

1986

Weber Memorial Care Center, Inc. and Chartham Management, Inc. v. Utah Department of Health, division of Health Care Financing : Brief of Appellee

Utah Court of Appeals

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DOCKET NO. 860482-CA

IN THE UTAH COURT OF APPEALS

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

Plaintiffs and
Appellants,

vs.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING

Defendants and
Respondents.

Case No. 860482

BRIEF OF APPELLEE

DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING

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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Court of Appeals

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UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING	:	
	:	
Defendants and Respondents.	:	

STATEMENT OF ISSUES PRESENTED ON APPEAL

I. Whether the administrative law judge and trial judge correctly ruled that Utah's Medicaid rate for long term care complies with federal Medicaid standards.

II. Whether the administrative law judge and trial judge correctly excluded evidence concerning Weber Memorial's individual facility cost data.

III. Whether the Utah Medicaid Agency has correctly classified patients at Weber Memorial.

IV. Whether the District Court used the correct standard of review.

PROCEEDINGS TO DATE

Plaintiffs are the owner and manager of a nursing facility in Roy, Utah. For convenience, they will be referred to jointly as Weber Memorial.

Plaintiffs received an evidentiary hearing before an administrative law judge for the Utah Department of Health. The

hearing officer ruled against plaintiffs on May 20, 1985. His Findings of Fact and Conclusions of Law were adopted by the Executive Director of the Health Department on June 4, 1985.

Plaintiffs appealed from that decision to the District Court for the Third District of Utah. The case was heard by Judge Fishler, who issued a Memorandum Opinion on June 3, 1986 upholding the hearing officer's determination. Final Judgement was entered August 4, 1986 by Judge Scott Daniels following Judge Fishler's retirement from the bench.

This is an appeal from the ruling of the District Court.

PERTINENT FACTS

Introduction

Title XIX of the Social Security Act, 42 USC § 1396 et seq., commonly known as the Medicaid Act, establishes a cooperative relationship in which federal and state governments share the costs of medical services to certain needy individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 USC § 1396 (1974).

If a state elects to participate in the Medicaid Program, it must establish a "state plan" for medical assistance which complies with statutory and regulatory requirements under the act. 42 USC § 1396(b). See also 42 USC § 1396A(a)(1) through (44) (1974); 42 CFR § 447 et seq. State plans are developed through state administrative rulemaking procedures and any changes or amendments thereto must undergo the same procedures and approval as before adoption. Utah Code Annotated § 63-46(a)-1 et seq.

After a state draws up a medical assistance plan consistent with guidelines contained in the Medicaid Act and the regulations promulgated thereunder, it must submit the plan to the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services (HHS), for approval. If HCFA approves the plan, the state becomes eligible for federal matching funds for reimbursement of the cost of medical assistance. 42 USC § 1396B(a).

In 1980, Congress enacted supplemental Medicaid legislation; part of an "Omnibus Reconciliation Act." Prior to 1980, Medicaid plans were required by federal law to reimburse nursing homes for their "reasonable costs." Section 962 of the Omnibus Reconciliation Act deleted the previous requirement that state agencies pay for long term care facility services on a "reasonable cost" basis. Instead, the new legislation allows states to pay providers through the use of predetermined rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers" Compare 42 USC § 1396A13E (enacted in 1976) (copy at Tab "A"), with 42 USC § 1396A(a)(13)(A) (replacing the earlier section in 1980) (copy at Tab "B").

Facts From The Record

In 1981, following the change in federal law mentioned above, the Utah nursing home industry, through the Utah Health Care Association, urged the Utah Legislature to adopt a "modified flat rate" methodology of reimbursement. The legislature responded by adopting an intent document directing the Department

of Health to establish a flat-rate committee to develop a method of payment for nursing homes that would foster cost containment and assure recipients of high quality care. After considering various alternative, the rate committee developed a modified flat-rate method of nursing home reimbursement based on the most recent available cost data. Transcript, Testimony of Roy Dunn at pp. 43 and 44. The modified flat-rate methodology was submitted through the rulemaking process for public comment, and a public hearing was held. Tr., Sharon Wasek at pp. 312-313. There were no dissenting votes from the nursing home industry. Id.

Pursuant to federal law, the defendant State Department of Health made findings and assurances to the Secretary of HHS that the flat rate methodology was "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers." That flat rate methodology was approved and certified by HHS as meeting all requirements of federal law and regulation. The flat rate methodology was then adopted by state rulemaking into law effective July 1, 1981. Id.

Two months after the effective date of the flat rate, in September of 1981, Mr. Don Bybee (who owns both plaintiff corporations) acquired an existing hospital facility from Weber County. Tr., Don Bybee at p. 572. Mr. Bybee was an experienced and sophisticated businessman in the health care industry. He had previously been employed as the executive vice president of Truscan Corporation which had acquired 26 nursing homes and had increased its revenue by approximately \$28,500,000 during the time of Mr. Bybee's employment between July, 1976 and December, 1980. Tr., Don Bybee, pp. 565-566.

After Mr. Bybee purchased the Weber County facility in his individual capacity he immediately leased the facility to the newly organized Oregon Corporation, Weber Memorial Care Center, Inc., of which he is president, director and 100% stock owner. Tr., Don Bybee, pp. 587, 588 and 603. Mr. Bybee then employed Chartham Management, Inc., a Washington corporation of which he is president, director and 100% stock holder, to manage the facility. Tr., Don Bybee at p. 603.

At the time Mr. Bybee purchased the Weber County Hospital facility, he knew of its costs and was cognizant of the fact that Weber County was losing \$90,000 per month on that facility. Tr., Don Bybee, p. 576. Mr. Bybee was aware that he was purchasing a hospital facility and that certain portions of it were not normally associated with nursing homes; including a large auditorium, surgical area, laboratory, and x-ray facilities. Tr., Roy Dunn, pp. 96 and 97; Tr., Don Bybee, p. 632. Despite these facts Mr. Bybee testified that he intended to pursue his previous pattern (as executive vice president of Truscan Corporation) of turning certain unprofitable nursing homes into profitable ventures. Tr., Don Bybee, pp. 566-567.

When Mr. Bybee acquired the Weber County facility on September 1, 1981, he was aware that the state's modified flat rate methodology had been in effect since July 1, 1981 and considered the flat rate in negotiating the purchase price. Tr., Don Bybee, p. 585. Further, at the time Mr. Bybee was negotiating to purchase, and actually did purchase the Weber County facility, he was operating other nursing homes in Utah

which were already being paid under the statewide modified flat rate. Tr., Don Bybee, p. 585.

