IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

MISSOURI HOSPITAL ASSOCIATION, **Petitioner/Plaintiff,** **v.** **MISSOURI DEPARTMENT OF SOCIAL SERVICES, et al.,** **Respondents/Defendants.**	)))))))))))	**Case No. 21AC-CC00226** **Division: III**

TEMPORARY RESTRAINING ORDER

On the 24th day of June, 2021, the Court took up Plaintiff Missouri Hospital Association's ("MHA") Motion for Temporary Restraining Order ("TRO") directed to the Missouri Department of Social Services ("DSS"), the Missouri HealthNet Division ("MHD"), Jennifer Tidball, Acting Director of DSS ("Tidball"), and Kirk Matthews, Acting Director of MHD ("Mathews") (collectively "Defendants"). The Court also takes up the Motion to Compel Joinder of Indispensable Parties filed by the Defendants.

The Plaintiff's Motion is supported by Verified Petition as required by rule, and the Court having fully considered the matter and being fully apprised of the premises, the Court GRANTS said Motion as follows:

FINDINGS OF FACT

The underlying factual issues are largely not contested by the parties.

Defendants intend to implement a new policy for Medicaid payments referred by the parties as the "directed payment policy." Under this new policy, the Defendants will set a range of allowable payments that Managed Care Companies may make to providers like MHA's member

hospitals to provide supplemental support to Medicaid providers. This new directed payment policy is intended to replace the current policy known as "Full Medicaid Pricing" payments.

The decision to institute this new directed payment policy was announced by the Defendants on June 4, 2021, via an email from MHD to Plaintiffs. *See* Ex. 2-6, *Verified Petition.* This announcement included draft managed care contract language on hospital directed payments and non-participating provider reimbursement, non-participating outpatient add-on exhibit, hospital inpatient rates, and amended directed payment documents.

As part of the June 4, 2021, announcement, MHD advised that these changes had been submitted to CMS, the federal agency with oversight of State Medicaid programs, for approval. As of the date of entering this order, CMS has yet to approve the changes to the directed payment policy. In the same June 4, 2021, email, MHD also announced that its new directed payment policy would be implemented solely through an amendment to the existing managed care contracts on July 1, 2021. MHD and the other named Defendants have advised this Court they are not required promulgate this new policy or terminate the previous policy or in any to submit these changes through the rulemaking process established in Chapter 536 RSMo.

Defendants in the hearing did not explain to this Court why the rulemaking requirements of §208.153 RSMo, does not apply to this policy change. No evidence has yet been submitted to the Court that these contractual changes have actually been implemented by the Defendants. Defendants conceded the proposed policy change was awaiting CMS approval.

Thus, the status quo is the current Medicaid contractual language which does not contain the directed payment policy.

MOTION FOR TEMPORARY RESTRAINING ORDER

A Temporary Restraining Order maintains the status of the parties until the merits of their claim are resolved. *Ballesteros v. Johnson,* 812 S.W.2d 217, 221 (Mo. App. E.D. 1991).

It does not purport to pass upon the merits of a controversy or dispose of any issue. *Zaegel v. Zaegel,* 697 S.W.2d 223, 225 (Mo. App. E.D. 1985).

Temporary restraining orders are emergency measures, often issued ex parte, where there is a need to protect an applicant from immediate and irreparable injury which may result to the applicant before a formal contested hearing can be scheduled. *Furniture Mfg. Corp. v. Joseph,* 900 S.W.2d 642, 646 (Mo. App. W.D. 1995).

Missouri courts consider the four factors when determining whether temporary injunctive relief is appropriate:

(1) the likelihood of success on the merits;

(2) the threat of irreparable harm;

(3) the balance of hardships with or without injunctive relief; and

(4) whether the public interest will be served by granting the requested injunctive relief.

State ex rel. Dir. of Rev. v. Gabbert, 925 S.W.2d 868, 869 (Mo. banc 1996).

No single factor is dispositive. *Furniture Mfg. Corp. v. Joseph*, 900 S.W.2d 642, 648 (Mo. App. W.D. 1995).

A. Likelihood of Success on the Merits

The principal legal issue for the Court to consider is straight forward—were the Defendants required to promulgate the directed payment policy via the rulemaking process? Plaintiff points to two independent reasons why these changes to Medicaid payment policy must be done through the rulemaking process. The first reason is found in §208.153, RSMo. which states:

> Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs, *manner*, *extent*, *quantity*, quality, *charges and fees* of MO HealthNet benefits herein provided. (*Emphasis added.*)

The second independent reason Plaintiff advances is the general proposition in Chapter 536 that policies of general applicability, which include Medicaid payment and reimbursement policy, must be promulgated by Rule as set explained in *NME Hosps., Inc. v. Dep't of Soc. Services, Div. of Med. Services*, 850 S.W.2d 71, 74 (Mo. 1993)

Defendants' entire argument against being required to submit the policy to the rulemaking requirements of Chapter 536 is to contest the latter point, claiming that its directed payment policy is not of general applicability, without any mention of §208.153, RSMo.

