

1988

Weber Memorial Care Center Inc., and Chartham Management Inc. v. Utah Department of Health Division of Health Care financing : Brief in Opposition to Petition for Writ of Certiorari

Utah Supreme Court

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UTAH SUPREME COURT
BRIEF

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DOCKET NO. 880146

IN THE SUPREME COURT OF THE STATE OF UTAH

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

Plaintiffs/Petitioner, :

-vs- :

UTAH DEPARTMENT OF HEALTH, :
DIVISION OF HEALTH CARE :
FINANCING, :

Defendants/Respondent. :

Case No. 880146

BRIEF IN OPPOSITION TO
PETITION FOR WRIT OF
CERTIORARI FROM DECISION
OF COURT OF APPEALS

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MAY 19 1988

Clerk, Sup

IN THE SUPREME COURT OF THE STATE OF UTAH

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

Plaintiffs/Petitioner, :

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FINANCING, :

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QUESTIONS PRESENTED FOR REVIEW

- I. Whether Petitioners have demonstrated a compelling reason for this Court to grant certiorari.
- II. Whether the Court of Appeals and the district court correctly affirmed the administrative law judge's determination that the Utah State Medicaid plan complies with federal Medicaid law.
- III. Whether the Court of Appeals and the district court correctly affirmed the administrative law judge's decision to exclude evidence concerning Weber Memorial's individual facility cost data at the administrative hearing.

STATEMENT OF THE CASE

Petitioners are the previous owner and manager of a nursing home facility in Roy, Utah. For convenience, they will be referred to jointly as Weber Memorial. Respondent is the state agency charged with administering a cooperative federal-state medical assistance program commonly called Medicaid.

In 1983, Petitioners requested an administrative hearing to challenge the method of reimbursement by which they received payment for services given to Medicaid eligible individuals in their facility. Petitioner claims that the state must pay all reasonable costs which they incurred in providing medical assistance.

Prior to 1980, the state was required by federal law to reimburse nursing homes for their "reasonable costs." In 1980, however, Congress enacted supplemental Medicaid legislation commonly referred to as the Boren Amendment. The new legislation allows the states to pay providers according to predetermined rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers . . . "

Consequently, the Department of Health developed a "modified flat rate" whereby all providers in the state are paid one rate plus a differential for property costs. The rate operates as the department's definition of an economically and efficiently operated facility.

The administrative law judge held four full days of hearings, however, pursuant to a motion made by the Department,

the hearing officer excluded proof of Weber Memorial's individual costs because they were irrelevant. The administrative law judge ruled that the Utah Medicaid plan complied with federal and state law on May 20, 1985. His proposed Findings of Facts and Conclusions of Law were adopted in a Final Determination issued by the Executive Director of the Department of Health on June 4, 1985.

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

Petitioners next appealed to the Utah Court of Appeals. On March 15, 1988 Judge Bench writing for the panel which included Judge Garff and Davidson, again affirmed the final determination of the executive director.

Petitioner now requests this court to grant certiorari to again review the administrative decision.

ARGUMENT

Point I: Petitioners have not demonstrated a compelling reason for this Court to grant certiorari.

Weber Memorial has had the benefit of two courts separately scrutinizing the administrative decision made in this case. Each court has rejected Petitioner's arguments and upheld the administrative action. Petitioner has not pointed to any error in either the district court's or the Court of Appeal's decisions which would support its request for this court to grant certiorari. In addition, the usual considerations governing review by a writ of certiorari are absent.

The district court reviewed the Executive Director's decisions as provided by Utah Code Ann. § 23-26-2 (1987) and found that the administrative decision was supported by sufficient evidence and was not arbitrary or capricious. The petitioners' underlying complaint is that they are not pleased with the previous courts' adverse decisions. They continue to allege that the district court applied the wrong standard of review by citing general case law applied by appellate courts. What petitioners have refused to recognize is that specific statutory enactments override all the general case law on the issue. In this case, the district court's standard of review of a final determination by the executive director is specified, "[t]he 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." Utah Code Ann. §

26-23-2(3) (1987). The district court, therefore, reviewed the record and memoranda on file and found that the final decision of the executive director was not capricious but supported by sufficient evidence. Weber Memorial v. Department of Health, C85-4268 Minute entry on June 2, 1986, Addendum A.

