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Commonwealth of Kentucky

Court of Appeals

NO. 2016-CA-001140-MR

COMMONWEALTH OF KENTUCKY,
CABINET FOR HEALTH AND FAMILY SERVICES — APPELLANT

v.

APPEAL FROM FRANKLIN CIRCUIT COURT
HONORABLE PHILLIP J. SHEPHERD, JUDGE
ACTION NOS. 13-CI-01001 and 13-CI-00767

APPALACHIAN REGIONAL HEALTHCARE, INC., D/B/A HARLAN ARH HOSPITAL, D/B/A HAZARD ARH REGIONAL MEDICAL CENTER, D/B/A MIDDLEBORO ARH HOSPITAL, D/B/A WHITESBURG ARH HOSPITAL, D/B/A WILLIAMSON ARH HOSPITAL; ASHLAND HOSPITAL CORPORATION, D/B/A KING'S DAUGHTERS MEDICAL CENTER; BAPTIST HEALTHCARE AFFILIATES, INC.; BAPTIST HEALTHCARE SYSTEM, INC.; BOURBON COMMUNITY HOSPITAL, LLC, D/B/A BOURBON COMMUNITY HOSPITAL; BOWLING GREEN-WARREN COUNTY COMMUNITY HOSPITAL CORPORATION; CRITTENDEN COUNTY HOSPITAL; CLINTON COUNTY HOSPITAL, INC.; COMMUNITY UNITED METHODIST HOSPITAL, INC., D/B/A METHODIST HOSPITAL; EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER, INC.; FLAGET HEALTHCARE, INC., D/B/A FLAGET MEMORIAL HOSPITAL; FLEMING COUNTY HOSPITAL FOUNDATION, INC.; GEORGETOWN COMMUNITY HOSPITAL, LLC; GRAYSON COUNTY HOSPITAL FOUNDATION, INC.;

HARDIN MEMORIAL HOSPITAL, INC.; HARRISON MEMORIAL HOSPITAL, INC.; HIGHLANDS HOSPITAL CORPORATION; HOSPITAL OF FULTON, INC., D/B/A PARKWAY REGIONAL HOSPITAL; HOSPITAL OF LOUISA, INC., D/B/A THREE RIVERS MEDICAL CENTER; JACKSON HOSPITAL CORPORATION, D/B/A KENTUCKY RIVER MEDICAL CENTER; JENNIE STUART MEDICAL CENTER, INC.; JEWISH HOSPITAL & ST. MARY'S HEALTHCARE, INC., D/B/A JEWISH HOSPITAL SHELBYVILLE; KENTUCKY HOSPITAL, LLC, D/B/A CLARK REGIONAL MEDICAL CENTER, INC.; KENTUCKYONE HEALTH, INC.; LAKE CUMBERLAND REGIONAL HOSPITAL, LLC, D/B/A LAKE CUMBERLAND REGIONAL HOSPITAL; LOGAN MEMORIAL HOSPITAL, LLC, D/B/A LOGAN MEMORIAL HOSPITAL; MEADOWVIEW REGIONAL MEDICAL CENTER, LLC, D/B/A MEADOWVIEW REGIONAL MEDICAL CENTER; MERCY HEALTH PARTNERS-LOURDES, INC., D/B/A LOURDES HOSPITAL; MUHLENBERG COMMUNITY HOSPITAL; MURRAY-CALLOWAY COUNTY PUBLIC HOSPITAL CORPORATION, D/B/A MURRAY-CALLOWAY COUNTY HOSPITAL; NORTON HOSPITALS, INC., D/B/A NORTON HOSPITAL; OUR LADY OF BELLEFONTE HOSPITAL, INC.; OWENSBORO MEDICAL HEALTH SYSTEMS, INC.; PAINTSVILLE HOSPITAL COMPANY, LLC, D/B/A PAUL B. HALL REGIONAL MEDICAL CENTER; PATTIE A. CLAY INFIRMARY ASSOCIATION, D/B/A PATTIE A. CLAY REGIONAL MEDICAL CENTER; PIKEVILLE MEDICAL CENTER, INC.; PINELAKE REGINAL HOSPITAL, LLC, D/B/A JACKSON PURCHASE MEDICAL CENTER; SAINT ELIZABETH MEDICAL CENTER, INC.; SAINT JOSEPH HEALTH SYSTEM, INC., D/B/A SAINT JOSEPH EAST, D/B/A SAINT JOSEPH LONDON, D/B/A SAINT JOSEPH HOSPITAL, SAINT JOSEPH MOUNT STERLING; SPRINGVIEW HOSPITAL, LLC, D/B/A SPRINGVIEW HOSPITAL; ST. CLAIRE MEDICAL CENTER, INC.; T.J. SAMSON COMMUNITY HOSPITAL; TAYLOR COUNTY HOSPITAL DISTRICT HEALTH FACILITIES CORPORATION D/B/A

