

1986

Weber Memorial Care Center v. Utah Department of Health : Brief of Appellant

Utah Court of Appeals

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UTAH COURT OF APPEALS

WEBER MEMORIAL CARE CENTER,
INC. and CHARTHAM MANAGEMENT,
INC.,

Plaintiffs/Appellants

vs

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING,

Defendant/Respondent.

Case No. 860342 - CA

* * * * *

BRIEF OF APPELLANTS

WEBER MEMORIAL CARE CENTER, INC., and CHARTHAM MANAGEMENT, INC.

* * * * *

Appeal from the Third Judicial District Court
of the State of Utah in and for the County of Salt Lake

* * * * *

THE HONORABLE SCOTT DANIELS, District Judge

* * * * *

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Priority Classification: 13.a.

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STATEMENT OF ISSUES

- I. Whether the Utah State Medicaid Plan fails to comply with federal law and is therefore invalid.
- II. Even if the Utah State Plan is not invalid per se, whether the Hearing Officer's refusal to allow Weber Memorial the opportunity to submit evidence of its costs and to prove it is an efficiently and economically operated facility was contrary to the applicable federal statute and regulations and in violation of Appellant's right to a fair hearing.
- III. Whether the Hearing Officer's and District Court's ruling regarding the Department's classification of patients in need of "Skilled" care as "Intermediate" patients is arbitrary and capricious.

JURISDICTION AND PROCEEDINGS BELOW

This is an appeal of a decision of the District Court, Third Judicial District, affirming the final decision of the Executive Director of the Utah Department of Health. A Memorandum Decision was entered by Judge Fishler on June 3, 1986, and was followed by a Final Judgment by Judge Daniels on August 4, 1986, after Judge Fishler had left the bench. A timely Notice of Appeal was filed with the Utah Supreme Court. Because appellant had a separate action for declaratory and injunctive relief pending before the Federal Court, the record was transferred to that Court for review, and has now been returned for purposes of this appeal. This case was transferred to this court pursuant to Rule 4A, Rules of the Utah Court of Appeals, and is properly before the court.

STATEMENT OF THE CASE

The Appellant, Weber Memorial Care Center, Inc. (hereinafter "Weber Memorial"), is a provider of long-term health care in Ogden, Utah. Chartham Management, Inc. is the management corporation which operates the Weber Memorial Care Center. A number of the patients of Weber Memorial qualify for Medicaid assistance, and under the state-administered Medicaid system, Weber Memorial is reimbursed by the State Department of Health, Division of Health Care Financing, which is the Defendant/Appellee herein. As will be developed throughout this brief, it is the current reimbursement system which is at the heart of the dispute between the parties.

In 1981 the State of Utah adopted a "flat-rate" system of reimbursing providers. Under this system, all long-term health care providers are paid a single rate per patient, per day for "intermediate" and "skilled" patients. Regardless of costs, the provider is reimbursed according to the flat rate set by the Department. If costs exceed the flat rate, the provider operates at a deficit, and if costs are lower, the provider operates at a profit.

42 U.S.C. §1396a(a)(13)(A), the so-called "Boren Amendment," instructs states participating in the Medicaid program to pay health care providers through the use of rates which are

"reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." These facilities operate in a heavily regulated environment, and, as the Boren Amendment also directs, the rates must take into account the costs associated with compliance with "applicable state and federal laws, regulations, and quality and safety standards, . . . insur[ing] that individuals eligible for assistance have reasonable access (taking into account geographical location and reasonable travel time), . . ." Id. See, also, Hillhaven Corp. v. Wisconsin Dept. of Health, 634 F.Supp. 1313, 1315 (E.D. Wis. 1986.)

Weber Memorial was purchased from Weber County in 1981. When that purchase occurred, the facility became a privately-held asset. With private ownership came burdens not associated with public ownership by Weber County. Property taxes now had to be paid and additions to the physical plant such as a sprinkler system had to be made. In spite of these additional costs, good management brought the overall cost down, accomplished by responsible reductions in staff, centralization of support functions and economies in purchasing. Despite significant efforts to reduce costs, including staff reductions, etc., the costs of complying with Medicaid standards of patient care and safety exceeded the flat rate. By early 1983 it became apparent that costs were not going to be met under the reimbursement system.

At all times, Weber Memorial contended, as it still does, that it was and is an efficiently and economically operated facility. Therefore, Weber Memorial requested a hearing under the rules promulgated by the Department, in order to contest the application of the rates as well as to challenge the classification by the Department of certain patients as "intermediate" rather than "skilled," i.e., as patients requiring relatively less care rather than increased care.

Weber Memorial made its request for hearing on July 28, 1983. Despite protests from Weber Memorial, the Department

informed it that it must first participate in an "informal hearing" prior to proceeding further. This informal meeting was held on September 20, 1983, with no resolution of the issues resulting therefrom. Weber Memorial was not permitted to submit evidence at that time.

After Weber Memorial was informed that it must again request a formal hearing, a new request was submitted on October 7, 1983. Thereafter, a certain amount of discovery took place, and the hearing officer set the matter for hearing on November 21, 1983. The hearing was reset for December 12, 1983, but before the hearing could be held, the Department filed a Motion for Continuance. The hearing officer granted the Motion, based upon the Department's representation that it needed until February 14, 1984 to prepare for the hearing.

On February 10, 1984 the Department, without warning, requested that the hearing officer essentially reject Plaintiff's appeal without hearing it. The Department took the position, which it has maintained throughout these proceedings, that the flat rate itself implicitly defines an efficiently and economically operated facility within the meaning of federal law and that it is not necessary to examine any individual facility's costs, efficiencies and economies.

On April 2, 1984 the Department filed a formal motion asking the hearing officer to rule as a matter of law and without a hearing that the Utah State Medicaid Plan did not violate

federal law, and that the Plan did not require an examination of Weber Memorial's costs nor a determination as to whether the particular facility is efficiently and economically operated. On June 20, 1984 the hearing officer ruled in favor of the Department, holding that the

Utah state and federal plan for reimbursing providers of Medicaid services in Utah does not require or contemplate examination of an individual facilities (sic) costs and a determination as to whether or not that particular facility is economically and efficiently operated -- nor does any other provision of state and federal law require such an examination.

(Letter of Hearing Officer, Brian Farr, June 20, 1984).

The administrative hearing finally commenced on August 3, 1984, over a year after it was originally requested. Pursuant to the hearing officer's ruling, Weber Memorial was never permitted to introduce evidence of its costs or to prove, as it was prepared to, that it is an efficiently and economically operated facility within the meaning of the federal statute.

On May 20, 1985, nearly two years after the request for hearing was submitted, the hearing officer issued his Proposed Decision, Findings of Fact and Conclusions of Law. The Executive Director adopted the findings on June 4, 1985. Weber Memorial appealed the decision to the District Court, which issued its opinion affirming the hearing officer on June 3, 1986, (Memorandum Opinion, J. Fishler), followed by a Final Judgment entered August 4, 1986 by Judge Daniels. Thereafter, this appeal was filed. Because Weber Memorial had previously filed an action

for declaratory and injunctive relief in the Federal Court, the record was transferred to that Court. In the meantime, the case was transferred to the Court of Appeals. The record having been recently returned to this court, the matter is now ready for review.

SUMMARY OF ARGUMENT

1. The State of Utah, by participating in the Medicaid program, has agreed to abide by all applicable federal statutes and regulations. The federal statute and regulations require participating states (1) to establish rates which are in fact reasonable and adequate to meet the costs of efficiently and economically operated health care providers (42 U.S.C. §1396a(a)(13)(A)); (2) to make "findings" that the rate is reasonable and adequate to meet the standard set forth in §1396a(a)(13)(A), (42 C.R.F. §447.252(b)); and (3) to provide "assurances" to the Secretary of HHS that the rate meets the standard set forth in 42 U.S.C. §1396a(a)(13)(A). Thus, the federal law establishes substantive limitations to a state's rate-setting authority. It is Plaintiffs' contention that Defendant established the "flat rate system" of reimbursement in violation of these substantive limitations. No objective study of the effect of the rates on any individual facility was conducted, and the rate was essentially based upon budgetary concerns. This is clearly in violation of federal laws. The State has argued all along that it need not

look at any facilities' costs, efficiencies, or economies -- that the flat rate itself defines "efficiency" and "economy" for purposes of federal law. This brief will demonstrate that such reasoning is not consistent with federal law. Furthermore, any "findings" and "assurances" submitted to HHS by the State, having no basis in fact, are defective as a matter of law.

2. The State's classification of a number of Plaintiffs' patients as "intermediate" rather than "skilled", is arbitrary and capricious. These patients were appropriately classified as "skilled" by medical personnel who actually examine and treat them. The State, never having seen or examined any of the patients, arbitrarily misclassified them as a further cost-savings measure.

ARGUMENT

I

THE UTAH STATE MEDICAID PLAN FAILS TO COMPLY WITH FEDERAL LAW AND IS THEREFORE INVALID

A. The Utah State Plan Exceeds the Substantive Limitations of the Federal Statute

The Appellant, Weber Memorial Care Center, is a provider of Medicaid services within the State of Utah and, as such, is subject to both state and federal regulations due to its participation in Title XIX, and has done its best to comply with all

relevant rules and regulations at both the state and federal levels since the commencement of its operation.

Weber Memorial accepts patients who qualify for medical assistance under the Utah state plan which was filed pursuant to Title XIX of the Social Security Act with the Secretary of Health and Human Services. Presently, however, the Department of Health of the State of Utah refuses to pay a fair and legally required rate of reimbursement to Weber Memorial for care rendered to the said patients. As already pointed out, the federal statute underlying the federal Medicaid regulations is found at 42 U.S.C. §1396a(a)13(A). The statute, as well as the federal regulations, are set forth in the Addendum in full (Addendum-1). The regulations, of course, reiterate the requirement set forth in the statute that rates must 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." (Emphasis added.) 42 C.F.R. §447.253(b)(1). The State is required to make "findings" that "the rates used to reimburse providers satisfy the requirements of the regulations." Id. at 447.253(b). After these "findings" are completed, the State must then make and submit "assurances" to the federal government that the requirements of the statute, as well as "all other parts of [the regulations]" are being met. Id. at 447.253(a). The State's

plan, which must be formulated pursuant to the statute and regulations mentioned above, must incorporate the affirmative requirements of the statute and regulations. 42 C.F.R. §447.252.

In this case, the hearing officer, as well as the District Court, apparently glossed over the requirement of "findings" and "assurances" in connection with a state plan. Apparently, because the State did submit assurances which were accepted by the federal government, the hearing officer failed to look beyond the surface at those assurances in order to determine whether or not they were supported by "substantive findings" and therefore had a basis in fact.

