

1988

Weber Memorial Care Center Inc., and chartham Management, Inc. v. Utah Department of Health, Division of Health Care Financing : 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,

Defendant/Respondent.

Case No. _____

Case No. 860342 - CA

PETITION FOR WRIT OF
CERTIORARI FROM DECISION
OF COURT OF APPEALS

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FILED

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Clerk, Supreme Court, Utah

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QUESTIONS PRESENTED FOR REVIEW

- I. Whether the Utah State Medicaid Plan fails to comply with federal law and is therefore invalid.
- II. Even if the Utah State Plan is not invalid per se, whether the Hearing Officer's refusal to allow Weber Memorial the opportunity to submit evidence of its costs and to prove it is an efficiently and economically operated facility was contrary to the applicable federal statute and regulations and in violation of Appellant's right to a fair hearing.
- III. Whether the Court of Appeals recognized the appropriate scope of review for a District Court's judicial review of an administrative hearing officer's decision.

REFERENCE TO COURT OF APPEALS OPINION

The opinion of the Court of Appeals is reported at
78 Utah Adv. Rep. 24.

ARGUMENT PRIORITY CLASSIFICATION

The argument priority classification of this matter
is 13.

GROUNDS FOR JURISDICTION

- A. The entry of the decision of the Court of Appeals is March 15, 1988.
- B. There was no petition for rehearing.
- C. The jurisdiction of the Court is conferred by 78-2-2(3)(a) Utah Code Annotated (1953 as amended).

CONTROLLING PROVISIONS OF STATUTES

The citations are lengthy, and are set out in full, infra. They are:

42 C.F.R. § 447.250(a)

42 C.F.R. § 447.252

42 C.F.R. § 447.253(b)(1)

42 U.S.C. § 1396a(a)(13)(A)

STATEMENT OF THE CASE

The Petitioner, Weber Memorial Care Center, Inc., (hereinafter "Weber Memorial"), was a provider of long-term health care in Ogden, Utah. Chartham Management, Inc. was the management corporation which operates the Weber Memorial Care Center. A number of the patients of Weber Memorial qualified for Medicaid assistance, and under the state-administered Medicaid system, Weber Memorial was reimbursed by the State Department of Health, Division of Health Care Financing, which was the Defendant Appellee herein. After some four years of litigation the Petitioner still has not had its opportunity to put on evidence which would tend to show the Utah Medicaid Plan is not in compliance with federal law.

In 1981 the State of Utah adopted a "flat-rate" system for reimbursing providers. Under this system, all long-term health care providers are paid a single rate per patient, per day for "intermediate" and "skilled" patients. Regardless of costs, the provider is reimbursed according to the flat rate set by the Department. If costs, no matter how unavoidable, exceed the flat rate, the provider must operate at a deficit.

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

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

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

At all times, Weber Memorial contended, as it still

does, that it was and is an efficiently and economically operated facility. Therefore, Weber Memorial requested a hearing under the rule promulgated by the Department, in order to contest the operation of the Utah Medicaid System.

Weber Memorial made its request for hearing on July 28, 1983. The administrative hearing finally commenced on August 3, 1984, over a year after it was originally requested. Pursuant to a hearing officer's ruling, Weber Memorial was never permitted to introduce evidence of its costs or to prove, as it was prepared to, that it is an efficiently and economically operated facility within the meaning of the federal statute.

On May 20, 1985, nearly two years after the request for hearing was submitted, the hearing officer issued his Proposed Decision, Findings of Fact and Conclusion of Law. The Executive Director adopted the findings on June 4, 1985. Weber Memorial appealed the decision to the District Court, which issued its opinion affirming the hearing officer on June 3, 1986 (Memorandum Opinion, J. Fishler), followed by a Final Judgment entered August 4, 1986 by Judge Daniels. Thereafter, an appeal was filed. This Petition is brought following the decision of the Court of Appeals which erroneously upheld the decision of the District Court. This petition raises important federal/state issues never before answered by this Court.

ARGUMENT

I

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

The Appellant, Weber Memorial Care Center, was a provider of Medicaid services within the State of Utah and, as such, is subject to both state and federal regulations due to its participation in the Medicaid program, and has done its best to comply with all relevant rules and regulations at both the state and federal levels since the commencement of its operation. During this appellate process the facility has been sold but the property right remains.