TAYLOR REGIONAL HOSITAL; THE HARDIN MEMORIAL HOSPITAL FOUNDATION; THE HARRISON MEMORIAL HOSPITAL, INC.; THE TROVER CLINIC FOUNDATION, INC., D/B/A REGIONAL MEDICAL CENTER OF HOPKINS COUNTY[1] APPELLEES

OPINION
AFFIRMING
** ** ** ** **

BEFORE: DIXON, COMBS, AND TAYLOR, JUDGES.

DIXON, JUDGE: The Cabinet for Health and Family Services ("Cabinet") has appealed from an opinion and order entered by the Franklin Circuit Court on July 7, 2016, regarding Medicaid reimbursement rates as well as administrative appeals of rates filed by fifty-eight acute care hospitals ("Hospitals"). The circuit court found the so-called "budget neutrality adjustment" ("BNA") in 907 KAR[2] 1:825[3] invalid and contrary to the "relate to cost" provision in KRS[4] 205.560(2). The

[1] Although Adair County Public Hospital District Corporation, d/b/a Westlake Regional Hospital was named the primary Appellee in the Notice of Appeal ("NOA"), it was dismissed on January 4, 2019.

Additionally, the spellings—and misspellings—of Appellees' names reflect the NOA.

[2] Kentucky Administrative Regulation.

[3] 907 KAR 1:825 was repealed and replaced with a new methodology in 907 KAR 10:830, without any BNA, effective October 1, 2015.

[4] Kentucky Revised Statutes.

circuit court also enjoined the Cabinet to hold appropriate dispute resolution and administrative procedures, so the Hospitals' appeals receive a full and fair determination at the administrative agency. Following a careful review, we affirm.

Medicaid is a cooperative federal-state program which reimburses healthcare providers rendering covered services to Medicaid eligible individuals. Federal regulations require Medicaid reimbursement payments be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." 42 C.F.R.[5] 447.253(b)(1)(i).

The Cabinet is the state agency charged by statute[6] with administering the state's Medicaid program—including setting reimbursement rates and promulgating regulations to administer its duties. The Cabinet operates through its Department for Medicaid Services ("DMS") in administering the state's Medicaid program. The Cabinet uses a fee-for-service formula to reimburse its contractual Medicaid providers—including the Hospitals party to this action—on a "per discharge" or "per case" basis. The state adopted a Diagnostic Related Group ("DRG") prospective per-discharge reimbursement method which codes clinically

[5] Code of Federal Regulations.

[6] Kentucky Medical Assistance Act, KRS 205.510, *et seq*.

similar groups of patients in determining base payments, which are further adjusted using the BNA, outlier payments for certain high-cost services, and high-volume payments based on how many Medicaid patients are discharged by the given facility. DMS approved the state plan including the DRG and its BNA methodology.

The Hospitals timely filed administrative appeals beginning with their October 15, 2007, rate notices raising issues about the adequacy and correctness of their individual reimbursement rates.[7] Beginning in the spring of 2010, the Cabinet conducted individual dispute resolution meetings ("DRM's") concerning the Hospitals' rate appeals pursuant to 907 KAR 1:671, Section 8. Rather than issuing dispute resolution decisions, the Cabinet waited until May 31, 2013, to write the Hospitals letters that they did not have appeal rights, dismissing the same without administrative evidentiary hearings or further due process. In these letters the Cabinet stated, "[a]s the appeals . . . concern only non-appealable issues, the [DMS] has determined no DRM response is required." The Hospitals requested administrative hearings from the Cabinet's dismissal letters within thirty days pursuant to 907 KAR 1:671, Section 9. The Cabinet responded to those requests with letters stating no administrative hearings would be conducted.