Again, the regulations implementing the federal Medicaid statutes require that the state Medicaid agency must find that the rates to reimburse providers satisfy the requirements of law, i.e., that the rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." 42 C.F.R. §447.250(a). As the record in this matter is reviewed, it becomes clear that the Department of Health of the State of Utah has not made findings sufficient to provide assurances to the Department of Health and Human Services, (hereinafter the HHS), of compliance with federal law. In fact, no findings at all have been made by the Secretary or the State of Utah relative to what methodology will meet the federal require-

ments. As the deposition of Vaughn Emmett, Director of the Bureau of Program Review, Department of Health, State of Utah, indicates, there have been no studies conducted by the Department of Health that have examined any provider in the state to determine whether such providers are efficiently and economically operated.

In Thomas v. Johnston, 557 F. Supp. 879 (W.D. Tex. 1983), the District Court granted the provider's motion for a preliminary injunction, in part, for the reason that the state rate setters failed to examine actual costs and provider efficiencies.

From all that appears to this Court . . . [the state] never sought to ascertain, and thus never knew, even the approximate extent of provision of unnecessary services or of provider inefficiency. No attempt was made to go outside of provider cost reports in an effort to determine the extent or nature of unnecessary services; admittedly, [the state] undertook no independent study of any facility's provision of services, or its economy and efficiency, nor did it attempt to determine in any manner what the cost of a required service should be.

(Emphasis added). Id. at 906. Similarly, the Court found that the rate-setters failed to "ascertain whether facilities within the same level of care indeed had a similar "mix" of residents before choosing to rely upon the Department of Health's Certification as its primary basis for determining adequacy of reimbursement rates." Id. In the context of this case, the record will likewise reflect the Department's failure to conduct any "independent study of any facility's provision of services, or

its economy and efficiency," nor did it examine the "costs" of any services at Weber Memorial or any other particular facility. Additionally, as discussed in Section III below, the special "mix" of residents at Weber Memorial, or other facilities for that matter, was in no way considered in the rate-setting process. As the Court in Thomas v. Johnston found, such a "manner" of adopting the "reimbursement rate structure was arbitrary, capricious, and in violation of federal law." Id. at 904.

In Nebraska Health Care Association v. Dunning, 778 F.2d 1291 (8th Cir. 1985) cert. denied, ___ U.S. ___, 107 S.Ct. 947 (1987), the District Court was upheld on appeal in its finding that the Nebraska state plan was invalid. After citing the regulations discussed above requiring findings and assurances, the Court stated:

The Defendants admit the Department did not conduct an any objective analysis or studies to determine the effect of §68-720's limitations on the level of care Medicaid patients would receive or the extent to which facilities would continue to participate in Medicaid. Slip Op. 9.

Thus, the quantified estimates of various effects of the 3.75% limitation, required to be submitted by the applicable regulation. . . could not have been submitted, because the staff never conducted any objective analysis or studies to determine these effects. Accordingly, as the District Court found, 'there is no objective evidence to support the assurances which the Department gave to the federal government.' Id. at 10. The State's submission of its new plan was simply not accompanied by any information even purporting to meet the requirements of the

federal regulations. This fact, without more, is sufficient to invalidate HCFA's purported approval of the 3.75% "cap" for the fiscal year 1982-83. There was no factual basis for the assurances Nebraska submitted to HCFA, and HCFA's approval, being based on unsupported assurances, is without legal effect. (citation omitted).

(Emphasis added). Id. at 1294. The same rationale applies to Utah's "findings" and "assurances." That is, as the record demonstrates, having failed to conduct and prepare "findings" in accordance with the regulations, any "assurances" submitted to the federal government, having no "factual basis" would be "without legal effect."

As the Court stated in Hillhaven Corp. v Wisconsin Dept. of Health, 634 F.Supp. 1313, 1319 (E.D. Wis. 1986):

The failure to provide the requisite findings, assurances, and additional information set forth in 42 C.F.R. § 442.255(b) with respect to modification of reimbursement rates under a state Medicaid plan renders invalid those modified rates and the state statute [or regulation] under which they were established. Edgewater Nursing Center, Inc. v. Miller, 678 F.2d 716 (7th Cir. 1982); Nebraska Health Care Association v Dunning, 778 F.2d 1291, 1294 (8th Cir. 1985); Washington State Heath Facilities Ass'n v. State of Washington Dept. of Social and Health Services, 698 F.2d 964, 965 (9th Cir. 1982); Forbes Health Systems v. Harris, 661 F.2d 282, 286 (3d Cir. 1981).

The Court, finding that the State failed to provide the requisite findings and assurances, enjoined the State from enforcing the rates set in violation of the regulations. Id.

Federal law also requires that methods and standards be developed by the State in devising a reimbursement system. 42 C.F.R. §447.252(b). However, in this case, there was no testing, nor were any standards or methods established by Utah regarding the efficiency or economy of services provided. Instead, based upon conversations with some health care providers legislators and others with an interest in the matter, the State established a budget oriented, flat-rate reimbursement system. There was never a substantive finding by the State of Utah that "the rates to reimburse the providers satisfy the requirements" of the regulations or 42 U.S.C. §1396a(a)(13)(A).

As the Court in Thomas v. Johnston, supra, pointed out,

The statute clearly and expressly leaves room for states to cut unnecessary costs in a wide variety of ways. On the other hand, however, it manifestly imposes a substantive limitation on state governmental action -- that rates determined by Medicaid agencies must be high enough to compensate efficiently and economically operated providers for costs necessarily incurred in providing the type of care for their residents that conforms to all applicable state and federal laws and requirements . . .As stated above, under this standard, state Medicaid agencies are free to deny providers compensation for provision of unnecessary services. Likewise, the states are not required to pay all costs incurred by providers that are not operating efficiently and economically. Thus, states not only have a great deal of flexibility in selecting the methods by which rates will be determined, but are also accorded freedom to decide what costs are necessary or unnecessary, and to determine whether and which providers are operating efficiently

and economically. In addition, the development of the Medicaid Act and the evolution of the reimbursement system away from Medicare principles of reimbursement make it clear that states are not required to make their decisions concerning 'efficiency and economy' and 'adequacy' with the greatest degree of precision. Nevertheless, the bottom line of the federal statutory standard, the substantive limit placed by Congress upon the states, is that rates must be sufficient to compensate efficiently and economically operated providers for the necessary costs they incur in providing required care to their residents.

(Emphasis added). Id. at 909. It is submitted that the State of Utah, through its Department of Health, clearly exceeded the "substantive limitation" imposed by the federal statute.

In the initial hearing, the Executive Director of the Utah Health Care Association, Dennis McFall, also a member of the Flat-Rate Committee which formulated the modified flat-rate system, testified as follows:

Q. I'm going to ask you some specific questions about those factors the Committee considered or did not consider in the adoption of the flat rate system about which we are speaking. Number one, did the Committee consider any rules or regulations of the state of Utah relating to the efficient or economic operation of long-term health care facilities in the state of Utah?

A. To my knowledge there was no discussion relating to efficiency or economy of operations.

Q. Did the Flat Rate Committee make any specific decision, Mr. McFall, as to whether the flat rate [established] was sufficient to meet the cost of a long-term health provider which was efficiently and economically operated?

A. Again, not in relation to efficiency or economically operated, no.

Q. Did the Committee reach any conclusion, Mr. McFall, as to whether the flat rate system established by it established a rate which was sufficient to meet the costs which must be incurred by an efficient and economical provider participating in the State of Utah Medicaid system?

A. No.

Q. Did the Committee have any empirical data before it, Mr. McFall, which would have allowed it to test for efficient and economical operations by the long-term health care providers?

A. No.

(Hearing transcript, at 153-54). See also, testimony of Roy Dunn, (Hearing transcript at 57-58).

Again, as suggested by the Thomas court, when the regulations require the State to make certain "findings," the State must look at economy and efficiency of actual operations. Operations occur at individual facilities. Thus, looking only at broad profitability percentages is looking in the wrong place. Some of the most profitable nursing homes may very well be the least economic and least efficient providers of quality care. See, Children's Memorial Hospital v. Illinois Department of Public Aid, 562 F. Supp. 165, 171 (N.D. Ill. 1983) ("an amount double the Illinois' ceiling might perhaps be paid out only to inefficient providers"). Mr. Elliott, the Administrator of Weber Memorial Care Center, for example, attempted to explain to the hearing officer that which

probably needs very little explanation: that bottom line costs do not necessarily indicate efficiency or the lack thereof. For example, Weber Memorial, prior to its purchase and when the county owned it, did not have to pay property taxes, but now does, because it is privately owned. (Hearing Transcript at 478). When asked what factors would account for a higher cost provider being actually more efficient and economical than a lower cost provider, Mr. Elliott answered:

There are several variables that can be considered. (1) The primary one is the needs of patients in various facilities may be different. Some may require more care that would involve more services. The facility may provide more services. One facility may provide more services to that patient than another. We have to look at the patient's rehabilitation potential in different areas of different facilities. Medical supplies going to those patients may vary, and the amount of supplies going to an individual patient may vary.

Utility costs may be different. As stated earlier, climates may be different. Some utilities may be more expensive. Some facilities may use a different type of heating fuel that may cost less. The labor market in a rural area may be different than in a large metropolitan area as far as costs of help and the costs of obtaining qualified help. The mill levy in different counties. . . construction of the facility may vary. The size of the facility and the ground maintenance costs may vary. The ages of the facilities may vary, and the property costs will vary in relation to the depreciation, insurance, taxes, etc.

(Hearing Transcript at 480). These cost and efficiency factors must be taken into account in the rate-setting process. In this

case they were not. Furthermore, as seen in Section II below, the hearing officer steadfastly refused to consider the very indicia of the State's compliance with the "substantive limitations" already pointed out, i.e., the costs, the efficiencies" and "economies" of Weber Memorial Care Center.

In order for the state agency to have made proper "assurances" to the federal government, it is apparent that examination of actual providers and actual facilities was required. As already mentioned, that did not occur. It is clear that the assurances made were but bald assertions based on the language of the regulations, but without substance in fact. Therefore, until the state plan meets those requisites, it is defective and should be declared invalid. See, e.g., Nebraska Health Care Association v Dunning, supra; Hillhaven Corp. v. Wisconsin Dept. of Health, supra.

While it is true that the actions of the Department of Health in formulating the state plan are presumptively valid, the law "by no means insulates or immunizes the plan from judicial scrutiny. . .," and "the burden of overcoming this presumption . . . is not insurmountable." Ex Parte Luverne Geriatric Center, Inc., 480 So.2d 562, 565 (Ala. 1985); Skinner v. United States, 594 F.2d 824, 830 (Ct. Cl. 1979).

There is of course no question that the federal government . . . may impose the terms and conditions upon which its money allotments to the

states shall be disbursed, and that any state law or regulation inconsistent with such federal terms and conditions is to that extent invalid . . . It is equally clear that to the extent HEW has approved any [state law or regulation] which conflicts with §406(a) of the Social Security Act. . . such approval is inconsistent with the controlling federal statute.

