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MEDICARE/MEDICAID REIMBURSEMENT ISSUES
A PROVIDER'S PERSPECTIVE

Deborah M. Naglak*

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I. BACKGROUND

A. *An Overview of the Acts*

In 1965, Congress took its first historical step towards the ideal of universally accessible health care services with the enactment of the Medicare¹ and Medicaid² programs. These programs are federally subsidized health insurance programs administered by the Health Care Financing Administration within the Department of Health and Human Services.

* This article was written as part of a directed research project at the George Washington University National Law Center, where the author is a candidate for the *Juris Doctor* degree. Mr. Eugene Tillman, Esq. and Mr. Joel Hamme, Esq. of Reed, Smith, Shaw & McClay, Washington, D.C., supervised this research and provided invaluable assistance in the preparation of this article.

¹ The Medicare Act is embodied in Title XVIII of the Social Security Amendments of 1965, Pub. L. No. 98-97, 79 Stat. 291 (codified as amended at 42 U.S.C. §§ 1395-1395tt (1976 & Supp. V 1981)).

² *Id.* 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396-1396m (1982)).

Under the Medicare statute, the federal government reimburses providers of medical services for care rendered to elderly or disabled patients, subject to guidelines and limitations. The Medicare Act establishes the costs allowed for reimbursement for services and authorizes the Secretary of the Department of Health and Human Services (HHS) to promulgate regulations that further interpret the costs.³

Medicaid, on the other hand, provides health care for the indigent⁴ and is funded by both federal and state governments.⁵ States which elect to participate in the Medicaid program use federal funds in combination with state funds to reimburse providers for their medical services. The programs may vary from state to state. While each program is designed to meet the needs of the state,⁶ it must comply with federal guidelines. Low income Medicare recipients may also qualify for Medicaid, in which case Medicaid will pay the Medicare premium, copayment and deductible.

The Secretary of HHS contracts with fiscal intermediaries as agents to assist in the administration of the programs.⁷ The intermediaries assist providers in recording and reporting program costs and determining allowable costs, and then distribute funds to the provider to cover the costs. The intermediary is the first line of administrative authority for the resolution of any type of Medicare dispute.⁸

B. The Medicare Prospective Payment System

In 1983, Congress enacted legislation establishing the Medicare Prospective Payment System.⁹ This statute altered the conventional practice of retroactive cost-based reimbursement of hospital costs by replacing it

³ 42 U.S.C. § 1395hh (1982).

⁴ The Medicaid asset limit is \$2600 for individuals, \$3,000 for two or more people.

⁵ The Medicaid program is a joint venture between the federal government and participating states. When a state decides to participate, it must submit to DHHS a satisfactory plan that meets the payment standards of the Boren Amendments. 42 U.S.C. § 1396a(a)(13)(A)(Supp. 1985).

⁶ For example, the District of Columbia provides Medicaid benefits to an optional classification of people known as the "medically needy." The medically needy are people who would qualify for AFDC (AID to Families With Dependent Children) or SSI (Supplemental Security Income) but for their excess income or assets. Through an income adjustment process called "spend down," the medically needy often qualify for Medicaid.

⁷ An intermediary may be a "national, state . . . public or private agency or organization." 42 U.S.C. § 1395(a)(1982).

⁸ 42 U.S.C. §§ 405.1803(a), 405.1809(1986).

⁹ Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983).

with a reformed payment system.¹⁰ Reimbursement alternatives were initiated out of concern for the need to increase efficiency within the health care delivery system.¹¹ The new system provides for payment of a predetermined amount for each discharged patient according to a classification system based on diagnostic related groups (DRGs).¹² A hospital receives a flat fee for treatment of a Medicare patient within a specific diagnostic category regardless of the cost actually incurred or services actually provided by the hospital.¹³ Under this system a hospital that incurs costs above the DRG payment rate will lose money.¹⁴ Conversely, an efficiently run hospital capable of keeping costs below the DRG rate will profit from the patient's treatment as it is permissible for the hospital to pocket the reimbursement payment in excess of the cost of care.¹⁵ Consequently, this reimbursement system gives hospitals an incentive to adhere to cost containment.

Medicare providers file an annual cost report with their assigned intermediary within three months of the end of the fiscal year.¹⁶ The in-

¹⁰ Congress initially gave hospitals and physicians almost complete autonomy to structure both their payment methodology and payment levels. The only constraint imposed on the Social Security Act of 1965 was that the payment level be "reasonable" and the services provided be "necessary" for the treatment of illness or injury. See Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L. J. 1-15 (citing Social Security Act § 1815, 42 U.S.C. § 1395 (Supp. III 1985)).

With the new system, reimbursement for inpatient services is no longer based on the costs incurred by the hospital. However, reimbursement for psychiatric hospitals, nursing homes, outpatient services, capital expenses, bad debt and medical education is still based on the cost reporting system. 42 U.S.C. §§ 1395ww(a)(4), (d)(1)(B)(Supp. III 1985).

Medicare reimbursement to nursing homes is still based on reasonable costs and is retroactive. 42 U.S.C. §§ 1395f(b)(1), (v)(11)(A)(1988); 42 C.F.R. § 413.9 (1990). Providers are reimbursed by using the interim rates of the last year. Reimbursement rules and the facilities Medicare utilization rate are used by the intermediaries to establish the total amount of reimbursement owed the nursing home. The interim rates are then adjusted either upward or downward to reflect the final reimbursement due. 42 U.S.C. § 1395g(1988).

¹¹ See Sharkey & Buckle, *The Medicare Prospective Payment System: Impact on the Frail Elderly and an Alternative Reimbursement Formula*, 3 NOTRE DAME J.L. ETHICS & PUB. POLY 227 (1988).

¹² The DRG classification scheme has twenty-three major diagnostic categories (MDCs), each of which corresponds to a major body system. The MDCs, in turn, are subdivided into 467 DRGs. Three additional DRGs were established for cases which require clarification or correction of hospital records. See Preamble to Interim Final Rule, 48 Fed. Reg. 39,752,760 (1983).

¹³ A "DRG weight" is assigned to each DRG category and multiplied by a "standardized amount," based on the average allowable cost in treating all DRGs to determine the reimbursement to the hospital. Thallner, *Prospective Payment System: Preclusion of Review of Hospital Base Year Cost Calculations*, 6 J. LEGAL MED. 509, 516 (1985).

¹⁴ Vladeck, *Medical Hospital Payments by DRGs*, 100 ANNALS INTERNAL MED. 576 (1984).

¹⁵ *Id.*

¹⁶ See 42 U.S.C. § 1395oo(a)(1)(1988).

termediary will audit the report and issue a Notice of Program Reimbursement (NPR).¹⁷ A provider who is dissatisfied with the reimbursement may request administrative review of the claim or later bring suit in federal court.