[7] Two hospitals only filed administrative appeals beginning with their July 1, 2012, rate notices.

The same day it sent initial dismissal letters to the Hospitals, the Cabinet initiated a lawsuit against the Hospitals in Fayette Circuit Court.[8] Its complaint sought a declaration that its Medicaid reimbursement rate methodologies were consistent with the "relate to cost" provision of KRS 205.560(2), which does not mandate that Medicaid reimbursement rate methodologies always result in rates meeting or exceeding 100 percent of a Medicaid provider's actual cost.

Within thirty days of the Cabinet's lawsuit, the Hospitals filed an action for declaratory relief, writ of mandamus, and KRS 13B appeal in the Franklin Circuit Court.[9] Pertinent to this appeal, the Hospitals sought a declaration that the Cabinet's rate setting methodologies were not consistent with KRS 205.560(2) and also requested the court order the Cabinet to provide administrative due process for the rate appeals.

The Hospitals moved the Fayette Circuit Court to dismiss or transfer the Cabinet's action against them. The Fayette Circuit Court granted the Hospitals' motion to transfer the action to Franklin Circuit Court.[10] The Hospitals then voluntarily dismissed their claims in their action and brought them as a

[8] Fayette Circuit Court, No. 13-CI-02270. Three of the hospitals were misnamed in the Cabinet's complaint.

[9] Franklin Circuit Court, No. 13-CI-00767.

[10] Following the case's transfer, it was renumbered to Franklin Circuit Court, No. 13-CI-01001.

counterclaim in the Cabinet's action. The two Franklin Circuit Court cases were later consolidated.

The Cabinet moved the Franklin Circuit Court for partial summary judgment on its petition for declaration and also requested the court dismiss Counts I, II, and IV of the Hospitals' counterclaim. The Hospitals cross-moved for partial summary judgment on Counts I and IV of their counterclaim, requesting the BNA rate-setting be declared invalid, as well as an award of interest on any rate increases they may receive. The Cabinet moved for partial summary judgment a second time on Counts I and II of the Hospitals' KRS 13B petition and Count III of the Hospitals' counterclaim. After hearing the parties' arguments, the circuit court declared the Cabinet's rate-setting method using the BNA invalid, enjoined the Cabinet to hold administrative hearings, and found the issue of any award of interest to be premature. This appeal followed.

On appeal, the Cabinet raises three issues: (1) whether the circuit court erred in finding the Cabinet's BNA rate-setting method to be facially invalid and arbitrary; (2) whether the circuit court erred in finding the Hospitals entitled to administrative process; and (3) whether the Hospitals' underlying claims are moot because the offending regulation has been repealed. After careful review, we discern no error.

The Cabinet's first two arguments concern whether the circuit court erred in its grant of partial summary judgment in favor of the Hospitals. Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, stipulations, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." CR 56.03. An appellate court's role in reviewing a summary judgment is to determine whether a lower court erred in finding no genuine issue of material fact exists and the moving party was entitled to judgment as a matter of law. *Scifres v. Kraft*, 916 S.W.2d 779, 781 (Ky. App. 1996). A grant of summary judgment is reviewed *de novo* because factual findings are not at issue. *Pinkston v. Audubon Area Community Services, Inc.*, 210 S.W.3d 188, 189 (Ky. App. 2006) (citing *Blevins v. Moran*, 12 S.W.3d 698, 700 (Ky. App. 2000)).

Additionally, the Cabinet also questions the court's review of its actions as an administrative agency. It is well-settled that:

> [t]he basic scope of judicial review of an administrative decision is limited to a determination of whether the agency's action was arbitrary. *Bobinchuck v. Levitch*, [380 S.W.2d 233 (Ky. 1964).] If an administrative agency's findings of fact are supported by substantial evidence of probative value, they must be accepted as binding and it must then be determined whether or not the agency has applied the correct rule of law to the facts so found. *Kentucky Unemployment Ins. Comm'n v. Landmark Community Newspapers of Kentucky, Inc*., [91

> S.W.3d 575 (Ky. 2002).] The Court of Appeals is authorized to review issues of law involving an administrative agency decision on a *de novo* basis. *Aubrey v. Office of the Attorney General*, [994 S.W.2d 516 (Ky. App. 1998)]. In particular, an interpretation of a statute is a question of law and a reviewing court is not bound by the agency's interpretation of that statute. *Halls Hardwood Floor Co. v. Stapleton*, [16 S.W.3d 327 (Ky. App. 2000).]