Without any argument or evidence to sway this Court otherwise, the plain language of §208.153, RSMo, controls. The statute plainly requires that "...the Division shall by rule and regulation define the reasonable costs, *manner*, *extent*, *quantity*, quality, *charges and fees* of MO HealthNet benefits herein provided.

Defendants' written submission to the Court confirms that the directed payment policy falls within this plain language. Defendants admit that "[w]hen MHD amends an MCO contract to include a directed-payment to health care providers, this simply means that *MHD is providing a range within which the payment must fall.*" *Defendants' Opposition to TRO*, pg. 3. MHD setting a range of acceptable payments is plainly "defining" the manner, extent and quantity of charges and fees under the Medicaid program. As such, the legislature has expressly required MHD to implement any such change via rule as set forth in §208.153, RSMo.

The Court is also convinced that MHA is likely to independently succeed on the merits that Chapter 536 requires the promulgation of these rules are policies of general applicability. Defendants' argument is that because this directed payment policy only affects the portions of the

State Medicaid program involving managed care contracts, this is not a policy of "general applicability" because it may not affect all recipients under the program. Defendants present no case law supporting the notion that a change that affects a portion of the Medicaid program somehow is not of general applicability. The Court finds that this argument unavailing, and further that it is largely the same argument our Supreme Court rejected in NME:

> The Department suggests that the policy change at issue is not one of general applicability because it governs only Medicaid participants, rather than all hospitals in Missouri; therefore, the Department contends, promulgation of a rule is not required. The Department is incorrect. The reimbursement policy applies generally to all participants in the Medicaid program.

NME Hosps., Inc. v. Dep't of Soc. Services, Div. of Med. Services, 850 S.W.2d 71, 74 (Mo. 1993).

Likewise, at this stage, it is clear that the directed payment policy is directed to affect all participants who receive care or Medicaid reimbursements or fees through managed care contracts. "Any agency announcement of policy or interpretation of law that has future effect and acts on unnamed and unspecified facts is a 'rule.'" *Dep't of Soc. Services, Div. of Med. Services v. Little Hills Healthcare*, L.L.C., 236 S.W.3d 637, 641 (Mo. banc 2007). Defendants' policy has stated an allowable range of directed payments that all medical providers in the State subject to managed care contract may receive under the Medicaid program.

The Defendants also point to the fact that it is only a contractual change to the managed care contracts, implying that this removes the need to promulgate rules, but this argument was also answered by the Supreme Court in NME. The Court in the NME case spent considerable time rejecting to this argument, even citing other State's court's decisions. See NME, at 75. In the NME case, DSS argued that because changes were already been memorialized in Medicaid provider contracts, the court was precluded from overturning the Department's newly announced Medicaid policy. *NME*, 850 S.W.2d at 75. "[S]tate agencies may not evade rulemaking by

contract." *Id.* And, it appears likely to the Court that this directed payment policy, which purports to be implemented in the near future solely via amendments to future Medicaid contracts is an attempt by the Defendants "to evade rulemaking by contract."

The Court finds that MHA is likely to prevail on the merits.

B. Irreparable Harm to Plaintiff

Plaintiffs set forth in their Verified Petition that their members are likely to lose as much as $45 million dollars under the new directed payment policy. Defendants contest this alleging that hospitals throughout the State will "potentially enjoy more reimbursement under their policy. *See Affidavit of Anthony Brite*, paragraph 8. However, Mr. Brite attaches no "model" that could be tested by the stakeholders, nor does Mr. Brite or Defendants point to any empirical study available to the public supporting such assertion, nor do the Defendants offer any correction by their Actuary, Mercer, that their projection of a $45 million loss would be incurred by providers.

"Bare assertions by counsel [in a motion] do not prove themselves and are not evidence of the facts presented." *Morphis v. Bass Pro Group, LLC*, 518 S.W.3d 259, 262 (Mo. App. 2017), *quoting Anderson v. Osmon,* 217 S.W.3d 375, 381 (Mo. App. W.D. 2007). But putting that aside, Defendant's argument contradicts their previous statement that the proposal would be "budget neutral." At this stage, the Court chooses to credit the sworn allegations made in Plaintiff's Petition over argument presented by Defendants which has been contradicted by previous statements from the Defendants.

Moreover, the Court is convinced that the harm of not maintaining the status quo is real and compelling. If MHD and the other Defendants do implement the changes to the managed care contracts, and it is later found that a rule was required, *NME* makes it abundantly clear that those provisions of the contracts will be rendered *void. NME,* 850 S.W.2d at 75. At this stage, given

the likelihood of success, the Court finds it better to maintain the status quo and hear this matter on the merits in an expedited fashion. It would be far worse to have this policy change go into effect for a few months, only to be struck down if and when the Court decides that the policy was void from the outset.