Ex Parte Laverne Geriatric Center, Inc., supra, 480 So.2d at 565, quoting King v. Smith, 392 U.S. 309, 333 (1968); 2 Am. Jur. 2d Administrative Law §300 ("It is a fundamental legal principle that a rule or regulation which is broader than the statute empowering the making of rules, or which oversteps the boundaries of the statutes by extending or restricting the statute contrary to its meaning, cannot be sustained"). Thus, "even though the [federal] Department of Health and Human Services had previously approved the plan," "the Secretary's approval is in nowise a conclusive determination of the plan's validity, but rather, is subject to judicial review." Id. at 595. See, also, Alabama Hospital Association v. Beasley, 702 F.2d 955 (11th Cir. 1983); Atchinson Topeka and Santa Fe Ry. Co. v. United States, 617 F.2d 485, 496 (7th Cir. 1980) ("A court does not defer to an administrative construction of a statute when there are 'compelling indications that it was wrong.'").

As the Ninth Circuit Court of Appeals recently found, a provider plaintiff does have a right to have its claim heard on the merits, and to receive a judicial determination as to

whether "the actions and non-action of the State . . . violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A)." Coos Bay Care Center v. State of Oregon, Department of Human Resources, 803 F.2d 1060, 1063, (9th Cir. 1986). It is indeed a very important function of both federal and state courts to assure compliance by administrative officials and agencies with applicable laws. See, e.g., Miller v. Youakim, 440 U.S. 125 (1979); Becker v. Toia, 439 F. Supp. 324 (S.D.N.Y. 1977); Robinson v. Pratt, 497 F. Supp. 116 (D. Mass. 1980) (court may order compliance with statutes and regulations regarding the administration of the Medicaid program); Washington State Health Facilities Association v. State of Washington Department of Social and Health Services, 698 F.2d 964 (9th Cir. 1982) (federal court enjoined state from enforcing a regulation which deviated from federal requirements); Illinois Hospital Association v. Illinois Department of Public Aid, 586 F. Supp. 360 (N.D. Ill. 1983) (federal court enforced hospitals' rights under 42 U.S.C. § 1396a(a)(13)(A); court need not defer to agency expertise); Addison Gilbert Hospital v. Rate Setting Commission, 390 Mass. 17, 453 N.E. 2d 424 (1983) (recognized cause of action by private providers to enforce both "procedural" and "substantive" requirements of 42 U.S.C. § 1396a(a)(13)(D). Court stated: "Although the defendants allege that no federal cause of action can be implied for providers from the Medicaid laws, declaratory

judgment or damage actions for rate reimbursements have been entertained by numerous state and federal courts. See, e.g., California Hosp. Ass'n. v. Obledo, 602 F.2d 1357 (9th Cir. 1979); Massachusetts Gen. Hosp. v. Weiner, 569 F.2d 1156 (1st Cir. 1978); Massachusetts Hosp. Ass'n. v. Harris, 500 F.Supp. 1270 (D. Mass 1980); Massachusetts Gen. Hosp. v. Sargent, 397 F.Supp. 1056 (D. Mass. 1975); Monomouth Medical Center v. State, 80 N.J. 299, 403 A.2d 487, cert. denied, 444 U.S. 942, 100 S.Ct. 297, 62 L.Ed. 2d 308 (1979). Such a private right of action has been consistently recognized by many courts; it is, therefore, 'simply beyond peradventure.' Herman & MacLean v. Huddleston, ____ U.S. ____, 103 S.Ct. 683, 687, 74 L.Ed. 2d 548 (1983)". The point is, therefore, that judicial oversight is appropriate with respect to the Medicaid reimbursement rates set forth by state administrators. This Court is in no way obligated, as the hearing officer apparently felt he was, to defer to the "expertise" or judgment of the state officials. A state plan which is out of compliance with federal standards is certainly subject to judicial intervention.

Weber Memorial, therefore, respectfully urges the Court to carefully scrutinize the rate-setting procedures in question here in light of the "substantive limitations" of federal law discussed above. When the record is reviewed, it is submitted that it will become clear that those limitations were breached with the imposition of the flat-rate system.

P. The Flat Rate in Question Was to an Impermissible
Extent Determined by Budget Factors

States are not required to participate in the Medicaid system. However, once a state chooses to participate, it must abide by federal statutes and regulations governing the program, including reimbursement to participating providers, Harris v. McRae, 448 U.S. 297, 301 (1980), and may not base its reimbursement system to an impermissible extent upon budget considerations, see, Thomas v. Johnston, supra, 557 F.Supp. at 914 (W.D.Tex. 1983); California Hospital Association v. Schweiker, 559 F.Supp. 110 (C.D. Cal. 1982), aff'd 705 F.2d 466 (9th Cir. 1983).

Testimony elicited at the administrative hearing, as well as during the deposition of Dr. James Mason, former Executive Director, Department of Health for the State of Utah, supports Weber Memorial's contention that the modified flat rate system was established primarily as the result of budget considerations, and therefore, violates federal law. See e.g., Hearing Transcript at 159-68; 181; 185; 187-88; 285-86; 391; 412-13; Deposition of James Mason, at 10; 15 22.

Dr. Mason stated that, "we then, within that budget, the Utah legislative appropriation[,] had to work things out so the bottom line equaled what was an adequate appropriation." Id. at 22.

Dennis McFall, member of the Flat Rate Committee, testified that upon threat of Dr. Mason to move to a less desirable, almost punitive, reimbursement system, the Committee recommended the modified flat rate system. During the hearing he testified that:

Q. Mr. McFall, were there discussions on the part of Dr. Mason regarding the necessity with the Flat Rate Committee to stay within the FY 1982 Medicaid budget regardless of what kind of reimbursement methodology was arrived at?

A. It's my impression that there were, yes. I recall several times, statements made by Dr. Mason that we must remember we've only got this number of dollars. We've only got this amount.

(Hearing Transcript at 166). See also, testimony of Jay Winslow, (Hearing Transcript at 412-13.)

It is clear that budget constraints were a major factor in establishing the modified flat rate system. Contrary to the implication in Judge Fishler's decision, the Court need not find that those budget constraints were the sole basis for the State's rates in order to find them illegal, but merely that budget concern were a major or significant factor. See, e.g. California Hospital Association v. Schweiker, supra.

In Hillhaven Corp. v. Wisconsin Dept. of Health, supra, the court invalidated a three-month rate freeze by the State of Wisconsin. While the court found as a matter of fact that the freeze was based solely upon budgetary concerns, the decision is

instructive here. Defendants argued that such a short-term rate freeze could not violate the statute. In rejecting the argument, the Court stated:

The defendants' argument is not persuasive. The length of the freeze would appear to be a pertinent consideration only if the state had undertaken a study prior to the enactment of the freeze which indicated that a three-month moratorium on rate increases would not affect the reasonableness and adequacy of the rates paid due to prevailing economic factors. A freeze [or rate] imposed without such considerations having been made beforehand, whether it be for three months or longer, would result in reasonable and adequate rates only by chance and not be design.

(Emphasis added.) Id. 634 F.Supp. at 1320. Thus, the Court found the rates in violation of "the requirement implicit in § 1396a(a)(13)(A) that rates not be set arbitrarily." Id. As pointed out in the previous section, the Utah flat rate was adopted without any study or objective analysis as to how the new rate would "affect the reasonableness and adequacy of the rates paid."

Therefore, the only conclusion that can be reached is that the State of Utah did indeed, to an impermissible extent, focus upon budgetary factors in setting its rate. Again, while the Boren Amendment was intended to give the states some flexibility, Congress has "recognized the paramount interest in securing adequate health care for our citizens." Luverne

Geriatric Center, supra, 480 So.2d at 568. As the House Committee which formulated 42 U.S.C. §1396a(a)(13)(A) stated:

The Committee is concerned that the reimbursement methods established by the states recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services. For example, the Committee does not intend that the only facility providing a specific type of treatment . . . not be available to Medicaid beneficiaries because the State's payment level is inadequate to meet the basic cost of care in that facility.

2 H.R. Rep. No. 158 at 293-94.

In Thomas v. Johnston, supra, 557 F.Supp. at 914-15, the Court found that, "[a]gainst the background of Defendant's fundamental lack of information and their failure to consider highly relevant factors bearing upon the adequacy of reimbursement rates," the state agency's overreliance upon budgetary considerations "cross[ed] the boundaries of permissible consideration of budgetary restraints and may, indeed, represent the very behavior that Congress sought to prevent."

As the Court noted,

the state Medicaid agency must make an objective, principled decision with regard to what rates are reasonable and adequate. The law is clear that "[i]nadequate state appropriations do not excuse noncompliance." Alabama Nursing Home Association v. Harris, 617 F.2d at 396. This must be true, for "[i]f a state could evade the requirements of the Act simply by failing

to appropriate sufficient funds to meet them,
it could rewrite the congressionally imposed
standard at will. That obviously is not the
case. Alabama Nursing Home Association v.
Califano, 433 F. Supp. at 1330.

Id. If the State is permitted to define "economy and efficiency"
(as those terms are set forth in the federal statute), as
whatever level of reimbursement the State chooses, one can
imagine in more severe economic times, for example, the State
setting the reimbursement rate at, say, 20%. Under the State's
view, and that implicitly adopted by the Hearing Officer and
District Court, the provider may not be heard to complain. The
rate itself defines efficiency and economy and he should either
accept it or get out of the business. The problem with such
reasoning is that it is simply not consistent with federal law.
Not only does the law require "an objective, principled decision
with regard to what rates are reasonable and adequate," (and
"inadequate appropriations do not excuse noncompliance,") id.,
but the very structure of the Medicaid system, as it applies to
long-term health care providers, is to induce private providers
to commit their assets, facilities and personnel to the provision
of needed health care services to elderly and disabled Americans.
Thus, Congress rejected the idea of the creation of government-
owned and operated facilities, with its massive price tag, in
favor of incentives for private participation. The "carrot" for
the private provider is the assurance that he who is efficient

and economical in his operations will have his costs met. When we have a budget-driven, arbitrarily established rate which ignores the very intent of Congress and goes against the grain of the implementing legislation, as is the case in Utah, it is the duty of the courts to take corrective action.

In this case, then, when one considers the total lack of objective information and principled decision making that went into the flat rate system, coupled with the underlying budgetary concerns present when the Flat Rate Committee deliberated, one can only conclude, as did the Court in Thomas v Johnston, that

the current [Utah] reimbursement rate structure [is] arbitrary, capricious and inconsistent with federal law and regulations, and that Defendant's findings and assurances to HCFA that reimbursement rates complied with the statutory standards likewise were arbitrary and failed to conform to federal law.

Id. at 915.

II

EVEN IF THE UTAH STATE PLAN IS NOT INVALID PER SE, THE HEARING OFFICER'S REFUSAL TO ALLOW WEBER MEMORIAL THE OPPORTUNITY TO SUBMIT EVIDENCE OF ITS COSTS AND TO PROVE IT IS AN EFFICIENTLY AND ECONOMICALLY OPERATED FACILITY, WAS CONTRARY TO THE APPLICABLE FEDERAL STATUTE AND REGULATIONS AND IN VIOLATION OF APPELLANT'S RIGHT TO A FAIR HEARING

The Hearing Officer's Evidentiary Rulings Denied Weber Memorial the Opportunity to Demonstrate That the Reimbursement Rates in Question Are Arbitrary and Capricious as Applied.