There are approximately one hundred Utah nursing homes which accept Medicaid patients. The modified flat rate is presently reimbursing somewhere between 79% and 93% of Utah's nursing homes at a level which meets or exceeds their actual costs. Tr., Roy Dunn, pp. 91, 92, 679 and 680. Weber Memorial is one of the small group of nursing homes whose actual costs for patient care are not being fully met by the modified flat rate. At least one reason for this is apparent -- and it has nothing to do with the "inadequacy" of the rate.

When Weber County owned the facility, it was licensed as a "chronic disease hospital." The scope of this licensure permitted the operation of a laboratory, x-ray machine, and pharmacy on the premises. Mr. Bybee relied on this revenue in making his purchase. Within a year after his purchase, however, the state abolished the license category of "chronic disease hospital." Thus, Weber Memorial could only operate its facility as a nursing home. This change in licensure resulted in a revenue loss of \$10,000 a month. It is perhaps no coincidence that this is the same amount of loss per month that Don Bybee and his administrator have testified that the facility loses every month. See Tr., Don Bybee, pp. 619 and 623; David Elliot Tr. at p. 772. In fact the owner, Mr. Bybee, blamed the phase-out of chronic disease hospitals on his present woes:

"To continue on with what I was saying, we're losing \$10,500 a month because the state phased out of the chronic disease hospital portion, which we lost prescription revenue

because we're not entitled to \$3.50 per patient per day per prescription as prescriptions were dispensed. We lost laboratory/x-ray revenue. The prescription revenue, laboratory, x-ray revenue amounted to \$10,500 a month. The state changed the regulation on us. There was nothing we could do on that. And that was the primary loss. If that had not changed we would be able to come close to the costs at present. But the state changes those regulations."

Tr., Don Bybee at p. 632. Thus, Weber Memorial's failure to have its costs met by the modified flat rate is a direct result of Mr. Bybee's purchase of a chronic disease hospital instead of a nursing facility. Utah's modified flat rate is perfectly adequate to reimburse nursing care. It may not be adequate to reimburse Mr. Bybee's mortgage costs on a hospital facility. Because Weber Memorial lost the opportunity to appeal the state's decision to phase out chronic disease hospital licensures by not filing in a timely manner, (see Utah Code Annotated § 26-21-10), it now has sought to recoup lost revenue by suing Utah's Medicaid nursing care program.

ARGUMENT

POINT I

UTAH'S MEDICAID RATE FOR LONG TERM CARE COMPORTS WITH FEDERAL MEDICAID STANDARDS.

A. Federal standards allow states the flexibility of defining efficiency and economy in terms of a statewide rate.

Prior to 1980, participating states were required to reimburse providers on the basis of "reasonable costs." This meant that nursing facilities could incur costs which the Medicaid Agency was obligated to repay in full. Under the pre-1980 system of reimbursement, Medicaid paid whatever rate the

facility charged its private paying patients. The result was a system in which the State paid as many different rates for a day of skilled and a day of intermediate care as there were facilities. Moreover, because each facility could simply recoup from the state whatever costs it incurred, there was no incentive whatsoever to contain costs. Hence, the costs of long term care in the Medicaid program were increasing at an alarming rate -- 18% to 20% each year. Tr., J. Winslow, p. 383. Some of this increase resulted from "trafficking" in nursing homes. Each successive buyer of a nursing home would purchase a facility, receive payment from the state inflated to the actual cost of his purchase, hold it for a short time, and then sell it at an enormous profit to the next buyer, who in turn would receive from the state inflated rates based on the actual cost of his purchase. Tr., of Jay Winslow at pp. 414 and 415; Roy Dunn at p. 663. Similar experiences nationwide led Congress to enact the Omnibus Reconciliation Act of 1980 (Public Law 96-499), which amended the Social Security Act to permit states to stop paying actual costs of long term facilities and, instead, to establish statewide rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards." 42 USC § 1396A(a)(13)(A) and 42 CFR § 447.252.

The purpose of the amendment was to permit states the flexibility to stop reimbursing the actual costs of individual

facilities and to enable them to move toward perspective payments systems which encourage efficiency and economy. The Senate Report accompanying the new language states:

The committee continues to believe that states should have flexibility in developing methods of payment for the Medicaid programs and that application of the reasonable cost reimbursement principles of the Medicare Program for long term care facilities 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. Under the bill, states 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.

Senate Report No. 96-471, 96th Congress, Second Session, Reprinted in 4 CCH Medicare and Medicaid Guide, paragraph 24,407 at 8780 - 81 (1981) and copied at Tab "C". Thus, states are no longer required to pay the rates demanded by individual facilities. It goes without saying that under a fixed rate methodology, some facilities will very likely recover their full costs plus a profit, and others will not receive their full costs. The State pays every facility the same rate, and it is the responsibility of nursing home owners and administrators to reduce costs in order to make a profit.

Following the 1980 amendments to the Social Security Act, Utah moved at the behest of the nursing home industry itself to adopt a statewide rate for long term care. Tr., Charles

Doane, p. 181; Tr., Roy Dunn at pp. 61, 62; Tr., Dennis McFall p. 159; Tr., Jay Winslow pp. 382-86. The Utah Legislature provided for the formation of a "flat rate committee" to be composed of nursing home representatives, legislators, a legislative fiscal analyst, and Department of Health officials. Tr., Charles Doane, p. 181. After considering a number of alternatives, and using as its data base the most recent information on the actual costs incurred by the nursing home industry, the committee adopted a "modified flat rate." Tr., Roy Dunn, pp. 43, 44, and 79, and p. 104.

The committee established a single weighted average rate for each class of patient: skilled care, intermediate care and mentally retarded care. Tr., Roy Dunn, pp. 722-23. This flat rate was the same statewide. The committee then decided to inflate this "base rate" annually on the basis of the consumer price index for urban areas minus mortgage interest costs (the CPI-U less mortgage). Next the committee developed a "property differential" derived from the historic costs of each individual facility plus a return on equity (i.e., profit). This differential was, therefore unique to each facility and was paid in addition to the flat base rate. Two-fifths of this property differential (or \$2.00 per day of care) was added to and inflated along with the base rate each year to cover increases in the costs of property tax, insurance, maintenance and contingencies. The remaining three-fifths of the property differential was not inflated and remained static. Tr., Roy Dunn, pp. 47-49, 655, 663. The methodology was submitted for public hearing in which

there was not one dissenting opinion from the nursing home industry. After federal review and approval, the methodology was adopted by rulemaking effective July 1, 1981. Tr., Sharon Wasek, p. 312-313.