Weber Memorial accepted patients who qualify for medical assistance under the Utah State Plan which was filed pursuant to Title XIX of the Social Security Act with the Secretary of Health and Human Services. The Department of Health of the State of Utah refused to pay a fair and legally required rate of reimbursement to Weber Memorial for care rendered to the said patients. As already pointed out, the federal statute underlying the federal Medicaid regulations is found at 42 U.S.C. § 1396a(a)(13)(A). The statute, as well as the federal regulations, are set forth in the

Appendix in full (Appendix-1). The regulations, of course, reiterate the requirement set forth in the statute that rates must be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards." (Emphasis added.) 42 C.F.R. § 447.253(b)(1). The State is required to make "findings" that "the rates used to reimburse providers satisfy the requirements of the regulations." Id. at 447.253(b). After these "findings" are completed, the State must then make and submit "assurances" to the federal government that the requirements of the statute, as well as "all other parts of [the regulations]" are being met. Id. at 447.253(a). The State's Plan, which must be formulated pursuant to the statute and regulations mentioned above, must incorporate the affirmative requirements of the statute and regulations. 42 C.F.R. § 447.252.

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

The regulations implementing the federal Medicaid statutes require that the state medicaid agency must find that the rates to reimburse providers satisfy the requirements of law, i.e., that the rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." 42 C.F.R. § 447.250(a). As the record in this matter is reviewed, it becomes clear that the Department of Health of the State of Utah has not made findings sufficient to provide assurances to the Department of Health and Human Services, (hereinafter "HHS"), of compliance with federal law. In fact, no findings at all have been made by the Secretary or the State of Utah relative to what methodology will meet the federal requirements. As the deposition of Vaughn Emmett, Director of the Bureau of Program Review, Department of Health, State of Utah, indicates, there have been no studies conducted by the Department of Health that have examined any provider in the state to determine whether such providers are efficiently and economically operated. All of this was neatly ignored by the hearing officer and lower courts.

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

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

(Emphasis added). Id. at 906. Similarly, the Court found that the rate-setters failed to "ascertain whether facilities within the same level of care indeed had a similar "mix" of residents before choosing to rely upon the Department of Health's certification as its primary basis for determining adequacy of reimbursement rates." Id. In the context of this case, the records will likewise reflect the Department's failure to conduct any "independent study of any facility's provision of services, or its economy and efficiency", nor did it examine the "costs" of any services at Weber Memorial or any other particular facility. Additionally, as discussed in Section III below, the special "mix" of residents at Weber Memorial, or other facilities for that matter, was in no way considered in the rate-setting process. As the Court in Thomas v. Johnston found, such a "manner" of adopting the "reimbursement rate structure was arbitrary, capricious, and in violation of federal law." Id. at 904.

Other cases are similar: e.g. In Nebraska Health Care Association v. Dunning, 778 F.2d 1291 (8th Cir. 1985) cert.

denied, ____ U.S. ____, 107 S.Ct. 947 (1987); Hillhaven Corp. v. Wisconsin Dept. of Health, 634 F.Supp. 1313, 1319 (E.D. Wis. 1986).

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

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

The statute clearly and expressly leaves room for states to cut unnecessary costs in a wide variety of ways. On the other hand, however, it manifestly imposes a substantive limitation on state governmental action -- that rates determined by Medicaid agencies must be high enough to compensate efficiently and economically operated providers for costs necessarily incurred in providing the type of care for their residents that conforms to all applicable state and federal laws and requirements As stated above, under this standard, state Medicaid agencies are free to deny providers compensation for provisions of unnecessary services. Likewise, the states are not required to pay all costs incurred by providers that are not operating efficiently

and economically. Thus, states not only have a great deal of flexibility in selecting the methods by which rates will be determined, but are also accorded freedom to decide what costs are necessary or unnecessary, and to determine whether and which providers are operating efficiently and economically. In addition the development of the Medicaid Act and the evolution of the reimbursement system away from Medicare principles or reimbursement make it clear that states are not required to make their decisions concerning 'efficiency and economy' and 'adequacy' with the greatest degree of precision. Nevertheless, the bottom line of the federal statutory standard, the substantive limit placed by Congress upon the state, is that rates must be sufficient to compensate efficiently and economically operated providers for the necessary costs they incur in providing required care to their residents.

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

The hearing officer steadfastly refused to consider the very indicia of the State's compliance with the "substantive limitations" already pointed out, i.e., the costs, the "efficiencies" and "economies" of Weber Memorial Care Center.

In order for the state agency to have made proper "assurances" to the federal government, it is apparent that examination of actual providers and actual facilities was required. As already mentioned, that did not occur. It is clear that the assurances made were but bald assertions based on the language of the regulations, but without substance in fact.