The Provider Reimbursement Review Board (Board)¹⁸ is a forum for the review of intermediary reimbursement decisions and adjudication of disputes between providers, who are dissatisfied with the amount of reimbursement or its timeliness, and their intermediaries.¹⁹ There is an appeal mechanism for the disputes and judicial review is available once the Board has exercised its jurisdiction over the appeal.²⁰ Because the inability to gain administrative review precludes later judicial review of a provider's claim, denial of jurisdiction at this level often becomes a critical issue.²¹

C. The Boren Amendment to the Medicaid Act

Prior to October 1, 1981, hospital Medicaid reimbursement was based on a "reasonable cost" standard.²² In 1980, Congress enacted the Boren Amendment²³ which changed the federal standard for reimbursement rates for nursing and intermediate care facilities and provided for both more stringent cost containment and less federal oversight of state reimbursement methodologies. In 1981, Congress expanded the new standard to include hospital reimbursement rates when it enacted the Omnibus

¹⁷ *Id.*

¹⁸ See S. REP. NO. 1230, 92d Cong., 2d Sess. 249 (1972). The Board was created by Congress in 1972 and is composed of five members appointed by the Secretary. Each member has knowledge of the field of reimbursement. Two of the members represent the provider. *Id.* See 42 U.S.C. § 1395oo(h) (1988).

¹⁹ See 42 U.S.C. § 1395oo(a)(1), (d) (1988). Intermediaries are required to send providers a final determination within a reasonable time (12 months) after filing a cost report. *Id.*; a provider who wishes to challenge the intermediary with respect to the NPR may appeal to the board. If the amount in controversy is more than \$1,000 but no greater than \$10,000, the provider may request a hearing before an intermediary hearing officer within 180 days of receipt of the NPR. 42 C.F.R. §§ 405.1811(a), 405.1809(b)(2)(1989).

²⁰ See 42 U.S.C. § 1395oo (1988); 42 C.F.R. §§ 405.1809, § 405.1835 (1989) (provides for Providers Reimbursement Review Board hearings, Medicare Part A disputes, and judicial review for cases involving \$10,000 or more, or for group appeals amounting to at least \$50,000); see 42 U.S.C. § 1395ff; see 42 C.F.R. § 405.801 (1989) (provides the appeal mechanism and judicial review for Medicare Part B disputes).

²¹ The jurisdiction and authority of the Board become a major issue if a provider has not initially presented a claim for reimbursement of particular costs to the fiscal intermediary. The Board may then lack statutory power to exercise jurisdiction over the appeal.

²² Pub. L. No. 90-248, § 237 (1968) (payment should not exceed reasonable costs consistent with efficiency, economy and quality of care); Pub. L. No. 92-603, Title II (1972) (payment for long term care services paid by states under Medicaid on a "reasonable cost-related basis"); 42 U.S.C. § 1396a(a)(13)(E)(1976) (standard from 1972-1980 required reimbursement on a "reasonable cost related basis").

²³ Pub. L. No. 96-499, § 962(d) (1980).

Budget Reconciliation Act (OBRA).²⁴ Currently, a state plan for Medicaid reimbursement must provide:

for payment . . . 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. . . .²⁵

The shift from reimbursement of all "reasonable costs" to reimbursement of those "reasonable and adequate costs" permitted states to alter their plans to encourage cost containment and cope with reductions in funds available to the states from the federal government under the Medicaid program.²⁶ Congressional intent was to grant greater flexibility to develop state Medicaid methods of payment for services.²⁷

This paper reviews various challenges to state Medicaid reimbursement plans brought by providers of Medicaid services. It is not intended to be a comprehensive summary of the issues.

II. A PROVIDER'S CONSTITUTIONAL CHALLENGES TO REIMBURSEMENT PLANS

A. *The Supremacy Clause*

A provider's challenge to a state reimbursement plan based on the supremacy clause²⁸ derives from the requirement that once a state elects to participate in the voluntary Medicaid program, it must comply with federal statutory requirements.²⁹ The Boren Amendment regulations establish the controlling guideline for Health Care Financing Administration (HCFA) review of state reimbursement plans.³⁰ The success of this argument is contingent upon a showing that the state statute fails to comply with the standards set forth in the Boren Amendment. The statute would then be void as a result of the supremacy clause.

In *Wisconsin Hospital Association v. Reivitz*,³¹ the plaintiff, a Wisconsin

²⁴ Pub. L. No. 97-35 (1981).

²⁵ 42 U.S.C. §§ 1396a(a)(13)(A) (Supp. V 1981).

²⁶ 42 U.S.C. §§ 1396b(s)(1)(A), (t) (Supp. V. 1981).

²⁷ J.L. HAMME & S.R. KANNER, LONG TERM CARE REIMBURSEMENT ISSUES: PRO AND CONTRA AIDS FOR LITIGANTS, in 1989 HEALTH LAW HANDBOOK 87, 89 (1989) (relying on STAFF OF SENATE COMMITTEE ON FINANCE, 96th Cong., 2d Sess., SPENDING REDUCTIONS: RECOMMENDATIONS OF THE COMMITTEE ON FINANCE 44-45 (Comm. Print 1980)); S. REP. NO. 471, 96th Cong., 1st Sess. 28, 29 (1979).

²⁸ U.S. CONST. art. VI.

²⁹ *Harris v. McRae*, 448 U.S. 297, 301 (1980).

³⁰ See 42 C.F.R. §§ 447.200-447.280; 52 Fed. Reg. 28,141-48 (July 28, 1987). (Final Regulatory Amendments).

³¹ No. 82-C-1055, slip op. (E.D. Wis. Jan. 11, 1983), reported in [1983-1 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) para. 32,380 (E.D. Wis. 1983), *rev'd & remanded*, 733 F.2d 1226 (7th Cir. 1984), *opinion on remand*, 630 F. Supp. 1015 (E.D. Wis. 1986), *aff'd in part, vacated in part & remanded*, 820 F.2d 863 (7th Cir. 1987).

not-for-profit corporation and three individual general care hospitals in Wisconsin, alleged that a Wisconsin rate freeze under a reasonable reimbursement plan denied them an inflationary rate increase in conflict with federal regulations, and thus was void as a result of the supremacy clause. The district court held that the Wisconsin provision freezing Medicaid rates for three months was a violation of the "reasonable and adequate" standard and, therefore, unconstitutional. The state had made assurances to the Secretary of Health and Human Services (HHS) that its reimbursement rates granted an inflationary rate increase to providers based on an increase for a federally defined hospital "market basket." The rationale behind the court's decision was that the state could not simultaneously assure HHS that its plan comports with federal "reasonable and adequate standards" while supporting the position that a freeze which ignores inflation continues to be "reasonable and adequate."