The methodology produced a number of benefits for both the nursing home industry and for the state. First, and most important, the methodology itself established the definition of what was an "efficiently and economically operated facility." Tr., Roy Dunn, p. 692. If the provider could reduce its costs below the established flat rate, it kept the difference as profit. If costs went over the established rate, the facility suffered a loss. Hence, the provider had every incentive to operate as efficiently and economically as possible. Tr., Roy Dunn, Tr., pp. 723-24.

The second benefit to the industry was that providers now had the opportunity to legitimately earn profit. Under the old system, the state legally could consider only "actual reasonable costs" which did not, by definition, include any profit. Tr., Roy Dunn, p. 61.

This led to a third benefit -- the opportunity for nursing home providers to operate with increased autonomy. They were now free to incur any expense they thought appropriate or necessary to the operation of their business, and the state did not retroactively review their costs, determine which of them it considered "reasonable" and then recoup the amount of costs disallowed as "unreasonable" or reduce the rate accordingly. Id.

A fourth important benefit to the industry and the state was that both were relieved of the onerous burden of the annual audit of nursing home costs to insure that the state had paid rates based only on "reasonable" actual costs. This administrative burden of conducting an audit annually on each nursing home and the equal burden of being audited annually produced an ongoing multitude of disputes, informal and formal hearings and appeals between the state and the nursing homes. All of this was eliminated under the flat rate: the state paid a fixed amount for a day of care; the nursing home operator could spend it as his or her best judgment dictated, and the state did not attempt to oversee those expenditures or recoup any money. Tr., Roy Dunn, pp. 713-14.

Fifth, the flat rate methodology brought a complete halt to spiralling costs in the Medicaid Program which resulted from the buying and selling of nursing homes. The flat rates remained the same regardless of a transfer of ownership, so that although anyone was free to buy or sell, to enter or leave the marketplace, his purchase bid of necessity had to take into account the payment rate the seller received. As a result, the marketplace stabilized and the state saved money. Tr., Roy Dunn, p. 718.

Clearly, the establishment of a modified flat rate has benefited both the state and the nursing industry.

B. Federal standards do not require states to reimburse the actual costs incurred by each nursing home.

In accordance with federal regulations, the defendant made findings and assurances to the Federal Government that the

rates established under the flat rate methodology were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers." Estimates at the time the flat rate was adopted and actual experience since, prove that 79% to 93% of nursing homes in the Medicaid Program have their costs met or are making a profit under the rates. Tr., Roy Dunn, pp. 679-680. Put another way, this means that only somewhere between 7% and 21% of the nursing homes in Utah do not have their costs fully met by the flat rate. The fact that a small number of nursing homes do not receive their actual costs from Medicaid is no indication that the flat rate methodology was improperly enacted. As the Supreme Court of Nebraska recognized in Haven Home, Inc. v. Department of Public Welfare, 346 N.W.2d 255, 260 (Nebraska 1984):

The Medicaid Program is not designed to protect health care providers from the consequences of their business decisions or business risks.

Weber Memorial worries that Utah's rate is arbitrary, inasmuch as some providers may be working to reduce costs, yet still experience costs above the rates. Weber Memorial asserts that:

Some of the most profitable nursing homes may well be the least economic and least efficient providers of quality care.

Appellant's Brief, p. 14, (emphasis in original). Hence, the implication is that the State may not define efficiency in terms of a bottom-line rate for nursing care. This contention was addressed in Mary Washington Hospital, Inc. v. Fisher, 635 F.Supp. 891 (E.D. Va. 1985). Mary Washington Hospital protested Virginia's Medicaid rate for hospitals on the basis that the

State had produced no evidence that "hospitals [with costs] above the median are uneconomical and inefficient" Id. at 899. The court responded:

[The Boren Amendment] clearly is intended to allow states to engage in price-conscious "shopping" for hospital services for Medicaid recipients. If two hospitals in a given locality, for instance, offer the same quality services at widely disparate rates, the average consumer need not do an efficiency study before determining not to pay the higher-priced hospital's rate. [The State] may now set the rates it is willing to pay in much the same fashion.

Id.

The Medicaid Agency realizes that both variable and fixed costs will differ -- sometimes substantially -- from facility to facility. Each facility providing Medicaid Services is examined on a regular basis to ensure that the services to patients meet the level of care standards. Rather than haggle with each facility over the necessity or wisdom of incurring particular costs, Utah has chosen to affix a bottom line rate (with allowance for fixed capital costs incurred by providers prior to institution of the rates) so that facility managers will have all decisionmaking authority concerning operations.

Weber Memorial spends considerable time making the point that Utah has not defined the terms "economy" and "efficiency", and that the Flat Rate Committee did not make written findings that the rate was adequate to reimburse efficiently and economically operated providers. Terms like efficiency and economy are not susceptible to precise linguistic definitions. Thus, the Federal Government has permitted states

to define efficiency and economy in terms of the rate itself. In its official comments to the final rule published in the Federal Register December 19, 1983, page 56049, the Federal Department of Health and Human Services stated:

We have also decided not to mandate that the states' plans specifically provide a definition of "efficiently and economically operated facility." The reason for this is that the states' methods and standards implicitly act as the states' definition of an efficiently and economically operated facility and no explicit definition is necessary.

In Mary Washington Hospital, Inc. v. Fisher, *supra*, 635 F.Supp. at 899, the Court specifically "rejects plaintiff's contention that Virginia must have made written findings. The federal regulations do not specify that the findings must be in writing." (emphasis in original). The fact that the flat rate committee defined economy and efficiency through its recommended rate does not render the rate out of compliance with federal law.

In essence, apart from a rate which is arbitrary and capricious, the determination of a fixed rate which reimburses the "economical" and "efficient" provider is left to the discretion of the participating states and the federal agency with oversight of Medicaid. Under the Boren Amendment, it is for states, subject to approval by the federal contracting agency, to supply meaning and content to the words "economy" and "efficiency."

Utah's modified flat rate was established by a broadly representative non-partisan body. The rate represents the flat rate committee's judgment as to the cut-off point for an efficiently and economically operated facility.

Weber Memorial's argument is similar to that made by the plaintiffs who lost their motion for a preliminary injunction in Coalition of Michigan Nursing Homes, Inc. v. Dempsey, 537 Fed. Supp. 451 (D.C. Mich. 1982). Dempsey was filed to stop Michigan's Medicaid Agency from setting a cap on reimbursement of variable costs in long term care facilities. The Michigan Legislature, acting under the pressure of impending deficits and a "balanced budget" provision in the State Constitution, cut its Medicaid budget by over \$3,000,000. In response, the state's Medicaid Agency capped long term care reimbursement at the eightieth percentile of variable costs for all providers. The court observed that this rate capping implicitly "represents the state's determination that homes whose allowable costs are in the top twenty percent of its class are not 'economically and efficiently operated.'" Id.