Liquor Outlet, LLC v. Alcoholic Beverage Control Bd., 141 S.W.3d 378, 381 (Ky. App. 2004) (emphasis added).

The parties' first arguments concern the validity of the BNA imposed by 907 KAR 1:825. According to 907 KAR 1:825, "'Budget Neutrality' means that reimbursements resulting from rates paid to providers under a per discharge methodology do not exceed payments in the base year adjusted for inflation based on the CMS[11] Input Price Index, which is the wage index published by CMS on the federal register." (Footnote added). In application, however, what the BNA accomplished was to ensure the Cabinet never paid more than a preordained amount for Medicaid reimbursements to its contractual providers. The BNA was further responsible for ensuring provider costs were effectively divorced from the reimbursement payments. The circuit court correctly found this to be violative of KRS 205.560(2), which mandates the Cabinet's "[p]ayments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental

[11] Centers for Medicare and Medicaid Services.

supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies."

As another panel of our Court has recently noted concerning the "relate to cost" provision of KRS 205.560(2), "[t]he exact meaning of these words has been hotly contested over the years." *Northkey Kentucky Mental Health-Mental Retardation Reg'l Bd., Inc. v. Commonwealth Cabinet for Health & Family Servs*., 538 S.W.3d 298, 300 (Ky. App. 2017). ("*Northkey II*.")[12] The Cabinet made arguments in *Northkey II* that are strikingly similar to the ones in the case at hand.

> The Cabinet contends the Medicaid Act affords it flexibility and authority to set Medicaid provider reimbursement rates as well as the methodologies used to calculate those rates. It further argues that these rates do not have to meet or exceed providers' actual costs. The Cabinet maintains its methodologies comply with all statutory provisions and therefore must be affirmed.
>
> The Cabinet is correct in that there are no provisions within either 42 USC 10 § 1396, *et seq*., or KRS 205.560 requiring a 100% Medicaid reimbursement rate. However, this fact does not give the Cabinet *carte blanche* authority to determine reimbursement rate methodologies. While *states* may be given "wide latitude in designing, creating and administering their own respective Medicaid program," the Cabinet does not

[12] In "*Northkey I*," the Franklin Circuit Court found the Cabinet acted in error when it did not relate Medicaid reimbursement payments to the cost of providing services as required by KRS 205.560(2). *Northkey Cmty. Care v. Commonwealth of Kentucky, Cabinet for Health Servs.*, Civil Action No. 03-CI-00804 (opinion and order entered April 15, 2004). The Cabinet chose not to appeal *Northkey I*.

> equate to a "state." It is the state legislature which determines the parameters of a state's Medicaid program. The Cabinet's authority to administer the program, and the extent to which it may do so, are determined by the legislature. In Kentucky, our legislature has determined that Medicaid reimbursement rates "shall be on bases which relate the amount of the payment to the cost of providing the services or supplies." KRS 205.560(2).

Id. at 303 (internal footnotes omitted). In *Northkey II*, our Court held the Cabinet's reduction of a psychiatric children's hospital's Medicaid reimbursement rate by a 19.5% parity adjustment factor was arbitrary and erroneous and did not "relate to costs" as required by statute. We adopt the logic espoused in *Northkey II* that the Cabinet does not have *carte blanche* to set regulations which are in clear conflict with the state legislature's mandate that Medicaid reimbursement rates reasonably relate to providers' costs.

Another panel of our Court addressed similar issues in *Commonwealth Cabinet for Health & Family Servs. v. RiverValley Behavioral Health*, 465 S.W.3d 460 (Ky. App. 2014). ("*RiverValley I*").[13] In that case:

> [t]he regulations adopted by DMS during the period at issue did not reasonably relate to RiverValley's actual costs, but arbitrarily froze the reimbursement at the 2000 level. The Secretary's Final Order does not discuss how the applicable statutes authorized DMS to promulgate this rule. The Secretary merely asserts that DMS had the

[13] *Commonwealth Cabinet for Health & Family Servs. v. RiverValley Behavioral Health*, Civil Action No. 09-CI-00797, is currently pending before another panel of our Court in a set of consolidated appeals, No.'s 2016-CA-001141-MR and 2017-CA-000855-MR. ("*RiverValley II*.")