Keeping in mind the thrust of the Boren Amendment, that efficiently and economically operating facilities are to have their costs met, Weber Memorial, feeling that it qualified under that standard and yet was not having its costs met, sought a hearing before a hearing officer appointed by the Utah State Department of Health. As already described earlier, when Weber Memorial was finally able to receive its hearing, it was totally precluded from producing evidence which would have demonstrated that it met the very objective of the statute.

As one court recently explained:

Although 42 U.S.C. §1396(a) was amended October 1, 1980, the change, known as the Boren Amendment, expressly reflects an emphasis in reimbursement to that which is reasonable and adequate to meet a cost incurred by a facility in order to conform to applicable state and federal laws and regulations. Therefore, . . . the new Boren Amendment requires full and current reimbursement of actual expenditures incurred by facilities. As well, it prohibits any device utilized by a state to lower reimbursement, other than that authorized by statute.

(Emphasis added). Geriatrics, Inc. v. Colorado Department of Social Services, 712 P.2d 1035, 1039, (Colo. App. 1985). Thus, the Court recognized that the intent of the law is to reimburse facilities for "actual expenditures incurred," as long as those expenditures are made in order to conform to applicable law, and assuming the facility is efficiently and economically operated. Indeed, the law requires that "the rate in fact must be reasonable

and adequate within the meaning of the statute." Hillhaven Corp. v. Wisconsin Dept. of Health, supra, 634 F.Supp. at 1318, citing 42 C.F.R. § 447.252(a)(1982). In this case, the preliminary ruling of the hearing officer referred to earlier speaks for itself. Several months prior to the hearing, he effectively closed the door to the evidence most crucial to Weber Memorial's case. Indeed, the transcript of the hearing is replete with examples of how the hearing officer's ruling effectively denied Weber Memorial an opportunity for a fair hearing. See, Excerpts from Transcript of Formal Hearing, Hearing held August 3, 1984 Before Brian L. Farr, Administrative Law Judge, Addendum. Plaintiff was effectively denied any opportunity to prove that the rate "in fact" was not "reasonable and adequate" to meet its costs "within the meaning of the statute."

In Children's Memorial Hospital v. Illinois Department of Public Aid, 562 F. Supp. 165 (N.D. Ill. 1983), an individual hospital, (which is reimbursed under the same statute involved here), brought an injunctive proceeding against the Illinois agency responsible for administering the Medicaid program in that state. The state had imposed a percentile "ceiling" on reimbursement. The Court, in determining that the rates in question were "arbitrary and irrational" as applied to the plaintiff, made several observations which apply in this case.

[The provider] is being penalized not for any inefficiency but because its patients fall into the more complex ends of the more complex primary diagnostic groups.

* * *

Any "efficiency" system based upon average hospital stays is obviously inapplicable to [the provider's] special circumstances. (Citation Omitted).

* * *

[The Department] rel[ies] on facts and studies irrelevant to the question of the efficiency of a hospital like Children's Memorial . . . They do not address the actual circumstances of Children's Memorial.

[The provider] has presented compelling evidence that [the rule establishing the ceiling rate] does not present a reasonable and adequate plan for reimbursing Medicaid costs at a hospital with Children's Memorial's special mix of patients. As applied to [the provider], [the rule] is the kind of arbitrary plan both Senate and House committees were at pains to deny Section 13(A) would justify . . . [The provider] has a reasonable likelihood of success on its claim [that the rule] violates Section 13(A) by failing to provide reimbursement for an "efficiently and economically operated" . . . facility.

(Emphasis added) Id. at 173. the Court clearly read the statute as permitting the individual provider the opportunity to demonstrate the arbitrary application of the rule to it -- by showing that given its particular circumstances, it is efficiently and economically operated, but is not having its costs met under the applicable rates.

It is a fundamental principle of due process that a party appearing before an administrative body is entitled to a fair hearing, including the opportunity to be heard at a meaningful time and in a meaningful manner. The effect of the hearing officer's ruling, as well as the District Court's affirmance thereof, is to deny Weber Memorial a meaningful and fair hearing on the central issue of the entire statutory scheme.

Thus, while the hearing officer certainly had the authority under his fact-finding powers to find that Weber Memorial was not in fact an efficiently and economically operating facility, or that it was in fact having its costs met, etc., he refused to even take any evidence on those issues. In essence, Weber Memorial has never had its day in court.

A participant provider in the Medicaid system no doubt has a property interest in achieving or enforcing its rights under that system. See, e.g. Bowens v. North Carolina Department of Human Resources, 710 F.2d 1015 (4th Cir. 1983). The question in this case, insofar as the Constitution is concerned is what type of hearing is required. The particular type of hearing "must be tailored to the capacities and circumstances of those who are to be heard." Goldberg v. Kelly, 397 U.S. 254, 268-69 (1970).

In this case, the only way Weber Memorial can be heard in a meaningful manner is to permit it to demonstrate its costs

and to submit evidence concerning its efficiencies. Weber Memorial's witnesses would, of course, be fully subject to cross-examination. It is only by permitting this kind of evidence, focused upon the individual provider, that the circuitous logic of the State, (that the rate is the definition of efficiently and economically operated, and that the only way to be considered efficiently and economically operated is to have costs below the flat rate), can be broken.

Assuming for purposes of argument that the Court does not find the flat rate system invalid per se, and in the alternative, Appellant seeks a remand to the District Court or the hearing officer for a true evidentiary hearing in which the Appellant, given the guidelines which the Court will hopefully provide concerning the requirements of federal law, will receive the opportunity to prove that it is an efficiently and economically operated facility and yet is not having its costs met under the Utah State Medicaid Plan.

III

THE DEPARTMENT'S CLASSIFICATION OF PATIENTS IN NEED OF "SKILLED" CARE AS "INTERMEDIATE" PATIENTS IS ARBITRARY AND CAPRICIOUS

Under the Medicaid system employed by the State of Utah, the Department classified Medicaid patients as either "skilled" or "intermediate," care for the former being reimbursed by the

State at some \$7.00 to \$8.00 per day higher than the latter. Apparently, the State uses the classification system, heavily weighted toward classifying patients as "intermediate," in order to cut its costs under Medicaid. Even though on a national basis approximately forty per cent (40%) of patients are classified as "skilled" (Hearing Transcript at 217), Utah classifies only three (3%) to ten (10%) per cent of all patients as "skilled." This is obviously a cost savings to the state, but further places a burden on a provider who must provide the service to the patients at the skill level required, regardless of a bureaucrat's arbitrary designation. Skilled patients, by definition, require more intensive care (Hearing Transcript at 445). Staffing must be higher, as is the use of ancillary materials and supplies.

Weber Memorial routinely sends its evaluation regarding the needs of patients to the Department, and designates the patient as "skilled" or "intermediate." This is based on a hands-on review of the patient by qualified health care professionals. Yet, the assessment of the patient is routinely reduced by the officials within the Department, and the "intermediate" rather than the "skilled" designation is over used by persons who have never seen these patients. (Hearing Transcript at 430; 545-547). Weber Memorial estimates that thirty-eight (38) patients at the facility, at the time of the hearing, had been arbitrarily classified by Department at an annual cost of approx-

imately One Hundred Twenty Thousand Dollars (\$120,000.00) -- a significant hardship for Weber Memorial. (Hearing Transcript at 402). This further illustrates that the flat rate system does not work effectively to satisfy the requirement of federal law. See, Children's Memorial Hospital v. Illinois Department of Public Aid, supra. These unreimbursed costs are never paid by the State of Utah and must be absorbed by the provider. Patients and their needs, in the aggregate, do not change. Reimbursement does change downward arbitrarily, so that the skilled population is squeezed more and more each year.

Coupled with the Utah change in regulations so that the Appellant can no longer bill for laboratory, pharmacy, and x-ray services (Hearing Transcript at 734), it is no wonder that the costs of the facility are not being met. This illustrates that the flat rate system does not and cannot comply with federal law in Weber Memorial's case. As the Court in Children's Memorial Hospital, supra, found, the law requires that a facility's "special mix" of patients be taken into account in determining whether the rate, as applied, is "arbitrary and irrational." Children's Memorial Hospital, supra, 562 F. Supp. 173. See, also, Thomas v. Johnston supra, 557 F. Supp. at 912 (the Department "did not take adequate steps to investigate the problem of provider specialization or its possible consequences, [nor did it

attempt] to verify its primary assumption that all facilities are responsible for approximately the same "mix of resident needs").

IV.

THE DISTRICT COURT ERRONEOUSLY APPLIED A DEFERENTIAL STANDARD TO THE AGENCY'S CONCLUSION OF LAW

One final point needs to be made concerning the standard of review in this case. In reviewing the Memorandum Decision of Judge Fishler (Addendum - 18) and the Final Judgment by Judge Daniels (Addendum - 19), it is evident that the District Court applied a deferential standard to the review of the Executive Director's decision with its incorporation of the Hearing Officer's findings and recommendations. Apparently, the District Court felt constrained by UCA § 26-23-1(3) to rule in favor of the State if the Executive Director's "final determination was supported by a residuum of legally admissible evidence in the record and was not arbitrary and capricious." As pointed out at length already, Plaintiffs submit that the record does not support the prior determination even as adjudged by the deferential standard. However, the District Court's ruling is fundamentally flawed for another reason. An Appellate Court is never required to defer to an agency ruling on questions of law and on rulings on the admissibility of evidence. The cryptic decision of the District Judges below, on their face, reflect a failure

to recognize the appropriate standard of review on these questions. Furthermore, this Court certainly has the inherent authority to review and correct erroneous rulings of law without any deference to either the agency's findings and conclusions or the District Court's erroneous determination.

In State of Minnesota v. Heckler, 718 F.2d 852 (8th Cir. 1983), in a Medicaid dispute between a state and the federal Department of Health and Human Services, the Court of Appeals reviewed the decision of the District Court which had reviewed the findings of the Health and Human Services Departmental Grant Appeals Board. The Appeals Board had disallowed federal financial participation to the state for certain costs incurred in three community residential facilities. The specific question concerned whether the three facilities were "institutions for mental diseases." If they were, they did not qualify for federal Medicaid participation. As the Court noted in deciding this question:

The HHS' Department Grant Appeals Board reached conclusions of both fact and law. The agency's formal findings of fact will be upheld if supported by substantial evidence in the record considered as a whole. (Citations omitted).

In contrast, the agency's guidelines interpreting a statutory term and regulation ultimately involve questions of law which are to be resolved by the Court. See, Bratterton v. Francis, 432 U.S. 416, 424-26 & n.9, 97 S.Ct. 2399, 2404-06 & n.9 53 L.Ed.2d 448 (1977); Social Security Board v. Nierotko, 327 U.S. 358, 368-69, 66 S.Ct. 637, 642-43, 90 L.Ed.2d 718 (1946); White Industries, Inc. v. Federal Aviation Administration, 692 F.2d 532, 534 (8th Cir. 1982); 5 U.S.C. § 706 (1982).