On appeal, the seventh circuit criticized the lower court's holding that a rate freeze is inherently unreasonable because of its arbitrariness in ignoring inflationary increases.³² The case the district court had relied on in making its determination, *Wisconsin Hospital Association v. Schmidt*,³³ involved a rate freeze of an indeterminate length of time, unlike the freeze at issue which was to last only three months. In addition, the district court failed to take into account the new standard instituted under the Boren Amendment. The Boren Amendment illustrates a congressional concern for cost containment which would not be furthered by a simple cost-plus adjustment. Because the record lacked the technical data required to evaluate the individual effects of this rate freeze in order to determine whether the reasonable and adequate standard was met, the seventh circuit remanded the case for further consideration.³⁴

On remand,³⁵ the court relied on testimony and evidence concerning the freeze's impact on the provider hospital to determine whether the freeze constituted a "material or significant change" requiring adherence to federal regulatory procedure.³⁶ Data provided at trial included a study comparing the interim rates for the year preceding the freeze with the interim rates for the year of the freeze. The study found that the freeze would decrease Medicaid interim rates for inpatient service by 2.136 million or 1.773 percent. Additional testimony established that the reimbursement rate for the three month period was actually 2.6 percent less than the actual rate of inflation and intensity for hospitals during that

³² *Wis. Hosp. Ass'n v. Reivitz*, 733 F.2d 1226 (7th Cir. 1984)

³³ Case No. 75-C-382, slip op. (E.D. Wis. Apr. 28, 1976).

³⁴ *Wis. Hosp. Ass'n*, 733 F.2d at 1234.

³⁵ *Wis. Hosp. Ass'n*, 630 F. Supp. at 1015.

³⁶ *Id.* at 1021. Under 45 C.F.R. § 205.5(a) (1989) "[i]f a state makes a 'material change in any phase of State law,' it must amend the State Plan." The Secretary must approve a state plan amendment for it to be effective. 45 C.F.R. § 201.3 (1989). Under 42 C.F.R. § 447.256(b)(2) (1987) the state must submit assurances to the Secretary for a "significant change" in the methods and standards for determining the rate for Medicaid reimbursement.

period.³⁷ The court found that the failure of the state to account for the actual increase in the inflation rate when coupled with the decrease in reimbursement for inpatient and outpatient services due to the freeze, rendered a "material change" in state law and a "significant change" in state methods for determining Medicaid reimbursement rates.³⁸ Because the states failed to submit assurances as required under the regulations, the freeze legislation was held void.³⁹

Similarly, in *Hillhaven Corporation v. Wisconsin Department of Health and Social Services*,⁴⁰ the district court determined that a three month rate freeze produced a significant change in state reimbursement methodology for nursing homes. The freeze decreased the reimbursement rates more than one percent and provided that the 1982 rates would be effective for fifteen months where federal law required redetermination of rates annually. Again, the state failed to provide the requisite assurances with respect to the modification of the rates thus rendering invalid the modified rates and the state statute which established them.⁴¹

1. Prior Review of State Plan Modifications by HHS

One element in determining whether an amended state plan complies with federal criteria, and thus would not violate the supremacy clause, is its prior review by the Secretary of HHS. Scrutiny by the Secretary informs the court of the reasonableness and adequacy of the amended state plan under the federal criteria. The Secretary's determination is not necessarily final as it is subject to judicial review. But the court in the *Reivitz* case, noted that a prior determination would be particularly appropriate where the issue involves application of the reasonableness standard to a highly technical subject outside the conventional competence of the courts.⁴²

³⁷ See J.L. HAMME & S.R. KANNER, *supra* note 27, at 101 ("Some states have attempted to curtail rates by reducing or limiting inflation factors in their rate methodologies. Instances when accepted inflationary indices do not support such limitations, they have generally been invalidated.")

³⁸ *Wis. Hosp. Ass'n v. Reivitz*, 630 F. Supp. 1015, 1023 (E.D. Wis. 1986), *aff'd in part, vacated in part & remanded*, 820 F.2d 863 (7th Cir. 1987).

³⁹ *Id.*

⁴⁰ Case No. 83-C-0016, slip op. (E.D. Wis. May 7, 1986) *reported in* MEDICARE & MEDICAID GUIDE (CCH) para. 35,498 (1986).

⁴¹ *Id.* at para. 11,617.

⁴² See *Wis. Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1235 (7th Cir. 1984), *opinion on remand*, 630 F. Supp. 1015 (E.D. Wis. 1986), *aff'd in part, vacated in part & remanded*, 820 F.2d 863 (7th Cir. 1987). In contrast, the Secretary's role of review of reimbursement plans was described as one of "oversight only" in *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419 (N.D. Ill. 1989) (holding that no private right of action exists against the Secretary of HHS under the Medicaid Act).

In *Reivitz*, the state did not submit assurances to HHS reflecting a three month freeze because it contended that the change was not a "significant change." Under prior regulations, any change expected to increase or decrease Medicaid payment by one percent or more during a twelve month period following the effective date of the change was considered "significant" enough to trigger the public notice requirements.⁴³ The court in *Reivitz* found the 1.8 percent change "significant" but did not establish a threshold percent change at which submission of assurance and public notice would be required.⁴⁴ The state of Michigan, in *Coalition of Michigan Nursing Homes, Inc. v. Dempsey*,⁴⁵ submitted assurances and followed public notice requirements when a change in the state plan resulted in less than a one percent decrease in the average daily reimbursement rate. Michigan, however, maintained that it was not required by law to do so. Federal regulations do not define the terms "material" or "significant" and few decisions involving the 1981 amendments have litigated the issue of what constitutes a "significant change."

B. Challenges Under the Equal Protection, Due Process and Contract Clauses

The Fourteenth Amendment to the United States Constitution provides that "no state shall . . . deny to any person within its jurisdiction the equal protection of the laws."⁴⁶ Falling within the constitutional definition of "persons" are corporations, such as nursing homes and hospitals. Consequently, such corporations frequently challenge state reimbursement plans as resulting in unequal treatment under the law.

In the *Hillhaven* case,⁴⁷ Wisconsin's three month freeze of nursing home reimbursement rates violated federal Medicaid provisions. These provisions prohibited significant changes in payment policies without assurances that resulting rates would be reasonable and adequate and prohibited less than reasonable and adequate rates in response to budgetary limits. Plaintiffs also successfully pursued a direct equal protection challenge of a recoupment provision within the state plan that denied capital-cost adjustments for Hillhaven Corporation while adjustments were granted to other nursing homes similarly situated.⁴⁸ Plaintiffs argued

⁴³ 42 C.F.R. § 447.252(a) (1987) (assurances as to reasonableness and adequacy must be provided when the state makes "significant changes in its methods and standards for determining payment rates"); 42 C.F.R. § 447.252(b) (1987) (requires that the agency must submit "detailed information concerning the impact of changes on different types of services," but the criterion with respect to "significant" change does not apply to this section); 42 C.F.R. § 447.205(a) (1987) (public notice requirement triggered by a significant change which "is expected to increase or decrease Medicaid payments for service by one percent or more").

⁴⁴ 820 F.2d 863 (7th Cir. 1987).