> legal authority to do so, and that DMS "correctly calculated and applied the reimbursement rate for RiverValley in the same manner as for all other like-providers and as established by regulation and the State Plan from 2000 to 2007." Upon reaching this conclusion, the Secretary went on to find that the reimbursement rate set for RiverValley was "not inadequate."
>
> We conclude that this legal determination was clearly erroneous on its face. In addition to the requirements of KRS 205.560, federal law requires that DMS must make sufficient findings to ensure that its Medicaid reimbursement rates fall "within a range of what could be considered reasonable and adequate." *Memorial Hospital, Inc. v. Childers*, 896 F.Supp. 1427, 1435 (W.D.Ky. 1995). Neither the Secretary nor the Cabinet made any attempt to explain how the methodology adopted by DMS complies with the express language of KRS 205.560 or the controlling federal statutes and regulations. Likewise, the Cabinet makes no attempt to show how this methodology relates to RiverValley's actual and allowable provider costs.

Id. at 469. In *RiverValley 1*, our Court held the Cabinet exceeded its statutory authority by arbitrarily freezing psychiatric hospital's Medicaid reimbursement rates for seven years without reference to its actual costs, and federal law requires that the Cabinet make sufficient findings to ensure its Medicaid reimbursement rates fall "within a range of what could be considered reasonable and adequate." *Memorial Hospital, Inc*., 896 F.Supp. at 1435. Again, we adopt the well-reasoned analysis of *RiverValley I* which unequivocally holds that the Cabinet does not have the authority to set regulations which are in clear conflict with the state legislature's mandate that Medicaid reimbursement rates relate to actual costs.

These cases are all byproducts of an ongoing healthcare providers' fight with the Cabinet which has progressively only become more entrenched in its outdated methodology, largely disconnected from actual costs for services, in clear violation of KRS 205.560(2). The battles began long ago when the Cabinet reimbursed hospitals using a per diem methodology. That methodology included a rate of increase control ("RIC") first implemented in 1993. The RIC capped annual increases of per diem rates to approximately four percent. Once the RIC applied to a hospital, the hospital's actual costs in providing Medicaid services no longer had any effect on the hospital's reimbursement rates. Hospitals challenged the per diem methodology in *Memorial Hospital, Inc*., 896 F.Supp. 1427, which upheld the methodology since it was determined the hospitals were receiving 93-96 percent of their allowable costs, falling within a permissible "zone of reasonableness." The Court opined the hospitals "may have justifiable reason to fear the RIC's future impact: it is not inconceivable that at some future time the RIC could cause unlawful consequences. . . ." *Id*. at 1438.

In 1999 and 2000, the Cabinet capped hospital reimbursement rates at 3 and 2.8 percent increases, respectively, from the previous year's rates. Then in 2001 and 2002, the Cabinet froze all per diem rates. As a result of the Cabinet's changes to its reimbursement methodology, hospitals' overall inpatient Medicaid

cost coverage decreased to percentages in the 70's by the year 2000. These problems carried over into the Cabinet's DRG methodology.

In 2003, the Cabinet abandoned the per diem methodology for general medical surgical hospitals and adopted a DRG methodology, patterned loosely after Medicare's model. Under this approach, payments are set for each hospital admission depending on its DRG classification as to the type of illness or injury treated. However, the Cabinet then devised a way to further adjust the reimbursement rates. The Cabinet took 2000 as a base year and tinkered with hospital-specific base rates and DRG weights until it reduced total projected payments to the same level as total Medicaid payments for hospital care made in 2000 and called these adjustments the BNA. The BNA is not required by statute or contained in any budget bill passed by the General Assembly—it is entirely a product of the Cabinet's internal policy. The Cabinet revised its DRG methodology in 2007, 2008, and 2011, but still maintained the BNA, which essentially tied hospital rates to hospital costs from the 1990's. From its inception to repeal, the BNA was applied annually with only approximately two percent inflation increases. The BNA served to keep hospitals' overall cost coverage percentages in the mid-70's.