Therefore, until the state plan meets those requirements, it is defective and should be declared invalid. See, e.g., Nebraska Health Care Association v. Dunning, supra; Hillhaven Corp. v. Wisconsin Dept. of Health, supra. This Court should recognize the refusal of the judicial system of the this state to date, to bring these facts to light and to recognize them as such.

As the Ninth Circuit Court of Appeals recently found, a provider plaintiff does have a right to have its claim heard on the merits, and to receive a judicial determination as to whether "the actions and non-action of the State . . . violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A)." Coos Bay Care Center v. State of Oregon, Department of Human Resources, 803 F.2d 1060, 1063, (9th Cir. 1986). That is all that is sought here.

II

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

Keeping in mind the thrust of the Boren Amendment, that efficiently and economically operated facilities are to have their costs met, Weber Memorial, feeling that it qualified under that standard and yet was not having its costs met, sought a hearing before a hearing officer appointed by the Utah State Department of

Health. As already described earlier, when Weber Memorial was finally able to receive its hearing, it was totally precluded from producing evidence which would have demonstrated that it met the very objective of the statute.

As one court recently explained:

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

(Emphasis added). Geriatrics, Inc. v. Colorado Department of Social Services, 712 P.2d 1035, 1039, (Colo. App. 1985). Thus, the Court recognized that the intent of the law is to reimburse facilities for "actual expenditures incurred" as long as those expenditures are made in order to conform to applicable law, and assuming the facility is efficiently and economically operated. Indeed, the law requires that "the rate in fact must be reasonable and adequate within the meaning of the statute." Hillcrest Corp. v. Wisconsin Dept. of Health, supra. 634 F.Supp. at 1318, citing 42 C.F.R. § 447.252(a) (1982). In this case, the preliminary ruling of the hearing officer referred to earlier speaks for itself. Several months prior to the hearing, he effectively

closed the door to the evidence most crucial to Weber Memorial's case. Indeed, the transcript of the hearing is replete with examples of how the hearing officer's ruling effectively denied Weber Memorial an opportunity for a fair hearing. See, Excerpts from Transcript of Formal Hearing, Hearing held August 3, 1984, before Brian L. Farr, Administrative Law Judge, Addendum. Plaintiff was effectively denied an opportunity to prove that the rate "in fact" was not "reasonable and adequate" to meet its costs "within the meaning of the statute."

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

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

A participant provider in the Medicaid system no doubt has a property interest in achieving or enforcing its rights under

that system. See, e.g., Bowens v. North Carolina Department of Human Resources, 710 F.2d 1015 (4th Cir. 1983). The question in this case, insofar as the Constitution is concerned, is what type of hearing is required. The particular type of hearing "must be tailored to the capacities and circumstances of those who are to be heard." Goldberg v. Kelly, 397 U.S. 254, 268-69 (1970).

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

Petitioners seek a remand to the hearing officer for a true evidentiary hearing in which the Petitioners, given the guidelines which the Court will hopefully provide concerning the requirements of federal law, will receive the opportunity to prove that Weber Memorial is an efficiently and economically operated facility and yet is not having its costs met under the Utah State Medicaid Plan.

III

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

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

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

As stated in Salt Lake City Corporation v. Department of Employment, 657 P.2d 1312, 1316 (Utah, 1982):

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

(Emphasis added). See, also, Madison v. Alaska Department of Fish and Game, 696 P.1d 168 (Alaska 1985) (issues of statutory interpretation and whether administrative board acted within its statutory authority "fall into the realm of special competency of the courts;" statutory interpretation of the words "customary and traditional" at issue); Gardiner v. Arizona Department of Economic Security, 623 P.2d 33, 36 (Ariz. App. 1980) ("court may substitute its judgment for the agency's conclusions regarding the legal effect of [the] facts"); International Brotherhood of Electrical Workers, Local 1357 v. Hawaiian Telephone Co., 713 P.2d 943 (Hawaii 1986) (agency's legal conclusions are freely reviewable by the courts); Dangerfield v. Montgomery Ward Co., Inc., 694 P.2d

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

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

CONCLUSION

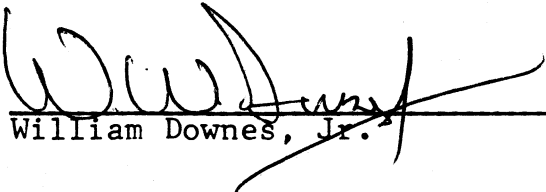
Based upon the foregoing, Weber Memorial respectfully requests that the Court declare the State of Utah Medicaid Plan,

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

The decision of the Court of Appeals was really not responsive to the points raised here and, with all due respect, seemed to ignore the principal issues. The Court of Appeals took a benign view of the system, stating, in effect, that if the Utah plan met most of the providers' needs, then Weber Memorial, not the State, must be out of line. That facile conclusion is exactly what the Petitioners wish to refute by the production of evidence. Common sense would indicate that the earth is flat; evidence would allow that notion to be dispelled. Please let this provider have its day in court.