⁴⁵ 537 F. Supp. 451, 459-60, 463-64 (E.D. Mich. 1982). *But see* *Coalition of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 463 (1982) (reduction resulting in less than a one percent decrease in the average daily reimbursement rate is not a "significant" change under the flexible standards of the Boren Amendments).

⁴⁶ U.S. CONST. amend. XIV.

⁴⁷ MEDICARE & MEDICAID GUIDE (CCH) para. 35,498 (1986).

⁴⁸ *Id.* at para. 11,618-19.

that all other providers which had acquired existing nursing homes, at or about the same time as plaintiffs completed their acquisition, received a capital allowance adjustment in accordance with a 1981-82 Method of Implementation Plan.⁴⁹ Plaintiffs never received such an adjustment. Because the Method of Implementation from 1983 based a facility's capital cost reimbursement on its capital allowances as of 1983, plaintiffs' subsequent adjustments were never appropriate.⁵⁰

Defendant based its position on a recoupment provision that provided that all capital cost adjustments allowed in the first three months of 1983 in connection with changes of ownership occurring during the last six months of 1982 were subject to recoupment under a six month formula. Therefore, the defendant maintained that the possibility of recovering the capital cost increases from the other providers placed all providers in the same position as the Hillhaven Corporation. The court noted, however, that the state, even if the recoupment were enforced, would only recover rate increases paid to other providers for the first three months of 1983, and this would not affect the increases paid to providers after that period. Therefore, the capital allowances adjustment received by other providers had a continuing (positive) effect on their reimbursement rates to date which the recoupment provision would not reverse. The court held that the different treatment accorded plaintiffs denied them equal protection of the laws. The defendant was ordered to recompute the plaintiffs' 1983 capital allowances for facilities acquired in 1982 and to use that recalculated allowance as the base rate for plaintiffs' current capital allowances.⁵¹

Defendant's contention that plaintiffs lacked standing to bring the suit because they operated their nursing homes through subsidiary corporations which were separate legal entities won only criticism by the court. The critical fact was that defendant's actions caused substantial monetary damage to the plaintiffs' corporation itself.⁵²

On the other hand, the Minnesota Court of Appeals in *Highland Chateau, Inc. v. Minnesota Department of Public Welfare*,⁵³ affirmed a summary judgment against a nursing home's equal protection challenge when the home attempted to circumvent Minnesota's equalization law by having a portion of its facility "decertified" from the Medicaid program. Under the equalization law, a limit was set on the amount by which private rates could exceed Medicaid reimbursement rates. The nursing home attempted to decertify a portion of the facility in order to charge higher rates to patients in the decertified portion of the facility.⁵⁴

Highland challenged the economic and social welfare classification created by the rate equalization laws as a violation of the equal protection clause. Highland contended that defendant's enforcement of the law sub-

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.* at para. 11,623.

⁵² *Id.* at para. 11,622-23 (relying on *Warth v. Seldin*, 422 U.S. 490, 498 (1975)).

⁵³ 356 N.W. 2d 804 (Minn. Ct. App. 1984), reported in *MEDICARE & MEDICAID GUIDE (CCH)* para. 34,200 (1984).

⁵⁴ *Id.* at para. 10,362.

jected nursing home residents to disparate treatment.⁵⁵ Specifically attacked was the discontinuance of a waiver policy which permitted noncomplying nursing homes to continue to be reimbursed for a period of time because there was a concern that patients would be uprooted if the home was required to comply immediately with the equalization law. When it became apparent that the waiver policy was preventing the equalization law from taking affect, the defendant discontinued the policy. Because an economic or social welfare classification can not be set aside under the equal protection clause unless it is shown to lack a rational or reasonable basis, no violation of the rights of the residents was found.⁵⁶ Effectively, the equalization law constituted an attempt to minimize disparate treatment of residents because of economic class.

A similar equal protection argument failed to sway the eighth circuit in the case of *Minnesota Association of Health Care v. Minnesota Department of Public Welfare*⁵⁷ which involved a challenge to the same equalization law. Under the rational basis test, the court found that the statute promoted the legitimate state interest of controlling rates charged by Medicaid participating homes to residents not receiving medical assistance.⁵⁸ Plaintiff argued that an inequity resulted because the statute was limited to nursing homes participating in the Medicaid program even though the rationale for the statute applied to other providers as well. The court noted that the rate discrepancy the statute was designed to check would not exist in nursing homes occupied only by private paying residents.⁵⁹ The Minnesota legislature could rationally have concluded that only discrepancies in charges by Medicaid participating nursing homes presented grave economic and personal harm to consumers and, therefore, only this class required regulation. A state legislature may deal with the most serious aspects of a problem consistent with equal protection principles, and it may select only one phase of a business activity to regulate and neglect all others.⁶⁰ Thus, the eighth circuit held that the classifications were neither invidious nor arbitrary and, hence, not violative of equal protection.⁶¹

In the same case, under a due process clause challenge, Minnesota Association of Health Care Facilities (MAHCF) contended that by limiting the rates charged to residents not receiving medical assistance, the Minnesota statute, together with an inadequate level of reimbursement to nursing homes for care of medical assistance recipients, deprived Minnesota nursing homes of substantive due process. This resulted in a taking of property without just compensation in violation of the Fifth and Fourteenth Amendments.⁶² In constructing the argument, MAHCF suggested

⁵⁵ *Id.* at para. 10,365.

⁵⁶ *Id.*

⁵⁷ 742 F.2d 442 (8th Cir. 1984).

⁵⁸ *Id.* at 447-48.

⁵⁹ *Id.*

⁶⁰ *Id.* at 448 (relying on *Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955)).

⁶¹ *Id.*

⁶² *Id.* at 446 (relying on *Bluefield Water Works & Improvement Co. v. Public Service Comm'n*, 262 U.S. 679, 690 (1923)).

that the court treat nursing homes and public utilities similarly with respect to state rate regulation. Public utility rates which are not sufficient to yield a reasonable return on the value of the property used have been held to be a deprivation of a utility company's property.⁶³ The eighth circuit distinguished nursing homes from public utility companies and declined to apply the public utility standard to the case. Nursing homes, unlike utility companies, have the freedom to decide whether to remain in business, and any participation in a Medicaid program is voluntary. The court reasoned that this voluntariness effectively foreclosed the possibility that the statute could result in an imposed taking of private property, giving rise to a constitutional right of just compensation.⁶⁴ Similarly, in the *Highland* case, the fact that medical assistance participation was voluntary, foreclosed the possibility of a due process violation.⁶⁵

In both the *Highland* case and the *MAHCF* case, plaintiffs argued that the Minnesota Statute § 256B.48(1)(a) impaired the obligation of the contracts clause in violation of Art. I, § 10 of the United States Constitution by making compliance with its terms a condition of Medicaid participation. The gist of the argument in both cases was that the statute altered the terms of agreements reached with private residents by limiting rates a nursing home could charge non-Medicaid patients. The eighth circuit applied the three part test of *Energy Reserves Group, Inc. v. Karras Power and Light Co.*,⁶⁶ and concluded that even if the impairment of the contract was substantial, the state's interest in controlling rates charged by nursing homes provided a legitimate public purpose for the statute. Ensuring that state subsidy of medical assistance residents did not work to the detriment of private paying residents was a legitimate exercise of police power. Therefore, prospective application of the statute was constitutional.⁶⁷

However, the portion of the statute which retroactively required restitution of charges in excess of a differential was held invalid in the *MAHCF* case because it caused a substantial impairment of contracts.⁶⁸ The rates charged were not unlawful at the time they were collected, and nursing homes could reasonably have expected that they were entitled to these funds. In addition, this part of the statute had a considerably narrower focus and was found to disrupt settled and completed financial arrangements.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ MEDICARE & MEDICAID GUIDE (CCH) para. 34,200 (1984).