Petitioner next appealed to the Court of Appeals which treated the case as if the appeal had come directly from the agency. They applied a correction of error standard, giving no deference to the expertise of the agency. Technomedical Labs, Inc., v. Utah Securities Division, 744 P.2d 320 (Utah App. 1987). This standard of review is the same standard applied by this court as enunciated in Bennion v. Utah State Board of Oil, Gas & Mining, 675 P.2d 1135 (Utah 1983).

The Court of Appeals found that "the modified flat rate plan for Medicaid reimbursement is in full compliance with federal and state law. The final determination of the executive director was not capricious, but amply supported by the evidence." Weber Memorial v. Utah Department of Health, 86342-CA (March 1987), Addendum B. Petitioner points to no error committed by the Court of Appeals, neither do they allege the development of new case law or new information which would prompt this court to review their arguments which have been repeatedly rejected as meritless.

An administrative law judge first heard this case which included four full days of testimony by numerous witnesses, generating four volumes of transcript totalling over 787 pages. In addition, seven depositions were admitted as evidence.

Petitioners have not only had their "day in court," but two separate appellate reviews of the administrative action. There is no reason for this court to now accept certiorari on this case.

POINT II: The Court of Appeals and the district court correctly affirmed the administrative law judge's determination that the Utah State Medicaid plan complies with federal Medicaid law.

Medicaid Background

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 government share the costs of medical services to certain needy individuals "whose income and resources are insufficient to meet the costs necessary medical services." 42 USC § 1396 (1974).

If the 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 Ann. § 63-46a-1 to -16 (1987).

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 known as the Boren Amendment which was 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 § 1396A 13E (enacted in 1976) (Addendum C), with 42 USC § 1396A(a)(13)(A) (replacing the earlier section in 1980) (Addendum D).

STATE MODIFIED FLAT RATE

In 1981, following the change in federal law mentioned above, the Utah legislature directed 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 alternatives, the rate committee developed a modified flat-rate method of nursing home reimbursement based on several factors. The modified flat-rate methodology was submitted through the

rulemaking process for public comment, and public hearing. Tr., Sharon Wasek at pp. 312-313. Pursuant to federal law, the 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." 42 C.F.R. § 447.253(b)(1). 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 rulemaking into law effective July 1, 1981.

Health care providers who accept Medicaid patients are paid a statewide flat rate fee per patient day according to the classification of such patient. The flat rate is modified by a "property differential," unique to each provider, to account for wide variations in property costs. The flat rate is also adjusted annually to account for inflation and other factors.

Two months after the effective date of the flat rate in September 1981, Mr. Don Bybee (who owns both plaintiff corporations) purchased Weber Memorial Care Center. In 1983, Weber Memorial requested a hearing before the Department of Health to challenge the modified flat rate system on the basis that Weber Memorial was an "efficiently and economically operated" facility and therefore entitled to have all "reasonable" costs met.

Petitioner's based their claim on the language in Title XIX of the Social Security Act, 42 U.S.C. § 1396(a)(13)(A) which provides:

A State plan for medical assistance must provide for payment . . . 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 . . .) 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

(Emphasis added). Petitioners argue that this provision requires the Department of Health to scrutinize the costs incurred by Weber Memorial Care Center and to pay them their reasonable costs. Petitioners in essence would have the state ignore the 1980 change brought by the Omnibus Reconciliation Act, (Public Law 96-499). This position has been rejected by the administrative hearing officer, the district court and the Court of Appeals.