DATED this 13th day of April, 1988.

WINDER & HASLAM



William Downes, Jr.

LOJEK & HALL, CTD.



Donald W. Lojek

CERTIFICATE OF MAILING

I HEREB CERTIFY that four true and correct copies of the foregoing Petition were mailed, postage prepaid, on the 13~~th~~ day of April, 1988, to:

David L. Wilkinson
Attorney General
Stuart W. Hinckley
Division Chief
Ruth Lybbert Renlund
Assistant Attorney General
236 State Capitol
Salt Lake City, UT 84114



Donald W. Lojek

IN THE UTAH COURT OF APPEALS

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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 1989

Timothy M. 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.

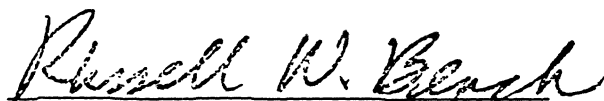
Utah Code Ann. § 26-23-2(3) (1987) states, "If the final determination of the executive director is consistent with the findings of fact and conclusions of law recommended by the hearing officer, the court shall review the record and may alter the final determination only upon a finding that the final 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.

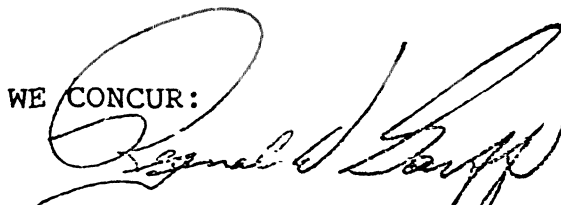
Requests for reconsideration of patient classifications are routinely granted by the Department, but Weber Memorial presented no evidence that such requests were made for the

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

§ 1396a. State plans for medical assistance.

(a) Contents

A State plan for medical assistance must—

42 § 1396a

PUBLIC HEALTH AND WELFARE

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

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

(13) provide—

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

(13) provide—

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

1984 AMENDMENT

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

[46 FR 58880, Dec. 3, 1981; 47 FR 8567, Mar. 1, 1982, as amended at 48 FR 56057, Dec. 19, 1983]

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

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

§ 447.250 Basis and purpose.

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

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

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

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

[48 FR 56057, Dec. 19, 1983]

§ 447.252 State plan requirements.

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

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

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

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

[48 FR 56058, Dec. 19, 1983]

§ 447.253 Other requirements.

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

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

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services—

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

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

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

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

[46 FR 47971, Sept. 30, 1981; 46 FR 54143, Nov. 4, 1981]

§ 447.252 State plan requirements.

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

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

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

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

[46 FR 56058, Dec. 19, 1981]

THIRD JUDICIAL DISTRICT
County of Salt Lake - State of Utah

FILE NO. C-85-4268

TITLE: (✓ PARTIES PRESENT) COUNSEL: (✓ COUNSEL PRESENT)
In re: WEBER MEMORIAL CARE CENTER, INC.; William Downes, Jr.
and CHARTHAM MANAGEMENT, INC., Donald W. Lojek
Plaintiffs/Appellants. : Attorneys for Plaintiffs
vs.
UTAH DEPARTMENT OF HEALTH, DIVISION OF : Clark C. Graves
HEALTH CARE FINANCING, Attorney for Defendants
Defendants/Appellees. :

CLERK

HON. PHILIP R. FISHLER

JUDGE

REPORTER

DATE: 6/2/86

BAILIFF

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.

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

151 Philip Fishler
PHILIP R. FISHLER
DISTRICT COURT JUDGE

opies mailed to:
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CLERK OF DISTRICT COURT
SALT LAKE COUNTY, UTAH

AUG 4 1986

In Department of Civil District Court
by James R. [Signature]
Clerk

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

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

Plaintiffs/Appellants :

vs. :

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING

Defendants/Appellees. :

FINAL JUDGMENT

Civil No. C-85-4268

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

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

DATED this 4 day of August, 1986.

ATTEST

... JIMON ...

[Signature]
Clerk, Court

[Signature]
JUDGE PRESIDING

SUBMITTED this 28th day of July, 1986.

CERTIFICATE OF MAILING

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

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

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

on this the 28th day of July, 1986.

[Signature]