C. Balance of Harm to Defendants

Defendants claim that if they are enjoined from carrying out their directed payment policy, CMS, as the federal agency overseeing Medicaid, may take adverse action against them for not implementing the policy. The Court has reviewed the record and can find no credible evidence at this stage supporting any adverse action by CMS. First, the Defendants submit a July 29, 2020, letter from Calder Lynch, Deputy Administrator and Director of CMS to Todd Richardson. The only statement in that letter is that "CMS requests that the state revise future contracts and rate certifications to transition the increased funding for Medicaid hospital stays under the current Full Medicaid Pricing arrangement into a state-directed payment." The Court has examined this letter, and can find no threat, implied or otherwise, from CMS, warning of consequences if a directed payment is not implemented. Moreover, Defendants ask that the Court to impute punitive action from CMS, even though by Defendants' own admission, CMS has yet to even approve the Defendants' directed payment policy.

In fact, there is evidence of a need for the Defendants to comply with §208.153 RSMo, and the traditional rulemaking process of Chapter 536 RSMo, which requires the agency to submit a fiscal note on the fiscal impact of the proposed Rule. Such a requirement insures the fiscal impact estimates of the agency will be reviewed and tested.

The Defendants have not established any counter veiling harm from being restrained for a few weeks until this matter can be heard on the merits.

D. Public Interest

The Court finds that the public interest will be served by granting this injunction. The Supreme Court in NME made it clear that there are weighty public policy reasons behind requiring Medicaid reimbursement and payment policy to be promulgated by rule:

> The very purpose of the notice procedure for a proposed rule is to allow opportunity for comment by supporters or opponents of the measure, and so to induce a modification.... To neglect the notice ... or to give effect to a *proposed* rule before the time for comment has run ... *undermines the integrity of the procedure.* (*Emphasis added.*)

NME, 850 S.W.2d at 74.

The General Assembly has also made it clear in §208.153, RSMo. that the policy of the State is to implement Medicaid changes through rulemaking. The Court finds that the public interest in preserving the transparency of the rulemaking process to be compelling. The public interest will be served through this injunction.

MOTION TO COMPEL JOINDER OF INDISPENSABLE PARTIES

The Court will briefly address the Defendants' assertion that the Office of Administration and the Managed Care Companies must be joined as necessary parties under Rule 55.28. Defendants have not shown yet that these parties are actually *necessary* to this proceeding. As to OA, Defendants' sole citation is to Sec. 37.020, a section that deals with OA's responsibility to engage minority and small businesses. It does not support Defendants' argument that OA is necessary to this rulemaking challenge. Additionally, the Court notes that in Defendants' Suggestions in Opposition they write that the proposed change will go into effect "[***w]hen MHD amends an MCO contract*** to include a directed-payment to health care providers..." *Defendants' Opposition to TRO,* pg. 3. There is no mention of OA being the agency who amends the contract.

As to the managed care companies, there is no authority presented that a rulemaking challenge requires all private parties who may be affected in some way by a rule or policy to be joined alongside the agency responsible for the rule in order to adjudicate the case.

The Court notes that putative counsel for one of the managed care companies appeared at the TRO hearing on June 24, 2021, and the Court over objection allowed said counsel an opportunity to comment on the record. However, the Court notes that while these parties are not necessary, the managed care companies may seek leave to intervene permissively, provided that their intervention can be done with knowledge the Court intends to proceed to the **July 9, 2021 hearing** on the merits. However, the Motion to Compel Joinder of Indispensable Parties is otherwise DENIED.

BOND

Rule 92.02 requires that a movant post bond for any temporary restraining order. MHA believes that a bond of $1,000 would be proper. With no counter argument from Defendants, MHA will be ordered to post a bond of $1,000 with the Court.

ORDER RESTRAINING DEFENDANTS

Having found that a Temporary Restraining Order should be granted the Court ORDERS as follows:

Defendants DSS, MHD, Tidball, Mathews and all of their respective officers, agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise are:

A. Restrained from implementing any changes to the Medicaid reimbursement formulas pertaining to their directed payments for inpatient and outpatient hospital services policy for fifteen days or further Order of this Court;

B. Restrained from restricting or reducing any payment or reimbursement from the Missouri HealthNet program to any care provider on the basis of the new un-promulgated directed payments for inpatient and outpatient hospital services policy for fifteen days or further Order of this Court and

C. Restrained from modifying or amending any existing or future managed care contract to implement the directed payments for inpatient and outpatient hospital services policy for fifteen days or further Order of this Court;

D. Defendants are further directed to disseminate this Order to all of their respective officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them in implementing policy changes to the Managed Care Contracts.

The Defendants and all of their respective officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise are so restrained for 15 days.

Hon. Cotton Walker
Circuit Judge, 19th Circuit

Date: 6/25/2021