In rejecting the plaintiff's argument that federal regulations require a review of all facilities on an individual basis to determine the impact of the 80% "cap", the court summarized its findings as follows:

Plaintiff's interpretation finds no support in statutes, regulations, legislative history or any of the testimony before the court. On the contrary, the essence of the Boren Amendment was to reduce this very type of detailed oversight.

Id. at 463. See also Mississippi Hospital Association, Inc. v. Heckler, 701 F.2d 511 (5th Cir. 1983).

Utah's long term care rate, like Michigan's, acts as an implicit Medicaid definition of economy and efficiency.

C. Utah's rate was set in accordance with federal standards and is neither arbitrary nor capricious.

One of the key words used by the Senate Finance Committee in its report on the 1980 amendments was "flexibility. The report stated:

The Committee continues to believe that states should have flexibility in developing methods of payment for their Medicaid programs and that applications of the reasonable costs reimbursements principles of the Medicare program for long term care facility services is not entirely satisfactory. The Committee bill deletes the present language . . . and substitutes language which gives the states flexibility and discretion."

S.R. No. 96-471, Tab "C".

Quoted in Federal Register, Volume 46, No. 189, Wednesday, September 30, 1981. Later, the federal administering agency stated as follows:

The major purpose of the regulation was to implement amendments to the Medicaid law that are designed to increase states' flexibility in setting payment rates for those purposes while keeping federal reporting and other administrative requirements to the minimum necessary to assure proper accounting.

Federal Register, Volume 48, No. 244, Monday, December 19, 1983.

The record shows that Utah exercised its discretion to set a payment rate in a logical and reasonable manner. There is nothing to indicate that the rate was set arbitrarily or capriciously.

Weber Memorial is a member of the Utah Health Care Association. In fact, Weber Memorial now has a member of its administration on the Flat Rate Committee - the group that develops and recommends nursing care rates to the Health

Department. In 1981 the nursing home industry, through the Utah Health Care Association, approached the Utah Legislature during its general session and urged it to adopt a modified flat rate methodology of reimbursement. In a letter to members of the Joint Social Services Appropriations Committee, the nursing association said:

Utah Health Care Association strongly supports and recommends adopting a system which will, in fact, return such operating control to the owner or administrator and we have taken steps toward the development of such as system, one which will relate to the cost of efficient operations and meet the requirements of state and federal regulations pertaining to the Medicaid program. Such a program gives recognition to the free enterprise system. It is a pro-competitive approach to reimbursement. Such a system can be defined as a modified flat rate system, the concept of which has been discussed with and approved by Dr. James Mason and other officials of the Department of Health.

Defendant's Exhibit 1, Trial Record.

The legislature responded by adopting a legislative intent document, directing the Department of Health to establish a committee to develop a "more cost-effective and economical system such as a modified flat rate system, . . . to assure Medicaid recipients of high quality care." Defendant's Exhibit 2, Trial Record. In accordance with the legislature's mandate, a committee was established consisting of nursing home representatives, legislators, legislative fiscal analysts, the Director of the State Department of Health and a Medicaid reimbursement specialist. Defendant's Exhibit 2, Trial Record.

In ongoing meetings, the flat rate committee considered various methodologies. Defendant's Exhibit 13, Trial Record. It

considered and rejected "Alternative B," which was simply to inflate the rates paid to nursing homes in April, 1981. It also considered "Alternative C," which was to establish the nursing home rates on the basis of available budget, but this was rejected outright because of the committee's awareness that such a methodology might not coincide with the reasonable needs of the Medicaid System. Finally, the committee (including the three nursing home representatives) developed and unanimously adopted "Alternative A," a modified flat rate method of statewide payment, based on an analysis of reasonable and adequate experienced costs throughout Utah." Tr., Roy Dunn, pp. 43-44, 64, 79, 104. Dennis McFall - the individual quoted in a Weber Memorial's brief - was on that Committee and voted in favor of the modified flat rate, along with the other nursing home owners, Dennis W. Nichols and Richard Brown.

The flat rate methodology was approved and certified by the Department of Health and Human Services as meeting all requirements of federal law and regulation, and was adopted into law effective July 1, 1981 as an amendment to the Utah State Plan for Payment to nursing home providers for Medicaid services rendered.

Thus, the entire procedure which the state followed was designed to ensure that the modified flat rate was both reasonable and adequate to meet the reasonable costs which must be incurred by economically and efficiently operated facilities in order to provide care and services in conformity with applicable state and federal laws. 42 USC § 1396A(a)(13)(A). In

essence, Weber Memorial is now asking this Appellate Court to revamp Utah's rate without the benefit of professional expertise or citizen input on the subject.

D. Utah's rate was not constructed "solely" or "principally" to fit the state budget .

Weber Memorial's argument appears to be predicated on the assumption that budgetary considerations should not enter into the determination of a state Medicaid plan. Nothing could be further from the truth, as the Fifth Circuit Court of Appeals pointed out in Mississippi Hospital Association v. Heckler, 701 F.2d 511 (5th Cir. 1983):

[The state's obligation to comply with federal regulations] should not be read to mean that states cannot consider cost efficiency in adopting reimbursement plans, or that the courts should engage in some type of "motivation analysis."

At this point in time, no one can reasonably hope to reconstruct the weight given to budgetary concerns by the seven members of the flat rate committee, nor is any such mental reconstruction called for by law or regulation. It is not our task to psychoanalyze the members of the flat rate committee in determining whether Utah's plan comports with federal regulations. It is the product of that committee which is of concern. If the state plan does not comport with federal regulations then the flat rate committee's motivation in formulating the plan adds nothing to the plaintiff's case. On the other hand, if, as the state maintains, the plan was in complete accord with federal regulations and guidelines, the flat rate committee's motivation in promulgating it is irrelevant.

The only case of which we are aware in which budgetary considerations were allowed to defeat a state plan was in an instance where, after designing a plan which was reasonable and adequate to meet the necessary costs of the program, it was discovered that the appropriation was insufficient. The rate schedule, which had already been developed, was then arbitrarily reduced so that projected payments would fit within the appropriation. It was held that the new rate was set under arbitrary conditions and did not comply with federal law. Country Home, Inc. v. Harder, 228 Kan. 756, 620 P.2d 1140 (1980).

