved from making findings and conclusions of medical necessity because Dr. Dammrose said so.[2]

The Board cannot abdicate its role as the fact finder in favor of Dr. Dammrose's unsupported and mistaken legal opinion about what services constitute "necessary medical services." Accordingly, to the extent the County is arguing that the Board did just that, the Board violated its statutory duty to determine whether the services rendered by St. Luke's were medically necessary and its decision denying assistance to the Patient for the dates in question should be reversed.

### 3. *St. Joseph Regional Medical Center v. Nez Perce County* is factually on point and should be considered by the Court.

The County only dedicates one paragraph in an attempt to distinguish the current case from the facts of *St. Joseph Regional Medical Center v. Nez Perce County*, 134 Idaho 486, 5 P.3d 466 (2000). *See* Resp't Br. at 9–10. This is likely because the County recognizes that there is no way to convincingly distinguish the two cases. The County's only attempt at distinguishing the two cases is to state: "This case can be distinguished from the facts in our case because the court used this analysis in determining an applicant's eligibility for assistance, *not* whether resources were available to the hospital." *Id.* at 10 (emphasis in original). Although somewhat

[2] Although certainly not binding on the Court, a recent case in Twin Falls County confronted a similar issue. *See In re Med. Indigency Application of M.S.*, Twin Falls Cnty. Case No. CV42-15-2357 (Dec. 14, 2015), provided in the Record at pages 60–74. In that case, the district court held that it was error for the county to rely on Dr. Dammrose's legal opinion interpreting the definition of "emergency services." This case warrants the same result.

unclear, it appears the County is attempting to distinguish *St. Joseph* on the premise that the issue in *St. Joseph* dealt with the availability of resources to the patient rather than resources available to a hospital. This argument, however, is fatally flawed because the question at hand is not whether there was a facility willing to provide a lower level of care to St. Luke's (St. Luke's was not in need of care) but, rather, whether there was care at a lower level facility available to the Patient. Thus, despite the County's assertion otherwise, the focus of the current case is exactly the same as in *St. Joseph*—can the County deny assistance on the premise that certain resources or services are theoretically, but not actually, available to the Patient?

As detailed in St. Luke's opening brief, *St. Joseph* answered this question in the negative. App. Opp. Br. at 21–22. Specifically, the court held in *St. Joseph* that in order to be considered by the county for purposes of determining eligibility under the Medical Indigency Statutes, the resources must be *actually available* to the patient. 134 Idaho at 490, 5 P.3d at 470. The court then further held that because there was no evidence in the record that any of the services alleged as available to the patient were *actually available*, the evidence did not support the county's denial of the patient's application. *Id.*

There is no credible distinction between *St. Joseph* and the current case. The County alleges that assistance should be denied because care at a lower cost facility was clinically appropriate for the Patient. However, the only evidence in the record is that there were no lower cost facilities actually available and willing to accept the Patient. *See* App. Op. Br. at 2–3, 12 & n.4. The only services available to the Patient for the dates in question were the services provided by St. Luke's. *Id.* Indeed, the County does not even attempt to identify or otherwise argue that there were services at a lower cost facility actually available, it simply asserts that

availability of the services should have no bearing on the Board's determination of eligibility. *St. Joseph*, however, clearly rebuts this argument—availability of services to the patient must be considered by the board in making its determination. *St. Joseph*, 134 Idaho at 490, 5 P.3d at 470.

Accordingly, because the evidence in the record is that St. Luke's was the only facility willing to provide care to the Patient (no lower level facility was willing to accept a transfer), the Court should follow *St. Joseph* and hold that the Board's decision to deny payment for services for the dates in question was not supported by the evidence and, thereby, reverse the Board's decision.

**B. The County's Remaining Arguments Are Without Merit.**

The County includes a section in its brief entitled "St. Luke's Analysis of the Statute's Plain Language and Purpose is Erroneous." Resp't Br. at 10. However, as noted above, the County fails to actually address the arguments made by St. Luke's Opening Brief. Specifically, the County does not reply to St. Luke's analysis of the use of the affirmative verb "are" or attempt to rebut St. Luke's arguments regarding construction of the statute as a whole or legislative intent. *See* App. Op. Br. at 8–20. The County also fails to address the fact that under the EMTLA, St. Luke's legally could not transfer the Patient without there being a facility willing to accept the Patient. *See id.*, 15–16. This is likely because the County appears to rely heavily on its brief filed with the District Court, *see* R. at 32–45, rather than respond directly to St. Luke's Opening Brief.

Thus, instead of responding to the arguments made by St. Luke's, the County attempts to suggest that because Idaho Code Section 31-3502(18)B(d) states that "[s]ervices related to, or provided by . . . skilled nursing facilities" are not considered necessary medical services, the

services provided by St. Luke's for the dates in question should be denied. *See* Resp't Br. at 6–7, 10–11. However, this argument, like the County's argument regarding the availability of services, relies on a hypothetical or theoretical scenario where the services provided to the Patient during the dates in question were provided by or related to a skilled nursing facility. The reality is that the services provided to the Patient during the dates in question were provided by St. Luke's, which is an acute care hospital, *not* a skilled nursing facility. Arguing that the services could have, or should have, been provided by a skilled nursing facility is simply an attempt to sidestep the reality that the services could not have been, and in fact were not, provided by a skilled nursing facility.