(Emphasis added). Id., 718 F.2d at 860. Particularly because the interpretation of a federal statute is involved here, and because a determination of Congressional intent is a necessary element of that interpretation, the agency's own interpretation of the law is entitled to no deference. As stated in Salt Lake City Corporation v. Department of Employment, 657 P.2d 1312, 1316 (Utah 1982)

In administrative cases, our scope of review of an agency's decision as to legal questions and questions of mixed law and fact is generally broader than our scope of review of questions of fact. On most questions of statutory construction, with some exceptions, our review is plenary with no deference accorded the administrative determination.

(Emphasis added). See, also, Madison v. Alaska Department of Fish and Game, 696 P.1d 168 (Alaska 1985) (issues of statutory interpretation and whether administrative board acted within its statutory authority "fall into the realm of special competency of the courts;" statutory interpretation of the words "customary and traditional" at issue); Gardiner v. Arizona Department of Economic Security, 623 P.2d 33, 36 (Ariz. App. 1980) ("court may substitute its judgment for the agency's conclusions regarding the legal effect of [the] facts"); International Brotherhood of Electrical Workers, Local 1357 v. Hawaiian Telephone Co., 713 P.2d 943 (Hawaii 1986) (agency's legal conclusions are freely reviewable by the courts); Dangerfield v. Montgomery Ward Co.,

Inc., 694 P.2d 439 (Kan. 1985) (questions of law are always open to review by courts); Conwell v. City of Albuquerque, 637 P.2d 567, 569 (N.M. 1981) (Court "may correct the [administrative] decisionmaker's misapplication of the law"); Clarke v. Shoreline School District No. 412, King County, 720 P.2d 793 (Wash. 1986) (reviewing court reviews the issues of law de novo).

In this case, then, because a resolution of this case requires an interpretation of the "Boren Amendment", 42 U.S.C. § 1396a(a)(13)(A) and the implementing federal regulations, the District Court erred in applying a deferential standard. This Court may then interpret the statute de novo in arriving at its decision. Additionally, since the refusal to permit the introduction of the evidence regarding Plaintiffs' costs and efficiencies, as discussed previously, was clearly prejudicial to Plaintiffs' case, as appears on the record, Downey State Bank v. Major-Blakeney Corporation, 578 P.2d 1286 (Utah 1978), and was contrary to the underlying purpose and intent of the governing statute, this Court should reverse the judgment of the Court below.

CONCLUSION

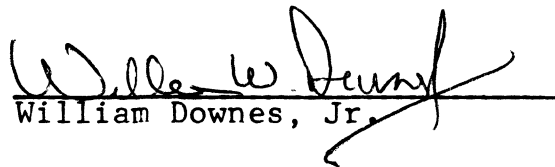
Based upon the foregoing, Weber Memorial respectfully requests that the Court declare the State of Utah Medicaid Plan,

and particularly the "flat rate" aspect thereof, invalid. Alternatively, Appellant simply seeks the opportunity to submit evidence before a hearing officer demonstrating that it is an efficiently and economically operated facility within the meaning of the federal law, but that it is not having its costs met within the flat rate.

Finally, Weber Memorial also seeks a reversal of the previous rulings concerning the classification of patients.

DATED this 30th day of April 1987.

HOUPT, ECKERSLY & DOWNES


William Downes, Jr.

LOJEK & HALL, CTD.


Donald W. Lojek

CERTIFICATE OF MAILING

I HEREBY CERTIFY that four true and correct copies of the foregoing Appellants' Brief were mailed, postage prepaid, on the 30th day of April, 1987 to:

Clark G. Graves
Asst. Attorney General
Utah State University
Office of the President
Logan, UT 83422-1400



Donald W. Lojek

§ 1396a. State plans for medical assistance.

(a) Contents

A State plan for medical assistance must—

42 § 1396a

PUBLIC HEALTH AND WELFARE

any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the disease of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; and

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports;

1984 AMENDMENT

42 CFR Ch. IV (10-1-85 Edition)

[46 FR 58680, Dec. 3, 1981; 47 FR 8567, Mar. 1, 1982, as amended at 48 FR 56057, Dec. 19, 1983]

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

SOURCE: 46 FR 47971, Sept. 30, 1981, unless otherwise noted.

§ 447.250 Basis and purpose.

(a) This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

(b) Section 447.253(a)(2) implements section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care;

(c) Section 447.271 implements section 1903(i)(3) of the Act, which requires that payments for inpatient hospital services not exceed the hospital's customary charges.

(d) Section 447.280 implements section 1913(b) of the Act, which concerns reimbursement for long-term care services furnished by swing-bed hospitals.

[48 FR 56057, Dec. 19, 1983]

§ 447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with 45 CFR 201.2.

(c) If the agency chooses to apply the cost limits established under Medicare (see § 405.460 of this chapter) on an individual provider basis, the plan must specify this requirement.

(Approved by the Office of Management and Budget under control number 0938-0193)

[48 FR 56058, Dec. 19, 1983]

§ 447.253 Other requirements.

(a) *State assurances.* In order to receive HCFA approval of a significant State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a significant change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are 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.

(ii) With respect to inpatient hospital services—

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) The methods and standards used to determine payment rates provide that reimbursement for hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1861(v)(1)(G) of the Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

[46 FR 47971, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981]

§ 447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

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(c) If the agency chooses to apply the cost limits established under Medicare (see § 405.460 of this chapter) on an individual provider basis, the plan must specify this requirement.

(Approved by the Office of Management and Budget under control number 0938-0193)

[48 FR 56058, Dec. 19, 1983]

BEFORE THE STATE DEPARTMENT OF HEALTH

**In Re: WEBER MEMORIAL CARE
CENTER, INC., AND CHARTHAM
MANAGEMENT, INC.,**

Plaintiffs,

v.

UTAH DEPARTMENT OF HEALTH
FINANCING,

Respondent.

PROPOSED DECISION,
FINDINGS OF FACT AND
CONCLUSIONS OF LAW

This matter was heard on oral argument. Having reviewed the transcripts of that argument, the exhibits admitted into evidence (including depositions taken herein), the written Final Arguments of the parties, the Proposed Findings of Fact and Conclusions of Law submitted by counsel, and applicable law, the hearing officer now submits the following Findings of Fact, Conclusions of Law and Proposed Decision to the executive director of the Department of Health in accordance with Rule 9 of the Administrative Hearing Procedures.

SUMMARY OF ISSUES

The Plaintiffs contend that the Utah State Plan for payment to Medicaid providers is defective because of the following:

- (1) The flat rate system was predetermined by the budget appropriated by the legislature of the State of Utah in 1981.
- (2) No standards were set by the State of Utah relating to efficient or economically operated facilities.
- (3) No "assurances" could be made to the Secretary of

HHS without appropriate findings being first made by the State of Utah in accordance with 42 C.F.R. § 447.252(c) and 447.255.

(4) The implementation of Utah of its definition of a "skilled" patient for purposes of Medicaid reimbursement is incorrect as to thirty-eight patients, at least, at the Weber Memorial Care Center, and suggestive of arbitrary and capricious State conduct.

Plaintiffs also defined the following issues:

1. Because the State of Utah has chosen to carve out an exception in the method of payment for services for the State Training School in American Fork, all providers should be afforded the opportunity to qualify for such an exception if good reasons exist for different treatment.
2. That Michael Stapley, acting director of the Utah State Department of Health is acting under color of state law and by so doing has violated 42 USC 1983 and 1988.

FINDINGS OF FACT

1. The Plaintiff, Weber Memorial Care Center Inc., is an Oregon corporation with its principal place of business in Roy, Utah, and is engaged in the principal business of providing longterm healthcare to the aged.
2. The Plaintiff, Chartham Management, Inc., is an Oregon corporation which provides management services to Weber Memorial Care Center, Inc.
3. The Respondent, the State of Utah, Department of Health, is the single state agency responsible for administering the Title XIX Medical Assistance Program within the state of Utah. Title XIX of the Social Security Act, as amended, is generally known as "Medicaid" and

establishes and governs the program for medical assistance to the indigent and developmentally disabled through the means of a cooperative effort between each of the participating states and the United States of America. The programs thus established are known generically as medical assistance programs.

4. Prior to 1981, the State of Utah reimbursed longterm healthcare facilities participating in the Medicaid program on a cost-related reimbursement schedule. Essentially, facilities would report their costs to the State of Utah, and, depending upon the state-determined propriety and necessity of those costs, they would be reimbursed in whole or in part. This was pursuant to the then current Utah state plan which had been approved by the Secretary of the Department of Health and Human Services.

5. Section 961 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499) deleted the medicaid requirement that skilled nursing facility and intermediate care facility services, be reimbursed on a reasonable cost related basis under standards and methods developed by the state and approved by the Secretary of Health and Human Services (HHS), and in its place, effective October 1980, the law required that states pay for these services on the basis of rates which the state finds, and makes assurances satisfactory to the Secretary of HHS, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable state and federal laws, regulations and quality and safety standards. This language is now codified at 42 U.S.C. §1396 (a) (13) (A) and 42 C.F.R. §447.252 and colloqually referred to as the "Boren Amendment."

6. Thereafter, the United States Department of Health and Human Services published regulations to implement said amendment, which regulations are found at 42 C.F.R. Part 447 and are incorporated herein by reference.

7. The Senate Report accompanying the new language stated:

The committee continues to believe that states should have flexibility in developing methods of payment for their medicaid programs and that application of the reasonable cost reimbursement principles of the medicare program for longterm care facility services is not entirely satisfactory. These principles are inherently inflationary and contain no incentives for efficient performance.

The committee bill deletes the present language . . . and substitutes language which gives the States flexibility and discretion, subject to the statutory requirements of this section, to formulate their own methods and standards of payment.

Senate Report No. 96-471, 96th Cong., 2d Sess., reprinted in 4 Medicare and Medicaid Guide Paragraph 24,407, at 8780-81 (CCH) (1981).

8. By letter, dated January 29, 1981, the Utah Health Care Association, which represents nearly all the nursing homes in the State of Utah, urged the State Legislature to endorse adoption of a system of payment to nursing homes furnishing long term care to medicaid patients, and defined the system as a "Modified Flat Rate" system. The letter represented that the system would return operating control to the owner or administrator, would relate to the cost of efficient operation, and would meet the requirements of State and Federal regulations pertaining to the medicaid program, and further that the system would be administratively less costly, and would virtually eliminate the potential for fraud or abuse of the system. The letter further represented the system had

been discussed with and approved by the State Department of Health, and asked for representation on an ad hoc committee to review and assist in the final development and approval of the specific elements of such a program. The letter then recommended a reduction in the nursing home budget for FY 1982 in the amount of 1.4 million dollars.