But it is by no means clear that a state plan is invalid, even when state appropriations are the sole consideration in adoption of the plan. In Charleston Memorial v. Conrad, 693 F.2d 324 (4th Cir. 1982), it was admitted by all sides that the regulations limiting allowable patient days per year was enacted solely to fit a smaller appropriation than had been expected. However, the Fourth Circuit ruled that budgetary concerns were a very real part of developing a statewide plan, and held the regulations valid, since 88% of the Medicaid inpatient population would still be served by the plan. Id. And in Colorado Health Care Association v. Colorado Dept. of Social Services, 598 F.Supp. 1400 (D. Colo. 1984), appeal pending, No. 85-1016 (10th Cir.), the court wrote that "clearly, budgetary considerations can enter into a State's evaluation and development of a funding plan." See also Mary Washington Hosp., Inc., supra., 635 F.Supp. at 900-01.

Utah's flat rate was not developed solely, or even primarily, to fit a budget. The modified flat rate was developed in a systematic manner and was never reduced thereafter to fit a budget, nor does the evidence developed at the hearing show anything more than a passing reference to budgetary concerns by the flat rate committee. Weber Memorial must hang its hat on Dr. Mason's remark that the flat rate committee should "remember that state resources are not infinite." This truism is not an evidentiary basis for finding that the Committee based the rate on State appropriations to an "inappropriate" extent, much less that budgetary concerns were the sole consideration.

Upon the conclusion of the formal administrative hearing, the independent administrative law judge made the following findings:

The flat rate derived for each class of patients was based on the most recent information on the actual costs being incurred by the nursing home industry in the aggregate, as recorded 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 VIII; on input from the Utah Health Care Association; on a trending factor of the historical costs as recommended by Luhan & 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. . . .No. 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.

Proposed Decision, findings of fact and Conclusions of Law entered May 20, 1985 adopted by the Executive Director June 4, 1985. In his Minute Book entry of June 2, 1986, Judge Fishler made the following findings:

The Court, having heard argument of counsel, reviewed the record and memoranda on file herein, and being fully advised in the premises, finds that the conduct of the State of Utah in establishing its modified flat rate plan of reimbursement for health care providers was reasonable and adequate. The Court finds that the State of Utah did not base its decision solely on budgetary constraints. Lastly, the Court determines that the decision of the administrative law judge was supported by sufficient evidence.

Weber Memorial argues that Utah's rate was based "to an impermissible extent" upon budget factors. The phrase itself implies that there is some permissible extent to which the rate may be influenced by budgetary concerns. Weber Memorial never attempts to explain where the line should be drawn between permissible and impermissible amounts of influence by budgetary concerns. On this point, Weber Memorial's legal argument is floating in the air. The textual grounding for the "budget concerns" argument is found in House Report No. 96-1167, reprinted at 1980 U.S.C and Congressional and Administrative News, Volume V, page 5944. That report merely discountenances sole reliance upon budgetary concerns:

The conferees would further note their intent that a state not develop rates under this section solely on the basis of budgetary appropriations. (emphasis added)

Thus, the conferees of the House and Senate used the term "solely" in clear recognition of the fact that budgetary concerns would inevitably play a part in establishing state rates.

Neither of the cases cited by Weber Memorial stands for the proposition that there is some vague line to be drawn between permissible and impermissible budgetary considerations.

California Hospital Association v. Schweiker, 559 F.Supp. 110 (C. D. Cal. 1982) and Thomas v. Johnston, 557 F.Supp. 879 (W.D. Tex. 1983) are both predicated (inter alia) on the fact that the rates were determined solely on the basis of budgetary appropriations. As the court said in Thomas, supra at 914:

The court has come to the reluctant conclusions that the appropriations cap is the only element in the record that begins to explain why TDHR set rates at the fortieth percentile level. (emphasis added).

The Thomas court cited with approval the standards set out in Coalition of Michigan Nursing Homes v. Dempsey, 537 F.Supp. at 463:

One court recently stated that Congress's primary concern in declaring that reimbursement rates should not be determined "solely on the basis of budgetary appropriation" was that the most recent change in the federal statutory standard "not be read as repealing the rate setting process and returning to pre-1972 reimbursement schemes which determined daily rates simply by dividing the annual budget allotment by the number of patient days." (emphasis added).

The Thomas court also observed that the state has very legitimate interests in tending to its budget:

In the court's view, defendant's argument that budgetary realities may properly be taken into account in the rate setting process is correct.

Id. There is no evidence in this record that the flat rate committee placed predominant, conclusive, or sole reliance upon budgetary factors in the development of the flat rate.

POINT II

THE ADMINISTRATIVE JUDGE AND DISTRICT COURT CORRECTLY EXCLUDED EVIDENCE CONCERNING WEBER MEMORIAL'S FACILITY COSTS.

A. Rate makers were nor required by federal standards to adjust the rate for every conceivable facility cost.

We have discussed the difference between the pre-1980 method of "cost" reimbursement and the post-1980 methodology utilizing standard rates. In the course of the fair hearing, Weber Memorial sought to introduce detailed evidence as to its facility costs, for the purpose of proving that the facility was being operated in an economical and efficient manner. The agency responded with a motion to exclude such evidence as irrelevant to the inquiry at hand. The hearing officer excluded the evidence, and was upheld on this point by the District Court on appeal.

There are three reason why evidence of Weber Memorial's costs was irrelevant. First, the State is not longer required to pay reasonable costs, as it was before the Boren Amendment. Second, the definition of "economy" and "efficiency" has been left to the discretion of the states, subject to approval by the federal administering agency. Utah has defined those terms by means of a statewide rate, which has received the approval of H.H.S. It is widely recognized that Congress may delegate discretionary powers to a federal agency and that decisions made by the agency pursuant to those discretionary powers are only reviewable on very narrow grounds. In one Medicaid case, the U.S. Supreme Court declared:

In view of this explicit delegation of substantive authority, the Secretary's definition of the term "available" is

"entitled to more than mere deference or weight." . . . Rather, the Secretary's definition is entitled to "legislative effect" because, "[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term." . . . Although we do not abdicate review in these circumstances, our task is the limited one of ensuring that the Secretary did not "exceed[] his statutory term authority" and that the regulation is not arbitrary or capricious.

Schweiker v. Gray Panthers, 453 U.S. 34, 44 (1981).

Evidence of Weber Memorial's costs would not have the slightest impact upon the judge's determination of whether the Utah rate is arbitrary or capricious.

Finally, Weber Memorial's costs are not relevant to the question of patient care. In a rate hearing, Weber Memorial must show that the rate adversely benefits patients. A mere showing that a particular health care provider cannot make money under the State's rate is meaningless.

In In re Estate of Smith v. O'Halloran, 557 F.Supp. 289 (D. Colo. 1983), the district court made a finding that the Secretary's actions were "facility oriented," rather than "patient oriented." Id., 557 F.Supp. at 295. Hearing the case on appeal the Tenth Circuit wrote:

Nothing the Medicaid Act indicates that Congress intended the physical facilities to be the end product. Rather, the purpose of the Act is to provide medical assistance and rehabilitative services [to patients].