A plain reading of the statute and indeed the enacting Senate interpretation (See Addendum E), allow the state to set a rate of reimbursement which is reasonable and adequate to meet the costs of efficiently and economically operated facilities as a class. The modified flat rate does just that and completely reimburses the costs of over 90% of the long care facilities in the state. Most of those facilities also realize a profit. To embrace Petitioner's arguments would require the state to reimburse nursing homes according to the state's pre-1980 methodology, a position which has been rejected by many other courts. Halo Care Centers v. Utah Department of Health, C-83-

4654 (Utah 3rd Dist. Ct. 1985); Mary Washington Hospital, Inc. v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985); Coalition of Michigan Nursing Homes, Inc. v. Dempsey, 537 F. Supp. 451 (D.C. Mich. 1982); See also Mississippi Hospital Association, Inc. v. Heckler, 701 F.2d 511 (5th Cir. 1983).

Petitioner's allegation that the state failed to comply with other federal requirements has likewise been rejected as meritless. (See Weber Memorial v. Utah Department of Health, 86342-CA (March 1987) Addendum B which is hereby incorporated by reference.)

Point III: The Court of Appeals and the district court correctly affirmed the administrative law judge's decision to exclude evidence concerning Weber Memorial's individual facility cost data. Thus, Petitioners received a full and fair hearing.

In the course of the administrative 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. The administrative law judge made a ruling that based on the 1980 Boren Amendment, the specific costs of Weber Memorial were irrelevant. It is this ruling that Petitioners claim prevented them from receiving a full and fair hearing held in a "meaningful manner." As previously discussed, the Boren Amendment amended the "reasonable cost" standard of reimbursement and replaced it with a statute giving more flexibility to the states to establish state wide rates of reimbursement. Thus, Weber Memorial's costs were irrelevant to the hearing and irrelevant evidence need not be admitted in order to have a "meaningful" hearing.

Under Utah law, an administrative law judge has the authority to "administer oaths, examine witnesses, and issue in the name of the department (of Health) notice of the hearings or subpoenas requiring the testimony of witnesses and the production of evidence relevant to any matter in the hearing." Utah Code Ann. § 26-23-2(1) (1987) (emphasis added). See also Utah Admin. Code R455-14-1(A) (9)(i)(5) (1987).

The administrative law judge explained his ruling:

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.

Weber Memorial Care Center v. Dept. of Health, ALJ Recommended Decision, May 20, 1985. (Addendum F).

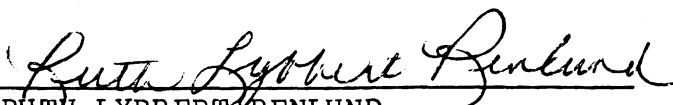
The executive director of the Department of Health adopted the Recommended Decision (Addendum G) and both the district court and Court of Appeals independently concluded that the executive director's final determination on this issue was not capricious, but supported by the evidence.

CONCLUSION

In summary, Petitioner's arguments have been repeatedly reviewed and rejected by the lower courts and they fail to advance any compelling reasons why this Court should grant certiorari. Both the district court and Court of Appeals have found that the modified flat rate plan for Medicaid reimbursement is in full compliance with federal and state law and that the administrative determination was supported by the evidence.

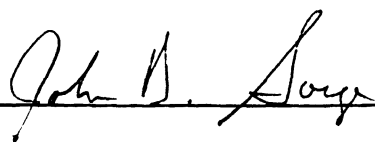
Therefore, this Court should reject Petitioner's request for certiorari.

Respectfully submitted this 16th day of May, 1988.


RUTH LYBBERT RENLUND
Assistant Attorney General
Attorney for Defendants

MAILING CERTIFICATE

I hereby certify that I mailed four true and exact copies of the foregoing Brief In Opposition to Petition for Writ of Certiorari from Decision of Court of Appeals to William Downes, Jr., WINDER & HASLAM, 175 West 200 South, #4004, P.O. Box 2668, Salt Lake City, Utah 84110-2668 and to Donald W. Lojeck, LOJECK AND HALL, CTD., P.O. Box 1712, Boise, Idaho 83701 on this the 16th day of May, 1988.