⁶⁶ 459 U.S. 400, 410 (1983) (The test to determine whether a law has unconstitutionally impaired a contract is: (1) whether the impairment is substantial; (2) whether the challenged regulation promotes a significant and legitimate public purpose; and (3) whether the regulation is a reasonable exercise of the State's police power); see also MEDICARE & MEDICAID GUIDE (CCH) para. 34,200 (1984); see also *Minn. Ass'n of Health Care v. Minn. Dept. of Public Welfare*, 742 F.2d 442, 449 (8th Cir. 1984).

⁶⁷ MEDICARE & MEDICAID GUIDE (CCH) para 34,200 (1984); *Minn. Ass'n of Health Care*, 742 F.2d at 450.

⁶⁸ *Minn. Ass'n of Health Care*, 742 F.2d at 451.

C. Eleventh Amendment as a Bar to Suit

The Eleventh Amendment has been interpreted as barring suits in federal court against a nonconsenting state brought by its own citizens, as well as those suits brought by citizens of another state.⁶⁹ The Supreme Court established a line of demarcation between suits which seek prospective injunctive relief and those which seek retroactive monetary awards. When a plaintiff sues a state official for a violation of federal law, a federal court may award injunctive relief which governs the future conduct of state officials but not retroactive monetary damages.⁷⁰ The court's reasoning is that prospective relief is a remedy designed to end a continuing violation of federal law and is necessary to vindicate federal interest in assuring the supremacy of that law. But compensatory or deterrence interests are insufficient to overcome the dictates of the Eleventh Amendment.⁷¹

The states generally will assert that the suit is barred by the Eleventh Amendment if the relief sought is retroactive in nature. However, the sovereign immunity afforded by the amendment is not absolute.⁷² If a state waives immunity and consents to suit "by most express language or by such overwhelming implications from the text as leave no room for any other reasonable construction," the Eleventh Amendment bar is removed.⁷³

In the *Amisub* case,⁷⁴ the tenth circuit dismissed the state as a named defendant in the suit. The state's silence on the issue of waiver and participation in the suit did not constitute an "effective waiver" under the *Edelman* standard.⁷⁵ Under *Atascadero State Hospital v. Scanlon*,⁷⁶ Congress must express its intention to abrogate the Eleventh Amendment in "unmistakable language" in the statute itself. The tenth circuit found no such language within the Medicaid Act.

Although defendants will generally try to characterize all requested relief as retroactive in nature, the court may nonetheless grant relief if it finds plaintiff's request not entirely retroactive. In the *Reivitz* case,⁷⁷ a question arose as to whether the state's legal obligation to reimburse the plaintiff hospital for services rendered, accrued upon the services performed or upon final settlement. If the legal obligation did not accrue

⁶⁹ *Edelman v. Jordan*, 415 U.S. 651, 662-63 (1974).

⁷⁰ *Id.* at 678; *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984) (reaffirming the holding of *Edelman*).

⁷¹ See *Green v. Mansour*, 474 U.S. 64, 68 (1985).

⁷² See *Amisub (PSL), Inc. v. State of Colo. DSS*, 879 F.2d 789, 792 (10th Cir. 1989).

⁷³ 415 U.S. at 673 (quoting *Murray v. Wilson Distilling Co.*, 213 U.S. 151, 171 (1909)).

⁷⁴ *Amisub*, 879 F.2d at 792.

⁷⁵ 415 U.S. 651 (1974).

⁷⁶ 473 U.S. 234, 243 (1985).

⁷⁷ 630 F. Supp. 1015 (E.D. Wis. 1986).

until final settlement (as of yet unperformed), the Eleventh Amendment did not bar recovery. The court found that the incurrence of the legal obligation was the pertinent event, not its subsequent transformation at final settlement into a finite sum.⁷⁸ Based on *Daubert v. Percy*,⁷⁹ the district court determined that the Eleventh Amendment should not preclude recovery of monetary relief for funds unpaid because of the freeze. The court held that the Eleventh Amendment barred recovery only up to the date when defendants were enjoined from implementing the freeze.⁸⁰ If the seventh circuit had upheld the district court's prior decision to enjoin the freeze, the relief requested would have been prospective in nature.⁸¹

A similar Eleventh Amendment argument was presented in the *Hillhaven* case.⁸² The issue was whether an order invalidating the rate freeze constituted retroactive relief barred under the Eleventh Amendment as interpreted in *Edelman*, or whether such relief was designed to end a continuing violation of federal law and, thus, prospective in nature as interpreted in *Green v. Mansour*.⁸³ The plaintiff argued that the holding of *Daubert* should control. A 1983 injunction placed the state on notice that the three month freeze was enacted in violation of federal law and that the state would in all likelihood be required to reimburse plaintiff based on an increased capital allowance. The court distinguished the *Daubert* and *Reivitz* cases from the case at bar because in those cases the state either knew what the anticipated payments would be or the payments were ascertainable and spanned a limited time period.⁸⁴ The state, in *Hillhaven*, however, had no way to determine the additional reimbursement payments for which it might be held liable.⁸⁵ The state had never determined with certainty what capital allowance adjustment the plaintiff would be entitled to or what formula to use in its calculation.⁸⁶ Thus, although plaintiff's requested relief was found to be not entirely retrospective in nature, award of monetary damages was denied.⁸⁷ The court stated that such an award would exceed the *Daubert* rule and violate the Eleventh Amendment.

⁷⁸ *Id.* at 1020.

⁷⁹ 713 F.2d 328, 329-30 (7th Cir. 1983). In *Daubert*, funds should have been paid to the plaintiff pursuant to a prospective injunction but were withheld because the injunction was erroneously modified. The seventh circuit affirmed the district court's ruling that these funds were not retroactive in nature, and thus the award was not barred by the Eleventh Amendment. *Id.*

⁸⁰ *See Id.*

⁸¹ *Id.* at 1021. Due to particular facts of the *Reivitz* case, plaintiffs did not recover any monetary damages because the freeze affected a period preceding the court's order and not thereafter.

⁸² MEDICARE & MEDICAID GUIDE (CCH) para. 35,498 (1986).