Moreover, there is simply no evidence that a skilled nursing facility would have been sufficient for the Patient during the dates of service in question. The Board makes no such finding and Dr. Dammrose only opines that the Patient "no longer needed the services of an acute care inpatient hospital." AR at 38. He does not state the services of a skilled nursing facility would have met the Patient's needs. For example, the services of a long-term acute care hospital ("LTACH"), rehabilitation hospital, or other lower care facilities may have been more appropriate during the dates in question. Indeed, Dr. Dammrose says the Patient's care during these dates was "rehabilitative" in nature. AR at 38. The fact is there simply is no finding by the County that the Patient's needs could have been met by a skilled nursing facility, and there is no evidence to support such an assertion. As such, even assuming Section 31-3502(18)B(d) somehow applied to St. Luke's (it does not), there is no evidence in the record to demonstrate that the services required by the Patient were services that could have been or should have been

provided by a skilled nursing facility rather than a LTACH, rehabilitation hospital or other lower care facility.

Finally, the County appears to respond to St. Luke's absurd results argument by arguing that requiring the Board to consider the availability of services in making determinations regarding the cost effectiveness of necessary medical services would result in hospitals being "paid to any end." Resp't Br. at 11. In support of this argument, the County provides a hypothetical scenario in which a "hospital could find that no one at a patient's home was available to assist with discharge and hold the patient at the acute care rate for a period of days." *Id.* Not only is this hypothetical scenario inconsistent with the facts of this case where there is no dispute that the Patient could not have been discharged home, it is statutorily impossible.

If the hypothetical patient was appropriate to be discharged home and the hospital refused or decided not to do so, holding the patient for additional days would be "primarily for the convenience of the person, physician or other health care provider," and would not be a necessary medical service. *See* I.C. § 31-3502(18)A(d). Similarly, in this case, if treatment at a lower cost facility was appropriate and *actually available* to the Patient, treatment at St. Luke's would not be a necessary medical service because it would not be the most cost-effective service available to the Patient. *See* I.C. § 31-3502(18)A(e). Thus, despite the County's hyperbolic assertion otherwise, requiring services to be *actually available* to the Patient would not result in compensation to hospitals "without limitation."

In sum, the facts of this case, rather than baseless hypothetical scenarios, are clear. The services provided to the Patient during the dates in question were not provided by or related to a skilled nursing facility; they were provided by St. Luke's, an acute care hospital. Further, there

is no question that the Patient in this case could not simply be discharged to home, and that treatment at a lower cost facility was not actually available to the Patient for the dates in question. *See* App. Op. Br. at 2–4, 12 & n.4. Accordingly, as the only services actually available to the Patient, the services rendered by St. Luke's were the most cost effective services and, therefore, were medically necessary. This does not mean, however, that there are no limitations whatsoever on what services are compensable under the Medical Indigency Statutes. Only those services that are medically necessary and "**are** the most cost-effective" are compensable. Requiring actual availability of the services in assessing which services "**are** the most cost-effective" does not remove that limitation. *See supra*, pp. 13–14, 7 n.1.

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

The County does not respond or otherwise argue that St. Luke's substantial rights have not been prejudiced. Thus, for the reasons outlined in its opening brief, *see* App. Op. Br. at 22-23, St. Luke's respectfully requests that the Court hold that its substantial rights have been prejudiced.

## IV. CONCLUSION

The County has not responded to or otherwise rebutted St. Luke's assertion that the plain language of Idaho Code Section 31-3502(18)A(e) requires the Board to consider the actual availability of services at a facility willing to provide those services in determining whether the services rendered "**are** the most cost-effective" services. Instead, the County has attempted to side-step the fact that there were no lower cost facilities willing to accept transfer of the Patient by making unfounded factual assertions, by attempting to shift responsibility for making medical necessity determinations to Dr. Dammrose, and by arguing that requiring availability would

erase the statutory limitations on compensation for medical services rendered to an indigent patient.

However, as discussed above, there is no factual support for the County's assertion that St. Luke's "decided to keep" the uninsured Patient out of some financial motivation. Such an assertion defies logic for multiple reasons including that St. Luke's paid for the Patient's treatment at another facility and is not seeking reimbursement for doing so. Further, there is no legal support for the County's assertion that the Board is bound by any legal conclusions offered by Dr. Dammrose or for the County's assertion that requiring actual availability would erase the statutory limitations placed on compensation for medical services. For these reasons, and those detailed in its Opening Brief, St. Luke's respectfully requests that the Court reverse the Board's decision and award attorney fees to St. Luke's.

DATED THIS 18th day of July, 2018.

HAWLEY TROXELL ENNIS & HAWLEY LLP

By _____
Mark C. Peterson, ISB No. 6477
Attorneys for Petitioner/Appellant St. Luke's Health System, Ltd.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 10th day of July, 2018, I caused to be served a true copy of the foregoing APPELLANT'S REPLY BRIEF by the method indicated below, and addressed to each of the following:

Tahja Jensen
GEM COUNTY PROSECUTING ATTORNEY'S OFFICE
306 E. Main St.
P.O. Box 671
Emmett, Idaho 83617
*Attorneys for Defendant/Respondent*

☐ U.S. Mail, Postage Prepaid
☐ Hand Delivered
☐ Overnight Mail
☐ E-mail
☐ Facsimile – 208.365.9411
☑ iCourt: tjensen@co.gem.id.us
efile@co.gem.id.us

Mark C. Peterson