ADDENDUM A

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

In re: WEBER MEMORIAL CARE	:	
CENTER, INC. and CHEARTAM	:	
MANAGEMENT, INC.,	:	FINAL JUDGMENT
	:	
Plaintiffs/Appellants	:	
	:	
vs.	:	
	:	Civil No. C-85-4268
UTAH DEPARTMENT OF HEALTH,	:	
DIVISION OF HEALTH CARE	:	
FINANCING	:	
	:	
Defendants/Appellees.	:	

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

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 _____ day of _____, 1986.

JUDGE PRESIDING

SUBMITTED this _____ day of _____, 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:

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William Downes, Jr.
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on this the 18th day of August, 1986.

Janita Fhreatt, Sec'y

ADDENDUM B

RECEIVED

IN THE UTAH COURT OF APPEALS MAR 15 P4:58

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U.S. DISTRICT COURT
ATTORNEY GENERAL

Weber Memorial Care Center, Inc.,)
and Chartham Management, Inc.,)

Plaintiffs and Appellants,)

v.)

Utah Department of Health,)
Division of Health Care Financing,)

Defendant and Respondent.)

Before Judges Bench, Garff and Davidson.

OPINION
(For Publication)

Case No. 860342-CA

FILED

MAR 15 1988

Timothy A. Shea
Clerk of the Court
Utah Court of Appeals

BENCH, Judge:

Plaintiffs appeal from the final judgment of a trial court affirming the final determination of the executive director of the Utah Department of Health (Department). We affirm.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1983), commonly referred to as the Medicaid Act, establishes a cooperative relationship in which the federal and state governments share the costs of medical services to the needy. If a state elects to participate, it must establish a state plan which complies with statutory and regulatory requirements under the Medicaid Act. Prior to 1980, states participating in the Medicaid program were required to reimburse health care providers for their "reasonable costs." Typically, a provider would submit an accounting of its costs to the Department. The Department would then review these costs on a case by case, charge by charge basis and reimburse those costs deemed reasonable. In 1980, Congress amended the Medicaid Act to allow a flat rate system of reimbursement. Subsection 1396(a)(13)(A), commonly referred to as the Boren Amendment, now provides:

A State plan for medical assistance must provide for payment . . . 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 . . .) 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

Defendant Department is the state agency responsible for administering the Medicaid program in Utah. In 1981, in response to the Boren Amendment and the urging of the Utah Health Care Association, the state legislature directed the Department to organize a committee to develop and propose a flat rate plan for reimbursement under the Medicaid program. Under the plan proposed by the committee, patients who qualify for Medicaid assistance are classified according to the degree of care needed. The health care provider is then paid a statewide flat rate fee per patient per day according to the classification of such patient. The flat rate is modified by a "property differential," unique to each provider, to account for wide variations in property costs. The flat rate is also adjusted annually to account for inflation and other factors.

The proposed plan was submitted through the statutory rulemaking process. A public hearing was held, and no objection was voiced from the health care industry. The plan was then submitted to the United States Department of Health and Human Services which certified that the plan satisfied all requirements of the law and that all assurances submitted under the requirements of the Medicaid Act were acceptable. The modified flat rate plan became effective July 1, 1981.

Plaintiff Weber Memorial Care Center, Inc. (Weber Memorial) is a long-term health care provider. In September 1981, Weber Memorial acquired the subject facility from Weber County. Plaintiff Chartham Management, Inc. manages the facility pursuant to a contract with Weber Memorial. In 1983, Weber Memorial requested a hearing before the Department to challenge the application of the modified flat rate plan and the classification of patients. Prior to the hearing, the Department filed a motion asking the hearing officer to rule, as a matter of law, that the state plan did not violate federal law and that the plan did not require an examination of Weber Memorial's costs nor a determination whether this particular facility is efficiently and economically operated. The hearing officer granted the Department's motion. Consequently, at the administrative hearing which commenced August 3, 1984, Weber

Memorial was not permitted to introduce evidence of its costs nor attempt to prove it is efficiently and economically operated.