In this case, the circuit court correctly found that the BNA in 907 KAR 1:825 was facially invalid and arbitrary as it conflicts with the plain language

of KRS 205.560(2) providing reimbursements for Medicaid providers that reflect actual costs. The circuit court found:

> [a]lthough the words "relate to" are not defined by the statute, a plain reading of the statute clearly provides that payments must reasonably relate to the actual costs incurred for providing the services. Instead, the budget neutrality adjustments made by the Cabinet, as outlined in the regulation, are arbitrary as they are partially based on historical costs, not actual costs. While the Court agrees that the Cabinet can make downward adjustments that are rationally related to objective criteria like efficiency and economy, they cannot simply make arbitrary adjustments based on historical rates.

We agree. The BNA also violated federal law as its suppression of Medicaid reimbursement rates into percentages in the 70's falls outside the range of what could be considered reasonable and adequate. Because the BNA violated state and federal law, there can be no doubt that the Cabinet's imposition of the BNA on Medicaid reimbursement rates was arbitrary and an abuse of its administrative powers. As such, the circuit court did not err in granting partial summary judgment to the Hospitals and denying the Cabinet's motion for partial summary judgment on these issues, or in finding the BNA in 907 KAR 1:825 to be facially invalid and arbitrary due to its clear conflict with KRS 205.560(2).

The parties' second argument concerns whether the Hospitals are entitled to administrative hearings. "Judicial review of an administrative agency's action is concerned with the question of arbitrariness." *Commonwealth Transp.*

Cabinet v. Cornell, 796 S.W.2d 591, 594 (Ky. App. 1990) (citing *American Beauty Homes Corporation v. Louisville and Jefferson County Planning and Zoning Commission*, 379 S.W.2d 450, 456 (Ky. 1964)). Section 2 of the Kentucky Constitution prohibits the exercise of arbitrary power by an administrative agency. *Id.*

> In determining whether an agency's action was arbitrary, the reviewing court should look at three primary factors. The court should first determine whether the agency acted within the constraints of its statutory powers or whether it exceeded them. Second, the court should examine the agency's procedures to see if a party to be affected by an administrative order was afforded his procedural due process. The individual must have been given an opportunity to be heard. Finally, the reviewing court must determine whether the agency's action is supported by substantial evidence. If any of these three tests are failed, the reviewing court may find that the agency's action was arbitrary.

Commonwealth Transp. Cabinet v. Cornell, 796 S.W.2d at 594 (citations omitted).

In the instant case, the circuit court found:

> [. . .] all matters disputing provider reimbursement rates are subject to administrative hearings under KRS 13B.140 and the Cabinet's regulation on dispute resolution. If the reimbursement rate is contested, the burden should be on the hospital in proving that the reimbursement rate is not adequate, which should be determined on a case-by-case basis. The Cabinet acted arbitrarily when it short-circuited the administrative process, and denied the hospitals any administrative remedy through dispute resolution or formal hearing.

We agree. Hospitals have brought rate appeals since the federal court agreed with the Cabinet that individual inequities caused by its rate-setting methodologies could and should be addressed through the administrative appeals process. *Memorial Hospital Inc.*, 896 F. Supp. 1427. The Cabinet's refusal to hear the Hospitals' rate appeals denied them due process and was, thus, arbitrary.

The Cabinet itself rightfully acknowledges Medicaid providers may challenge certain issues pertaining to their rates as set forth in 907 KAR 10:815, Section 21, subsection (2), which provides:

> **An administrative review shall be available for a calculation error in the establishment of a per diem rate.**

(Emphasis added). Therefore, and at the least, issues raised by the Hospitals concerning calculation errors are entitled to administrative appeals according to the Cabinet's own regulations. This includes challenges to payments concerning the application of the reimbursement methodology. Because such issues should have been afforded due process by the Cabinet but were not, the Cabinet's actions were arbitrary. Such errors were brought to the Cabinet's attention in the Hospitals' initial letters appealing the rates, in the DRM's as evidenced in their transcripts, and consistently throughout the pleadings. These issues were wrongfully, arbitrarily, and prematurely dismissed by the Cabinet, and properly remanded by the circuit court for further administrative proceedings. We further note that the

issue of the validity of the BNA—which the Cabinet purported to be "nonreviewable" via administrative appeals—has now been decided by the court, meaning it need not, cannot, and will not be decided at the administrative level.