Estate of Smith v. Schweiker, 747 F.2d 583, 589 (10th Cir. 1984). Weber Memorial's proffer was clearly "provider oriented," and not "patient oriented."

The fair hearing officer's power to exclude irrelevant evidence is supported by the state statute establishing the hearing process:

In any such hearing, the hearing officer shall have authority to administer oaths, examine witnesses, and issue in the name of the department notice of the hearings or subpoenas requiring the testimony of witnesses and the production of evidence relevant to any matter in the hearing. (emphasis added).

Utah Code Annotated § 26-23-2 (1953 as amended 1981). (Emphasis added.) Under the explicit authority of the foregoing provision, the Health Department has adopted a set of procedures entitled "Administrative Hearing Procedures for Medicaid Recipients and Providers." That document governs the Department's informal and formal hearings. Those procedures substantially follow the general rules of evidence, and require the fair hearing officer to exclude irrelevant evidence. The section covering evidence in formal hearings reads as follows in pertinent part:

The rules of evidence, as applied in civil actions in the courts of this state, shall be generally followed in the hearings. Irrelevant, immaterial and unduly repetitious evidence shall be excluded. (emphasis added).

Administrative Hearings Procedures for Medicaid Recipients and Providers § 9(I)(5), p. 17.

By saying that evidence of Weber Memorial's costs is irrelevant, we are not implying that evidence respecting an individual facility would be irrelevant in every Medicaid rate challenge. The federal statute and guidelines thereunder do provide grounds for challenging a state's rate structure - but

only when that challenge is based upon the needs of Medicaid recipients, not the needs of health care providers; and only when the statutory provision is not committed to the discretion of the agency to interpret and apply.

For example, federal law requires the state to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." 42 U.S.C. § 1396A(a)(13)(A). This was precisely the issue in the case most heavily relied on by Weber Memorial, Thomas v. Johnston, supra. In Thomas, plaintiffs were mentally retarded and physically disabled children who were eligible for nursing care. When the State of Texas set its rate at the fortieth percentile of aggregate nursing industry costs, the court concluded that the State "did not adequately take into consideration certain highly relevant factors, most importantly, that some providers such as Ada Wilson Hospital, are responsible for the care of a greater proportion of persons whose needs are greater, and therefore whose care is more costly than other providers." Id. The hospital prevailed in Thomson v. Johnson because it convinced the court that indigent, mentally retarded children would not be cared for properly under Texas' rate. Id. at 893.

If Weber Memorial had come to the hearing offering evidence that it cared for a patient group with specialized needs, such evidence would have been admissible. No such evidence was proffered by Weber Memorial.

Likewise, a provider or recipient of Medicaid is entitled to offer evidence that patients in one or more geographic areas are not being served as a result of the rate. See 42 U.S.C. § 1396A(a)(13)(A) (states must "assure that individuals eligible for medical assistance have reasonable access, taking in account geographic location and reasonable travel time to inpatient hospital services of adequate quality.") If Weber Memorial were the only nursing facility located in its region of Utah, such an argument might be presented. However, Weber Memorial is located in the heart of Utah's population center on the Wasatch Front, where nursing homes abound.

Finally, Weber Memorial might have, but it did not, argue that Utah's rate was inadequate "to provide care and services in conformity with . . . quality and safety standards." 42 U.S.C. § 1396a(A)(13)(A)

At the hearing, Weber Memorial proposed to introduce its costs into the record simpliciter, to show that the facility was being economically and efficiently operated. It would then, in their eyes, be the state's responsibility to show that their operation was uneconomical or inefficient. Counsel for Weber Memorial stated it as follows:

The cornerstone of what we're trying to do in the context of this appeal is to literally make ourselves naked in front of the State of Utah [quite a thought] and to say, "please examine us and please look at all of these costs and we'll prove it to you that we have done everything in our power to get those costs down to rock bottom . . ." What we would like, ultimately, for a court to do, is to come to a finding or a hearing officer, saying that this facility is efficiently and economically operated by whatever standards

are used, it is, and if somehow we're wasting money and they can show that then that's fair game. I don't think they'll be able to.

In re: Weber Memorial Care Center, Inc. v. Utah Department of Health, Civil No. C-85-4268, Reporter's Transcript of Proceedings, January 22, 1986, pp. 48, 49. Weber Memorial's proffer, if it had been accepted by the hearing officer, would have placed every facility cost on Utah in the examining table for a determination of its reasonableness and necessity. This is precisely the system of reasonable cost reimbursement which was rejected by Congress in 1980. In the pre-1980 period, the Health Department was frequently involved in haggling over costs and their "reasonableness and necessity." Bitter disputes were had between nursing homes and the department of health over whether snowmobiles could be considered a "reasonable expense" related to patient care. By authorizing the states to use rates Congress did away with this scrutiny of individual facility costs.

Judge Fishler responded to counsel for Weber Memorial's argument with the following statement:

What you're saying is you have a problem with the flat rates; because if you have such a hearing [to examine facility costs] what you're doing is you're eliminating the flat rate. That's basically what you're saying. Because once you make the inquiry into the cost of the quart of milk, the cost of hiring registered nurses -- once you've done that you've eliminated the flat rate.

Id. at page 58. Judge Fishler was absolutely correct. A detailed examination of individual facility costs for reasonableness for economy or efficiency would put us right back to the old system of reasonable cost reimbursement.

This identical issue was ruled upon by Judge Judith Billings in a similar District Court case. In Halo Care Center, Inc. v. Department of Health, Third District Court, Utah, February, 1984, C-83-4654, Judge Billings held that, "It is not required, nor is there a need, to examine the costs of a particular nursing home to determine whether that nursing home is economically and efficiently run." Id. "Findings of Fact and Conclusions of Law." Whereas costs relating to specialized care or geographical access to care are relevant in rate cases, such evidence was not proffered by Weber Memorial. The proffer in this case was a bald attempt to establish the administrative law judge as a super administrator to reformulate Utah's Medicaid rates so as to cure the business errors of the owners and managers of Weber Memorial.

In essence, apart from a rate which is arbitrary and capricious, the requirement that states set payment rates at a level which reimburses the "economical" and "efficient" provider is a matter left to agency discretion. Under the Boren Amendment, it is for states, subject to approval by the federal contracting agency, to supply meaning and context to the words "economy" and "efficiency."

POINT III

THE UTAH MEDICAID AGENCY HAS CORRECTLY CLASSIFIED PATIENTS AT WEBER MEMORIAL.