9. The State Legislature on January 30, 1981 directed the Department of Health to work with provider organizations in developing such a system, and a committee was formed, known as the "Modified Flat Rate Committee," and instructed to develop and ready the system for implementation by July 1, 1981. The committee consisted of a representative from the legislature, a legislative analyst, the Executive Director of the Department of Health, a medicaid reimbursement specialist, the Executive Director of Utah Health Care Association, the President of the Utah Health Care Association, and a representative of the industry (a nursing home operator, not a member of the Health Care Association).

10. The Modified Flat Rate Committee, hereinafter referred to as the Committee, assisted by staff members of the Department of Health and members of the health care industry, developed a system for payment of a fee for services to providers, which system has become known as the "modified flat rate" system and is often referred to as the "flat rate" system.

11. Pursuant to said system, patients who qualify for Medicaid assistance are classed according to the degree of care needed, the potential for rehabilitation, whether they are mentally retarded, etc. The nursing homes that render such services are to be paid a "flat rate" fee per

patient per day according to the classification of such patient. The flat rate to be paid for patients within each classification is the same statewide.

12. The flat rate derived for each class of patient was based on the most recent information on the actual costs being incurred by the nursing home industry in the aggregate, as reported by each facility on its 1980 "facility cost profile" (FCP); on comparison with the rates that other states were paying for nursing home services in Federal Region 8; on input from the Utah Health Care Association; on a trending factor on the historical costs as recommended by Lewin and Associates, a consulting firm that was retained by the State; on comparison with 1976 rates as inflated forward; on the legislative budget allocation; and on discussions and interactions on the Committee. The budget allocation itself was based on costs for prior years, projected forward.

13. The flat rate thus derived is inflated annually on the basis of the Consumer Price Index for urban areas less mortgage interest cost and is renegotiated with the industry annually.

14. Much of the discussion of the Committee centered around the treatment of property costs because there are significant differences in those costs between facilities and because of the opportunities to abuse the system through real estate transactions. In the letter mentioned in paragraph 8 above, the Utah Health Care Association said the modified flat rate system would "eliminate the incentive to engage in real estate transactions for profit on sale or lease of facilities." Two dollars per patient per day was added to the flat rate as partial compensation for historical property costs and return on equity. That amount is inflated

annually with the flat rate to cover increases in property tax, insurance, maintenance and contingencies. In addition to the flat rate, each facility also receives a "property differential" as additional compensation for property costs, which is unique to each facility and approximates three-fifths of the property costs as of March 27, 1981. Said property differential is not inflated.

15. The Committee did not do a facility by facility analysis to determine whether each particular facility could be operated more economically or efficiently.

16. Congressional intent expressed in the Senate committee's report states:

Under the bill, (the) State would be free to establish rates on a statewide or other geographic basis, a class basis, or an institution-by-institution basis, without reference to medicare principles of reimbursement.

(See citation in paragraph 7 above.)

17. The "Modified Flat Rate" methodology of payment was properly taken through the rule making procedure, a public hearing was held and there were no objections from the industry. It was submitted to the U.S. Department of Health and Human Services, who certified that it satisfied the requirements of the law, and that all assurances submitted under the requirements of the act were acceptable. It was then adopted into law as an amendment to the state plan effective July 1, 1981.

18. The State Plan does not contain a specific definition of what it means to be "efficiently and economically operated." Rather, the State has set rates for payment for services that the State deems are reasonable and adequate and maintains that an "efficiently and economically

operated facility" is one that is able to operate at or below that standard. Such approach is proper under current law.

19. In explanations accompanying regulations of the Department of Health and Human Services, the Department states:

We have also decided not to mandate that the State plan specifically provide a definition of an "efficiently and economically operated facility." The reason for this is that the State's methods and standards implicitly act as the State's definition of an efficiently and economically operated facility, and no explicit definition is necessary. Moreover, States are best equipped to determine what is an efficient and economically operated facility for its Medicaid program and a prescriptive Federal definition would be contrary to State flexibility. The term "efficiently and economically operated facility" is one that has not been precisely defined by the Congress, the Department or the health care industry.

This decision is also consistent with our approach used for other key statutory terms such as disproportionate numbers of low income patients with special needs and reasonable and adequate payment rates in which we have not provided definitions. The use of a Federal definition would infringe on the discretion of the State. With regard to the latter term "reasonable and adequate" it should be noted that the term is not a precise number, but rather a rate which falls within a range of what could be considered reasonable and adequate.

(See 42 C.F.R. Part 447 Federal Register Vol. 48 No. 244, Dec. 19, 1983 pp.56049).

20. Because the "Modified Flat Rate" is applied uniformly statewide, and is the standard by which all nursing homes are measured, it was not necessary to examine the specific costs of Weber Memorial Care Center, Inc. to determine if it could be more efficiently and economically operated and that was not done.

21. Over ninety percent of the long term care facilities in Utah furnishing medicaid services are meeting their costs through the

Modified Flat Rate system. The vast majority of those facilities are showing a profit.

22. At any given time there are several hundred vacant beds in long term care facilities throughout the State, though no showing was made as to the geographical location of such beds.

23. Plaintiff Weber Memorial Care Center was organized and the facility purchased after the "Modified Flat Rate" methodology was in place and operating.

24. The classifications of required level of care into which Medicaid patients are placed by the State of Utah include skilled, intermediate and three classes of intermediate mentally retarded.

25. In making a determination into which classification a particular patient should be placed, doctors and nurses at the Department of Health consider the recommendations of the patient's attending physician, the recommendation of the nursing home where that patient will reside and detailed information supplied by the attending physician and the nursing home on forms provided by the Department of Health. The doctors and nurses at the Department of Health do not examine the patient themselves.

26. The long term care facilities do not have a right to appeal the classification made by the Department of Health but may request a reconsideration of the classification, which is routinely honored. It was not clear from the evidence presented whether such a request was made for any of the thirty-eight patients that Plaintiffs contend are not properly classified.

27. The patient and/or the patient's next of kin and/or guardian have the right to appeal the classification made by the Department of

Health. If such appeal is made the informal hearing is generally held at the facility where the patient resides. The record indicates that none of the thirty-eight patients that are claimed to be wrongly classified filed such an appeal.

28. Within each class, some patients require more care than others. In setting the rate to be paid for patients in each class, the State derived an average rate based upon the costs of the various levels of care within that class.

29. The Utah State Medicaid definition of skilled care is as follows:

MEDICARE (TITLE XVIII)/MEDICAID (TITLE XIX)
CRITERIA FOR SKILLED NURSING FACILITY

The care required and received by the patient must meet the following criteria:

1. A skilled service (at least one)

- a. Skilled nursing
- b. Skilled physical therapy
- c. Skilled speech therapy
- d. Skilled occupational therapist
- e. Skilled respiratory therapy
- f. Skilled management of an aggregate of unskilled services
- g. Skilled services required to maintain a patient's condition (to prevent deterioration).

and

2. On a daily basis

- a. Skilled nursing - 7 days a week
- b. Skilled physical therapy - 5 days per week by a licensed physical therapist
- c. Skilled speech therapy by a licensed speech therapist
- d. Skilled occupational therapy by a licensed occupational therapist
- e. Skilled respiratory therapy
- f. Combination of different services on different days may meet "daily" requirement.

and

3. As a practical matter, the daily skilled services must be rendered in an inpatient SNF setting. Certified for both Medicare (Title XVIII) and Medicaid (Title XIX).

Said definition is essentially the same as the Title XVIII Medicare definition except that the Medicare requirements that skilled services must commence within 30 days of a hospital discharge is not a requirement, and that care must be related to a minimum acute hospital stay of three days is not a requirement. The Medicare age requirement also does not apply.

30. There is insufficient evidence in the record to warrant a finding that any of the thirty-eight patients claimed to be improperly classified meet the requirements to be classified for skilled care.

31. The State Training School is a unique facility that provides unique services and care. It is therefore proper that the State Training School be treated differently as to payment for services. The methodology for payment to the State Training School went through appropriate rulemaking procedures, is contained in the State plan, and was approved by the Federal Government. There is nothing in the record to support a finding that Plaintiffs provide unique services or would otherwise qualify for exceptional treatment.

32. There is nothing in the record to support a claim of a civil rights violation either by James Mason, former director of the Department of Health, or by defendant Michael Stapley, acting in his official capacity as acting director of the Department of Health. Michael Stapley played no role in the development or promulgation of the "Modified Flat Rate" methodology. He was appointed acting director after the "Modified Flat Rate" methodology was promulgated into law.

33. Plaintiffs have failed to show by a preponderance of the evidence that the "Modified Flat Rate Committee" or the Department of Health acted arbitrarily or capriciously in the development and promulgation of the "Modified Flat Rate" methodology of payment.

CONCLUSIONS OF LAW


1. The "Modified Flat Rate" methodology of paying providers for furnishing long term care services to Medicaid patients in the State of Utah, and as set forth in the State Plan, complies with all provisions of Federal and State Law.

2. Neither the "Modified Flat Rate Committee", nor the Department of Health nor any other defendant herein acted arbitrarily, capriciously, or contrary to the law in the development, implementation, and/or operation of the "Modified Flat Rate" methodology of paying providers for services rendered to Medicaid patients.

3. Defendants James Mason and Michael Stapley did not violate Plaintiffs' civil rights.

4. Plaintiffs' petition must be dismissed.

Dated this 20th of May, 1985.



Brian L. Farr, J.D.
Hearing Officer

STATE OF UTAH
DEPARTMENT OF HEALTH

NORMAN H. BANGERTER GOVERNOR

SUZANNE DANDY, M.D., M.P.H. EXECUTIVE DIRECTOR

BEFORE THE STATE DEPARTMENT OF HEALTH

In Re: WEBER MEMORIAL CARE :
CENTER, INC., AND CHARTHAM :
MANAGEMENT, INC., :
: FINAL DETERMINATION
Plaintiffs, :
:
v. :
:
UTAH DEPARTMENT OF HEALTH :
DIVISION OF HEALTH CARE :
FINANCING, :
Respondent. :

Having reviewed the recommended findings of fact and conclusions of law of the duly appointed Administrative Hearing Officer in the above entitled matter, a copy of which is attached hereto and incorporated herein, and having found that they are supported by substantial evidence in the record,

NOW THEREFORE, IT IS ORDERED:

That the aforementioned recommended findings of fact and conclusions of law be, and hereby are, sustained, and that the Hearing Officer's recommended decision be, and hereby is, affirmed.

An appeal from this final determination may be secured pursuant to Utah Code Ann., Section 26-23-2 (1953 and Supp. 1983) by filing a petition in the appropriate District Court of the State of Utah within 30 days after this final determination is

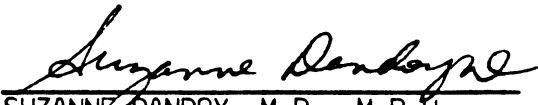
OFFICE OF THE EXECUTIVE DIRECTOR

3180 STATE OFFICE BUILDING • P.O. BOX 45500 • SALT LAKE CITY, UTAH 84145-0500 • (801) 533-6111
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received. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal this determination.