⁸³ *See* 415 U.S. 651, 662-63 (1974); *Green v. Mansour*, 474 U.S. 64 (1985) (claim seeking declaration that an official's prior conduct in violation of federal law was retroactive relief barred by the Eleventh Amendment).

⁸⁴ *Hillhaven Corp. v. Wis. Dept. of Health and Social Services*, No. 83-C-0016, slip op. (E.D. Wis. May 7, 1986) reported in MEDICARE & MEDICAID GUIDE (CCH) para. 35, 498 (1986).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

An Eleventh Amendment defense will not religiously foreclose recovery of retroactive funds. Providers may in some cases be successful in recovering funds retroactively in a state forum.⁸⁸ Also, an Eleventh Amendment defense may not completely defeat a jurisdiction where a preliminary injunction or temporary restraining order is sought.⁸⁹

III. PROVIDERS' CHALLENGES UNDER THE FEDERAL STANDARD

A. Zone of Reasonableness

The Boren Amendment requires that reimbursement plans be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities."⁹⁰ The Supreme Court, in the context of utility rate setting, supports a "zone of reasonableness" doctrine in interpreting the statutory reasonableness standard:

[t]here is no single cost-recovery rate, but a zone of reasonableness: statutory reasonableness is an abstract quality represented by an area rather than a pinpoint. It allows a substantial spread between what is unreasonable because too low and what is unreasonable because too high.⁹¹

Consequently, in the *Reivitz* case, the seventh circuit, though limited by an inadequate record on review, predicted that Wisconsin's rate increase and resulting rates as modified by a limited three month freeze would have fallen within a zone of reasonableness and adequacy.⁹² Thus, in asserting a challenge to a rates adequacy and reasonableness, a provider must establish its substantial negative impact.

B. Federal Court Standard of Review

In review of state Medicaid plans, the federal courts must determine whether the plan is procedurally and substantively in compliance with

⁸⁸ See *Coalition of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 464 (E.D. Mich. 1982); see *Hillhaven Corp. v. Wis. DHSS*, 733 F.2d 1224, 1226 (7th Cir. 1984) (Wisconsin state Medicaid plan provided an appeals mechanism by which plaintiff could recover retroactive payment).

⁸⁹ J.L. HAMME & S.R. KANNER, *supra* note 27, at 99.

⁹⁰ 42 U.S.C. § 1396a(a)(13)(A) (1987).

⁹¹ *Federal Power Comm'n v. Conway Corp.*, 426 U.S. 271 (1976) (relying on *Montana-Dakota Utilities Co. v. Northwestern Public Serv. Co.*, 341 U.S. 246 (1951)).

⁹² 733 F.2d 1226, 1233 (despite probable "reasonableness and adequacy," the freeze was held to violate federal regulations because the state failed to submit assurances and comply with public notice requirements).

the federal Medicaid Act and its implementing regulations. The tenth circuit in the *Amisub* case explained that the court must not limit its analysis to whether the nonadjudicatory agency findings are arbitrary and capricious.⁹³ The first step in the analysis is to determine whether payment under the plan resulted in noncompliance with federal statute and regulations. This issue is subject to *de novo* review in federal court and no deference is accorded the state agency's determination of compliance with federal law. Once the requirements have been met, the court must defer to the state agency unless it has acted arbitrarily and capriciously.

In contrast, the third circuit's ruling on the substantive scope of review in regards to the adequacy of rates stressed a deferential approach in its use of the "arbitrary and capricious" standard to determine whether federal statutory requirements have been met.⁹⁴

We believe that this scheme also contemplates deferential standard of review by the courts in assessing compliance with the 'reasonable and adequate' requirement of section 1396a(a)(13)(A). Applying a higher standard would run counter to the congressional intent that states be accorded considerable freedom in pursuing ways of limiting Medicaid costs and encouraging efficiency.⁹⁵

Even under this narrow scope of review the court invalidated Pennsylvania's Medicaid reimbursement methodology for out-of-state hospitals because the state agency was unable to demonstrate a rational basis for its differing treatment of the hospitals.⁹⁶

C. Submission of Balanced Assurances and Findings by the State

Procedural claims may be raised by providers if the state, when changing its Medicaid rate methodology, either failed to submit a plan amendment to HCFA or sought to implement the plan earlier than permitted under federal regulations.⁹⁷ The state agency is required to submit adequate assurances and related information to the federal government when

⁹³ *Amisub (PSL), Inc. v. Colo. DSS*, 879 F.2d 789, 795-96 (10th Cir. 1989); see also *Colo. Health Care Ass'n v. Colo. DSS*, 842 F.2d 1158, 1165 (10th Cir. 1988).

⁹⁴ See *W. Va. Univ. Hosp., Inc. v. Casey*, 701 F. Supp. 496 (M.D. Pa. 1988), *aff'd in part and rev'd in part*, 885 F.2d 11 (3d Cir. 1989), *pet. for cert. pending*, 58 U.S.L.W. 3430 (U.S. Dec. 22, 1989) (No. 89-994).

⁹⁵ *W. Va. Univ. Hosp.*, 885 F.2d 11 at 23-24.

⁹⁶ *Id.* at 29.

⁹⁷ See 42 C.F.R. § 447.256(c)(1987); see 45 C.F.R. §§ 201.3, 205.5 (1989); see *Wis. Hosp. Ass'n v. Reivitz*, No. 82-C-1055, slip op. (E.D. Wis. Jan. 11, 1983), reported in [1983 Transfer Binder] *MEDICARE & MEDICAID GUIDE (CCH)* para. 32,380, *rev'd and remanded*, 733 F.2d 1226 (7th Cir. 1984), *opinion on remand*, 630 F. Supp. 1015, 1021-23 (E.D. Wis. 1986), *aff'd in part, vacated in part and remanded*, 820 F.2d 863, 868-69 (7th Cir. 1987).

seeking to amend its rate methodology.⁹⁸

In *California Hospital Association v. Schweiker*,⁹⁹ assurances given by the state with respect to the reasonableness and adequacy of the proposed rates were not based on a balanced objective view of the data. Instead, the state based the findings on a best case scenario, considering only those factors favorable to the State Plan Amendment and intentionally excluding and failing to consider equally relevant unfavorable factors. Implementation of the plan was permanently enjoined until the State Department of Health Services could consider all relevant factors to determine whether the reasonableness standard was met.