A. Weber Memorial has not made a prima facie case of incorrect patient classification.

Weber Memorial's argument on patient classification is, if possible, even less substantial than the previous arguments.

During the hearing, one expert testified that approximately thirty-eight patients at the facility had been arbitrarily classified by the Department as intermediate rather than skilled patients. Skilled patients, by definition, require more intensive care and receive a higher rate of reimbursement. The thirty-eight patients were never named nor identified. The State, therefore, had no opportunity to rebut the testimony since only the conclusory allegation that "approximately thirty-eight patients" had been improperly classified was introduced. A general allegation that about thirty-eight unnamed patients have been incorrectly classified does not form a satisfactory basis for a ruling by the court. What could the court possibly have done on that information? It would have been absurd for the fair hearing officer to order the State to upgrade the classification on thirty-eight patients from intermediate to skilled care without even knowing which patients were involved.

The State's definition of "skilled care" under Medicaid is essentially identical to the definition of skilled care used by the Medicare Program. See 42 C.F.R. § 409.30 to 409.35 and Tr. pp.362-64. The Medicare definition of skilled care adopted by the State on December 15, 1981 involves a four-pronged analysis. First, the severity of the patient's illness and the degree of impairment is assessed. Second, the intensity of services ordered by the patient's attending physician is reviewed in light of the patient's severity of illness and degree of impairment, to insure that the patient is neither overserved nor underserved. Third, the patient's anticipated outcome is

analyzed, i.e., the purpose of the services ordered for the patient is reviewed. (For example, is the patient in need of rehabilitation to regain lost functions? Or, is the patient's condition stable, but chronic?) Fourth, the treatment setting is reviewed to insure that the facility in which the patient resides can provide all the services necessary for the patient and yet be the least restrictive setting possible, so as to minimize the deleterious effects of institutionalization. Tr., Kurt Matthia, pp. 364-67. This four-pronged definition of skilled care is used nationwide and has gained wide acceptance in the medical community generally. Tr., Kurt Matthia pp. 367-8.

Plaintiffs contend that the percentage of skilled patients in Utah's Medicaid Program is low compared to other states. This argument is extremely unpersuasive. Since each state participating in Medicaid is entitled to establish its own definition of skilled care, it is not clear that any comparison between states is legitimate. This is especially true with comparison states such as California which choose not to provide intermediate care at all, so that their percentage of skilled patients would be artificially high -- indeed 100%. Tr., Sharon Wasek, p. 305-07. Finally, and most important, even if such a comparison were possible, it is difficult to see how the practice of other states bears on the ultimate question of whether Utah's adoption or application of the Medicare definition of skilled care is unreasonable. The evidence belies a radical decline following the December, 1981 adoption of the Medicare definition of skilled care. Beginning as early as 1976 and continuing to

the present, there has been a gradual sloping decline in the number of skilled care patients. This gradual and continual decline in the percentage of skilled patients did not result from any artificial manipulation of the definition, but from two independent factors. First, the increasing sophistication and medical expertise of the persons doing level of care determinations and utilization review. Tr., Kurt Matthia, p. 356-61. Second, the increasing trend toward deinstitutionalizing patients in every setting, which for example, has resulted in the availability of hospice care for the terminally ill. Tr., Kurt Matthia, p. 442, 443.

In addition, there was no physicaian testimony to indicate that these patients were in fact skilled care level patients. Ruth Croft, an R.N. at Weber Memorial testified that the thirty-eight odd patients had been identified in a review of intermediate care patients (apparently it was assumed no skilled patients in the facility were wrongfully classified) performed by herself (an R.N.), one additional registered nurse, the administrator of the facility (who is neither a registered nurse nor a physician) and the facility's "business manager". The review did not involve any physicians at all. The attending physicians of the approximate thirty-eight patients were not consulted, although they are legally responsible for prescribing the appropriate medical services and making the initial determination of the level of care. Tr., Ruth Croft, pp. 765-69.

B. Weber Memorial has not utilized the available method of challenging patient classification.

Most importantly, the formal hearing and trial process is not the proper forum in which to resolve issues involving the proper assignment of level of care for these and other individual patients. The patients themselves or their representatives can appeal the determination of level of care. The record indicates that none of the patients at Weber Memorial Care Center has ever done so. Tr., Kurt Matthia, p. 368-69. The facility itself can request a reconsideration of a patient's level of care at any time. Tr., Kurt Matthia, p. 351. The record further indicates that in the three years prior to the hearing in which Weber Memorial Care Center operated, no requests for reconsideration were ever made. Ruth Croft testified that she had never notified the State that she felt any of the "about" thirty-eight patients had been improperly classified. Neither had any of the approximate thirty-eight patients or their families ever contacted the State concerning an allegedly improper classification of level of care. Weber Memorial has simply failed to use the avenues which are open to it for getting a reconsideration of individual persons' level of care.

POINT IV

THE DISTRICT COURT USED THE CORRECT STANDARD OF REVIEW.

Weber Memorial argues for the first time that the District Court incorrectly employed the "capricious, or not supported by the evidence" standard set forth in Utah Code Ann. § 26-23-2(3).

A. Weber Memorial cannot raise this issue for the first time in the Intermediate Court of Appeals.

Weber Memorial knew, before Judge Fishler ever made a finding of fact or conclusion of law, that Judge Fishler would employ the standard of review set forth in Utah Code Ann.

§ 26-23-2(3) which provides as follows:

If the final determination of the Executive Director is consistent with the findings of fact and conclusions of law recommended by the hearing officer, the Court shall review the record and may alter the final determination only upon a finding that the final determination is capricious, or not supported by the evidence.

The State Department of Health filed a reply brief in Judge Fishler's Court on January 16, 1986. The first page of that brief states as follows:

I. Standard of Review.

It is worthwhile to recall standard for the District Court's review of the agency's hearing decision. Sections 26-23-2(3) of the Utah Code directs that: "The Court shall review the record and may alter the final determination only upon a finding that the final determination is capricious, or not supported by the evidence." . . . With this standard in mind we turn now to plaintiff's arguments.

Id. pp. 1-3. After the quoted pleading was filed by the State Weber Memorial filed several other documents with the District Court, argued before the Court twice, and met with Judge Fishler in chambers on at least one occasion-and at no time did counsel for Weber Memorial challenge the aforesaid standard of review. It is fundamental in Utah, that issues not raised to a lower Court are not reviewable for the first time on appeal. Bundy v. Century Equipment Co., Inc., 692 P.2d 754 Utah 1984; Trayner v.