The parties' third argument concerns whether the repeal of 907 KAR 1:825—and its offensive imposition of the BNA upon Medicaid reimbursement rates—renders the circuit court's opinion and order moot. The Cabinet failed to raise any argument of mootness before the circuit court. Nothing prevented the Cabinet from bringing this issue to the circuit court's attention prior to its entry of its opinion and order on July 7, 2016, nearly a year after the regulations were repealed and amended. Therefore, because the Cabinet's present attack was neither pursued nor presented to the circuit court for a ruling, it will not be considered for the first time on appeal. "Our jurisprudence will not permit an appellant to feed one kettle of fish to the [circuit] judge and another to the appellate court. *See Elery v. Commonwealth*, 368 S.W.3d 78, 97 (Ky. 2012) (citing *Kennedy* [*v. Commonwealth*], 544 S.W.2d [219, 222 (Ky. 1976)]." *Owens v. Commonwealth*, 512 S.W.3d 1, 15 (Ky. App. 2017) (footnote omitted). Only issues fairly brought to the attention of the circuit court are adequately preserved for appellate review. *Elery*, 368 S.W.3d at 97 (citing *Richardson v. Commonwealth*, 483 S.W.2d 105, 106 (Ky. 1972); *Springer*, 998 S.W.2d at 446; and *Young v. Commonwealth*, 50 S.W.3d 148, 168 (Ky. 2001)).

Furthermore, even had the issue of mootness been properly preserved for our review, the Cabinet's argument is not well taken. The BNA's replacement with 907 KAR 10:830 did not become effective until October 1, 2015. Thus, it is disingenuous for the Cabinet to argue this regulation solved anything concerning the Hospitals' rates from 2007 through October 1, 2015. Neither the correct amounts of reimbursements nor any award of interest or other damages have been determined and the remaining rate appeals have been remanded for further administrative proceedings. The circuit court's declaration of the Hospitals' rights concerning the validity of the BNA and entitlement to administrative due process has real economic consequences. The Hospitals may seek monetary damages for past underpayments from the Cabinet. Pursuant to KRS 45A.245, the Cabinet waived its sovereign immunity for contract damages by entering into the Provider Agreements with the Hospitals. *Commonwealth v. Samaritan All., LLC,* 439 S.W.3d 757, 761-62 (Ky. App. 2014). Therefore, despite the BNA's repeal, there still exists a "live" controversy regarding the calculations of the correct Medicaid reimbursement rates for the Hospitals, as well as other contract remedies.

For the foregoing reasons, the opinion and order of the Franklin Circuit Court is AFFIRMED.

ALL CONCUR.

BRIEFS FOR APPELLANT:

Catherine York
Deputy General Counsel
Office of Legal Services
Frankfort, Kentucky