In his proposed findings, conclusions, and decision, the hearing officer concluded the modified flat rate plan complied with all provisions of federal and state law, and the Department did not act arbitrarily, capriciously, or contrary to law in the development, implementation, and operation of the plan. The executive director of the Department adopted the hearing officer's findings in her final determination dated June 4, 1985. Weber Memorial filed a petition for review in the Third District Court.¹ In a memorandum decision and final judgment, the trial court affirmed, finding "the Executive Director's final determination was supported by a residuum of legally admissible evidence in the record and was not arbitrary or capricious." Weber Memorial appeals from the trial court's final judgment.

When a trial court reviews an administrative decision and the court's judgment is challenged on appeal, this Court reviews the administrative decision as if the appeal had come directly from the agency. Technomedical Labs, Inc. v. Utah Securities Division, 744 P.2d 320 (Utah App. 1987). Therefore, it is not necessary to address Weber Memorial's contention that the trial court applied the wrong standard of review. When reviewing an administrative agency's interpretation of general questions of law, including acts of Congress, "this Court applies a correction-of-error standard, with no deference to the expertise of the [agency]." Utah Dep't of Admin. Servs. v. Public Serv. Comm'n, 658 P.2d 601, 608 (Utah 1983).

On appeal, Weber Memorial first argues that contrary to the executive director's final determination, the modified flat rate plan does not comply with federal law and regulations. Section 1396(a)(13)(A) requires the state to find that the rates, which are to be determined by methods and standards developed by the state, reasonably and adequately meet the

1. Under the new Administrative Procedures Act, Utah Code Ann. §§ 63-46b-1 through -21 (1987) (effective January 1, 1988), the district courts have jurisdiction to review by trial de novo all final agency action resulting from informal adjudicative proceedings, while the Supreme Court or Court of Appeals, as designated by statute, has jurisdiction to review all final agency action resulting from formal adjudicative proceedings.

costs of efficiently and economically operated facilities. The state must also make satisfactory assurances to the federal Department of Health and Human Services. Weber Memorial contends the Department failed to make the necessary findings and assurances that the rates satisfy the statutory requirements. See 42 C.F.R. § 447.253 (1985); Mary Washington Hospital, Inc. v. Fisher, 635 F.Supp. 891 (E.D. Va. 1985) (federal law does not require written findings).

The committee organized by the Department consisted of a representative from the legislature, a legislative analyst, the president and executive director of the Utah Health Care Association, and a nursing home operator. Prior to selecting the modified flat rate plan, the committee considered several alternative methods of reimbursement. The committee based its rate determinations on 1) 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"; 2) a comparison with the rates paid by other states in the region; 3) input from the Utah Health Care Association; 4) a trending factor on the historical costs as recommended by a consulting firm retained by the state; 5) a comparison with 1976 rates, as adjusted for inflation; 6) the legislative budget allocation;² and 7) discussions and interactions between committee members. Pursuant to statute, the Department submitted to the Secretary of the federal Department of Health and Human Services its assurances that the rate reasonably and adequately meets the costs of efficiently and economically operated facilities. The Secretary certified the assurances as satisfactory.

A reasonable basis existed for the Department to find the proposed rates were reasonable and adequate to meet the costs of an efficiently and economically operated facility. Ninety-three percent of all long-term health care facilities in Utah were shown to be meeting their costs under the modified flat rate plan, with a majority showing a profit. We conclude the Department developed reasonable methods and standards to determine the rates. The modified flat rate plan therefore complies with federal law.

2. Weber Memorial claims the rates were based to an impermissible extent on the budget factor. The budget allocation was clearly only one of several factors considered by the committee.

Weber Memorial next argues that, even if the modified flat rate plan is valid, the hearing officer erred in refusing to allow Weber Memorial to submit evidence of its costs and proof of its efficient and economic operation. Prior to the hearing, the Department filed a motion to exclude as irrelevant all evidence of Weber Memorial's costs and operation. The hearing officer granted the motion. Weber Memorial claims the hearing officer's ruling was contrary to law and a denial of its right to a fair hearing.

Utah Code Ann. § 26-23-2(1) (1987) states:

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.