Cushing, 688 P.2d 856 Utah 1984; Combe v. Warrens Family Drive Inns, Inc., 680 P.2d 733 Utah 1984. Weber Memorial should not be allowed to challenge Judge Fishler's ruling on grounds that he employed an inappropriate standard, when that issue was never presented to Judge Fishler for consideration.

B. The District Court employed the correct standard.

The cases cited by Weber Memorial are simply not on point. To begin with, Weber Memorial cites the case of State of Minnesota v. Heckler, 78 F.2d 854 (8th Cir.) 1983 involving review of agency decisions under the Federal Administrative Procedure Act, 5 U.S.C. Section 5551 et. seq. In the case of Mary Washington Hospital, Inc. v. Fisher, 635 F.Supp. 891 (E.D. Va. 1985) the Court considered whether the Federal Administrative Procedure Act applied to decisions by State agencies operating Medicaid programs. The Court concluded that "the [A.P.A.] is clear on its face that it applies only to federal agencies" id. at 897. The only federal guidelines for State agency review of Medicaid rates is set forth in the Code of Federal Regulations:

The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. section 447.253 1983. Thus, the federal statute merely provides that States must provide some kind of "appeals or exception procedure" and that the procedure must give review to "such issues as the [state] agency determines appropriate". This does not provide any formulaic standard of review for states to use, and allows maximum state discretion in establishing such appeals or exceptions procedures.

The only Utah case with is provided by Weber Memorial to support its argument is Salt Lake City Corp. v. Department of Employment, 657 P.2d 1312, 1316, Utah 1982 in which the Court states as follows:


On most questions of statutory construction, with some exception, our review is plenary with no deference accorded the administrative determination. (emphasis added).

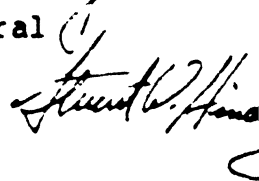
The Salt Lake City Corp. case does not deal with the judicial review of an administrative action of the Health Department under Section 26-23-2, and even the general language quoted from Salt Lake City Corp. alludes to exceptions to the general rule. Weber Memorial is simply asking the Court to overturn Judge Fishler because he employed the standard of review which is mandated explicitly by U.C.A. § 26-23-2(3).

CONCLUSION

In summary, Utah's modified flat rate is not unreasonable nor arbitrary. The hearing officer and district court judge correctly ruled on the admissibility question and plaintiffs have not even made a prima facie case for incorrect patient classification. The District Court's ruling was based on the appropriate standard of review, was correct as a matter of law, and should be upheld.

RESPECTFULLY SUBMITTED this 13th day of May, 1987.


CLARK C. GRAVES
Assistant Attorney General
Attorney for Defendants



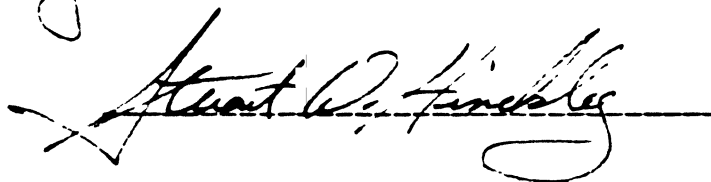
CERTIFICATE OF MAILING

I hereby certify that I mailed a true and exact copy of the foregoing Brief of Appellee, postage prepaid, to the following attorneys for plaintiffs:

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on this the 13th day of May, 1987.



Tab A

**TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE
PROGRAMS**

§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—
(13) provide—

(A)(i) for the inclusion of some institutional and some non-institutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under the State's plan approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301–304, 306, 1201, 1202, 1203, 1204, 1206, 1351–1355, 1381–1383c, or 601–610], for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a) [42 USCS § 1396d(a)], and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) [42 USCS § 1396d(a)(1)–(5)] or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (14) of such section [42 USCS § 1396d(a)(1)–(14)] and

(II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home [facility], and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122 [42 USCS § 1320a-1], which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) [42 USCS § 1395x(v)] as the reasonable cost of such services for purposes of title XVIII [42 USCS §§ 1395–1395b, 1395c–1395i, 1395i-2, 1395j–1395w, 1395x–1395dd, 1395FF–1395pp], and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;

Tab B

TITLE 42—THE PUBLIC HEALTH AND WELFARE

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(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

(B) for payment for services described in section 1396d(a)(2)(B) of this title provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

Tab C

96TH CONGRESS }
1st Session

SENATE

{ REPORT
No. 96-471

MEDICARE-MEDICAID ADMINISTRATIVE
AND REIMBURSEMENT REFORM ACT OF 1979

REPORT
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON
H.R. 934. A BILL FOR THE RELIEF OF BRIAN
HALL AND VERA W. HALL



DECEMBER 10 (legislative day, NOVEMBER 29), 1979.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

**SECTION 227—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED
NURSING AND INTERMEDIATE CARE FACILITIES**

Present law requires States participating in medicaid to pay skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) on a reasonable cost-related basis. This requirement, added by Section 249(a) of the Social Security Amendments of 1972, was designed to assure that payment rates would more closely reflect the reasonable costs necessary to provide nursing home services of adequate quality. Section 249(a) gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

States have argued that the complex and long-delayed Federal regulations implementing the statutory requirement of section 249(a) have unduly restrained their administrative and fiscal discretion and that the Federal approval process has forced States to rely heavily on medicare principles of reimbursement. Neither of these consequences was intended when section 249(a) was enacted.

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 long-term 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 of section 1902 (a)(13)(E) of the act (which was added by section 249(a) of the 1972 Amendments) and substitutes language which gives the States flexibility and discretion, subject to the statutory requirement of this section

and the existing requirements of section 1902 (a) (30) and section 1121 of the Act, to formulate their own methods and standards of payment.

Under the bill, States 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. The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care. Under the bill, the State would be required to find, and make assurances satisfactory to the Secretary that the payment rates, taking into account projected economic conditions during the period for which the rates are set 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 standards. The State would also be required to assure the Secretary that it has provided for the filing by the facilities of uniform cost reports and for their periodic audit by the State.

The Congress expects that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

In establishing rates, a State, at its option, could include incentive allowances designed to encourage cost containment through efficient performance, as well as incentives to attract investment where such investments would serve to alleviate demonstrated shortages of long-term care services. In addition, States would continue to have the option provided in current Federal Regulations to adjust rates downward for facilities with service deficiencies where facilities are classed by quality of service or level of care.

The Secretary would be expected to continue to apply current regulations which require that payments made under State plans do not exceed amounts which would be determined under the medicare principles of reimbursement. Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement, the Secretary would only be expected to compare the average rates paid to SNFs participating in medicare with the average rates paid to SNFs participating in medicaid in applying this limitation.