DATED this 4th day of June, 1985.

UTAH DEPARTMENT OF HEALTH


SUZANNE DANDUY, M.D., M.P.H.
Executive Director

W. 1000

FILE NO. C-85-4268

COUNSEL: (✓ COUNSEL PRESENT)

William Downes, Jr.
Donald W. Lojek
Attorneys for Plaintiffs

VS.

Clark C. Graves
Attorney for Defendants

CLERK

HON. PHILIP R. FISHLER

JUDG

REPORTER

DATE: 6/2/86

BAILIFF

Judgment for the defendant. Defense counsel is to prepare formal Findings of Fact, Conclusions of Law, and Judgment in accord with this Decision.

151 Philip Fishler
PHILIP R. FISHLER
DISTRICT COURT JUDGE

Copies mailed to:

William Downes, Jr.

Donald W. Lojek, Esq. ✓

Clark C. Graves, Esq.

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FILED IN CLERK'S OFFICE
SALT LAKE COUNTY, UTAH

AUG 4 1986

H. Byron Hordley, Clerk and Dist. Court
By James Bush
Deputy Clerk

IN THE THIRD JUDICIAL DISTRICT COURT
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH

In re: WEBER MEMORIAL CARE
CENTER, INC. and CHARITAM
MANAGEMENT, INC.,

Plaintiffs/Appellants :

vs. :

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING

Defendants/Appellees. :

FINAL JUDGMENT

Civil No. C-85-4268

This case comes to the District Court from an Administrative Decision in favor of the agency. The Administrative Law Judge made extensive findings of fact and conclusions of law following a trial on the merits. The Executive Director of the Utah Health Department issued a final determination consistent with the Findings of Fact and Conclusions of Law recommended by the Hearing Officer, and hence, our review is limited to a review of the record to determine whether the final decision of the agency was "capricious, or not supported by the evidence," UCA 26-23-2(3) (1953, as amended

supported by the evidence," UCA 26-23-2(3) (1953, as amended 1981). The Court finds that the Executive Director's final determination was supported by a residuum of legally admissible evidence in the record and was not arbitrary or capricious. Judgment, accordingly, for Defendant, the Utah Department of Health.

DATED this 4 day of August, 1986.

ATTEST

DIXON MURPHY

Karen A. Bush
Deputy Clerk

Scott Davis
JUDGE PRESIDING

SUBMITTED this 28th day of July, 1986.

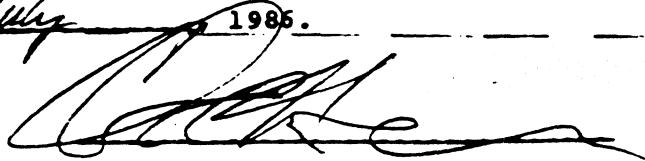
CERTIFICATE OF MAILING

I hereby certify that I mailed a true and exact copy of the foregoing Proposed Findings of Fact and Conclusions of Law, postage prepaid, to the following:

Donald W. Lojek
LOJEK & PENLAND
Attorneys for Weber Memorial
Care Center
P.O. Box 199
Boise, Idaho 83701

William Downes, Jr.
419 Boston Building
Salt Lake City, Utah 84111

on this the 28th day of July, 1986.



THIRD JUDICIAL DISTRICT **County of Salt Lake - State of Utah**

Centre Weber Memorial Care
Plaintiff
Center, et al
Utah Dept. of Health
Defendant

CASE NO: CS5-4268

Type of hearing: Div. _____ Annul. _____ Supp. Order _____ OSC. _____ Other _____
 Present: Pttf. _____ Def. _____
 P. Atty: Donald W. Lopez ✓
 D. Atty: Clark G. Graub ✓
 Sworn & Examined: _____
 Pttf: _____ Def: _____
 Others: _____
 Summons _____ Stipulation _____
 Waiver _____ Publication _____
☐ Default of Pttf/Def Entered
 Date: July 28, 1986
 Judge: Philip R. Goshier
 Clerk: B. Sundberg
 Reporter: G. Clegg
 Bailiff: B. Unsworth

ORDERS:

- ☐ Custody Evaluation Ordered ☐ Custody Awarded To _____
☐ Visitation Rights _____
☐ Pttf/Def Awarded Support \$ _____ x _____ = _____ Per Month
☐ Pttf/Def Awarded Alimony \$ _____ Per Month/Year ☐ Alimony Waived
☐ Payments to be made through the Clerk's Office: _____
☐ Atty. fees to the _____ in the amount of _____ ☐ Deferred
☐ Home To: _____
☐ Furnishings To: _____ Automobile To: _____
☐ Each Party Awarded their Personal Property
☐ Pttf/Def. to Maintain Debts and Obligations
☐ Pttf/Def. to Maintain Insurance on Minor Children
☐ Restraining Order Entered Against _____
☐ Pttf/Def. Granted Judgment for Arrearage in the Sum of \$ _____
☐ 90-Day Waiting Period is Waived
☐ Divorce Granted To _____ As _____
☐ Decree To Become Final: ☐ Upon Entry ☐ 3-Month Interlocutory
☐ Former Name of _____ Is Restored _____
☐ Based on the failure of Def to appear in response to an order of the court and on motion of Pttfs counsel, court orders _____ / _____ shall issue for Def. _____
 Returnable _____ Bail _____
☐ Based on written stipulation of respective counsel/motion of Plaintiff's counsel, and good cause appearing therefor, court orders the above case be and the same is hereby dismissed without prejudice.
☐ Based on written stipulation of respective counsel/motion of Plaintiff's counsel, court orders _____
Pttfs objections to proposed findings are resolved
as read into the record.

EXCERPTS FROM TRANSCRIPT OF FORMAL HEARING

HEARING HELD AUGUST 3, 1984 BEFORE

BRIAN L. FARR, ADMINISTRATIVE LAW JUDGE

Vol. 1, p.9, 1.14 through p.11, 1.7

MR. LOJEK: We would like to raise one additional issue of which I believe you have already ruled. I would like the record to be clear on this. We would like to present evidence here this morning of the costs incurred, the specific costs incurred by Weber Memorial Care Center in each and every cost category over the past three years. The reason we would like to do that is to be able to demonstrate to the hearing officer that the Weber Memorial Care Center is that kind of an efficiently and economically operated provider, which is contemplated by the federal statute and federal rules which I have just mentioned.

MR. QUIGLEY: Your Honor, I don't mean to interrupt. That's an issue that has already been settled now and we did not come to this hearing to listen to the costs of this facility. We went into it. We briefed it to you. You've written your opinion on it. I think we ought to leave it right there.

THE HEARING OFFICER: I will let you finish your remarks, then I'll rule on that. Are you finished?

MR. LOJEK: I'll wait for a ruling on the interruption.

THE HEARING OFFICER: Because of that prior ruling, I would rule that it's not appropriate to take evidence on at this time. I suppose that if you are not satisfied with the ruling of this hearing, that you will end up appealing, and that's the time to consider whether that evidence ought to be heard.

MR. LOJEK: I wonder if you might take evidence on this issue, then recommend to Mr. Stapley, who receives your recommendation, you might recommend to him not to review that evidence. So if he chose to ignore your recommendation, he could, then have the evidence to review.

MR. QUIGLEY: We thoroughly briefed on this, received your decision on it. I didn't come here this morning at all to discuss the costs of this facility. You ruled that

the costs of the facility are immaterial to the hearing. So there will be no purpose served by having them demonstrate what all their costs are. They may be reasonable, I don't know, under certain definitions. They simply don't meet the standards set by the State, which is the flat rate. I think your ruling is very clear on that.

THE HEARING OFFICER: We'll let the former ruling stand.

MR. LOJEK: Can my objection be noted for the record?

THE HEARING OFFICER: Yes.

Vol. II, P.223, 1.4 through P.224, 1.8.

Mr. Lojek continuing to question Mr. Brocksome.

Q. (by Mr. Lojek) Moving along to another area, Mr. Brocksome, the Hearing Officer in this case has ruled that we cannot go into specific costs at Weber Memorial in order to demonstrate whether you are or not an efficiently and economically operated facility.

This is in the nature of an offer of proof and only one question, Mr. Farr.

But if we were permitted to go into this area, Mr. Brocksome, would you be able to show to the Hearing Officer's satisfaction that the costs at Weber Memorial Care Center are reflective of an efficient and economical operation?

A. Yes.

Cross examination by Ms. Jenson of Mr. Elliott.

Q. Are you unaware of any of these benefits or the financial arrangements of your own facility?

MR. LOJEK: I'm going to object. I'm not sure Mr. Elliott did that, testified that his particular facility is efficiently an economically operated. I think because of the ruling of the Hearing Officer, we were specifically precluded from going into that area, could not demonstrate our costs as we wished to do so and as we disclosed in our brief to the Hearing Officer we would do. Therefore, it is difficult to offer that evidence without anything to back it up.

MS. JENSON: Your Honor, I think that he did testify to factors such as medical supplies, the climate, the mil levy, the age of the facility about the efficiency of his facility.

THE WITNESS: I was referring to all facilities.

MS. JENSON: In theory.

THE WITNESS: As far as responding to your last question on economy and efficiency and the reason that if facilities -- that it costs more to take care of a patient may be more economic and efficient than one that costs less. I can use Weber as an example.

Q. (by Ms. Jenson) You could use Weber as an example. You are unfamiliar with the financial arrangement of your particular facility.

A. I don't know what that means. You didn't discuss anything that relates to the financials that I have to be aware of to operate on a daily basis. And --

Q: Isn't it true that part of the cost of operating on a daily basis are your property costs and your tax costs?

MR. LOJEK: I'm going to object to that question. The reason, again, is that she's trying to dissect the costs in order to show somehow we are inefficiently an uneconomically operated.

MS. JENSON: Your Honor, I'm not.

MR. LOJEK: That's fair if that's an issue in this hearing. But since the ruling of the Hearing Officer, that has been removed as an issue from the hearing, and we haven't offered any evidence on it. If the Hearing Officer choses [sic], we will come in with a lot of exhibits and go through all of the costs and prove we are efficiently and economically operated.

THE HEARING OFFICER: Your objection is sustained. I think that's something you can argue anyway.

MS. JENSON: Well, except if I may respond to the objection. I am not pursuing the costs. In fact, I didn't ask him how much things are being appreciated. I attempted to establish that this particular witness is not qualified. I want to impeach his opinion of his ability to assess whether facilities are economically and efficiently operated. One of the factors of efficiently and economically operated is the ability to assess property costs and to understand tax rights and things like that. I think that my line of questioning goes to his ability to assess whether facilities are efficiently and economically operated.

MR. LOJEK: I think counsel has misconstrued the reasons for which he offered his previous testimony. It is not to prove any facility, specific facility, is economically and efficiently operated. It is to show simply if one were to attempt to find out if a given facility is economically and efficiently operated, or, indeed, if the whole system would respond to those which are efficiently and economically operated, then one must take into consideration the factors that were enumerated by this witness. That's the only purpose of that testimony.