In *Nebraska Health Care Association v. Dunning*,¹⁰⁰ the claim was that the underlying data base provided inadequate support for the state's assurances, and that the state failed to perform the objective studies necessary for reasoned rate-making. The state had assured HCFA of nursing home payment at the 65th percentile ranking of nursing homes' allowable costs.¹⁰¹ The law, however, imposed a 3.75 percent limit on increases in payment, making this assurance impossible to implement.¹⁰² Payment would be below the 65th percentile (rate deemed sufficient by HCFA to enable efficiently run facilities to participate in Medicaid) and would force facilities to reduce their services to Medicaid patients.¹⁰³ The failure of the state to satisfy the requirements of federal regulations when the plan was submitted was a sufficient basis for the eighth circuit to affirm the district court's judgment enjoining the plan.¹⁰⁴

A recent decision, *Pinnacle Nursing Home v. Axelrod*, suggests that the courts may be leaning towards a stricter review of state assurances.¹⁰⁵ In this case, the district court of New York compared the federal regulations governing submission of assurances (42 C.F.R. § 447.253(b)) with New York state's assurances and concluded that "[t]he assurances are patently and painfully insufficient, constituting nothing more than a formalistic recitation of the federally mandated requirements of the Medicaid Plan."¹⁰⁶ The court invalidated New York's 1987 amendment to the plan due to the procedural insufficiency of the agency's findings and assurance.¹⁰⁷

⁹⁸ See 42 C.F.R. §§ 447.250-.272 (1987). (The State Medicaid Agency must engage in a "finding" process that all federal requirements have been met to substantiate assurances. It must also supply HCFA with "assurances" that all federal requirements have been met, including the "efficiency and economy" requirement.)

⁹⁹ 559 F. Supp. 110, 117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

¹⁰⁰ No. CV82-L-472 (D. Neb. July 9, 1984), *reported in* [1984-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) para. 34, 100 (D. Neb.), *aff'd in part and vacated in part on other grounds*, 778 F.2d 1291, 1296 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ MEDICARE & MEDICAID GUIDE (CCH) para. 34,100.

¹⁰⁴ 778 F.2d at 1294.

¹⁰⁵ 719 F. Supp. 1173 (W.D.N.Y. 1989).

¹⁰⁶ *Id.* at 1179-89.

¹⁰⁷ *Id.*; see also J.L. HAMME, *Long-Term Care Reimbursement Issues*, in 1990 HEALTH LAW HANDBOOK (1990).

D. Effect of the State Plan on the Quality of Patient Care and Access to Services

A crucial factor in challenging a state rate reduction is its adverse impact on the quality of care and/or patient access to services. Pertinent support for the challenge may be provided by evidence that the rates cause grave financial loss to the facility, resulting in curtailment of services to patients.¹⁰⁸ Also of significance is whether the altered rates result in a greater degree of private patient subsidization of Medicaid patients or a decrease in acceptance of Medicaid patients to the facility.¹⁰⁹

In *Cascade County Convalescent Nursing Home v. Department of Social and Rehabilitation Services*,¹¹⁰ the court considered four factors in determining whether the plaintiffs would suffer irreparable harm if a preliminary injunction were not issued. First, plaintiffs needed to show that facilities were required to reduce nurses aids and housekeeping staff with a resulting increase in patient falls.¹¹¹ Second, that a reduction in staff levels would violate licensure and certification requirements and would cause a freeze of admission levels and close of certain floors.¹¹² Third, that private pay rates would have to be increased to compensate for decreased Medicaid rates.¹¹³ Finally, the plaintiffs needed to show that fixed contractual obligations would be affected.¹¹⁴ Harm to patients resulting from the reduction also tipped the balance of hardship strongly in plaintiffs' favor. The court granted the preliminary injunction concluding that public interest could only be served so long as facilities received a level of reimbursement sufficient to render adequate care to patients.¹¹⁵

E. Compliance of Overall Medicaid Rate with Federal Standard

Some cases have suggested that the main issue in Boren Amendment litigation is whether the overall Medicaid rate, rather than an isolated component of the rate, is reasonable and adequate to reimburse the costs of efficiently and economically operated facilities. In *Colorado Health Care*

¹⁰⁸ J. L. HAMME & S.R. KANNER, *supra* note 27, at 102-03.

¹⁰⁹ *Id.*

¹¹⁰ No. CDV-83-867, slip op. (8th Jud. D. Mont. Aug. 30, 1984), reported in [1986 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) para. 34, 810.

¹¹¹ *Id.* at para. 9075-78; see also *Neb. Health Care Ass'n v. Dunning*, 578 F. Supp. 543, 545 (D. Neb. 1983) (preliminary injunction granted when "threat of irreparable harm is genuine" because the rate reduction was found to result in the inability of providers to furnish the "nature of services contemplated by the federal program").

¹¹² *Cascade County Convalescent Nursing Home v. Dept. of Social and Rehabilitation Serv.*, No. CDV-83-867, slip op. (8th Jud. D. Mont. Aug. 30, 1984), reported in [1986 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) para. 34,810.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ [1986 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) para. 34,810.

Association v. Colorado Department of Social Services, the tenth circuit held that the state can terminate one component of reimbursement even if only for budgetary reasons, as long as the overall payment complies with statutory requirements.¹¹⁶ The central issue in this case was whether the state's decision to eliminate payment of an incentive allowance resulted in a violation of the Medicaid standards.¹¹⁷ Under Colorado's plan, if a nursing home's actual costs were below the ninetieth percentile, an incentive allowance was added to the reimbursement rate.¹¹⁸ The state eliminated the incentive payment plan because of a projected \$24 million shortage in Medicaid funds. Appellant providers argued that the district court dismissed the case in error because the eliminated incentive factor resulted in a reduction in providers' overall payment effectuated solely for budgetary concerns.¹¹⁹ Therefore, the incentive factor was unlawful despite the Secretary's approval of the state's action.¹²⁰ The court found that the state had considered relevant factors including some forty different options for cutting program costs so that a rational relation existed between the factors and the state's conclusion that the incentive payment should be terminated. The argument that the state is precluded from reducing payments solely on the basis of budgetary appropriations has been rejected by the courts.¹²¹ The elimination of the incentive factor resulted in payment based on allowable costs incurred, limited only by the ninetieth percentile ceiling. As the courts have found rates below the ninetieth percentile to be in compliance with federal standards, the tenth circuit found no basis for holding that the ninetieth percentile ceiling violated statutory requirements and affirmed the district court's dismissal.¹²²

In contrast to the scenario in *Colorado Health Care Association (CHCA)*, when a state agency bases its findings solely on budgetary constraints, as in the *Amisub (PSL)* case, the court is likely to find no reasonable basis for assurances made to the HCFA.¹²³ In *Amisub (PSL)*, the tenth circuit distinguished its prior position in the CHCA case by noting that

¹¹⁶ 842 F.2d 1158 (10th Cir. 1988); see also *Wis. Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1233 (7th Cir. 1984), *opinion on remand*, 630 F. Supp. 1015 (E.D. Wis. 1986), *aff'd in part, vacated in part & remanded*, 820 F.2d 863 (7th Cir. 1987) (prior Medicaid reimbursement rate is not per se the only reasonable and adequate rate).

¹¹⁷ *Colo. Health Care Ass'n v. Colo. DSS*, 842 F.2d 1158 (10th Cir. 1988).

¹¹⁸ *Id.* at 1162. Reimbursement was calculated as follows: Actual costs (limited by statute) + incentive allowance (if actual cost below ninetieth percentile) + inflation factor (based on consumer price index) = PPD (*Per Patient* rate paid *Daily* to service provider). *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Coalition of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 463 (E.D. Mich. 1982).