BRIEF FOR APPELLEES BOURBON COMMUNITY HOSPITAL, LLC, D/B/A BOURBON COMMUNITY HOSPITAL; KENTUCKY HOSPITAL, LLC, D/B/A CLARK REGIONAL MEDICAL CENTER, INC.; CRITTENDEN COUNTY HOSPITAL, INC.; EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER, INC.; FLEMING COUNTY HOSPITAL FOUNDATION, INC.; GEORGETOWN COMMUNITY HOSPITAL, LLC; APPALACHIAN REGIONAL HEALTHCARE, INC., D/B/A HARLAN ARH HOSPITAL, D/B/A HAZARD ARH REGIONAL MEDICAL CENTER, D/B/A MIDDLEBORO ARH HOSPITAL, D/B/A WHITESBURG ARH HOSPITAL, D/B/A WILLIAMSON ARH HOSPITAL; HARRISON MEMORIAL HOSPITAL, INC.; PINELAKE REGIONAL HOSPITAL, LLC, D/B/A JACKSON PURCHASE MEDICAL CENTER; JENNIE STUART MEDICAL CENTER, INC.; JACKSON HOSPITAL CORPORATION, D/B/A KENTUCKY RIVER MEDICAL CENTER; ASHLAND HOSPITAL CORPORATION, D/B/A KING'S DAUGHTERS MEDICAL CENTER; LAKE CUMBERLAND REGIONAL HOSPITAL, LLC, D/B/A LAKE CUMBERLAND REGIONAL HOSPITAL; LOGAN MEMORIAL HOSPITAL, LLC, D/B/A LOGAN MEMORIAL HOSPITAL; MERCY HEALTH PARTNERS-LOURDES, INC., D/B/A LOURDES HOSPITAL; MEADOWVIEW REGIONAL MEDICAL CENTER, LLC, D/B/A MEADOWVIEW REGIONAL MEDICAL CENTER; COMMUNITY UNITED METHODIST HOSPITAL, INC., D/B/A METHODIST HOSPITAL; MURRAY-CALLOWAY COUNTY PUBLIC HOSPITAL CORPORATION, D/B/A MURRAY-CALLOWAY COUNTY HOSPITAL; OWENSBORO MEDICAL HEALTH SYSTEMS, INC.; HOSPITAL OF FULTON, INC., D/B/A PARKWAY REGIONAL HOSPITAL; PATTIE A. CLAY INFIRMARYASSOCIATION, D/B/A PATTIE A. CLAY REGIONAL MEDICAL CENTER; PAINTSVILLE HOSPITAL COMPANY, LLC, D/B/A PAUL B. HALL REGIONAL MEDICAL CENTER; THE TROVER CLINIC FOUNDATION, INC., D/B/A REGIONAL MEDICAL CENTER OF HOPKINS COUNTY; SPRINGVIEW HOSPITAL, LLC, D/B/A SPRINGVIEW HOSPITAL; T.J. SAMSON COMMUNITY HOSPITAL; TAYLOR COUNTY HOSPITAL DISTRICT HEALTH

FACILITIES CORPORATION D/B/A TAYLOR REGIONAL HOSITAL; HOSPITAL OF LOUISA, INC., D/B/A THREE RIVERS MEDICAL CENTER; MUHLENBERG COMMUNITY HOSPITAL:

Stephen R. Price, Sr.
Carole D. Christian
John W. Woodard, Jr.
Allison L. Brown
Louisville, Kentucky

BRIEF FOR APPELLEES KENTUCKYONE HEALTH, INC.; JEWISH HOSPITAL & ST. MARY'S HEALTHCARE, INC., D/B/A JEWISH HOSPITAL SHELBYVILLE; SAINT JOSEPH HEALTH SYSTEM, INC., D/B/A SAINT JOSEPH EAST, D/B/A SAINT JOSEPH LONDON, D/B/A SAINT JOSEPH HOSPITAL, SAINT JOSEPH MOUNT STERLING; FLAGET HEALTHCARE, INC. D/B/A FLAGET MEMORIAL HOSPITAL:

Wesley R. Butler
Jeffery T. Barnett
Holly R. Iaccarino
Lexington, Kentucky

BRIEF FOR APPELLEE NORTON HOSPITALS, INC. D/B/A NORTON HOSPITAL:

Kevin G. Henry
Bryan H. Beauman
Sarah Charles Wright
Lexington, Kentucky

BRIEF FOR APPELLEES BAPTIST HEALTHCARE SYSTEM, INC.; BAPTIST HEALTHCARE AFFILIATES, INC.; CLINTON COUNTY HOSPITAL, INC.; HIGHLANDS HOSPITAL CORPORATION; ST. CLAIRE MEDICAL CENTER, INC.; SAINT ELIZABETH MEDICAL CENTER, INC.; BOWLING GREEN-WARREN COUNTY COMMUNITY HOSPITAL CORPORATION; GRAYSON COUNTY HOSPITAL FOUNDATION, INC.; OUR LADY OF BELLEFONTE HOSPITAL, INC.:

Matthew R. Klein
David M. Dirr
Crestview Hills, Kentucky

BRIEF FOR APPELLEE PIKEVILLE MEDICAL CENTER, INC.:

Harry Dadds
Perry M. Bentley
Lexington, Kentucky

Erich E. Blackburn
Pikeville, Kentucky