Vol. IV, P. 590, 1.3 through P. 591, 1.2

Ms. Jenson questioning Don R. Bybee.

MR. LOJEK: I'm going to object to the question because it's the same repetitive pattern again. I think the implication is being made here that Mr. Bybee and his company are not reasonable cost conscious prudent managers, are simply engaged in an interlocking scheme to not cut costs so costs are higher, that indeed is why they're not being able to exist under the flat rate system. Well, that's not the case. So I think the implication is being made. Everything would be fine and Weber Memorial Care Center --

MS. JENSON: Your Honor, is this an objection or an argument? Excuse me.

MR. LOJEK: Excuse me. If that's the case that's being made by the State of Utah, that's fine. We're prepared to fully and frankly disclose each and every cost of Weber Memorial Care Center to justify those costs, to explain how they're arrived at, to allow Madame to conduct her cross-examination as she will. We don't have any problem with that. We feel we are being hamstrung by the Hearing Officer's previous ruling that costs will not be allowed to be examined in this case on one hand. And on the other hand, they have this implication drawn by this present line of questioning. I think, based on the Hearing Officer's previous ruling, this line of questioning is irrelevant, and I would make my objection and ask the Hearing Officer to instruct counsel to move to another area.

Vol. IV, P. 617, 1.18-24.

Ms. Jenson continuing to question Mr. Bybee.

MS. JENSON: I think we're getting into costs. I think Mr. Bybee has already testified that he thought this was a good price, that the basis on which he felt that, the interest rate and the appraisal. I think anymore would be getting into costs of the facility.

MR. LOJEK: I think we're done with that testimony anyway.

Vol. IV, P.629, 1.1 through P. 630, 1.9

Mr. Lojek questioning Mr. Bybee.

Q. Mr. Bybee, did you ever do a comparison of the costs of other chain providers who are provided with management services to their nursing home facilities?

A. Yes, I have.

Q. How does Chartham Management compare with these other chain providers?

A. The other providers run approximately \$2.75 to \$3 per patient day to 6 to 7 percent of revenue as a general statement. There are some exceptions. That's generally true.

Our costs are running about \$1.45, \$1.47 per patient day, about half. But then when you move in the allocation of various personnel to get the true costs, we're still under other management fees charged by other chains and other organizations, other private individual operators. So we're under them. We're more competitive.

Q. Are you prepared to testify today as to those first steps that the Weber Memorial Care Center has taken over

the years in order to cut costs as far as practical and possible?

A. Yes.

Q. Are you prepared to testify here today concerning your experience with the State of Utah officials which led to the filing of this appeal?

A. Yes.

Q. Are you prepared to testify here today as to your opinion as to whether the Weber Memorial Care Center is being reimbursed at a level sufficient to meet the costs of an efficiently and economically-operated facility?

A. Yes.

Q. If you were permitted to so testify, would you?

A. Yes.

Vol. 1, P. 88, 1.3 through P.94, 1.12

Q (by Ms. Jensen) Are those facilities making a profit under the modified flat rate?

MR. LOJEK: Mr. Farr, since the State made an objection, we can't go into our costs or any declaration of our costs or whether efficient or non-efficient. It seems to me the State is now waiving its objection. I'm not going to object to this line of questioning at all. I'm going to come back and go into our costs in great detail and attempt to show the hearing officer that, indeed, our costs are quite efficient and quite economical, cannot be improved upon. I just want the hearing officer to be aware and perhaps give some direction to the State of Utah as to why I'm not objecting to this.

MS. JENSEN: If I may speak to that objection: This morning we spent more than an hour going into the use of the modified flat rate as a methodology to distinguishing those profitable efficient and economic providers from those which were not profitable, therefore, not efficiently and economically operated.

Also, Mr. Dunn was asked, if you will recall, by Mr. Lojek, whether there were any factors which Roy felt came to bear on the fact that Weber Memorial was not making a profit. We don't want to go into the costs of Weber Memorial. Indeed, under your earlier ruling, we will not go into those costs. . .

MR. LOJEK: I would add to my objection, Mr. Farr, to the idea with which counsel appears to be obsessed for the last nine months, profitability is somehow an issue in this hearing. Profit has nothing to do whatsoever with the flat rate system or of this particular facility. We are not in this room--we have not brought this appeal to seek a profit. We don't care about a profit. We are willing to forego a profit. We are petitioning in a profitless system. The point is, we're supposed to achieve our costs up to the parity of costs but not beyond. So any questions or allusions, allegations to profit are beside the point. I objected to this before and the State knows our position on this very, very clearly.

I think it's appropriate to go into costs. I think we should examine all of our costs. I think that we should stay here until next week and go through each and every cost of Weber Memorial Care Center and have these erudite ladies and gentlemen from the State of Utah point out to this provider why those costs are inefficient and uneconomical, how they could cut out some of these costs. I would love to be able to do that. This hearing officer has ruled we are not permitted to do that. The State made its motion and objected to our proceeding along those lines. . .

MR. LOJEK: In one sentence, I would object to that if we're not permitted to prove up our costs in terms of efficiency and economy by expert testimony from a lot of people who run nursing homes on a day-to-day basis and who don't sit in governmental chairs to pass judgment on things which they haven't defined.

MS. JENSON: Your Honor, we do not want to go into Weber Memorial's costs. We want to compare them with those facilities, the 79 to 90 percent for whom the flat rate does meet their costs and, indeed, provides them some profit.

THE HEARING OFFICER: You may proceed, but be careful not to get into the cost issue. I will go a little further to say with the direction you are heading in this questioning, I may come back and rule on his motion differently.

Vol. 1, P. 97, 1.10-21.

THE HEARING OFFICER: Let's just take a minute and go back and restate what the issues are that are being considered by that prior ruling. We did decide it would be necessary to discuss whether Weber was an efficiently and economically operated facility. That question has been ruled on. So the issues that are before us have to do with whether the State plan was adopted by some reasonably principled means or whether it was just determined by the budget and then those exceptions relating to the State Training School and the definition of skilled and unskilled so I think the questions ought to go to how the plan was adopted and what you know.

Vol. 1, P.143, 1.20 through P. 145, 1.12.

Questioning by Ms. Jenson to Roy Dunn

Q. So that you testified earlier that Mr. Bybee was aware of the effect of the modified flat rate when he purchased the facility. Does this letter support that?

A. Yes.

Q. Are you aware what any other bidders may have bid as a purchase price to Weber Memorial based on their calculation of what would meet their costs under the modified flat rate?

A. Yes.

Q. What were those bids and from whom?

MR. LOJEK: I'm going to object again to this area of inquiry. What counsel is attempting to do, Mr. Farr, is to indicate that the Appellant here is improvident or an uneconomical or inefficient provider, and is not a bad defense, particularly if you are going to have to defend the State.

Since we have not been permitted to go into it -- since we are not permitted to go into this area and prove up our costs as to why, indeed, they are efficient and economical and in all respects, I don't think that counsel can go ahead and introduce that kind of an answer, ask those kinds of questions. I would object to them. She's attempting to show opposite what we would like to show. We cannot because of your previous ruling. I'm not quarreling too much. I have made my objection. It does seem to be radically unfair to allow her to do what we cannot. That's the reason for my objection.

Vol. II, P. 209, 1.7 through P.211, 1.21

Mr. Lojek questioning Mr. Brocksome.

Q. Now, if Weber Memorial wanted to save money shouldn't they fire Chartham and just do their accounting internally? Wouldn't it be more cost efficient to them?

A. Well, it was -- No. Prior to the acquisition of our facility, they were running 75- to \$90,000 per month in the red. So --

MS. JENSON: I object to this testimony. I object. I think that we, yesterday, we did go into some factors that when you compare Weber Memorial to other facilities operating under the flat rate may have affected its efficiency. I think that we're getting much more deeply into costs and actually costs of the facility, which we have agreed we would not get into. . .

THE HEARING OFFICER: How many more questions do you think you need to pose along that line? . . .

Q. Could you just explain what facets, what you do to facilitate in accounting.

A. We provide the mechanism and vehicle for all of the financials on a monthly basis to be provided to include profit/loss detail, of course, balance sheet as well as payroll. We recently purchased a stand-alone data processing system, which will lower the overall cost to all of our facilities.

MS. JENSON: I object. I don't think we need to get into costs. If you want to explain what you do as in terms of an accountant, that's fine.

MR. LOJEK: I think that's what he's trying to do.

MS. JENSON: No. He's trying to demonstrate how Chartham and Weber Memorial and all of its other facilities have cut their costs, which has no relevance, which we have agreed not to get into.

Vol. 1, P.34, 1.22 through P.35, 1.22

Q. (by Mr. Lojek) I would like you to tell the hearing officer of any data, any findings, any study you have ever made, by "you" I mean in aggregate the Department of Health, indicating rates being paid to Weber Memorial Care Center are reasonable and adequate to reimburse an efficiently and economically operated provider within the meaning of the definition found at 42 C.F.R. Section 447.252.

A. (Mr. Dunn) That's where I'm getting confused.

MR. QUIGLEY: May I interrupt just a moment.

THE HEARING OFFICER: Let me make a statement, Mr. Lojek. I think I understand what you are driving at, and I know what the testimony is, that the State has not taken Weber county and examined all of their reports and decided whether they are economically and efficiently operated. But that data has been taken into account in setting the flat rate. So I think we're in agreement. We don't need further testimony on that. Is that sufficient for you?

MR. LOJEK: In part.

THE HEARING OFFICER: What more do you need?

MR. LOJEK: I would like Mr. Dunn to advise the hearing officer as to whether the State of Utah has ever adopted any criteria, rules, regulations or standards indicating which providers are efficiently and economically operated, which are not.

Vol. 1, P. 58, 1.15 through P. 59, 1.2

Q. We have had a previous ruling from the hearing officer that we cannot go into individual costs of the provider. And I don't intend to do that. But can you tell me as we sit here now, any way in which the Weber Memorial

Care Center could be made more efficient and more economic?

MR. QUIGLEY: I don't know what counsel means by efficient and economic. Could he define it for us.

MR. LOJEK: We don't either, Mr. Quigley. That seems to be the point here. The State of Utah has never defined those terms.

MR. QUIGLEY: We defined it by the flat rate.

MR. LOJEK: I guess you understand.

Testimony of Roy Dunn

Vol. 1, p.31, 1.8 through p.32, 1.1.

Q. (by Mr. Lojek) Assuming that you did receive such a cost report was that cost report examined by the State of Utah in order to determine whether the rate established for the Weber Memorial Care Center was reasonable and adequate to meet the costs that must be incurred by efficiently and economically--

MR. QUIGLEY: I'm going to object to this line of questioning. We're right back to the same thing that we briefed and had given to you before. We do not pay the reasonable costs of a facility of a provider. We do not pay reasonable costs. We pay rates. And that rate is established industrywide. He keeps referring "Did we examine this particular facility." The simple answer is, "No, we don't examine the costs of a facility." And that's been answered many times.