Utah Admin. Code R455-14-1(A)(9)(i)(5) (1987) also provides:

The rules of evidence as applied in civil actions in the courts of this State shall be generally followed in the hearings. Any relevant evidence may be admitted if it is the type of evidence commonly relied upon by prudent men in the conduct of their affairs. . . . Irrelevant, immaterial and unduly repetitious evidence shall be excluded.

In his proposed findings, the hearing officer explained his ruling:

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.

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.

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.

Utah Code Ann. § 26-23-2(3) (1987) states, "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 executive director, in sustaining the hearing officer, found that since the modified flat rate implicitly defines an efficiently and economically operated facility, evidence of Weber Memorial's costs and operation was irrelevant and, therefore, inadmissible. We conclude the executive director's final determination on this issue was not capricious, but supported by the evidence.

Weber Memorial last argues the classification of patients under the modified flat rate plan is capricious. Under the plan, a health care provider routinely submits recommendations for patient classifications to the Department. Department officials consider these recommendations and other information supplied by the providers in making final classifications. Weber Memorial contends the Department arbitrarily classified thirty-eight of its patients as "intermediate" rather than "skilled care." Skilled care patients, by definition, require more specialized care and receive a higher rate of reimbursement.

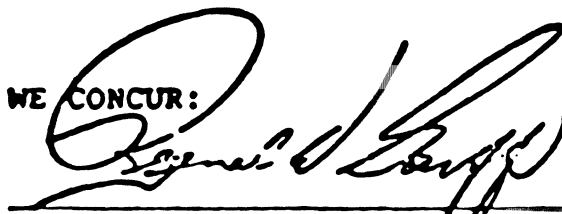
Requests for reconsideration of patient classifications are routinely granted by the Department, but Weber Memorial presented no evidence that such requests were made for the

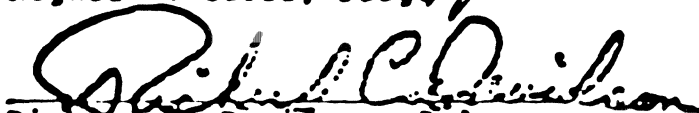
thirty-eight patients. Weber Memorial also failed to present any evidence that the thirty-eight patients qualified as skilled care patients. The only evidence Weber Memorial presented in support of its claim is that the national percentage of skilled care patients is higher than Utah's. Such evidence is insufficient to convince this Court that the state classification system is capricious. Section 26-23-2(3).

In conclusion, the modified flat rate plan for Medicaid reimbursement is in full compliance with federal and state law. The final determination of the executive director was not capricious, but amply supported by the evidence. The final judgment of the trial court is therefore affirmed. No costs awarded.


Russell W. Bench, Judge

WE CONCUR:


Regnal W. Garff, Judge


Richard C. Davidson, Judge

ADDENDUM C

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

§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—
(1) 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, 1395j-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;

ADDENDUM D

TITLE 42—THE PUBLIC HEALTH AND WELFARE

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396u. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) 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 1395f(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

ADDENDUM E

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 20), 1979—Ordered to be printed

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)(F) of the act (which was added by section 249(a) of the 1972 legislation) 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.

ADDENDUM F

BEFORE THE STATE DEPARTMENT OF HEALTH

In Re: WEBER MEMORIAL CARE)	
CENTER, INC., AND CHARTHAM)	
MANAGEMENT, INC.,)	
)	
Plaintiffs,)	
)	
v.)	PROPOSED DECISION,
)	FINDINGS OF FACT AND
)	CONCLUSIONS OF LAW
UTAH DEPARTMENT OF HEALTH)	
FINANCING,)	
)	
Respondent.)	

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

ADDENDUM G

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:

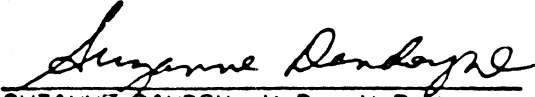
That the aforementioned recommended findings of fact and conclusions of law be, and hereby are, sustained, and that the Hearing Officer's recommended decision be, and hereby is, affirmed.

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

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