¹²² See *Miss. Hosp. Ass'n v. Heckler*, 701 F.2d 511, 517-18 (5th Cir. 1983) (eighth percentile); cf. *Neb. Health Care Ass'n v. Dunning*, No. CV 82-L-472, slip op. (D.C. Neb. July 4, 1984) (sixty-fifth percentile in compliance until state subsequently imposed pro rata cut).

¹²³ *Amisub (PSL), Inc. v. Colo. DSS*, 879 F.2d 789, 800-01 (10th Cir. 1989).

CHCA had considered elements in addition to budget constraints in its decision to eliminate incentive payments, including forty cost cutting options, relevant cost and data factors, and the "efficient and economic" standard.¹²⁴ While a state agency is entitled to rely on budget constraints in setting payment rates, these alone are never a sufficient basis upon which to amend a current plan, implement a new plan, or make annual mandatory findings.¹²⁵ In *Amisub*, appellants' contention was that payment rates were arbitrary and capricious as a result of the application of a budget adjustment factor (BAF). Although applicants of the factor resulting in a forty-six percent reduction in provider reimbursement was held to violate Medicaid law, the tenth circuit was careful to caution against foreclosing its future use. "[S]o long as the resulting [overall] provider rates comply with federal law," use of a BAF is not prohibited under this decision.¹²⁶

F. Providers' Right to Sue Under 42 U.S.C. § 1983

Section 1983 provides a remedy under color of state law for deprivation of "any rights . . . secured by the Constitution and laws."¹²⁷ The Supreme Court interpreted this language in the case of *Maine v. Thiboutot*¹²⁸ as referring not only to equal rights laws and constitutional violations, but generally to all federal statutory law. One of the chief defenses brought in Boren Amendment litigation is that a provider may not maintain a private right of action against a state official under 42 U.S.C. § 1983. The Supreme Court has granted *certiorari* in *Virginia Hospital Association v. Bailes*, to decide the question of whether providers may use Section 1983 to enforce reimbursement provisions of the Medicaid Act against state officials.¹²⁹ A Supreme Court ruling in *Virginia Hospital* that providers lack a private means of enforcing reimbursement provisions against state officials would severely limit enforcement of the Boren Amendment through private suits in federal court although judicial review of state administrative proceedings would remain available.¹³⁰ Absent the right of providers to bring suit, a federal court could not issue retroactive damages against a state because of the Eleventh Amendment bar.¹³¹

However, the third, fourth and tenth circuits,¹³² under similar analyses,

¹²⁴ *Id.* at 800.

¹²⁵ *Id.* at 800-01.

¹²⁶ *Id.* at 801.

¹²⁷ 42 U.S.C. § 1983 (1982).

¹²⁸ 448 U.S. 1 (1980).

¹²⁹ 868 F.2d 653 (4th Cir. 1989), *cert. granted*, 110 S. Ct. 49 (1989).

¹³⁰ See J.L. HAMME, *supra* note 107.

¹³¹ See prior discussion in section II C of text.

¹³² *W. Va. Univ. Hosp., Inc. v. Casey*, 701 F. Supp. 496 (M.D. Pa. 1988), *aff'd in part and rev'd in part*, 885 F.2d 11 (3d Cir. 1989); *cert. granted*, 110 S. Ct. 1294 (1990); *Va. Hospital*, 868 F.2d at 653; *Amisub (PSL), Inc. v. Colo. DSS*, 879 F.2d 789 (10th Cir. 1989) (in complete accord with the analysis used by the fourth circuit); *Coos Bay Care Center v. Or.*, 803 F.2d 1060 (9th Cir. 1986), *cert. granted* 481 U.S. 1036 (1987), *vacated as moot*, 484 U.S. 806 (1987) (allowed health providers to challenge state medicaid plans under section 1983 because they considered the interests of health providers and medicaid patients to be "parallel.").

have held that providers have a right of action under Section 1983. For example, under the analysis of the third circuit in the *West Virginia University Hospital*, the first inquiry is whether the Medicaid Act creates a private right in favor of hospitals participating in a state's medicaid program. In reviewing the language, purpose, and legislative history of 42 U.S.C. § 1396a(a)(13)(A), the court found that the language of the statute is "cast in the imperative" and "succinctly sets forth a congressional command . . . in the direction of providing appropriate reimbursement of hospitals treating medicaid patients."¹³³ "We believe that Congress's concern with appropriate hospital remedies implies an intent to supply hospitals with an indispensable right to enforce state compliance with federal standards."¹³⁴ The court concluded that the beneficiaries of Section 1983 are hospital providers who have an enforceable private right.

The second concern was whether the Medicaid statute reflected a congressional intent to foreclose private enforcement. Title XIX gives no indication that the cut-off of funds to the federal agency is intended to supplant a Section 1983 remedy. The third circuit held that the remedial devices contained in the Medicaid Act do not reflect an intent to prohibit private enforcement of the Boren Amendment.¹³⁵ The states have not been very successful in challenging this issue.

IV. CONCLUSION

A provider's challenge to a state reimbursement plan or rates may be premised on procedural or substantive grounds. Under a successful constitutional challenge, the claim is generally of substantive noncompliance of the state plan with the federal criteria of "reasonable and adequate", as well as a procedural noncompliance (for example, lack of public notice, failure to submit adequate assurances). Claims invoking the Equal Protection Clause frequently pursue a complaint of disparate treatment based on an economic or social welfare classification. Because state plan equalization laws are commonly enacted to promote a legitimate state interest in controlling rates charged by Medicaid participating homes to private paying residents, an equal protection claim under these laws is not likely to succeed, unless bolstered by a showing of a decrease in the quality of patient care or access to services.

Procedural claims based on the inadequacy of assurances or findings are successful when it can be shown that the state based its assurance on an intentionally imbalanced interpretation of the data or upon insufficient findings. Recent decisions indicate the courts may be heading for a stricter review of state assurances than in the past. Attacks targeted against reduction of an isolated component of a rate have not generally

¹³³ *W. Va. Univ. Hosp.*, 885 F.2d at 20.

¹³⁴ *Id.* at 21.

¹³⁵ *Id.* at 22.

been successful. The courts base a determination as to the “reasonableness and adequacy” of a rate on the total reimbursement rather than an isolated component. Under a tenth circuit ruling, the state agency may rely on budget constraints in setting its payment rates, but they alone will not be a sufficient basis upon which to amend a current plan, implement a new plan, or make annual mandatory findings. Although the federal circuits have held that 42 U.S.C. Section 1983 confers providers a right to sue state officials, an upcoming Supreme Court decision will determine whether providers have a private right to enforce the reimbursement provisions of the Boren Amendment in federal court. The States, to date unsuccessful in challenging this issue, are hoping that the Supreme Court will bail them out with a ruling adverse to the providers.

